The Injustice of a D&C or D&E Procedure to Resolve a Crisis Pregnancy

To the Editor: Dilation and curettage (D&C) is a surgical procedure in which the cervix is opened and the contents of the uterus are removed with a shredding tool called a curette. A variant of the D&C is the D&E, dilation and evacuation, in which suction is applied to empty the uterus of its contents. In both cases, the fetal child’s body is dismembered. There has been much discussion among Catholic bioethicists recently about whether or not a D&C or a D&E procedure done to resolve a crisis pregnancy constitutes a direct or an indirect abortion.

In response to a recent position paper to which I am a signatory, I have been approached by several colleagues and asked to clarify my thoughts on the morality of the D&C and the D&E procedures. For now, I put aside the question of whether or not a physician who is performing either a D&C or a D&E to resolve a crisis pregnancy is directly intending the death of the fetal child. Instead, I would like to examine the moral character of the procedures in themselves, because it is clear that at a minimum, the physician working to resolve a crisis pregnancy necessarily intends either to shred (D&C) or to suction out (D&E) the fetal child’s body, whether or not he directly or indirectly intends the death of the child. Instead, I would like to examine the moral character of the procedures in themselves, because it is clear that at a minimum, the physician working to resolve a crisis pregnancy necessarily intends either to shred (D&C) or to suction out (D&E) the fetal child’s body, whether or not he directly or indirectly intends the death of the child. Thus, the question at hand is the following: Is the shredding or the suctioning out of the body of a fetal child a just act?

For St. Thomas, justice is the virtue that regulates our relationships with others. It is that virtue that directs a human agent’s operations in so far as they tend toward external things. Therefore, before performing a D&C or D&E procedure to resolve a crisis pregnancy, a virtuous physician would have to determine whether or not it is a just act. Or to put it another way, is it just to shred or to suction out the body of a living fetal child?

Since justice involves giving to another what is his due, we need to consider whether or not the intentional dismemberment of the fetal child’s body is giving that child his due. As St. Thomas rightly acknowledges, the parts of the fetal body are for the sake of the whole child. They are the child’s because God has given them to him. As such, no one may do injury to the child’s body unless it is for the sake of the child:

Now a member of the human body is of itself useful to the good of the whole body, yet, accidentally it may happen to be hurtful, as when a decayed member is a source of corruption to the whole body. Accordingly so long as a member is healthy and retains its natural disposition, it cannot be cut off without injury to the whole body. If, however, the member be decayed and therefore a source of corruption to the whole body, then it is lawful with the consent of the owner of the member, to cut away the member for the welfare of the whole body.

This is the moral principle that undergirds the prohibition of mutilation.

I think that it is clear that the dismemberment of the fetal child’s body that occurs during the resolution of a crisis pregnancy is not done for the child’s sake. Rather, it is done for the sake of saving the mother’s life. As such, in itself, the dismemberment of the fetal child’s body, whether it is done by a D&C or by a D&E, is unjust. It is unjust
whether or not the D&C or D&E to resolve a crisis pregnancy constitutes a direct abortion. Hence, I contend that a D&C or D&E procedure—or indeed any procedure done to a fetal child that is not done for his benefit, including the “reshaping” or crushing of his skull in a craniotomy—is and always remains a grave evil, whether or not the death of the fetal child is directly intended.

REV. NICANOR PIER GiORGIO AUSTRIOACO, OP, PhD, STL
Providence College
Providence, Rhode Island


3 Thomas Aquinas, Summa theologiae II-II.58.1.
4 Ibid., II-II.58.9 ad 2.
5 Ibid., II-II.65.1.
6 Ibid.

Defining Disease with the Biomedical Model: A Response to Robert Kinney

To the Editor: As the health care system and new technologies are continually developing, the question of how to define a disease becomes increasingly challenging. In his article “Liberalism, Health Care, and Disorder: A MacIntyrean Approach,” Robert Kinney notes that the liberal tradition in our society defines the good on the basis of preferences, which is problematic for Catholics, who hold to an objective moral order.1 Liberalism’s use of a particular concept of the good to define health and disease is thus likely to conflict with the way that goods of the person are defined in the Catholic tradition. Kinney supports his claim that liberalism’s preference-based definition of disease is operating in our medical system with two examples: the definition of “pedophilia” in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a disorder only when the paraphilia causes distress, impairment, or harm; and the inclusion of contraceptive coverage as a health benefit in the Patient Protection and Affordable Care Act. Kinney argues that “definitions of health, health care, disease, and disorder should be based on the functions of the human body, not on the preferences of individuals or the ruling elite” (271–272) and claims that such a definition fits the Catholic tradition’s objective definition of the good.

Kinney’s examples highlight his MacIntyrean critique of this system, which is that different traditions have multiple conceptions of the good and thus of health. Liberalism’s definition of the good based on preference does indeed present a problem for traditions with more robust moralities and anthropologies. Kinney makes an important point, which has relevance extending past insurance coverage and psychiatric diagnoses, to deciding toward what ends medicine should orient itself and what technologies it should use to do so. His conclusion, though—that as Catholics who rely on objective moral order, we should define health and disease by the proper functioning of organs—is not an adequate response.
Kinney relies on the biomedical model of disease, which holds that illness and disorder are deviations from normal functioning, but he underestimates the complexity of defining disease and ignores the debate on the issue. He cites the definition of “disorder” given by a medical dictionary without acknowledging the controversy surrounding the biomedical model and without describing alternative models or citing foundational thinkers in the debate, who provide arguments for and challenges to the biomedical model.²

Moreover, Kinney fails to acknowledge how defining mental illness on the basis of the proper functioning of organs and systems is extremely difficult. The complex inner workings of the brain remain a mystery, and attempts to show physical manifestations of mental illness have largely failed. Michael First, an editorial consultant for DSM-5, states, “Although the past two decades have produced a great deal of progress in neurobiological investigations, the field has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacological treatment.”³ For this reason, mental disorders are not recognized by a scientific definition of disease based on disruption or absence of normal functioning.⁴

Although Kinney is correct in his assessment of the problem with subjective interpretations of most physical illnesses—for example, a heart problem is a problem whether or not it causes distress (271)—many diagnoses of mental illness are necessarily made on the basis of self-reported distress and behaviors. In such a case, an objective analysis of the functioning of the brain (e.g., with an fMRI) will probably fail to find a biological basis for a particular psychological issue.⁵

Finally, although much more could be said to this point, the biomedical model will not always yield conclusions about health and disease that adequately map onto a Catholic theological vision of the person. Although it may claim so at times, medicine is not based on objective truth but on limited knowledge. It is true that Catholics appeal to science and medicine for guidance in many areas with ethical relevance (e.g., brain death), and through natural law Catholics accept the existence of an objective truth regarding the proper functioning of the person. Still, neither limited trust in science nor acknowledgment of objective good implies that we have the ability to know such truths. Defining disease on the basis of normal function requires us to make anthropological assertions about what is “normal” for a human being, and connecting nuanced theological claims about human nature with biological functioning is no small task. In short, it is not the job of the doctor to make theological claims, and Catholics cannot and should not define illness and disease by appealing exclusively to a biomedical model.

Emily Trancik
Ethics Fellow
Ascension Health
St. Louis, Missouri

⁴ Ibid.
⁵ We also cannot ignore the practical limitations of providing advanced diagnostic technology to the large population of patients suffering from mental illness.

Levonorgestrel and Moral Certitude

To the Editor: Father Austriaco’s letter in the Summer 2014 issue of the NCBQ contains a long-overdue admission that the scientific record does not establish moral certitude precluding a postfertilization mechanism of action for Plan B (levonorgestrel).¹ Acknowledging that one cannot dismiss “prudent
dubt over the mechanism of action,” Austriaco concedes that “better data are needed” to resolve such doubts.2

The existing scientific record is not definitive but does yield powerful data pointing to a postfertilization mechanism of action. The insufficiency of the scientific data to preclude reasonable doubt that Plan B has an abortifacient MOA has been a central contention of various authors writing in this Journal and elsewhere for several years.3 Yet Austriaco, contra argumentum, had long argued that the scientific data establish both moral and scientific certitude that Plan B is not an abortifacient.4 In 2010, he cited a study by Gabriela Noé et al. in support of his view.5 But Noé et al. actually showed that Plan B, while no more efficacious at preventing ovulation than a placebo, was 100 percent efficacious at preventing pregnancy (defined as implantation). That dramatic finding proves that Plan B must have a robust postovulatory MOA and has led responsible scientists to conclude that a postfertilization MOA cannot be prudently ruled out.6 Some propose that a postfertilization MOA is likely.7

Austriaco’s acknowledgment that “prudent doubt” subsists is a welcome seismic shift. That he continues to advocate a possible prefertilization MOA, known as the hard-to-fertilize-egg theory, is problematic. In doing so, he fails to adequately address critiques of the theory that have appeared in at least two prior letters and a major article in this Journal8 even as he tacitly admits that the theory remains unproven, untested, and purely speculative. In a letter in the Winter 2013 issue, a group of authors that includes recognized experts in gynecology and obstetrics—Hanna Klaus, MD, Patrick Yeung Jr., MD, Bruno Mozzanega, MD, and Justo Aznar, MD—exposed various serious flaws in the theory.9 “Biologically plausible” is the best Horacio Croxatto can offer about it, and he is the principal authority on whom Austriaco relies in defending it. Such a weak claim hardly answers the challenges regarding moral certitude and the specter of predestined embroyocide if that MOA is assumed.

The critical issue is and always has been moral certitude regarding MOA. Where prudential doubt exists as to MOA—and that is the minimum at play here—Plan B must not be used without some means of providing moral certitude of the imperfect kind precluding embroyocide.10 That level of certitude is a specific term well understood in Catholic thought and well explicated by Rev. Thomas Slater, SJ, in his classic _Manual of Moral Theology_: Certainty in general is a firm assept of the mind to something known, without the fear of mistake. In mathematics and in other branches of exact science we can often attain absolute certainty, which rests on the evident truth of the principles which are employed to arrive at it. … In the science of morality we have frequently to be content with a lower degree of certainty … with what is called moral certainty; but this again is of various degrees. I am morally certain of the existence of Berlin, though I never saw the city. Any person who doubted of its existence would be thought to be insane. The grounds on which the judgment that Berlin exists are based are so many and so strong that they leave no room for prudent doubt in the matter. In such cases we have perfect moral certainty. In other cases I may be conscious that mistake is possible but not probable, as when a man has been condemned on evidence which has satisfied a jury of intelligent men. In such cases if there can be no prudent doubt about the justice of the verdict I have moral certainty of an imperfect but real kind. If I could not safely rely in guiding my conduct on such a degree of certainty, I should have to abstain from action altogether. Ordinarily greater certainty cannot be obtained in human affairs. In order to act lawfully and rightly, I must have at least moral certainty of the imperfect kind that the proposed action is honest and right. This degree of certainty will be sufficient, for ordinarily no greater can be had, as we have just seen. It is also required for right action; for if I am not at least to this extent morally certain that my action is right, I am conscious that it may be wrong. In this case I am bound to pause, and satisfy myself that it is right before acting; for if I do not do so my will is ready to embrace what may be wrong.11

In other words, certainty precluding reasonable doubt is required for moral certitude of
Colloquy

the imperfect kind. Pope Pius XII explained that it is “characterized . . . by the exclusion of well-founded or reasonable doubt.”

Even a well-known Plan B advocate readily acknowledges that moral certitude requires “that the agent has excluded all reasonable possibility of error.”

The burden of proof rests with the proponents of Plan B. It is a burden they have not and cannot meet because the scientific record cannot exclude reasonable doubt that such treatment will have as a “direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.”

Rev. Deacon Thomas J. Davis Jr., JD
Saint John Paul II Bioethics Center at Holy Apostles College and Seminary Cromwell, Connecticut

Justo Aznar, MD, PhD
Life Sciences Institute Catholic University of Valencia Valencia, Spain

Kathleen M. Berchelmann, MD
CatholicPediatrics.com St. Louis, Missouri

Donna Harrison, MD
American Association of Pro-Life Obstetricians and Gynecologists Eau Claire, Michigan

Bruno Mozzanega, MD
Department of Woman’s and Child’s Health University of Padua, Italy

Rebecca Peck, MD
Florida State University Tallahassee, Florida

Dominic M. Pedulla, MD
Oklahoma Vein and Endovascular Center Oklahoma City, Oklahoma

Kathleen Raviele, MD, FACOG
American Association of Pro-Life Obstetricians and Gynecologists Tucker, Georgia

Walter Rella, MD
Institute for Medical Anthropology and Bioethics (MABE) Vienna, Austria

Julio Tudela, PharmD, PhD
Catholic University of Valencia Valencia, Spain

Rev. Juan Velez, MD, PhD
Darien, Illinois

Patrick Yeung Jr., MD, FACOG
Department of Obstetrics, Gynecology and Women’s Health Saint Louis University St. Louis, Missouri


2 Ibid., 203.


8 Davis, letter, Spring 2013; Davis et al., letter, Winter 2013; and Peck and Velez, “Postovulatory Mechanism of Action.”

9 Davis et al., letter, Winter 2013, 583.


12 Pius XII, Address to Roman Rota (October 1, 1942), quoted in John Paul II, Address to Roman Rota (February 4, 1980), n. 6.
