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THREAT OF IMMINENT DEATH IN PREGNANCY: A ROLE FOR DOUBLE-EFFECT REASONING

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In the Phoenix case, pulmonary hypertension threatened the life of an eleven-week pregnant mother. Removal of the placenta as the organ threatening the mother's life necessarily included extracting the amniotic membranes containing the fetus. The author proposes this argument: the principle of double effect clarifies that causing the death of the fetus (destined to die, whatever transpired) while avoiding a direct physical assault on it constitutes an indirect and unintended (albeit foreseen) side effect, thereby justifying the intervention.

THE PHOENIX CASE RAISES THE ETHICAL DILEMMA of causing the death of an embryo to save the life of the mother in circumstances of pulmonary hypertension that threaten her life. The embryo will inevitably die but an intervention can save one life, the mother's. This analysis considers different arguments, from the perspective of Catholic teaching against abortion, to justify the intervention in the Phoenix case. Because Catholic hospitals have to be responsive to the bishops of the dioceses in which they are located, there is need for an argument defending the Phoenix case that could be persuasive to Catholic bishops.

THREAT OF IMMINENT DEATH IN PREGNANCY

The case deals with causing the death of an eleven-week-old fetus in Phoenix, Arizona. The mother was 27-years old with four children

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and is a practicing Catholic. She had a prior condition of pulmonary hypertension that appeared to have been well controlled. An unanticipated pregnancy was confirmed at seven and a half weeks after a routine test in fall 2009. The patient opted to continue with the pregnancy even though her pulmonary hypertension would likely become more problematic. Within a month the patient was brought to the emergency room at a Catholic facility, St. Joseph's Hospital and Medical Center in Phoenix, Arizona. The diagnosis was dire, including severe pulmonary arterial hypertension, from which two other pathologies emerged, right-sided heart failure, and cardiogenic shock that can result in cardiac arrest.[1] It appears that the placenta had exacerbated the patient's prior condition into an emergency life-threatening circumstance so severe that the patient could not be transferred to another hospital. After the ethics committee's deliberation about the patient's situation at the hospital, a Catholic religious sister communicated to the physicians the committee's approval of the dilation and curettage (D&C) procedure that ended the pregnancy, naturally with the mother's consent. In November 2010, a year after the procedure and after several steps including reviewing an expert moral opinion submitted by the hospital to defend the procedure, the bishop of the Phoenix diocese announced publicly that the religious sister was automatically excommunicated for approving a procedure deemed to be a direct abortion.[2] In December 2010, the bishop, basing himself on this case and in the context of other related doctrinal concerns about practices at the hospital, revoked his consent for the hospital to claim the name "Catholic" according to canon 216.[3] The Catholic Health Association, while recognizing the authority of the local bishop as the authoritative interpreter of these directives, issued a statement that it deemed the D&C at the hospital to be in accord with Catholic directives on medical ethics; the hospital indicated that it would continue its health care service despite forfeiting its official designation

[1] See M. Therese Lysaught, "Moral Analysis of Procedure at Phoenix Hospital," *Origins* 40 (2011) 537–49, at 538; and John F. Touhey, "A Fatal Conflict: Can Catholic Hospitals Refuse to Save Lives?" *Commonweal* 38.2 (January 28, 2011) 8–10, at 8.

[2] See Michael Clancy, "Nun Excommunicated for Allowing Abortion," *National Catholic Reporter*, May 18, 2010.

[3] See Anne Hendershot, "Catholic Hospitals vs. the Bishops," *Wall Street Journal*, December 31, 2010, sec. A; and the Roman Catholic Archdiocese of Phoenix, Decree: Revoking Episcopal Consent to Claim the "Catholic" Name According to Canon 216 (December 21, 2010), http://ncrnews.org/documents/olmsted_decre2_dec21_2010.pdf. This and all other URLs cited in this article were accessed August 10, 2011.

as a Catholic hospital.[4] Not surprisingly, there has been a great deal of debate about this case among scholars and the general public.[5]

Obtaining specific details about the case is difficult insofar as federal privacy laws on patient rights prevent the woman from being identified. Moreover, the religious sister and bishop have opted not to further discuss the case in public. Given this difficulty, this article addresses the medical scenario in the Phoenix case—that the pregnant woman's life was imminently threatened by pulmonary hypertension. The previously controlled hypertension had become severe, being exacerbated by the placenta. The subsequent analysis refers to this life-threatening pathological condition of placenta-exacerbated pulmonary hypertension as the hypertension case.

Two debates arose around this controversial case. One concerns whether the relevant canons (especially cc. 1323 and 1324) in Catholic canon law warrant an automatic excommunication of the religious sister who supported the procedure.[6] The debate on automatic excommunication (referred to in c. 1398 as *latae sententiae* excommunication) involves formal cooperation in direct abortion by assisting in the procedure—conditional on the action being deliberate (c. 1321) and having knowledge of the attached penalty.[7] The other debate addresses whether the intervention that causes the death of a fetus in such circumstances could be ethically justified.[8] The issue of excommunication, which is canonical, depends on the ethical issue of the procedure being determined as wrong. Hence, the ethical issue needs clarification first, not least because of the implications for Catholic health care services. Ethicist John Touhey insightfully explains that if this intervention is deemed to be a direct abortion, when a Catholic facility refuses a termination or refuses to transfer the patient for a termination elsewhere, the facility may be in violation of the federal Emergency

[4] See Joshua U. McElwee, "Phoenix Hospital to Continue 'Faithful Mission,'" *National Catholic Reporter*, February 28, 2011, http://ncronline.org/news/phoenix-hospital-continue-faithful-mission.

[5] See, e.g., Nicholas D. Kristof, "What Would Jesus Have Done? A Bishop Excommunicates a Nun for Saving a Woman's Life," *Pittsburgh Post-Gazette*, January 28, 2010, sec. B; and Kevin O'Rourke, "What Happened in Phoenix?" *America* 202.20 (June 21, 2010), Web only: http://www.americamagazine.org/content/article.cfm?article_id=12348.

[6] See *The Code of Canon Law* (London: Collins, 2001); Thomas P. Doyle, "Shades of Grey in a World of Apparent Absolutes," *National Catholic Reporter*, May 26, 2010; and Michael Liccione, "Excommunicating Intentions," *First Things* (May 21, 2010), http://www.firstthings.com/onthesquare/2010/05/excommunicating-intentions.

[7] See *Catechism of the Catholic Church* (Vatican: Libreria Editrice Vaticana, 1994) no. 2272; and Pope John Paul II, *The Gospel of Life* (New York: Random House, 1995) no. 62.

[8] See Tom Roberts, "Ethicists Fault Bishop's Action in Phoenix Abortion Case," *National Catholic Reporter*, June 8, 2010.

Medical Treatment and Labor Act. He notes that transferring a patient for a termination elsewhere could be tantamount to immediate material cooperation in a preventable death, which is forbidden by the Catholic Ethical and Religious Directives.[9] There are high stakes dealing with whether the intervention constitutes an abortion from the perspective of Catholic teaching.

The ethical debate deals with a situation when the placenta exacerbates an underlying condition of hypertension that becomes so severe as to imminently threaten the lives of both the mother and fetus. For some, the procedure that causes the death of the fetus constitutes a direct abortion and therefore is unjustifiable—presumably, this was the bishop's position. For others, the procedure is construed as being what the Catholic tradition has called an indirect abortion, that is, a procedure whereby the death of the fetus is an indirect and unintended side effect and hence justified in the Catholic tradition to save the life of the pregnant mother[10]—presumably, this is the position of the religious sister.

Ambiguity of Moral Principles

Surprisingly, the Catholic ethical tradition appears not to have reached a satisfactory consensus on appropriate action in the circumstances of this sort of life-threatening dilemma. Two ethical principles usually offer guidance, but when the two are brought together, they can be confusing. The U.S. Catholic bishops have identified these principles in the *Ethical and Religious Directives for Catholic Health Care Services* (*ERD*).[11]

One principle, which appears to be the basis for the judgment of the bishop, explains that any direct abortion is morally wrong. This principle expresses Catholic doctrine that forbids direct abortion as an "abominable crime,"[12] whether it is "willed either as an end or a means,"[13] (that

[9] See Touhey, "A Fatal Conflict" 8–10; and United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington: USCCB, 2009) no. 70: "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion."

[10] See, e.g., Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* (Braintree, Mass.: Pope John Center, 1987) 266.

[11] At the time of the Phoenix case the 4th edition (2001) was operative, but the relevant texts for this analysis are the same in each edition.

[12] Sacred Congregation for the Doctrine of the Faith (CDF), Declaration on Procured Abortion (June 28, 1974) no. 7, referring to Vatican II, *Gaudium et spes* no. 51.

[13] *Catechism* nos. 2271, 2322; see also no. 2258: "no one can under any circumstance claim for himself the right directly to destroy an innocent human being"; John Paul II, *Gospel of Life* no. 62; and CDF, Declaration on Procured Abortion, no. 7.

is, as "a means to a good end")[14]—based on "the inviolability of the innocent human being's right to life 'from the moment of conception until death.'"[15] What is condemned here is the direct killing of innocent human life. Hence, Pope John Paul II prohibited "the deliberate and direct killing . . . of a human being."[16] *ERD* no. 45 states the ethical principle: "Abortion (that is the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion."

The other principle provides support for an alternative ethical stance that presumably was adopted by the religious sister to justify the removal of the fetus. This principle is based on Catholic doctrine as expressed in the *Catechism of the Catholic Church* that a bad effect in moral action "is not imputable if it was not willed either as an end or as a means of an action."[17] *ERD* no. 47 states the ethical principle this way: "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 after the unborn child is viable, even if they will result in the death of the unborn child."

Assuming that direct abortion is always unjustified in the Catholic tradition (the point of *ERD* no. 45),[18] the question is whether an intervention that causes the death of a fetus in such circumstances as the Phoenix case may be justified as an indirect and unintended side effect (the point of *ERD* no. 47).[19] There appears to be a stark choice between

[14] John Paul II, *Gospel of Life* no. 57; and Pius XII, "Address to the Society of Italian Catholic Midwives," October 29, 1951, *Acta Apostolicae Sedis* (hereafter *AAS*) 43 (1951) 835–54, cited in Odile M. Liebard (compiler), *Love and Sexuality*, Official Catholic Teachings (Wilmington, N.C.: Consortium, 1978) 104. Pius XII condemned the "direct [and] deliberate disposal of an innocent human life; that is to say, a disposal that aims at its destruction whether as an end or as a means to another end. . . . Thus for example, to save the life of the mother is a very noble end; but the direct killing of the child as a means to that end is not lawful" (*Love and Sexuality* 104).

[15] CDF, *Instruction on Respect for Human Life* (Rome: Vatican, 1987), Intro., no. 4. See also John Paul II, *Gospel of Life* no. 53: "no one can, in any circumstances, claim for himself the right to destroy directly an innocent human being"; and no. 57 referring to the *Catechism* no. 2258.

[16] John Paul II, *Gospel of Life* no. 58.

[17] *Catechism* no. 1737.

[18] "The inviolability of the innocent human being's right to life 'from the moment of conception until death' is a sign and requirement of the very inviolability of the person to whom the Creator has given the gift of life" (CDF, Instruction on Respect for Human Life in its Origins, Intro., no. 4).

[19] See Richard McBrien, "The Phoenix Case," *National Catholic Reporter*, July 6, 2010.

ending the life of the fetus and losing both the pregnant mother and the fetus. Yet, Catholic teaching repudiates direct abortion even to save the life of the pregnant mother because "the end does not justify the means," that is, "one may not do evil so that good may result from it."[20] Hence, the critical question is whether the Catholic tradition can justify causing the death of a fetus in a manner that avoids the moral charge of direct abortion in circumstances like placenta-exacerbated pulmonary hypertension.

Pulmonary Hypertension

Pulmonary hypertension, carrying a risk of maternal mortality rates between 30% and 56%,[21] is characterized by both the narrowing of pulmonary arteries and increased vascular resistance, placing increased pressure on the heart's right ventricle, a condition that creates significant risk for a pregnant woman and her fetus.[22] Medical literature documents that pulmonary hypertension can be associated with a variety of medical conditions,[23] and can in many cases be managed effectively.[24] However, the disease may also be associated with dysfunction of the placenta, including during the first trimester of pregnancy.[25] In pregnancy the placenta can induce or exacerbate a patient's condition of pulmonary hypertension. When hypertension leads to right-sided heart failure and cardiogenic shock, the blood supply to organs is constrained, thereby compromising blood oxygenation for both fetus and mother, leading to the placenta as a

[20] *Catechism* nos. 1753, 1756. See also CDF, Instruction *Dignitas Personae* on Certain Bioethical Questions (September 8, 2008) no. 21: "It is never permitted to do something which is intrinsically illicit, not even in view of a good result: the end does not justify the means."

[21] See Maureen A. Seckel et al., "Undiagnosed Pulmonary Arterial Hypertension," *Critical Care Nurse* 30 (2010) 45–52, at 45; A. M. Higton et al., "Pulmonary Hypertension in Pregnancy," *Internal Medicine Journal* 39 (2009) 766–70, at 766.

[22] See D. M. Paternoster et al., "Pulmonary Hypertension during Pregnancy," *Archives of Gynecology and Obstetrics* 281 (2010) 431–34, at 431; Sheilyn Huang and Evelyn R. Hermes DeSantis, "Treatment of Pulmonary Hypertension in Pregnancy," *American Journal of Health-System Pharmacy* 64 (2007) 1922–26, at 1922.

[23] See B. P. Madden, "Pulmonary Hypertension and Pregnancy," *International Journal of Obstetric Anesthesia* 18 (2009) 156–64, at 156.

[24] Michael D. McGoon and Garvan C. Kane, "Pulmonary Hypertension: Diagnosis and Management," *Mayo Clinic Proceedings* 84 (2009) 191–207, at 204–5.

[25] See Leona C. Y. Poon et al., "First-Trimester Prediction of Hypertensive Disorders in Pregnancy," *Hypertension* 53 (2009) 812–18, at 817. John Alpin specifically focuses on the eleventh week of gestation, which is the stage of fetal development in the Phoenix case. John D. Alpin, "Hypoxia and Human Placental Development," *Journal of Clinical Investigation* 105 (2000) 559–60, at 559.

shared organ becoming hypoxic.[26] As a result, the lives of the fetus and the mother are seriously jeopardized. When hypertension is associated with placental dysfunction, such as in preeclampsia and eclampsia, the resolution of the danger caused by hypertension can require the removal of the placenta during the first trimester.[27] Hence, when pulmonary hypertension imminently threatens the lives of the mother and fetus, termination of the pregnancy is presented in the medical literature as a function of saving what life can be saved, that is, the life of the mother.[28]

The placenta assumes the physiological function as an organ shared by mother and fetus (a fetomaternal organ) for metabolic interchange between them with two distinct cardiovascular systems.[29] The placenta, which is attached to the embryo by the umbilical cord, helps initiate the growth of organs in the early stages of the embryo's development. The placenta helps maintain the mother's pregnancy in a stable manner. Placental perfusion is maintained by maternal blood flow and fetal circulation, though there is no direct mixing of fetal and maternal blood.[30] The placenta, then, is a shared organ with fetal and maternal components. The maternal portion (the decidua basalis) facilitates the interaction of uterine lining with the trophoblast. Insofar as the placenta differentiates from the trophoblast,[31] the placenta is not an integral part of the fetus. The fertilized egg that generates the embryo also generates the placenta as a membranous vascular organ, thereby sharing the same genetic materials. However, as the placenta develops it contributes no genetic or cellular elements to the substance of the embryo or fetus, and it is completely discarded at the end of gestation.[32]

The purpose of the medical intervention in the Phoenix case was to remove the placenta as the organ exacerbating the pulmonary hypertension that both created and maintained the imminent threat to the mother's

[26] See G. J. Burton, E. Jauniaux, and A. L. Watson, "Maternal Arterial Connections to the Placental Intervillous Space during the First Trimester of Human Pregnancy," *American journal of Obstetrics and Gynecology* 181 (1999) 718–24.

[27] See J. M. Roberts and D. W. Cooper, "Pathogenesis and Genetics of Preeclampsia," *Lancet* 357 (2001) 53–56.

[28] See Carole A. Warnes, "Pregnancy and Pulmonary Hypertension," *International Journal of Cardiology* 97 (2004) 11–13, at 13.

[29] See Mitsuko Furuya et al., "Pathophysiology of Placentation Abnormalities in Pregnancy-Induced Hypertension," *Journal of Vascular Health and Risk Management* 6 (2006) 1301–13, at 1302.

[30] See Furuya, "Pathophysiology of Placentation Abnormalities" 1301–2.

[31] Janet Rossant and James Cross, "Placental Development: Lessons from Mouse Mutants," *Nature Reviews in Genetics* 2 (2001) 538–58.

[32] See Gerard Magill and William B. Neaves, "Ontological and Ethical Implications of Direct Nuclear Reprogramming," *Kennedy Institute of Ethics Journal* 19 (2009) 23–32, at 28.

life.[33] Even if the fetus was already dead in the uterus, the placenta could remain as a functional organ for some time, perhaps for several weeks. That is, the placenta can continue to function and undergo significant morphological changes after the fetus dies.[34] This can occur because the placenta is a shared organ of the fetus and the mother. Moreover, the possibility of prolonged uterine retention of a dead fetus clarifies as erroneous any notion that causing the death of the fetus might remedy the medical emergency in these circumstances. The placenta needs to be removed even if the fetus is already dead. Any hypothetical notion of directly killing the fetus to resolve the pathological condition of the mother is untenable. The death of the fetus, or causing its death, is not part of the means to resolve the pathology. Removal of the placenta was the necessary intervention to resolve the pathological condition.

Nonetheless, removing the placenta requires removing the amniotic membranes that contain the developing fetus. This occurs by evacuating the uterus. In the first trimester there are two surgical options for this procedure, vacuum aspiration and D&C. In the first trimester the most widely used procedure to empty the uterine contents (the placenta and amniotic membranes that contain the fetus) is surgical vacuum aspiration; it has a 99% efficacy rate. This intervention removes the products of conception, including the placenta and embryo, from the uterine wall into a collection cannula.[35] The use of D&C for this purpose occurs much less frequently,

[33] Ethicist Christopher Kaczor argues in a similar manner with regard to an ectopic pregnancy. Recognizing the placenta as an organ common to the mother and child, double-effect reasoning would permit treatment to resolve the ectopic pregnancy despite the loss of the embryo. Based on the theory of probabilism that justifies an opinion when there are legitimate doubts, he permits, albeit tentatively, both the removal of the embryo from the fallopian tube (salpingostomy) and the use of the drug methotrexate to inhibit the growth of the trophoblast, thereby preserving the tube in each case. See Christopher Kaczor, "The Ethics of Ectopic Pregnancy," *Linacre Quarterly* 76 (2009) 265–82, at 275–76; Kaczor, "Is the Medical Management of Ectopic Pregnancy by the Administration of Methotrexate Morally Acceptable?" in *Issues for a Catholic Bioethic*, ed. Luke Gormally (London: Linacre Center, 1999) 353–58, where Kaczor originally opposed the use of methotrexate; and Kaczor, *The Edge of Life: Human Dignity and Contemporary Bioethics* (Dordrecht, S.A.: Springer, 2005), chap. 6.

[34] See H. Fox and M. C. Path, "Morphological Changes in the Human Placenta Following Fetal Death," *Journal of Obstetrics and Gynaecology of the British Commonwealth* 75 (1968) 839–43, at 839; and R. A. H. Kinch, "Management of Prolonged Retention of the Dead Fetus in Utero," *Canadian Medical Association Journal* 85 (1961) 932–37, referring to a 1934 study of fetal death in utero lasting longer than three weeks.

[35] See Sigrid Bri Tristan and Melissa Gilliam, "First Trimester Surgical Abortion," *Clinical Obstetrics and Gynecology* 52 (2009) 151–59, at 153, 155; and J. Wen et al., "Manual versus Electrical Vacuum Aspiration for First-trimester Abortion: A Systematic Review," *International Journal of Obstetrics and Gynecology* (2007) 5–13, at 5.

typically being used more for diagnostic purposes or to treat other disorders such as bleeding and miscarriage.[36] In the Phoenix case, a D&C was done.

ETHICAL ARGUMENTS

Different ethical arguments can be mustered to defend an intervention in which causing the death of a fetus results from efforts to save the mother's life. Three major approaches can justify interventions that occur in situations like the Phoenix case: secular discourse that supports abortion in general; Catholic arguments that claim the physical assault on the fetus is not a moral assault; and the use of double-effect reasoning. I consider the first briefly as inconsistent with the Catholic tradition; the second at greater length as consistent with the Catholic tradition yet nonetheless problematic; and the third in most detail as both consistent with the Catholic tradition and plausible for bishops who oversee Catholic hospitals in their dioceses.

First, secular discourse that permits abortion in general would permit causing the death of an embryo or fetus to save the mother's life. Medical literature focuses on saving the life that can be saved, the mother's: the clinical circumstance of the hypertension case warrants termination of the pregnancy insofar as the embryo was destined to die and the mother could be saved. The uncontroversial nature of this perspective is suggested by the lack of discussion about it within the general abortion debate, such as among women scholars or feminist bioethicists who justify abortion for a variety of reasons. Feminist discourse on bioethics in general and abortion in particular is continually developing,[37] ranging widely from theoretical approaches[38] to practical issues that include

[36] American Congress of Obstetricians and Gynecologists, "Dilation and Curettage," http://www.acog.org/publications/patient_education/bp062.cfm.

[37] See, e.g., Jackie Leach Scully, Petra E. Baldwin-Ragaven, and Petya Fitzpatrick, *Feminist Bioethics: At Center, on the Margins* (Baltimore: Johns Hopkins University, 2010); Susan Sherwin, "Whither Bioethics? How Feminism Can Help Reorient Bioethics," *International Journal of Feminist Approaches to Bioethics* 1 (2008) 7–27; Stephanie Gilmore, *Feminist Coalitions: Historical Perspectives on Second-Wave Feminism in the United States* (Champaign: University of Illinois, 2008); Joni Lovenduski, *State Feminism and Political Representation* (New York: Cambridge University, 2005); Rosemarie Tong, Gwen Anderson, and Aida Santos-Maranan, *Globalizing Feminist Bioethics: Crosscultural Perspectives* (Boulder, Colo.: Westview, 2001); Susan M. Wolf, ed., *Feminism and Bioethics: Beyond Reproduction* (New York: Oxford University, 1996).

[38] See, e.g., the debate on care-focused versus power-focused feminist approaches as developed by Rosemarie Tong, Gwen Anderson, and Aida Santos-Maranan, eds., *Globalizing Feminist Bioethics: Crosscultural Perspectives* (Boulder, Colo.: Westview, 2001); and the feminist standpoint theory as developed by Mary Briody Mahowald in *Bioethics and Women across the Life Span* (New York: Oxford University, 2006).

sexuality and reproductive ethics,[39] respect for the human embryo,[40] support for a woman's rights including reproductive rights,[41] and debate over maternal-fetal conflict that tries to negotiate the dignity of all human life within the limits of bodily integrity.[42] Discoveries about the biology of embryogenesis and the continuing disagreement over the moral status of the human embryo have brought the abortion debate into dialogue with research on embryonic stem cells and therapeutic cloning.[43] More specifically, the sequencing of the human genome has expanded the abortion debate to include issues like prenatal genetic screening,[44] preimplantation genetic diagnosis, "savior babies," and "designer babies."[45] Yet in the general abortion debate there appears to be little discussion about cases of pulmonary hypertension that necessitate the termination of pregnancy. Moreover, Catholic discourse on abortion, including among women scholars or feminist bioethicists, evidences little attention to the termination of a pregnancy in the circumstance of life-threatening pulmonary hypertension—the topic typically does not appear in mainstream scholarship.[46] However, this analysis considers different arguments to

[39] See, e.g., Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago: University of Chicago, 2010); Estelle Freedman, *Feminism, Sexuality, and Politics* (Chapel Hill, NC: University of North Carolina, 2006).

[40] For example: Cynthia B. Cohen, *Renewing the Stuff of Life: Stem Cells, Ethics, and Public Policy* (New York: Oxford University, 2007).

[41] See, e.g., Isabelle Engeli, "The Challenge of Abortion and Assisted Reproductive Technologies Policies in Europe," *Comparative European Politics* 7 (2009) 56–74; Rosemary Nossiff, "Gendered Citizenship: Women, Equality, and Abortion," *New Political Science* 29 (2007) 61–76; Sheila McLean, "Termination and Pregnancy," in Sheila McLean and J. K. Mason, *Legal and Ethical Aspects of Healthcare* (San Francisco: Greenwich Medical Media, 2003) 131–45.

[42] See, e.g., Deborah Hornstra, "A Realistic Approach to Maternal-Fetal Conflict," in *Contemporary Bioethics: A Reader with Cases*, ed. Jessica Pierce et al. (New York: Oxford University, 2010) 312–16.

[43] See, e.g., Lori Gabel and Lori Gruen, "Ethics and Stem Cell Research," in *Stem Cell Research: The Ethical Issues*, ed. Lori Gruen, Lori Grabel, and Peter Singer (Malden, Mass.: Blackwell, 2007) 1–15.

[44] See, e.g., Mary Ann Bailey et al., eds., *Ethics of Newborn Genetic Screening* (Baltimore: Johns Hopkins University, 2009).

[45] See, e.g., Rebecca Bennett, "Reproductive Choice," in *The Blackwell Guide to Medical Ethics*, ed. Rosamond Rhodes, Leslie P. Francis, and Anita Silvers (Malden, Mass.: Blackwell, 2007) 201–19.

[46] See the writings of Barbara Hilkert Andolsen, Lisa Sowle Cahill, Sidney Callahan, Margaret A. Farley, Elizabeth Schüssler Fiorenza, Christine E. Gudorf, Kristin E. Heyer, Christine Firer Hinze, Patricia Beattie Jung, Marjorie Reiley Maguire, Anne E. Patrick, Susan A. Ross, Maura Ryan, Rosemary Radford Ruether, Susan L. Secker, and Carol A. Tauer—e.g.: Kristin E. Heyer, *Catholics and Politics: The Dynamic Tension between Faith and Power* (Washington: Georgetown University, 2008).

justify the intervention in the Phoenix case from the perspective of Catholic teaching. Hence, the general secular debate permitting abortion as an argument to legitimate the intervention in the Phoenix case need not be considered further insofar as it is inconsistent with Catholic teaching against abortion.

A second approach to justify the intervention in situations like the Phoenix case occurs in Catholic bioethics whereby the physical assault on the fetus, as being necessary to save the mother's life, is not construed as a moral assault. Scholars who adopt a revisionist approach in Catholic morality, such as Richard McCormick and Charles Curran, have sought to expand the traditionally restricted meaning of indirect moral action. Their main focus has been on proportionate reasoning—to weigh the relevant nonmoral goods in order to justify fetal death in such circumstances.[47] The basic point is to explain that physical action is not synonymous with moral action. But John Paul II in his encyclical on morality repudiated such "proportionalist theories" for which "the criteria for evaluating the moral rightness of an action are drawn from the weighing of the non-moral or pre-moral goods."[48]

However, other more traditionalist religious ethicists appear to make a similar argument—that physical action is different from moral action—even though they do not adopt the proportionalist approach of weighing goods. Methodist theological ethicist Paul Ramsey suggested ways to justify causing the death of an unborn nonviable fetus either as a direct but justifiable action or as an indirect result of an intervention to save the mother's life (assuming both will die), by construing the fetus as a type of an involuntary aggressor.[49] But this argument appears contrary to Catholic teaching that upholds unborn human life as innocent and thereby incapable of being an aggressor.[50]

[47] For an astute analysis of Catholic scholars and Jewish counterparts seeking to provide a more lenient understanding of indirect moral action in such circumstances, see Aaron L. Mackler, *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis* (Washington: Georgetown University, 2003) 133–36.

[48] John Paul II, *The Splendor of Truth* (Washington: United States Catholic Conference, 1993) nos. 75, 79.

[49] See Paul Ramsey, "The Morality of Abortion," in *Moral Problems: A Collection of Philosophical Essays*, ed. James Rachels (New York: Harper & Row, 1971) 3–27; and Ramsey, "Abortion: A Review Article," *Thomist* 37 (1973) 174–226.

[50] On resisting arguments that construe the fetus as some type of aggressor that can threaten the mother's life, see Patrick Lee, "Is Abortion Justified as Nonintentional Killing?" in *Abortion and Unborn Human Life* (Washington: Catholic University of America, 1996) 105–30; and Alfonso Gómez-Lobo, *Morality and the Human Goods: An Introduction to Natural Law Ethics* (Washington: Georgetown University, 2002) 91–96.

Catholic bioethicist Germain Grisez has listed several conditions to justify an intervention that causes the death of a fetus in these circumstances, but not intended as an end or adopted as a means: when a pathology threatens the lives of a fetus and mother, insofar as waiting is not safe and the child will unavoidably die, an intervention to save the mother is permitted despite resulting in death of the fetus. Grisez claims that it is morally irrelevant if the good effect of saving the mother is subsequent in time and physical process to the evil effect of causing fetal death, because the entire process needs to be evaluated in an indivisible manner. However, the stark inference he draws is that even craniotomy can be interpreted as not being direct killing, provided the death of the fetus is not intended (the intention being to save the mother when otherwise both will die, with the embryo's death being a side effect).[51] The difficulty with this approach is that it appears to be contrary to Catholic teaching (in the sense that the intervention cannot be safely taught) against actions like craniotomy as directly lethal (*directe occisiva*) assaults on the fetus.[52]

Recently, Catholic moral philosopher Martin Rhonheimer, focusing his analysis on ectopic pregnancies, discussed similar interventions that cause the death of the embryo. He upholds Catholic teaching that forbids direct abortion, explaining that the traditional argument to defend the life of the embryo or fetus is based on not infringing on the virtues, specifically the virtue of justice and including the principle of equality.[53] However,

[51] Germain Grisez, *The Way of the Lord Jesus*, vol. 2, *Living a Christian Life* (Quincy, Ill.: Franciscan, 1993) 470, 500–503; and Grisez, *Abortion: The Myths, the Realities, and the Arguments* (New York: Corpus, 1970) 340. Similarly Helga Kuhse (*The Sanctity-of-Life Doctrine in Medicine: A Critique* [Oxford: Clarendon, 1987] 94, 102) argues that fetal death is not "a causally prior means" in situations like those of a craniotomy or of a pregnant woman with a serious heart condition when both will die.

[52] Holy Office (May 31, 1884), *ASS* 17 (1884) 556; *ASS* 22 (1889) 748; and *ASS* 28 (1895) 384; all cited by John Connery, *Abortion: The Development of the Roman Catholic Perspective* (Chicago: Loyola University, 1977) 284–92; herein see also Connery's chapters 12–14 on the craniotomy controversy in the Catholic tradition.

[53] See the following by Rhonheimer: *The Perspective of Morality: Philosophical Foundations of Thomistic Virtue Ethics* (Washington: Catholic University of America, 2011) 226, 250, 355, 362, 392–93, 396; *Ethics of Procreation and the Defense of Human Life* (Washington: Catholic University of America, 2010) 24–29; *The Perspective of the Acting Person* (Washington: Catholic University of America, 2008) 190–91; and *Vital Conflicts in Medical Ethics* 13–14, 31–49, 84, 115, 124; on how the principle of justice and equality emerge from the Catholic tradition of Natural Law, see "Natural Law and the Thomistic Roots of John Paul II's Ethics of Human Life," *National Catholic Bioethics Quarterly* 9 (2009) 517–42, at 534; *Natural Law and Practical Reason: A Thomistic View of Moral Autonomy* (New York: Fordham University, 2000) 334; on relating natural law theory with action theory in morality, see *The Perspective of the Acting Person: Essays in the Renewal of Thomistic Moral Philosophy* (Washington: Catholic University of America, 2010).

he interprets the action to save the mother and unintentionally to cause the death of the embryo (when nothing can be done to save the embryo, which is destined to die whatever occurs) as being outside the ethical context of justice that typically protects the life of the embryo. He concludes that unintentionally causing the death of the embryo should not be construed as killing in a moral sense.[54] Hence, in ectopic pregnancy the intervention to save the mother should be understood as nothing other than the removal of a pathological situation to save the mother, recognizing that the embryo will die no matter what transpires.[55] His analysis accepts that the intervention may be construed as physically direct killing (to use his words, "*physically* direct"; "aimed directly at the embryo in a physically causal way") even if the moral intention is to save the mother.[56] For Rhonheimer what is physically direct action in itself is not morally decisive insofar as morality also requires intentionality.

Two prima facie problems with these approaches can be specified with regard to Rhonheimer's analysis. First, Rhonheimer does not explain how permitting a direct assault on the fetus is acceptable within Catholic teaching that proscribes direct and deliberate killing. Indeed, he explains that the killing he justifies is not deliberate in the sense that the moral intention focuses on saving the mother. Yet, recent Catholic teaching has opposed any physical assault on a fetus that directly causes its death. For example, the USCCB's Committee on Doctrine addressed this issue, insisting that "the surgery does not directly target the life of the unborn child."[57] Second, Rhonheimer's analysis rejects the traditional notion that two effects are present in such circumstances, the good effect of saving the mother and the bad effect of causing the death of the fetus.[58] Yet, despite arguing against the traditional reasoning of double effect, he appears to conclude precisely what that traditional approach seeks to accomplish, that the death of the embryo in these circumstances is a "non-intentional side effect" that occurs "*praeter intentionem.*"[59] However, he does not apply his analysis on ectopic pregnancy to the circumstances of hypertension other than to note that direct therapeutic abortion to save a mother's life is morally inadmissible.[60]

[54] Rhonheimer, *Vital Conflicts in Medical Ethics* 84, 115, 123–26.

[55] Ibid. 108–9, 125. For an opposing critique of this argument, see Benedict M. Guevin, "Vital Conflicts and Virtue Ethics," *National Catholic Bioethics Quarterly* 10 (2010) 471–80.

[56] Rhonheimer, *Vital Conflicts in Medical Ethics* 124, 129.

[57] Ibid. 125. Committee on Doctrine, The Distinction between Direct Abortion and Legitimate Medical Procedures (Washington: USCCB, June 23, 2010), http://www.priestsforlife.org/magisterium/bishops/10-06-23-direct-abortion.pdf.

[58] Rhonheimer, *Vital Conflicts in Medical Ethics* 40, 109–11.

[59] Ibid. 125, 129.

[60] Ibid. 125.

The argument of Catholic ethicists like Rhonheimer and Grisez was applied to the Phoenix case by Therese Lysaught, who was invited by the Phoenix hospital (at the request of the diocese's bishop) to submit an independent moral analysis to justify the D&C that terminated the pregnancy. Nonetheless, the bishop rejected Lysaught's argument. The critical threshold in Lysaught's analysis of the hypertension case adopts the same line of argument made by Rhonheimer and Grisez (albeit on different cases): the principle of double effect does not pertain; a direct physical assault causing the death of the fetus does not necessarily constitute the moral object of the action; and the moral object of the action is saving the life of the mother while recognizing that the death of the fetus is unavoidable and already in process before the D&C.[61]

While this stance has ethical appeal from a traditional Catholic perspective, it may not be maximally persuasive for several reasons. On the one hand, conceding that the D&C involves a direct physical assault on the fetus could be construed as being at odds with the Committee on Doctrine's requirement for surgery not to directly target the life of the fetus (of course, the debate here would have to focus on the meaning of "target" as referring to the moral object). On the other hand, asserting that double-effect reasoning does not pertain to the hypertension case insofar as there are not two effects raises other problems. First, describing the death of the fetus as being "indirect," "nondirect," or "*praeter intentionem*" looks like adopting the language of double-effect reasoning while claiming not to use the principle of double effect. Second, the claim that "it is inaccurate to understand the death of the fetus as an accessory consequence to the intervention" (using the language of Pius XII)[62] because the fetus was already dying appears inconsistent with the author's prior analysis where "accessory consequence" is described as meaning "nondirect." That is, it appears inconsistent to refer to fetal death as "nondirect" and also to claim that the death is not an accessory consequence, a phrase that has previously been deemed as meaning nondirect. Moreover, although the fetus may have been dying before the intervention, it was assuredly dead as a result of the intervention, inevitably raising the issue of physical and moral causality.[63]

The arguments that seek to distinguish physical from moral action have merit insofar as they struggle with the dilemma by adopting legitimate strands in the Catholic tradition on moral discourse. Yet, there

[61] Lysaught, "Moral Analysis of Procedure" 537–49.

[62] Pius XII, "Address to the Associations of the Large Families," November 26, 1951, *AAS* 43 (1951) 855–60, at 859, cited in Liebard, *Love and Sexuality* 125. The pope used the term to explain that the unintended death of a fetus was not "a direct attempt on the innocent life" (ibid.).

[63] Lysaught, "Moral Analysis of Procedure" 541, 548.

remains a difficulty: the acceptance of a direct physical assault on the fetus appears to conflict with Catholic teaching's construal of a direct physical attack on the fetus as being immoral.

Hence, a third approach can be considered to justify the intervention in the Phoenix case from the perspective of Catholic teaching against abortion. This approach relies on the traditional Catholic principle of double effect to justify the death of the fetus as an unintended, albeit foreseen, side effect of the morally justified intervention to save the mother. The next section explores this approach.

DOUBLE-EFFECT REASONING

The purpose of this discussion is to explain how the traditional Catholic distinction between direct and indirect moral action,[64] as enunciated in double-effect reasoning, can be adopted to resolve circumstances like the Phoenix case. It can be helpful to note that the USCCB's Committee on Doctrine referred to this traditional distinction to establish an appropriate moral framework for discussing such circumstances. The bishops provide general guidance that the death of a fetus can be interpreted as an indirect and unintended result of a morally legitimate procedure to save the life of the mother. However, they did not resolve the specific dispute in the Phoenix case.[65] Hence, the following analysis interprets the hypertension case within the context of this traditional distinction that was explicitly upheld by the Committee on Doctrine's statement related to the Phoenix case, even though the bishops did not apply the principle to the case.

There is a perception that double-effect reasoning should not apply to cases where the life of a woman and her fetus are under imminent threat from conditions like eclampsia or hypertension.[66] The reason for that perception may be that the Catholic Church from the late 19th century has interpreted killing the fetus to save the mother's life such as in craniotomy as a direct abortion.[67] For example, John Paul II reiterated long-standing church teaching that "the direct and voluntary killing of an innocent human being is always gravely immoral."[68] Pius XII explicitly condemned the

[64] The distinction between direct and indirect does not depend on the certainty of the bad effect occurring. See Connery, *Abortion* 297.

[65] See USCCB, Committee on Doctrine, Distinction between Direct Abortion and Legitimate Medical Procedures.

[66] See, e.g., A. B. Shaw, "Two Challenges to the Double Effect Doctrine: Euthanasia and Abortion," *Journal of Medical Ethics* 28 (2002) 102–4, at 103 (claiming that "the doctrine forbids" assistance in such cases).

[67] See, e.g., Rhonheimer, *Vital Conflicts in Medical Ethics* 5, 17–18, 58, referring to Catholic Church statements on craniotomy being morally illicit, in *Acta sanctae sedis* (hereafter *ASS*) 17 (1884) 556.

[68] John Paul II, *Gospel of Life* no. 57.

"direct attack on innocent human life, as a means to an end" even "to the end of saving another life."[69] Also, Pius XII emphasized in an address to midwives: "to save the life of a mother is a very noble end; but the direct killing of the child as a means to that end is not lawful."[70] The crucial question, then, is whether double-effect reasoning can be used to interpret causing the death of a nonviable fetus as a permitted side effect in a D&C procedure.

Double-effect reasoning generated the principle of double effect. Catholic teaching has adopted this principle[71] specifically in settled cases like removing a cancerous uterus in pregnancy,[72] removing a fallopian tube to resolve an ectopic pregnancy,[73] using medication that causes sterilization,[74] justifying analgesics for pain relief that may hasten death,[75] and justifying terminal sedation for pain relief.[76] Scholars have widely used the

[69] Pius XII, "Address to the Associations of the Large Families" 125.

[70] Pius XII, "Address to the Society of Italian Catholic Midwives" 835–54.

[71] See USCCB, Ethical and Religious Directives no. 47.

[72] Pius XII, e.g., wrote: "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 foetus, such an act could not be called a *direct* attempt on the innocent life. In these conditions the operation can be lawful, . . . provided . . . that it is not possible to postpone it till the birth of the child, or to have recourse to any other efficacious remedy" (Pius XII, "Address to the Associations of the Large Families" cited in Liebard, *Love and Sexuality* 126–27, emphases original).

[73] See John F. Touhey, "The Implications of the *Ethical and Religious Directives for Catholic Health Care Services* on the Clinical Practice of Resolving Ectopic Pregnancies," *Louvain Studies* 20 (1995) 41–57.

[74] Pius XII justified medication that resulted in "indirect sterilization, which is permitted according to the general principles governing acts with a double effect" ("Address to the Seventh International Hematological Congress in Rome" [September 12, 1958], *AAS* [1958] 735–36, cited in Liebard, *Love and Sexuality* 237).

[75] Pius XII used the principle of double effect to justify using drugs for pain control even "if the suppression of the pain could be obtained only by the shortening of life" provided that "the actual administration of drugs brings about two distinct effects, the one the relief of pain, the other the shortening of life" assuming "a reasonable proportion" in the case ("Religious and Moral Aspects of Pain Prevention in Medical Practice," address to the Ninth National Congress of the Italian Society of the Science of Anesthetics, February 24, 1957, *AAS* 49 [1957] 129–47).

[76] See Joseph Boyle, "Medical Ethics and Double Effect: The Case of Terminal Sedation," *Theoretical Medicine and Bioethics* 25 (2004) 51–60; Raymond J. Devettere, *Practical Decision Making in Health Care Ethics: Cases and Concepts*, 3rd ed. (Washington: Georgetown University, 2010) 331–32; and Rita L. Marker, "End-of-Life Decisions and Double Effect," *National Catholic Bioethics Quarterly* 11 (2011) 99–119.

principle[77] especially with regard to bioethical dilemmas, again to resolve situations like a cancerous uterus or an ectopic pregnancy to save the mother's life despite the loss of the embryo or fetus.[78]

The principle originated with a distinction between effects made by Thomas Aquinas when discussing self-defense.[79] At times the principle has been expressed in terms of the lesser evil.[80] Aquinas distinguished between the intended good effect and the unintended bad effect. This distinction presents the bad effect as being beyond the agent's intention (*praeter intentionem*) in the sense that an action causes a result that would be immoral to intend as a means or as an end.[81] While double-effect reasoning can be attributed to Aquinas,[82] its meaning developed especially in the 17th to the 19th centuries.[83] Three distinct phases in the historical development of the principle can be tracked between Thomas Aquinas in

[77] See J. T. Mangan, "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10 (1949) 41–61; Richard A. McCormick, *Ambiguity in Moral Choice* (Milwaukee: Marquette University, 1973); and Daniel Sulmasy and Edmund Pellegrino, "The Rule of Double Effect," *Archives of Internal Medicine* 159 (1999) 545–50.

[78] See, e.g., Daniel M. Cowdin and John F. Touhey, "Sterilization, Catholic Health Care, and the Legitimate Autonomy of Culture," *Christian Bioethics* 4 (1998) 14–44, at 25; Christopher Kaczor, "Ethics of Ectopic Pregnancy" 265–82, at 266–67.

[79] See Thomas Aquinas, *Summa theologiae* (hereafter *ST*) 2–2, q. 64, a. 7. Aquinas developed his view from Augustine's support for self-defense; see Thomas A. Cavanaugh, *Double-Effect Reasoning* (Oxford: Clarendon, 2006) 2–4, 196. Catholic teaching adopts the use of the principle of double effect to legitimate self-defense; see *Catechism* no. 2263.

[80] Aquinas developed his understanding of double effect from selecting a lesser evil in a particular dilemma; see Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Los Angeles: University of California, 1988) 312. Also, the CDF explains that when "moral principles are invoked, such as those of the lesser evil or double effect," they may not be used "to do something which is intrinsically illicit, not even in view of a good result: *the end does not justify the means*" (Instruction *Dignitas personae* on Certain Bioethical Questions, no. 21, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html).

[81] See Rhonheimer, *Vital Conflicts in Medical Ethics* 20; and the following by Joseph M. Boyle Jr.: "*Praeter intentionem* in Aquinas," *Thomist* 42 (1978) 649–65; "Double Effect and a Certain Type of Embryotomy," *Irish Theological Quarterly* 44 (1977) 303–18; "Towards Understanding the Principle of Double Effect," *Ethics* 90 (1980) 527–38; "Who Is Entitled to Double Effect?" *Journal of Medicine and Philosophy* 16 (1991) 475–94.

[82] See, e.g., Mangan, "Historical Analysis of the Principle of Double Effect" 41–61.

[83] Josef Ghoos, basing himself on the work of Bartolomeo Medina (1528–80), Gabriel Vasquez (1551–1604), and John of St. Thomas (1589–1644), has argued that the principle originated after Aquinas ("L'Acte à double effet: Étude de théologie positive," *Ephemerides theologicae lovaniensis* 27 [1951] 30–52).

the 13th century, Jean Pierre Gury in the 19th century, and Peter Knauer in the 20th century.[84] The formulation of the principle with distinct conditions or criteria that pertains today arises from the work of Jean Pierre Gury (1801–1866).[85]

In secular discourse, the plausibility of double-effect reasoning elicits ongoing critique while not always rejecting it.[86] Nonetheless, the Catholic tradition continues to use the principle to resolve ethical dilemmas. The principle differentiates between the purpose of a moral action and the intention of the agent (presented by the traditional distinction between *finis operis* and *finis operantis*),[87] while clarifying effects that are foreseen but not intended,[88] and describing these as morally licit side effects.[89] In Catholic teaching the principle is based on the following understanding of moral action: "The morality of the human act depends primarily

[84] Kaczor insightfully argues that the history of double-effect reasoning has three critical junctures in its development: from Aquinas, to Jean Pierre Gury in the 19th century as the originator of the modern notion of the double-effect principle, to Peter Knauer in the 20th century for whom the principle of double effect is the fundamental principle of morality. Christopher Kaczor, "Double-Effect Reasoning from Jean Pierre Gury to Peter Knauer," *Theological Studies* 59 (1998) 297–315. On the history of the principle, see Cavanaugh, *Double-Effect Reasoning* 1–37.

[85] See Jean Pierre Gury, *Compendium theologiae moralis* (New York: Benzinger, 1874) tr. 1, c. 2, n. 9, discussed by Kaczor, "Double-Effect Reasoning" 301.

[86] See, e.g., the President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington: President's Commission, March 1983); Timothy E. Quill, Rebecca Dresser, and Dan W. Brock, "The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making," *New England Journal of Medicine* 337 (1997) 1768–71; Georg Spielthenner, "The Principle of Double Effect as a Guide for Medical Decision-Making," *Medicine, Health Care, and Philosophy* 11 (2008) 465–73; and Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University, 2009) 162–66.

[87] The technical debate addresses the difference between the *finis operis* (the purpose of the action) and *finis operantis* (the end sought by the agent). See Aquinas, *ST* 1-2, q. 1, a. 3; q. 18, a. 2–7, 10. For a discussion of the distinction see Peter Knauer, "The Hermeneutic Function of the Principle of Double Effect," *Natural Law Forum* 12 (1967) 132–62; Louis Janssens, "Ontic Evil and Moral Evil," *Louvain Studies* 4 (1972) 115–56; and Bernard Hoose, *Proportionalism* (Washington: Georgetown University, 1987) 1–13, 27–37, 101–30. On Catholic teaching about this basic distinction, see John Paul II, *Splendor of Truth*, section IV, "The Moral Act."

[88] On the necessity for this distinction between intending and foreseeing harm, see Alison Hills, "Defending Double Effect," *Philosophical Studies* 116 (2003) 133–52; Thomas A. Cavanaugh, *Double-Effect Reasoning* chaps. 3, 4.

[89] See G. E. M. Anscombe, "Medalist's Address: Action, Intention, and 'Double Effect,'" *Proceedings of the American Catholic Philosophical Association* 56 (1982) 12–25.

and fundamentally on the object rationally chosen by the deliberate will."[90] In this context, direct killing of innocent life has to be both deliberate and voluntary. Catholic teaching conveys this clearly: "the direct and voluntary killing of an innocent human being is always gravely immoral";[91] "procured abortion is the deliberate and direct killing . . . of a human being . . . extending from conception to birth";[92] "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."[93] Direct abortion, then, is an example of moral actions that Catholic teaching refers to as "intrinsically evil" (*intrinsice malum*) in this sense: "there exist acts which *per se* and in themselves, independently of circumstances, are always seriously wrong by reason of their object."[94]

In the Catholic tradition the principle functions in a hermeneutical manner to interpret complex cases. Bioethicist David Kelly explains that the principle should be construed not as a particular principle among many others but as a general framework (applicable to most, if not all, dilemmas in medical ethics) for interpreting which effects may be permitted or proscribed.[95] This interpretative understanding of the principle emphasizes the significance of distinguishing between a morally intended action and its unintended side effects.

Over centuries, this sophisticated form of moral analysis has arisen from and been illustrated in established cases that can enlighten new cases as they emerge. Moral theologian James F. Keenan has described the role of these cases as being the heuristic function of the principle. He argues that historically the principle developed when practical moral analysis established that "one case is congruent with a paradigm case and that the rightness of the solution is already internal to the case."[96] His point is twofold: first, that moral justification of action ("rightness of the solution") arises from a practical and integrative analysis of each circumstance ("internal to the case"); second, that a previously resolved case can enlighten a new case insofar as its moral analysis is as comparably

[90] John Paul II, *Splendor of Truth* no. 78, referring to Aquinas, *ST* 1–2, q. 18, a. 6.
[91] John Paul II, *Gospel of Life* no. 57.
[92] Ibid. no. 58.
[93] Ibid. no. 62. Curiously, the U.S. bishops' definition of abortion in *ERD* no. 45 does not mention the language "as an end or as a means."
[94] John Paul II, *Splendor of Truth* no. 80. See also Rhonheimer, *Natural Law and Practical Reason* 475–83.
[95] See David F. Kelly, *The Emergence of Roman Catholic Medical Ethics in North America* (New York: Edwin Mellen, 1979) 259–64.
[96] Keenan, "Function of the Principle of Double Effect" 294–315. On the heuristic function of the principle, see Philippa Foot, "The Problem of Abortion and Double Effect," in *Virtues and Vices: And Other Essays in Moral Philosophy* (1978; Oxford: Basil Blackwell, 1981) 19–32.

persuasive. In other words, "the principle provides the heuristic insight that the case's logic seems comparable to the logic in the paradigm cases."[97] Keenan argues that as a result of this process there arises "a shorthand expression" of the "relationship among a number of paradigm cases,"[98] which generated the four conditions of the principle that led to settled cases in the Catholic tradition.

SETTLED CASE

The principle of double effect distinguishes between the direct (intended) and indirect (unintended) features of moral action. This distinction has been adopted typically in the Catholic tradition to justify the removal of a cancerous uterus from a pregnant woman.[99] This settled case can enlighten the hypertension case insofar as in each case a specific organ is the source of the pathology.

In the case of removing a cancerous uterus the death of a previable fetus is considered to be an indirect, unintended outcome. The moral object (often referred to as the "act in itself") is the removal of the cancerous uterus, despite the foreseen, unavoidable, but unintended death of the developing fetus.[100] And the deadly cancer provides the proportionate circumstances for the intervention. When discussing the Phoenix case, the USCCB's Committee on Doctrine accurately summarized the removal of a cancerous uterus during pregnancy in this way:

> The second scenario describes a situation in which an urgently needed medical procedure *indirectly* and unintentionally (although foreseeably) results in the death of an unborn child. In this case the surgery *directly* addresses the health problem of the woman, i.e., the organ that is malfunctioning (the cancerous uterus). The woman's health benefits directly *from the surgery*, because of the removal of the cancerous organ. The surgery does not directly target the life of the unborn child. The child will not be able to live long after the uterus is removed from the woman's

[97] See James F. Keenan, "The Function of the Principle of Double Effect," *Theological Studies* 54 (1993) 294–315, at 312–13.

[98] Ibid. 295; see also 313.

[99] For an explanation of applying double effect to the removal of a cancerous uterus in the early 20th century, see Connery, *Abortion* 295; and Kelly, *Emergence of Roman Catholic Medical Ethics* 260–61, 265–66, 291, 302. For another traditional interpretation of the legitimacy of double-effect reasoning in the case of removing a pregnant woman's cancerous uterus, see Arthur Vermeersch, "Avortement direct ou indirect," *Nouvelle revue théologique* 60 (1933) 600–620. Vermeersch opposed Gemelli's stance that such a case was a form of direct abortion; see Agostino Gemelli, "Application à avortement des notions de causalité per accidens et de causalité per se," *Nouvelle revue théologique* 60 (1933) 500–527.

[100] See, e.g., David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington: Georgetown University, 2004) 111–12; and Kelly, *Emergence of Roman Catholic Medical Ethics* 247–58.

body, but the death of the child is an unintended and unavoidable side effect and not the aim of the surgery.[101]

The case of the cancerous uterus and the hypertension case are obviously different, especially insofar as the need to remove a cancerous uterus could pertain independently of a pregnancy. However, there are important similarities. In each case, the threatening organ may be removed to prevent the imminent death of the mother—there is no direct attack on the fetus, though causing its death is inevitable. In one situation it is the uterus that is removed, within which the fetus is contained; in the hypertension case, the surgical procedure removes the placenta and amniotic membranes containing the fetus. Insofar as the placenta is not an integral part of the fetus alone, removing it does not constitute an attack on the fetus (though the removal of a pathological organ could be justified even if the placenta was exclusively an organ of the fetus).[102] In neither case does the intervention involve a direct physical assault on the fetus—as the Committee on Doctrine emphasized, the intervention or procedure must "not directly target the life of the unborn child."

Edward Furton of the National Catholic Bioethics Center (NCBC) provides a contrary and controversial explanation of the point at stake here by indicating that a direct attack on the life of a fetus occurs when the action "touches on the body of another human being in such a way as to bring about that person's death."[103] Of course, Furton's moral interpretation of touching the physical body can be contested as reflecting a truncated view of Catholic morality, such as occurs in a recent essay by another NCBC ethicist.[104] Even in Furton's extreme position, the procedure under consideration in this application of double-effect reasoning to the Phoenix case would not be construed as being immoral insofar as there is no action that physically directly kills the embryo.

In Catholic teaching physical life constitutes a fundamental value: "on this physical life all the other values of the person are based and developed."[105] Hence, the purpose of double-effect reasoning in the hypertension case is to clarify that removing the placenta to save the mother can

[101] Committee on Doctrine, The Distinction between Direct Abortion and Legitimate Medical Procedures.

[102] Ethicists from the NCBC note that "the placenta is not part of the body by which the individual is identified; therefore, to take actions to remove it when it is diseased is not an attack on the person" (Peter. J. Cataldo and T. Murphy Goodwin, "Early Induction of Labor," in *Catholic Health Care Ethics*, 2nd ed., ed. Edward J. Furton et al. [Philadelphia: NCBC, 2009] 111–18, at 118 n. 2).

[103] Edward J. Furton, "The Direct Killing of the Innocent," *Ethics and Medics* 35 (October, 2010) 1–2.

[104] Stephen Napier, "'Direct' Versus 'Indirect,'" *Ethics and Medics* 36 (2011) 3–4.

[105] CDF, Instruction on Respect for Human Life, Intro., no. 4.

be construed as the moral object (being deliberate and voluntary), albeit with the foreseen and unavoidable death of the fetus (being indirect and unintended). There is an assurance that the death of the fetus is unintended insofar as directly killing the fetus would itself not resolve the underlying pathology of pulmonary hypertension (or the pathology of the cancerous uterus in the other case). For example, even if the fetus were already dead, the intervention both in the hypertension case and in the case of the cancerous womb would be justifiable.

Another case might be considered to shed light on double-effect reasoning from the perspective of Catholic teaching against abortion. The traditional application of the principle has been applied to a medical circumstance that is similar to the removal of the placenta by evacuating the uterine contents. NCBC ethicists have argued that the principle applies legitimately in the case of a 16-week previable pregnancy where there is severe infection of the chorionic and amniotic membranes that imminently threatens the life of the fetus and mother. In their view, to remedy the pathology, the principle permits the induction of labor that causes the expulsion from the uterus of the infected chorionic and amniotic membranes along with the expulsion of the previable fetus. The NCBC analysis explains that the action "is a good kind of thing to do" despite the death of the fetus, which is foreseen but unintended. This perspective is shared by NCBC ethicists Peter Cataldo and Edward Furton.[106]

However, there is a crucial question that may differentiate these cases (removing the cancerous uterus or inducing labor) from the hypertension case. Insofar as the D&C procedure can cause the fetus to be dismembered, perhaps the action could be construed as a direct physical assault on the life of a fetus.[107] For some Catholic scholars, both from traditionalist and revisionist perspectives, a physical assault on the fetus can be construed as not being morally significant in circumstances to save the mother's life.[108] But double-effect reasoning adopts a different approach. The D&C procedure does not touch on the body of the fetus in a direct manner. Nevertheless, dismemberment of the fetus can occur during the procedure, even though it is an unintended side effect. Similarly, damage to the fetus obviously can occur when removing a cancerous uterus by abdominal, vaginal, or laparoscopic hysterectomy. Also, when a pregnant woman undergoes chemotherapy or radiation for cancer, serious fetal abnormalities and intrauterine fetal deaths can result, especially in the

[106] See Cataldo, "Principle of Double Effect" 83–84; Edward J. Furton and Albert S. Moraczewski, "Double Effect," in *Catholic Health Care Ethics: A Manual for Ethics Committees*, ed. Peter J. Cataldo and Albert S. Moraczewski, foreword Edmund D. Pellegrino (Boston: NCBC, 2001) 23–26, at 25.

[107] See Leies, *Handbook on Critical Life Issues* 68.

[108] See my discussion of the views of Rhonheimer and Grisez above, pp. 859–62.

first trimester.[109] In each of these situations, the physical damage to the fetus in its dying process and indeed, even worse, its physical death are unintended side effects of the morally permissible intervention.

In the historical development of double-effect reasoning there was caution among traditional scholars about emptying the uterus such as by perforating the amniotic sac. These scholars interpreted directly emptying the uterus or perforating the membranes to empty the uterus as being direct and illicit means to save the mother's life.[110] In contrast, medical science today clarifies that, in circumstances when the placenta induces or exacerbates hypertension, it is the removal of the placenta that resolves the pathological condition. With this scientific information, the removal of the placenta with the amniotic membranes containing the fetus could satisfy the cautious approach of traditional scholars. Traditional scholars legitimized "the employment of means for some other end than the expulsion of the fetus, although it is foreseen that they may unintentionally cause the expulsion of the fetus."[111] The foreseen but unintended side effect occurs *per accidens* (in the language of Aquinas),[112] which the subsequent Catholic tradition refers to as being indirectly voluntary.[113]

By adopting this principle, the hypertension case can be explained in this manner. Using the language of *ERD* no. 45, "the directly intended" action was the removal of the placenta (as required to resolve the pathological condition) and not the death of the fetus whose unavoidable loss is foreseen but not intended. The "sole immediate effect" was the removal of the placenta and amniotic membranes (recognizing that the fetus is contained within). Using the language of *ERD* no. 47, the procedure had as its "direct purpose the cure of a proportionately serious pathological condition of a

[109] For a classical study, see Elyce Cardonick and Audrey Iacobucci, "Use of Chemotherapy during Human Pregnancy," *Lancet Oncology* 5 (2004) 3282–91; a recent survey, Elyce Cardonick et al., "Perinatal Outcomes of a Pregnancy Complicated by Cancer," *American Journal of Clinical Oncology* 33 (2010) 221–28; and Mary Schmitt, "Use of Chemotherapy in Pregnant Breast Cancer Patients," *Journal of Nursing Student Research* 2 (2009) 3–6.

[110] See Kelly, *Emergence of Roman Catholic Medical Ethics* 287–88, 299–302, referring to works on medical ethics by Andrew Francis Klarmann, Edward F. Burke, and Patrick A. Finney.

[111] Ibid. 302, citing Patrick A. Finney, *Moral Problems in Hospital Practice: A Practical Handbook* (St. Louis: Herder, 1922, 1956) 96–97.

[112] Aquinas explains that moral judgment pertains to "what is *per se*" and not to "what is *per accidens*" (*ST* 2–2, q. 20, a. 5). For an explanation, see Eric Rovie, "Reevaluating the Historical Evolution of Double Effect: Anscombe, Aquinas, and the Principle of Side-Effects," *Studies in the History of Ethics* 2 (2006) 1–34, at 27.

[113] See CDF, Declaration on Euthanasia (May 5, 1980), section III. For a historical explanation of the meaning of "indirectly voluntary" with regard to an unintended but foreseen effect when using the principle of double effect, see Rhonheimer, *Natural Law and Practical Reason* 548–75.

pregnant woman" that would unavoidably "result in the death of the unborn child." Hence, the moral analysis of the hypertension case can be expressed in shorthand manner by referring to the four conditions or criteria of the principle as discussed in the next section.

CONDITIONS OF DOUBLE EFFECT

The principle of double effect has four conditions that at times are described from a theoretical perspective in different ways.[114] For example, Knauer argued that the first three conditions can be reduced in a teleological manner to the fourth condition of proportionate reason. His stance became a foundation for the development of what was called "proportionalism" in Catholic moral theology, a movement that was eventually rejected by John Paul II.[115] In contrast, Bruno Schüller argued in a more traditional manner that the principle's conditions should be interpreted within the deontological context of an underlying moral approach that was grounded on prohibiting intrinsically wrong action. Hence, the first condition became necessary for the other three.[116] It is sufficient for the present practical analysis to indicate how the hypertension case satisfies the traditionally accepted conditions of the principle.

The first condition, which deals with the object of the action, requires that the morally intended action is either good or morally indifferent with respect to the moral object.[117] As in the legitimate removal of a life-threatening cancerous uterus during pregnancy, so in the hypertension case, this first condition deals with the legitimate removal of the placenta and amniotic membranes containing the fetus to resolve the mother's pathological circumstances.

The second condition, which deals with the material cause of the action, requires that the bad effect must not cause the good effect. The bad effect cannot be the means to attain the good effect; the good effect must not follow from the bad effect. However, the two effects may occur simultaneously—the good effect must follow from the action at least as

[114] See, e.g., Gerald Andrew Kelly, *Medico-Moral Problems* (Saint Louis: Catholic Health Association: 1958) 12–14; McCormick, *Ambiguity in Moral Choice* 1; Kelly, *Emergence of Roman Catholic Medical Ethics* 251, and *Contemporary Catholic Health Care Ethics* 109–11; Hoose, *Proportionalism* 101–31; and Rhonheimer, *Vital Conflicts in Medical Ethics* 2.

[115] See Peter Knauer, "La determination du bien et du mal par le principe de double effet," *Nouvelle revue théologique* 87 (1965) 5356–76; John Paul II, *Splendor of Truth* no. 79.

[116] See Bruno Schüller, "The Double Effect in Catholic Thought: A Reevaluation," in *Doing Evil to Achieve Good* 165–92, at 167.

[117] See Kelly, *Contemporary Catholic Health Care Ethics* 109; Rhonheimer, *Vital Conflicts in Medical Ethics* 2.

immediately as the harmful effect.[118] As the removal of the cancerous uterus is not achieved by causing the death of the fetus, so in the hypertension case the removal of the placenta and amniotic membranes is not achieved by causing the death of the fetus. The good and bad effects occur together as permitted by this condition of the principle.

The third condition, which deals with the agent's intention, requires that the good effect is directly intended and the bad effect is merely foreseen but unintended—the agent must not intend the bad effect.[119] As in removing a cancerous uterus where causing fetal death is a side effect, so in the hypertension case by removing the placenta as the offending organ the death of the fetus is a foreseen but unintended side effect. In each case the moral intent is focused on removing the offending organ to resolve the woman's pathological condition.

The fourth condition, which deals with proportionate reason, requires an appropriate balance between the intended good effect and the permitted but unintended evil effect—the unintended bad effect may not outweigh the intended good effect.[120] This condition of proportionality should be understood not only as meaning that there are sufficiently serious moral reasons for the intervention,[121] but also as requiring that there is no other effective way to achieve the good effect.[122] A cancerous womb containing a fetus may be removed legitimately when the mother's life is in imminent danger, even though the death of the fetus is foreseen.[123] Likewise in the hypertension case, the placenta and amniotic membranes containing the fetus may be removed legitimately when the mother's life is in imminent danger, even though the death of the fetus is foreseen.

These four conditions express in shorthand the complex reasoning that occurs in using the principle of double effect. However, it appears

[118] See Kelly, *Contemporary Catholic Health Care Ethics* 109–10; Rhonheimer, *Vital Conflicts in Medical Ethics* 2.

[119] See Kelly, *Contemporary Catholic Health Care Ethics* 110–11; Rhonheimer, *Vital Conflicts in Medical Ethics* 2.

[120] See Kelly, *Contemporary Catholic Health Care Ethics* 111; Rhonheimer, *Vital Conflicts in Medical Ethics* 2.

[121] See, e.g., Boyle, "Who Is Entitled to Double Effect?" 476.

[122] Spielthenner argues that the standard principle does not include the requirement that there is "no other way (or at least no better way) of producing the good effect" ("Principle of Double Effect as a Guide" 467). However, the classical case of using this principle (to justify removal of a cancerous uterus despite foreseeing the death of the fetus) explicitly asserts the observation "provided . . . that it is not possible . . . to have recourse to any other efficacious remedy" (Pius XII, "Address to the Associations of the Large Families" [November 26, 1951] *AAS* 43 [1951] 859, cited in Liebard, *Love and Sexuality* 127.

[123] Cataldo, "Principle of Double Effect" 83.

that confusion in the Phoenix case revolves around the second condition permitting the good and bad effects to occur simultaneously. The causal distinction of effects clarifies how willingly doing one action to achieve the good effect can unwillingly permit the bad effect.[124] The death of the fetus does not occur instrumentally as a means to a good end, but occurs incidentally as a bad side effect that arises from the morally intended good effect.[125] To understand the importance of this second condition of the principle, two points need to be emphasized.

First, the evil effect should not cause the good effect.[126] The principle forbids both the bad effect causing the good effect and intending the bad effect as a means to achieving the good effect.[127] Ethicist Gerald Kelly explained that "the evil effect must not be the means of producing the good effect" but instead must be "simply unavoidable by-products" of an action that seeks the good effect.[128] The good effect should not depend on the bad effect.[129]

Second, the good and bad effects may occur together. Ethicist Joseph McFadden explained that "the good effect of the action must precede the evil effect or at least be simultaneous with it"—and David Kelly in his landmark historical study of Catholic medical ethics interprets this stance as requiring no causal relation from the bad to the good effect.[130] The traditional language that was adopted to convey the concurrent occurrence of the good and bad effects was immediacy. For example, Joseph Mausbach and Gustav Ermecke (followers of Jean Pierre Gury) explained that "the good effect should proceed from the cause as immediately as the evil effect"—this emphasis on the simultaneous emergence of the two effects was subsequently highlighted by other interpreters like Marcelino Zalba, Eduardo Fernández Regatillo, and Benoit Henri Merkelbach to argue that "the good effect should at least be equally immediate as the

[124] For this distinction on what Ramsey calls "indirect voluntareity" see "Incommensurability and Indeterminacy in Moral Choice," in *Doing Evil to Achieve Good* 78.

[125] McIntyre makes this distinction between the harmful event being instrumental or incidental to critique the traditional use of the distinction ("Doing Away with Double Effect" 219).

[126] See Griese, *Catholic Identity in Health Care*, chap. 7, "The Principle of the Double Effect" 246–99, at 252.

[127] See Spielthenner, "Principle of Double Effect as a Guide" 466.

[128] Stated in his explanation of the four conditions of double effect (Kelly, *Medico-Moral Problems* 12–14).

[129] See Salvatore Privitera, "Duplice effetto," in *Dizionario di bioetica*, ed. Salvino Leone and Salvatore Privitera (Bologna: EDB, 1994) 308–9.

[130] See Joseph McFadden, *Medical Ethics*, 4th ed. (Philadelphia: F. A. Davis, 1956) 33; Kelly, *Emergence of Roman Catholic Medical Ethics* 252.

evil effect."[131] Richard A. McCormick described the concurrent relation between the good and bad effects as being "equally immediate causally,"[132] provided that the bad effect remains outside the agent's moral intention (*praeter intentionem*).[133] And Bernard Hoose describes this relation between effects as forbidding actions in which the evil effect is a cause of the good effect: "The good accomplished is at least as immediate as the evil."[134] The explanation of the principle of double effect in the *New Catholic Encyclopedia* provides an excellent summary of this second condition of the principle whereby the good and bad effects may occur simultaneously:

> The good effect must flow from the action at least as immediately (in the order of causality; though not necessarily in the order of time) as the bad effect. In other words the good effect must be produced directly by the action, not by the bad effect. Otherwise, the agent would be using a bad means to a good end, which is never allowed.[135]

In sum, this analysis has considered different approaches that might justify the intervention in the hypertension case. It is the approach of double-effect reasoning that may have most plausibility from the perspective of Catholic tradition and church teaching. However, the causality of these effects in a D&C appears to cause confusion among some traditional Catholic bioethicists. To clarify the moral meaning of the Phoenix case, my final section discusses what appears to be a mistaken understanding of the simultaneous effects in a D&C procedure.

CRITIQUE OF OPPONENTS OF THE PHOENIX CASE

To further clarify the significance of good and bad effects occurring simultaneously in a D&C procedure, it might be helpful to consider two

[131] Kaczor, "Double-Effect Reasoning" 302. See also Eduardo F. Regatillo, S.J., and Marcellino Zalba, S.J., *Theologiae moralis summa*, 3 vols. (Madrid: Editorial Católica, 1952) 1:211; Benoit Henri Merkelbach, O.P., ed., *Summa theologiae moralis: Ad mentem d. Thomae et ad normam iuris novi*, 3 vols., 8th ed. (Paris: Desclée de Brouwer, 1949) 1:166–67.

[132] McCormick, *Ambiguity in Moral Choice* 1; and "Principle of Double Effect," in *How Brave a New World?* 413–29, at 413.

[133] On the significance of the distinction between psychological and moral intention for the meaning of intention and foresight in double-effect reasoning, see Kaczor, "Double-Effect Reasoning" 301–2, 309–10

[134] Hoose, *Proportionalism* 101–2.

[135] F. J. Connell, "Double Effect, Principle of," *New Catholic Encyclopedia*, vol. 4 (New York: McGraw-Hill, 1967) 1020–22, at 1021. Griese makes a similar point that immediacy refers to causality and not the order of time (*Catholic Identity in Health Care* 252, referring to Francis J. Connell, *Outlines of Moral Theology* [Milwaukee: Bruce, 1953] 23 n. 3).

hypothetical circumstances. First, if a hysterectomy were the typical way of having an abortion, it would not follow that a hysterectomy in the circumstance of removing a cancerous uterus from a pregnant woman would constitute an abortion. Similarly, because a D&C at times is used for an abortion does not mean that in circumstance like hypertension a D&C necessarily involves an abortion. Second, if a hysterectomy were the only surgical means of removing the placenta when the placenta causes life-threatening hypertension (akin to removing a life-threatening cancerous uterus), the hysterectomy would not be construed as a direct physical assault on the fetus (just as removing a cancerous uterus via hysterectomy is not a direct assault on the fetus). However, medical science provides a less invasive procedure than a hysterectomy to remove the placenta, that is, a D&C procedure—and that procedure also preserves the woman's reproductive potential. In other words, in the circumstance of the Phoenix case, a D&C procedure is not a direct assault on the fetus, and it safeguards the woman's reproductive potential. These hypothetical circumstances clarify that a D&C procedure can have different moral meaning in varying situations. There are three perspectives among Catholic bioethicists that appear to misconstrue the moral meaning of a D&C procedure. The following analysis provides a response to these perspectives.

First, the construal of a direct abortion occurring in situations like the hypertension case is based on an assumption that a D&C in such circumstances necessarily entails wrongdoing. An example of this view is articulated by Helen Watt from London's Linacre Center. She argues (not referring to the Phoenix case) that both in a D&C and in induction of labor before fetal viability, "breaking up the placenta and amniotic sac constitute the infliction of a lethal wound on the fetus and are thus an impermissible invasion of its body"—an assertion that assumes an intervention like a D&C "involves a lethal bodily invasion of the fetus" which she claims "will be morally conclusive itself."[136]

This perspective is inadequate for the following reasons. On the one hand, while Watt recognizes that "the placenta and amniotic sac . . . are organs of the fetus," she does not recognize that the placenta also is an organ of the mother. This is a morally significant oversight insofar as cases like the one in Phoenix revolve around the legitimate resolution of the pathological condition of the mother (not of the fetus) by removing the disease-causing organ, the placenta. Even if the placenta were only an organ of the fetus, removing a pathological organ could in principle be justified. On the other hand, when Watt claims that a D&C "involves a lethal bodily invasion of the fetus" as being "morally conclusive itself," she does not recognize a crucial distinction in the Catholic tradition's use of the

[136] Helen Watt, "Side Effects and Bodily Harm," *Ethics and Medics* 36 (2011) 1–2.

principle of double effect. That is, when a D&C unavoidably causes the death of the embryo, it does not mean that its death is intended.

Watt adds a helpful qualification to her position in a subsequent article on bodily invasions. She argues (again not referring to the Phoenix case) that "foreseen harm (and absence of benefit) for the person affected is sometimes morally conclusive when linked to an immediate intention to affect that person's body (or, at least, to invade the space it fills)"; and a few paragraphs later she further emphasizes the significance of this "immediate intention" by referring to the "deliberate bodily assault on a known innocent" and "deliberate removals of an unborn child before viability."[137] In other words, she offers a nuance that focuses on the deliberate intention to harm the fetus. This subtler stance appears more amenable to the principle of double effect, which seeks to clarify when deliberate intention is not focused on fetal death in a dilemma circumstance, such as the legitimate removal of the placenta despite foreseeing the death of the fetus—as in the Phoenix case.

A second perspective that can cause confusion about the moral meaning of a D&C appears in a recent publication from the NCBC. In a commentary on circumstances in which the placenta's normal functioning causes the risk of maternal death (a situation akin to the Phoenix case), the NCBC publication explains that killing the fetus is immoral in this sense: "terminating a pregnancy by dilation and extraction does not fulfill the terms of double effect (specifically, the first condition), because this procedure involves directly killing the fetus prior to its extraction or the extraction of the placenta."[138] Such a stance reiterates a traditional condemnation, for example by Griese, of what is described as "*induced* abortions whereby the life of the nonviable fetus is attacked *directly*" such as by "the instrumental evacuation of the uterus."[139] However, this view is premised on the assumption that the procedure involves "directly killing the fetus" in a manner that is "prior to . . . the extraction of the placenta."

The NCBC's description of D&E (dilation and extraction) differs from what occurred in the Phoenix case. In the Phoenix case the D&C procedure did not involve "directly killing the fetus," nor did it involve causing the death of the fetus "prior to . . . the extraction of the placenta." Rather, the Phoenix case meets the criteria mentioned by ethicists, such as Griese, for what the Catholic tradition refers to as *indirect* abortions: "An *indirect* abortion is the foreseen but merely permitted uterine evacuation of a

[137] Helen Watt, "Bodily Invasions: When Side Effects Are Morally Conclusive," *National Bioethics Quarterly* 11 (2011) 49–51.

[138] Cataldo and Murphy Goodwin, "Early Induction of Labor" 113. For a stance that condemns induction of labor for a previable fetus as a direct abortion, see Griese, *Catholic Identity in Health Care* 280.

[139] Griese, *Catholic Identity in Health Care* 266.

nonviable fetus which is the side-effect of a procedure which is directed toward some good and legitimate purpose."[140] In the Phoenix case the good effect (directly intending to save the mother by removing the placenta and the amniotic membranes) and the bad effect (the unintended but foreseen death of the fetus contained within the amniotic membranes) occurred simultaneously, as permitted by the third condition of the principle of double effect.

A third perspective that can cause confusion about the moral meaning of a D&C also interprets the death of the fetus as wrongdoing, but with more nuance than the first perspective enunciated by Watt. In the NCBC's official commentary on the Phoenix case,[141] the analysis mistakenly asserts a premise on which moral judgment is passed: "the child is removed from the uterus to eliminate the conditions contributing to the hypertension"; and then the analysis continues, "this action would generally not be justified by the principle of double effect."[142] A similarly mistaken assertion is made in a subsequent discussion of the Phoenix case by NCBC's ethicist Furton, where he contests Lysaught's analysis, claiming that "in the case at hand, the killing of the infant is the object chosen"—meaning the moral object.[143] Of course, removing a fetus in a manner that causes its death to eliminate someone else's conditions cannot be justified by double-effect reasoning. But that is not what occurred in the Phoenix case. Furton's assertion seems to address Lysaught's position that in the Phoenix case there was a direct physical assault causing the death of the fetus (even though Lysaught argued that the physical assault did not constitute the moral object of the action). However, she did not seek to justify her opinion by using double-effect reasoning. Hence, the NCBC's response that double-effect reasoning does not pertain seems to address a straw figure in addition to the unwarranted premise it makes for its moral analysis.

Although the NCBC's commentary claimed that the principle of double effect does not apply to the Phoenix case, the commentary does suggest a case in which double-effect reasoning might be morally legitimate. The analysis argues that in a case where "the placenta becomes infected," "the uterus may 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."[144] Surprisingly, this type of circumstance appears to be what occurred in the Phoenix case. Lysaught in her moral opinion about the case

[140] Ibid. 266.

[141] NCBC, "Commentary on the Phoenix Hospital Situation," *Origins* 40 (2011) 549–51.

[142] Ibid. 550.

[143] Edward J. Furton, "Ethics without Metaphysics: A Review of the Lysaught Analysis," *National Catholic Bioethics Quarterly* 11 (2011) 53–62, at 58.

[144] NCBC, "Commentary on the Phoenix Hospital Situation" 551.

makes clear that the woman's pulmonary hypertension caused two additional pathologies to emerge (right-sided heart failure and cardiogenic shock), with the resulting decrease in maternal cardiac output and blood oxygenation typically causing the uterus and placenta to become hypoxic.[145] There appears to be an insignificant difference between an organ being "infected"—using the NCBC's language—and an organ (the placenta) becoming "hypoxic"—using Lysaught's language. Hence, the NCBC's analysis would appear to justify evacuating the uterus, so that the hypoxic organ (the placenta) threatening the life of the mother may be removed, even when foreseeing that the fetus will inevitably die. In other words, the NCBC seems to accept the application of the principle of double effect in the Phoenix case (despite its official commentary to the contrary as discussed above) after the relevant medical facts have been clarified.

CONCLUSION

In the Phoenix case the D&C procedure to remove the placenta appears to constitute a directly intended moral action that was necessarily undertaken to resolve the pathological condition of the mother. Removing the placenta could occur only by removing the amniotic membranes containing the fetus. However, causing the death of this nonviable fetus (destined to die, whatever transpired) while avoiding a direct physical assault on it, can be construed as being an indirect and unintended (*praeter intentionem*) side effect of the justified moral action. Such an argument assumes and confirms that direct and deliberate killing of innocent human life is always wrong. In this case, the moral object, the agent's intention, and the material cause of the moral act can be distinguished from the intrinsic evil of deliberate and direct ending of innocent human life. Further education appears to be needed about dilemmas like the Phoenix case that threaten imminent death in pregnancy.

[145] Lysaught, "Moral Analysis of Procedure at Phoenix Hospital" 538–39.