Ethics & Medics

A CATHOLIC PERSPECTIVE ON MORAL ISSUES IN THE HEALTH AND LIFE SCIENCES

Uterine Isolation: A Euphemism?

It is no secret that Catholic hospitals are struggling with their policies on sterilization. Against the current obstetrical milieu that routinely endorses therapeutic and elective contraception and sterilization, it is increasingly difficult, first, to conform the content of a hospital's sterilization policy to the Church's teaching that all directly contraceptive sterilization is seriously immoral and, second, to persuade the obstetrician-gynecologists on staff to accept this teaching and put it into practice.

The controversy surrounding a procedure called *uterine isolation* (henceforth, UI) is a case in point. The question we want to ask is this: Given medical indications, is the procedure involved in UI—the isolation of the uterus at the tubal adnexa—*morally* acceptable because it is only indirectly contraceptive, or is it directly contraceptive and hence immoral? After attempting to answer this question, the article concludes with recommended action for ethics committees of Catholic hospitals.

Background

In the 1970's Father Thomas O'Donnell took up the question of whether it is morally permissible to substitute UI for a cesarean hysterectomy when, because of previous cesarean sections, the mother's uterus was incapable of supporting another pregnancy and, therefore, in danger of rupture if such a pregnancy should occur (cf. *The Medico-Moral Newsletter*, October, 1979; see also Thomas O'Donnell, S.J., *Medicine and Christian Morality*, revised edition, 1991).

Although O'Donnell concluded that it was morally probable to make the substitution, he cautioned that this opinion was not a blanket approval for an indiscriminate use of UI. Certain circumstantial criteria are morally relevant: At the time of the cesarean section, the mother is too physically taxed to undergo yet another major surgery, and her uterus, because of repeat cesarean sections, is in such a pathological condition—scarred or severely weakened—that the probability of uterine rupture in any subsequent pregnancy is very high. O'Donnell further cautioned that without a prudential employment of UI the procedure would not only be an excuse for direct sterilizations but also a possible source of scandal to others.

It should be noted that, initially, UI was analyzed as a sort of truncated version of an abdominal hysterectomy, i.e. as the first step in a hysterectomy which, instead of being completed by the removal of the uterus, was stopped at the first step, the tubal ligation, with the uterus left "in situ" or isolated at the tubal adnexa. The moral reasoning behind the sanctioned substitution was that if the cesarean hysterectomy was morally acceptable with its morally problematic "first step" of a tubal ligation, a procedure that simply stopped after that "first step" would present no further moral objections.

Why is this procedure controversial? First of all, appeals from directors of nursing service, for example, indicate that their policy permitting UI (or tubal ligation following a cesarean section, as the case may be) *is* being abused. Based on the percentage of hospital deliveries that are cesarean sections and the small percentage of those that are repeat c-sections, the number of women with a pathologically weakened uterus incapable of another pregnancy without the threat of rupture should be relatively small. Yet a large number of requests for UI are made, leading some obstetricians to remark candidly, when speaking of UI, that this is simply *Catholic* sterilization. Second, doubts have been raised whether uterine isolation is truly only "indirectly" contraceptive as O'Donnell maintains.

It is important to be intellectually honest on this issue. Obstetricians whom I have consulted suggest that the procedure involved in UI should be called by its proper name, tubal ligation, rather than be described euphemistically as the "first step" of a distinctly different surgical intervention, namely, cesarean hysterectomy. This suggestion seems sound. Thus,

(continued on page 2)

IN THIS ISSUE

(continued from page 1)

our purpose is to determine whether UI is directly intended to prevent uterine rupture and only indirectly contraceptive and hence morally permissible, or whether it is simply a euphemistic way of describing a tubal ligation directly intended as a means of preventing conception.

The Relevance of the Principle of Double Effect

When any action (e.g., UI) has two effects, one good and one bad, it is morally right to perform such an act only after one shows that it satisfies the criteria of the principle of double effect. According to this principle, an action having both good and bad effects is morally permissible if and only if the following criteria are fulfilled: (1) the act, precinding from its bad effect, is not morally wrong: (2) the good effect is directly intended, whereas the bad effect is only indirectly intended; (3) the bad effect is not the *means* for attaining the good effect; and (4) there is a proportionately serious reason for permitting or tolerating the bad effect.

UI has a double effect, for it (1) prevents the rupturing of the weakened uterus from a subsequent pregnancy (the good effect) and (2) causes the woman to be sterile (its contraceptive or bad effect).

To see whether UI, which we will call Case A, meets these criteria of the principle of double effect, it is useful to compare it to a cesarean hysterectomy, done at the time of a cesarean section, which we will call Case B.

The **first criterion** of the principle of double effect is that the act under consideration must be morally good or at least morally neutral. In Case B, the action—a hysterectomy, is morally neutral. The same is true of Case A. The isolation of the uterus at the tubal adnexa, or tubal ligation, is morally neutral in itself, prescinding from a consideration of intention and circumstances.

The **second criterion** of the principle of double effect is that the good effect must be directly intended, i.e., the direct object of the human will, and the bad effect only tolerated or permitted, i.e., "indirectly intended," even if foreseen. In Case B, (cesarean hysterectomy) the immediate or present direct intention is to remove an organ, the uterus, which is badly damaged and incapable of carrying out its purpose, and the further or ulterior intention is to prevent uterine rupture is a subsequent pregnancy should occur, i.e., to prevent a life-threatening situation for the mother. Thus, in Case B, the second criterion of the principle of double effect is satisfied. In Case A, however, the immediate or present direct intention is to prevent a pregnancy by "isolating the uterus," i.e., by performing a tubal ligation. The further or ulterior intention is to prevent uterine rupture should a pregnancy occur and thus to prevent a life-threatening situation for the mother. But in Case A, the immediate, present direct intention is to prevent a subsequent pregnancy, i.e., the present direct intention is to render the woman sterile.

The **third criterion** of the principle of double effect requires that the bad effect must not be the *means* to the good effect. In Case B, the cesarean hysterectomy has two good effects: (a) the removal of a seriously damaged organ incapable of carrying out its purpose and (b) the prevention of a potentially life-threatening situation for the woman. The ulterior good effect (b) is achieved by means of the present good effect (a), and the bad effect of the intervention, the sterilization of the woman, is not the means for achieving either of these goods but is rather an inescapable effect of the removal of the damaged uterus. Thus Case B satisfied the third criterion of the principle of double effect. In Case A, (UI) on the other hand, the prevention of uterine rupture and of a life-threatening situation to the mother (the good effect) is achieved only by ligating the tubes and thereby preventing conception. It thus seems that the tubal ligation is a straightforward contraceptive procedure. Unlike the removal of a pathological uterus by means of a hysterectomy, the tubal ligation is not done to correct a pathology in the fallopian tubes. These are healthy. The good effect sought in this procedure—prevention of uterine rupture that might threaten the mother's life—is achieved *by means of* the bad effect, the sterilization. Thus Case A does not satisfy the third condition of the principle of double effect.

The **fourth criterion** of the principle of double effect requires that there be a proportionate reason to tolerate or permit the bad effect. Even if the bad effect is not directly intended and is not the means for achieving the good effect, one nonetheless ought not to cause this bad effect without a "proportionate reason." What does this mean? The second and third criteria of the principle of double effect prohibit actions in which evil is done for the sake of good to come (cf. Romans 3.8). But we can act immorally in other ways, for instance, when we needlessly or unjustly cause evil.

How does all this apply to a cesarean hysterectomy or to Case B? [The relevance of the fourth condition of the principle of double effect to UI will not be considered, since it has already been shown that UI does not satisfy the second and third conditions of the principle of double effect and is, therefore, not morally permissible.] It seems that, apart from emergency situations such as a uterine hemorrhage or rupture at the time of the cesarean section, a cesarean hysterectomy does not satisfy this condition of the principle of double effect. The procedure itself can have serious complications, and there are alternative ways of coping with the situation that entail neither the woman's sterilization (the bad effect of the procedure) nor the medical complications of a hysterectomy (namely, reliance on methods of fertility awareness that will enable the woman and her husband to exer-

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(continued from page 2)

cise responsibility by practicing the virtue of marital chastity). In other words, when the woman's uterus, because of previous cesarean sections, is judged to be incapable of carrying out its function and, instead, poses a serious threat to life should a pregnancy occur, both good medicine and good ethics lead to the conclusion that the right choice appears to be not a hysterectomy but the chaste practice of periodic continence.

Conclusion

This essay has shown, I believe, that UI is directly contraceptive and that it cannot be justified by the principle of double effect. The conclusion is that the procedure ought not be permitted in Catholic hospitals. In the wake of that conclusion, the following recommendation would appear to be reasonable. First, ethics committees of Catholic hospitals should critique our moral analysis of this procedure. If a similar conclusion is reached, then ethics committee members need to reevaluate written or unwritten policies that permit uterine isolation at the time of a cesarean section for a woman whose uterus is weakened beyond the point of supporting another pregnancy. Second, in order to minimize negative reaction from obstetrician-gynecologists or family practice physicians who will be affected by a possible restriction, the ethics committee members need to be personally versed in and convinced of the wisdom of the "why" behind the "what" of Catholic teaching on sterilization and why it restricts procedures that are directly contraceptive. Concomitantly, the moral option of periodic continence as a morally good solution to the difficulties faced by the woman should be presented. Third, this knowledge and conviction need to be shared with the physicians directly involved in obstetrical procedures through existing in-house educational formats. The reasonableness of the Church's teaching, given its theological and philosophical premises, should be tenable whether or not the individual physician is a Catholic. Promotion of human goodness and fulfillment within marriage is the desired objective of conforming to the Church's teaching on sterilization.

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