Ethics and Medical Standards of Care: Hysterectomy, Tubal Ligation or Salpingectomy?

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Editor's Note: The issue of foreseen future pregnancies that may be hazardous to mother, child or both have been an ethical challenge for ethicists and clinicians alike. The ERDs do not allow direct sterilizations even to avoid future complications. The recent "Response to a Question on the Liceity of a Hysterectomy in Certain Cases" (10 December 2018) from the Congregation for the Doctrine of the Faith (CDF), says that in cases where the uterus is irreversibly incapable of sustaining a pregnancy, a hysterectomy is licit. However, that causes conflicts with medical standards of practice which always prefer treatments that are less invasive and less risky. In this article, Sr. Patricia Talone, RSM, Ph.D., and Dr. Amy Warner present and discuss two cases that highlight the tension between ethical standards and medical standards. A further discussion of some questions that arise from the CDF responsum *follows.*

ALISON

Alison, a 29-year-old woman in her 26th week of pregnancy was in town for the day, shopping with her mother. She began cramping and leaking fluid and went immediately to the hospital where she learned her water had broken. She received regular prenatal care in her hometown an hour away, and recounted her complicated pregnancy history, including three previous cesarean sections. The first was performed due to the breech presentation of her baby. During surgery her doctors diagnosed her with a bicornuate uterus resulting in an abnormally shaped cavity. Her uterus, she was told, is divided by a muscular wall which limited the ability of her baby to change position.

Her next delivery, two years later, was also breech and she underwent a second cesarean delivery. This delivery had been complicated by placenta accreta, a condition in which the placental tissue abnormally grows into the wall of the uterus, most often around the previous uterine incision. Removal of the placenta can lead to profound hemorrhage and require hysterectomy at the time of delivery. Her physicians removed the placenta and saved her uterus, but they warned her of the risk of future pregnancies. They advised her to use effective contraception, giving her uterus time to recover fully prior to attempting another pregnancy. She was using oral contraceptives when she conceived four months later.

During this pregnancy her placenta had implanted away from her previous uterine scar and the accreta had not recurred. However, at 36 weeks, they discovered the scar on her uterus left by previous surgeries had ruptured. Fetal membranes and part of the umbilical cord were protruding through the uterine wall into the abdominal cavity. She reported no pain, bleeding, or contractions prior to this and the baby was delivered safely.

The separated area of the incision was not bleeding uncontrollably, so the doctors removed the damaged scar tissue and repaired the uterus rather than undertaking a hysterectomy with its additional risks of bleeding and damage to other pelvic organs. After careful consideration and reflection, she and her husband chose etonogestrel, a long-acting reversible contraceptive that she understood to be as least as effective as surgical sterilization.

Within days she began having terrible mood swings and a few weeks later she was almost completely bed-ridden with depression. When these side effects didn't subside, she started an antidepressant medication, but after several months her symptoms still had not improved. She finally made the decision to have the implant removed and resume oral contraceptives, this time combined with condoms.

This worked well for nearly three years, but again she became pregnant. There was no evidence of placenta accreta or surgical scar rupture. Alison planned for another cesarean delivery, this time with bilateral tubal ligation at the time of delivery.

Unexpectedly, her membranes ruptured. When she learned that the Catholic facility would not be able to perform a tubal ligation after delivery, she requested transfer to her hometown hospital. Just as the transfer began, nursing called for emergency assistance as Alison was in excruciating pain and hemorrhaging vaginally. Her son was delivered in surgery 16 minutes later in critical condition. He survived, but the staff reported that if this event had happened outside the hospital, it probably would have been fatal for both mother and child.

Her surgeon believed that she will not be able to carry another pregnancy to term, and possibly not even to viability, and requested permission to proceed with a salpingectomy. He recommended this over hysterectomy because, even though her bleeding was currently controlled, she had already lost a considerable amount of blood. She bled into the tissues surrounding the uterus, distorting the anatomy making a hysterectomy difficult, lengthy, and risky.

JEN

Jen is a 38-year-old patient pregnant for the sixth time. Her first two children did not survive due to premature delivery at 22- and 23-weeks' gestation because of cervical incompetence, a condition in which the cervix fails to support a growing pregnancy, often resulting in premature delivery with little or no warning. Her physicians believe her cervical incompetence is due to a series of LEEP procedures she had in her early twenties to treat abnormalities found on her Pap smear.

With her next pregnancy, she had a cervical cerclage placed. This surgical suturing of her cervix was an effort to support her dysfunctional cervix and allow her to carry a pregnancy. The pregnancy went well until 25 weeks' gestation when she began hemorrhaging due to failure of the cerclage. Her daughter was delivered by cesarean and survived but was challenged with physical and mental disabilities. Jen and her husband then lost a child at 17 weeks, before a cerclage was placed. With her fifth pregnancy, her physician had cautioned her that placement of the suture had been difficult as she had little remaining cervical tissue and this was badly damaged by the failure of the previous cerclage. He added weekly progesterone injections to her care in the hopes of delaying delivery. At 24-weeks, her cerclage again failed. The son she delivered died a few hours after birth.

All of this took an emotional and financial toll on Jen and her family. Her daughter needed a great deal of support and expensive care. Her husband, an oil field worker, was often away for long periods of time and her family was unable to offer much support. "We could never place our daughter in a situation in which she faced certain serious harm or death," she said, "and we can't knowingly do this to our unborn child either." In view of the risks, she chose a long acting contraceptive implant.

The implant was in place when Jen conceived a sixth time. Her physician again started progesterone injections and placed a cerclage, but has warned her to prepare for a likely preterm delivery. She asked for a tubal ligation if her delivery is caesarean section. The doctor agreed and wanted to deliver at the Catholic hospital because the facility had the needed neonatal intensive care services and because after the birth, she lived almost an hour away from the closest hospital.

COMMENT

These two cases are not common, but they represent very real clinical scenarios. But there are other factors, as well. They show how a woman's risk may be exponentially increased by factors such as geographic location and access to care. What might be considered reasonable risk for a woman living within easy access of specialized obstetric services and neonatal intensive care may be catastrophic for a woman in an isolated rural community.

The American College of Obstetricians and Gynecologists reaffirmed in April 2018 their position calling for transparency regarding institutional policy, so that a patient may seek transfer of care early in her pregnancy if she desires an elective procedure that is not routinely provided.[1] However, transfer to another provider is not always possible and it may not represent the best or most compassionate care for mother or baby, especially if alternate facilities lack needed medical and surgical subspecialties including neonatal intensive care. Transferring a child with a foreseeable need for intensive care services, or mother with a complicated medical condition away from a long-established relationship with a specialist physician, places both patients at unnecessary risk.

Hysterectomy at the time of cesarean, even in controlled situations, carries significant risk of harm including hemorrhage, injuries to other organs, and additional operating time. Additionally, removal of the uterus in its entirety disrupts the ligaments of the pelvis resulting in loss of support for the bladder,

vagina, and rectum. The creates an increased long-term risk of bowel and bladder complications including incontinence.

It is important to note that the uterus develops embryologically from the fusion of the two paramesonephric ducts which fuse in the midline to form the uterine body and fundus. The free ends of these ducts remain as appendages forming the uterine, or fallopian, tubes.[2] Anatomically, the uterus and the uterine tubes may be understood as one organism. In this case, especially when therapeutic choices are limited, removal of a *portion of the uterus, the uterine tubes,* by a complete or partial salpingectomy rather than the uterus in its entirety, may represent the best surgical option.

The quandary for the physician is this: If the outcome of the procedures is identical and the indications are the same, how does one justify choosing the ethically acceptable alternative – a hysterectomy – if it places mother or baby at risk of additional or unnecessary harm?

In these complex cases in which both clinical and social circumstances result in scenarios in which a viable birth is increasingly unlikely, both ethics and good medicine suggest the less invasive procedure and the avoidance of future pregnancies is not just an option, but the best course.

In our experience, physicians face these cases frequently and generally describe them as medically-indicated sterilizations. They believed, as we do, that each situation is unique and complex and must be judged in a wholistic sense, respecting the clinical and familial realities of each patient. These circumstances are frequently tragic and raise serious challenges for the families involved in them as well as moral quandaries for physicians and other health-care professionals serving them. We are convinced that those who minister in Catholic health care can and must engage in serious scientific and theological study and dialogue about cases like these.

Moralists have grappled with these problems for many years, from the mid-seventies when Mercy Health System, Detroit, opened a dialogue about the possibility of performing sterilizations for serious medical reasons. Clinicians, theologians and bishops continued in this dialogue (with no real resolution) until the publication of the Congregation for the Doctrine of the Faith's promulgation of *Quaecumque Sterilizatio* (July 31, 1993). This brief document forbade direct sterilization even if it was performed for a subjectively good intention.[3]

How then to address this problem? Because church teaching maintains that sterilization is intrinsically evil, the principles of double effect, toleration of evil and the lesser of two evils do not apply.[4] *The Ethical and Religious Directives for Catholic Health Care Services* (Directive 53) clearly states that "direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." Cancer of the uterus is an example of such a pathology; whereas a potential pregnancy is hypothetical and not a present pathology.

Yet when confronted with cases like those we have described, committed physicians, nurses and ethicists often reflect that a literal application of this interpretation seems "too

burdensome for most people."[4] Furthermore, for clinicians, it doesn't pass the "common sense" test. A hysterectomy is a more extensive and sometimes dangerous operation, requiring longer recuperation time for the woman than does a tubal ligation. Acknowledging the teaching that direct sterilization is not permitted because it is intrinsically evil (some moralists use the term "disordered") and aware *Quaecumque* rules out the use of subjectively "right intention," it seems that analysis of the moral liceity of a procedure may benefit by revisiting an objective/subjective analysis. That is, respecting the objective teaching that sterilization is immoral (or disordered) but recognizing that in some limited, subjective situations, it may be the only pastoral solution to prevent an even graver evil, abortion. It is also important to note that today we deal with medical conditions whose long-term consequences – such as a womb that is unable to carry a future pregnancy to term – are known to us in a way they never were in the past. This strains our traditional reasoning, which assessed liceity primarily on the basis of immediate, rather than probable long-term effects.

Two examples of an application regarding a related topic, contraception, occurred in the past 60 years. The first involves the distribution of the contraceptive "pill" to religious women in the Belgian Congo during the horrendous years of the Congo Crisis from 1960-65. Roman Catholic sisters had become the targets of rape by Congolese rebels outraged by years of poverty and foreign rule in their country. Three respected and recognized Catholic theologians offered slightly different arguments, but concurred that sisters in the Congo missions could legitimately take the pill to prevent pregnancy in the case of rape. They argued that the sisters' intention in using the pill was to protect themselves from pregnancy as the result of unjust aggression. The theologians, Msgr. Pietro Palazzini, Secretary of the Sacred Congregation (later bishop), Professor Franz Hurth, SJ, of the Pontifical Gregorian University, and Msgr. Ferdinando Lambruschini of the Pontifical Lateran University were internationally respected scholars.[5] None of the three refuted the church's objective teaching against contraception but observed that elements like circumstances and intention factored into the subjective analysis of the painful situation.[6] Even though their opinion did not represent official magisterial teaching, it did bear the weight of three "auctores probati", and as far as we know was never challenged or overruled by church authorities.

Forty years later in an interview with a German journalist, Pope Benedict XIV commented upon the use of condoms to prevent the transmission of HIV. His nuanced remarks were touted by some commentators as a change in church teaching regarding contraception. However, reading the Pope's statement in its entirety, one recognizes that the Pontiff upheld the teaching about the immorality of contraception, while subjectively recognizing the importance of the intention of the one acting. Responding to a question from the journalist, The Holy Father said "[the Church] of course does not regard it [condom use] as a real or moral solution, but, in this or that case, there can be nonetheless in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality."[7]

The church's moral tradition, born in response to its sacramental teaching and practice,

especially regarding the Sacrament of Reconciliation, instructs confessors and anyone endeavoring to judge the morality of a given case to examine three things. First, one must look at the moral act itself determining the moral good or evil of the act. Then one must consider the intention of the one acting, and finally the circumstances in which the moral agent finds him or herself. This approach regards the moral agent holistically, recognizing that people perform actions in specific situations often facing "damned if you do, and damned if you don't" kinds of circumstances.

While moral wisdom traditionally cautions that a good intention may not justify an evil action, intention does matter in the total moral analysis of a situation. Thomas Aquinas emphasized the significance of intentionality in the *Summa* (I-II, Q. 12, a. 1-5). In this section, he noted that some moral actions are extremely complex and thus, the moral agent may have more than one intention or goal in acting.[8] Thomas provides an example that involves taking medicine to attain health. He says, "I am determined to take this medicine because I am determined to get well." There are two purposes: the first is to take medicine, the second, ultimate goal is to get well. In speaking of intention, Thomas is writing for confessors, and it seems that the role of the skillful confessor or counselor is, in conversation with the agent, to determine the agent's primary intention.

In our two tragic examples, we meet women whose lives and marriages have been open to new life. Alison is in her fourth pregnancy, Jen in her sixth. We have met many women like them. We have never heard one state, "I want to be rendered sterile" but rather, "I want to live to care for and raise my children. I want to carry out the responsibility I was given at their births." Additionally, in speaking with countless physicians, we met few whose goal is rendering a woman sterile. Obstetricians and perinatologists commit themselves to help women and their babies achieve the maximum medical outcome by bringing forth healthy new lives.

The varied circumstances of our ministries are important too, especially for our hospitals in rural, underserved areas.[9] Pius XII, in his November 24, 1957 allocution on the Prolongation of Life, noted that means to prolong life may "vary according to circumstances of persons, places, times, and culture."[10] What is ordinary means to preserve life in a Western, metropolitan area would not necessarily apply in the Amazon jungle of Brazil. Jen, like many other women lives in a rural area. Given her tenuous physical condition, forcing her to travel beyond a local hospital might cause her physical harm or even death. And, it certainly may cause moral distress to physicians whose primary intention is to prolong the woman's life and who commit themselves to use their professional expertise to save lives.

In sum, we do not believe that the 1975 and 1993 definitions and pronouncements of the CDF take adequate account of the complexity of obstetrical cases nor the advances in perinatal medicine and diagnosis since then. We also believe that our cases and our analysis fall short of a comprehensive response. However, it seems from the church's response in limited contraception cases like the "pill" in the Belgian Congo or condom use with sexually-active persons with HIV, that our rich, moral tradition possesses the pastoral wisdom to enable patients and physicians to remain true to the church's teaching while at the same time

making complex medical decisions. It is our fervent hope that Catholic health care, committed to life from conception to natural death, can again openly examine these cases and come to a conclusion that is both medically and morally sound.

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ENDNOTES

[1] The American College of Obstetricians and Gynecologists. (2018). Restrictions to comprehensive reproductive health care. [Position statement]. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Restrictions-to-Comprehensive-Reproductive-Health-Care.
[2] Thomas W. Sadler, *Langman's Medical Embryology,* 13th edition, (Philadelphia: Wolters, Kluwer Health, 2015) 266. Sadler's view is affirmed in Moore's *The Developing Human: Clinically Oriented Embryology,* 10th edition (Elsevier, 2015) and Schoenwolf, *Larsen's Human Embryology*, 5th edition (Elsevier, 2014).
[3] Congregation for the Doctrine of the Faith, "Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters." July 31, 1993. The full history of the 1975 case is recorded in Richard McCormick's *Notes on Moral Theology 1981-84* (Lanham, MD., University Press of America, 1984) 187.
[4] Pope Pius XII. "The Prolongation of Life." November 24, 1957. Granted, the Pope was speaking about use of ordinary/extraordinary means to prolong life. But the pastoral concern expressed in his statement roots the moral tradition in the real lives of the faithful.
[5] A full account of their reasoning is found in "Una Donna Domanda: Come Negarsi Alla Violenza," *Studi Cattolici* 5(1961) 63-71.
[6] This line of reasoning reappeared again in 1993 when Father Giacomo Perico, writing in *Civiltà Cattolica* argued that contraception for Bosnian women during the Serbo-Croatian war was a means of legitimate self-defense against an unjust aggressor. Reported in the *Chicago Tribune*, March 5, 1993.
[7] Quoted in Alan Holdren. *CNA/EWTN News*. "Analysis: What the Pope really said about Condoms." November 22, 2010.
[8] Aquinas, *Summa Theologica*, I-II, q. 12, a.3 states that "[one] can intend several things at the same time, for…intention can go out to both the eventual end and the intermediate end." *Summa Theologiae*, Thomas Gilby, OP, ed., vol. 17, *Psychology of Human Acts* (Blackfriars/McGraw Hill, New York, 1970) 114-121.
[9] Catholic hospitals serve one in six patients throughout the United States, and 26.6% of Catholic hospitals are rural. The Catholic Health Association reported in 2018 that 133 of its member hospitals are critical access hospitals.
[10] Pope Pius XII. Ibid.