"It Gives the Mother the Best Chance for Her Life": U.S. Catholic Health Care and the Treatment of Ectopic Pregnancy

Jessica Martucci

It is widely understood that the Catholic Church prohibits abortion.[1] Few women today would likely approach a Catholic hospital with the hope of obtaining an elective abortion. That this is so normalized in our society is a reflection of both a long history of Catholic influences in American health care and the Catholic Church's long-standing position on the matter.[2] This association between Catholicism and antiabortion politics dates back to the 1869 proclamation by Pope Pius IX that officially declared abortion at any point in gestation—either its conduct or its procurement—to be an excommunicable offense.[3] Yet despite the apparent clarity and consistency of their convictions, the implementation of this position in Catholic health care institutions has never been quite so straightforward.

In her prescient 2002 essay, "The Evil of Abortion and the Greater Good of the Faith," religious studies scholar Kathleen M. Joyce argued that leaders in Catholic medicine had learned to strategically diminish their "condemnation of practices their church deemed evil in the pursuit

1. The quotation in the title comes from Austin O'Malley and James J. Walsh, *Essays in Pastoral Medicine* (Cambridge, Mass.: University Press, 1906), 34–35.

2. For more background on Catholic medicine in America, see Bernadette McCauley, *Who Shall Take Care of Our Sick? Roman Catholic Sisters and the Development of Catholic Hospitals in New York City* (Baltimore: Johns Hopkins University Press, 2005); Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions* (New Brunswick, N.J.: Rutgers University Press, 2011); Jessica Martucci, "Religion, Medicine, and Politics: Catholic Physicians' Guilds in America, 1909–32," *Bull. Hist. Med.* 92, no. 2 (2018): 287–316; Jessica Martucci, Ronit Stahl, and Joris Vandendriessche, "One Religion, Two Paths: Making Sense of US and Belgian Catholic Hospitals' Approaches to IVF," *J. Religious Hist.* 46, no. 3 (September 2022): 552–79.

3. Kathleen M. Joyce, "The Evil of Abortion and the Greater Good of the Faith: Negotiating Catholic Survival in the Twentieth-Century American Health Care System," *Religion Amer. Cult.* 12, no. 1 (Winter 2002): 91–121, 96.

of . . . the preservation of a Catholic voice in the American health care system."[4] Here I examine this characterization and perhaps push it even further. As nursing historian Barbra Mann Wall has demonstrated, Catholic medical organizations have a long history of evolving and negotiating to maintain and grow their success.[5] In the pages that follow, I discuss how one of the staunchest antiabortion forces in America has grappled with the limits and consequences of a religious ban on procedures that are central to the provision of women's health care. Through a brief analysis of the case of ectopic pregnancy, I emphasize the historical weight behind what has become a well-known mantra in modern reproductive health activism, as well as the namesake of a proposed bill in the U.S. Senate: "Abortion is Healthcare."[6]

From a Fatal Condition to Lifesaving Treatments

Sometimes described in the historical medical literature as an "extrauterine" pregnancy, ectopic pregnancy describes a condition in which a fertilized egg implants somewhere other than in the main cavity of a woman's uterus and begins to grow. The most common presentation of this is a tubal pregnancy, which occurs in the Fallopian tubes due to preexisting infections, endometrial growth, or a structural abnormality.[7] Once implanted, the embryo attempts to form connections with the blood vessels in the tube. The tube wall swells and weakens as the embryo develops, and if left untreated, the tube can burst, causing hemorrhage and death for the embryo and often the mother. The condition is considered so pathological that contemporary bioethicists have suggested we stop referring to it as a "pregnancy" at all.[8]

The condition was first described in an eleventh-century Arabic medical text, but the development of lifesaving interventions did not emerge until the late 1800s as anatomical knowledge and antiseptic methods improved. Medical data collected by nineteenth-century physicians suggested a 25 percent survival rate without intervention. Those who lived faced a life-

4. Ibid., 93.

5. Wall, *American Catholic Hospitals* (n. 2).

6. H.R. 1670, Introduced in the House March 9, 2021, by Rep. Janice Schakowsky (D-IL). See www.repealhelms.org for updates.

7. Monika M. Skubisz and Stephen Tong, "The Evolution of Methotrexate as a Treatment for Ectopic Pregnancy and Gestational Trophoblastic Neoplasia: A Review," *ISRN Obstet. Gyn.* 2012 (2012): 637094, 5.

8. Bernard M. Dickens, Anibal Faundes, and Rebecca J. Cook, "Ectopic Pregnancy and Emergency Care: Ethical and Legal Issues," *Int. J. Gyn. Obstet.* 82 (2003): 121–26, 121.

time of complications as a result of the ordeal.[9] As early twentieth-century obstetrician Joseph B. DeLee wrote in 1915, "The prognosis as to health is also bad, because the condition leaves peritonitic adhesions, which often result in sterility; if untreated, decomposition and abscess cause hectic fever, invalidism, etc."[10] Given these poor outcomes, it is no wonder that the 1884 report of a successful surgical treatment for ectopic pregnancy by a Scottish gynecologist and surgeon named Robert Lawson Tait caused such a stir in the late nineteenth-century medical world. By 1888, Tait had operated on a total of twenty-eight patients who suffered from a ruptured tubal pregnancy and had lost only one, a feat made only more remarkable at the time by his complete disavowal of germ theory and aseptic and antiseptic techniques.[11] The new technique made ectopic pregnancies a treatable condition and saved lives. Between 1876 and the turn of the twentieth century, the documented mortality rate for a ruptured ectopic pregnancy fell from over 76 percent to under 3 percent with surgery.[12]

Despite this innovation in treatment, however, physicians continued to struggle through the next century with the problem of diagnosis. Even after a rupture, physicians weren't always certain about what they were seeing, and delays in treatment due to diagnostic uncertainty placed women at further risk.[13] By the end of the 1980s, the development of laboratory and clinical techniques involving hormone assays for human chorionic gonadotropin (hCG) alongside ultrasonography improved early diagnosis.[14] However, for the majority of the twentieth century, physicians grappled with extreme uncertainty whenever they confronted a female patient with a potential ectopic pregnancy.

9. Joseph B. DeLee, *The Principles and Practice of Obstetrics*, 2nd ed. (Philadelphia: W.B. Saunders, 1915), 405.

10. Ibid., 409.

11. Lawson Tait, "General Summary of Conclusions from a Second Series of One Thousand Consecutive Cases of Abdominal Section," *Brit. Med. J.*, November 17, 1888, 1096–1100. On Tait's antigerm theory stance, see Anna Greenwood, "Lawson Tait and Opposition to Germ Theory: Defining Science in Surgical Practice," *J. Hist. Med. & Allied Sci.* 53, no. 2 (April 1998): 99–131.

12. Charles Nucci, "A Ten-Year Survey of Ectopic Pregnancy," *Penn. Med. J.* 49, no. 9 (June 1956): 953–63.

13. DeLee, *Principles and Practice of Obstetrics* (n. 9), 403–8.

14. N. Kadar, G. DeVore, and Roberto Romero, "Discriminatory hCG Zone: Its Use in the Sonographic Evaluation for Ectopic Pregnancy," *Obst. Gyn.* 58 (1981): 156–61; Roberto Romero, Nicholas Kadar, Danilo Castro, Phillipe Jeanty, John C. Hobbins, and Alan H. DeCherney, "The Value of Adnexal Sonographic Findings in the Diagnosis of Ectopic Pregnancy," *Amer. J. Obstet. Gyn.* 158, no. 1 (January 1988): 52–55; American College of Obstetricians and Gynecologists, "Ectopic Pregnancy: ACOG Technical Bulletin Number 150—December 1990," *Int. J. Gyn. Obstet.* 37 (1992): 213–19.

Ectopic Pregnancy and the Catholic Doctrine of Double Effect

The Church's position on ectopic pregnancy has been shaped by two fundamental dictates: that killing is wrong and that life begins at conception. In 1898 the Holy Office, a commission of Cardinals to "promote and defend the doctrine of the faith and its traditions," responded to a series of questions specifically about ectopic pregnancy: (1) "Is laparotomy licit in the case of extra-uterine pregnancy or ectopic conceptions?" and (2) "Whether it is sometimes licit to remove from the mother ectopic fetuses which are immature, before the expiration of the sixth month after conception?"[15] In the case of the former, the Holy Office wrote, "In case of urgent necessity laparotomy for the removal of ectopic conceptions, is licit, provided serious and opportune provision is made, so far as is possible, for the life of both the fetus and the mother." To the second question they answered, "Negative . . . no hastening of delivery is allowed unless it be done at a time and in a manner which are favorable to the lives of the mother and the child."[16] Taken together, the answers showed an almost willful ignorance of the physiology of ectopic pregnancy—there was no intervention that could preserve the life of an ectopic embryo or fetus. Catholic moralists and physicians, forced to interpret these answers due to their vague and conflicting messages, continued to debate their implications.

Catholic physicians in the United States began organizing themselves into professional guilds in the early 1900s, slightly ahead of the formation of the Catholic Hospital Association (1915). These early Catholic physicians' guilds created networks of communication, mentorship, and moral support as well as a discursive space in which they could wrestle openly with the conflicts they experienced as both physicians and Catholics.[17] Not surprisingly, ectopic pregnancy figured prominently in the guilds' debates throughout the first half of the twentieth century. Early guild leaders, James J. Walsh, founder of the movement in the United States, and his colleague, Austin O'Malley, a founding member of the guild in Philadelphia, were two prominent voices in these discussions.[18]

15. On the Holy Office, see "Dicastery for the Doctrine of the Faith," https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_pro_14071997_en.html. On ectopic pregnancy, see Timothy Lincoln Bouscaren, *Ectopic and Pathological Pregnancy in Catholic Morality: Catholic Ethics Regarding Ectopic and Pathological Pregnancies* (1933; Tradibooks, 2016), 32–33.

16. Bouscaren, *Ectopic and Pathological Pregnancy* (n. 15), 32–33.

17. Martucci, "Religion, Medicine, and Politics" (n. 2), 287–316.

18. Ibid., 292–93.

Walsh and O'Malley first took up the subject of ectopic pregnancy in their jointly authored 1906 book on medical ethics, *Essays in Pastoral Medicine*. In it, they argued that because an ectopic pregnancy grew *unnaturally* outside the walls of the uterus it could be understood to be an unjust aggressor against the mother's life, and thus the surgeon could be justified in removing the fetus to save the mother's life. As they saw it at the time, this made sense because "the ectopic foetus will die anyhow, and operation only *indirectly* . . . accelerates the inevitable death of a materially unjust aggressor, while it gives the mother the best chance for her life."[19] Their perspective seemed practical, albeit read through a Catholic lens: if in the course of saving the mother's life the fetus died, then the physician could not be guilty of sin because the ectopic pregnancy was itself a pathological and unnatural condition. In describing the ectopic pregnancy in this way, Walsh and O'Malley could argue, in the absence of any clear prohibition from the Church, that surgical removal of an ectopic pregnancy was morally acceptable because the surgeon needed to act to save the mother from a very real threat against her life.

These medico-moral opinions remained highly contingent upon the state of medical knowledge about ectopic pregnancies. By 1919, O'Malley had reversed his position. In his popular work, *Ethics of Medical Homicide and Mutilation*, O'Malley stated that it had become clear to him that ectopic pregnancies resulted from an underlying pathology in the Fallopian tube, which caused the embryo to wind up in the wrong spot. As O'Malley put it, "The fetus is necessarily passive always, never aggressive in any sense of the term, until the rupture occurs."[20] O'Malley's shift in thinking was perhaps in response to an emerging medical theory that there was a significant correlation between ectopic pregnancy and sexually transmitted infections, which cast a moral pall over the topic.[21]

By the 1930s, general medical opinion coalesced around the idea that the underlying material cause of ectopic pregnancy was generally the health of the Fallopian tube itself.[22] Unlike O'Malley, however, many Catholic moralists and physicians seized upon this perspective to argue in favor

19. O'Malley and Walsh, *Essays in Pastoral Medicine* (n. 1), 34–35.

20. Austin O'Malley, *The Ethics of Medical Homicide and Mutilation* (New York: Devin-Adair, 1919), 131.

21. J. Whitridge Williams, *Obstetrics*, 4th ed. (New York: D. Appleton and Co., 1917), 677–82; Eben Foskett, "A Study of 117 Cases of Ectopic Gestation: From the Service of Dr. Henry C. Coe, Bellevue Hospital," *Amer. J. Obstet. Dis. Women Child.* 74, no. 2 (1916): 232; Thurston Schott Welton, "Extrauterine Pregnancy with a Report of Three Unusual Cases," *Trans. Amer. Assoc. Obstet. Gyn.* 71, no. 3 (1915): 434.

22. R. S. Statham and H. L. Shepherd, "Ectopic Pregnancy," *Bristol Med. Chir. J.* 48, no. 179 (1931): 15–34.

of intervention based on the Doctrine of Double Effect. Developed by Saint Thomas Aquinas during the thirteenth century, the doctrine allows that in doing good to prevent evil, sometimes unforeseen negative consequences can occur.[23] Despite the doctrine's simplicity, the early twentieth-century Catholic moralist Timothy L. Bouscaren argued that determining when and how to deploy it "is one of the hardest practical problems in moral theology."[24] In the case of ectopic pregnancy, however, he argued that the "indirect killing or destruction" of an ectopic pregnancy could be "permitted for a good and proportionately grave reason . . . by virtue of the principle of the double effect."[25]

Embracing Surgical Treatment

These shifts in medico-moral thinking helped provide Catholic health care providers with justification for the treatment and care that patients demanded. In a 1938 work, Henry Davis, S.J. of Heythrop College in London conducted a survey of U.S. physicians (Catholic and non-Catholic) on their opinions and practices surrounding ectopic pregnancy. He asked his respondents to consider the following: "Catholic ethics permits the removal of a uterus, even during pregnancy, when there is a tumour threatening the life of the mother. [So] in tubal pregnancy, can it be said that there is a pathological condition which threatens the life of the mother, as the uterine tumour does?"[26] Of his forty-nine respondents, forty-one replied that tubal pregnancy was a "pathological condition; in other words, a disease." Furthermore, he noted, not only did the Catholic and non-Catholic respondents agree upon the underlying nature of ectopic pregnancy, they reported it to be "far more dangerous than cancer of the uterus." Thus, he concluded, "there is practically unanimous agreement that an ectopic is always a very serious threat to the mother."[27] Davis also pointed out that the Holy Office allowed the removal of a "diseased pregnant womb" in the case of uterine cancer, regardless of pregnancy, and that this was "rightly defended on the principle of double effect." Similarly, he argued, "it must also be admitted . . . on the same reason-

23. Bouscaren, *Ectopic and Pathological Pregnancy* (n. 15), 46.

24. Ibid., 47.

25. Ibid., 60.

26. Henry Davis, S.J., *Moral and Pastoral Theology in Four Volumes*, vol. 2: *Commandments of God, Precepts of the Church*, 3rd ed. (London: Sheed and Ward, 1935), 174–75.

27. Ibid., 174–75.

ing, that a swollen tube . . . may be excised, whether the fetus is viable or inviable."[28]

In arguing in favor of surgical intervention in the context of their religious beliefs and moral constraints, Catholic medico-moral experts learned to frame their understanding of the pathology of ectopic pregnancy in increasingly reductionist and scientifically complicated terms. Although they acknowledged that sexually transmitted infections might be present in women with ectopic pregnancies, they also noted that this was not the case for all presentations of the condition. Even more importantly, as one author put it, "the acute inflammatory process occasioned by the presence of an ectopic gestation so distorts the previous structure or previous structural changes that it is impossible to observe any old pathology."[29]

Throughout the mid-twentieth century, while most physicians approached treatment of ectopic pregnancies with little, if any, moral apprehension, Catholic moralists and physicians continued to theorize both the physiological and the moral processes involved in the development and treatment of ectopic pregnancy.[30] By the 1950s, Catholic moralists and physicians alike could comfortably discuss salpingectomies, the removal of the Fallopian tube, as a morally licit operation. Writing in 1956, Catholic medical ethicist Edwin J. Healy, for example, reasoned that in the case of ectopic pregnancies, "it is the tube itself, not the fetus, which constitutes the present grave danger to the mother; and so, given certain conditions, it may be excised."[31] By that time, the "certain conditions" discussed by Healy included any ectopic pregnancy discovered at any time, whether symptomatic or asymptomatic.

Moral Issues with Medical Treatment

This ability to deploy modern, lifesaving treatments through a Catholic perspective was nowhere more visible than in debates over the use of methotrexate, a drug developed in 1956 to treat choriocarcinoma, a cancer that occurs in the cells that become the placenta. The drug is an antifolate, meaning it acts to inhibit the metabolism of folic acid and prevents DNA synthesis—which also make it a highly effective abortifacient.

28. Ibid., 175.

29. Elmer Schleuter, "Ectopic Gestation: Medical Aspects," *Ecclesiastical Rev.* 105, no. 2 (August 1941): 81–94, quotation on 92.

30. J. Morris Slemons, "Ectopic Pregnancy—Its Recognition and Treatment," *Calif. West. Med.* 41, no. 5 (1935): 298–99.

31. Edwin J. Healy, S.J., *Medical Ethics* (Chicago: Loyola University Press, 1956), 225.

By the 1960s improvement in early diagnosis along with the development of methotrexate meant physicians could offer women timely, safe, and effective treatment without surgery.[32] Women also learned from the pages of popular women's magazines to look out for warning signs of ectopic pregnancies and to seek early treatment.[33]

To this day, the Catholic Church's statements on ectopic pregnancy continue to allow room for interpretation, and confusion. In the United States, the Ethical and Religious Directives (ERDs), a set of guidelines that governs health care provision in Catholic medical centers, incorporates this lingering opaqueness in directive 48: "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."[34] In 2011, the U.S. Conference of Catholic Bishops, which oversees the U.S. Catholic health system, determined that salpingectomies in the case of an ectopic pregnancy are morally licit.[35] Research has shown that ectopic pregnancy care in Catholic hospitals, however, remains limited because many providers will not endorse the use of methotrexate, a method that is often safer and less likely to result in fertility loss for many early ectopic pregnancies.[36] Nonetheless, Catholic health providers and ethicists have continued to seek ways to provide lifesaving treatment for ectopic pregnancy to mothers in a way that does not cause direct conflict with their religious and institutional obligations. In 2000, bioethicist and Catholic clergyman Peter A. Clark walked a well-worn path when he argued that the use of methotrexate in ectopic pregnancies was moral because the drug attacks the cells that become the placenta, not the embryo itself. Thus, the death of the embryo is indirect, unintended, and morally permissible.[37] Although Clark's interpretation remains only

32. Skubisz and Tong, "Evolution of Methotrexate" (n. 7).

33. See, for example: "Doctor Talks about Ectopic Pregnancy," *McCall's* 85, no. 4 (July 1958): 4; Goodrich C. Schauffler, "Tell Me, Doctor . . . ," *Ladies' Home J.* 77, no. 4 (April 1960): 34, 36, 38; "What Is Meant by an Ectopic Pregnancy," *Good Housekeeping* 165, no. 2 (August 1967): 175.

34. Ron Hamel, "Catholic Hospitals and Ectopic Pregnancies," *Health Care Ethics USA* 19, no. 2 (Winter 2011): 27–29, 28.

35. Matthew A. Hamilton, "Choose Compassion during Complex Pregnancies," *U.S. Catholic Mag.*, April 15, 2021, https://uscatholic.org/articles/202104/choose-compassion-during-complex-pregnancies.

36. A. M. Foster, A. Dennis, and F. Smith, "Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study," *Women's Health Issues* 21, no. 2 (2011): 104–9.

37. Peter A. Clark, "Methotrexate and Tubal Pregnancies: Direct or Indirect Abortion?," *Linacre Quart.* 67 (2000): 7–24; Thomas A. Shannon, "Reflections on Peter Clark's Moral Analysis of the Use of Methotrexate in Ectopic Pregnancies," *Virtual Mentor* 9, no. 5 (May 2007): 356–58.

one in a still turbulent discourse on ectopic pregnancy management in Catholic medical ethics, that it persists and provides a pathway to treatment for some is noteworthy.[38]

The history of Catholic debates over ectopic pregnancy highlights the extent to which the antiabortion politics of the Church have influenced the most intimate aspects of women's health care for over a century. At the same time, this seemingly rigid stance against abortion has still allowed room for treatments that look remarkably like abortion, even while limiting the range of treatment choices available to women, causing confusion, and putting their lives at risk.[39] One of the key stories revealed through this history, however, is the responsive nature of Catholic health care to changes in medical knowledge, therapeutics, markets, and patient needs. Taking care of women requires abortion—whether it is due to ectopic pregnancy or some other life-threatening condition. This is a reality that Catholic health care has had to grapple with despite the Church's clear stance on the issue. Banning abortion complicates life-threatening situations as much as it robs women of their bodily autonomy. The case of ectopic pregnancy in U.S. Catholic health care highlights the extent to which providing abortion care is not and never has been optional, but is integral to the health care of women.

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Jessica Martucci is the associate director of undergraduate studies and an adjunct associate professor in the History & Sociology of Science Department at the University of Pennsylvania. She has written extensively for academic and public audiences on the history of women's health, disability, and issues of religion, belief, and fairness in modern science and medicine. Her first book, *Back to the Breast: Natural Motherhood and Breastfeeding* (2015), traces the story of grassroots activism behind the late twentieth-century resurgence in breastfeeding in America. Her interest in the history of Catholic health care in women's health grew out of this work when she discovered connections between the mid-century breastfeeding movement and Catholic physicians' guilds.

38. Hamel, "Catholic Hospitals and Ectopic Pregnancies" (n. 34), 28.

39. Fr. Tad Pacholczyk, "When Pregnancy Goes Awry," in *Making Sense of Bioethics* (Philadelphia: National Center for Catholic Bioethics, October 2009).