

Ectopic Pregnancy and Catholic Morality

A Response to Recent Arguments in Favor of Salpingostomy and Methotrexate

Marie A. Anderson, Robert L. Fastiggi,
David E. Hargroder, Rev. Joseph C. Howard Jr.,
and C. Ward Kischer

Abstract. Respected Catholic ethicists, namely, William E. May, Christopher Kaczor, and Rev. Martin Rhonheimer, have recently defended methods for managing ectopic pregnancies, such as the use of salpingostomy and methotrexate, that very few Catholic moralists previously endorsed. This article examines the arguments for the revised assessments to determine whether there are sound reasons to believe that these two methods do not constitute the direct and immediate killing of innocent human beings. *National Catholic Bioethics Quarterly* 11.1 (Spring 2011): 000–000.

The moral debate regarding ectopic pregnancies has increased in recent years. Respected Catholic ethicists, namely, William E. May, Christopher Kaczor, and Rev. Martin Rhonheimer, have begun defending the use of methods for managing

Marie A. Anderson, MD, FACOG, is an obstetrician and gynecologist in private practice in northern Virginia. Robert L. Fastiggi, PhD, is a professor of systematic theology at Sacred Heart Major Seminary in Detroit. David E. Hargroder, MD, is a former transplant surgeon who now practices general, bariatric, and trauma surgery in Joplin, Missouri. Rev. Joseph C. Howard Jr., is a Catholic priest and a graduate student in moral theology and bioethics at the Catholic University of America in Washington, D.C. C. Ward Kischer, PhD, is professor emeritus of human embryology at the University of Arizona College of Medicine in Tucson. Address correspondence to Fr. Howard at frjosephhoward@yahoo.com.

ectopic pregnancies, such as salpingostomy and methotrexate, that very few Catholic moralists previously endorsed.¹ What has led to this change? Are the arguments advanced for this revised assessment convincing? These are the principal questions this article seeks to address.

The Medical Aspects of Ectopic Pregnancy

The word *ectopic* literally means “out of place,” from the Greek *ek* (“out of”) and *topos* (“place”). An ectopic pregnancy can be defined as “one in which the human embryo does not implant in the endometrium (lining of the uterus), which is the normal site of implantation. Instead, the embryo implants somewhere outside of the endometrial cavity, such as the fallopian tube, cervix, ovary, or in the abdominal or pelvic cavity.”² Between 1970 and 1992, cases of ectopic pregnancies in the United States increased 600 percent.³ In 1970, ectopic pregnancies occurred in about 4.5 per thousand pregnancies, but by 1992 this rate had risen to 19.7 per thousand pregnancies.⁴ The associated mortality has decreased markedly, to 0.5 deaths per thousand pregnancies, mainly because of early diagnosis and treatment before rupture. Nevertheless, ruptured ectopic pregnancies continue to account for 6 percent of all maternal deaths.⁵

¹ Compare William E. May’s treatment of the management of ectopic pregnancies in his *Catholic Bioethics and the Gift of Life* (Huntington, IN: Our Sunday Visitor, 2000), 182–186, with his treatment of the same topic in the book’s second edition (2008), 199–202. In the first edition, May rejects salpingostomy and methotrexate as means for managing ectopic pregnancies, whereas in the second edition he defends them. Unless otherwise specified, subsequent citations to May’s *Catholic Bioethics* are to the first edition. Christopher Kaczor and Janet E. Smith note that only a “minority of faithful theologians argue that salpingostomy, the procedure that removes the embryo but keeps the tube intact, does not involve a direct attack on the embryonic human being.” In the same book, the authors also note that only “a very small minority of faithful theologians argue that methotrexate does not cause a direct abortion.” Janet E. Smith and Christopher Kaczor, *Life Issues, Medical Choices: Questions and Answers for Catholics* (Cincinnati, OH: Servant Books, 2007), 55. In a later article, however, Kaczor argues for the moral acceptance of the use of both salpingostomy and methotrexate in resolving ectopic pregnancies. Kaczor, “The Ethics of Ectopic Pregnancy: A Critical Reconsideration of Salpingostomy and Methotrexate,” *Linacre Quarterly* 76.3 (August 2009): 265–282. For Rhonheimer’s defense of salpingostomy and methotrexate, see *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies* (Washington, DC: Catholic University of America Press, 2009), 90–119.

²Peter J. Cataldo, “Ectopic Pregnancy,” in *New Catholic Encyclopedia: Supplement 2009*, ed. Robert L. Fastiggi (Farmington Hills, MI: Gale Cengage Learning, 2009), 253.

³Eugene F. Diamond, *A Catholic Guide to Medical Ethics: Catholic Principles in Clinical Practice* (Palos Park, IL: Linacre Institute, 2001), 15.

⁴*Ibid.*

⁵Sally F. Dorfman, “Deaths from Ectopic Pregnancy, United States, 1979 to 1980,” *Obstetrics and Gynecology* 62.3 (September 1983): 334–338.

What has led to the increased rate of ectopic pregnancies? Many researchers point to the rise of sexually transmitted diseases, the use of certain forms of reproductive technology (e.g., in vitro fertilization), and other risk factors such as drug use, smoking and stress.⁶ Likewise, sexual promiscuity has led to an increase in pelvic inflammatory disease, which contributes to the higher incidence of ectopic pregnancy.⁷ Other contributing factors are “an age over 35 years and many lifetime sexual partners.”⁸ Various forms of contraception, such as intrauterine devices and progesterone contraceptive pills, as well as tubal ligations, are also cited as factors.⁹ It can be argued that rise in ectopic pregnancies is linked to behaviors that violate the divine and natural law.¹⁰

Most ectopic pregnancies occur in the fallopian tubes, and less than 10 percent occur in other locations, such as the ovary or the cervix.¹¹ Women who have had one prior ectopic pregnancy have a 10 percent risk of having another, and women who have had two or more have a 25 percent risk of having another.¹² Some studies suggest that up to 70 percent of all ectopic pregnancies resolve themselves spontaneously;¹³ others put the percentage closer to 64 percent,¹⁴ and still others between 40 and 64 percent.¹⁵ Some physicians warn against relying on expectant management (watchful waiting and close monitoring instead of immediate treatment) because of the potential risk of tubal rupture,¹⁶ and others maintain that “more than three-quarters of women who are diagnosed with ectopic pregnancies are not candidates for medical or expectant management.”¹⁷

Diagnosing an ectopic pregnancy and then determining whether the unborn child is alive can be difficult. The diagnosis of an ectopic pregnancy begins by excluding a normal intrauterine pregnancy. For a gestation of more than five and a half weeks, an intrauterine pregnancy can be identified with nearly 100 percent

⁶ See Cataldo, “Ectopic Pregnancy,” 253; and Diamond, *Catholic Guide to Medical Ethics*, 15.

⁷ Diamond, *Catholic Guide to Medical Ethics*, 15.

⁸ Kurt T. Barnhart, “Ectopic Pregnancy,” *New England Journal of Medicine* 361.4 (July 23, 2009): 379.

⁹ See May, *Catholic Bioethics*, 182; and John A. Rock, “Ectopic Pregnancy,” in *Telinde’s Operative Gynecology* (Philadelphia: J. B. Lippincott, 1992), 412–414.

¹⁰ This is not to suggest that all women who have ectopic pregnancies are morally culpable. It is, instead, a simple observation that the tremendous increase in ectopic pregnancies is apparently linked with various forms of sexual behavior that are opposed to the divine and natural law.

¹¹ Barnhart, “Ectopic Pregnancy,” 379.

¹² *Ibid.*, 379–380.

¹³ *Ibid.*, 385.

¹⁴ May, *Catholic Bioethics*, 183.

¹⁵ Kaczor, “Ethics of Ectopic Pregnancy,” 266.

¹⁶ Barnhart, “Ectopic Pregnancy,” 385.

¹⁷ Cataldo, 253.

accuracy by transvaginal ultrasound findings, such as a gestational sac, yolk sac, fetal pole, and, later, cardiac motion (usually around six weeks).¹⁸

If evidence of intrauterine pregnancy is not seen, then serial quantitative levels of the glycoprotein beta-human chorionic gonadotropin (B-hCG) must be obtained to determine whether the pregnancy is healthy. In a healthy pregnancy, the B-hCG level rises 66 percent every two days.¹⁹ There is a correlation between the level of B-hCG and ultrasound findings. The “discriminatory cutoff” is that level of B-hCG at which evidence of intrauterine pregnancy must be seen on an ultrasound, and it ranges from 1,500 to 2,500 mIU/ml.²⁰ If no intrauterine pregnancy is visualized at this level of B-hCG, then an ectopic pregnancy must be suspected. Sometimes, ultrasound evidence of an ectopic pregnancy is visualized outside the uterus. If fetal cardiac activity is present, then the unborn child is alive even though he or she is in an ectopic location.

If cardiac activity is not seen, then the unborn child either has died or is too small to be visualized on ultrasound. In this case, following serial B-hCG levels is indicated. If the B-hCG level does not rise appropriately, then it can be assumed that the unborn child has died. If the unborn child is dead, then any acceptable medical or surgical treatment can be employed. If there is any doubt regarding the state of the unborn child, and the mother’s condition is stable, then tests should be repeated until clear evidence is obtained regarding whether the unborn child is alive.

In certain cases progesterone levels can be somewhat helpful, because a progesterone level of less than 5 ng/ml can rule out a normal pregnancy with almost 100 percent accuracy, but it does not show whether that pregnancy is an abnormal one in the uterus or at an ectopic site.²¹ Progesterone levels in the context of the other tests give one more opportunity for objective evidence to assess the well-being of the unborn child. This is important, because the next step in the usual diagnostic algorithm in the case of uncertainty is to evacuate the uterus, which constitutes a direct abortion if the unborn child is alive.

Methods for Managing Ectopic Pregnancies

The discovery of an ectopic pregnancy involves concerns of a medical, moral, and pastoral nature. Couples who desire to have children are faced with the likely death of their child. This is compounded by fears for the health and even the life of the mother. Catholic couples who wish to be faithful to the Church’s moral teaching are often given conflicting reports on what the Church does or does not allow, and many have genuine concerns about how various treatments might affect future fertility. Many medical professionals, unfortunately, are not aware of the moral

¹⁸ Beata Seeber and Kurt Barnhart, “Ectopic Pregnancy,” in *Danforth’s Obstetrics and Gynecology*, 10th ed., ed. Ronald S. Gibbs et al. (Philadelphia: Lippincott Williams and Wilkins, 2008), 74.

¹⁹ *Ibid.*, 75.

²⁰ *Ibid.*, 74.

²¹ *Ibid.*, 76

issues involved, and often their focus is on resolving “the problem” as quickly and as efficiently as possible.

The Traditional Catholic Evaluation of Methods for Treating Ectopic Pregnancies

Because most ectopic pregnancies are “tubal,” we will take this as the paradigm in discussing the issue. Traditionally, Catholic moralists have noted three categories of treatment: (1) expectant management; (2) surgical treatment, which includes partial salpingectomy (the removal of a portion of the fallopian tube), total salpingectomy (the removal of all of the affected fallopian tube), and salpingostomy (the extraction or removal of the embryo from the fallopian tube itself); and (3) drug therapy, which consists largely of using the drug methotrexate, which is an agent that interferes with the nucleic acid synthesis (DNA and RNA) of rapidly multiplying cells such as trophoblastic cells and also the blastomeres, the cells of the embryo proper which are also rapidly dividing by mitosis.²² As a known teratogen, methotrexate is highly toxic to embryonic tissue.²³ Its molecular mechanism of action is to inhibit the enzyme dihydrofolate reductase, which is essential for the replication of nucleic acids and, hence, dividing cells. This is why it was once used as an abortifacient.

Until recently, almost all Catholic ethicists accepted expectant therapy and salpingectomy (either partial or total) as morally permissible (salpingectomy under the principle of double effect). Almost all, however, rejected both salpingostomy and the administration of methotrexate as direct assaults on the innocent life of the human embryo and, therefore, indefensible.²⁴ Let us examine the moral reasoning involved in each of these therapies

Expectant Therapy

Expectant therapy for ectopic pregnancy is perfectly acceptable from a Catholic perspective. No direct or intended killing of the embryo is involved, and there is no moral problem unless the mother’s life is put unnecessarily at risk. To avoid such risk, careful monitoring is needed, which usually involves B-hCG testing and ultrasound imaging.²⁵ If it becomes clear that an ectopic pregnancy has not resolved spontaneously, then other forms of management are indicated. Because expectant

²²The trophoblast is a layer covering the blastocyst that erodes the uterine mucosa and through which the embryo receives nourishment from the mother. The trophoblast differentiates into an outer layer called the syncytiotrophoblast and an inner layer called the cytotrophoblast. The origin of the DNA within the cells of the trophoblast is the embryo—not the mother.

²³See D. Goffman et al., “Failed Methotrexate Termination of Pregnancy: A Case Report,” *Journal of Perinatology* 26.10 (October 2006): 645–647.

²⁴See May, *Catholic Bioethics*, 186, and Kelly Bowring, “The Moral Dilemma of Management Procedures for Ectopic Pregnancy,” in *Life and Learning*, vol. 12, *Proceedings of the Twelfth University Faculty for Life Conference at Ave Maria Law School 2002*, ed. Joseph W. Koterski (Washington, DC: University Faculty for Life), 97–126.

²⁵Kaczor, “Ethics of Ectopic Pregnancy,” 266.

therapy is morally acceptable, it should be recommended as an initial option until another means of resolving the ectopic pregnancy is clearly needed.

Salpingectomy

This surgical procedure involves removal of all (total) or some portion (partial) of the fallopian tube with the embryo inside it. It is morally acceptable under the principle of double effect, which requires the following five components: (1) The action, in itself, must be good or at least not morally evil. (2) The good effect cannot be obtained in some other way without harm or evil. (3) The good effect must not be the result of an evil means, or, to put it another way, the evil act cannot be the means for producing the good effect. (4) The evil effect is not willed but merely permitted. (5) There is a proportionate reason for performing the action.²⁶

Managing an ectopic pregnancy by means of a total or partial salpingectomy is morally acceptable, as shown by applying the principle of double effect. If an embryo continues to develop in the fallopian tube, rupture of the tube and possible death of the mother and the unborn child may result. When the fallopian tube (or a portion of it) is removed, the death of the unborn child is an unintended secondary effect. However, the removal of the tube containing the unborn child will end the mother's fertility if the opposite tube is occluded or surgically absent. This may be the risk the mother needs to take to avoid dying from a ruptured fallopian tube.

Salpingostomy

This procedure involves the removal of the embryo from the mother's tube while leaving the tube intact. Although this method usually does not involve the loss of the mother's fertility, it seeks to achieve a good end by an evil means, i.e., the direct killing of the human embryo. Although this procedure is morally acceptable if the embryo has already died, it does not appear to be acceptable if he or she is alive, because it involves the direct and intentional killing of an innocent human being.²⁷

The 1971 *Ethical and Religious Directives for Catholic Health Care Facilities* (ERDs) allowed for partial or total salpingectomy provided that "the operation is not just a separation of the embryo or fetus from its site ... (which would be a

²⁶ Adapted from Diamond, *Catholic Guide to Medical Ethics*, 17–18; and Joseph C. Howard Jr., "The Principle of Double Effect as Applied to the Maltese Conjoined Twins," *National Catholic Bioethics Quarterly* 9.1 (Spring 2009): 87.

²⁷ Some research indicates that, in cases of ectopic pregnancies, it often happens that both fallopian tubes are prone to ectopic pregnancies. The risk of recurrent ectopic pregnancy is related to both the underlying tubal disorder that led to the initial ectopic pregnancy and to the choice of treatment procedure. For example, a study of surgical and medical treatment of ectopic pregnancy reported the rates of recurrent ectopic pregnancy after single-dose methotrexate, salpingectomy, and linear salpingostomy as 8, 9.8, and 15.4 percent respectively among patients who attempted to conceive. See M. Yao and T. Tulandi, "Current Status of Surgical and Non-surgical Management of Ectopic Pregnancy," *Fertility and Sterility* 67.3 (March 1997): 421.

direct abortion from a uterine appendage).”²⁸ The 1994 and 2001 editions of the *ERDs* simplified this to one basic directive: “In the case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”²⁹ While salpingectomy does not involve a direct abortion, it would seem that salpingostomy does. In the first edition of *Catholic Bioethics and the Gift of Human Life* (2000), William E. May writes,

I similarly hold that managing ectopic pregnancies by the use of salpingostomy and methotrexate constitutes direct abortion, i.e., abortion as killing, inasmuch as these procedures are lethal and are performed on the body person of the unborn child; they are performed on it not for its good, but for the good of the mother; moreover, they are *not necessary* to save her life if this is jeopardized by the tubal pregnancy inasmuch as her life can be preserved by a salpingectomy, whether partial or complete, a procedure performed on the body of the mother, not the child, and one that is not itself a lethal invasion of the unborn *child's body person*.³⁰

This clear analysis seems to be in complete harmony with the *ERDs* of 1971, 1994, and 2001. Moreover, it corresponds to the traditional moral teachings of the Catholic Church.

Methotrexate

Methotrexate is a form of drug therapy for the management of the ectopic pregnancy. Up to 25 percent of women with unruptured tubes opt for the use of methotrexate in treating ectopic pregnancies,³¹ and there are indications that the actual percentage is much higher.³² Medical professionals who do not regard the embryo as a human person praise methotrexate because studies have shown its “success” rate to be as high as 93 percent. Methotrexate was first developed in the 1950s as a drug for the treatment of cancer.³³ Eugene Diamond, MD, explains that its effect, directed against rapidly replicating cells, is to interfere eventually with DNA synthesis. Its effects would be on the trophoblast—the early precursor of the placenta—which functions as the life-support system for the developing child as the embryo proper.³⁴

²⁸ Catholic Hospital Association, *Ethical and Religious Directives for Catholic Health Care Facilities* (St. Louis: CHA, 1971), n. 16, quoted in Bowring, “Moral Dilemma,” 18.

²⁹ National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, DC: NCCB, 1994), n. 28, quoted in Bowring, “Moral Dilemma,” 18. See also U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, DC: USCCB, 2001), n. 48. On the differences between the 1971 and 1994 *ERDs*, see Bowring, 18.

³⁰ May, *Catholic Bioethics*, 184, original emphasis.

³¹ Cataldo, “Ectopic Pregnancy,” 254.

³² Kaczor, “Ethics of Ectopic Pregnancy,” 272.

³³ Diamond, *Catholic Guide to Medical Ethics*, 18.

³⁴ *Ibid.*

This means that the actual cells of the embryo proper—blastomeres—are inhibited from dividing through mitosis.

Until recently, most Catholic moralists rejected the use of methotrexate because of its abortifacient effect and purpose. Of course, the administration of methotrexate would be moral if the embryo has already died, but most commonly it is used to destroy the life of the embryo. Some have argued that methotrexate is directed only against the trophoblastic tissue and not the life of the child, who dies as an indirect result of the medical treatment of the tissue.³⁵ This justification of the use of methotrexate ignores the fact that the trophoblastic tissue “is a vital organ of the unborn child.”³⁶ Charles Cavagnaro, MD, and others consider the administration of methotrexate for the resolution of ectopic pregnancies “a direct and lethal attack on the body of an unborn child.”³⁷

Christopher Kaczor’s Defense of Salpingostomy and the Use of Methotrexate

Kaczor’s defense of the use of both salpingostomy and methotrexate convinced May to change his positions on these treatments.³⁸ Careful consideration, therefore, must be given to Kaczor’s arguments.

Kaczor’s argument in favor of salpingostomy is based on the claim that the simple act of removing the embryo from the fallopian tube is not intrinsically evil, because such removal would be morally acceptable if the embryo could be moved to a safe haven, such as the uterus. For Kaczor, something cannot be intrinsically evil if certain circumstances could justify it. It might be circumstantially evil but not intrinsically evil.³⁹

Kaczor’s argument fails to take into account the totality of the moral object chosen in salpingostomy, however. The embryo is not being removed to transfer it to a place, such as the uterus, where it can continue living. Rather, the embryo is being removed from the tube with the knowledge that no attempt will be made to move the embryo to “a safe haven.” This changes the moral object completely, in spite of Kaczor’s claim that the killing is not intentional.

Circumstances and intention often specify whether the moral objects of two acts are good or bad when the physical acts are identical. For example, if we were in an operating room and saw a surgeon administer potassium chloride to induce cardiac cessation, we could not know simply by observing the physical act whether the surgeon was doing this to put the patient on a heart–lung machine and thus

³⁵ Albert Moraczewski, “Managing Tubal Pregnancies: Part I,” 21.6 (June 1996) and “Managing Tubal Pregnancies: Part II,” 21.8 (August 1996) *Ethics & Medics*.

³⁶ May, *Catholic Bioethics*, 185.

³⁷ May, *Catholic Bioethics*, 185, citing Charles E. Cavagnaro III, “Treating Ectopic Pregnancy: A Moral Analysis,” *NaProEthics Forum* 3.6 (November 1998).

³⁸ See May, *Catholic Bioethics*, 2nd ed., 201–202.

³⁹ Kaczor, “Ethics of Ectopic Pregnancy,” 269.

bypass coronary vessels, or to stop the heart permanently to procure organs and bring about the patient's death. Kaczor, though, seems to focus simply on the physical act of the removal of the embryo from the fallopian tube with regard to the question of intrinsic evil. His analysis, therefore, is flawed, because the moral object in this case also includes the reason why the embryo is being removed.

Perhaps an analogy will help. If an adult human being were moved out of a burning house to a safe place and died in the process, there would be no intentional killing. The person died in the act of being moved, but the intention was to bring the person into a safe haven from the fire. Suppose, however, that a person were moved out of a burning house and into a gas chamber, which leads to certain death. Then it could not be claimed that the death of the person was not directly willed.

The act of being moved to a safe haven is different from the act of being moved to a place where certain death follows. The claim of a different intention does not alter the fact that, with salpingostomy, one directly intends an act that kills the embryo. If, however, one were removing the embryo from its position in the fallopian tube to transfer it to the uterus, the moral object would be different. If the embryo died during the process of transfer, the death would be completely unintentional. With salpingostomy, however, the death of the embryo is intentional in spite of Kaczor's claim to the contrary. Edward Furton's assessment is correct: "One cannot fail to intend what one directly does, and so the direct killing of the child [in salpingostomy] is indeed a part of the surgeon's 'proposal.'"⁴⁰

Kaczor's defense of the use of methotrexate is based on the erroneous assumption that the administration of methotrexate is done "to stop the ongoing damage to the fallopian tube by the trophoblast."⁴¹ But methotrexate attacks both the trophoblast *and* the embryo proper. Kaczor's analysis, therefore, is based on flawed medical science. Methotrexate is a known teratogen and is highly toxic to embryonic tissue. It is a derivative of aminopterin, a potent teratogen that produces major congenital anomalies, especially of the skeletal and central nervous system. Aminopterin is a folic acid antagonist. Folic acid deficiency has been identified as a causative condition for some forms of spina bifida, or failure of the neural tube to close. At one time, methotrexate was used as an abortifacient.⁴²

Kaczor points out that the embryo in the uterus may be in the process of dying, and therefore the methotrexate does not hasten its death.⁴³ He then goes on to claim that "in the vast majority of actual cases in which [methotrexate] is medically indicated, the death of the embryo has indeed already occurred."⁴⁴ From a Catholic perspective, there is no moral problem in administering methotrexate if the death of the embryo has indeed occurred. However, the mere fact that the embryo is in

⁴⁰ Edward Furton, "The Direct Killing of the Innocent," *Ethics & Medics* 35.10 (October 2010): 2.

⁴¹ Kaczor, "Ethics of Ectopic Pregnancy," 274.

⁴² See Goffman et al., "Failed Methotrexate Termination of Pregnancy."

⁴³ Kaczor, "Ethics of Ectopic Pregnancy," 277.

⁴⁴ *Ibid.*, 278.

the process of dying does not justify hastening its death by the use of methotrexate anymore than the use of a lethal drug to hasten the death of a dying adult patient can be justified.

Martin Rhonheimer's Defense of Craniotomy, Salpingostomy, and the Use of Methotrexate

Rev. Martin Rhonheimer's defense of the use of salpingostomy and methotrexate in resolving ectopic pregnancies is based on his version of virtue ethics. His book *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies*, which appeared in English in 2009, is a detailed, subtle, and sophisticated study, but a number of Catholic ethicists have described the central thesis as "fatally flawed"⁴⁵ and "lacking a certain moderate realism about killing and the way people normally intend."⁴⁶

For Rhonheimer, killing is wrong because it violates the virtue of justice.⁴⁷ In certain extreme cases, such as those that "required" a craniotomy prior to the development of cesarean section or, in the contemporary context, cases of ectopic pregnancy, the unborn child or embryo has no chance of survival. Therefore, according to Rhonheimer, the killing that occurs is only physically direct and immediate, but on the part of the agent there is no "*intentionality that violates justice*."⁴⁸ As a result, the prohibition of intentional killing is not violated because, without a chance of survival, the unborn child or embryo cannot claim, in justice, any immunity from killing. Moreover, the intention of the agent is not to kill the unborn child but to save the life of the mother. Thus, in these extreme cases of vital conflict, the physical act of directly bringing about the embryo's death is not a violation of justice, and therefore it is not wrong.

A number of points need to be raised regarding Rhonheimer's position. The first concerns his presentation and analysis of the question of craniotomy, the procedure of crushing a baby's skull because its cranium is too large to pass through the dilated cervix of the mother. In the nineteenth century, this procedure was done to save the life of the mother.⁴⁹ Rhonheimer admits that cesarean sections have now rendered craniotomies virtually obsolete, but he believes that the historic question of craniotomy "is very instructive" because it involves a case of "vital conflict" in which both the mother and the child will die without the procedure.⁵⁰ Rhonheimer argues that craniotomy can be justified when both the mother and the child will die.

⁴⁵ Nicanor Pier Giorgio Austriaco, review of *Vital Conflicts in Medical Ethics* by Martin Rhonheimer, *National Catholic Bioethics Quarterly* 10.1 (Spring, 2010): 206.

⁴⁶ Basil Cole, review of *Vital Conflicts in Medical Ethics* by Martin Rhonheimer, *Thomist* 74.1 (January 2010): 164.

⁴⁷ Rhonheimer, *Vital Conflicts*, 12.

⁴⁸ *Ibid.*, 14, original emphasis.

⁴⁹ Joseph Howard, "Craniotomy," in *New Catholic Encyclopedia Supplement 2009*, ed. Robert L. Fastiggi, 197–198.

⁵⁰ Rhonheimer, *Vital Conflicts*, 88.

The craniotomy, which brings about the death of the baby, “falls entirely outside the ethical context of ‘justice’” and, for this reason, can be morally justified.⁵¹ The intention is to save the life of the mother, which is a praiseworthy act; it is not the intentional, unjust killing of an innocent human being.

It should first be noted that Rhonheimer’s position stands in direct opposition to the decisions of the Holy Office of 1884 and 1889, both of which ruled that the moral legitimacy of craniotomy “cannot be safely taught” (*tuto doceri non posse*) in Catholic schools.⁵² Rhonheimer sees the decisions of the Holy Office as “problematic” and a cause for “confusion.”⁵³ In terms of Catholic ecclesiology, however, these rulings represent teachings of the ordinary magisterium. Unless such decisions have been qualified by subsequent magisterial interventions (which has not been the case), they merit religious assent on the part of the faithful.⁵⁴

Rhonheimer also misrepresents what the Holy Office ruled in 1884 and 1889 concerning craniotomy. It did not state that the morality of craniotomy “could not be taught as certain,”⁵⁵ but that “it cannot be safely taught.”⁵⁶ One might be tempted to think this is merely an issue of the translation found in the English edition of Rhonheimer’s book, but he himself states that a judgment of “*tuto doceri/tradi non posse*” means only that “one cannot teach something with certainty of conscience (because it is *perhaps* wrong).”⁵⁷ This, though, is not what such a ruling means. There are many theological positions that are tolerated or permitted, but they have not been taught as certain by the magisterium.

Contrary to Rhonheimer, what the Holy Office taught in 1884 and 1889 was that Catholic professors could not *safely* uphold the moral permissibility of craniotomy. In other words, the moral defense of craniotomy was judged to be a dangerous and impermissible position to teach.⁵⁸ In a similar way, the Holy Office ruled in 1944 that the position “of mitigated millenarianism” (which teaches that, before the final

⁵¹ *Ibid.*, 84.

⁵² See Heinrich Denzinger, *Enchiridion symbolorum, definitionem et declarationem de rebus fidei et morum*, 40th ed., ed. Peter Hünermann (Freiburg im Breisgau: Herder, 2005), n. 3258, page 875.

⁵³ Rhonheimer, *Vital Conflicts*, 78.

⁵⁴ Vatican Council II, *Lumen Gentium* (November 21, 1964), n. 25; and *Catechism of the Catholic Church*, 2nd ed., trans. U.S. Conference of Catholic Bishops (Vatican City: Libreria Editrice Vaticana, 1997), n. 892.

⁵⁵ This is how “*tuto doceri non posse*” is translated in *Vital Conflicts*, 77.

⁵⁶ Rhonheimer, *Vital Conflicts*, 77; and Denzinger, *Enchiridion symbolorum*, n. 3258.

⁵⁷ Rhonheimer, *Vital Conflicts*, 78, footnote 73.

⁵⁸ The German edition of Denzinger translates “*tuto doceri non posse*” (n. 3258) as “kann nicht sicher gelehrt werden,” which could possibly be translated into English as “cannot be taught as certain,” because *sicher* can mean “certain,” “safe,” or “secure.” A translation directly from Latin into English, though, would not support such a rendering. According to the *Harper’s Latin Dictionary*, by C. T. Lewis and C. Short (New York: American Book

resurrection, Christ will come to reign visibly over the earth) “cannot be safely taught” (*tuto doceri non posse*).⁵⁹ The Holy Office was *not* saying that “mitigated millenarianism” was permitted as long as it was not taught “as certain.” Rather, it was saying that this position could not be “safely taught.” In other words, it was a position that could not be publicly sustained and defended by Catholics.

Apart from the question of authority, we need to examine Rhonheimer’s argument that craniotomy is justified in those cases when, without the procedure, both the mother and the child would die. In such cases, according to him, “the only morally good thing that can be *chosen* here is to save the life of the mother.”⁶⁰ Because the child will die anyway, the physically direct action of craniotomy, even though it results in the death of the fetus, is not an act of injustice and, therefore, is not unjust killing. Rather, the intention is to save the life of the mother, not to kill the child. Thus, the killing of the fetus is not direct, because “only if the fetus would otherwise survive could its death be said to be chosen as a means—and thus caused ‘directly’ in a morally relevant way.”⁶¹

Rhonheimer applies a similar analysis to cases of ectopic pregnancies, and as a consequence he defends both salpingostomy and the use of methotrexate. In the case of salpingostomy,⁶² he argues that there is no moral difference between a salpingectomy and a salpingostomy, since both are concerned with treating a “pathological phenomenon.”⁶³ Furton, though, is correct in noting that Rhonheimer obscures the traditional distinction between indirectly causing the death of the embryo (salpingectomy) and directly causing the death of the embryo (salpingostomy).⁶⁴ Rev. Basil Cole, OP, is likewise correct in his observation that Rhonheimer’s position lacks a certain “realism” regarding what intending to kill means.⁶⁵

Rhonheimer justifies the use of methotrexate because it is “nothing other than a method for removing the tubal pregnancy, analogous to a salpingostomy.”⁶⁶ Like Kaczor, he holds to the erroneous view that methotrexate attacks only the trophoblast and not the embryo proper.⁶⁷ For Rhonheimer, however, the same justification ultimately applies to using methotrexate as to permitting a salpingostomy: the unborn

Company, 1907), the meaning of *tutus* is “safe, secure, out of danger,” and it does not mean “certain” (1907).

⁵⁹ Denzinger, *Enchiridion symbolorum*, n. 3839.

⁶⁰ Rhonheimer, *Vital Conflicts*, 123.

⁶¹ *Ibid.*, 124.

⁶² Rhonheimer uses the term *salpingotomy*, which differs from *salpingostomy* only in terms of the technical details of the procedure. From a medical-moral perspective, salpingostomy and salpingotomy are identical.

⁶³ Rhonheimer, *Vital Conflicts*, 103.

⁶⁴ Furton, “Direct Killing,” 2.

⁶⁵ See Cole, review of *Vital Conflicts*, 165.

⁶⁶ Rhonheimer, *Vital Conflicts*, 116.

⁶⁷ *Ibid.*

human being has no chance to live and therefore “is no longer even subject to a decision between ‘killing or allowing to live.’”⁶⁸ To cause the death of an unborn human being in this situation, according to Rhonheimer, is not a violation of justice. Therefore, it is morally licit.

What are we to make of Rhonheimer’s appeal to justice as the ultimate criterion for deciding whether causing the death of an unborn human being is moral? This appeal seems prone to all types of problems. The most obvious is that judging whether or not the virtue of justice is violated can be quite subjective. For example, Rhonheimer claims that a fetus without any chance of surviving loses a just claim for protection from being killed. On what basis, though, does he make this claim? Certainly the opposing claim can also be made, namely, that shortening the life span of a living human being by direct killing *does* violate the virtue of justice. Indeed, until a living human being actually dies, he or she remains the subject of a decision between being killed or being permitted to live.⁶⁹

Rhonheimer is aware that some believe his position opens the door to “a subjectivist morality.”⁷⁰ He tries to reply by noting that to “every kind of ethical argument ... there can always be an alternative view or another set of reasons.”⁷¹ Moreover, he argues that determining how “‘justice’ pertains in a certain situation is not an arbitrary judgment,”⁷² and traditional Catholic morality going back to St. Thomas Aquinas acknowledges the importance of the “ethical context” for identifying “the moral identity of a human action.”⁷³

Rhonheimer is correct to emphasize the importance of ethical arguments and ethical contexts in assessing the morality of any given action. According to Pope John Paul II, however, there are certain “acts which *per se* and in themselves, independently of circumstances, are always seriously wrong by reason of their object.”⁷⁴ Included among such actions is “the direct and voluntary killing of an innocent human being.”⁷⁵ For Rhonheimer to defend the killing of the embryo in a tubal pregnancy, it would seem necessary to claim either (1) that the embryo is not an innocent human being or (2) that causing the embryo’s death by salpingostomy or methotrexate is not direct killing. Rhonheimer’s argument, though, is that the situation of “vital conflict” removes the embryo from the category of a human being whose life is subject to a just claim of protection from destruction. Moreover, the situation of “vital conflict” means that the intentionality is not to cause the death of the embryo but to save the life of the mother. According to Rhonheimer, therefore,

⁶⁸ Ibid., 123.

⁶⁹ See Austriaco, review of *Vital Conflicts*, 206.

⁷⁰ Rhonheimer, *Vital Conflicts*, 135.

⁷¹ Ibid., original emphasis.

⁷² Ibid., 136.

⁷³ Ibid.

⁷⁴ John Paul II, *Veritatis splendor* (August 6, 1993), n. 80.

⁷⁵ John Paul II, *Evangelium vitae* (March 25, 1995), n. 57.

“the act that causes the death of the embryo or fetus is not to be assessed intentionally and thus morally, as a ‘direct killing.’”⁷⁶

Rhonheimer’s argument, therefore, is based on his claim that an embryo implanted in the fallopian tube loses its claim to protection from being killed because *not* ending its life will result in the death of another human being (i.e., the mother).⁷⁷ According to Rhonheimer, when “the brief continued life of the embryo is coupled immediately and necessarily with the threat to or destruction of the life of another person,”⁷⁸ it is morally acceptable to cause its death. For him, such a situation of “vital conflict” justifies the direct killing of the embryo because “‘killing’ can be seen as a morally evil act only insofar as ‘killing’ is a violation of justice.”⁷⁹ In so many words, Rhonheimer is saying that killing an embryo is not intrinsically wrong if the continued living of the embryo is a threat to the mother’s life.

In response to Rhonheimer’s argument, a number of points must be examined. The first is his claim that the direct killing of an innocent human being is permitted when ending its life does not offend the virtue of justice. This appears to be a somewhat idiosyncratic way of assessing moral failure or sin. It is true that, according to Aquinas, “the gravity of sins depends on the excellence of the virtues to which they are opposed.”⁸⁰ The basic meaning of sin, however, is “an utterance, a deed, or a desire contrary to the eternal law.”⁸¹ Thus, in the Catholic tradition, the fundamental definition of sin is not an offense against the virtue of justice but an offense against God’s eternal law. To be sure, all sin offends justice because justice requires a firm resolve “to give God and neighbor their due.”⁸² To disobey God’s law is a failure to give God his due, and, therefore, it is an injustice. In cases of tubal pregnancies, however, the morality of salpingostomy or the administration of methotrexate must be evaluated principally in reference to God’s law expressed in the commandment “You shall not kill.” Rhonheimer, though, has introduced a new criterion for deciding when this commandment applies: namely, killing is forbidden only when it violates the virtue of justice. Therefore, because it is not unjust, in cases of vital conflict, to cause the death of an unborn human being by use of a craniotomy, salpingostomy,

⁷⁶ Rhonheimer, *Vital Conflicts*, 135.

⁷⁷ *Ibid.*, 131.

⁷⁸ *Ibid.*, 132.

⁷⁹ *Ibid.*, 12.

⁸⁰ Thomas Aquinas, *Summa theologiae*, I-II, q. 73, a. 4.

⁸¹ *Ibid.*, q. 71, a. 6; Augustine, *Contra Faustum*, book 22, n. 42; *Catechism of the Catholic Church*, n. 1849.

⁸² See *Catechism of the Catholic Church*, n. 1807. It is interesting that Rhonheimer’s modification of the teaching against lying also involves the same problem of applying a subjective assessment of what is just or unjust with regard to truth-telling. Here he stands in opposition to the change in the definition of lying placed in the 1997 *editio typica* of the CCC, n. 2483. This change was approved by John Paul II, and it removed the prior qualification of the 1992 CCC that the lying was not involved in cases in which those deceived lacked a “right to know the truth.” See Rhonheimer, *Vital Conflicts*, 12–13, note 20.

or methotrexate, there is no violation of the commandment “You shall not kill.” At face value, it seems that Rhonheimer is ultimately saying that the direct killing of an innocent human being is wrong except in cases where it is justified. Or to put it even more simply, killing is wrong except when it is not wrong.

To be sure, the Catholic tradition has, historically, permitted killing in self-defense and in cases of capital punishment.⁸³ Neither of these, though, involves the taking of *innocent* human life. For Rhonheimer, however, the prohibition against killing the innocent does not apply in cases of “vital conflict” between the life of the mother and the continued living of the embryo or fetus. But does such an exception have any real support in the Catholic tradition? When the Holy Office ruled that it could not be safely taught in Catholic schools that a craniotomy may be permitted “when it is likely, if it is not done, the mother and the child will die, and, on the other hand, if it is done, the mother may be saved while the child will die,”⁸⁴ the magisterium explicitly *rejected* the moral reasoning of Rhonheimer, who claims that in such situations of “vital conflict” the killing of an unborn human being is permitted. It must be recognized, however, that the magisterium condemns all direct abortion, that is, abortion willed as an end or as a means.⁸⁵

With regard to tubal pregnancies, Rhonheimer’s own criterion of “vital conflict” simply does not apply. This is because the mother’s life can be saved by use of a salpingectomy without recourse to a salpingostomy or the administration of methotrexate. What May stated in the first edition of *Catholic Bioethics and the Gift of Life* remains true:

Managing ectopic pregnancies by the use of salpingostomy and methotrexate constitutes direct abortion, i.e., abortion as killing, inasmuch as these procedures are lethal and are performed on the body person of the unborn child; they are performed on it, not for its good, but for the good of the mother; moreover they are not necessary to save her life if this is jeopardized by the tubal pregnancy, inasmuch as her life can be preserved by a salpingectomy, whether partial or complete, a procedure performed on the body of the mother, not the child, and one that is not itself a lethal invasion of the unborn child’s body. A salpingostomy, on the other hand, is performed on the *child’s body person*, securing its death in the very act of removing it. Methotrexate operates in a similar way.⁸⁶

Rhonheimer’s defense of salpingostomy and the use of methotrexate as moral means for treating ectopic pregnancies, therefore, fails for one basic reason: the “vital conflict” that forms the rationale for his analysis of the situation on the basis

⁸³ See Rhonheimer, *Vital Conflicts*, 70–72. In the case of capital punishment, there is now a clear and decided preference by the Church that it *not* be used: see John Paul II, *Evangelium vitae*, n. 56, and the *Catechism of the Catholic Church*, n. 2267.

⁸⁴ *Acta Sanctae Sedis* 17 (1884): 556, noted in the introduction to Denzinger *Enchiridion symbolorum*, n. 3258.

⁸⁵ *Catechism of the Catholic Church*, 2271.

⁸⁶ May, *Catholic Bioethics*, 184, original emphasis.

of justice is simply absent. The mother's life can be preserved by a salpingectomy without recourse to a salpingostomy or the use of methotrexate.

His defense of the morality of salpingostomy and methotrexate, therefore, seems to hinge on his claim "that there is no morally relevant distinction between salpingectomy and salpingostomy, but only a distinction in the physical 'directness' of the intervention."⁸⁷ Rhonheimer's assertion, though, is highly questionable in terms of the traditional criteria for the application of the principle of double effect. As noted above, the good effect (i.e., saving the life of the mother) cannot be achieved when the good effect is the result of an evil means, such as the direct and immediate destruction of innocent human life. In spite of Rhonheimer's claims to the contrary, both salpingostomy and methotrexate involve the direct killing of an innocent human being.⁸⁸

It is always difficult to assess motives, but we might wonder why Rhonheimer would wish to defend the use of salpingostomy or methotrexate to resolve tubal pregnancies if the threat to the mother's life can be removed by recourse to salpingectomy. The answer seems to be in his observation that salpingostomy "has the advantage of preserving the tube."⁸⁹

It is, of course, difficult for a woman who wishes to have a child to be told she must have an operation that will result in the partial or total removal of her fallopian tube.⁹⁰ It would, however, be an exercise in proportionalism or utilitarianism to say that preserving the fallopian tube is a good reason for justifying the direct killing of an unborn human being. If a direct attack on the life of an unborn child is permitted in this case, then there might be many other "proportionate" reasons that could justify direct abortion at later stages in the pregnancy. Rhonheimer is aware of the objection that his analysis could result in a "slippery slope" with regard to similar cases of moral conflict.⁹¹ His defense is that the ethical context of justice is not something arbitrary even though the context must be considered.⁹²

In spite of his claim to the contrary, it *does* seem that his appeal to "justice" is prone to subjective interpretations.⁹³ After all, a woman might claim that it is unjust for her to sacrifice one of her tubes for the sake of an embryo that is going to die anyway. This type of reasoning has a certain emotional appeal, but it opens the door to the "slippery slope." A similar type of emotional appeal might justify the

⁸⁷ Rhonheimer, *Vital Conflicts*, 114.

⁸⁸ See Furton, "Direct Killing," 2.

⁸⁹ Rhonheimer, *Vital Conflicts*, 103; see also 112 and 146.

⁹⁰ From a medical point of view, the loss of one fallopian tube does not necessarily mean sterility. Moreover, the factors that predispose women to have ectopic pregnancies often affects both tubes, so preserving the tube does not insure against similar problems in conceiving normally.

⁹¹ *Ibid.*, 135.

⁹² *Ibid.*, 136.

⁹³ We need only consider how appeals to justice are used to justify "rights" to abortion, homosexual marriage, etc.

intentional dehydration of patients in a persistent state of unconsciousness. After all, why should so much time and expense be expended on someone who is not aware of what is going on?

In his preface, Rhonheimer mentions that, in year 2000, the Congregation for the Doctrine of the Faith asked that the German edition of his book be published “so that the theses it contains could be discussed by specialists.”⁹⁴ We believe the Congregation for the Doctrine of the Faith acted wisely in allowing these points to be made known and critiqued. Rhonheimer has offered some very subtle and sophisticated arguments that strive for a reassessment of prior magisterial judgments regarding cases of “vital conflict.” In spite of his good efforts, we believe he has failed. He has not offered a convincing case for the moral acceptability of salpingostomy and methotrexate for resolving tubal pregnancies. Both of these involve the direct killing of an innocent human being, and “the vital conflict” that Rhonheimer believes would justify their use is simply not present. Thus, not only are his moral criteria questionable in themselves but his application of them to tubal pregnancies is without foundation in terms of the medical realities involved.

Recommendations

Because of the increasing numbers of ectopic pregnancies, Catholic moralists, counselors, and confessors need to know what medical and moral issues are involved. Until recent years, the Catholic consensus has been that only expectant therapy or salpingectomy would qualify as moral means for treating tubal or other forms of ectopic pregnancy. Recent attempts to justify salpingostomy and methotrexate by Kaczor and Rhonheimer might seem appealing, because these methods do not ordinarily result in the loss of a fallopian tube. But neither Kaczor nor Rhonheimer has provided sound arguments for believing that these two methods do not, in themselves, constitute the direct and immediate killing of an innocent human being, an action that is forbidden by the divine and natural law and the magisterium of the Church.

We acknowledge that tubal pregnancies are tragic and pose delicate and difficult pastoral challenges. In light of the increase in the incidence of tubal pregnancies, we would like to offer the following suggestions:

1. Medical scientists should seek to develop techniques for relocating embryos from the fallopian tube into the uterus without directly intending the death of the embryo. Then, removing the embryo from the fallopian tube would be moral if there is a good-faith effort to move it into the uterus where it has a chance to survive. If, however, salpingostomies and methotrexate treatments become more and more accepted, there will be little motivation for developing such techniques of embryo relocation.
2. The “lifestyle” factors that contribute to ectopic pregnancies need to be made better known. Women have a right to know that their risk of having ectopic pregnancies increases with a previous ectopic pregnancy, sexual promiscuity, sexually transmitted disease, drug use, smoking, stress, pelvic inflammatory disease, use of an intrauterine device, and in vitro fertilization.
3. The Congregation for the Doctrine of the Faith, in conjunction with the Pontifical Academy for Life, should study the issue of tubal pregnancies and offer sound guidelines for what Catholics may or may not do to resolve

them. Otherwise, the moral arguments will continue, and the faithful will be told conflicting things by different philosophers and theologians who are moralists, as well as by the clergy.

When the dignity and inviolability of human life are at stake, we turn to the Supreme Roman Pontiff and the magisterium of the Church, and we ask them to address such matters of vital conflict, trusting that the Author of Life will guide them.