Ectopic Pregnancy and Catholic Morality

To the Editor: In their article "Ectopic Pregnancy and Catholic Morality," Marie Anderson and her colleagues engage with my book *Vital Conflicts in Medical Ethics*.[1] Their article, however, is based on serious misrepresentations, omissions, and a futile attempt to call into question my faithfulness to the magisterium of the Church. In the following, I will give a brief account of the main reasons for my considering this a rather confusing and unhelpful contribution to an otherwise necessary debate.

1. First, Anderson et al. note (on page 75) that my position "stands in direct opposition to the decrees of the Holy Office of 1884 and 1889," and they at least implicitly charge me with therefore being unfaithful to the magisterium. Yet, provided this is really what they mean, the charge is inappropriate because, as I mention in the preface to *Vital Conflicts*, my study was elaborated in agreement with the Congregation for the Doctrine of Faith and then published on the Congregation's explicit request, to make it available in different languages and to initiate a discussion of its theses among specialists. (I was allowed by the CDF to mention this fact in the preface of my book.) Drafting the study and publishing it were, therefore, an act of obedience to the very Church authorities Anderson et al. accuse me of having contravened. Only on the last page of their article do the authors concede that the study was published at the request of the Congregation (although they falsely say that this request extended only to the German edition). Without espousing my views, the Congregation obviously wanted the mentioned decrees of the Holy Office to be publicly and freely discussed.[2]

2. Anderson et al. persistently assert that I defend the use of methotrexate in the treatment of ectopic pregnancies. This is untrue, and their affirmation is based on a careless and highly selective reading of my text. In *Vital Conflicts* I hold that the use of methotrexate to treat an ectopic pregnancy is *illicit* because it is "something approaching a direct attack on the embryo, with the end not only of saving the mother's life, but also of sparing her problems by avoiding a possible operation later," and that this "is not sufficient in itself to justify the intervention morally" (*VC*, 116). I add that such use of methotrexate falls short of a doctor's duty to "make every attempt to save the lives of both mother *and* child," and that "he cannot simply assume from the outset that the life of the child is less important" (*VC*, 117).

Anderson et al. rely exclusively, and mistakenly, on my remark on a hypothetical case in which methotrexate is used as an alternative to salpingotomy, where—always supposing that it attacks only the trophoblast (as the literature known to me says)—I would consider it equal to salpingotomy. Yet in my book this is mentioned only hypothetically, because to my knowledge treatment with methotrexate is done only in a very early stage of ectopic pregnancy when neither salpingotomy nor salpingectomy is an option. Anderson et al. thus falsely present the hypothetical part of my reasoning as "defense of the use of methotrexate."

3. Anderson et al. blame me for giving an erroneous interpretation of the phrase *tuto doceri non posse*. I am not a specialist in the English language, and I admit that the translation "cannot be safely taught" may be the more correct one. Yet such a translation would not necessarily contradict my interpretation. More importantly, however, Anderson et al.

omit to mention that I have surveyed past discussions of this phrase, which was already controversial in the nineteenth century (see *VC* 18 note 31 and accompanying text, and *VC* 78 note 73). As I report, the important moral theologian H. Noldin, "who—some years after the decisive decrees by the Holy Office—taught explicitly that craniotomy was not allowed, admitted that these decrees did indeed forbid the teaching and practice of craniotomy, though this did not mean that the contrary teaching was simply declared to be false ('doctrina opposita non declaretur simpliciter falsa')."[3]

Anderson et al. try to suggest that according to my reading of the phrase *tuto doceri non posse*, I deny that "the moral defense of craniotomy was judged to be a dangerous and impermissible position to teach" (75). Yet this is not true. On page 18 of *VC* I say, "Because it concerns a practical question regarding grave matter in a fundamental question of human life, the Decree is to be understood to declare that craniotomy cannot be taught to be morally licit (and cannot be practiced) with certitude of conscience (which leads, in practice, to its being ruled out as a possible option)." Whether *tuto* is translated as "safely" ("without risk or danger") or as "with certitude of conscience" comes to the same thing, because the essential point is that the decree, as I wrote, is not doctrinal but disciplinary (which of course has consequences on what can be licitly *taught* and *practiced*: it clearly forbids both the teaching and the practice of craniotomy). This is the difference with regard to similar decrees, e.g. those on ontologism or mitigated millenarism, which admittedly use the same formula. But these were *dogmatic* questions; craniotomy is a question of *moral* doctrine, and refers to the realm of the practical. Therefore, the decrees on such issues must also be understood as guidance for moral praxis. In this context, I think, *tuto* also refers to the certitude of conscience regarding one's actions, a certitude which must never be absent, especially in questions of life and death.

4. Anderson et al. moreover completely ignore what I explicitly and repeatedly say (e.g., *VC*, 13–14): that my view does not aim at a (normative) justification of craniotomy and analogous interventions, but only tries to argue that *a physician* is not guilty of "directly killing the innocent" when, in a case of vital conflict and after having done what is possible to save both mother and child, he performs a surgical intervention causing the immediate death of the child to at least save the mother. Overlooking the distinction made in *VC* between "normative justification" and "exculpation" leads Anderson et al. to a severe misrepresentation of my position. Thus they write, "Rhonheimer's argument … is that the situation of 'vital conflict' removes the embryo from the category of a human being whose life is subject to a just claim of protection from destruction" (77).

Yet on pages 56 and 57 of *Vital Conflicts* I exactly reject such a position as unacceptable and as leading to a slippery slope, because it implies that "in every such conflict the issue would be to clarify which of the two people has a greater or 'prevailing' right to life, with this 'greater' right being decisive. On this basis, every act of killing could actually be permitted—certainly any kind of therapeutic abortion to save the mother's life." This latter position, however, clearly rejected by me, is the one Anderson et al. suggest to be mine. They write, "In so many words, Rhonheimer is saying that killing an embryo is not intrinsically wrong if the continued living of the embryo is a threat to the mother's life" (78).

I consider such a grave misrepresentation to be a clear sign that something went wrong in their reading of *Vital Conflicts*. The truth is that I do not deny the unborn's right of life, not even in a situation of vital conflict, but I hold that this actually existing right *is not intentionally and thus culpably violated* by a surgical intervention like craniotomy. The reasons why I hold this can be found in my book. These reasons certainly do not lead to a slippery slope or to what Anderson et al. falsely suggest to be my view, namely, "that killing an embryo is not intrinsically wrong if the continued living of the embryo is a threat to the mother's life."

5. This is perhaps why Anderson et al. also misunderstand the assumption underlying my argument, namely, that killing is morally evil *because and insofar it is against justice*. They make this idea look stupid and present me as a fool when they conclude, "At face value, it seems that Rhonheimer is ultimately saying that the direct killing of an innocent human being is wrong except in cases where it is justified. Or to put it even more simply, killing is wrong except when it is not wrong" (79). This reveals that Anderson et al. do not seem to have grasped the real meaning of this basic assumption (which is genuinely Aristotelian and Thomistic): that on the level of natural law every morally evil or sinful act is evil and thus sinful insofar as it is opposed to a determinate moral virtue, that is, to the rationale of that virtue. This is what St. Thomas Aquinas programmatically declares in the prologue to part II-II of his *Summa theologiae*: "The knowledge of every sin comes from the knowledge of the virtue to which it opposes" so that "the whole subject of morals is reduced to the consideration of the virtues."

This is also how Aquinas proceeds in II-II, where homicide is treated under the virtue of justice, as an act against commutative justice. Why for Aquinas is it wrong or morally evil to kill a human being, choosing its death as a means to an end or as an end itself? It is wrong because and insofar as it is *against justice*, insofar as it is an intentional violation of the right to life. As Aquinas says in the prologue to II-II q. 64, homicide is an act "whereby a man inflicts the greatest injury on his neighbor" (*maxime nocetur proximo*).The *nocumentum* is not simply the harm on the ontological level which is done, but the violation of justice. The moral evil does not lie in the pure *fact* of the deprivation of one's life (this might also be done by a robot or a tsunami, though no *injustice* would be committed and no moral evil would be implied in it); the moral evil lies in the death being intentionally brought about by the choice of a human agent: this makes it vicious, and a sin.

Now, my basic argument is that in the case of craniotomy, the child's death is caused *praeter intentionem* (beside the intention) and that a physician who does it is not vicious, nor does he commit a sin of injustice. He cannot be held responsible for the death of the child. This judgment is not novel but corresponds to the sound moral intuition of a physician, and it was traditionally respected even by moral theologians like D. Prümmer, OP, who on the basis of the decrees of the Holy Office considered craniotomy to be immoral, although he advised confessors to allow that penitents who had practiced it had acted in good faith![4] This crucial cornerstone of my argument is never, not even once, mentioned by Anderson et al.—and this is a serious and significant omission which sheds light on the carelessness with which they have worked. They simply ignore all the features of my approach which do not fit their own moral methodology (which in my view is not mistaken, but has some blind spots). To repeat: by judging the causing of the death of the child in cases of vital conflict to be *praeter intentionem*, I do not deny the child's continuing right to life, but only assert that because of the peculiar constellation of such cases, this right is not intentionally and culpably violated by the surgical intervention.

Anderson et al. interpret my use of "intention" as follows: the intention of the medical intervention is to save the life of the mother which is threatened by the child; *in consequence*, the death of the child is not intended and is thus justified. But this "intentionalist" and subjectivist argument is not mine; my reasoning is different and decisively so: owing to the objectively given constellation of the case, the causing of the death of the child is *praeter intentionem*; *in consequence*, the only intentionality that remains and thus shapes the act is the saving of the mother's life. Large parts of *Vital Conflicts* are dedicated to showing why the causing of the death of the child is *praeter intentionem*, and why this is due to the objective constellation of the case.[5]

6. Anderson et al. assert on page 78 that according to me "the fundamental definition of sin" is to be "an offense against the virtue of justice." Against this view, which is not mine, they contend—referring to Aquinas's *Summa theologiae* I-II, q. 71, a. 6—that the

definition of sin is to be "an offense against God's eternal law." They err, however, because when defining sin in this article of his *Summa theologiae*, Aquinas mentions a *double* measure for human actions: one that is the immediate and "homogeneous" measure—namely, human reason—and one that is what he calls the remote measure—the divine reason, that is, the eternal law. The reference to the latter, however, specifically belongs to a theological perspective. (See *ST* I-II, q. 71, a. 6, ad 5: "The theologian considers sin chiefly as an offense against God; and the moral philosopher, as something contrary to reason.")

To discern good and evil in human acts, however, the theologian—and Aquinas is essentially a theologian—also needs to refer to the order of reason, which is the order of natural law and the virtues. Except in what we know only by faith, the theologian is dependent on the work of the moral philosopher. The reason for this is that the eternal law in itself is unknown to us: we know it by our own natural reason, in which is the image of God, or by some complementary revelation (see *ST* I-II, q. 19, a. 4, ad 3). Abstracting from revelation, this refers us to natural law, which contains the principles of the virtues and commands us to live them. Every sin is opposed to right reason, to natural law, or to a determinate moral virtue: this all comes to the same. (See also what I said in n. 5 above.) However, not all sins are sins against justice, as Anderson et al. make me assert! But killing, considered on the level of natural law, is essentially and most formally sinful or evil—and in consequence also against charity—precisely *because and insofar it is unjust*. Why else would killing be morally evil in the first place, if not for being opposed to justice?[6]

7. Anderson et al. assert that "the magisterium explicitly *rejected* the moral reasoning of Rhonheimer, who claims that in such situations of 'vital conflict' the killing of an unborn human being is permitted" (79). This statement is not correct: it hides and even distorts what really is the case. What the Holy Office rejected in 1884, in a decision approved by the Pope, was not "the moral reasoning of Rhonheimer" but the assertion that craniotomy could be safely taught in Catholic schools and thus practiced; that is, it excluded craniotomy from being a morally acceptable way of saving the mother in such situations. Yet this decision was made after an intense debate in which the nineteenth century defenders of craniotomy used an unsound kind of moral reasoning—considering the fetus as an unjust aggressor—which I show in *Vital Conflicts* to be inadequate and which I reject. I propose a different argument. Anderson et al. do not mention my detailed account of this earlier debate and fail to discuss, or even to mention, the core of my own solution—that is, that causing the baby's death is *praeter intentionem* and the physician is therefore inculpable, however not as a person acting in self-defense is). The reference to the magisterium's alleged rejection of my *moral reasoning* allows them to spare themselves a fair discussion of my real argument.

I wish to emphasize that until further intervention by the magisterium, the decrees of the Holy Office affirming that the medical procedure of craniotomy cannot be safely taught in Catholic schools are, of course, still of practical relevance for Catholics, for Catholic health care institutions, and for pastoral guidance. But this does not mean that the moral reasoning which led to these decrees (which judge craniotomy to be a case of direct abortion) cannot be critically discussed and rejected in scholarly debates. If the magisterium ever comes to qualify these decrees on the basis of a revised and clearer understanding of what "direct abortion" implies—as is advocated in *Vital Conflicts*—it will certainly happen only on the basis of debates like the one initiated by my book.

8. Finally, Anderson et al. maintain that "with regard to tubal pregnancies, Rhonheimer's own criterion of 'vital conflict' simply does not apply. This is because the mother's life can be saved by use of a salpingectomy" (79). This is a valuable and important objection, and it refers to perhaps the most intricate difficulty of my defense of salpingotomy. Yet what again is not mentioned by Anderson et al., and is thus withheld from

the reader, is that in *Vital Conflicts* I have explicitly addressed this difficulty, discussing it in detail. (See *VC* 107–115 under the heading "Cases Where Salpingotomy Makes Medical Sense: Does Extreme Vital Conflict Exist?") On these pages I show that, provided one accepts salpingectomy and the basis of Lincoln Bouscaren's arguments, salpingotomy must also be considered licit, and I show that the qualification of vital conflict applies also to this case. For the detailed argument, I must refer the reader to my book.

To summarize: Rather than trying to engage in a serious discussion of my solution presented in *VC*, Anderson et al. actually try to delegitimize my arguments by putting them into the most unfavorable light, omitting to mention some of their key features, and distorting others. Despite calling my arguments "very subtle and sophisticated" and praising my "good efforts" (81), they present these arguments in a simplistic and biased way. This is why I think that their contribution to the debate is not really helpful.

I do not consider my views on this issue to be a necessary consequence of my overall moral theory and my understanding of Aquinas, nor do I think this theory and my reading of Aquinas would be affected if it should prove that I am wrong on this issue (which I never exclude as a possibility). This topic is not about moral norms but rather about the question of how far our responsibility as moral agents reaches. I continue to be convinced, however, that if I turned out to be right, this could be very salutary for Catholic moral teaching, helping to overcome a certain tendency to moral rigorism, and would definitely take the wind out of proportionalists' sails. This is what *Vital Conflicts* was always meant to be in the first place: an argument against proportionalism and a defense of the moral teaching of *Veritatis splendor*. If others see it in a different way, this must be seriously and serenely discussed. But things should not be presented in a way that renders such a discussion superfluous or even impossible.

Rev. Martin Rhonheimer
Pontifical University of the Holy Cross
Rome

[1] Marie A. Anderson et al., "Ectopic Pregnancy and Catholic Morality: A Response to Recent Arguments in Favor of Salpingostomy and Methotrexate," *National Catholic Bioethics Quarterly* 11.1 (Spring 2011): 65–82, at 75. Martin Rhonheimer, *Vital Conflicts in Medical Ethics*: *A Virtue Approach to Craniotomy and Tubal Pregnancies* (Washington, DC: Catholic University of America Press, 2009).

[2] To avoid causing any misapprehension, I added the following statement on my own initiative in the preface of *Vital Conflicts*: "Obviously, the observations made here are my personal opinions and not those of the Congregation for the Doctrine of the Faith" (xiii).

[3] *Vital Conflicts,* 18 note 31, quoting H. Noldin, *Summa Theologiae Moralis* II (Regensburg, Germany: F. Rauch, 1917), 365.

[4] See *Vital Conflicts*, 20, where I refer to Prümmer's, *Manuale theologiae moralis* II, 15th ed. (Freiburg: Herder, 1961), 127: "Moderni medici etiam catholici haud raro sunt in bona fide circa liceitatem craniotomiae in casu, quo aliter salvari nequeat vita matris. … Prudentis igitur confessarii est iudicare, num praestet delinquere medicum in bona fide, dummodo tamen baptismus conferatur proli moriturae. Sic enim salus aeterna infantis procuratur et matris vita salvatur. Aliquando namque permittenda sunt peccata materialia, ut vitentur peccata formalia. Ita quoque docent Lehmkuhl, Noldin aliique." Two things are to be mentioned: Prümmer explicitly notices that omitting to save the mother's life by performing a craniotomy could make a physician punishable by civil penal law (as being held responsible for the mother's death) and that making sure that the child at least is baptized before it is killed by the surgical intervention according to Prümmer seems to justify leaving the physician in good faith. All this is somewhat surprising, because Prümmer equally affirms (on 125ff) that a craniotomy is a direct killing of the innocent and is thus intrinsically evil, and that all the arguments in favor of craniotomy, though having, as he says on 127, "some appearance of truth" (*aliqua species veritatis*), are erroneous. If this is so, Prümmer should have accused civil laws which force physicians to do craniotomies of being gravely unjust. Yet there is no word about this—and I do not think this silence was unintentional. It paved the way out of an unsolvable dilemma of conscience for both the confessor and the penitent—the dilemma of physicians engaged in saving life which I call the dilemma of vital conflict.

[5] More about this topic can be read in my response to Fr. Benedict Guevin's "Vital Conflicts

and Virtue Ethics," (*National Catholic Bioethics Quarterly* 10.3 [Autumn 2010]: 471-480), forthcoming in this journal.

[6]For other aspects of what Anderson et al. say in this respect, see my response to Fr. Guevin (forthcoming in the *NCBQ*), who committed a similar fallacy. See also my "Sins Against Justice (IIa IIae, qq. 59–78)," in *The Ethics of Aquinas*, ed. Stephen J. Pope (Washington, DC: Georgetown University Press, 2002), 287–303.

Dr. Anderson and her colleagues reply: We are very grateful to Fr. Rhonheimer for his detailed response to our article, "Ectopic Pregnancy and Catholic Morality," which appeared in the Spring 2011 issue of *The National Catholic Bioethics Quarterly*. We will try now to reply briefly to his eight points.

1. Fr. Rhonheimer claims that we are attempting to "at least implicitly" charge him with being unfaithful to the Church's magisterium because we note that his position stands in opposition to the 1884 and 1889 decrees of the Holy Office concerning craniotomy. He goes on to explain that his book was published at the "explicit request" of the Congregation for the Doctrine (CDF) of the Faith "to initiate a discussion of its theses among specialists."

It is difficult for us to understand why Fr. Rhonheimer should take offense at our discussion of his theses if that is what the CDF intended when it gave permission for his book *Vital Conflicts in Medical Ethics* to be published in its original German version in 2000. (His preface to the 2009 English version seems only to touch on the CDF's permission for the original German version, but we'll take him at his word that the permission was also extended to translations of the book.) We certainly commend Fr. Rhonheimer for submitting his work to the CDF and for acknowledging that the observations in his book are his own and not those of the Congregation. It seems, though, that the CDF was *inviting* scholars to respond to Fr. Rhonheimer's theses critically, and this is what we have done. It also seems clear that his position on craniotomy stands in opposition to the 1884 and 1889 decrees of the Holy Office on this matter. If Fr. Rhonheimer does not wish to be criticized for taking a position in opposition to these decrees then he should avoid describing them as "problematical" and a cause for "confusion" (see *VC* 78). It is up to the CDF, not us, to decide whether this constitutes infidelity to magisterial teaching. We were simply being accurate in our description of Fr. Rhonheimer's attitude toward the 1884 and 1889 rulings of the Holy Office.

2. Fr. Rhonheimer disputes our claim that he defends the use of methotrexate for curing ectopic pregnancies. We are well aware that he defends only the use of this drug "in the extreme situation of a vital conflict … in which it is established that either mother and child *both* die, or only the mother can be saved" (*VC* 116). Nevertheless, he clearly defends the use of methotrexate in such cases, so we are not being "careless or highly selective" in our reading of his position. The very question under discussion, however, is whether such cases of vital conflict allow for the direct killing of the embryo. The Holy Office in 1884 and 1889 rejected this type of reasoning with regard to craniotomy, and we are not persuaded by Fr. Rhonheimer's argument that cases of "vital conflict" also allow for the direct killing of the embryo by methotrexate (which, in spite of what Fr. Rhonheimer claims, attacks both the embryo and the trophoblast, as we explained in our article on page 73). The burden of proof we believe is on Fr. Rhonheimer to explain how using methotrexate or salpingostomy to resolve ectopic pregnancies does *not* involve the direct killing of innocent human life.

3. We are glad that Fr. Rhonheimer admits that "cannot be safely taught" may be a more correct English translation of *tuto doceri non posse* (in the 1889 decree of the Holy Office on craniotomy[1]). He tries, though, to salvage his position by saying that in matters of moral doctrine (as opposed to dogmatic questions) the formula *tuto doceri non posse* refers primarily to a disciplinary rather than a doctrinal issue. It therefore

provides practical moral guidance on what can be safely taught and practiced and also what can constitute "certitude of conscience regarding one's actions."

We do not wish to belabor this point with Fr. Rhonheimer. The observations he brings out by Prümmer and Noldin are interesting but not essential to the issue at hand. We agree that the magisterium provides guidance that is doctrinal, moral, and disciplinary. We question, however, Fr. Rhonheimer's overly sharp distinction between matters of doctrine and morals. The magisterium, after all, provides teaching (*doctrina*) on matters pertaining to "faith or morals."[2] Moreover, when the magisterium chooses to use the formula "cannot be safely taught" (rather than a condemnation like "false"), it does not mean that the position is not indeed false. It means only that the magisterium believes a warning against teaching this position is sufficient in the present circumstances.

The essential point is that the Holy See decided in 1889 that craniotomy "and [any] surgical operation whatever that directly kills the fetus or the pregnant mother" is a practice that "cannot be safely taught," even in those cases "when it is likely, if it is not done, the mother and the child will die, and, on the other hand, if it is done, the mother may be saved while the child will die."[3] Fr. Rhonheimer, however, still persists in believing that craniotomy could be morally licit in those cases in which both the mother and the child will die if it is not performed. This means that he endorses an action that consists in the evacuation of the contents of the baby's cranium via suction, which results in the collapse of the skull and the baby's death. If this is not the direct killing of the fetus then what is it? If he protests that the moral object is to save the life of the mother, not to kill the child, he appears to be departing from the moral teaching of *Veritatis splendor* n. 80, that there are certain acts (such as the direct killing of an innocent human being) that are "intrinsically evil" (*intrinsice malum*) regardless of the intention or circumstances. The key point is that intentions do not and cannot change the moral object in cases of intrinsically evil acts. In Fr. Rhonheimer's analysis, there is a persistent tendency to allow the intention to determine the moral object.

4. Fr. Rhonheimer claims that we fail to appreciate his distinction between "normative justification" and "exculpation" on pages 13 and 14 of *Vital Conflicts*. But this distinction hinges on his thesis that directly causing the death of a child via salingostomy or craniotomy is permitted because there is no violation of justice in such cases of "vital conflict." We disagree with this approach to the question for reasons we explain in the article.

5. Along these same lines, Fr. Rhonheimer claims that we do not appreciate the basic assumption "that on the level of natural law every morally evil or sinful act is evil and thus sinful insofar as it is opposed to a determinate moral virtue." He then goes on to cite some passages from St. Thomas Aquinas that show that homicide is wrong because it is against justice. We do not, however, dispute the fact that homicide is against justice, nor do we deny that moral evil involves the deliberate choice of a human agent (as opposed to harm caused by a robot or a tsunami). Our only point here is that the fundamental definition of sin is "an utterance, a deed, or a desire contrary to the eternal law." This definition of sin goes back to St. Augustine and is repeated in the *Catechism of the Catholic Church* n. 1849. Moreover, St. Thomas explicitly endorses this same Augustinian definition of sin in the *Summa theologiae* I-II, q. 72, a. 1. We highlighted this concept of sin because evaluating the morality of killing in terms of justice can give way to subjective standards as to what violates justice and what does not.

We believe we are on solid Catholic and Thomistic grounds in highlighting the eternal law of God as the determining factor in evaluating the morality of individual acts. To be sure, God's eternal law can be grasped by natural reason via the natural law, but the recognition that justice is violated in acts of homicide is more a *confirmation* of the wisdom of God's command against homicide

than the determining factor in specifying it as a moral evil.

This latter issue is more theoretical. The more practical question is whether the choice by a physician to perform a craniotomy is *praeter intentionem* (beside the intention), as Fr. Rhonheimer insists. This seems to get to the heart of our disagreement with his position. We do not believe the choice to perform a craniotomy is *praeter intentionem*, because there is a manifest intent to perform an operation (e.g., evacuating the contents of the cranium) that is known will cause the baby's death. The fact that the physician performs this operation with the intention to save the life of the mother does not remove the other intention to perform an operation that directly brings about the death of the child.

6. Our article was focused on a practical moral question: how to deal with ectopic pregnancies in a moral way. We do not dispute the Thomistic analysis of measuring human acts by both human reason and the divine law. For Aquinas, however, the natural law is not different from the eternal law but rather "the participation of the eternal law in the rational creature" (*participatio legis aeternae in rationali creatura*; *ST* I-II, q. 91, a. 2). The defining factor in sin, as we saw above, is that it is "contrary to the eternal law."

7. Fr. Rhonheimer might be correct that the Holy Office did not make its rulings of 1884 and 1889 against craniotomy in light of his *praeter intentionem* argument. We are not convinced, however, that this argument should lead to a reconsideration of these decisions. It is not at all clear how the deliberate choice to evacuate the contents of baby's cranium is "beside" or "beyond" an intention to perform a procedure that results in the child's death. On a subjective level, a physician who performs such a procedure in desperation, confusion, or moral ignorance might have diminished culpability. This, though, does not change the objective nature of the act chosen, which is one that directly brings about the death of the child.

We do not dispute the possibility of critically discussing the moral reasoning involved in the 1884 and 1889 decisions of the Holy Office against craniotomy. Nor do we dispute the right of Catholic scholars to discuss the possible use of methotrexate or salingostomy for the treatment of ectopic pregnancy. It is ultimately up to the magisterium, not to us, to decide these matters. Our article, however, challenged those who support possible recourse to craniotomy, methotrexate, or salingostomy to explain how these actions do not involve deliberate choices to kill innocent human beings. For the reasons given in our article, we believe these authors have failed to prove their case that such actions do not involve the direct killing of innocent human beings.

8. We are happy that Fr. Rhonheimer has acknowledged the value of our one objection, specifically, that there is no case of vital conflict if the mother's life can be saved by recourse to salpingectomy rather than salingostomy. He claims, though, that he dealt with this difficulty in his appeal to Bouscaren's reasoning, which leads to the conclusion that "there is no morally relevant distinction between salpingectomy and salpingotomy, but only in the physical 'directness' of the intervention" (*VC* 114). By way of response, we must point out that the physical directness of causing the death of the embryo is no incidental matter. Instead, this is one of the major components involved in the analysis of the principle of double effect. When an action directly brings about the death of an embryo rather than indirectly, it fails to measure up to requirements of the application of the principle of double effect (see page 70 of our article).

By way of conclusion, we must repeat that the focus of our article was more practical than theoretical, namely, how to treat ectopic pregnancies in a moral way. The focus of our article was not on the moral system of Fr. Rhonheimer. Nevertheless, we made an effort to understand his moral reasoning on the specific issue of ectopic pregnancy and the related issue of craniotomy. We do not believe we presented his arguments in "a simplistic and biased way," because we consistently cited his own words. While we respect Fr. Rhonheimer as a gifted and subtle thinker, we are not persuaded by his claim

that recourse to craniotomy, methotrexate, or salpingostomy does not involve a deliberate choice to bring about the death of an innocent human being.

Marie A. Anderson, MD, FACOG
Private Practice
Fairfax, Virginia

Robert L. Fastiggi, PhD
Sacred Heart Major Seminary
Detroit

David E. Hargroder, MD
Private Practice
Joplin, Missouri

Reverend Joseph C. Howard Jr.
Catholic University of America
Washington, DC

C. Ward Kischer, PhD
University of Arizona
College of Medicine
Tucson, Arizona

[1]Heinrich Denzinger, *Enchiridion symbolorum, definitionum et declarationum de rebus fidei et morum*, ed. Peter Hünermann (Freiburg: Herder, 2005), DH 3258.

[2] "*Doctrina de fide vel moribus.*" Vatican Council II, *Lumen Gentium*, n. 25.

[3]See introduction to DH 3258 and *Acta Sanctae Sedis* 17 (1884): 556.

To the Editor: In his letter to the editor in the Spring 2011 issue of the *National Catholic Bioethics Quarterly*, Fr. Martin Rhonheimer makes a distinction between cases of immoral therapeutic abortion (involving the so-called right of a mother to choose) and cases of "vital conflict." For Rhonheimer, the two scenarios are specifically different, whereas for Fr. Nicanor Austriaco (letter to the editor, *National Catholic Bioethics Quarterly*, Autumn 2010) they are different only by reason of intention, because materially they are the same, that is, in both cases a fetus is physically and immediately killed. In addition, if an abortion of either sort saves the life of the mother, then both are therapeutic. In other words, Rhonheimer seems to make a meaningless distinction.

Rhonheimer asserts that the killing of the fetus in a case of a "therapeutic abortion" is a direct killing based upon an evil intention, whereas the killing of a fetus in a case of "vital conflict" is an indirect killing because of a good intention of the doctor, whose aim is to save the life of the mother, not kill the fetus. In other words, the circumstances of a case determine the species of a killing. But are the circumstances of the action in either case properties within the act or merely extrinsic to the act?

Imagine a reverse vital conflict case, in which the child would survive only if the mother dies. Removing the threat to the child by stopping the mother's heart, for example, would appear to be morally licit so long as it was done without the intention of killing her. Rhonheimer's logic seems to defend this, morally speaking, because the case is simply another "vital conflict." However, *prima facie*, this is very counter intuitive.

I do not think it is too difficult to understand that killing someone with a knife or a gun or crushing someone's skull is of itself a direct action (an efficient cause), whereas removing a gravely diseased womb that happens to have a fetus in it is an indirect not a direct killing, a physically and morally different species. It is a death the doctor does not will because he is not its direct cause. On the other hand, doing an action that immediately and absolutely causes death, regardless of the intention, must necessarily be a direct not an indirect action. It is easy to understand the distinction between an efficient cause and an accidental, or occasional, cause, which transcends motives and immediate intentions.

If Austriaco concedes that from the beginning the action in a case of "vital conflict" is not direct but always indirect by reason of intention, he would have to agree with Rhonheimer. Likewise if killing, metaphysically speaking, were an indifferent act of itself, Austriaco would also have to concede that his arguments are erroneous. Surely, he would not be willing to make either of these concessions. Therefore it would seem that Rhonheimer is conflating the *finis operis* with

the *finis operantis* in his defense of killing someone without intending to kill in a case of "vital conflict."

Rev. Basil Cole, OP, STD
Professor of Theology
Dominican House of Studies
Washington, DC

How Levonorgestrel Works

To the Editor: I thank Deacon Thomas J. Davis Jr., Allison LeDoux, and Dr. Kathleen M. Raviele for their letters responding to earlier comments I made on the mechanism of action of levonorgestrel (LNG), which can be administered as emergency contraception as Plan B, the so-called morning-after pill.[1] They raise concerns about the mechanism of action of LNG when the drug is taken by women during their fertile days preceding the LH (luteinizing hormone) surge that leads to ovulation, especially when these women actually undergo ovulation. Rightfully so, they affirm that Plan B, if it is to be used in Catholic facilities in cases of sexual assault, should not be an interceptive or an abortifacient. I have two comments in response to their letters.[2]

First, Davis argues that the proposal that LNG may act to impede sperm migration has been proven false by the findings of Josiane do Nascimento et al., who found that Plan B "had no effect on the quality of cervical mucus or in the penetration of spermatozoa to the uterine cavity."[3] Thus, Davis concludes that this study undermines the conclusions found in an earlier investigation by E. Kesserü et al. that had shown that LNG interferes with sperm migration.[4] This would leave LNG without a prefertilization mechanism of action in those women who ovulate even after taking Plan B.

A close reading of the two papers does not support Davis's conclusions. Kesserü et al. examined sperm migration *within hours* of LNG administration. In their studies, inhibition of sperm activity began three to four hours after administration of LNG and reached a maximum inhibitory effect at nine hours. In contrast, do Nascimento et al. examined sperm behavior at twenty-four hours and forty-eight hours after treatment. At these later time points—a day or two after taking Plan B—LNG did not impair cervical mucus activity or sperm viability. Therefore, a more accurate reading of these papers suggests that Plan B, when taken as emergency contraception, *does* inhibit sperm viability and migration within hours of ingestion but that this mechanism of action is only temporary, not lasting more than twenty-four hours. This phenomenon is not unusual for drugs—every individual who has to take an aspirin every four to six hours to relieve muscle soreness or an antihistamine twice a day to alleviate an allergy is acutely aware of the limited efficacy of most drugs. Nonetheless, this temporary inhibitory effect of sperm activity would be enough to account for some of LNG's prefertilization mechanism of action as an emergency contraceptive.

Next, as LeDoux notes in her letter, Davis highlights the principal model supporting a potential postfertilization mechanism of action, described by Patrick Yeung, Erica Laethem, and Joseph Tham,[5] by which preovulatory administration of LNG disrupts the delicate ratio of estrogen and progesterone essential to healthy endometrial development and induces the equivalent of luteal phase insufficiency, jeopardizing implantation. Davis concludes that the latest evidence tacks in direction of support of this model.

The very latest evidence, however, tacks in the opposite direction. In a paper published in the December 2010 issue of *Contraception*, Marta Durand and her colleagues at the Instituo Nacional de Ciencias Médicas y Nutricion Salvador Zubirán in Mexico City studied the effects of LNG administered during the preovulatory phase approximately two days before the LH surge.[6] Thus, this paper investigates the very plausibility of the Yeung et al. model. Their study showed that in women who had ovulated despite their ingestion of LNG during their preovulatory stage, "the apparently normal E_2 and P_4 production during the luteal phase suggested a normal luteinization and corpus luteum function in LNG-ov cycles, which

agree with the lack of deleterious effects of this hormonal contraceptive regimen on the endometrium."[7] In other words, this study discovered that LNG, when it is taken prior to ovulation, appears *not* to disrupt the normal hormonal levels needed for proper endometrial development. Thus, these data undermine the foundations of the model advocated by Davis and by Yeung et al. that LNG taken during the preovulatory stage would disrupt corpus luteum function and the endometrial function needed for implantation.

Even more significantly, however, this very recent study by Durand et al. also showed that LNG taken during the preovulatory stage increases serum and intrauterine concentrations of glycodelin at the time of ovulation. Glycodelin is a molecule important for the timing and the events that lead to fertilization. Since there are well-established glycodelin inhibitory effects on fertilization—in other words, high levels of glycodelin have been shown to disrupt sperm–egg binding[8]—these findings could represent an additional prefertilization mechanism of action of LNG in women who still ovulate despite their taking LNG as an emergency contraceptive.

In sum, contrary to Deacon Davis's, Allison LeDoux's, and Dr. Raviele's claims, there are robust data that support the claim that LNG has a prefertilization mechanism of action—either as an inhibitor of sperm activity or as an inhibitor of fertilization—that accounts for its efficacy as an emergency contraceptive, even in women who take Plan B just prior to the LH surge and ovulation. In contrast, especially in light of the recent paper by Marta Durand et al., there is less evidence to suggest that Plan B has a postfertilization effect that would make it either an interceptive or an abortifacient.

Rev. Nicanor Pier Giorgio Austriaco, OP, PhD, STL
Assistant Professor of Biology
Providence College
Providence, Rhode Island

[1]Thomas J. Davis Jr., letter, *National Catholic Bioethics Quarterly* 10.4 (Winter 2010): 641–643; and Allison LeDoux and Kathleen M. Raviele, letters, 11.1 (Spring 2011): 11–15.

[2]I would like to thank Dr. Gabriela Noé from the Instituto Chileno de Medicina Reproductiva for her email comments that have helped me better understand the mechanism of action of LNG in women who take this drug before the LH surge and ovulation.

[3]Josiane A.A. do Nascimento et al., "In Vivo Assessment of the Human Sperm Acrosome Reaction and the Expression of Glycodelin-A in Human Endometrium after Levonorgestrel-Emergency Contraceptive Pill Administration," *Human Reproduction* 22.8 (August 2007): 2194.

[4]E. Kesserü et al., "The Hormonal and Peripheral Effects of d-Norgestrel in Postcoital Contraception," *Contraception* 10.4 (October 1974): 411–424.

[5]Patrick Yeung, Erica Laethem, and Joseph Tham, "Argument against the Use of Levonorgestrel in Cases of Sexual Assault," in *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton (Philadelphia: National Catholic Bioethics Center, 2009), 143–150.

[6]Marta Durand et al., "Hormonal Evaluation and Midcycle Detection of Intrauterine Glycodelin in Women Treated with Levonorgestrel as in Emergency Contraception," *Contraception* 82.6 (December 2010): 526–533.

[7]Ibid., 532.

[8]Markku Seppälä et al., "Glycodelin: A Major Lipocalin Protein of the Reproductive Axis with Diverse Actions in Cell Recognition and Differentiation," *Endocrine Reviews* 23.4 (August 2002): 401–430.

Deacon Davis replies: I thank Fr. Austriaco for his comments but disagree with his conclusion. The Noé study he reported in the Summer 2010 issue of the *NCBQ* and other studies firmly establish that levonorgestrel is a poor anovulant when administered in the preovulatory fertile window, and the absence of pregnancy in the Noé study must be explained almost entirely by other mechanisms.[1] Fr. Austriaco offers two possibilities, neither of which precludes a postfertilization mechanism of action (MOA) to a moral certainty.

First, Fr. Austriaco notes the time differential between findings on intrauterine sperm concentrations by Kesserü et al. (three to nine

hours after intake)[2] and by do Nascimento et al. (twenty-four to forty-eight hours after intake),[3] and reads the findings as compatible with inhibited sperm migration for up to twenty-four hours. However, in assessing their own findings, Kesserü et al. hypothesized that increased alkalinization correlating with levonorgestrel use, beginning four to five hours after intake and remaining constant for at least forty-eight hours, explained interference in sperm migration. But if increased alkalinization impeded sperm concentration and quality, that effect should continue through the minimum forty-eight hours of elevated pH reported by the study. If the disappearance of sperm from the intrauterine cavity reported by Kesserü et al. was real, accurately measured, and causally related to the presumed action of levonorgestrel, it should be detected at twenty-four and forty-eight hours as well.

However, Kesserü et al. did not examine uterine sperm concentrations or quality at those times. But do Nascimento et al. did and found no effect. That finding strongly contradicts the Kesserü hypothesis. Some aberration between the studies could have been the result of inferior methodology for spermatozoa recovery decades ago when the Kesserü study was conducted, and do Nascimento et al. note as much. But that possibility only adds to the questionable value of the Kesserü findings. Finally, Trussell and Raymond report a recent study that found an effect on sperm function only with much higher levels of levonorgestrel than are used for emergency contraception,[4] further undermining the Kesserü findings.

Fr. Austriaco's second proposed prefertilization mechanism points to a recent study by Marta Durand et al. reporting elevated intrauterine glycodelin-A in women taking levonorgestrel in the preovulatory stage.[5] Since high levels of glycodelin-A may inhibit sperm–egg binding, Fr. Austriaco suggests that the Durand findings may explain prefertilization efficacy. There are several difficulties with that conclusion. First, there is no evidence that the effect could happen under in vivo conditions, a critical point, since it has been demonstrated that glycodelin-A can be displaced from spermatozoa when passing through the oocyte–cumulus cell complex by a cumulus isoform of glycodelin known as glycodelin-C. In a 2007 study, Chiu et al. demonstrated that such a process not only removes the zona pellucida binding inhibitory activity of glycodelin-A, "but that [in the process] spermatozoa acquired enhanced zona pellucida binding ability."[6] In other words, exogenous glycodelin-A can be stripped from sperm as it encounters the oocyte and be converted to a different isoform, the net effect of which promotes rather than impedes sperm–egg binding.

Second, the authors of the article on which Fr. Austriaco relies plainly state that "it is unknown whether the content of uterine glycodelin-A reached at midcycle is optimal to affect the fertilization process."[7] That is doubly significant. At face value it means the proposed MOA is purely speculative, lacking essential foundation. In addition, other research seems to show that concentrations of 25 μg/ml are necessary for any significant inhibitory action,[8] if in vivo conditions were to permit it at all. The concentrations measured in the study Fr. Austriaco cites ranged from much lower to slightly lower (17.7 ± 5.9 μg/ml).[9] Fr. Austriaco's second proposed prefertilization MOA is speculative at best.

Fr. Austriaco correctly points to the 2010 Durand study as challenging one possible postfertilization MOA for preovulatory use of levonorgestrel, since Durand et al. found apparently normal E_2 (estrogen) and P_4 (progesterone) production during the luteal phase, indicating normal corpus luteum function. However, that study does not address the possibility of other deleterious effects on the endometrium originating in the preovulatory fertile window. Also significant is the Durand finding that preovulatory levonorgestrel shortens the luteal phase, thereby confirming findings by Tirelli, Cagnacci, and Volpe in 2008.[10] Although debate continues over what length of luteal phase constitutes a luteal phase defect, many physicians maintain that a luteal phase of less than twelve days' duration may not permit sustained implantation. The Durand data show the luteal phase reduced to less than

twelve days in some cases, which the authors attribute to levonorgestrel, and the Tirelli findings demonstrate significant reduction of the luteal phase when levonorgestrel is administered in the follicular phase. That supports a reasonable hypothesis that Plan B is abortifacient in some preovulatory uses through this type of luteal phase defect. Such potential postfertilization MOAs are consistent with disclosures in the product labeling mandated by the Federal Drug Administration.[11]

Proponents of Plan B have steadily presented "new" studies through which they argue for moral certainty that the drug is neither interceptive nor contragestive. In 2007, Fr. Austriaco asserted in this journal that "scientific certitude" had been achieved showing that Plan B was not an abortifacient.[12] He abandoned that claim after challenges in letters in this journal from Yeung, Tham, and Laethem, and adopted the more modest claim that an abortifacient effect is "unlikely."[13] Interestingly, even the most ardent proponents of Plan B readily acknowledge that women should be advised that postfertilization effects cannot be ruled out, even as they advocate for prefertilization explanations of the MOA.[14] The existing data are not decisive. Neither "scientific certitude" nor moral certitude has been established precluding postfertilization MOA.

Rev. Deacon Thomas J. Davis Jr., JD, LLM, MA
Associate Director
Pope John Paul II Bioethics Center
at Holy Apostles College and Seminary
Cromwell, Connecticut

[1]Gabriela Noé et al., "Contraceptive Efficacy of Emergency Contraception with Levonorgestrel Given Before or After Ovulation," *Contraception* 81.5 (May 2010): 414–420. Other studies are Marta Durand et al., "On the Mechanisms of Action of Short Term Levonorgestrel Administration in Emergency Contraception," *Contraception* 64.4 (October 2001): 227–234; and Durand et al., "Hormonal Evaluation and Midcycle Detection of Intrauterine Glycodelin in Women Treated with Levonorgestrel as in Emergency Contraception," *Contraception* 82.6 (December 2010): 526–533. See also the letter from Kathleen Raviele, MD, past president of the Catholic Medical Association and a gynecologist, in the Spring 2011 *NCBQ*, where she notes the incredibly high ovulation rate of 79 percent (as demonstrated by follicular rupture) among preovulatory women who received Plan B in the Noé study.

[2]E. Kesserü et al., "The Hormonal and Peripheral Effects of d-Norgestrel in Postcoital Contraception," *Contraception* 10.4 (October 1974): 411–424. 1974): 411–424.

[3]Josiane A. A. do Nascimento et al., "In Vivo Assessment of the Human Sperm Acrosome Reaction and the Expression of Glycodelin-A in Human Endometrium after Levonorgestrel-Emergency Contraceptive Pill Administration," *Human Reproduction* 22.8 (August 2007): 2190–2195.

[4]James Trussell and Elizabeth G. Raymond, "Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy," June 2011, Princeton University Office of Population Research, 5, http://ec.princeton.edu/questions/ec-review.pdf, reporting W. S. Yeung et al., "The Effects of Levonorgestrel on Various Sperm Functions," *Contraception* 66.6 (December 2002): 453–457.

[5]Durand et al., "Hormonal Evaluation and Midcycle Detection."

[6]Philip C. N. Chiu et al., "Cumulus Oophorus–Associated Glycodelin-C Displaces Sperm-Bound Glycodelin-A and -F and Stimulates Spermatozoa–Zona Pellucida Binding," *Journal of Biological Chemistry* 282.8 (February 23, 2007): 5378.

[7]Durand et al., "Hormonal Evaluation and Midcycle Detection," 532.

[8]Howard R. Morris et al., "Gender-Specific Glycosylation of Human Glycodelin Affects Its Contraceptive Activity," *Journal of Biological Chemistry* 271.50 (December 13, 1996): 32159–32167. See also Marta Durand et al., "Late Follicular Phase Administration of Levonorgestrel as an Emergency Contraceptive Changes the Secretory Pattern of Glycodelin in Serum and Endometrium during the Luteal Phase of the Menstrual Cycle," *Contraception* 71.6 (June 2005): 455.

[9]Durand et al., "Hormonal Evaluation and Midcycle Detection," 529 and 532, fig. 6, panel A.

[10]Alessandra Tirelli, Angelo Cagnacci, and Annibale Volpe, "Levonorgestrel Administration in Emergency Contraception: Bleeding Pattern and Pituitary-Ovarian Function," *Contraception* 77.5 (May 2008): 328–332.

[11]For a review of the FDA analysis, see Thomas J. Davis Jr., "Plan B Agonistics: Doubt, Debate, and Denial," *National Catholic Bioethics Quarterly* 10.4 (Winter 2010): 755–756 notes 52–58 and accompanying text.

[12]Nicanor Pier Giorgio Austriaco, "Is Plan B an Abortifacient? A Critical Look at the Scientific Evidence," *National Catholic Bioethics Quarterly* 7.4 (Winter 2007): 703–707. See also Austriaco, letter, 8.1 (Spring 2008): 12–13.

[13]Austriaco, letter, *National Catholic Bioethics Quarterly* 8.3 (Autumn 2008): 424. See also Yeung et al., letters, 8.2 (Summer 2008): 217–219, and 8.3 (Autumn 2008): 418–420. For a discussion of that evolution from scientific certitude to a level of probability, see Davis, "Plan B Agonistics," 763–764 notes 82–88 and accompanying text.

[14]"Women should continue to be informed, as they are now in the Plan B labeling, that its use may affect postfertilization events." F. Davidoff and J. Trussell, "Plan B and the Politics of Doubt," *Journal of the American Medical Association* 296.14 (October 11, 2006): 1777. "To make an informed choice, women must know that [emergency contraceptive pills] … may at times inhibit implantation of a fertilized egg in the endometrium." Trussell and Raymond, "Emergency Contraception," 6.

The Question of Human Embryo Adoption

To the Editor: While I realize that the debate about human embryo adoption must continue in academia, it is my assertion that it ought not to continue in practice. I say this in reference to Professor William May's letter in the Winter 2010 issue of the *NCBQ*.[1] While I am a long admirer of Professor May, I do believe his argument lacks significant persuasiveness.

May attempts to draw a comparison between rescuing an unborn child who will die because of a procedure to cure an existing pathology present in the mother and adopting an unborn child who has been cryogenically preserved. But there is a decided difference in the two examples. In the former, the child will die because of the medical procedure performed, while in the latter example the child is not dying at all. In fact, it is possible that the child to be "adopted" could die during transfer, which is an unnecessary risk to his life.

Furthermore, I believe that the clearest reason why embryo adoption cannot be recommended at this time is because it is impossible to arrive at a certain conscience about the Church's teaching on this matter. If a person truly seeks to form his conscience according to the teaching of the Church, he will find that *Dignitas personae* introduces significant doubt into the debate. The Congregation for the Doctrine of the Faith clearly states that using these embryos as a treatment for infertility is not acceptable. Further, the CDF notes that adverting to "prenatal adoption" also presents various problems. Finally, the CDF says that "there seems to be no morally licit solution."[2]

As all moral theologians know, one cannot act with a doubtful conscience in such a grave situation. While we would all agree that the current state of these unborn children represents an "absurd fate," it also seems quite clear that the Church has not left enough room for one to arrive at a certain conscience. No doubt it appears that a number of people have arrived at a certain, although erroneous, conscience; it should be presumed that their consciences are not properly formed.

Rev. John Ehrich, STL
Director of Medical Ethics
Diocese of Phoenix, Arizona

[1] William E. May, letter, *National Catholic Bioethics Quarterly* 10.4 (Winter 2010): 646–647.

[2]Congregation for the Doctrine of the Faith, *Dignitas personae* (September 8, 2008), n. 19.

Dr. May responds: I thank Rev. John Ehrich for his letter in response to my comments in the Winter 2010 issue of *NCBQ* regarding the "adoption" of a child cryogenically preserved. In his letter, Ehrich writes that "one cannot act with a doubtful conscience in such a grave situation." I agree fully with him. A sentence later he writes, "it also seems quite clear that the Church has not left enough room for one to arrive at a certain conscience." Here I do not agree with Ehrich, and I want to explain why I do not.

First, Archbishop Rino Fisichella, the president of the Pontifical Academy for Life

at the time *Dignitas personae* (*DP*) was published, told reporters at the press conference held by the Vatican after the document was released that "the discussion is still open" and the Vatican *has not ruled out the possibility of embryo adoption*.[1] Second, the U.S. Conference of Catholic Bishops declared that *DP* "raises cautions or problems about these new issues but does not formally make a definitive judgment against them."[2]

Moreover, in the Autumn 2009 issue, the *NCBQ* published a "Symposium on *Dignitas personae*," in which two contributions, Luke Gormally's "The 'Various Problems' Presented by Embryo Adoption (n. 19)" and John Finnis's "Understanding *Dignitas personae* on Embryo Adoption," offer arguments for and against interpreting *DP* n. 19 as rejecting the adoption of frozen and abandoned embryos. Gormally, who, like his wife, Mary Geach, has long opposed such adoption, frankly acknowledges that "*Dignitas personae*'s formulation can hardly be construed as offering well-defined teaching."[3] Finnis's essay, which argues that *DP* n. 19 does not reject embryo adoption, is important, I believe, for his analysis and presentation of the teaching in *Donum vitae* relevant to this issue.

Finally, in its own analysis and commentary on *DP*, The National Catholic Bioethics Center raises the question, does *DP* allow for the adoption of frozen embryos remaining from in vitro fertilization procedures?[4] John Haas, President of The NCBC, and my former student, says no and offers his reasons for doing so, but Stephen Napier, an ethicist at The NCBC, says yes and gives his reason for doing so.

I have discussed this issue with many colleagues—*in particular, colleagues who think that it is not morally justifiable to* "*adopt*" *frozen and abandoned embryos*. Even though they hold this view, they agree that *DP*'s teaching on the matter is not at all clear, that the question is not closed, and that one can adopt such embryos so long as there is no complicity with those who "produced" them in vitro.

Because of all this, I have concluded that one can in good conscience be morally certain that the magisterium of the Church has not decided this issue, but leaves it an open question. The same is true of the "GIFT" (gamete intrafallopian tube transfer) procedure. With many theologians, I believe this procedure *substitutes* for the conjugal act and is therefore intrinsically immoral. Other theologians believe that it *assists* the conjugal act in attaining its procreative end. The magisterium has not decided whether it is or is not. Therefore one can in good Catholic conscience make use of this procedure. I submit that the situations are analogous.

I do not wish to act in any way contrary to magisterial teaching, and if anyone demonstrates that I am so acting, I willingly reject whatever position I took against that teaching. If that can be shown to be the case here, I will immediately abandon this position. I do not, however, think that Fr. Ehrich has shown this to be the case.

William E. May
Professor Emeritus
John Paul II Institute for
Studies on Marriage and Family at
the Catholic University of America
and Senior Fellow
Culture of Life Foundation
Washington, DC

[1] Cindy Wooden, "Adopting Embryos Raises Moral Questions, Vatican Officials Say," Catholic News Service, December 12, 2008, http://www.catholicnews.com/data/stories/cns/0806229.htm.

[2] U.S. Conference of Catholic Bishops, "Questions and Answers: The Instruction *Dignitas Personae* on Certain Bioethical Questions," December 9, 2008, http://usccb.org/comm/Dignitaspersonae/Q_and_A.pdf.

[3] Luke Gormally, "The 'Various Problems' Offered by *Dignitas personae* (n. 19)," *National Catholic Bioethics Quarterly* 9.3 (Autumn 2009): 471.

[4] See the NCBC analysis and commentary on *Dignitas personae,* esp. "*Dignitas personae* and Embryo Adoption: A Debate on Dignitas personae part 2, nn. 18–19," by Stephen Napier and John M. Haas (October 2009), http://www.ncbcenter.org/NetCommunity/Page.aspx?pid=1010.