MARITAL RIGHTS OF THE SINFULLY STERILIZED

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THE concern of nature for the continuance of humankind is nowhere more strikingly manifested than in man's instinctive reaction against artificial sterility. Biting contempt has been visited on this crime. Nor has law, human and divine, failed to proscribe, even from the dawn of history, the same baneful practice. Here may be cited the law of Deuteronomy: "If two men have words together, and one begins to fight against the other, and the other's wife, willing to deliver her husband out of the hand of the stronger, shall put forth her hand and take him by the secrets, thou shalt cut off her hand, neither shalt thou be moved with any pity in her regard."[1] According to Hummelauer's citation, the explanation of the chastisement is found "in the shameful female crime whereby injury to this member cuts off the very fountainhead of posterity."[2]

Nor has the pagan world restrained its contempt. There are the stinging words of Martial, excoriating heathen voluptuousness: "Cur tantum eunuchos habeat tua Gallica, quaeris Pannica. Vult futui Gallia non parere."[3] And Juvenal satirizes Roman matrons: ". . . illa voluptas, summa tamen, quod iam calida matura iuventa inguina tradantur medicis, iam pectine nigro."[4] And out of medieval times Sixtus V denounces the same crime: "Who does not consign to harsh punishment the criminals who with poisons and potions and maleficent medicaments induce sterility in womankind?"[5] And in our own times we have heard the stern teaching of Pius XI upon sterilization.

> Finally that pernicious practice must be condemned which closely touches upon the natural right of man to enter matrimony but affects also in a real way the welfare of the offspring. . . . Public magistrates have no direct power over the bodies of their subjects. Where no crime has taken place they can never directly harm or tamper with the integrity of the body either for reasons of eugenics or for any other reason. Private individuals have no other power over their bodies than that which pertains to their natural end. They are not free to destroy or

[1] Deut. 25:11–12.
[2] *Comment. in Deut., in h.l.*, n. 51.
[3] *Ad Pannicam de Gallia Uxore.*
[4] *Sat. VI.*
[5] Constitutio *Effrenatum, Fontes Iuris Canonici*, n. 165.

mutilate their members except where no other provision can be made for the good of the whole body.[6]

These witnesses, ancient and modern, proclaim that self-procured sterility is a heinous crime worthy of the contempt of men. For it trespasses not only against the integrity of the individual, but likewise against the conservation of the race. And this latter malice leads every but a decadent generation to brand as derelicts to their kind such as defraud the race of its natural expectation. In its instinctive reaction against such arts, popular imagination has seized upon the word, "cheats," to designate women who deceive therein their unsuspecting husbands. Moreover, it is a fact of racial psychology, which illumines this same instinct for race conservation implanted in human nature, that mothers react with more anxious concern to genital deformities in their *neo-nati* than to any other corporal defect.

However, our interest here lies less with the sinfulness of voluntary sterilization and more with the ethical issues of marital relations subsequent to deliberate sterilization. Wherefore a pertinent query must be raised. May the sinfully sterilized husband or wife lawfully engage thereafter in marital relations? To that question the answer waits upon a distinction: whether indeed the sterilization is remediable or irremediable, whether the condition is permanent or temporary in its effects. The moral answer, then, is conditioned largely by the physiological status of the individual. As the effects of sterilization vary in the male and the female, they must be studied separately.

Two methods of sterilizing the male are in use. One is surgical, the other is hormonal. Surgical procedure includes roentgen-ray, radium, and vasectomy. Prolonged exposure to irradiation either of roentgen-ray or radium induces gonadal atrophy with consequent aspermia. While intercourse thereafter is not impaired and eases the ardor of passion, it fails none the less in its primary purpose, generation. Irradiation brings to pass spermacrasia but it does not defunctionalize the seminiferous ducts. Contrariwise, vasectomy severs these seminal canals yet leaves spermatogenesis intact. To be effective, vasectomy must incise both vasa or tubes. Were only one resected, the other would remain capable of furthering spermigration and subsequent

[6] *Casti Connubii.*

conception. For completeness, mention is here made of vasoligature. Because it is often ineffective it is rarely used. Neither vasectomy, let it be remarked, nor ligation of seminal ducts impairs either coition or the desire for it; for surgical interference with the tubes does not eliminate the internal secretions which stimulate male potency.

Vasectomy is done according to various patterns or techniques. Thus the ducts are sometimes merely severed. But permanent sterilization, as we shall later show, is not thereby always assured. Hence this method meets with disapproval. Resection with ligation finds more favor. The tubes are ligated at two points and the sections between the ligatures are excised. Three-fourths of an inch of each tube is usually removed. This excision has, at times, been too inadequate to forestall a natural reintegration of the tubal lumina or passageways. Advocates of birth control, therefore, insist on a larger excision of the tube. A variant technique proceeds to crush the tubal ends after resection. Again, the tubal ends may be pocketed or buried in adjacent tissue or sewed to the scrotal skin or closed by sutures. Vasectomy, then, is a simple but very effective method of sterilization. Later on, sterilization through the use of estrogens will be discussed.

If we now turn to sterilization of the female, we learn that surgery uses for its accomplishment a wide variety of operations. Thus radiation of the gonads inhibits ovulation. Permanent sterilization results. But the process has its drawbacks. For cessation of ovulation precipitates a premature climacteric with all its physical and psychological disorders. Conservative surgeons are therefore loath to adopt this technique. Recourse is more often made to ligation or resection of the fallopian tubes. These tubes are conduits between the ovaries and the uterus and aid the spermatozoa in their climb towards the ovaries as well as the ovum in its descent into the uterus. Removal of these tubes means effective sterilization. Full occlusion of their lumina likewise produces sterilization. Hysterectomy and ovidectomy obtain similar results.

The above brief outline of surgical sterilization of the male and female would hardly serve its purpose if it were not correlated to recent studies in sex hormones and their influence upon sterility. Stilbestrol, a female sex hormone, has, for instance, been used successfully to prevent further metastasis in carcinoma of the prostate. Unfor-

tunately, a by-product of this therapy has been the onset of sterility, either temporary or permanent. Moreover, experience demonstrates that any protracted dosage of stilbestrol leaves impotence behind it. There is no evidence to show that stilbestrol has been used for contraceptive purposes. Against such illicit use stilbestrol has its own protection. For this estrogen kills desire and potency by its effect upon the androgens of the males. Neo-onanists, however, seek methods which impede conception but leave sexual desire and potency unimpaired.

Experimentation has been carried forward to discover the effects of testicular injections upon the process of spermatogenesis. Animals mostly have been the subjects of these trials. Rabbits have been injected with their own semen or with a serum from some other animal. A notable reduction in spermatogenesis has resulted therefrom. Moreover, through subcutaneous injections of spermatozoa temporary sterility has been brought about in female rabbits. Female rats likewise exhibit great sensitivity to various types of semen. And semen from bulls has been often used to immunize other animals against procreation from spermatozoa of their own kind. But how successful similar experiments have been in human beings remains a matter of controversy. "In Russia it is the custom to use a preparation of human semen obtained from a condom specimen diluted with two parts of salt solution and to give from twelve to eighteen intromuscular injections in the buttocks twice a week. One is forced to conclude that the value of this procedure as a contraceptive measure is still *sub judice.*"[7] Moreover, after a thorough review of the literature on the subject, Weisman reaches this conclusion: "Before immunization by spermatozoal injection can be adopted as a contraceptive measure, research on a large scale will be necessary to determine whether this procedure is as reliable as the use of the contraceptive pessary and the spermicidal jelly."[8] Here, too, it may be noted that contraceptionists do not approve the procedure as a dependable method of sterilization.[9]

With these physiological notions in mind, we may now proceed to

[7] "Selected Questions and Answers," *Journal of the American Medical Association*, 1939, p. 293.

[8] A. I. Weisman, *Spermatozoa and Sterility*, 1942, p. 207.

[9] *Journal of Contraception*, Sept. 1936, p. 137.

address ourselves to the main issue of the present paper, namely, the moral obligations of the sinfully sterilized who intend to cohabit. At once an opposite division presents itself. Of the sinfully sterilized some have been victimized, others have lent a willing co-operation. The victims are the issue of surgical sin; for some surgeons, with self-constituted authority, sterilize a patient. They neither ask his permission nor inform him of his condition. Females, especially, who have undergone one or more caesareans have been victims of such criminal surgery. And, in the course of an appendectomy, it is not unknown for a surgeon to ligate, if not resect, the fallopian tubes of the unconscious subject. Such criminally produced sterility, however, creates no moral problem for the unfortunate victim. From his standpoint it is morally indeliberate and accidental. Nor do his obligations differ in any way from those of the naturally sterilized. Both are sterile independently of their wills; the former by nature, the latter entirely through the will of another. For the latter's condition is not his sin nor the effect of his sin but totally the effect of another's sin.

Now this distinction between sin and the effect of sin occupies a large place in the solution of the problems set up by criminal sterilization. Reference to it is made by the moralists in various treatises. Most moralists use the distinction in clarifying the law on integrity of confession. Some refer to it in discussing the time factor of imputability in the double effect, others again when they establish conditions necessary to incur censure. Since moralists use the term, "effect of sin," in a technical sense, it may serve our purpose well to stop a moment and discuss it. To do so, we must first of all point out three stages in the enactment of sin. First come the mind and will to sin, second, the external act of sinning, and third, the effect of that same external act. Illustration thereof in the present matter singles out these elements: (1) the mind and will to sterilize, (2) the external act of surgery, (3) the effects of that external act, to wit, permanent barrenness. Now what moralists teach in regard to this third element, namely, the effect of sin, comes to our aid in solving the problem of the licitness of marital relations on the part of the sinfully sterilized; for many moralists, and we shall quote them afterwards, maintain that the effect of sin is neither a sin nor sinful in itself. Rather this effect of sin is something purely physical or material, bereft of any moral character. Hence it

follows that seminal frustration consequent upon sinful sterilization, if it is an effect of sin, is not, considered purely objectively, a sin nor sinful, and as such cannot infect future marital relations with the guilt of sin.

Before us, then, lies the task of proving seminal frustration an effect of sin. To accomplish this purpose, we must consult the moralists. Let it be remarked at once that different moralists use different ideas in setting forth the nature of an effect of sin. Wherefore our task calls for a citation of leading moralists and then a summation of the characteristics which they ascribe to an effect of sin, with finally an examination to discover whether these same characteristics fit the seminal frustration of the sinfully sterilized.

We may well begin our citation with Cardinal De Lugo, who writes the classical text on the effect of sin. As an illustration of his doctrine on the effect of sin, he uses the case of death from poison.

> In the sin of killing another by poison, there enters, first of all, the internal act of the will of wishing to give poison; secondly, the external act of preparing poison and administering the same; and thirdly, the death which follows. Now a rather common opinion holds that this external effect must be declared. But there is a contrary opinion and the same has always seemed to me to be more true. Now the reason is that the external act is truly and properly speaking a sin, because it is a free act, informed with the actual freedom of the internal act. But the effect which occurs afterwards, for example, while the sinner is asleep, is not properly speaking a sin. Rather it is the effect of a sin. Now in confession all sins are to be declared but only sins. Hence the external action, if free, must be disclosed. Not so, however, the subsequent effect. For this effect cannot be an actual sin in him who does not act. Nor can he actually sin who does nothing. The man who sleeps while his neighbor dies of poison does not then act and hence he cannot then sin. So there is no formal malice in the effect, nor any subject capable of being denominated a sin by reason thereof. The total influence of the will lies in this, namely, in having posited a cause which cannot now be revoked.[10]

Practically all modern authors comment on this text of De Lugo and stress certain elements which carry conviction to them. "A more probable opinion" states Genicot, "holds there is no *per se* obligation of confessing an effect of sin which occurs after the free act has entirely ceased, as, for example, in the death of an enemy from poison, even

[10] *Disputationes Scholastici et Morales de Sacramentis*, disp. XVI, nn. 437, 439, 440 449.

though this effect has been foreseen. For one cannot sin in act who does not act. Moreover, when the effect takes place, he who placed the sinful cause may be idle, nay, he may be asleep."[11] Instead of this time element, Wouters seizes upon the notion and, in his viewpoint, the need of revoking the sinful act of the will prior to the incidence of the effect. "The effect need not be declared [in confession] if the evil will has been retracted. For, with therecalling of the malicious act of the will, there now remains no source from which morality can be predicated of the effect. Hence the effect cannot come by the name of sin."[12]

Following up this opinion of Wouters, which is likewise that of St. Alphonsus,[13] their leader, Marc-Gesterman add that "in the case of revocation of the original act of the will, the effect now follows as something merely material and without moral malice."[14] De Lugo rejects the need of any revocation of the original act of the will. To him,

> . . . the whole force of the will lies in having placed a cause which cannot now be displaced ("Totus influxus ex parte voluntatis est posuisse causam quam iam nunc tollere non potest"). Therefore, since a revocation does not influence the positing of the cause nor a failure of revocation add potency to the cause already posited, the consequence remains that the will influences the aftereffect in exactly the same manner whether there is or is not a revocation of the will act.[15]

Lehmkuhl supports De Lugo and remarks, "In the case of an aftereffect no longer under the control of the will, there is no need to confess it. An example is death from poison, where it is sufficient to mention the giving of poison. But if the effect remains under the control of the will, it is a sin."[16]

Gathering up the ideas set forth by various authors upon the nature of that specialized entity, an effect of sin, we may state that they use the following notions as marks by which an effect of sin may be recognized. First, the effect must occur after all freewill activity has entirely ceased (Genicot). Secondly, the original act of the will must be revoked before the effect has taken place (Wouters, Marc-Gestermann).

[11] *Institutiones Theologiae Moralis* (ed. 1909), n. 289.
[12] *Manuale Theologiae Moralis*, II, n. 230 (4).
[13] *Theologia Moralis*, IV, 149; V, 10.
[14] *Institutiones Morales Alphonsianae*, II, n. 1692 (5).
[15] *Op. cit.*, disp. XVI, n. 446. [16] *Theologia Moralis*, II, n. 411.

Thirdly, the total influx of the will upon the effect consists in having placed the cause which cannot now be removed (De Lugo). Fourthly, the effect must be an aftereffect, no longer under the control of the will, and not an immediate effect, still under the control of the will (Lehmkuhl).

We now turn the light of this teaching upon the effects of sinful sterilization. Do these effects meet the requirements set down by moralists for classification as an effect of sin? We reply with a distinction. Certainly the effects of remediable sterilization fail to meet the requirements; for such effects remain here and now under the control of the will. But the effects of irremediable sterilization seem in every way to meet the test. First, the effect, seminal frustration, occurs after the free act of the will has entirely ceased to function. Secondly, the act of the will may be morally revoked prior to the occurrence of the precognized effect. Thirdly, the total influx of the will, objectively considered, consists in having posited a cause which it is now impossible to remove. Fourthly, the effect is indeed an aftereffect, no longer subject to the free action of the will, and not an immediate effect, still under the dominion of free will. Wherefore seminal frustration, when it takes place in the sinfully but irremediably sterilized, is neither a sin nor sinful but something rather physical and material. It is incapable, therefore, in itself, of infecting future marital relations with the malice of sin. Hence Noldin's definition of confessional integrity is to the point: "There must be a declaration of all postbaptismal mortal sins which have not been directly remitted nor properly declared according to species and number, and likewise external acts, but not the effects of sin."[17]

With this teaching on the effects of sin clear before our mind, we may now return to a more detailed discussion of the circumstances surrounding the case, previously mentioned, of the unwitting victim of sterilizaton. Such a victim is usually a female. Her condition, a pure effect of sin, imposes upon her no further obligations. But another factor often present in such cases calls for attention, namely, the connivance on the part of the husband. Where the husband suggested, or consented to the surgeon's suggestion of, the operation, several moral issues stand out. Beyond all cavil his first duty is repentance for his part in

[17] *Summa Theologiae Moralis* (ed. 16), n. 273.

the criminal action. But the physical effects of his sin are no longer under control of his will. Their undoing now rests upon the free choice of his spouse. And here again various possibilities confront us.

If the wife refuses a second operation, then the adage, *nemo tenetur ad impossibile*, works in the husband's favor and continuance of marital intimacy is licit. If she is willing, a double contingency emerges. First the sterility may be irremediable. Here we may recall that natural sterility is no bar to licit marital intercourse. And artificial sterility purged of its sinfulness and fortified with the will to repair, so far as possible, the harm done, differs naught, morally considered, from natural sterility. Secondly, if the sterility is remediable but the victim is unwilling to undergo medication, then again marital relations are licit. For no obligation presses upon the victim to submit to another operation. However, if the woman is willing, all further difficulty vanishes. These principles would likewise apply to the victims of Nazi-imposed sterilization (or State sterilization, justly or injustly inflicted).

But male sterilization by the State, Nazi or otherwise, conjures up other possibilities which demand a brief consideration; for such sterilization presents us, likewise, with the question: what of the criminal punished by vasectomy for a sex crime? May we recall here that the legality and hence the morality, as far as papal teaching ventures, remains an open question. For the words of Pius XI are indeed pointed. "Where no crime has taken place and there is no cause present for grave punishment, public magistrates can never directly harm or tamper with the integrity of the body either for reasons of eugenics or for any other reason."[18] But Catholic moralists refuse this right to the State by denying the supposition, namely, that vasectomy is a punishment. Were a married criminal unwillingly subjected to vasectomy, the question whether his right to marital congress would remain intact depends upon other factors than sterilization.

For vasectomy, be it innocently or sinfully brought to pass, projects itself, in the view of many moralists, beyond the confines of sterility into the field of impotency. Consultation of modern manualists manifests a divergence of sentiment on this issue. Thus Merkelbach: "Double vasectomy, or resection of both seminal tubes, constitutes male im-

[18] *Casti Connubii.*

potence."[19] To which Wouters adds, "That man is impotent who is unable to posit an act in itself capable of generation, one, namely, incapable of intromission accompanied by an outpouring of seed. The vasectomized is incapable of such an act."[20]

Contrary to such expression of opinion run these statements of Vermeersch: "Many writers number amongst the impotent men who have undergone vasectomy. But to us, impotence is not an established fact; for the internal stimulating secretions are not suppressed. Nor is sufficient attention paid, in our opinion, to the difference between a eunuch and a vasectomized male."[21] With Vermeersch, doubting that impotence and vasectomy are identical, stand—as quoted by Aertnys—Arendt, Mulder, and Gosam.[22] To these may be joined Jorio, the latest manualist who candidly doubts the identity of impotence and vasectomy. Moreover, he adds the significant statement that "the Holy See, interrogated in the matter of vasectomy, has thus far returned no answer either for or against the existence of the impediment."[23]

If the opinion of the theologians who teach that the vasectomized are not impotent creates probability, then marital relations may not be forbidden them. Surely the reason for claiming that the vasectomized are merely sterile is indeed sound. The vasectomized are capable of coition in all its phases. Their ejaculate lacks testicular secretions, though it does contain the secretions from the seminal vesicles, the prostate, the bulbo-urethral glands, and the glands of Littre.[24] But if such reasoning does not render dubious the position of Wouters and others, who maintain that the vasectomized do not emit *verum semen* in the sense of the decree, *Cum Frequenter*, of Sixtus V, nothing else can be done but forbid to the vasectomized marital relations. Such at least is the theoretical answer. But what of the practical response?

Here let it be recalled that we are considering the validly married. They have acquired a right in justice to intercourse, not only in view of its primary purpose, procreation, but likewise of its secondary end, the appeasement of concupiscence. Coition of the vasectomized satiates nature. And therein it differs widely from the coition of the

[19] *De Castitate*, p. 16.
[20] *Manuale Theol. Mor.*, II, n. 774.
[21] *Theologia Moralis*, IV, n. 41.
[22] Aertnys-Damen, *Theologia Moralis*, II, n. 716, q. 3.
[23] *Theologia Moralis*, III (2), n. 1178.
[24] Weisman, *Spermatozoa and Fertility*, p. 15.

castrated, which not only fails to ease passion but, according to Sixtus V, becomes a greater incentive to lust.[25] Now only such a type of marital congress is excluded from this acquired right as would terminate in an extravaginal ejaculate. Of the older theologians, Sanchez[26], Schmalzgrueber,[27] and the Salmanticenses[28] defend that position, while of the moderns, Cappello,[29] Jorio,[30] and Vermeersch[31] stand behind the same outpost.

No discussion of vasectomy and the moral issues resulting therefrom would be complete without a consideration of its counterpart in the female. At once we are faced with diverse kinds of surgical interventions which may be all contraceptive in purpose. Ligation of the fallopian tubes, resection of the same, irradiation or extirpation of the ovaries, removal of the uterus with its appendages, all such measures are types of surgical procedure inimical to female fertility. From the viewpoint of impotence, however, these operations cause little or no concern; for the Holy See has constantly answered queries about the marriages of females whose genital tract, the vagina excepted, has been excised, with the statement, "Matrimonia non impedienda sunt."[32] Consequent upon such replies of the Holy See, the use of matrimony may not be forbidden.

But several ethical questions open out of these replies from the Holy See. The first comes to this: does the female lie under the obligation of revealing her state to a future husband? The male has a right not only to intercourse but likewise to the natural fruit of that same intimacy. Here has been placed an interference with the natural fruit of intercourse and consequently an interference with the right of the male. Justice then seems to demand the informing of the husband. But if the argument from justice is not compelling, experience of life informed by charity calls for such information prior to marriage, lest postmarital life, due to recriminations once the facts are evident, become unbearably unhappy.

A second difficulty arising from sinful sterility envisages the obliga-

[25] Sixtus V, *Cum Frequenter.*
[26] *De Matrimonio*, 1, 7, d. 102, n. 6.
[27] *De Matrimonio*, 1, 4, t. 15, n. 32.
[28] *Cursus Theologiae Moralis*, IX, c. 12, n. 134.
[29] *De Matrimonio*, n. 379.
[30] *Theol. Mor.*, III (2), n. 1178.
[31] *Theol. Mor.*, IV, n. 41.
[32] Cappello, *De Matr.*, n. 357.

tion of the penitent to restore fertility by operative procedure. Any solution of this difficulty depends upon the physical condition of the individual, namely, whether the sterility is remediable or irremediable. If the latter state prevails, due to surgical extirpation of the organs, the moral issue is easy of resolution. But the ethical duty remains of repentance for the sin of illicit self-mutilation. Repentance, it is true, must prompt the will to make amends. Here, however, restitution of fertility is impossible. Sterility is now technically an effect of sin—an effect, too, independent of the will. The bond which fastened the will to the state of sinful sterility has been loosed by contrition. Morally, then, and physically the penitent is free to resume normal marital intimacy.

But where restoration of fertility is possible, the repentant will must see to its accomplishment. It may, however, be asked, when is restoration possible? Replacement of excised organs is out of the question. Hence there remains for consideration only ligation of the tubes. Untying the tubes requires surgical intervention. And if such an operation becomes a threat to life, an obligation thereto would be outlawed; for there is no obligation to do something uncertain. The operation here is at best a probable remedy. Older moralists look upon any abdominal operation as a risk to like. Modern surgeons, despite their technical skill, regard many an individual as a risk in the sense that general conditions of heart, kidney, and nervous shock would sway their judgment to counsel against the said operation.

But if the physical condition of the individual foreshadows no hazard, the paramount issue remains, nevertheless, of determining how successfully such an operation would restore the patency of the tubes. It lies well within the possibilities that the binding of the tubes has caused adhesions which obstruct the lumen thereof. Where such is the case, the mere removal of the ligature would be of no avail. Here again we are confronted with a doubtfully successful surgery to which none may be bound. Add the probability that the ligatures have with the passage of time dissolved. Again there would be no obligation to do the useless. But if the ligatures used were nonsoluble, the latter contingency drops out of consideration.

Prior, however, to any operation to relieve occlusion, the Rubin potency test would be tried. In this test either gas or air is introduced

into the genital tract. If the tubes are open, the air passes into the abdominal cavity. Thereupon the reading on the manometer used in the test falls to 90–130 mm. of mercury, and the patient, if allowed thereafter to sit erect, will feel pain in the right shoulder. If, however, the pressure rises to 200 mm. of mercury, an indication is present that both tubes are closed. This insufflation test is repeated two or three times prior to a diagnosis of occlusion. The test may likewise relieve adhesions.

Where a Rubin test terminates in a diagnosis of permeable fallopian tubes, the penitent may take up marital life without any qualms of conscience. Nature has somehow cleared out the artificial barriers. Where the test results in a decision of tubal impermeability, all the possibilities reviewed in the preceding paragraphs confront us. For what is the cause of such a condition? Ligatures, adhesions, tortion, or a host of other natural causes which stop up normal tubes.

Now moralists are loath to place an obligation of undergoing surgery unless the elements involved stand out clearly defined against the background of conscience. Among these elements, moral certitude of the successful outcome of the surgery contemplated is paramount. In the issue under advisement, the existence of the obligation to restore fertility is conditioned on the moral certainty of success in the surgery proposed. No man is constrained to risk an uncertain operation. Were it otherwise, he would be bound by probabilities. "It is hardly human," states Vermeersch, "that man should be morally bound to fulfill uncertain or probably nonexistent obligations. So too of human legislators spoke the ancient wisdom: 'Laws should be more prompt to liberate than to bind.' "[33] Where, then, the success of restoring fertility is only probable, the obligation of attempting the task is likewise only probable. *Lex dubia non obligat.*

To focus this general principle upon the specific case under consideration, let us look into the minds of moralists who express themselves upon the obligation of surgery to remove ligation of the tubes. Alberti denies any obligation to submit to an operation for untying the tubes. He reasons that sterility, natural or artificial, does not inhibit matrimonial relations.[34] Vermeersch, however, demands an operation.[34bis] To him ligation of the tubes is a temporary bar to generation. The

[33] *Theol. Mor.*, I, n. 360 (4). [34] *De Sexto et Nono*, n. 160. [34bis] *De Cast.*, n. 231.

duty of using ordinary means to prevent conception contains, in his opinion, the obligation of untying the tubes. Several contingencies issue from this.

First, the operation must promise moral certainty of success. Otherwise insistence on an obligation thereto is, as Vermeersch's own text proclaims, an indefensible proposition. Secondly, one may rightly inquire whether an abdominal operation is an ordinary means. On this point there is divergence of opinion. Certainly the older moralists and many of the modern manualists regard an abdominal operation as an extraordinary means. Jorio claims that a man in peril of his life from a stone in his entrails need not undergo an abdominal incision for its removal. Such surgery is an extraordinary means.[35]

But does the moral aspect of the means to be employed change, if a man has sinfully created the danger to himself? Does the fact that the guilty one has mutilated himself cry out for the use of extraordinary means to save himself from his own folly? Must the man who deliberately ingests a stone take extraordinary means to stave off death therefrom? No moralist pronounces explicitly on the subject. An analysis of the principle guiding the use of extraordinary means manifests its derivation from the more primary principle that no one is bound to the impossible. Something may be impossible either physically or morally. What is extraordinary is termed morally impossible. Vermeersch evidently does not deem extraordinary the operation of untying the tubes. But he recognizes the principle in permitting the repentant, permanently sterilized, to resume their marital life.

Here it is in order to consider how successful medical surgery has accomplished the task of restoring fertility. The subject is extensive and intricate. But a fairly comprehensive idea of what can and cannot be done may be gathered from a study of the two most widely used sterilizing operations. The literature abounds with informative lucubrations on female sterilization. So we shall start from it. Of the tubal operations, statistics reveal that the Madlener, named after the originator, is most extensively employed. "It consists in lifting a loop of the fallopian tube in its middle portion, crushing it with a clamp, and replacement of the clamp by a ligature of non-absorbable matter."[36] German statistics of the years 1934–36 indicate how popular the Mad-

[35] *Theol. Mor.*, II, n. 194 (3). [36] Curtis, *Gynecology* (4th ed.), p. 509.

lener technique became. In a series of 5541 sterilizations, 2067 were carried out in the Madlener way; 1213 by transplanting the tubes; 611 by salpingectomy with conical incision; 1553 by conical excision of the tube; 95 by the radical method of hysterectomy. By the most favorable clinical statistics, failure of the Madlener technique reached a possible high of one or two percent.[37]

Because of the injury done to the structure of the tubes by the Madlener and other surgical operations, small hope accompanies the efforts of remedial techniques to effect the re-establishment of fertility. Plastic surgery, rebuilding the crushed tubes, transplanting the ovarian tissue in the uterus, cutting a new uterine opening for the tubes—all such remedial work has largely failed. The *Journal of the A. M. A.* for 1939 stated: "Whether or not to operate on impermeable tubes is a difficult question to decide. The results are not very promising."[38] The latest authoritative work on this subject comments thus: "Operative intervention for bilateral closure has been disappointing, even in the hands of the expert. Plastic operation on the tubes is successful in about six percent of the cases operated. The occurrence of ectopic pregnancies following tubal operations is frequent. Other operations such as implantations of the ovary within the uterine wall have very rarely been successful."[39]

To emphasize the same small success attendant upon operative procedure in relieving natural or artificial barrenness, a brief glance at one of the latest and prominent texts on gynecology will be of distinctive advantage. Dr. Curtis, chief of obstetrics at Northwestern University Medical School, reports as follows: "Relief of sterility through abdominal operations on patients who have had pelvic infections is more frequent than is generally assumed, but the prognosis still remains too dubious to warrant more than an occasional operation. Resection of the fallopian tube with implantation into the uterus is looked upon with much greater favor."[40] Concerning the last mentioned technique, a remark is in place. There has been a favorable percentage of success in selected cases; but in unselected cases the percentage has been low.

In reporting upon the generally unsuccessful results of surgery in

[37] *Journal of Contraception*, 1936, pp. 133–34.

[38] "Selected Questions and Answers," *Journal of the Amer. Med. Assoc.*, 1939, p. 293.

[39] Weisman, *Spermatozoa and Fertility*, pp. 161–62.

[40] *Gynecology*, pp. 506–7.

renewing fertility, mention must be made of an odd phenomenon. Nature sometimes outwits the sterilizing surgeon. Some of the most mutilating surgery has not reached its goal, the prevention of generation. Eastman of Johns Hopkins reports:

> Pregnancy has occurred after all types of sterilization with the exception of bilateral oöphorectomy. Failures have been reported following tubal ligation, wedge-shaped excision of the tubal cornua, burial of the uterine end of the tubal stump, bisection of the tubes with cautery and bilateral salpingectomy. Liepman has even reported an abdominal pregnancy following supervaginal hysterectomy. The very fact that so many methods of sterilization have been advocated is in itself evidence that no single one has proved generally satisfactory.[41]

Must the moralist weigh this factor of nature's power to renew fertility, prior to declaring, in a given instance, an obligation to resort to remedial surgery? Personally we doubt it. The percentage of failures in sterilizing operations is too meagre to be reckoned in the making of a moral judgment. As pointed out, unsuccessful operations in the Madlener type attain a possible one or two percent of a vast series. Moralists found their judgments not on the exceptional but on the common factors of a situation. Here it may not be unwarranted to note Genicot's judgment based on percentages. His case is that of a hunchback who wishes to marry; his inamorata refuses, unless he divests himself of his hump. To the query whether the man may licitly suffer the scalpel for this purpose, Genicot replies: "If the danger is small, possible rather than probable, as, for example, in a twenty percent mortality, we say he may licitly run the hazard involved."[42] No American surgeon would look upon a twenty percent mortality with any degree of complacency. Nor would any of us be prone to assert of a twenty percent mortality that it was only a possible danger. But the statement of Genicot affords us grounds for maintaining that a one or two percent failure would render the operation morally perfect.

But there is a case in which failure of sterilization makes itself felt as a factor of moral judgment. Nor to the reader is the case new. We quote again from Dr. Eastman, writing of tubal ligation:

> For purposes of sterilization the fallopian tubes were tied with a strong silk ligature about one inch from the uterine attachment. The method was soon modified by Duhrssen who used a double ligature on each tube and in 1897 was

[41] *Journal of Contraception*, 1936, p. 131.
[42] *Casus Conscientiae*, Cas. n. 143.

improved by Kehrer who doubly ligated each tube at the isthmus and bisected the tube between the ligatures. As early as 1905 a number of failures had been reported following each of these procedures, a fact in keeping with the earlier animal studies of Fraenkel who had shown that in 40 percent of his series the tubal lumina remained patent and of normal diameter irrespective of the use of one, two, or three ligatures. The mechanism of failure following tubal ligation was described by Nurnberg who found the ligature produces simply a local atrophy of the tubal muscularis; the muscle then retracts to both sides of the ligature which then encloses only the Mucosa and Serosa. This releases the constricting action about the lumen which becomes patent again. These methods have consequently long since fallen into disrepute.[43]

A last blow, this, it would seem, to Vermeersch's notion of moral obligation for surgical untying of the tube, at least in cases where the ligature is not of recent attachment.

We may now turn to reparative surgery upon the sterilized male. Vasectomy is usually employed to bring male infertility to pass; for ease of performance has popularized its use. Some of the techniques resect the tubes and suture the open ends; some resect and ligate the ends; some resect and bury the ends in adjacent tissue. Few failures have been reported. Such mischances are due to simple ligation, or simple severance without sutures, or to a reservoir of sperm cells in the seminal vesicles. The persistence of nature here again comes to the fore. Most extraordinary obstacles have been conquered by sperm cells in their migration toward the ovum. Because of some rare reports, variously explained, of pregnancies after vasectomy, surgeons have devised techniques for doing vasectomy which exclude all possibilities of failure.

Hosts of men have been sterilized. It is only natural that some would desire to regain their fertility. Medical records express the regret of many men and many women sterilized at their own request over their inability to procreate, when circumstances of life so change as to make parenthood the single worthwhile ambition of their careers. Nature exacts a heavy toll of those who defraud her. And the cold, scientific annals of medicine harbor the tragic sequelae visited upon such as have deliberately and forever wrecked their chances for parenthood.

What, then, is the prognosis in vasectomy? Far from hopeful; for remedial surgery has accomplished but little in the way of restoring male fertility. A glance at the records brings confirmation of this.

[43] *Journal of Contraception*, 1936, p. 133.

And the obligation to submit to remedial surgery must wait upon the factual history of surgery. First, be it noted here, there is a lack of reports upon this subject. Consultation of the official *Quarterly Medical Index* of the years 1938–1944 reveals the fact that very few operations were performed to restore the lumen in the resected male vasa. Less than a dozen cases of anastomosis or re-establishment of communication between the several parts of the vasa are reported. Nor are the end results thereof such as to inspire confidence in attempts at anastomosis. As the operation is delicate and calls for great technical skill, and as the success of renewal of fertility is doubtful, there can be no grounds for claiming a moral obligation to resort to it. Here may be added the information that one case of spontaneous re-establishment of communication is reported.

If the successful accomplishment of anastomosis were an ordinary event following upon surgical intervention, the literature on the subject would be indeed copious. The inference seems valid. On the counterpart of this operation in the female, where some success has accompanied operative interference, the literature is generous and very detailed. Here, however, must be mentioned a statement of Jorio, a statement which runs counter to our discouraging view of anastomosis. To the query whether the doubly vasectomized male is impotent, he replies, reason given, in the negative. To these reasons he says, "Add moreover that the re-establishment of fertile communication can, according to the statements of specialists, be easily effected."[44] To this statement of Jorio we can only oppose our inability to find such expression of opinion on the part of specialists listed in the *Quarterly Index*, the authoritative reference book on medicine and surgery for America. In this volume not only work done in the United States is mentioned but likewise work done the wide world over.

Conclusions, after penance: (1) No obligation to undergo remedial surgery exists in any case of vasectomy. (2) No obligation thereto exists in any case of oöphorectomy, excision of the tubes, excision of tubal cornua, burial of uterine ends, bisection of the tube with cautery, bilateral salpingectomy—in a word, all uses of the scalpel. (3) In simple ligation of the fallopian tubes, a divergence of opinion prevents the imposition of a moral obligation.

[44] *Theol. Mor.*, III (2), n. 1178.