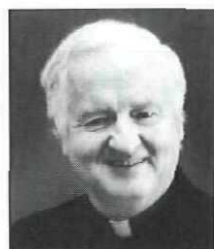


APPLYING THE DIRECTIVES

The Ethical and Religious Directives Concerning Three Medical Situations Require Some Elucidation

BY REV. KEVIN D.
O'ROURKE, OP, JCD



Fr. O'Rourke is director of the Center for Health Care Ethics, Saint Louis University.

The *Ethical and Religious Directives for Catholic Health Care Services (ERD)* were approved by the National Conference of Catholic Bishops (NCCB) in November 1994.

The committee that prepared the text for consideration by the NCCB labored for more than five years. Given the many drafts, study sessions, and consultations which preceded the final text, one might think that all doubts had been answered and that the directives would be comparatively easy to understand.¹ True, some directives—for example, Directive 13, which states that hospital patients and nursing home residents should be informed about opportunities to receive the sacraments—are essentially self-explanatory. However, experience has demonstrated that other directives need further elucidation if they are to be applied with some degree of moral certitude.

This is not surprising. All rules need to be applied, and in their application further specification is often needed. When the *ERD* require elucidation, it is for one of the following reasons:

- Because new developments in medical technology must be evaluated to determine whether they are compatible with a stated directive
- Because the clinical situation is not fully explained and further specification is needed if one is to understand the parameters of acceptable procedures
- Because the law is not well stated and needs further specification

The authors of the directives realized that their work would require elucidation. They wrote:

While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic

health care today. . . . While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of *approved authors* [italics added] can offer appropriate guidance for ethical decision-making.²

This article will consider the five directives that, insofar as their application is concerned, have caused the most consternation and doubt:

- Directive 48, which deals with extrauterine pregnancy
- Directive 36, concerning the treatment of rape victims
- Directives 56, 57, and 58, which concern the use of artificial hydration and nutrition for persons in a persistent vegetative state

EXTRAUTERINE PREGNANCY

Directive 48 states: "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion." An extrauterine pregnancy is often called a "tubal" ectopic pregnancy because ectopic pregnancies do in fact usually occur in one of the two fallopian tubes (though they can also occur in the cervix, ovary, or peritoneal cavity). Because pregnancies in the fallopian tube are the most common kind of extrauterine pregnancy (constituting 95 percent of the total), and because they can be diagnosed and treated in various ways, we shall confine our considerations to them.

Sixty-four percent of ectopic pregnancies resolve themselves spontaneously.³ In treating ectopic pregnancies that have some viability, however, the therapist must not perform surgery that

constitutes a direct abortion—must not, that is, directly intend the termination of pregnancy before viability or directly intend the destruction of a viable fetus (see Directive 45). Ectopic pregnancy in the fallopian tube—the implantation of the developing fetus in the tube's inner wall—endangers the health and even the life of the woman. Because it cannot adapt to the growing pregnancy, the

tube's inner wall becomes painful, bleeds, and ultimately ruptures. Today, fallopian tube pregnancies can often be diagnosed earlier than in previous years, even before bleeding or rupture of the tube occurs.⁴

The main ethical issue here concerns the method of treating an ectopic pregnancy after it has been diagnosed. If it were possible, obstetricians would remove such an embryo from the fallopian tube wall and implant it in the uterus, where gestation could occur normally. However, no current technique ensures this result.

At present, there are three accepted therapies for ectopic pregnancies.

Salpingectomy This therapy—in which the obstetrician surgically removes either the pathological segment of the fallopian tube or the entire tube⁵—is justified by the principle of double effect. Preserving the mother's life is the physician's direct intention; the action performed directly accomplishes this goal. The ensuing death of the fetus is an unintended and unwanted effect. The rationale justifying salpingectomy is similar to that justifying the removal of a cancerous tumor from a woman who happens to be gravid.

Salpingostomy Salpingostomy does not destroy the fallopian tube. The surgeon makes a slit in the tube, removes the embedded trophoblast, and sutures the slit, the tube remaining intact.

The surgeon detaches an injury-producing trophoblast from the fallopian tube, knowing that the fetus will die because it can no longer receive nutrition via the trophoblast. (Note that

Salpingectomy

is justified by

the principle of

double effect.

the trophoblast is not pathological; it is performing its natural function, but in the wrong place.) As Moraczewski states: "The specific focus of the surgical action is the removal of the damaged tubal tissue and damaging trophoblastic tissue, not the destruction or death of the embryo, even though one foresees that the death of the embryo will take place."⁶

Some theologians maintain that salpingostomy is a direct attack on the fetus.⁷ However, when a trophoblast becomes embedded in the fallopian tube wall it seems to create a pathological condition. There is an objective difference between the trophoblast and the embryoblast of the blastocyst. A salpingostomy thus appears to be an acceptable therapeutic practice.⁸

Methotrexate An even simpler procedure, one that is especially effective if bleeding has not yet occurred, involves the use of methotrexate (MTX).⁹ MTX is a drug that, because it inhibits cell multiplication, is often used in very high doses as chemotherapy for the treatment of cancer. The drug, which can be either oral or intramuscular, interferes with a cell's ability to synthesize DNA.¹⁰ Trophoblastic cells are extremely sensitive to the action of MTX.

The problem with methotrexate, as with salpingostomy, is that the death of the fetus follows upon the action which inhibits the destructive implantation process of the trophoblast. Can the principle of double effect be applied to the use of MTX? Some would say no, maintaining that the cells of the trophoblast and the cells of the fetus are so intimately connected as to form one entity.¹¹

Others, using the analogy of normal childbirth—in which the result of the trophoblast, the placenta, is definitely separate from the developing fetus—maintain that MTX may be used because the directly intended effect, the treatment of the pathology by inhibiting the trophoblastic cells, is distinct from the unintended effect, the death of the fetus.

Given that in an ectopic pregnancy the fallopian tube is pathological (e.g., will bleed or rupture) because of the manner in which the trophoblast has imbedded itself in the tube's inner wall, it seems well within moral probity for the obstetrician to intend the removal of the trophoblast and to employ the means to fulfill the intention, even though that means the death of the

fetus will result. It seems this opinion has an intrinsic probability—that is, a probability founded on the physical facts of fetal development in an ectopic pregnancy.¹²

TREATMENT OF RAPE VICTIMS

Directive 36, concerning the treatment of rape victims, also presents some difficulties. After mentioning the need for compassionate and understanding care of victims of sexual assault, the directive states: "A female who has been raped should be able to defend herself against a potential conception. . . . She may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization." The directive adds: "It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."

Thus the directive is clear in its intent: A woman who has been raped may defend herself against conception, but may not do anything that would injure a fetus already conceived. Some people are surprised to realize that the teaching of the Church allows a woman who has been raped to use contraceptive medication when such medication is prohibited for married women who have engaged in intercourse with their husbands. A woman who has consented to intercourse accepts a responsibility to use the act in keeping with its intrinsic significance of love and procreation. The rape victim, however, has no such responsibility because she has not consented to the sexual act.¹³ A statement in *La Civilita*

A woman who

 has been raped may

 defend herself

 against conception.

Cattolica, an influential Vatican newspaper, confirms this opinion by saying that women facing a risk of rape may use contraceptives as a legitimate form of self-defense.¹⁴

Directive 36 sets forth the following procedure when treating rape victims:

- Conduct a pregnancy test to see if conception has already occurred.
- If there is no evidence of conception,

treat the patient with a contraceptive medication.

These two steps are somewhat anomalous because no pregnancy test will be positive as the result of a recent rape.¹⁵ Indeed, if the test were to be positive, conception would have to have been the result of intercourse prior to the rape, because pregnancy tests are not reliable until 10 days after conception. The problem with the second procedure is that the medication usually given to suppress ovulation, Ovral, will also render the endometrium hostile to implantation by a fertilized ovum.¹⁶ If the drug is given after ovulation has occurred, and the woman has conceived as the result of the rape, an abortion will occur—the Ovral acting as an abortifacient.

The timing of ovulation is critical in preventing an Ovral-induced abortion. If ovulation has not occurred, then Ovral may be administered in the hope that it will at least delay ovulation. If ovulation is under way, or very recently completed, Ovral should not be used.

Is it possible to be so precise in determining the time of ovulation? Joseph J. Piccione, JD, and Gerald McShane, MD, both members of the Ethics Committee of St. Francis Medical Center in Peoria, IL, have recently devised a method by which occurrences of ovulation can be measured accurately.¹⁷ Employing this method, the obstetrician first gives the rape victim a progesterone level test and then uses a urine "dip stick" (Ovu Kit) to test for the presence of luteinizing hormone (LH). If the LH test is negative and supported by progesterone level findings, ovulation is not occurring and Ovral may be used. If the LH test is positive, the process of ovulation is

under way and Ovral should not be used. The method seems to obviate the quandary that occurs when a rape victim is unsure whether she has ovulated.

In some states, a rape victim must be informed that she may visit a healthcare facility that will use medications to prevent the continuation of a pregnancy resulting from the rape. This legal obligation may cause

ethical difficulties for a Catholic hospital. Would obeying the law in this case be a form of formal cooperation in an intrinsically evil act? Directive 36 calls on Catholic healthcare facilities to "cooperate with law enforcement officials [and] offer the person psychological and spiritual support and accurate medical information." It seems the civil law can be followed in such a way that, at most, only mediate material cooperation results.

Another method of discerning whether ovulation has occurred is by examining the texture of the cervical mucus at the vulva of the rape victim's vagina; this can be done with a test, called "ferning," that assesses the capability of the mucus for transmitting spermatozoa.¹⁸ If the mucus is sticky, it will not allow the sperm to penetrate the reproductive tract. But if the mucus is stringy, that is a sign that ovulation has occurred, enabling the sperm to penetrate. Unfortunately, few emergency room physicians are adept at discerning the texture of cervical mucus, so ferning is not the standard of care followed in emergency rooms.¹⁹

Since about 50 percent of female rape victims are already using contraception, and since conception from rape is very rare, some people wonder why theologians seeking to apply the Church's teachings are so concerned about measuring the time of ovulation. Although impregnating a woman through rape would be a great injustice, it would not be so great an injustice as killing an infant whom rape has brought into being. Thus the foregoing distinctions are required.

The direct intention
of withdrawing AHN
is to discontinue
futile therapy.

**CARE OF THOSE IN A
PERSISTENT VEGETATIVE
STATE**

Directives 56, 57, and 58—which concern the use of artificial hydration and nutrition (AHN) for persons in a persistent vegetative state (PVS)—also need explication. PVS, a valid medical diagnosis, occurs when a cerebral cortex becomes permanently dysfunctional because of trauma or degenerative pathology of the brain.²⁰

Directive 58 presumes that a valid diagnosis of PVS has been made. This article is accordingly concerned not with patients in a coma from which they may recover or those who have a "locked in syndrome"²¹ but, rather, with people who have lost irreparably their cognitive-affective function (insofar as medical science can determine) even though their brain stems remain functional.

For years there has been a debate within the Catholic community about the nature of AHN: Is it medical therapy, or does it constitute the comfort care due every dying person? If it is comfort care, then the only reason for withholding or withdrawing it would be because it does not provide comfort. If AHN is a medical therapy, then it may be withdrawn if "it does not offer hope of benefit or entails an excessive burden or imposes excessive expense on the family or the community" (Directive 57).

The medical community has decided without equivocation that AHN is a medical therapy and may therefore be withdrawn from PVS patients because it is not beneficial.²² To the medical community, an argument offered by some Catholic theologians—that removing AHN results in extreme suffering and "starving" patients to death—is groundless.²³ Because PVS patients have no sensory capacity, they feel no pain as a result of withdrawal of AHN. Moreover, though death is foreseen, it need not be the direct intention of withdrawal. Rather, the direct intention of withdrawing AHN is simply to discontinue futile therapy—therapy that offers little hope of benefit (Directive 57). A fear that

those removing AHN may have the wrong direct intention—that they may in fact intend to end the life of the patient—seems to have led several groups of U.S. bishops to recommend that AHN not be removed unless it is physiologically ineffective²⁴ (see *ERD*, Part Five, Introduction). Other bishops, acting individually or as participants in state conferences, have said that AHN is ineffective therapy for PVS patients and that withdrawing it is morally acceptable.²⁵

Catholic theologians and philosophers who maintain that AHN should be maintained unless it is an excessive burden and the death of the patient is imminent do so because, they say, keeping patients alive in a PVS condition is “a great benefit.”²⁶ Other Catholic writers challenge this statement, maintaining that preservation of physiological function alone is not of benefit.²⁷ The latter’s strongest argument is that a person in PVS cannot perform those human acts of intellect and will that, according to Catholic tradition, are necessary to attain the purpose of life.²⁸

If guidance on the use or withdrawal of AHN had been left up to Directives 56 and 57, there would be no difficulty. Such decisions would be made according to whether AHN constituted a “hope of benefit” or an “excessive burden” for a given PVS patient. But in order to recognize the position of those bishops who oppose withdrawal of AHN, the authors of the *ERD* added another directive—Directive 58—which confuses the issue.²⁹ Directive 58 says, “There should be a presumption in favor of providing hydration and nutrition to *all* [emphasis added] patients . . . as long as this is sufficient benefit to outweigh the burdens involved to the patient.” In fact, the presumption should be *against* the use of AHN for PVS patients because there is no possibility of benefit for such patients once a valid diagnosis of PVS has been made.

The *ERD*’s efforts to recognize the opinion of the aforementioned bishops do not result in an

“Imminent death” has never been required for the removal of life support.

absolute prohibition of withdrawal of AHN for PVS patients. AHN need not be used if the benefits do not “outweigh the burdens,” Directive 58 essentially says. But the directive does muddy the waters. It no doubt results in innumerable PVS patients being sustained by AHN in Catholic nursing homes because “the bishops mandate it” or because “it is the Catholic

thing to do,” whereas in reality, it is not morally required. Indeed, as one Catholic theologian has stated: “How can we pretend that we believe in life after death if we maintain that life must be prolonged at all costs?”³⁰

Finally, a misunderstanding has resulted from the desire of some bishops and theologians to ensure that the removal of life support will not be an excuse for euthanasia. They think they protect dying persons from euthanasia by stating that “death must be imminent” before support is removed. This phrase is used even in the recent encyclical *Evangelium Vitae*³¹ and in a recent compilation of Church teachings on medical ethics issued by the Pontifical Council for Pastoral Assistance to Health Care Workers.³² “Imminent” death means that death will ensue within a short time, no matter what means are used to postpone it. But “imminent death” has never been required in Catholic tradition for the removal of life support. There is no statement of this condition in the *ERD*. Moreover, the traditional statement of Church teaching does not require the presence of this condition before life support is removed.³³

One confused by the term “when death is imminent” should recall that, while life support may be removed when death is imminent, it may also be withheld or removed when death is not imminent but the therapy in question either offers no “reasonable hope of benefit” or imposes an “excessive burden” on the patient or an “excessive expense on the family or community” (Directives 56 and 57).

CONTINUAL STUDY IS NEEDED

Thomas Aquinas stated that lawmakers cannot envision the innumerable circumstances which will affect the application of laws. Hence, prudence and perspicacity will always be needed in the application of laws to particular cases. This need becomes even more obvious when one deals with laws involving scientific facts. The natural world does not change; rather, our knowledge of it becomes more comprehensive. Thus, in order to apply the ERD accurately, one must study them continually. □

NOTES

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995, p. 2.
2. ERD, pp. 2 and 5. The term "approved authors" is frequently used to signify authors whose writings are in accord with the magisterium of the Church. The fact that an author is popular or well-known does not in itself imply that he or she is approved; neither does the fact that he or she is "conservative." Approved authors of the past include St. Thomas Aquinas, St. Alphonsus Ligouri, and scores of others. Contemporary authors are approved according to their adherence to Part III, *Splendor Veritatis*, and other magisterial teachings.
3. C. Beckman, et al., "Ectopic Pregnancy," *Obstetrics and Gynecology*, 2d ed., Williams and Wilkins, Baltimore, 1995, pp. 321-331.
4. Beckman.
5. W. E. May, "The Management of Ectopic Pregnancies: A Moral Analysis," in P. Cataldo and A. Moraczewski, eds., *The Fetal Tissue Issue: Medical and Ethical Issues*, Pope John Center, Braintree, MA, 1994, pp. 121-147.
6. A. Moraczewski, "Managing Tubal Pregnancies I," *Ethics & Medics*, June 1996, p. 4; see also A. Moraczewski, "Managing Tubal Pregnancies II," *Ethics & Medics*, August 1996.
7. May; P. Boyle, unpublished letter, August 16, 1996.
8. J. Connery, unpublished essay, April 2, 1986.
9. C. Floridon, et al., "Ectopic Pregnancy, Histopathology and Assessment of Cell Proliferation with or without Methotrexate Treatment," *Fertility and Sterility*, April 1996, pp. 730-738.
10. Moraczewski.
11. Boyle.
12. J. Tuohey, "The Implications of the Ethical and Religious Directives on the Clinical Practice of Resolving Ectopic Pregnancies," *Louvain Studies*, no. 20, 1995, pp. 41-57; M. Prieur, "Ectopic Pregnancies: A Theological Debate," *Canadian Health Care Review*, Spring 1996, p. 18.
13. B. Ashley and K. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed., Georgetown University Press, Washington, DC, 1997, p. 303.
14. "Contraception as Self-Defense Is OK, says Roman Publication," *Davenport (IA) Messenger*, July 10, 1993, as reported by Catholic News Service.
15. Beckman, p. 66.
16. E. Diamond, "Ovral in Rape Protocols," *Ethics & Medics*, October 1996.
17. J. J. Piccione and G. McShane, "Sexual Assault: Contraceptive Treatment Component," an unpublished paper approved by Msgr. Steven Rohlf, Diocese of Peoria; see also J. J. Piccione, "Rape and the Peoria Protocol," *Ethics & Medics*, September 9, 1997, p. 22. For a copy of the protocol, write to J. J. Piccione, JD, OSF Healthcare System, 800 N.E. Glen Oak Avenue, Peoria, IL, 61603.
18. T. Hilgers, unpublished response to the Ethics Committee of the Archdiocese of Chicago, February 1993; for a more complete description of fanning, see J. Billings, *The Ovulation Method*, Advocate Press, Melbourne, Australia, 1983, p. 51.
19. J. Tintinalli, et al., *Emergency Medicine*, McGraw-Hill, New York City, 1996, p. 1,372.
20. Multi-Society Task Force on PVS, "Medical Aspects of Persistent Vegetative State, Part I," *New England Journal of Medicine*, vol. 21, no. 330, 1994, pp. 1,499-1,508.
21. Multi-Society Task Force on PVS, p. 1,502.
22. B. Jennet, "Letting Vegetative Patients Die," in *Euthanasia Examined*, J. Keown, ed., Cambridge University Press, Cambridge, England, 1995, p. 181.
23. R. Cranford, "The Persistent Vegetative State: The Medical Reality," *Hastings Center Report*, February-March 1988, pp. 27-32.
24. Committee on Pro-Life Activities, National Conference of Catholic Bishops, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 9, 1992, p. 705.
25. Texas bishops, *Origins*, June 7, 1990, p. 53; J. Liebrecht, *Origins*, January 11, 1990, p. 525; W. Bullock, *Origins*, January 30, 1992, p. 553.
26. W. May, et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law and Medicine*, Winter 1987, pp. 203-211; J. Boyle, "A Case for Sometimes Tube Feeding Patients in Persistent Vegetative State," *Euthanasia Examined*, J. Keown, ed., Cambridge University Press, Cambridge, England, 1995, pp. 189-200.
27. R. McCormick, "Moral Considerations III Considered," *America*, March 14, 1992, p. 214; D. Brodeur, "The Ethics of Cruzan," *Health Progress*, October 1990, pp. 42-47.
28. Thomas Aquinas, *Summa Theologica*, I-II q 1, a 1; John Paul II, *Veritatis Splendor*, n. 72; *Origins*, October 14, 1993.
29. See ERD, Part Five, Introduction.
30. McCormick.
31. *Origins*, April 1996.
32. *Charter for Health Care Workers*, Vatican Press, Rome, 1995, n. 115 and 120.
33. D. Cronin, *The Moral Life in Regard to Ordinary and Extraordinary Means of Conserving Life*, Gregorian, Rome, 1958; reprint, Pope John Center, Braintree, MA, 1993. J. Connery, "Prolonging Life: The Duty and Its Limits," *Catholic Mind*, October 1980, pp. 42-57.