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Two recent cases in Manila hospitals of dying women about to give birth brought into sharp focus some basic questions in medical ethics. In the cases at hand, the two pregnant women went into irreversible comas shortly before the expected births. For the first woman, it was her sixth pregnancy and she had no previous history of hypertension. She arrived at the hospital for what appeared to be a routine delivery. Suddenly, she had a severe stroke with massive brain damage and very high blood pressure. The neurosurgeon ordered an electroencephalogram (EEG).

There were no brain waves registering. In spite of a continuing slight heart beat and breathing, the neurosurgeon pronounced the woman clinically dead and ordered an immediate caesarean section to save the unborn child and prevent fetal brain damage. At that point, the fetal heart beat was very weak. However, the obstetrician refused to give her approval for a caesarean section, insisting that the shock of the surgery would kill the mother. Only a postmortem caesarean would be permitted.

The husband was present but would not give written approval for a caesarean until his wife was dead. When it was explained that death was inevitable and imminent, he left the decision to the doctors but would not put it in writing. As a result of the disagreement of the doctors there was no caesarean. Oxygen was administered to the mother, making her, equivalently, a "heart-lung machine," keeping her baby alive but with danger to the brain of the unborn child if the oxygen was excessive.

Some hours later, the mother went into labor and delivered the baby naturally. After five hours all vital signs ceased and the mother, who never recovered from the coma, was pronounced dead. The baby seemed normal but it will be years before it will definitely be known if there were harmful effects from a possible

excessive amount of oxygen.

The other case under discussion is quite similar. It was the first pregnancy in a thirty-five year old woman expecting to deliver in a few days. For one month, there had been increasing signs of impending danger, but nothing incapacitating, until about four hours before admission when she suddenly lost consciousness and was rushed to the hospital deeply comatose with no reaction to stimuli. The fetal heart tones were strong and regular when the patient was admitted to the hospital, but the attending doctor ruled out a caesarean section because of the serious condition of the mother.

In the third hour after admission, the gravity of the situation led the doctor to speak to the husband of the option of a caesarean section to save the baby. The husband agreed and signed a consent for a postmortem section. Upon further discussion, he agreed orally to an immediate caesarean section but would not sign a consent for it, even if it would lead to his wife's death but would save the baby.

Unfortunately, in the fifth hour after admission, the fetal heart beat could no longer be detected. The baby was presumed to be dead. In the seventh hour, the neurosurgeon declared the mother in a state of brain death clinically, ruling out an EEG as unnecessary since it would merely confirm the fact, and it was too risky to move the patient just to confirm brain death. The patient was hooked to a respirator and she continued in that condition for many hours until the relatives decided to take her home to die, with the unborn child dead in her womb.

Thus in both cases the mothers died. In both cases caesarean sections had been ruled out due to concern for the critical condition of the mothers. In one case the child died in the womb; in the other the child was born, apparently normal, but after running the risk of brain damage due to excessive oxygen.

MORALITY OF MEDICAL INTERVENTION

The question naturally arises about the morality of caesarean sections in these cases. At what point may the doctor concentrate all his efforts on saving the baby and disregard the effect a caesarean section will have on the dying mother? In reply, if an

EEG indicates brain death, the doctor is fully justified morally in proceeding to do a caesarean section. The mother is dead for all practical purposes. As B. Haring, the eminent German moralist says, "the arguments for the equation of the total death of the person with brain death are fully valid."[1] Other vital signs such as breathing and heart beat may still continue, but true human life has ceased. The residual vital signs will gradually weaken and cease, but there is no need to wait for that when the life of the unborn child is at stake.

A caesarean section is not a lethal attack on a mother. It is a routine procedure for delivery under certain conditions. Since it involves surgery, there will be a shock to the system of the mother. But once she is diagnosed as "brain-dead," the shock will only hasten the weakening and final cessation of the remaining vital signs which are no longer humanly significant, especially in comparison with the life of the child.

If the diagnosis of brain death is proven by an EEG, there is as much certainty of brain death as modern science can provide. But what if an EEG is not possible for want of the machine, because of mechanical difficulties, or for any reason whatsoever? How is the judgment to be made? As in the second case under discussion, the neurosurgeon made a professional judgment of brain death based on all the medical data available to him. He was morally certain that an EEG would only confirm his diagnosis. In medical matters no more can be demanded. On any given day, around the world, doctors without the aid of machines are declaring accident victims dead and their judgments are accepted because of their professional expertise. We trust them to know when to hesitate, when to seek confirmation of their decision in such a serious matter. When the neurosurgeon affirms the brain death of a woman about to give birth, even without an EEG, he should be believed and all attention and effort should then be concentrated on saving the unborn child. Any shock or harm to the mother becomes a secondary issue, an unavoidable side effect of the caesarean section that should cause no moral scruples.

However, what if the condition of the mother is less serious, with no indication of brain death, but the unborn child is in grave danger unless a caesarean section is performed promptly? This is

1. Bernard Haring, *Medical Ethics* (Notre Dame, Ind.: Fides, 1973), p. 136.

a more difficult case to judge. It would be immoral to so proceed as to put the mother in serious danger of death just to prevent the death of the unborn child. The mother is not bound to die in order that her child be born. No one is allowed to endanger her life deliberately to procure a safe delivery of the child. In the cases under discussion the mothers were clinically dead, in an irreversible condition of brain death, with residual life signs that would gradually disappear. But if a mother still has a firm grasp on life in spite of her illness and/or the complications of delivery, her life must not be endangered even to save the life of the baby. It is up to the attending physician to provide as best as he can for both mother and child without deliberately endangering either one.

Who makes the decision concerning the caesarean section of the dying comatose mother? Since the patient is unable to speak, the husband or next of kin should be consulted. If the two cases under discussion are typical, the husband will approve in writing of a postmortem caesarean but will only give oral approval of an immediate caesarean which might hasten the death of his wife. The doctor should act on this oral approval. Legal medical experts assure us that Philippine Law will endorse the decision of the doctor in such a situation. If a comatose patient was alone and there was no one to speak for her, the doctor would be morally and legally justified in deciding on a caesarean section in the cases under discussion.

GUIDING MORAL PRINCIPLES

What moral principles guide us in making these decisions?

Once the mother is declared clinically dead, with or without an EEG, the *traditional* understanding of the principle of double effect would justify the caesarean section. This principle demands the following conditions:

1. That the action undertaken be good in itself, or at least be indifferent (not morally evil). Here the action is a caesarean section, an acceptable medical intervention when natural child birth is impossible or contraindicated for serious medical reasons. Thus, the first condition is fulfilled.
2. That the intention of the agent (doctor) is upright, that is, the evil effect (shortening the life of the mother) is not in-

tended. In the cases under discussion, the doctors are dealing with pregnant women in irreversible comas. There is no hope for their recovery. Medical science today knows no way to reverse their brain death. Keeping their residual vital signs going is meaningless from the human point of view. Still, the doctors do not intend to terminate those vital signs. They intend to save the life of the baby, seriously endangered by the imminent death of the mother. This is the sole intention of the doctors. The fact that the residual vital signs will cease more quickly due to the shock of the caesarean section is not intended but is an unavoidable side effect of their lifesaving intervention.

3. That the good effect must follow from the action at least as immediately as the evil effect, for otherwise the evil effect would be a *means* to the good effect, and would be *intended* as such, thus breaking the second condition.[2] In the cases under discussion, the evil effect of shortening the life of the mother (who is already brain dead) follows simultaneously from the very same action that is lifesaving for the unborn child. The caesarean section saves the child and at the same time is a shock to the dying mother.
4. There must be a proportionately grave reason to permit the evil to occur. Here, the proportionate reason is manifest: the life of the baby in the womb is proportionate to the shortening of the fast disappearing vital signs in the dying mother.

Thus, we see a clear application of a traditional moral principle used in countless conflict situations where a choice must be made between two evils. In the cases at hand, if the principle is not invoked to justify a caesarean section, both mother and child will die (as happened in one case) or the child will be exposed to serious harm (brain damage) that can affect him for life (as in the other case). As one leading moralist puts it:

> The rule of double effect is a vehicle for dealing with conflict situations . . . . It was facing conflict situations where only two courses are available: to act or not to act . . . . The concomitant of either course of action was harm of some sort. Now in situations of this kind, the rule of Christian reason, if we are governed by the *ordo bonorum*, is to choose the

2. See C. Henry Peschke, S.V.D., *Christian Ethics*, vol. 1 (Manila: Catholic Trade, 1973), p. 209; Heribert Jone, O.F.M. Cap., *Moral Theology* (Westminster: Newman Press, 1955), p. 5, no. 14.

> lesser evil. This general statement is, it would seem, beyond debate; for the only alternative is that in conflict situations we should choose the greater evil, which is patently absurd. This means that all concrete rules and distinctions are subsidiary to this and hence valid to the extent that they actually convey to us what is factually the lesser evil.[3]

Thus, we apply double effect as a means of discovering the lesser evil. In the cases under discussion, we apply it to justify the shortening of the residual vital signs of the dying mother (the lesser evil) rather than allow the death or serious danger to the unborn child (the greater evil). It is *not* a question of preferring the life of the unborn child to that of the mother. The possibility of such a choice was never present in the cases under discussion. The mothers were in irreversible death situations. Their lives were slipping away, being clinically dead with only rapidly diminishing residual vital signs, now meaningless from the human life point of view.

Catholic medical-moral teaching never puts more value on one life rather than on another. There is never a medical situation when the mother is to be arbitrarily subordinated to her unborn child, nor the child to the mother. In conflict situations, good morality seeks the lesser evil. To prevent the greater evil of allowing both to die, a medical lifesaving intervention is allowed. If harm to the other party in the conflict situation can be avoided, it must. But if the lifesaving intervention involves unavoidable harm to the other, it is permitted when there is a proportionate reason, e.g., saving one life rather than allowing both to die. The harm to the other, is unavoidable, never intended, merely permitted and justified to prevent a greater evil.

FURTHER CONFLICT SITUATIONS

In the cases under discussion, the traditional understanding of the principle of double effect has been applicable. But in recent years, conflict cases have been noted in which a literal application of double effect would have led to the *greater evil* – the death of both mother and child. Let us mention some of these examples.

3. Richard A. McCormick, S.J. and Paul Ramsey, eds., *Doing Evil To Achieve Good* (Chicago: Loyola University Press, 1978), p. 38.

In 1973, B. Haring, C.S.S.R., cited the case of a doctor called upon to remove a benign uterine tumor of a woman in her fourth month of pregnancy.[4] On the womb there were numerous, very thin, and fragile varicose veins which bled profusely, and attempts to suture them only aggravated the bleeding. To save the woman from bleeding to death, the doctor opened the womb and removed the fetus. Thereupon the uterus contracted, the bleeding ceased, and the woman's life was saved. The doctor was proud of the fact that, in addition to saving the life of the woman, he had preserved the uterus undamaged so that the woman, who was childless, could bear other children. To his astonishment, the doctor was told by a noted moralist that he had acted in good faith, but what he had done was objectively *immoral* because he had directly attacked the fetus, thus violating the principle of double effect as *traditionally* understood.

If the doctor had followed the traditional understanding of the principle of double effect, he would have been allowed to remove the bleeding uterus with the fetus itself (indirect attack on fetus), but he would not have been permitted to interrupt the pregnancy while leaving the womb intact (direct attack). The fact that he preserved the womb and the fertility of the woman would not enter into the traditional understanding of the morality of the doctor's procedure. But as we shall explain later, there are sound moral views of contemporary moralists that uphold the objective morality of the doctor's action.

Other similar examples of mother-child conflicts are mentioned in the work by McCormick and Ramsey cited earlier. One is the case of

> (a pregnant woman who) has a misplaced, acute appendicitis and who will die from its rupture unless a physician goes straight through the uterus (that is, kills the baby first, then saves her life). Also there are cases of aneurysm of the aorta in which the wall of the aorta is so weakened that it balloons out behind the pregnant uterus. Again, the physician must first kill the fetus in order to deal with the aneurysm that threatens the mother's life. In both of these cases the baby is in the way, it shields the mother from the necessary cure.[5]

Traditional understanding of the principle of double effect would condemn these lifesaving interventions of the physician

4. Haring, *Medical Ethics*, p. 108.
5. McCormick and Ramsey, *Doing Evil to Achieve Good*, p. 208.

precisely because they are *direct* attacks on the fetus. The *directness* of the action was sufficient to merit condemnation as immoral. Instead of equally immediate causality, one action producing the good and the evil effects simultaneously, (condition three as explained above), we have a direct attack on the fetus as the first action, to remove the threat to the mother's life that the fetus has unfortunately become. Removing the fetus prepares the way for the cure of the pathological condition that is threatening the life of the mother.

Moralists felt instinctively that the doctors were justified in these admittedly rare cases in directly intending the removal of the fetus as the first, preparatory step in the attempt to save the mother's life when it was impossible to save both the mother and the child to be born. It is absurd to say that the doctor should do nothing and allow the greater evil, standing back and watching both die. But how can we reconcile these lifesaving interventions of the doctors with *traditional* moral principles, specifically, the third condition of double effect, and the time-honored condemnation of doing evil (removing the fetus first) to obtain good (saving the life of the mother)?

Theologians devoted themselves to a reexamination of the principle of double effect, concentrating on the third condition demanding simultaneous causality of the good and evil effects.[6]

RESULT OF THEOLOGICAL REEXAMINATION

The result of the theological reexamination of the principle is that many contemporary Catholic moralists hold that although there are times when there is a significant moral difference be-

6. Double effect has evolved over the centuries as Catholic theologians came to grips with conflict cases and unavoidable evil effects. The principle has been the exclusive property of Catholic theologians although there is nothing specifically Catholic about it. It appears as the by-product of dubious casuistry to many non-catholic ethicists, and Protestant authors generally do not accept the principle. They usually resort to some "proportionate-cause" reasoning to resolve conflict situations involving abortion. Paul Ramsey, the eminent American Methodist theologian, originally praised the principle, but lately has abandoned, at least in practice, the all important third condition of the principle. See Charles Curran, *Transition and Tradition in Moral Theology* (Notre Dame: University of Notre Dame Press, 1979), p. 34. It has been shown by historical research (with some dissenting voices) that St. Thomas Aquinas, credited with originally formulating the principle, did not hold this third condition of simultaneous causality. Ibid, p. 222.

tween *direct* and *indirect,* still, the physical structure and immediate causality (simultaneity) of the act cannot *always* and *necessarily* determine the morality of the act.[7]

The best, presently available source in this ongoing discussion is the co-edited work of McCormick and Ramsey cited earlier. McCormick puts it very well when he presents double effect as a vehicle for dealing with conflict situations whose whole purpose is to convey to us what is factually the lesser evil.[8] It is not the directness or indirectness in itself which determines the morality of the action. All the human values must be considered and weighed. Abortion could be moral in these admittedly rare cases even though it is a direct attack on the fetus. It is willed as a *means* to save the life of the mother, when there is no other means available, rather than let both fetus and mother die. The lesser evil (the death of the fetus) is being chosen for a proportionate reason as the only way to avoid the greater evil of both dying. The one so acting has the proper intentionality because he is making the best of a destructive and tragic situation. Reluctantly, and regretfully, he may intend the unavoidable evil involved as a means to the all important end of saving one life rather than watching both die. He is minimizing evil, choosing the lesser to prevent the greater. But how can the choice of evil be morally justified? What of the ancient Christian condemnation of one who tries to justify evil by alleging a good intention (the end justifying the means)?

For more than a decade the theologians had been reflecting on the notion of evil, reexamining the traditional elements constituting the morality of human acts. Moral theologians have traditionally judged the morality/immorality of the human act by analyzing its object (e.g. killing, lying), its intent or goal (e.g. revenge, self-defense), and the circumstances (relevant details). Traditionally some actions were judged as immoral in themselves, prescinding both from the intent or goal and from all circumstances. Such actions were said to be *intrinsically evil* in themselves so that nothing could ever justify them. A direct atack on the fetus was always so judged.

In 1971, Joseph Fuchs, S.J. published his important work on the absoluteness of moral terms, concluding that *theoretically*

7. Curran, *Transition and Tradition in Moral Theology,* p. 34.
8. McCormick and Ramsey, *Doing Evil to Achieve Good,* p. 38.

speaking there can be no universal norms of behavior in the strict sense of defining an act that is intrinsically evil in itself.[9] His argument was based on the suppositions that: (1) an action cannot be judged morally by itself but only together with all the circumstances and the intention, and (2) we cannot foresee adequately all possible combinations of circumstances and intention. On the practical level, however, there can still be norms stated as universals to which we cannot conceive of any kind of exception.[10]

Most contemporary moral theologians agree that moral evil is found *only* in the *total human act.* Many of them accept a theory of physical (premoral or ontic) evil as distinguished from moral evil. The physical (premoral or ontic) evil is that which is found in an action considered in itself, before the totality of the human act is considered; for example, the death of the fetus in the cases under discussion.

Moral evil may *never* be intended. It may never be used as a means to an end. We may not do moral evil in order to obtain good. Premoral (physical or ontic) evil *may* be justified if there is a proportionate reason. This is the position of many contemporary theologians.[11]

In the cases under discussion, the total lifesaving intervention of the doctor would be judged as moral, and the evil in the death of the fetus would be judged as physical or premoral or ontic evil, justifiable to save the life of the mother. The evil here is intrinsically inseparable from the cure of the mother. The day when medical science progresses to the point where it can save both mother and fetus, there would no longer be a justification for any other procedure. It is interesting to note that the Belgian hierarchy in its

9. Joseph Fuchs, S.J., "The Absoluteness of Moral Terms," *Gregorianum* 52 (1971): 450.

10. Richard A. McCormick, S.J., "Notes on Moral Theology," *Theological Studies* 36 (1975): 85-100; 38 (1977): 68-84;39 (1978): 104-116.

11. Following McCormick, as long as the agent intends the nonmoral evil as a *means* to the end, he can disapprove of the evil, accepting it only because it is intrinsically inseparable from the good he seeks to accomplish. His attitude would be fundamental disapproval, as though saying to himself: "I would not be willing to perform this deed if there were any other way available to save the mother." Whereas to intend the evil (the death of the fetus) as an *end* would necessarily involve approval of the evil. In this analysis, the decisive moral factor is *not* "directly intending" but "directly intending as a *means.*" McCormick concludes that if this analysis is correct, the mistake of the traditional understanding of double effect was believing that intending as a means necessarily implied approval of the evil. See McCormick-Ramsey, p. 264.

1973 pastoral on abortion, summarized the matter as follows: "The moral principle which ought to govern the intervention can be formulated as follows: since two lives are at stake the Christian will, while doing everything possible to save both, attempt to save one rather than allow two to perish."[12] The Bishop of Augsburg, J. Stimple, in his pastoral of 27 April 1974, explicitly allowed the exception we have been discussing when he stated: "Whoever commits an abortion, unless to save the life of the mother, sins seriously and lays on his conscience the death of human life."[13] Common sense, right reason, a Christian sense of proportion and of charity, would seem to demand approval of this approach to such tragic conflict cases.

12. *La Documentation Catholique* 70 (6 May 1973): 433.
13. Charles Curran and Richard A. McCormick, S.J., eds., *Readings in Moral Theology*, No. 1 (New York: Paulist Press, 1979) p. 159.