



eCOMMONS

Loyola University Chicago
Loyola eCommons

Social Justice

Centers

January 2011

Moral Analysis of a Procedure at Phoenix Hospital

M. Therese Lysaught

Loyola University Chicago, mlysaught@luc.edu

Follow this and additional works at: https://ecommons.luc.edu/social_justice



Part of the [Bioethics and Medical Ethics Commons](#)

Recommended Citation

Lysaught, M. Therese, "Moral Analysis of a Procedure at Phoenix Hospital" (2011). *Social Justice*. 26.
https://ecommons.luc.edu/social_justice/26

This Article is brought to you for free and open access by the Centers at Loyola eCommons. It has been accepted for inclusion in Social Justice by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.

Moral Analysis of Procedure at Phoenix Hospital

M. Therese Lysaught

A Catholic hospital in Phoenix “acted in accord with the Ethical and Religious Directives, Catholic moral tradition and universally valid moral precepts” in carrying out a controversial procedure on an ill pregnant woman that resulted in the death of the unborn child, theologian M. Therese Lysaught said in a moral analysis of the situation. Phoenix Bishop Thomas J. Olmsted determined that the November 2009 procedure constituted a direct abortion, and he subsequently stripped St. Joseph’s Hospital and Medical Center of its Catholic status. (See Origins, Vol. 40, No. 31, for more documentation on the case.) In discussions leading up to the bishop’s decision to

“It was not a case of saving the mother ‘or’ the child. It was not a matter of choosing one life ‘or’ the other.”

rescind the hospital’s Catholic status, he asked the hospital and Catholic Healthcare West, the system to which St. Joseph’s belongs, to provide an independent moral analysis of the situation. Lysaught, a Marquette University professor who specializes in moral theology and bioethics, provided the analysis; Bishop Olmsted rejected her conclusions. “In spite of the best efforts of the mother and of her medical staff, the fetus had become terminal, not because of a pathology of its own but because of a pathology in its maternal environment,” Lysaught wrote. She added, “There was no longer any chance that the life of this child could be saved.” Lysaught looked at the clinical history of the case, provided theoretical background for her conclusions and commented on statements by the National Catholic Bioethics Center and the U.S. Conference of Catholic Bishops’ Committee on Doctrine. The moral analysis follows.

Clinical History and Events

a 27-year-old woman with a history of moderate but well-controlled pulmonary hypertension was seen on Oct. 12, 2009, at her pulmonologist’s office for worsening symptoms of her disease. The results of a routine pregnancy test revealed that in spite of her great efforts to avoid it, she had conceived and was then 7 1/2 weeks pregnant.

The pulmonologist counseled her that her safest course of action was to end the pregnancy, since in the best case, pregnancy with pulmonary hypertension carries a 10-15 percent risk of mortality for a pregnant

continued on page 538



contents

- 537 Moral Analysis of Procedure at Phoenix Hospital
by M. Therese Lysaught
- 549 Commentary on the Phoenix Hospital Situation
by the National Catholic Bioethics Center
- 552 Datebook
- 552 On File

January 27, 2011
Volume 40
Number 33

Father John Ehrich, the medical ethics director for the Diocese of Phoenix, wrote the following statement in May 2010:

“A recent news story has brought to our attention the potential dangers that still exist during pregnancy for both mother and child. We naturally ask, what is the right thing to do if a pregnant woman’s life is in danger? Is it ever legitimate to perform an abortion to save the mother’s life? As Catholics, we have clear teaching in this area that helps us to act in accord with God’s will and in recognition of the human dignity of every person.”

“Some Basic Principles

“It is important to note at the outset that these are very complex issues which demand careful reflection. We first need to start with some basic moral principles.

“First, no one can do evil that good may come. We commonly know this as ‘the end does not justify the means.’ Just because we can do something does not mean that we should.

“Second, when speaking of a woman who is pregnant, we are always referring to two people: mother and child.

Therefore, any medical intervention must seek the good of both mother and child. In short, we are dealing with two patients, not just one. So, we never would speak of how the mother’s life is at risk without reference to her unborn child. Her child has as much dignity and value as she does. Morally speaking we can never prefer one life over the other.

“Third, the unborn child can never be thought of as a pathology or an illness. That is, the child is not that which threatens the life of the mother, rather it is the pathology or illness (cancer, premature rupture of membranes, hypertension, pre-eclampsia, etc.) which threatens the mother’s life. While it is often possible that

continued from page 537

woman trying to carry to term, and because of the severity of her disease, her own prospects were closer to 50-50. Importantly, the woman, a Catholic with four children, decided not to terminate.

On Nov. 3, 2009, the woman was admitted to St. Joseph’s Hospital and Medical Center with worsening symptoms. At this time, the woman was 11 weeks pregnant. A cardiac catheterization revealed that the woman now had “very severe pulmonary arterial hypertension with profoundly reduced cardiac output”; in another part of the record, a different physician confirmed “severe, life-threatening pulmonary hypertension,” “right heart failure” and “cardiogenic shock.” The chart noted that she had been informed that her risk of mortality “approaches 100 percent,” is “near 100 percent” and is “close to 100 percent” if she were to continue the pregnancy. The chart also noted that “surgery is absolutely contraindicated.”

“The chart noted that she had been informed that her risk of mortality ‘approaches 100 percent,’ is ‘near 100 percent’ and is ‘close to 100 percent’ if she were to continue the pregnancy. The chart also noted that ‘surgery is absolutely contraindicated.’”

Pulmonary hypertension is a type of high blood pressure that affects only the arteries in the lungs and the right side of the heart. It begins when the arteries and capillaries in the lung become narrowed, blocked or destroyed, making it harder for blood to flow through the lungs, raising the pressure in those arteries.

One consequence of this restricted flow is that the heart’s lower right chamber (the right ventricle) has to work harder to pump blood into the lungs, which eventually causes the

heart muscle to weaken and fail. Pulmonary hypertension is a serious illness that becomes progressively worse; it is not curable but it can be treated, easing the symptoms; it is sometimes fatal.¹

The normal physiologic changes accompanying pregnancy — increased blood volume (40 percent), increased cardiac output (30-50 percent by 25 weeks) and slightly decreased systemic blood pressure (10-20 percent by 28 weeks) — exacerbate pulmonary hypertension, leading to the increased risk of mortality for the mother.²

In the current case, the patient’s attempt to continue the pregnancy in order to nurture the child’s life led to two negative physiological outcomes: the failure of the right side of the patient’s heart and cardiogenic shock.

Failure of the right side of the patient’s heart means that the heart can no longer pump blood into the lungs so that the blood can be oxygenated. Without oxygenated blood, the body’s organs and tissues quickly begin to die. Cardiogenic shock is “a state in which the heart has been damaged so much that it is unable to supply enough blood to the organs of the body.”³

In cardiogenic shock, cardiac output decreases and one begins to see evidence of tissue hypoxia — lack of oxygenation of the patient’s tissues and major organs. Clinical criteria for cardiogenic shock are “sustained hypotension (systolic blood pressure <90 mm Hg for at least 30 min) and a reduced cardiac index (<2.2 L/min/m²) in the presence of elevated pulmonary capillary occlusion pressure (>15 mm Hg).” In addition, visible signs of cardiogenic shock can be observed at the bedside, including “hypotension and clinical signs of poor tissue oxygenation, which include oliguria [low urine output], cyanosis [blue coloration of the skin], cool extremities and altered mentation.”⁴

There is no cure for pulmonary hypertension. In this case, however, two additional pathologies emerged — the pathology of right side heart failure and cardiogenic shock. These pathologies were immediately caused by the physiologic changes accompanying pregnan-

cy that exacerbated the underlying pathology of pulmonary hypertension. The physiologic changes accompanying pregnancy at 10 weeks initiated the emergency situation. These changes not only put the mother’s life at risk. Rather, they put the mother’s life in peril.

Moreover, the life of the fetus was equally in peril due to the pathologies of right heart failure and cardiogenic shock. Oxygen delivered to the placenta and fetus is dependent on maternal arterial oxygen content and uterine blood flow. Decrease in maternal cardiac output and decrease in blood oxygenation can adversely affect fetal oxygenation; the uterus and placenta number among the organs becoming hypoxic during this crisis. Further, maternal hypotension may constrict the uterine artery, decreasing blood flow to the fetus.⁵

Therefore, on Nov. 5, 2009, mother and fetus were both in the process of dying. Due to the age of the fetus, there was no possibility that it could survive outside the womb. Nor, due to the mother’s heart failure and cardiogenic shock, was there any possibility that the fetus could survive inside the womb. In short, in spite of the best efforts of the mother and of her medical staff, the fetus had become terminal, not because of a pathology of its own but because of a pathology in its maternal environment. There was no longer any chance that the life of this child could be saved. This is crucial to note insofar as it establishes that at the point of decision, it was not a case of saving the mother *or* the child. It was not a matter of choosing one life *or* the other. The child’s life, because of natural causes, was in the process of ending.

There was, however, a chance that the life of the mother could be saved. There was one possibility for treating and reversing the pathology of the emergent conditions of right heart failure and cardiogenic shock. The intervention for treating this pathology was to eliminate the cause of the increased blood volume and increased demand for cardiac output. The cause of this increased blood flow and cardiac demand was not the fetus but rather the placenta — an organ in its own right. This requires clarification.

Until about nine weeks into a pregnancy, the ovaries are responsible for the production of progesterone, which maintains the pregnancy in the uterus and causes the increase in blood volume cited above. At about 10 weeks, the placenta is the organ that takes over this work, becoming a shared organ between the mother and the child. In this case, having reached week 11, the placenta was producing the physiological changes that imperiled the mother’s and child’s lives. No organ, however,

exists in a vacuum. The human body is a complex and carefully balanced network.

In this case, the normal functioning of an organ (the placenta) within a diseased network (of pulmonary arteries) created a lethal situation. Importantly, although in one respect the placenta was functioning “normally,” it was also functioning pathologically in two ways. First, once the placenta initiated its normal function at week 10, a crisis was created. Second, once the patient entered cardiogenic shock, the placenta also became hypoxic. In these two ways, then, the placenta not only initiated a threat to the mother’s life; it also became the immediate/presenting cause of the inevitably fatal threat to the fetus.

“The child’s life, because of natural causes, was in the process of ending.”

These facts are important to establish because the claim has been made that the hospital sought primarily to end the life of the fetus as the means to saving the mother’s life. This, however, is physiologically inaccurate. It is likely that in this case as in many cases of natural fetal demise, the death of the fetus *in se* would have had no physiologic effect on the mother.

In many cases of fetal demise, the pregnancy itself continues; fetal death is often not detected for weeks or months, although the pregnancy itself continues to proceed and develop because the hormones required for sustaining and advancing the pregnancy come not from the fetus but from the placenta.

Based on these facts, the ethics committee at St. Joseph’s Hospital and Medical Center was asked for a determination of whether or not the intervention to address the placental issue via a dilation and curettage would be morally appropriate according to Catholic teaching. Per their reading of the “Ethical and Religious Directives for Catholic Health Care Services” (4th edition) and their understanding of the Catholic moral tradition, the ethics committee determined that the intervention would not be considered a direct abortion. They therefore approved the intervention, which was carried out on Nov. 5, 2009.

Moral Analysis

The primary question in this case is whether the ethics committee at St. Joseph’s Hospital and Medical Center was correct in their determination that the intervention did not consti-

the pregnancy will aggravate an existing condition, we should never accuse the child of being a threat to the mother.

“In difficult situations when the mother’s life is threatened by an underlying condition, the solution can never be to directly kill her unborn child. To do so is an abortion. A dilation and curettage or dilation and extraction procedure in this context is the same thing as an abortion since it is the direct killing of an unborn child. The reason for such a procedure never matters. It is also important to note that the secondary intention or goal does not change the moral evil of this act. As John Paul II taught infallibly in his encyclical ‘The Gospel of Life’:

“I declare that direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being. This doctrine is based upon the natural law and upon the written word of God, is transmitted by the church’s tradition, and taught by the ordinary and universal magisterium’ (No. 62).

“What Can Be Done?”

“So what can be done in such a situation? That depends upon the actual pathology or illness. The pathology should always be treated, to the extent possible, all the while remembering that there are two patients who are at risk. When treating the illness, physicians should always try to protect the life of the child, who has just as much a right to life as the mother.

“In the best of circumstances a physician will treat the mother’s pathology and hold off on more aggressive treatment until the child is past the point of viability, at which time labor can be induced. Sometimes, however, the actual pathology must be treated prior to the viability of the child and may indirectly cause the death of the child.

“This situation is altogether different from a dilation and curettage, since a dilation and curettage is the dismembering and removing of the body of the child. A dilation and curettage or dilation and extraction in this circumstance is the same as an abortion, since it is the direct killing of the child.

“There is a significant difference, morally speaking, between directly killing versus allowing a child to die as an unintended side effect of life-saving treatment. A similar, although not completely analogous, distinction is made between murder and self-defense. The end result is the same, but the action taken and the circumstances change the way we evaluate the end result. Once again, the end does not justify the means.

“The Catholic Position

“Today we often hear people say, ‘I’m against abortion unless in cases of rape, incest or situations that threaten the life of the mother.’ The Catholic position is much simpler: ‘we are always against abortion.’ Every abortion is murder since it constitutes the unjust killing of an innocent life. Thus, it can never be justified under any circumstance.

“The question might arise, ‘Isn’t it better to save one life as opposed to allowing two people to die?’ One thing we must always remember is that no physician can predict what will happen with 100 percent accuracy. We will never be able to eliminate all risks associated with pregnancy. What we should not do, however, is lower risks associated with pregnancy by aborting children. It is not better for a woman to have to live the rest of her existence knowing that she had her child killed because her pregnancy was high risk.

“When we try to control every possible situation in life, we end up playing the role of God. As people of faith we know that our lives are always in God’s hands. In

tute a direct abortion and was therefore justifiable according to the Catholic moral tradition. “Direct” is a technical term in the Catholic moral tradition, as is “abortion.” Therefore, an extended presentation of the tradition in this regard is required to evaluate the committee’s decision.

Magisterial Teaching

Catholic Healthcare West strives to embody the fundamental commitment of the Catholic faith “to promote and defend human dignity ... the foundation of [our tradition’s] concern to respect the sacredness of every human life from the moment of conception until death.”⁶

They understand this commitment to embody a preferential option for those who are the most vulnerable, including and especially those persons who are not yet born.⁷

Consequently, direct abortions are forbidden in all Catholic Healthcare West hospitals. Catholic Healthcare West bases this decision on magisterial teaching on abortion and intrinsically evil acts. Important magisterial documents here include: The “Declaration on Procured Abortion” (1974), *Veritatis Splendor* (1993) and *Evangelium Vitae* (1995). Key passages from these documents are provided below. As the “Declaration on Procured Abortion” states:

“Divine law and natural reason, therefore, exclude all right to the *direct* killing of an innocent man. However, if the reasons given to justify an abortion were always manifestly evil and valueless the problem would not be so dramatic. The gravity of the problem comes from the fact that in certain cases, perhaps in quite a considerable number of cases, by denying abortion one endangers important values to which it is normal to attach great value, and which may sometimes even seem to have priority. We do not deny these very great difficulties. It may be a serious question of health, sometimes of life or death, for the mother. ... We proclaim only that none of these reasons can ever objectively confer the right to dispose of another’s life.”⁸

Veritatis Splendor includes abortion among its long list of intrinsically evil acts, which it describes as follows:

“Reason attests that there are objects of the human act which are by their nature ‘incapable of being ordered’ to God, because they radically contradict the good of the person made in his image. These are the acts which, in the church’s moral tradition, have been termed ‘intrinsically evil’ (*intrinsece malum*): They are such *always and per se*, in other words, on account of their very object, and quite apart from the ulterior intentions of the one acting and the circumstances. Consequently, without

in the least denying the influence on morality exercised by circumstances and especially by intentions, the church teaches that ‘there exist acts which *per se* and in themselves, independently of circumstances, are always seriously wrong by reason of their object.’”⁹

These teachings were reiterated by John Paul II in *Evangelium Vitae*:

“Procured abortion is the *deliberate and direct killing*, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth. ... It is true that the decision to have an abortion is often tragic and painful for the mother, insofar as the decision to rid herself of the fruit of conception is not made for purely selfish reasons or out of convenience, but out of a desire to protect certain important values such as her own health. ... I declare that *direct* abortion, that is, abortion *willed* as an end or as a means, always constitutes a grave moral disorder, since it is the *deliberate* killing of an innocent human being.”¹⁰

While never wavering from this position, magisterial teaching has also affirmed an important nuance in the Catholic tradition, namely, that not all interventions that result in the death of the fetus qualify as abortions. Pius XII’s “Address to the Associations of Large Families” (Nov. 26, 1951) states this position most clearly. He provides the foundation for the magisterial teaching outlined above, noting: “The direct attack on an innocent life, as a means to an end — in the present case to the end of saving another life — is illicit.”¹¹ Yet he also goes on to explicitly clarify an important dimension of this position, namely, the qualifier “direct”:

“It has been our intention here to use always the expressions ‘*direct* attempt on the life of the innocent person,’ ‘*direct* killing.’ The reason is that if, for example, the safety of the future mother, independently of her state of pregnancy, might call for an urgent surgical operation, or any other therapeutic application, which would have as an accessory consequence, in no way desired or intended, but *inevitable*, the death of the fetus, such an act could not be called a *direct* attempt on the innocent life. In these conditions the operations can be lawful, as can other similar medical interventions, provided that it be a matter of great importance, such as life, and that it is not possible to postpone it till the birth of the child, or to have recourse to any other efficacious remedy.”¹²

This passage clarifies three essential points.¹³

First, “direct” is characterized as having the desire, intention or will to kill. Actions in which

the death of the fetus is not desired, intended or willed cannot “be called a direct attempt on the innocent life.” Second, it suggests that the opposite of “direct” is “nondirect” rather than “indirect.” The term “indirect” suggests that an agent could “indirectly will” an end, which is not descriptively accurate, per Pius. Rather, the agent is not willing, desiring or intending the “accessory consequence”; therefore, “nondirect” (or “nonwilled”) seems more accurate. Third, Pius makes clear that the term “direct” is a description of a moral act, not a physical act; in other words, whether the operation/therapeutic application causes the inevitable death of the fetus in a physically direct or indirect manner does not enter into his argument.

“Due to the age of the fetus, there was no possibility that it could survive outside the womb. Nor, due to the mother’s heart failure and cardiogenic shock, was there any possibility that the fetus could survive inside the womb.”

These clarifications are noteworthy because the classical tradition at times refers to certain interventions (such as those described by Pius XII above) as “indirect abortions.” This language of “indirect” has carried over into the contemporary literature and is still, at times, used within the Catholic literature.

Such a description, however, is predicated upon a confusion of the Thomistic notion of the moral object of an action, has led to a misapplication of the principle of double effect and suggests that there could be exceptions to the absolute moral norm prohibiting the intrinsically evil act of abortion.

Moreover, it is notable that none of the magisterial documents cited above — nor, as we shall see, the June 23, 2010, statement entitled “The Distinction Between Direct Abortion and Legitimate Medical Procedures” issued by the USCCB Committee on Doctrine — use the phrase “indirect abortion.”

Therefore, these documents, in addition to the Catholic moral tradition at large, make clear that direct, deliberately willed abortion is intrinsically evil and, as such, never justifiable. The questions central to our particular case, therefore, are:

1. Was the procedure that occurred at St. Joseph’s Hospital on Nov. 5, 2009, in this case properly described as an “abortion,” in terms of

its *moral object*? Was it, in other words, a *direct* killing, a “deliberate or intentional” action in which the death of the fetus was “willed as an end or a means”?

2. If not, ought the intervention be properly understood as an action that had a different moral object but also had a *nondirect* (not desired, intended or willed) accessory consequence of the inevitable death of the fetus (a category allowed by the tradition as morally acceptable in certain cases)?

3. Or, is it the case that given the inevitable and immediate demise of the fetus (due to lack of viability and lack of oxygenation), it is not accurate to even speak of the death of the fetus as an accessory consequence of the intervention?

To address these questions requires a brief overview of the Thomistic notion of the “moral object.” I will then outline the reasoning and conclusions of two leading scholars of the Catholic moral tradition who specifically address cases analogous to the one that occurred at St. Joseph’s.

The Moral Object

Determining the object of an act is one of the most critical steps in moral analysis. Understanding how the moral object is constituted in an act, however, remains one of the most difficult and complex components of Catholic moral theology. The notion of the moral object was articulated by St. Thomas Aquinas in the *Summa Theologica* (I-II, Q 18-21), which formed the basis of the development of the subsequent Catholic moral tradition.

Many leading contemporary Thomistic scholars hold, however, that with Thomas’ neo-Scholastic interpreters and much of the classical tradition, important nuances in the understanding of the moral object — and, indeed, of the morality of human actions — were lost. This resulted in methodological problems in 20th-century Catholic moral theology, problems to which revisionism and proportionalism attempted to respond, unfortunately creating a whole host of new methodological problems.

One of the most valuable contributions of *Veritatis Splendor* has been the renewed attention it has brought to the notion of the moral object. William J. Murphy Jr., associate professor of moral theology at the Pontifical College Josephinum in Columbus, Ohio, and editor of the Josephinum Journal of Theology, highlights six specific affirmations about the moral object offered by John Paul II in §78. Echoing Pius XII, John Paul II reiterates that the moral object of an action is determined by the proximate

these situations the reality of our dependence upon him becomes ever more clear and pronounced.”

Father Ehrich’s statement, along with many other documents, can be found on a website set up by the Diocese of Phoenix, www.arizonacatholic.org.

The Jan. 13, 2011, edition of *Origins*, Vol. 40, No. 31, includes a statement by Phoenix Bishop Thomas J. Olmsted and a document from St. Joseph’s Hospital and Medical Center. The margin notes section of that edition also includes more information.

end deliberately chosen by the will (in conformity with reason). In John Paul II's words:¹⁴

"The morality of the human act depends primarily and fundamentally on the 'object' rationally chosen by the deliberate will" (emphasis in original).

"In order to be able to grasp the object of an act which specifies that act morally, it is therefore necessary to place oneself in the perspective of the acting person" (emphasis in original).

"The object of the act of willing is a freely chosen kind of behavior." "It is in conformity with the order of reason."

"By the object of a given moral act, then, one cannot mean a process or an event of the merely physical order, to be assessed on the basis of its ability to bring about a given state of affairs in the outside world."

"Rather, that object is the proximate end of a deliberate decision which determines the act of willing on the part of the acting person."

Moreover, as Murphy notes, "in insisting that this moral object must *not* be understood as 'a process or an event of the merely physical order,' John Paul's primary target was revisionist theory, which inherited what might be called 'a physical understanding of the moral object' from the post-Tridentine casuist tradition. The pope's approach, however, also challenges many more traditional Thomists, who sometimes treat the object that determines the morality of the human act as something of the merely physical order, or as what is caused physically."¹⁵

Nonetheless, the "exterior act" is not irrelevant — together the "interior act of the will" and the "exterior act" comprise one act. However, it is clear from Thomas that moral actions get their object — their "form" — from the interior act of the will.¹⁶

Murphy describes this complex balance as follows:

"A proper description of the moral object would not be my arm, which is a thing of the physical order, and not simply raising my arm, which lacks reference to an end — but raising my arm in order to greet someone; not removing Tom's watch, but removing Tom's watch to play a trick or removing Tom's watch to appropriate it; not shooting someone, but shooting someone to repel his aggression or shooting someone to carry out capi-

tal punishment or shooting someone to bring about their death; not taking an anovulant pill, but taking an anovulant pill to prevent the procreative consequences of the marital act or taking an anovulant pill to treat endometriosis."¹⁷

A proper description of the moral object, then, certainly includes the "exterior act" — since it is a necessary part of the moral action as a whole — but it derives its properly moral content first and foremost from the proximate end deliberately chosen by the will. Thus, the object is named as greeting a friend, repelling aggression, capital punishment, murder, contraception or healing.

It is absolutely necessary to emphasize, then, that in the Catholic tradition, the moral object of an act is not equivalent or reducible to its physical/material component. Three examples might help to clarify this point.

First, as mentioned by Murphy, the object of the action of taking an anovulant pill cannot be construed only in terms of the physical act of taking the pill. The object of the act — as either "contraception" or "therapy" — is determined by the end or intention chosen rationally by the deliberate will. Therefore, if the intention of taking such a pill is to prevent conception the moral object of the action is contraception, which is by its species intrinsically evil. If the intention of taking the same pill, in the same manner, is to treat endometriosis, the moral object of the action is healing, which by its species is good.

Second, St. Thomas himself offers the example of killing in self-defense. In doing so, he explicitly intends to differentiate between actions which, in the physical order, may look exactly the same, but in terms of their species (good or evil) are radically different because of their different moral objects. What differentiates actions of the object "self-defense" (good moral object) from those of the object "homicide" (intrinsically evil moral object) is the intention or end of the agent, which is either to preserve his or her own life or to end the life of another.

Importantly, in this passage in the *Summa*, Thomas does not attend to the physical/material component of the action. The self-defender may have used a variety of agents in a variety of ways (e.g., hitting the assailant over the head with a tire iron; pushing the assailant

over a cliff, etc.). Prima facie, an observer cannot immediately determine to which moral species this action belongs; only when it is understood "from the perspective of the acting person"¹⁸ and evaluated according to the acting person's intention can we know the proper object and species.¹⁹

Third, a woman could be faced with a threat to her life due to pregnancy. That woman could, via what would look physically/externally like one and the same action to an external observer, pursue two very different moral ends and therefore two very different species of moral action, good or evil. She could deliberately will to sacrifice her life for her child, based on a call to martyrdom. To do so, she would reject certain kinds of medical interventions. However, she might also have a history of depression, feel oppressed by the demands of raising her other children, perhaps have a history of attempting to take her own life. She could, via the same action above (rejecting certain kinds of medical interventions), intend to end her own life. In so doing, the moral object of her act would be "suicide" (intrinsically evil), not martyrdom, which would make her act evil in species.

More examples could be offered, but I hope these three are sufficient to demonstrate that within Catholic moral theory, there is a complex interplay between the physical/exterior act (that which can be observed by a third party) and the actual moral act, which is comprised of both the interior act of the will and the exterior act, but whose object/species is determined by the formal component, the interior act of the will. The physical/material action is not irrelevant to the determination of the object, but it is also not sufficient.

More specifically, it is clear that within the Catholic tradition not all surgical or pharmacological interventions which prima facie physically directly end the life of a fetus fall into the species of acts named "abortion." As Pius XII noted, the Catholic tradition holds that certain medical interventions aimed at healing a mother or saving her life that simultaneously cause fetal death (at the level of physical causality) may be justified and in fact are not categorized as "abortions."

Justified via the principle of double effect, the three primary types of such interventions include:

—Surgical removal of a fallopian tube containing a fetus.

—Surgical removal of a cancerous uterus containing a fetus.

—Administration of chemotherapy or other pharmaceuticals required to treat maternal diseases or conditions which may result in fetal death.

In these cases, precision of description and terminology is critically important. Such cases are not referred to — and are not generally considered — to be abortions, even though in the first two cases, a living fetus is surgically removed from the mother's body and in the third, the pharmaceuticals may effectively be abortifacient.

Significantly, the recent statement from the Committee on Doctrine discusses these interventions but does not refer to them as "abortions." The object of the act in these cases is deemed to be properly described as "benefitting the health of the mother" or, in some cases, as "saving the life of the mother" (if, for example, the fallopian tube has ruptured). These actions are not *exceptions* to the norm prohibiting direct abortion. These actions are properly described as a different category of action because of their different moral object, which is, in the words of *Veritatis Splendor*, "capable of being ordered to God."²⁰

The Moral Object of the Intervention

at St. Joseph's Hospital

Two leading scholars of the Catholic moral tradition bring the perspective of *Veritatis Splendor* and a nuanced understanding of the Thomistic concept of "moral object" to bear on cases analogous to the one at St. Joseph's. I will here draw on the analyses and arguments of Father Martin Rhonheimer and Germain Grisez to assess that case.²¹

Martin Rhonheimer

Father Martin Rhonheimer is a Catholic priest, incardinated in the Prelature of the Holy Cross and Opus Dei. He is currently professor of ethics and political philosophy at the School of Philosophy of the Pontifical University of the Holy Cross in Rome. His writings have focused specifically on the work of Thomas Aquinas as well as abortion and contraception.²²

The following analysis relies on his recent work *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies* (Catholic

University of America Press, Washington, D.C., 2009).²³ Here he offers analyses informed by the *Summa Theologica* and *Veritatis Splendor* with regard to extra-uterine pregnancy, particularly tubal or ectopic pregnancies, and craniotomy for obstructed delivery.²⁴

He considers craniotomy not because it is a current procedure; contemporary advances in cesarean section have rendered this question mostly moot. However, he recognizes that: (a) craniotomy was a key case of debate for 19th- and early 20th-century moral theologians and magisterial authors; (b) scholars on both sides of the debate relied on problematic methodologies that misconstrued Thomas; and (c) the question embodies key elements that continue to trouble contemporary debates over potentially analogous interventions (i.e., craniotomy, by definition, consists in a physically direct intervention on the fetus and therefore looks, from an external observer perspective, like an apparent morally direct attack on a child to save the life of a mother).

Rhonheimer also focuses on these two cases because in these cases medical personnel are faced with a situation in which it is certain that without medical intervention, both mother *and* child will die.

Rhonheimer agrees that direct abortion is intrinsically evil and can never be justified. He specifically rejects any moral methodology (i.e., proportionalism) that involves the "weighing of goods": "It is morally impermissible," he notes, "to weigh two lives against each other and to make a preferential choice."²⁵ Such a method, he argues, entertains the possibility of choosing against the life of the child, a possibility that is never permitted in the Catholic moral tradition.

While many cases of obstetric conflict do present such a possibility — the possibility of choosing against the life of the mother or the life of the child — in certain instances the child's chance of survival is negligibly small or, in fact, nonexistent. These cases, he argues, have a distinguishing, morally relevant feature, namely, that:

"Only the life of the mother is at the disposal of another human being — the fetus is no longer even subject to a decision between 'killing or allowing to live'; the only morally good thing that can be *chosen* here is to save the life of the

mother."²⁶

With respect to the life or death of the embryo, the question "to kill or let live" can no longer be decided about or chosen. The only practical and moral question that remains regards the mother: "To let die or save?" He also states clearly that "the decision to allow both mother *and* child to die — at least when the mother can be saved and the child will die *in any case* — is simply irrational"; this is not an *ad hominem* comment but rather a very specific Thomistic critique, based on the critical role of reason in moral discernment and action.²⁷

While the justification for the classic cases of maternal-fetal conflict in the tradition (cancerous uterus, etc.) have relied on the principle of double effect, Rhonheimer argues that in cases where there is no chance for the child to survive, the principle of double effect is not applicable *because there are not in fact two effects*.

Given that no action can save the life of the child, its death effectively falls outside the scope of the moral description of the action. Moreover, since there are not two effects, one cannot argue that the death of the child is a means to the end of saving the life of the mother:

"In this case [of ectopic pregnancy or craniotomy], the killing of the fetus would not consist in a choice of the death of a human being as a means to save the life of the mother. ... 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. But in our case, the death of the fetus is not *willed in order* to save the mother; as far as the life of the fetus is concerned, it is beyond any kind of willing."²⁸

Here Rhonheimer follows St. Thomas in his account of the moral object of the act. He notes, as discussed above, that for many analysts the "physical directness" of the act seems highly significant, but he argues that it is not morally determinative. He maintains that the object of the act in these cases is properly described as "the saving of the mother's life":

"The killing of the fetus [in salpingectomy or craniotomy] falls here under the pure and simple *genus naturae* of the moral (intentional) act of 'saving the mother's life.' (Stated in Thomistic terms: The fatal medical intervention by which the fetus or embryo is removed is

the material part of the act, whereas the basic intention or the *finis proximus* of the life-saving act is the formal part of the moral object of the act).²⁹

In these cases, where the fetus is not dying at the time of the intervention but will not be able to survive due to the imperiled state of the mother, Rhonheimer argues that the death of the fetus is “to be considered a purely physical evil caused *praeter intentionem* [outside of the moral intention].”³⁰

This is shown, he argues, “by the fact that one would not feel justified in performing the intervention if the child had a real chance of survival. But in our case, it is not only that the death of the embryo is regretted ... but that it is decided to perform the operation solely because it is known — and regretted *for this reason* — that the child will not survive. This is a significant difference.”³¹

He bases this analysis on Aquinas’ example of self-defense. Rejecting the argument that obstetrical cases ought to be understood under the rubric of self-defense, he demonstrates that for Aquinas, the object of the act of legitimate self-defense is “good” — even if it involves a physically direct act of killing — because the act of self-defense, on the basis of its moral object, is an act of “self-preservation,” which is a good. In Rhonheimer’s words:

“What is effectively *done* here [in Thomas’ case of self-defense] is nothing other than an act of killing; but the *intentio* is the preservation of one’s life and, because the act of killing occurs *praeter intentionem*, the object of the action is determined *formally* by the intention of self-preservation. ... The parallel [to the obstetrical case] consists only in this: that an act can be an act of killing *materialiter* but something else entirely *formaliter*, e.g., self-preservation, the saving of a life, medical therapy. The object of an action is determined on the basis of the formal aspect, not the material.”³²

Consequently, he argues, certainly interventions on extrauterine pregnancy but also craniotomy are not properly understood, per their object, as “abortion”:

“With respect to the moral object of the action, this intervention has nothing to do with an abortion; it is rather a therapeutic measure in favor of the woman, with the only intentional content of the action being the healing and the saving

of the mother’s life.”³³

Rhonheimer’s analysis is directly applicable to the case at St. Joseph’s insofar as: (a) it is a case where both mother and child are in immediate danger of dying *and* (b) there is no chance that the child can be saved. Even more clearly than in cases of extrauterine gravidity or the cancerous uterus, the child at St. Joseph’s had already begun to die and his or her death was, at the point of intervention, inevitable.

“A pathology threatened the lives of both the pregnant woman and her child, it was not safe to wait or waiting surely would have resulted in the death of both, there was no way to save the child and an operation that could save the mother’s life would, at least prima facie, result in the child’s death.”

Therefore, Rhonheimer would claim that (a) one cannot properly in that case speak of the intervention as having two effects; and (b) that even if one could establish that the “matter” of the action of the dilation and curettage was or appeared to be a physically direct act of killing, morally, the death of the child would have been *praeter intentionem*, outside the scope of the intention and therefore outside of the proper moral description of the action.

He holds the latter position both on formal grounds (the intention of the intervention was not to kill the child but to save the mother) and on material grounds (that the child’s death was inevitable and so therefore could not be chosen).

Consequently, Rhonheimer would likely argue that the object of the act of intervention at St. Joseph’s was “saving the life of the mother” or “legitimate medical therapy,” not “abortion.”³⁴ He would also argue that there was no other reasonable (in the Thomistic sense) or morally good course of action that could have been chosen or pursued.

Germain Grisez

Germain Grisez is a Catholic moral theologian and author of the magnum opus three-volume treatment of Christian morality entitled *The Way of the Lord Jesus* (1983). Grisez spent his career articulating a new form of natural law thinking, deeply grounded in the work of Thomas Aquinas and his interpreters, and his work is thoroughly consonant with the teachings of the magisterium. In addition to works on natural law, he has consistently written on questions of contraception and abortion. He is currently emeritus professor of Christian ethics at Mount St. Mary’s University in Emmitsburg, Md.

In Volume 2 of *The Way of the Lord Jesus*, subtitled *Living a Christian Life*, Grisez takes up the question, “Is abortion always the wrongful killing of a person?”³⁵ As with Rhonheimer, Grisez’s argument again centers on the concept of the moral object with specific attention to intention. As he notes, “Intentional killing is synonymous with another expression sometimes found in the church’s teaching: direct killing,”³⁶ but yet “one can knowingly cause something without intending it.”³⁷

In other words, Grisez argues, following Pius XII, one can knowingly cause a death without it being a direct killing. By this logic, not all intentional abortion involves intentional killing; in other words, “someone might choose to abort without choosing to kill.”³⁸

Grisez posits two scenarios where one might choose to abort without choosing to kill, those situations in which:

“A woman suffering from kidney disease becomes pregnant and wants to avoid the health problems that will result from carrying the child, or a woman becomes pregnant as a result of rape and wants to be freed of her ongoing suffering. In either case, and perhaps in a few others, in seeking abortion the precise object of the pregnant woman’s choice might be, not the baby’s death or any consequence of it. On this assumption, the proposal adopted is, not to kill the unborn baby, but to have him or her removed from the womb, with death as a foreseen and accepted side effect. An abortion carrying out such a choice would not be an intentional killing.”³⁹

He continues on to argue that even though these cases would count as “abortion” but would not count as intentional

killing, it would still be wrong to abort the child or accept the baby’s death.⁴⁰ Simply because it is not an intentional killing, for Grisez, does not make it justifiable.

The only circumstance in which Grisez holds that it would be licit to accept the baby’s death would be to save the mother’s life, and then only when certain conditions are met.⁴¹ He argues as follows:

“Sometimes the baby’s death may be accepted to save the mother. Sometimes four conditions are simultaneously fulfilled: (i) some pathology threatens the lives of both a pregnant woman and her child, (ii) it is not safe to wait or waiting will surely result in the death of both, (iii) there is no way to save the child, and (iv) an operation that can save the mother’s life will result in the child’s death.

“If the operation was one of those which the classical moralists considered not to be a ‘direct’ abortion, they held that it could be performed. For example, in cases in which the baby could not be saved regardless of what was done (and perhaps in some others as well), they accepted the removal of a cancerous gravid uterus or of a fallopian tube containing an ectopic pregnancy. This moral norm plainly is sound, since the operation does not carry out a proposal to kill the child, serves a good purpose and violates neither fairness nor mercy.”⁴²

He recognizes that some moralists, both classical and contemporary, would classify certain other procedures as “‘direct killing,’ since the procedure in question would lead to the baby’s death.”⁴³ Like Rhonheimer, he cites the question of craniotomy for obstructed delivery. He wishes to challenge this position and does so as follows:

“However, assuming the four conditions are met, the baby’s death need not be included in the proposal adopted in choosing to do a craniotomy. The proposal can be simply to alter the child’s physical dimensions and remove him or her because, as a physical object, this body cannot remain where it is without ending in both the baby’s and the mother’s deaths. To understand this proposal, it helps to notice that the baby’s death contributes nothing to the objective sought; indeed, the procedure is exactly the same if the baby has already died.

“In adopting this proposal, the baby’s death need only be accepted as a side effect. Therefore ... even craniotomy

(and, *a fortiori*, other operations meeting the four stated conditions) need not be direct killing, and so, provided the death of the baby is not intended (which is possible but unnecessary), any operation in a situation meeting the four conditions could be morally acceptable.”⁴⁴

“The purpose of a dilation and curettage in and of itself is not, as the National Catholic Bioethics Center states repeatedly, ‘the dismemberment of a fetus.’”

In the subsequent section, he makes clear that “sometimes the baby’s life should be given priority”⁴⁵ and that “if the mother’s life is not at stake, it is unfair to accept the baby’s death.”⁴⁶ But he also emphasizes that “in a situation in which the lives of both a pregnant woman and her child are at stake and both cannot be saved, if an operation can be performed with a prospect of saving one or the other, fairness can require the procedure more likely to save at least one.”⁴⁷

Again, the application to the case at St. Joseph’s Hospital is clear. The case clearly meets Grisez’s four criteria: (i) a pathology threatened the lives of both the pregnant woman and her child, (ii) it was not safe to wait or waiting surely would have resulted in the death of both, (iii) there was no way to save the child, and (iv) an operation that could save the mother’s life would, at least prima facie, result in the child’s death.

Grisez would therefore likely hold that the intervention enacted at St. Joseph’s ought not be categorized as a direct killing, for the baby’s death was not what was intended.

As mentioned earlier, Rhonheimer explicitly argues that in such cases, the moral object is not “abortion” properly speaking but rather “saving the life of the mother.” Grisez includes the foregoing discussion under a general heading “Ch. 8, Question D: Is Abortion Always the Wrongful Killing of a Person?,” suggesting that even these interventions ought to be named “abortion” but ought also to be considered “indirect” since the death of the child is outside of the intention of the agent/act.

Importantly, however, in the section where Grisez outlines the above argument, he does not use the term “abortion.” In the preceding sections, he clearly uses the term (Ch. 8, D3b: “Sometimes intentional abortion does not involve intentional killing”; Ch. 8, D3c: “Abortion, even if not intentional killing, usually is wrong”).

Yet when he moves to discuss cases meeting these four criteria, the word “abortion” disappears: the heading for the section is “Ch. 8, D3d: Sometimes the baby’s death may be accepted to save the mother”; and the word “abortion” only appears once in this discussion, and not in relation to interventions which result in or accept the death of the child.

It appears that Grisez wants to suggest that not only are cases meeting these four criteria properly identified as “indirect,” but that their object is not “abortion” but rather “saving the mother’s life.”

Analogies to Cases

Therefore, should any ethics committee at a Catholic hospital research the literature on this question, they would obtain a consensus opinion from two leading conservative scholars of the Catholic moral tradition, both of whom have written in defense of *Humanae Vitae*, who are expert scholars of Thomas Aquinas, are dedicated to *Veritatis Splendor* and *Evangelium Vitae*, and who have made clear their dedication to magisterial teaching.⁴⁸

That opinion would have supported the conclusion reached by the ethics committee at St. Joseph’s Hospital and Medical Center.

The ethics committee’s deliberations were also no doubt influenced by the general knowledge within Catholic health care of the obstetrical cases mentioned above that are understood to be justified according to Directive 48. Reasoning analogously from these cases would lead the committee to:

a. Attempt to rely on the principle of double effect, although both Rhonheimer and Grisez suggest that in these particular cases, there are no longer two effects.

b. Reason that in the cases of a cancerous uterus, ectopic pregnancy or chemotherapy, the intervention does in fact physically directly kill the child although it is understood to be “indirect” on the moral level; therefore, the committee would likely have viewed the interven-

tion proposed in this case (dilation and curettage to detach the placenta) to be analogous, and perhaps less grave, given that here the child was already in the process of dying.

c. Understand that given the terminal condition of the baby, the moral object of the intervention was properly described as “saving the life of the mother.”

Evaluation of Analyses and Statements

As part of this analysis, an evaluation of the opinion offered by the National Catholic Bioethics Center was requested. A comment on the applicability of the statement by the Committee on Doctrine of the USCCB was also requested. These follow below.

The National Catholic Bioethics Center Analysis — June 11, 2010

The National Catholic Bioethics Center offers a number of objections to the intervention at St. Joseph’s Hospital. First, they claim: “The pregnancy was seen as a pathology. However, there was no evidence of any pathology of the reproductive organs, nor of the fetus, its placenta or its membranes.”

Here the National Catholic Bioethics Center draws too stark a distinction between particular organs and the entire physiological system of which they are a part. I do not mean here to invoke the principle of totality; rather, this is simply a biological fact. While some pathologies can be localized to a particular organ or site, most pathologies, particularly those that are life-threatening, cannot be restricted in this manner.

Pulmonary hypertension is, on one level, “located” in the lungs; but insofar as the lungs are critical for the oxygenation of the blood, which is critically important for the entire physiological organism, and insofar as immediate effects of this pathology are cardiac impairment, and so forth, it is difficult to accept an argument which attempts to simply localize pathology.

As noted in Part I above, it can be legitimately, medically argued that the pregnancy resulted in physiological changes that exacerbated an underlying pathology, resulting in two new critical pathologies (right heart failure and cardiogenic shock), all of which created a pathological and ultimately fatal context for the fetus.

Second, the National Catholic

Bioethics Center rejects Catholic Healthcare West’s use of the phrase “termination of pregnancy” and suggests, without charity, that it is best understood as “misleading terminology which hides the truth.” Precision in terminology is, however, critical to the work of moral analysis, as the foregoing account has demonstrated.

“The material intervention here was equally or potentially less of a direct attack on the child than other obstetrical interventions justified within the Catholic tradition.”

Given the clinical facts of the situation, the phrase “termination of pregnancy” is an accurate medical description of what the intervention was trying to achieve (to terminate the burden of the pregnancy, not to kill the child); “save the life of the mother” is an accurate moral description of the intervention.

Third, while I agree with Rhonheimer that this case does not fall under the principle of double effect, I believe the National Catholic Bioethics Center analysis of the principle of double effect in this case is inadequate on a number of counts:

1. The first criterion for the principle of double effect requires that the action be good or morally neutral in and of itself. The National Catholic Bioethics Center response to this criterion begs the question. “Action” here has traditionally been understood as the most basic description of the action itself. For example, when the principle of double effect is used to justify the use of narcotic agents that might hasten death, the response to the first criterion is usually framed as follows: “The use of narcotics to treat pain is a morally acceptable and even good medical action.”

Following this model, one would begin an analysis of the intervention at St. Joseph’s using the principle of double effect by noting that the procedure of dilation and curettage is, in and of itself, a morally neutral and most often a good medical intervention. A dilation and curettage is used in a variety of gynecological situations as a legitimate therapy.

It is most commonly used to treat disorders resulting in abnormal bleeding, polyps and incomplete miscarriages, and management of placental issues. It is only rarely used as a method of abortion (2.4 percent of the cases of abortion in the U.S.⁴⁹). Therefore, the purpose of a dilation and curettage in and of itself is not, as the National Catholic Bioethics Center states repeatedly, “the dismemberment of a fetus.”

Furthermore, as Rhonheimer notes: “One could add ... that neither is the principle of double effect suited to determining the ‘species’ of an action according to its object. Indeed, every application of the principle of double effect presupposes (in accordance with the first condition ...) that the act performed is already seen as good or at least indifferent according to its object. But the controversial and most delicate cases are precisely those in which it is not clear what the object of the chosen and performed act actually is.”⁵⁰

2. Similarly, regarding the second criterion, the National Catholic Bioethics Center seems unduly focused on the notion of the “dismemberment of the fetus.” To claim that what was “intended in the procedure was the dismembering of the fetus in order to remove it” can only be made by disregarding all that Catholic Healthcare West has said about this case.

This also stands in direct contradiction to John Paul II’s clear position that “in order to be able to grasp the object of an act which specifies that act morally, it is therefore necessary to place oneself *in the perspective of the acting person.*”⁵¹

As demonstrated with Rhonheimer above, the formal intention of the acting person (or in this case persons), not the material action, defines the moral object. On no basis can it be argued that what was *intended* in this case was the dismemberment of the fetus insofar as:

a. The mother and medical staff had, to this point, done all in their power to promote the life of the child.

b. Ending the life of the child per se would have no effect on the medical condition of the mother. Therefore, the death of the child could not be intended as a means to the end of saving the life of the mother. An act cannot be intended as a means to an end if it will not accomplish that end. The intentional object of the procedure centered on the placenta,

which was medically and physiologically the cause of the crisis.

c. The “attack” on the placenta does not differ, from the perspective of the fetus, from the “attack” on the cancerous uterus — in both cases, the organ is a maternal/fetal organ upon which the fetus is vitally dependent.

d. In the current situation, however, because of the mother’s loss of heart function, the placenta was no longer fulfilling its life-sustaining function vis à vis the child but was imperiling the life of both the mother and the child.

e. The National Catholic Bioethics Center claims that in discussions with physicians, no physicians believe it is practically possible to perform a dilation and curettage without dismemberment. However, this fact is clinically disputed.

f. Catholic Healthcare West states clearly that the physicians took every effort to avoid harming the child, though it is, of course, difficult to do so. A similar risk to the fetus holds, however, in cases of extracting a cancerous uterus or removing an ectopic pregnancy. In the case of the chemotherapeutic agents ingested by a cancer-ridden mother, the chemotherapy poisons the child. The material intervention here was equally or potentially less of a direct attack on the child than other obstetrical interventions justified within the Catholic tradition.

3. The fetal death was in no way the cause of or necessary to bringing about the good effect (the alleviation of the cardiac overload). Fetal dying had already initiated with the medical crisis of the mother, and the medical crisis of the mother would have continued to exacerbate even if the fetus had died before the mother underwent any external intervention. This was established in Part I above.

Fetal demise happens frequently with no effect on pregnancy; in this instance, it was the pregnancy that was imperiling the mother, a pregnancy that could no longer sustain the fetus. It was not the child that was imperiling the mother. The death of the child, therefore, could not medically be the means toward the good end of saving the mother’s life.

As mentioned above, the National Catholic Bioethics Center analysis focuses quite intently on the image of the dismemberment of the fetus. In light of John Paul II and Rhonheimer, I would argue

that in doing so they reduce the object of the act to the physical action of the dilation and curettage and in doing so fail to offer an accurate, Thomistic account of the moral object of the action in keeping with the Catholic moral tradition.

Statement of the USCCB Committee on Doctrine — June 23, 2010

The Committee on Doctrine also offered a brief clarification on some questions that can arise in obstetrical situations in their June 23, 2010, statement entitled “The Distinction Between Direct Abortion and Legitimate Medical Procedures.”

“The Committee on Doctrine statement does not address the situation faced by St. Joseph’s Hospital where two lives were in peril and it was clear that the child was in the process of dying and would die shortly.”

They offer two scenarios. The first scenario they offer is the case of a direct abortion, one in which “a pregnant woman is experiencing problems with one or more of her organs, apparently as a result of the added burden of pregnancy,” and a surgical intervention “*directly* targets the life of the unborn child. ... The surgery does not directly address the health problem of the woman, for example, by repairing the organ that is malfunctioning. The surgery is likely to improve the functioning of the organ or organs, but only in an *indirect* way, i.e., by lessening the overall demands placed upon the organ or organs, since the burden posed by the pregnancy will be removed. The abortion is the means by which a reduced strain upon the organ or organs is achieved.”⁵²

The second scenario they offer is that of the cancerous uterus discussed above and they correctly note that such procedures “*indirectly* and unintentionally (although foreseeably) result[s] in the death of the unborn child. In this case the surgery *directly* addresses the health problem of the woman. ... The woman’s health benefits *directly from the surgery.* The surgery does not directly target the

life of the unborn child. The death of the child is an unintended and unavoidable side effect and not the aim of the surgery.”⁵³

The Committee on Doctrine does not draw any conclusions about the St. Joseph case in this brief. However, per the foregoing analysis, John Paul II, Rhonheimer and even Grisez would likely argue that their analysis conflates the notion of direct/indirect with medical/physical directness. As we have seen, the notion of direct/indirect applies to the will and intention of the agent vis à vis the moral object of the act as a whole, not to the directness of the medical intervention vis à vis either a pathological organ or the fetus.

The Committee on Doctrine statement does not address the situation faced by St. Joseph’s Hospital where two lives were in peril and it was clear that the child was in the process of dying and would die shortly. As we have seen, in that situation, an intervention cannot effectively directly or indirectly result in the death of the child.

Had the mother followed her physician’s advice at 7 1/2 weeks, then clearly, the mother would have found herself in the committee’s first scenario, undergoing a direct abortion. As we have noted, however, she steadfastly refused to have a direct abortion because of her Catholic faith.

It is my understanding that St. Joseph’s Hospital understood its intervention to most closely resemble the second scenario offered by the Committee on Doctrine. I would suggest that it is notable, per our discussion of Rhonheimer above, that the committee does not use the term “abortion” in that scenario and instead refers to it under the auspice of a different (and accurate) object: “legitimate medical intervention.” Following the Committee on Doctrine, St. Joseph’s Hospital would be justified in understanding the intervention they authorized as a “legitimate medical intervention.”

Summary

In summation, the ethics committee at St. Joseph’s Hospital and Medical Center, fully aware of the magisterial teaching on direct abortion, was faced with a scenario in which they needed to discern whether the proposed intervention would: (a) properly be described as an abortion in the moral sense; or (b) if it

rather entailed a different moral object.

Given the medical facts of the case, it was germane to their deliberation that in this instance it was not a matter of weighing one life against another or choosing one life over another; they were faced with a scenario in which without action both mother and child would die and that regardless of the course of action, the child was now terminal.

Their decision to proceed with the dilation and curettage to relieve the pressure placed by the placenta on the mother's cardiovascular system in order to address the immediate pathologies of right-side heart failure and cardiogenic shock and thereby save the mother's life would find full support from the careful, rigorous arguments provided by two of the Catholic moral tradition's leading figures, Father Martin Rhonheimer and Germain Grisez.

Analysis of the works of both of these authors also suggests that the action taken at St. Joseph's is fully in keeping with the position of *Veritatis Splendor*.

Following the opinions of these authors, I would argue that the intervention that occurred at St. Joseph's Hospital on Nov. 5, 2009, cannot properly be described as an “abortion,” in terms of its moral object. At most, the effect on the child can only be categorized as “indirect,” which is morally permitted by the Catholic tradition.

Most important, the death of the child was not willed, either by the mother or the medical staff; the child was a deeply wanted child. Effecting the death of the child would not achieve any medical or ancillary end. Therefore the death of the child was not the means to any end in this case.

It is difficult to see how any Catholic hospital or member of their staff could have reached a conclusion different from the one taken by St. Joseph's Hospital given: (a) the opinions of two highly reputable conservative scholars in the Catholic moral tradition; (b) the medical facts of the case; (c) the hospital's familiarity with justified cases of indirect fetal termination in the literature; and (d) their familiarity with the principle of double effect.

It is my opinion that the intervention performed at St. Joseph's Hospital and Medical Center on Nov. 5, 2009, cannot properly be described as an abortion. The moral object of the intervention was

to save the life of the mother. The death of the fetus was, at maximum, nondirect and *praeter intentionem*.

More likely, the fetus was already dying due to the pathological situation prior to the intervention; as such, it is inaccurate to understand the death of the fetus as an accessory consequence to the intervention.

I conclude that St. Joseph's Hospital and Medical Center acted in accord with the Ethical and Religious Directives, Catholic moral tradition and universally valid moral precepts in working to respect the sanctity and dignity of life, first doing what they could to foster the lives of both the mother and the child and then, when it was clear the child had begun the dying process, to do what they could to save the mother.

Notes

- ↑ The Mayo Clinic, “Pulmonary Hypertension,” www.mayoclinic.com/health/pulmonary-hypertension/DS00430.
- ↑ Tarun Madappa, MD, MPH, and Sat Sharma, MD, FRCPC, “Pulmonary Disease and Pregnancy,” *eMedicine*, http://emedicine.medscape.com/article/303852-overview.
- ↑ “Cardiogenic Shock,” National Library of Medicine, www.nlm.nih.gov/medlineplus/ency/article/000185.htm.
- ↑ Sat Sharma, MD, FRCPC, and Michael E Zevitz, MD, “Cardiogenic Shock,” *eMedicine*, http://emedicine.medscape.com/article/152191-overview.
- ↑ Madappa and Sharma, *ibid*.
- ↑ U.S. Conference of Catholic Bishops, “Ethical and Religious Directives for Catholic Health Care Services,” 4th edition (2001), Part I.
- ↑ *Ibid.*, Directive 3.
- ↑ Congregation for the Doctrine of the Faith, “Declaration on Procured Abortion,” §14, emphasis added.
- ↑ Pope John Paul II, *Veritatis Splendor*, §80, emphasis in original.
- ↑ Pope John Paul II, *Evangelium Vitae*, §§58 and 62, emphasis added.
- ↑ From Pope Pius XII, “Address of Pope Pius XII to the Associations of Large Families, Nov. 26, 1951,” in *Love and Sexuality*, ed. Odile M. Liebard (Wilmington, N.C.: McGrath Publishing Company, Consortium Books, 1978), 125. Quoted in Martin Rhonheimer, *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies* (Washington, D.C.: Catholic University of America Press, 2009), 34. It is worth noting that while the question of the “life and death of the mother” is mentioned here by Pius XII and in the “Declaration on Procured Abortion,” none of the documents speak to the situation faced at St. Joseph's where both the mother's *and* the child's lives are in peril.
- ↑ Liebard, 126-7; Rhonheimer, 35, emphases in Rhonheimer. It should be noted that one difference between the case Pius XII describes and the case at St. Joseph's is that in the former, the mother's condition is independent of the fact that she is pregnant. Pius' example remains important, however, insofar as it demonstrates that the moral object of the action, even in cases that involve physically direct killing, derives from what is intended, not from what is not intended (St. Thomas Aquinas, *Summa Theologica*, II-II, q. 64, a. 7: “(Moral) acts do not take their species from what is not intended.”).
- ↑ Here I follow Rhonheimer, 35ff.
- ↑ Here I follow William F. Murphy's helpful analysis of *Veritatis Splendor* and his careful exposition of the Thomistic notion of the moral object in “A Reading of

Aquinas in Support of *Veritatis Splendor* on the Moral Object,” *Logos: A Journal of Catholic Thought and Culture* 11.1 (2008): 100-126. The six affirmations here are direct quotes from *Veritatis Splendor* §78.

¹⁵ Murphy, 102, emphasis in original.

¹⁶ Aquinas, *Summa Theologica* I-II q. 19, a. 2 and q. 20, a. 1. Also *Summa Theologica* I-II, q. 1, a. 3, ad. 1. In *Summa Theologica* I-II, q. 18, a. 6, Aquinas notes: “Acts are called human insofar as they are voluntary, as we have said. Now there is a twofold act in voluntary action: the interior act of the will and the external act; and each of these has its object. Hence just as the exterior act receives its species from the object it is concerned with, so the interior act of the will receives its species from the end, which is its proper object. ... Now that which is on the part of the will is related as form to that which is on the part of the exterior act, for the will uses members as instruments for action. ... The species of a human act, therefore is considered formally in terms of the end, but materially in terms of the object of the external act” (Excerpts from the *Summa Theologica* are taken from *Treatise on Happiness*, translated by John A. Oesterle (Notre Dame, IN: University of Notre Dame Press, 1964). Thus, the *finis* of the internal act of the will is the crucial moral element for Aquinas, because exterior actions, which flow from the internal act, are only moral and truly human insofar as they proceed from a person's operations of intellect and will. Aquinas explicitly says the moral object as *finis* or end is related to action in the manner of a form, because it gives the action its species [*Ad secundum dicendum quod obiectum non est materia ex qua, sed materia circa quam, et habet quodammodo rationem formae, inquantum dat speciem*. *Ibid.*]. In short, the object provides the moral act with its intelligibility-giving *telos*. This is why in question 20, a. 3, Aquinas says that “the interior act of the will and the external act are one act considered morally.”

Thomas continues in *Summa Theologica* q. 18, a. 7, to distinguish between moral acts in which the exterior act is per se ordered to the end and those that are not: “The object of an exterior act can be related in two ways to the end willed. In one way, it can be ordered per se to it, as fighting well is ordered per se to victory; in another way, accidentally, as taking what belongs to another is ordered accidentally to giving alms.” In the former case, or “if the object is ordered per se to the end, [then] one of the differences determines the other per se. In this way, one of the species will be contained under the other.” More specifically, “the specific difference derived from the end is more general, while the difference derived from an object ordered per se to that end is specific in relation to it. For the will, whose proper object is the end, is the universal mover with respect to all powers of the soul, whose proper objects are the objects of their particular acts.” In other words, in acts where the exterior act is ordered to the interior act, the species of the interior act (via the will) determines the species of the act as a whole. This is further explicated and confirmed by Aquinas in *Summa Theologica* q. 20, a. 3.

¹⁷ Murphy, 113.

¹⁸ *Veritatis Splendor*, §78.

¹⁹ In Aquinas' account of self-defense (*Summa Theologica* II q. 64, a. 7), no mention is made of whether the aggressor is innocent, unjust, or ir/rational. Aquinas speaks only of “an aggressor.” One does not have to describe the fetus or child as an aggressor, however, in order to use the case of self-defense analogously to analyze cases in which there is threat to life.

²⁰ *Veritatis Splendor*, §80.

²¹ It is worth noting that a position consonant with those of Rhonheimer and Grisez was offered almost 40 years ago by Bernard Haring: “The malice of abortion is an attack on the right of the fetus to live. Since the doctor in this situation can determine with great moral certainty that there is no chance for both the mother and the fetus to survive with his ‘direct’ intervention, he accepts the only chance to protect and serve life which Divine Providence has left to him. He saves the life of the mother while he does not truly deprive the fetus of its right to live since it could not possibly survive in the event of the doctor's failure to save the mother's life” (*Medical Ethics* (Fides Publishers, 1973), 109).

²² Martin Rhonheimer, *Natural Law and Practical Reason: A Thomist View of Moral Autonomy* (Fordham University Press, 2000); Martin Rhonheimer, *The*

Perspective of the Acting Person: Essays in the Renewal of Thomistic Moral Philosophy (Catholic University of America Press, 2008); and Martin Rhonheimer, *The Ethics of Procreation and the Defense of Human Life: Contraception, Artificial Fertilization, and Abortion*, edited by William F. Murphy Jr. (Catholic University of America Press, 2010).

²³ William Murphy mentions that this study was written and published by Martin Rhonheimer at the request of the Congregation for the Doctrine of the Faith. See Murphy, 126, fn. 35. Rhonheimer notes in his preface: “This wide-ranging study was drafted for the Roman Congregation for the Doctrine of the Faith and completed and submitted to the congregation in 2000. After it was carefully studied in the congregation and by its then prefect, Cardinal Joseph Ratzinger, the congregation in turn asked that it be published so the theses it contains could be discussed by specialists” (xiii).

²⁴ Importantly, reputable Catholic moral theologians have recently argued that the drug methotrexate, a commonly used abortifacient agent, is licit for the treatment of ectopic pregnancies. See William E. May, *Catholic Bioethics and the Gift of Human Life* (Our Sunday Visitor, 2008), 201-202, *Nihil Obstat*, Rev. Michael Heintz; *Imprimatur*, John M. D'Arcy. See also Benedict M. Ashley, Jean K. de Blois, and Kevin D. O'Rourke, *Healthcare Ethics: A Theological Analysis*, 5th ed. (Washington, D.C.: Georgetown University Press, 2007), 82, *Nihil Obstat*, Rev. Patrick J. Boyle; *Imprimatur*, Rev. George J. Rassas. Unlike surgical excision of the fallopian tube (salpingectomy), the use of methotrexate works by addressing the unfortunately pathological interface between the embryo and the fallopian tube. In May's words, “Methotrexate attacks the DNA in the trophoblastic tissue that attaches the unborn child to its site within the mother's body; it thus attacks the trophoblast attaching the child to the fallopian tube or cervix or other part of an ectopic pregnancy. ... With other moral theologians I thus judge that use of methotrexate can be used to ‘remove’ the unborn child implanted outside the womb; the death of the child is the foreseen but not intended side effect of an action morally specified as the necessary removal of the unborn child from the mothers body as the means, not morally evil in itself, chosen to protect the mother's life.” www.zenit.org/rssenglish-29448. Ashley, et al., similarly argue that the pathology here lies not in the fallopian tube but in the way the embryo is attached to the fallopian tube. Therefore, the intervention (methotrexate) addresses the pathological interface. As such, it is a close analog to the use of the procedure dilation and curettage to address the pathological interface between the placenta and the mother's cardiovascular system. In both cases, the pregnancy — not the child — presents the threat to the mother's life; in both cases, the child will inevitably die; in both cases, without intervention, both mother and child will die; and in both cases, the intervention targets the pathological interface between mother and pregnancy.

²⁵ Rhonheimer, 122.

²⁶ *Ibid.*, 123, emphasis in original.

²⁷ *Ibid.*, emphasis in original.

²⁸ *Ibid.*, 124, emphasis in original.

²⁹ *Ibid.*

³⁰ *Ibid.*, 125.

³¹ *Ibid.*, emphasis in original.

³² *Ibid.*, fn. 44.

³³ *Ibid.*, 129. He continues: “(The so-called ‘therapeutic abortion,’ on the other hand, is in fact a euphemism; it is not ‘therapeutic’ because it is performed at the cost of the life of an innocent person and, furthermore, because the disease for which the child is aborted is not healed at all by the abortion; on medical grounds alone it is illegitimate to call such an intervention a ‘therapy.’)” (129)

³⁴ As he concludes: “The death of the child can be claimed to be *praeter intentionem*, not because the intention is related solely to the removal of the pregnancy (with the end of saving the mother's life), but because the intention in the action here in question *can* be directed *only* at saving the mother's life, i.e., because the removal of the pregnancy in this case *cannot* include any decision against the life of the child, since the child has no known chance of survival. No other outcome is even in question for the child, nor can any other outcome (i.e., saving the child) be

conceived of as a rational basis for action, nor can the action be criticized as an injustice against the life of the child. Consequently, the death of the embryo *is not chosen*; rather, it is similar to an unintentional side effect, which is to say it is not a ‘direct killing.’ In no way is it chosen as a means, and for this reason neither is it willed in any way; that the operation is possibly aimed directly at the embryo in a physically causal way is thus of little importance” (129, emphasis in original).

³⁵ Germain Grisez, *The Way of the Lord Jesus*, Vol. 2, *Living a Christian Life* (Quincy, Ill.: Franciscan Press, 1993), *Nihil Obstat*, Rev. Kevin T. McMahon, and *Imprimatur*, Cardinal James Hickey.

³⁶ *Ibid.*, 470.

³⁷ As he states: “In making a choice, one intends as one's end the satisfaction or benefit desired for oneself and/or others in and/or through carrying out the choice. One chooses as a means something in one's power — some performance or omission — thought more or less likely to bring about the intended end. But it also is more or less clearly foreseen that, either possibly or surely, the performance or omission will have various good or bad consequences distinct from its intended end, and in making the choice these good or bad consequences are accepted, gladly or reluctantly as the case may be, as side effects” (471).

³⁸ *Ibid.*, 500.

³⁹ *Ibid.*, 501.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*, 502-3.

⁴² *Ibid.*, 502.

⁴³ *Ibid.*

⁴⁴ *Ibid.*, 502-3.

⁴⁵ *Ibid.*, 503.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ This number increases to five leading scholars of the Catholic moral tradition if we include May, Ashley/de Blois/O'Rourke and Haring.

⁴⁹ “Dilation and Curettage.” www.emedicinehealth.com/dilation_and_curettage_dancd/article_em.htm. Also, U.S. Centers for Disease Control, “Abortion Surveillance — United States, 2002,” www.cdc.gov/mmwr/preview/mmwrhtml/ss5407a1.htm.

⁵⁰ Rhonheimer, 3.

⁵¹ *Veritatis Splendor*, §78.

⁵² USCCB, Committee on Doctrine, “The Distinction Between Direct Abortion and Legitimate Medical Procedures,” 2-3, emphasis in original.

⁵³ *Ibid.*, 3, emphasis in original. ■

Bishop Thomas J. Olmsted, who died in 2009, was the first bishop to publicly support the procedure.

resulted in the death of the unborn child. Bishop Thomas J. Olmsted of Phoenix determined that the November 2009 procedure at St. Joseph's Hospital and Medical Center in Phoenix constituted a direct abortion, and he has since stripped the hospital of its Catholic status. The hospital maintains that if it believed it could have saved the lives of both the mother and the unborn baby, it would have done so. (See Origins, Vol. 40, No. 31, for more documentation on the case.) The Philadelphia-based National Catholic Bioethics Center said in its Dec. 24 commentary that in such cases, the church teaches that a good action may be performed even if a bad effect will arise only if four conditions are met: the act itself must be good; only the good act can be intended, not the foreseen but unintended bad effect; the good effect cannot arise from the bad effect; and the unintended but foreseen bad effect cannot be disproportionate to the good being performed. The center noted that removing an advanced cancerous uterus from a pregnant woman would meet these conditions, but that causing the death of an unborn child in order to alleviate a mother's hypertension would not meet these conditions. The mother in the Phoenix case suffered from pulmonary hypertension. The center's commentary follows.

The National Catholic Bioethics Center, which is based in Washington, D.C., has refrained from commenting on the procedure.

The National Catholic Bioethics Center has refrained from any public comment on the procedure that took place at St. Joseph's Hospital, Phoenix, in November 2009 and the disagreement which arose between the hospital and the local bishop, the Most Reverend Thomas Olmsted, as to whether the procedure constituted a direct abortion. Since the National Catholic Bioethics Center has provided counsel to both Catholic Healthcare West, the system of which St. Joseph's Hospital is a member, and to the bishop of Phoenix, it previously made no public statement.

However, the time has come that the center should provide some commentary, particularly since portions of its confidential analysis have been circulated by Catholic Healthcare West. It should be noted the following comments deal only with information that is public and not with any confidential information that may have been gained through the consultation services pro-

vided by the National Catholic Bioethics Center.

The Heroism of Mothers

The tragic situation that occurred at St. Joseph's Hospital in Phoenix in November 2009 should be a reminder of the extraordinary courage and self-sacrifice that mothers take upon themselves in the service of new life. Although modern medical science has thankfully reduced the life-threatening risks that women may assume in becoming mothers to almost nil, there still can arise extraordinarily dangerous situations for the mother and the child she is carrying.

Even if it does not come to situations threatening death, women must still bear many burdens and health risks in bringing a child to term. As a society, and as family members, our gratitude to mothers can surely know no bounds.

Difficult Pregnancies

On occasion, life-threatening risks can indeed still arise, even though rarely. As a Catholic health care institution treats and cares for both the mother and the unborn child it must commit itself never to crossing a clear, bright line: It may never directly take the life of an innocent human being as it cares for both patients. Those admitted to Catholic institutions know one indisputable fact about the care they receive: They and their children are safe from a direct assault upon their lives.

This humane practice of medicine follows on the tradition of the great Greek physician Hippocrates whose oath states unequivocally: "I will never give a woman a medication to cause an abortion; I will give no one a deadly medicine even if asked, nor counsel any such thing." Such a commitment never to violate a human life has always been a hallmark of Christian health care as well.

As much as physician-assisted suicide or euthanasia or direct abortion may appear to be the best way out of a difficult medical situation, Catholic health care institutions assure everyone coming to them for help that there are other options.

The "Ethical and Religious Directives for Catholic Health Care Services" have been written and approved by the U.S. Conference of Catholic Bishops to provide guidance to Catholic health care

institutions on what may or may not be done in order to protect and advance human dignity in the context of Catholic health care.

The bishops are the authoritative interpreters of this document. One of the directives makes provision for addressing conflict situations where it would appear that one person must die in order to save another in the course of a difficult pregnancy.

Directive 47 reads: "Operations, treatments and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."

The Principle of Double Effect

Directive 47 applies what is known as the moral principle of double effect which asks whether one may perform a good action when it is foreseen that there might also be a bad effect resulting from that action (the "double effect").

The principle of double effect in the church's moral tradition teaches that one may perform a good action even if it is foreseen that a bad effect will arise only if four conditions are met: 1) The act itself must be good. 2) The only thing that one can intend is the good act not the foreseen but unintended bad effect. 3) The good effect cannot arise from the bad effect; otherwise one would do evil to achieve good. 4) The unintended but foreseen bad effect cannot be disproportionate to the good being performed.

This principle has been applied to many cases in health care, always respecting the most fundamental moral principle of medical ethics, *primum non nocere*, "first, do no harm."

The classic case of a difficult pregnancy to which this principle can be applied is the pregnant woman who has advanced uterine cancer. The removal of the cancerous uterus will result in the death of the baby but it would be permissible under the principle of double effect.

One can see how the conditions would be satisfied in this case: 1) The act itself is good; it is the removal of the diseased organ. 2) All that one intends is the removal of the diseased organ. One does not want the death of

the baby either as a means or an end. Nonetheless, one sees that the unborn child will die as a result of the removal of the diseased organ. 3) The good action, the healing of the woman, arises from the removal of the diseased uterus, not from the regrettable death of the baby which is foreseen and unintended. 4) The unintended and indirect death of the child is not disproportionate to the good which is done which is saving the life of the mother.

The principle, however, cannot be applied to the following case in order to justify an action that would result in the death of the child. A mother is suffering from hypertension which is not caused by any pathology of the reproductive system but aggravated by the pregnancy. Almost always these pregnancies can be carefully managed and the child brought to the point of viability.

The hypertension, if unchecked, however, may become a danger to the health or even the life of the woman. The child is removed from the uterus to eliminate the conditions contributing to hypertension.

This action would generally not be justified by the principle of double effect: 1) The first and immediate action performed by the physician is the destruction of the child by crushing or dismembering it and removing it from the uterus. Such a procedure would violate the first condition of the principle of double effect, that is, the action itself must be good. 2) In a direct abortion the physician intends the death of the child as a means toward the good end of enhancing the woman's health. Therefore, the second condition is also violated. 3) Evil is done, the killing of the child, so that the good of the woman's health might be enhanced, protected or restored. In this case, evil is done that good might come of it. 4) One might argue that there is a proportionate reason to take the life of the child because the mother's life is at risk. However, this condition is not applicable because proportionality applies only to a foreseen and unintended evil, not one that a physician has chosen to bring about.

Of course, there are many complications that can arise with a pregnancy which would morally permit an intervention that would result in the death of the child. They are too numerous to consider here. Also, one must weigh all

the factors that are part of a given situation, some of which may never arise again.

But as another example of what would be morally licit under the principle of double effect, one can mention a case in which there is an early rupture of the membrane and the placenta becomes infected. In such a case, the uterus may indeed be evacuated, that is, the infected material threatening the life of the mother may be removed, even though it is foreseen that the child will die.

The Case at St. Joseph's Hospital

It must be said that the National Catholic Bioethics Center does not know the clinical facts of the case; rather it was asked to comment on the analysis initially submitted to the bishop by Catholic Healthcare West. The center was not given access to the clinicians involved, and it can only be presumed that it was a very difficult situation in which the physicians had to act with dispatch and undoubtedly with regret.

Consequently, without the clinical facts the center can only articulate again the moral teachings of the church and their proper application rather than speaking directly to the case.

Portions of a moral analysis of the case have been circulated by Catholic Healthcare West. However, they really have to do with debates over moral theory rather than the specifics of the St. Joseph's case, the precise details of which remain unknown. However, one factor which certainly appears to have contributed to the difficulties in Phoenix is that the hospital was not in consultation and communication with the bishop regarding the appropriate interpretation and application of the Ethical and Religious Directives.

One of the most dismaying facts to come to light as a result of the bishop withdrawing the Catholic status of the hospital is the hospital's involvement in and profit from the Mercy Health Plan which provides contraceptive drugs and devices (some of which have abortifacient properties) and also provides for abortion under certain circumstances.

Also, by its own admission, the hospital has performed other abortions in the past and will not promise to refrain from performing abortions in the future. Who knows what the nature of those

procedures were? Some might have conformed to the moral law as indirect abortions, others may not have. It is impossible to know without the facts. What is quite remarkable is that such procedures were apparently never subjected to ethical review by ecclesiastical authority.

Catholic Owned "Community Hospitals"

There was another disputed issue between Catholic Healthcare West and the bishop of Phoenix. Chandler Medical Center in the Diocese of Phoenix is a "community hospital" which is part of the Catholic Healthcare West system. The bishop insisted that Chandler Medical Center also abide by the Ethical and Religious Directives since it was a member of a Catholic health care system which was clear from its literature, website and promotional material.

"One factor which certainly appears to have contributed to the difficulties in Phoenix is that the hospital was not in consultation and communication with the bishop regarding the appropriate interpretation and application of the Ethical and Religious Directives."

The U.S. Conference of Catholic Bishops agreed with the judgment of Bishop Olmsted, that is, "community hospitals" owned, operated, financed or managed by a Catholic health care system were to be considered Catholic hospitals and subject to the Ethical and Religious Directives.

The refusal of Catholic Healthcare West to have Chandler Medical Center comply with the directives would have been sufficient grounds for the bishop of Phoenix to deny Catholic Healthcare West the privilege of operating in his diocese as a Catholic system even without the tragic incident that occurred at St. Joseph's Hospital.

The bishop has final responsibility for all the Catholic ministries that oper-

ate in his jurisdiction and is ultimately accountable for their fidelity to Catholic faith and practice which guarantees humane and compassionate practices.

Humane and Compassionate Care

Individuals approaching Catholic social service and health care institutions should be able to have the assurance that what takes place in such facilities will be consistent with Catholic moral beliefs and teachings. The day the bishop of Phoenix removed the Catholic status of the hospital, a hospital spokesman wanted to assure the public that pregnant women were safe in St. Joseph's Hospital.

But what of their unborn children? And what of mothers who desperately want to be able to bring their children to term? Do they have the assurance that physicians will not encourage, urge or even pressure them into aborting their children when a difficulty arises?

We are not suggesting that the physicians practicing at St. Joseph's Hospital would do any such thing. But the value of solemn promises, such as the Hippocratic oath or commitment to the Ethical and Religious Directives, is that the assurance that such pressures would never be brought to bear, even in difficult situations.

Women in the United States have known since 1973 that they can go into most hospitals in the country and have an abortion if they desire. Yet expectant mothers have still chosen Catholic hospitals. Why? Certainly one reason is that Catholic hospitals have publicly committed themselves to the Ethical and Religious Directives which promise compassionate and sound medical care and a commitment never to violate human dignity through surgically mutilating procedures or through the direct killing of the unborn or the elderly.

The public is free to choose the kind of health care they want. In the United States they have the options.

Since 1973 religious health care institutions and personnel have been protected from having to perform abortions through various legal protections such as the Church and Hyde amendments. The majority of Catholic hospitals are thoroughly committed to state-of-the-art health care which is also uncompromisingly respectful of human dignity. ■

Feb. 2-5

Annual Southwest Liturgical Conference Study Week. Sponsors: Twenty-seven dioceses in seven southwestern states. Theme: "Ever Ancient, Ever New: Preparing for the Revised Roman Missal." Radisson Hotel Salt Lake City Downtown. Salt Lake City, Utah. www.swlc.org

Feb. 13-16

Catholic Social Ministry Gathering. Sponsors: U.S. Conference of Catholic Bishops and 14 other national Catholic organizations. Theme: "Protecting Human Life and Dignity: Promoting a Just Economy." Omni Shoreham Hotel. Washington, D.C. www.catholicsocialministrygathering.org

Feb. 13-18

Institute for Diocesan Vocation Personnel. Sponsor: National Conference of Diocesan Vocation Directors. Sacred Heart School of Theology. Hales Corner, Wis. www.ncdvd.org

Feb. 28-March 3

National Organization for the Continuing Education of Roman Catholic Clergy Annual Convention. Theme: "To Shepherd With Wisdom and Prudence: The Ministry of Governance and the Ongoing Formation of Priests." Loews New Orleans Hotel. New Orleans, La. www.nocercc.org

March 1

Symposium: "Religion in American Politics and Society: A Model for Other Countries?" Sponsor: Berkley Center for Religion, Peace and World Affairs and Walsh School of Foreign Service. Georgetown University. Washington, D.C. <http://berkeleycenter.georgetown.edu/events>

***March 11-12**

Catholic Studies Conference: "In Search of God in the World: Scholarly Perspectives in Conversation." St. Thomas More College. Saskatoon, Saskatchewan. ctstconference@stmcollege.ca

*signifies new entry

On File

Pope Benedict XVI approved a miracle attributed to Pope John Paul II's intercession, clearing the way for the late pope's beatification on May 1, Divine Mercy Sunday. Pope Benedict's action followed more than five years of investigation into the life and writings of the Polish pontiff, who died in April 2005 after more than 26 years as pope. The Vatican said it took special care with verification of the miracle, the spontaneous cure of a French nun from Parkinson's disease — the same illness that afflicted Pope John Paul in his final years. "There were no concessions given here in procedural severity and thoroughness," said Cardinal Angelo Amato, head of the Congregation for Saints' Causes. On the contrary, he said, Pope John Paul's cause was subject to "particularly careful scrutiny, to remove any doubt." The Vatican said it would begin looking at logistical arrangements for the massive crowds expected for the beatification liturgy, which will be celebrated by Pope Benedict at the Vatican.

The Vatican announced Jan. 15 that the Congregation for the Doctrine of the Faith had erected a personal ordinariate for England and Wales "for those groups of Anglican clergy and faithful who have expressed their desire to enter into full visible communion with the Catholic Church." Father Keith Newton was named head of the new ordinariate almost immediately after he was ordained a Catholic priest along

with two other former Anglican bishops. Father Newton, who is a 58-year-old married man and former Anglican bishop of Richborough, was ordained to the Catholic priesthood earlier Jan. 15 by Archbishop Vincent Nichols of Westminster. Also ordained Catholic priests during the Mass in Westminster Cathedral were former Anglican Bishop John Broadhurst of Fulham and former Anglican Bishop Andrew Burnham of Ebbsfleet. The world's first personal ordinariate for former Anglicans is dedicated to Mary, Our Lady of Walsingham, who is venerated by both Catholics and Anglicans in England.

A Vatican official downplayed a 1997 Vatican letter to Irish bishops about handling cases of clerical sex abuse, saying the letter did not tell bishops to keep the cases secret from the police. Jesuit Father Federico Lombardi, the Vatican spokesman, said the letter aimed at ensuring the bishops fully followed church law for dealing with accusations in order to avoid a situation in which an abusive priest could return to ministry on the technicality of his bishop mishandling the process. The letter, brought to public attention Jan. 17 by Ireland's RTE television and published by the Associated Press, was written by Archbishop Luciano Storero, then-nuncio to Ireland. The letter summarized the concerns of the Congregation for Clergy regarding proposed Irish norms for dealing with the sex abuse crisis.

