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**Targeting the Fetal Body and/or Mother-Child Connection:**

**Vital Conflicts and Abortion**.

**Helen Watt and Anthony McCarthy**

**Introduction**

Is the "act itself" of separating a woman and her embryo or fetus, as opposed to e.g. the doctor's further intentions, neither good nor bad morally, considered in the abstract? [[1]](#footnote-1) Maureen Condic and Donna Harrison (2018) present an ethical framework for resolving maternal-fetal conflicts that would justify intentional separation of the mother from her previable fetus,[[2]](#footnote-2) where fetal death is not intended. The authors claim that: "…so long as separation does not involve direct killing of the fetus, separation should be performed in the manner that best preserves the health and fertility of the mother" (Condic and Harrison 2018, 248). Separations to protect maternal health do not (and we agree they *need* not) involve any intention, the authors note,[[3]](#footnote-3) to cause the baby’s death. Such separations are not, they claim, abortion–which in contrast they take to be absolutely wrong and to involve necessarily an intention to cause death.

We fully accept that an intention to cause death is *one* way in which interventions on a very young human being can be ruled out absolutely. However, we maintain that to understand "abortion" as performed *only* where the aim is to kill is to define the term too narrowly. Whatever word we use to describe the targeted, expressly aimed-at ending of a pre-viable pregnancy, the more urgent task is to judge whether such intentional ending is ever morally permissible. With or without any further aim to kill, expressly intended pre-viability[[4]](#footnote-4) separations – as opposed to already-required removals of maternal body-parts – are, we argue, morally excluded in themselves. Questions of bodily rights and wrongs in this area cannot be reduced to asking simply whether harm for one subject is intended, and whether any unintended harm is in some way proportionate to the good intended for the other subject. The "Principle of Double Effect" requires that the immediate act in focus[[5]](#footnote-5) be judged permissible in principle before addressing other factors. Despite the need to weigh further side-effects where the immediate "act itself" – the "object" – is not morally excluded, that act will indeed be excluded in the case of some side-effects of some (immediate) intentions that can never be outweighed.

Moreover, whether or not targeted pre-viability separation is always in itself morally excluded, such separations often do not constitute in-themselves-innocuous "movings" of the living fetus. Rather, the very act of removing will often do the fetus immediate, serious bodily harm of, arguably, a morally conclusive kind. Gripping, squeezing and crushing of a kind to do serious bodily harm, as well as deliberate removal of fetal body parts – including the amniotic sac/fetal placenta – are, we suggest, morally unacceptable, given the lack of benefit for the fetus. Even at the cost of real and important benefits for the mother such as increased safety and protection of fertility, we must manage cases always in a way that respects the inviolable bodily rights of both mother and child, and the unique bond between them.

**Church statements on vital conflicts**

Although this paper is written from the perspective of philosophy, not theology or Church history, we believe that our approach is in harmony with, and may even help to explain, certain Church statements on these questions made over the past century and more. It must be remembered that the suggestion that death is not intended in certain cases of pre-viability removal is not new, but has been made repeatedly in theological discussions and in representations to Church authorities. Nor is it clear that, when the authorities responded in the negative to questions concerning pre-viability removal of the fetus, referring to earlier judgements on craniotomy, this was because those authorities were imputing an intention in every case to kill. Targeted (that is, aimed-at[[6]](#footnote-6)) pre-viability separations of mother and fetus, even with the good further aim of protecting the mother’s life and health, may rather have been seen as morally problematic simply in themselves.[[7]](#footnote-7)

Moreover, in regard to any act invasively focused on an unborn child, it is worth remembering that the CDF documents *Donum Vitae* and *Dignitas Personae* repeatedly and explicitly draw attention to the need to respect the *bodily integrity* as well as the life of the child – including in such contexts as prenatal diagnosis where such integrity is often disrespected. On the question of abortion definitions, while repeating *Evangelium Vitae’s* definition of abortion as deliberate killing, *Dignitas Personae* also helpfully cites the words of *Evangelium Vitae* to the effect that the "category"[[8]](#footnote-8) of abortion:

is to be applied also to the recent forms of intervention on human embryos which, although carried out for purposes legitimate in themselves, inevitably involve the killing of those embryos… Although "one must uphold as licit procedures carried out on the human embryo which respect the life and integrity of the embryo and do not involve disproportionate risks for it, but rather are directed to its healing, the improvement of its condition of health, or its individual survival", it must nonetheless be stated that the use of human embryos or fetuses as an object of experimentation constitutes a crime against their dignity as human beings who have a right to the same respect owed to a child once born, just as to every person.[[9]](#footnote-9)

Although our main focus in this paper is on procedures certainly lethal to the fetus (or the mother) or particularly likely to cause grave harm, it is worth stressing that *Evangelium Vitae* is also concerned with procedures such as invasive prenatal tests for fetal anomalies: one of the commonest kinds of procedure in obstetrics where the risk of causing fetal death remains significantly higher than we would tolerate in the case of a comparable test on a born human being. The vast majority of invasive prenatal testing is non-therapeutic, and tests such as amniocentesis which invade the fetal as well as the maternal body pose a risk of miscarriage disproportionate to possible gains for the parents such as peace of mind or preparedness for the birth of a disabled child. As regards any benefit for the child, non-harmful ultrasound or MRI assessment is far preferable as is genetic assessment later in pregnancy when the risk of prematurity (as opposed to miscarriage) is proportionate to the benefit sought.

**"Intention" in rival Natural Law approaches**

Before returning to the topic of intentional pre-viability separations of mother and child, we will first sketch out our general approach to identifying and assessing human actions, including actions causing death. We should stress that, like Condic and Harrison, we use the word "intention" in the everyday sense to refer to "aim" or "purpose": what a person *plans*, as an end or means. This is very much the sense in which the term has been used by New Natural Law proponents such as John Finnis, Germain Grisez and Joseph Boyle (2001) and Christopher Tollefsen (2006): writers who lay great stress on the moral significance of intention in this sense, "plan-intention." The term "intention" is in contrast sometimes used by Traditional Natural Law proponents such as Matthew O'Brien and Robert Koons (2012) in a wider sense to include some features of an action that are not (it may be agreed) selected as part of a first-person plan even if they are voluntarily accepted.

Far more important, though, than the semantic issue of what one means by "intention" (or "proposal", for example[[10]](#footnote-10)) is one's attitude to certain features of an act which may be morally conclusive but are outside the plan-intentions of the acting person – outside these both according to NNL and (at least sometimes) TNL proponents. At other times, TNL authors do impute plans such as plans to kill in cases where it does not seem to us that any such plans necessarily exist.[[11]](#footnote-11) On that point, if not on the permissibility of the acts in question, we agree with NNL proponents. We believe other tools are needed to arrive at otherwise plausible moral conclusions on these cases. Plan-intentions are certainly important, but they should not be made to do too much of the work – and this can be a danger for TNL thinkers as well as for NNL thinkers who neglect certain morally conclusive albeit unintended features of human behaviour. In the kind of case at hand, these features involve not so much the effects of exercising human powers more generally considered[[12]](#footnote-12) as the effects of bodily invasion of innocent human beings and/or the purposeful rupture of a sui generis human bond.

**Craniotomy**

To explain our own approach, it may be helpful to look at several cases, including a procedure much discussed in the literature, although not mentioned by Condic and Harrison, perhaps because of its limited clinical relevance. This is the procedure of craniotomy where the skull of the fetus is lethally collapsed: a procedure still sometimes used in developing countries in cases of obstructed labour where the woman’s life and health are under threat. Since Condic and Harrison rightly oppose certain other obviously invasive interventions on the fetus such as dismemberment, which they see as necessarily involving the intention to kill,[[13]](#footnote-13) we believe they would join us in opposing craniotomy as absolutely morally excluded.

However, unlike many others who oppose craniotomy, including, we would assume, Condic and Harrison, we ourselves do *not* believe that this abhorrent lethal assault on the baby must always involve the aim to kill. On the contrary, the doctor may be intending *nothing in addition* to what he or she would intend were the baby who is stuck in the birth canal already dead. While the collapsing of the skull promotes the baby’s removal, the *death caused* by such collapsing does not itself promote this removal in any way. A doctor for whom such causal issues are clear may well *not* intend the fatal effect of what *is* intended: the collapsing of the baby’s skull.

"Direct intention" is not the same as "direct causation", nor is it the same as merely foreseeing as inevitable the effect that one is causing. What a person intends (plans) is simply a matter of fact about that person’s mental state, whether now or when the intention was first formed.[[14]](#footnote-14)Whether or not death or injury is intended by a doctor, for example, will depend on the individual psychology of the person concerned. The doctor's aim cannot be simply assumed from what follows causally – or even from what the person *foresees* will follow causally and inevitably from what he or she *does* intend.

**Unintended morally determinative aspects (UMDAs)**

Crucially, however, the doctor performing a craniotomy is intending *something* vis-à-vis the baby: an effect on its body that the doctor *knows* at least will do the baby only lethal harm. The question then arises: is this effect on the baby "just another" side-effect that good effects for the mother can outweigh – at least if both will otherwise die? Is it right to treat a living baby, in respect of the living body one deliberately and immediately affects, as if that baby were already a corpse?

We have argued elsewhere[[15]](#footnote-15) that, in considering moral absolutes, it is wrong to treat *all* unintended side-effects as if they were "mere" side-effects which sufficiently good intended outcomes could in principle outweigh. Rather, *some* side-effects or aspects of human actions are *morally conclusive when combined with some intentions.* For ease of reference we dub these Unintended Morally Determinative Aspects (or UMDAs for short).

Acknowledging the reality of UMDAs is, we think, crucial in evaluating human acts, both in and outside medicine, perhaps especially those which focus on the bodies of young/otherwise innocent human beings. Bodily respect for innocent human beings, including respect for certain absolute bodily rights, goes well beyond the mere avoidance of *intentional* causation of death and serious injury. Uncompensated[[16]](#footnote-16) harm to the lethally-assaulted body of the victim is not necessarily *intended,* any more than the fact the victim is innocent; however, *both* these aspects of the immediate act are UMDAs: they are conclusive for the moral evaluation of that act.[[17]](#footnote-17)

***Lethal/mutilating organ harvesting***

We offer two more brief examples before turning to more familiar cases of maternal-fetal conflict. Notoriously, it is possible to harvest vital organs from an organ donor known to be still alive. Even if the intention to kill or maim the donor is absent (as we believe that psychologically, it could be), such harvesting nonetheless involves a lethal/mutilating bodily assault on an innocent, still-living human being. It involves treating the bodily substance of the donor in some important ways as if he or she were already a corpse – i.e. a sub-human object. Even if life is not *deliberately targeted* in such vital organ harvesting, life and health are nonetheless *treated as irrelevant* as regards the donor’s bodily rights. Though the donor’s death and prior injury are not intended as an end or as a means, and do not causally assist the achievement of good health for the organ recipient, the harvesting fails the first condition of double effect reasoning: the act is *wrong in itself.* This is because, again, the immediate intention *combined* with a morally conclusive aspect/effect (serious permanent harm and no health benefit foreseen or intended[[18]](#footnote-18) for the donor) is enough to rule it out.

The immediate moral character of such an act is not fixed only by those aspects which motivate the acting person. The act is unjust in how it relates to another, innocent human being’s bodily presence. The acting person deliberately (and destructively) affects that on which the victim’s continued existence in fact depends: the vital organ harvested – just as in craniotomy it was the baby’s intact skull.[[19]](#footnote-19)

***Pseudocaesarians***

A final analogy, which brings us back to pregnancy, may also help to illustrate our point (indeed, it bears some relation to Condic and Harrison’s own example of maternal-fetal separation caused by an assault on a pregnant woman).

Imagine that a doctor, perhaps a doctor in a remote area deprived of the equipment needed for a genuine caesarian, wants to deliver a heavily pregnant terminally ill woman whose wound will not heal and who will die as a result, though her viable baby will be saved. The case to imagine is one where the method and/or circumstances make the procedure not a caesarian at all in the normal sense of the term, and not the standard case where the woman herself will derive some health benefit from the lifting of the physiological burden of pregnancy.

Despite the fact that, in making the incision, the doctor need intend no harm to the woman as such – harm and death for the woman do not in themselves advance the goal of rescuing the baby – he or she is nonetheless deliberately invading the woman’s body in a way foreseen to do her lethal harm (and no compensating health good – the woman will very quickly die[[20]](#footnote-20)). Again, double effect reasoning cannot acquit the doctor, as the immediate act is *wrong in itself* (i.e. it fails the very first condition of double effect reasoning). This is again due to the combination of the immediate intention to invade the woman’s body and the foreseen lethal harm and no proportionate health benefit to her*.* The procedure constitutes an intrinsically unjust bodily assault on the woman, despite the fact that the woman is already terminally ill while her viable fetus has a chance of life. The doctor relates to the woman in a way that fails utterly to respect her living human embodiment: she is treated, to a wholly unjust degree, like a mere temporary barrier to the rescue of her child.

In their own reference to a violent assault on a pregnant woman, perhaps earlier in pregnancy and outside a medical context, Condic and Harrison say: "…the act of separation of the mother and the fetus as part of a violent assault on the mother is obviously immoral…it is not the '*act of separation*', but rather the intention with which that act is carried out and the circumstances under which it occurs, that determines the goodness or evil of the moral object of separation of the mother and fetus" (Condic and Harrison 2018, 245). We ourselves do not see it as helpful to identify the wrong of such an assault merely in circumstances "surrounding" the act and/or any vicious further intentions such as that of killing the baby.

Purposefully separating a mother from her pre-viable fetus, here as elsewhere, is not "the same thing" i.e. the same immediate act as a life-giving, life-respecting post-viability delivery, but is an act immediately wrong in itself. To say that cutting into the woman is somehow morally neutral in itself, or would be acceptable if only "it" were therapeutic, not gravely harmful to those immediately affected, is not unlike (or not entirely unlike) saying that "sexual intercourse" would be acceptable –"that very same act" it might be claimed – if only the raped woman had consented (Watt 2016, 99). These are very different immediate acts (rape, for example, is not properly characterised as consensual intercourse minus consent (McCarthy 2016, 27-30)). In each case, the morally conclusive aspect – grave harm to the mother and/or fetus, or lack of sexual consent – need not itself be intended, even if sufficiently understood by the acting person. The rapist, for example, may be acting *regardless* of lack of consent, not *because* of lack of consent; indeed, lack of consent may even be regretted, particularly if consent was withdrawn last-minute by a previously consenting sexual partner. And the surgeon who immediately intends to separate a woman and her previable fetus may be motivated solely by the (in this case, altruistic) further intention of saving the mother's life, and in no way motivated by the lethal harm separation will cause the unborn child. That does not, however, mean that the surgeon is not acting absolutely wrongly here.

**UMDAs, "circumstances" and bodily respec**t

Again, not all side-effects are "mere" side-effects, justified or not according to the intended benefits: some are morally conclusive. Such UMDAs are part of the immediate "act itself" which needs to be described with sufficient precision to identify it morally, even before one passes to any aggravating features or further wrong-making aims such as the aim to kill. Specifying an immediate act only as a "cutting", say, does not reflect the crucial difference between a cutting *accompanied* by a further therapeutic aim for the person, and a lethal/mutilating cutting where there is no such further aim. The non-therapeutic and lethally harmful nature of some cutting is not a "circumstance" so much as part of the immediate act itself albeit remaining unintended. Unintended features such as that the target of our action is alive, innocent and vulnerable should really be given another name than "circumstances" as they identify the moral character of the immediate act in focus,[[21]](#footnote-21) in conjunction with what we *do* intend. Cutting lethally into someone who is alive (and innocent) and who is known to be alive (and innocent) is quite a different act from cutting into someone dead. This is so even if such cutting has the same immediate intention – such as clearing away some threat posed by the person’s body – and the same further intention – saving another person under threat. There may be nothing wrong with *some* cuttings-up of bodies, but the "circumstance" that the "body" in front of me is alive – the living body of an innocent human being – is not a *mere* circumstance, even if my intentions focus only on cutting away what is before me.

In a world where it is unreasonable to expect all harmful impact on others of our actions to be avoided – we do, after all, share "space" in the sense of what surrounds us – it is perfectly possible and reasonable to expect everyone to respect each other’s bodily space, in the sense that we do not deliberately invade the space of (innocent) others or change their bodies in what we know are seriously harmful, non-beneficial ways. The principle of totality in medicine clearly reflects this general moral principle. And just as outside medicine painful conflicts between innocent adults may not be resolved by a lethal assault (we might think of the classic case of the fat man stuck in the cave entrance who could be dynamited out), this is also true of obstetrics, where the issue of targeted removal/separation as well as force immediately and deliberately applied to the fetal body can come into play.

**Direct separations: non-invasive?**

But is there any moral absolute at stake in the case of targeted, expressly intended pre-viability separations? Before turning to the issue of separation as such, carried out by whatever method, we should note that Condic and Harrison reject absolutely such interventions on the fetus as "dismemberment, decapitation, methotrexate injection" (Condic and Harrison 2018, 248). While we do not share the view of Condic and Harrison that these interventions[[22]](#footnote-22) necessarily involve the aim to kill, we welcome their rejection of any method where parts of the "fetus proper" are targeted for invasion (which would include D&Cs which simultaneously scrape away the "fetus proper" and the fetal placenta[[23]](#footnote-23)).

Nonetheless, Condic and Harrison’s defence of "mere" separation in other cases not only fails to acknowledge a distinct moral wrong in previability separation itself but glosses over the immediately harmful nature of methods likely to be used. This is an issue helpfully raised by Samuel Hager in regard to tubal ectopics:

Invasive medical procedures are moving away from the traditional laparotomy (incision to open the abdominal cavity for the surgeon's hands and tools) and towards laparoscopy, in which small incisions are made in the abdomen, through which a camera and remotely operated tools are inserted. Video-recorded examples of salpingostomies performed laparoscopically often do not proceed with a neat slit in the tube and precise severing of the trophoblast, an ideal some may imagine is the reality. Rather, the laparoscopic tools cut open the tube and then remove the pregnancy either by teasing it out, plucking it, or cutting it. The embryo is then suctioned or pulled out through the laparoscopic incisions, a process which may require cutting the embryo into smaller pieces. (Hager 2016)

As Hager rightly says, the trophoblast targeted is in any case a part of the unborn child: a part both in origin and in current function. Unless we are imagining a very gentle detachment of the fetus uncovered via traditional laparotomy (such as might be done, as Christopher Kaczor notes, by someone intending to transplant the fetus to the uterus[[24]](#footnote-24)) it is hard to see how the standard reality of gravely harmful invasion of fetal placental tissue that is not in any way in the health interests of the fetus itself can be defended.

With removal of the fetus from a non-tubal ectopic site, where the fetus may be more developed, the violent assault involved in such removal can perhaps be seen most clearly. Medical videos[[25]](#footnote-25)showing later-term removals do nothing to support the view that such procedures are in themselves benign – and not just because fetal placental tissue is deliberately stripped away. Even leaving aside damage to (eg) the amniotic sac/fetal placenta, such videos can show visible wounds to the "fetus proper" likely caused before death if the fetus is still attached via its umbilical cord to the site of implantation.

Philosophical analogies which may spring to mind here of (say) an already-dying man being pushed off an overcrowded life-raft that his weight is causing to sink need to imagine the man being first deprived of his skin and then moved with sharp hooks or clamps causing further serious injury. Such "moving" would be a targeted intervention of a kind to cause either death or serious bodily harm immediately, and not merely "downstream" of the moving when the man would sadly (and quite predictably) fall into the water and then drown. Surely this immediately-harmful moving and harmful targeting of the man’s body-parts is not so dissimilar to certain ectopic pregnancy procedures, whether the fetus moved has implanted tubally or elsewhere.

**Pre-viable inductions and "caesarians"**

What about other cases of vital conflict where the embryo/fetus has implanted in the uterus? Inducing labour before viability, for example, may seem like a more benign procedure than suction aspiration, D&Cs or D&Es as the doctor’s own actions may seem at first glance similar to inducing labour after viability. However, here too, the physical reality of the moving process needs to be addressed. In breaking the waters before viability, for example, the doctor will inevitably be inflicting serious harm on the fetal body, while the woman’s body itself – often very much to her regret – is likely to harm and indeed kill the pre-viable fetus by means of its contractions.[[26]](#footnote-26) It is not a sufficient defence to say that the doctor (or the woman) intends no more than would be intended if labour were induced a few weeks on when the fetus would be more robust. Even if true, this ignores the role of UMDAs: it is like saying that a doctor performing a craniotomy intends no more than would be intended if the baby were already dead, or saying that a doctor performing the incision in our pseudocaesarian example intends no more than would be intended at the first stage of a genuine caesarian from which the woman would recover and which is in her overall health interests, as well as possibly her child’s.

Similarly, "caesarians" carried out pre-viability for maternal health reasons, and induced labour carried out pre-viability for the same reasons, are simply not the same immediate actions as superficially similar procedures carried out post-viability in terms of harmful disruption caused to the fetus and its own bodily tissues. (Note that we are not speaking here of emergency deliveries where the baby, though likely to die as very premature, has reached what is normally the stage of viability and may perhaps be safer delivered than left in the uterus as the mother is critically ill.)

Squeezing out a pre-viable child via the mother’s contractions is often lethal in itself to the child: it is, as we have seen, less like pushing a dying man off an overcrowded life raft than it is like lifting him off with crushing tweezers whose compressive force will likely kill him in the act of removal – even if that is not intended, as an end or means.

Would this not be a lethal bodily assault on the man, even if not intended to harm him in any way? But in any case, the fetus is not a man on a life-raft: the bond between the woman and her baby that pregnancy immediately creates is uniquely close, not only physically but in terms of the formation of fundamental moral roles and responsibilities and rights. That applies even in cases where, as in ectopic or other life- and health-threatening pregnancies, the maternal-fetal bond is in some way disordered. We will return to this below.

**Maternal-fetal separation as a side-effect of removal of maternal body-parts**

It goes without saying that we have no problem at all with procedures targeted simply on maternal organs where either the baby was never the problem, as with uterine cancer,[[27]](#footnote-27) or else the baby has caused a now-independent threat justifying removal of the affected maternal part simply in itself. With hysterectomy or emergency salpingectomy (when the tube has burst or is thought to be close to bursting) the baby will die when its blood supply is effectively cut off, but the baby is not (or no longer) what is causing the need for surgery.

True, pregnancy partly consists of supplying blood for the purpose of nourishing and oxegenating the fetus. And if an ongoing pregnancy were threatening *future* harm to the woman, to which early, *preemptive* salpingectomy was responding, then deliberately breaking one at least of the "reproductive strands" connecting mother and child when the maternal blood vessels are clamped would, we think, be failing to respect that ongoing connection, even if the connection as a whole were not the target.[[28]](#footnote-28)

However, *emergency* salpingectomy where it is known or feared that the tube is already critically damaged may have nothing to do with the short-term persistence of the imminently doomed pregnancy, but may merely concern averting catastrophic bleeding that now threatens irrespective of the continued presence of the fetal body. The emergency procedure passes the first hurdle of double effect reasoning, i.e. it is not wrong in itself. It must then be assessed according to the remaining conditions of double effect reasoning which it will also standardly pass: the harm is not intended nor does it even causally achieve the good further aim, and is certainly balanced by the good outcome for the mother, not least as the baby’s own prospects are so poor.[[29]](#footnote-29)

**Targeted removal using the maternal body part as a vehicle**

But what of deliberate, *targeted* removals of the maternal part plus fetus – where there is, however, no immediate invasion of the bodily integrity of the fetus who is moved within the relevant part? What if the point of the procedure is not to remove a maternal body-part presumed to be already badly damaged by the pregnancy, but to remove a *future* threat posed by the presence of the fetus (whether dead or – in the problem case – alive) within a part in principle still salvageable,[[30]](#footnote-30) whose pathology largely consists of that continuing fetal presence?

Here the tube (or ovary, or even uterus) would be removed very much as a *means to remove the fetus* and stop its connection with the mother bringing *future* harm to that/other parts of the maternal body. The intention to "disconnect" the fetus pre-viability (as opposed to maternal surgery which merely has that foreseen effect) is, we believe, itself a wrongful intention. As we argue below, the mother-child link in pregnancy is like no other and, at a stage when the child is totally dependent, should rather be unconditionally respected, even when the pregnancy is in some way pathological.[[31]](#footnote-31) Note that something similar applies to interventions such as the Morning After Pill: any intended "abortifacient" as opposed to "contraceptive" effect[[32]](#footnote-32) of the MAP would be abortion morally speaking even if the intention was not to kill the embryo but "merely" to withdraw access to uterine support – say, because a later uterine pregnancy was thought to be dangerous to the woman and/or to have no chance of going to term (see below).

**Disordered maternal-fetal connections**

Previable removal of a uterine pregnancy separates the child from that very special place which can be reasonably regarded as its natural home:  if we target the previable fetus and wrench it from that place we are responsible for that targeting and its foreseen lethal effects. But, it might be asked, is not the mother-child connection *disordered* in ectopic pregnancies? Granted that a normal pregnancy is "ordinary" means of support, is not an *ab*normal pregnancy something rather different? The tube may be the baby’s "home" in effect – but a highly temporary, precarious home, and not one functionally geared in any way to its shelter and protection at this stage. As Condic and Harrison observe:

…in the case of ectopic pregnancy, that pathological condition is the disordered physical union between the mother and her fetus. It is the continuation of the disordered union that gravely threatens the life of the mother. The separation of the mother from her embryo or fetus is indeed “the means by which” the pathology is *actually* addressed. The death of the fetus is an indirect result of the separation. (Condic and Harrison 2018, 243-244)

Note, however, that in uterine pregnancy too, the child can be "misplaced" (e.g. where the placenta covers the opening to the cervix): if these considerations are to count it will be difficult to draw clear lines with regard to targeted removals/separations should a crisis arise pre-viability, whether or not the child’s body is invaded. And indeed, Condic and Harrison refer to the "disordered connection" not only of ectopic/misplaced pregnancy but of a uterine pregnancy which is "disordered" not so much in itself (if we define pregnancy as a local phenomenon) but in the effect it has on other, non-reproductive parts of the woman’s body.

**Other vital conflicts during pregnancy**

One condition sometimes cited as an example of a threat to life (though not by Condic and Harrison) is pulmonary hypertension in a pregnant woman – though in fact, there is no research finding that abortion is safer in this case than continuing the pregnancy, official advice to terminate notwithstanding (Calhoun 2017). However, with other medical conditions abortion may indeed be safer than continuing the pregnancy, for the woman and/or for other fetuses whom she may be carrying. In the case of a high-order multiple pregnancy, granted that feticide is clearly intended to kill, what if one pre-viable fetus could instead be "merely" expelled without causing a miscarriage of the others? If one supports (as we do not) "mere" purposeful removals/separations due to "disorder" in the pregnancy then it is not at all clear what morally would prevent such a sacrifice of one baby to promote the chance of siblings surviving and/or to protect the mother’s health.

**Respecting or sustaining the maternal-fetal connection?**

We agree with Condic and Harrison that it would be wrong to *intervene to sustain medically* in situan ectopic or otherwise abnormal pregnancy, furthering endangering the mother. Legitimate medical procedures are those calculated to do more good than harm (or at least, to do no serious lasting harm overall) to the subject or subjects on whom the doctor intervenes. Inevitably, an intervention during pregnancy will be made deliberately on the woman, even where it also has a purpose, whether therapeutic or otherwise, with regard to her unborn child. And while the woman’s own *reproductive* health and success is certainly engaged if she can be helped to continue a pregnancy, it is wrong and futile to attempt to promote actively a woman’s reproductive health at serious risk or cost to the woman’s health across the board. Here as elsewhere, any actual interventions on the mother herself would need to be in her health interests overall – or, at least, not very harmful to her.

Omitting to sustain medically a disordered maternal-fetal connection is not the same as intervening to end it. The connection between the mother and baby pre-viability must be *respected*, as opposed to always *promoted.* Actively targeting the link itself previability (as opposed to remedying maternal damage caused) should, we think, be ruled out, even if the link is targeted on serious health grounds. Concern for the woman’s life and health would, however, fully justify *abstaining* from any intervention that would make things very much worse for the woman on whom we intervene.

**Disordered connections and maternal-fetal teleology**

Why should a disordered connection even be respected though, if the link is non-teleological? Well, to begin with, there are *elements* of teleology present on the woman’s side, as well as the child’s, even in the case of ectopic pregnancy, let alone uterine pregnancy which, however normal "in itself", may have a serious knock-on effect on the woman’s overall health. Pregnancy is a process beginning with conception, and reproductive functioning such as release of pregnancy hormones can and does occur even if maternal dysfunction (or indeed, a life-limiting condition of the fetus) means that a pregnancy cannot go to term. In such a case, a woman – like any other woman – has procreated[[33]](#footnote-33) (i.e. become a mother) once she and the father have conceived. Similarly, like any other woman, she has gestated once she has had an embryo in her reproductive tract and/or has had an embryo implant in some part of her body.

After all, with ectopic pregnancy the woman is providing what the fetus needs in terms of pregnancy hormones, nutrition and oxygen, for example, even if these are not hitting their target in the normal way. From a moral and social point of view, the woman is still a mother, which she became in conceiving/becoming pregnant. Indeed, even if we imagine a woman who has gestated a child *only* in her abdomen, and one to whom she is not genetically related – say, a donor embryo was transferred to her abdomen because she lacks a uterus – it seems that such a woman would still be the gestational mother of that child with presumptive rights to raise the child if, unlikely as this might be, the child not merely implanted but survived.[[34]](#footnote-34) To deny the woman is a mother because her child was always in her abdomen and never in her reproductive tract does not seem right: it fails to acknowledge what seems a genuine, albeit to a large degree dysfunctional, form of maternal biological nurture – physiological in some of its components even if not in others.[[35]](#footnote-35)

As mentioned, uterine pregnancy can also be "misplaced" to a greater or lesser degree. And in the case of a life-threatening uterine pregnancy in particular, can we really claim that there is nothing teleological[[36]](#footnote-36)and indeed maternal to respect?

The concern here is for maternal teleology (goal-directedness) as expressed in the maternal-fetal bond. This bond is unique, and is highly sex-specific. If pregnancies in biological males are ever achieved, whether following uterus transplants or simply ectopically in the abdomen, the maternal bond will not be present as there will be no genuine maternal teleology present in the form of physiologically appropriate hormones, for example. While any fetus so gestated should still not be deliberately assaulted in its own bodily integrity, it might conceivably be deliberately removed pre-viability by means which do not involve such an assault (for example, the entire donor womb could be removed in the case of serious risk to the pregnant male). Unlike female ectopic pregnancies, which are teleological at least at the level of the mother’s natural hormones and some of their results, a male ectopic pregnancy, in or outside a transplanted uterus, would not be teleological in any shape or form.

**Separation to avoid non-lethal maternal harm**

Moreover, there is another problem with glossing over the difference between targeted previability separations/removals (of any kind) on the one hand, and on the other hand, treatments of the mother which cause miscarriage as a side-effect and only thus – again, as a "mere" side-effect, not an UMDA – cause the fetus lethal harm. If pregnancy is in no way a "special" connection such that terminating it *deliberately* should be treated differently from causing miscarriage as a side-effect, then a doctor could presumably on this view deliberately induce labour pre-viability not just to save the woman’s life but to stop her going blind, for example. After all, in a different case where miscarriage was *not* intended*,* but a mere side-effect of some treatment to prevent blindness, we might indeed be willing to accept such a serious side-effect of treatment of the woman’s body alone. Avoiding for the mother a very serious harm such as blindness or paralysis does seem to justify accepting even significant fetal harm where maternal-fetal separation is not the aim. So if "direct" and "merely foreseen" separations were entirely equivalent, pre-viability inductions to avoid blindness or paralysis would be seen then as morally acceptable, at least in principle, even if the child could otherwise go to term.

Again, where miscarriage is a "mere" unintended side-effect, we might be willing to perform, on standard double effect grounds, a cancer intervention which had a reasonable chance, but only a reasonable chance, of saving the woman, even if the probability of causing miscarriage is in contrast 100%. Would Condic and Harrison support targeted previability separations with a similar 100% chance of killing the baby and only, say, a 60% chance of saving the woman – even in a case where the fetus had a good chance of survival if not deliberately removed?

What is at stake, here and elsewhere, is not "only" a life, or lives, but a relationship. At issue is the basic, unconditional bond of the pregnant woman with her baby: "till death [or birth] us do part."[[37]](#footnote-37) Perhaps there is some value in the mother-child relationship beginning at least, however it matures, in this starkly unconditional way. If so, then pregnancy would be (perhaps unsurprisingly) a special case: the duty not to act specifically to evict or withdraw maternal support, at least before the baby is viable, would be, uniquely, absolute. Such unconditionality would enable pregnant women quite generally to bond especially closely psychologically with the child they are carrying, whose life is accepted by the mother as inextricably bound up with her own. While later on, parenthood is a matter of gradual "letting go", introduction to other carers, and encouragement to independence, perhaps it is important that both mothers and children feel that there was one time, at least, at which the child was supported literally unconditionally. Pregnancy would then involve a particularly generous commitment to the baby, whose presence is accepted as a "given": any willingness to remove/separate the child pre-viability and/or withdraw reproductive parts to protect one’s body from an ongoing pregnancy would cut against that primal commitment.

**Conclusion**

We welcome Condic and Harrison’s clarification of key medical facts at stake with ectopic pregnancy, not least the very important fact that many embryos will be dead when the ectopic pregnancy is diagnosed – meaning, of course, that a variety of methods for removing the embryonic/fetal remains may potentially be employed. We also welcome the authors’ practical suggestions, which can best be judged by those with the relevant clinical and scientific expertise, for determining death in an embryo in an ectopic site.

However, we take issue with Condic and Harrison’s stark distinction between "abortion" as these authors understand it and targeted pre-viable separation where the aim is not to kill. Most fundamentally, we reject a premise which Condic and Harrison share with many others, including those taking a very different view on which interventions are morally permissible. That is the premise that the only salient, absolute-based question for judging an intervention on a pregnancy where the mother is threatened, and the fetus will in any case die, is whether this involves the aim to kill.

Respect for the mother, the fetus and the bond between them goes well beyond avoiding any such aim.  While we do not doubt that where the aim to kill is *also* present, an abortion will be in question, we believe an abortion can be in question too with a range of interventions where the aim is not to kill but "merely" to remove a pre-viable child.

Condic and Harrison appeal to the Principle of Double Effect in order to justify what they see as licit "acts of separation." Our contention is that double-effect reasoning has not been correctly applied to the cases Condic and Harrison consider because the immediate "act itself" of targeted pre-viable separation, even separation achieved by not-obviously-violent means, is morally excluded. Such expressly-intended separation fails the first condition of double effect reasoning: the immediate act is wrong in itself.

Previability removal/induction will often additionally involve a relatively obvious form of bodily assault on the fetus in the course of removing it, where the fetus is treated as if he/she were already a corpse or some other non-human object. Fetal tissues are torn asunder, sometimes not merely inevitably – though morally relevantly – in the course of moving the fetus, but deliberately to induce labour, or in the course of removing an ectopic embryo where the fetal placental tissue is deliberately invaded/stripped away. But even where there is no immediate, intended effect internal to the fetus – as when a maternal part is removed, not in spite of, but because of the presence of the still-living fetus – the specific intention to separate (lethally) a pre-viable fetus from its mother is, we believe, excluded in itself.

We need to focus on the special nature of pregnancy and not merely on questions of intentional homicide – or even immediate assaults on fetal (or maternal) bodily integrity. We need to distinguish between legitimate treatments simply aimed at treating or removing a damaged part of the mother and illegitimate treatments that focus harmfully (while the fetus is still alive) on the fetal body and its presence within the mother and/or on withdrawal of maternal parts because of future harm the pregnancy may cause.  Even a perfect-case separation that does not immediately touch/assault the fetus but "just" removes it intentionally (or thwarts its implantation in the case of the MAP) involves an active, wrongful assault on a very special human bond. That applies, we think, whether the fetus has implanted in or outside the uterus (though in neither case would it be right to intervene medically to sustain a dysfunctional connection, seriously harming the mother's health).

It is of the highest importance that the mother-child relationship in pregnancy should be seen as having a certain unconditionality, beyond the generic need to avoid intending death for, or an obvious bodily assault on, one’s child. There is more to the ethics of pregnancy, and ethics in general, than concerns over *intended* death or harm, or even the weighing of good and bad effects. Ethics ultimately concerns practical reason expressed through virtuous behaviour in our personal roles. It cannot be reduced to a single, simple formula, or even several formulae, but must reflect the demands of sui generis roles – roles which may bring with them very special experiences but also sometimes wrenching dilemmas. In short, ethics is or should be sensitive to very particular bodily and family bonds, and par excellence that of pregnancy, which is of enormous import for our understanding of motherhood, and a core symbol of other unconditional attachment too.

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1. "We propose that the proper moral object in question (i.e., the immediate objective or action taken for medical management of ectopic pregnancy) is *the act of separating the mother and the embryo or fetus.* The act is neither intrinsically morally good nor intrinsically morally evil and interpreting its moral character depends critically on the context in which it occurs." (Condic and Harrison 2018, 244-245). [↑](#footnote-ref-1)
2. Like Condic and Harrison (2018) we often use the term "fetus" to cover also "embryo". [↑](#footnote-ref-2)
3. Later in the article the authors comment: "…while the distinction between direct killing and allowing to die can be subtle, it is an important distinction to avoid viewing killing simply as a convenient means of achieving a positive outcome for the mother." (Condic and Harrison 2018, 249). [↑](#footnote-ref-3)
4. Of course, what countsas "pre-viability", affecting when known the responsibilities of the pregnant mother and/or her medical team, depends on available care and equipment for premature babies. The principle of respect for the child's right to avoid deliberate lethal eviction remains the same – just as the principle of respect for the bodily rights of the mother of a (viable) baby remains the same despite available care and equipment affecting what counts as a genuine caesarian, rather than a lethal maternal cutting (see below). Note that although responsible agents will try to be aware of facts on the ground, it is their factual *perceptions* rather than the facts themselves that count in identifying wrongdoing in such cases: a mother or doctor who mistakenly thought a child was non-viable would be acting no less wrongly (whether culpably or otherwise) in removing the child than a mother or doctor who was correct in thinking the child was non-viable. [↑](#footnote-ref-4)
5. See footnote 29. [↑](#footnote-ref-5)
6. It is not clear to what extent Church authorities were focusing here on cases of emergency salpingectomy where the target of the operation is not fetal removal so much as urgently and now independently needed removal of the tube itself. In any case, salpingectomy came to be generally accepted in the following decades as morally similar to permissible removal of a cancerous uterus where the woman is also pregnant. See Connery 1977, 303; for more recent accounts of Church history in this area, see Jones 2014 and Flannery 2011. [↑](#footnote-ref-6)
7. "Directly lethal" (directe occisiva) in these answers may possibly refer to "direct" causation and not to "direct" intention. In any case, the answers are what they are. Even outside these responses, the Church has repeatedly, including in the past decade (CDF 2009) condemned abortion on serious maternal health grounds. That said, the issues of deliberate killing and deliberate lethal pregnancy termination are not infrequently run together in Church statements, whether because it is indeed assumed that the purpose of the latter must be to kill or because a wider notion of the "intentional" is being used including mere voluntary acceptance of certain effects for which one is especially responsible. [↑](#footnote-ref-7)
8. In *Evangelium Vitae,* "evaluation". [↑](#footnote-ref-8)
9. *Evangelium Vitae* (the passage cited includes a citation from *Donum Vitae*). [↑](#footnote-ref-9)
10. As Tollefsen (2013, 758-759) notes, O'Brien and Koons (2012) sometimes use terms like "plan" or "proposal" to refer only to what motivates the agent, but at other times include features of the action that do not motivate the agent – any more than other features that all would accept to be mere side-effects. [↑](#footnote-ref-10)
11. See e.g. Gormally (2013), and the response by John Finnis in the same volume. [↑](#footnote-ref-11)
12. See O'Brien and Koons (2012). Although there is much of interest in this paper, we do not agree with the authors' account of human actions, which seeks to identify "proposals" and means-end reasoning by appealing to standard effects of human powers being used, including powers connected to skilled human practices such as medicine. In our view, this approach does not allow space to distinguish between aimed-at results of giving a therapeutic drug, for example, and results merely foreseen such as nausea – results expected as part of the doctor's knowledge of the human body and caused via an established medical practice but forming no part of the doctor's plan or proposal (at least in the usual sense of these terms). [↑](#footnote-ref-12)
13. "An important distinction in the medical management of ectopic pregnancy is the difference between actions that directly cause the death of the fetus (dismemberment, decapitation, methotrexate injection, etc.) and actions that allow the fetus to die (induction of premature labor or other means of removing the fetus from the body of the mother at a developmental stage when it is not able to survive independently.)" (Condic and Harrison 2018, 248). [↑](#footnote-ref-13)
14. As Jonathan Bennett rightly puts it, "If you do not believe that in Φing you will be πing then it is not the case that in Φing you intend to π."(Bennett 1995, 208) [↑](#footnote-ref-14)
15. McCarthy 2015, 51; Watt 2016, 76-77 (other sections from this chapter are also reproduced here in part). For similar approaches to double effect reasoning, see Brock 1998; Garcia 1997, 161-81. [↑](#footnote-ref-15)
16. By uncompensated we mean that the (or a) target of the operation, in this case the fetus, is in no way benefitted by the operation but is rather very seriously harmed. Such procedures cannot be justified according to the principle of totality, which in contrast allows for e.g. the amputation of a gangrenous leg: an amputation may inevitably involve some loss of function as a side-effect but this may be greatly outweighed by the benefits for the person’s overall health. [↑](#footnote-ref-16)
17. We are referring here to a bodily invasion which is not only gravely harmful, but would harm even a healthy person of the relevant age. In contrast, if an intervention that would be harmless to a healthy person would harm a dying person – let’s say, opening his clenched jaws to remove a whistle needed to attract rescuers’ attention – this might be permissible in extremis even if the person’s death would be foreseeably brought forward. In the same way, inducing labour at 8 months when this is likely to end the life of an anencephalic baby will be morally permissible in some circumstances, since for a healthy baby of that age this would not be a particularly harmful intervention. [↑](#footnote-ref-17)
18. Note again that it is the doctor's own factual beliefs, not the physical facts of the case concerning permanent harm to the donor, or even the practice of medicine which may or may not have formed the doctor's beliefs (O'Brien and Koons, 2012) which are *directly* relevant to whether the action is immoral as opposed to disastrously mistaken. A doctor who is insane or otherwise utterly ill-informed about the prospects of the donor will not be doing "the same thing" as a doctor who is well aware the donor will be killed (and this is not a question of *culpability* for the latter's wrongdoing which is a separate issue again). [↑](#footnote-ref-18)
19. The baby’s skull is indeed, as David Crawford has pointed out, the *person* and not a mere part (Crawford 2010, 277-278). We would, however, take issue with Crawford’s identification of a necessary aim to kill here (McCarthy 2015, 155). [↑](#footnote-ref-19)
20. Even if a competent woman requested the procedure to save her baby’s life, it is hard to see how doctors could be justified in such a harmful incursion on one of the patients in their care (Watt 2016, 78). [↑](#footnote-ref-20)
21. In the words of Aquinas: "But the process of reason is not fixed to one particular term, for at any point it can still proceed further. And consequently that which, in one action, is taken as a circumstance added to the object that specifies the action, can again be taken by the directing reason, as the principal condition of the object that determines the action's species. Thus to appropriate another's property is specified by reason of the property being "another's," and in this respect it is placed in the species of theft; and if we consider that action also in its bearing on place or time, then this will be an additional circumstance. But since the reason can direct as to place, time, and the like, it may happen that the condition as to place, in relation to the object, is considered as being in disaccord with reason: for instance, reason forbids damage to be done to a holy place. Consequently to steal from a holy place has an additional repugnance to the order of reason. And thus place, which was first of all considered as a circumstance, is considered here as the principal condition of the object, and as itself repugnant to reason. And in this way, whenever a circumstance has a special relation to reason, either for or against, it must needs specify the moral action whether good or bad." *Summa Theologiae* 1-11 q 18 a10.

In other words, an external "circumstance" viewed from the perspective of identifying one sin can be absolutely central (even if unintended – what we call an UMDA) from the perspective of identifying another sin. [↑](#footnote-ref-21)
22. Recently, it has been suggested (Treloar and Williams, in preparation) that MTX should more accurately be thought of as promoting the woman’s health via focus on the maternal placenta, not the fetal placenta – even if collateral damage to the fetal placenta is foreseen to occur in the course of cutting off maternal blood to the maternal placenta. While this may indeed be the case, it still leaves us with a similar question to that posed by early, preemptive salpingectomy, i.e. whether a maternal reproductive part is being deliberately "withdrawn" less because of existing maternal damage than because of a future threat caused by its contribution to an ongoing pregnancy. [↑](#footnote-ref-22)
23. On the role of the placenta and abortion methods, see Bringman and Shabanowitz 2015, 31-37. See also the subsequent discussion of this paper in the *National Catholic Bioethics Quarterly.* [↑](#footnote-ref-23)
24. "…the removal of the embryo from the fallopian tube does not constitute an "attack" on the body of the human embryo, for it can be performed  - although it is usually not - in such a way that the embryo's physical integrity is not undermined. Removal of the embryo from the pathological location of implantation could be done such that the tubal maternal tissue that has been damaged is removed - leaving the embryo's bodily integrity intact.   Indeed, if transplantation is facilitated, the removal would constitute a therapeutic intervention for both the mother as well as the human embryo." (Kaczor 2009, 270). Kaczor goes on to defend not only deliberate removals from the mother’s body where there will be no attempt to reimplant the embryo (the normal kind of case) but deliberate laparoscopic removals of the kind described by Hager. He argues – and we agree – that harm to the embryo need not be intended, but does not address the possibility of an absolutely impermissible bodily assault without the intention to kill or harm. In any case, in our view the "circumstance" that the embryo is not, in standard practice, being moved to a safer place in its mother’s body is not a *mere* circumstance but a morally determinative albeit unintended aspect of the action – see the discussion above. [↑](#footnote-ref-24)
25. <https://www.youtube.com/watch?v=2Rt1eur1zfg>; <https://www.youtube.com/watch?v=w31u0i_VkzA> [↑](#footnote-ref-25)
26. It is worth noting that some women nevertheless see such an approach as more "natural" than surgical abortion: what is undergone may look and feel in some ways like a naturally occurring miscarriage. Morally, however, it is not clear why such expulsions, where the woman’s own body may sadly cause lethal injury to her baby, are preferable to other forms of harmful removal such as previability "caesarians" which also harmfully disrupt fetal tissues. In any event, the previability separation (abortion) is in neither case justified, we believe. [↑](#footnote-ref-26)
27. Condic and Harrison rightly draw attention to recent research showing the extent to which cancer treatment may, in fact, be fully compatible with fetal survival. [↑](#footnote-ref-27)
28. See footnote above with regard to Treloar and Williams’ suggestion re MTX. [↑](#footnote-ref-28)
29. Note, however, that a woman who has a good chance of succeeding is entitled to protect her health directly even at greater risk to the child than she would otherwise have incurred herself (so that, for example, urgently-needed treatment for cancer need not be delayed, even if there would otherwise be a good chance of a pregnancy – even a twin pregnancy – going to term or viability). The situations cannot be symmetrically reversed since a pregnant woman’s body must be "gone through" in order to treat an unborn baby, and this "going through" must be justified in terms of risks to the woman herself. To return to maternal treatment: because the baby or babies are still entirely surrounded by the woman’s body, even the side-effects take place uniquely within the outer (and the inner) borders of another human being. The space affected, albeit unintentionally, is the baby or babies’ own body-space – which however is still within the woman’s special "sphere of influence". For that reason, such side-effects appear more tolerable morally than side-effects for someone located entirely outside a woman’s body – say, a breastfeeding baby (Watt 2016, 78-79). [↑](#footnote-ref-29)
30. Condic and Harrison argue that the tube is not a diseased organ but is healthy or relatively healthy (Condic and Harrison 2018, 244). We agree that the tube may not be damaged apart from harbouring an ectopic embryo – the tube may be endangered rather than damaged as such. Just as with uterine cancer the womb is standardly removed as a means of removing the cancerous cells inside it, in *non-emergency* salpingectomy the tube is removed precisely as containing, not a cancer but an embryo who may cause future harm, before or after its future death. [↑](#footnote-ref-30)
31. As with later separation from the mother, the MAP could be given *either* for social reasons – which, however, Condic and Harrison would reject as morally insufficient – or for fear of medical complications in later pregnancy due to a serious medical condition. [↑](#footnote-ref-31)
32. It is worth noting that objections can be levelled at interventions such as the MAP purely on the grounds of a possible contraceptive intention. In a somewhat similar way (although they are morally more serious) both MAP use with an abortifacient intention and post-implantation abortion after sexual conception (as opposed to after IVF/another ART) are not only homicidal but "anti-fertility" and thus a matter of specifically *sexual* ethics and not *just* reproductive ethics or ethics of homicide. [↑](#footnote-ref-32)
33. It is true that live birth is the objective end or purpose of the procreative process, as the CDF recently noted (CDF 2019).  However, this does not mean that a woman who has just conceived has not already procreated, in conjunction with the father and with God's creative power. On the contrary, the woman is a mother as soon as she conceives, even if sadly she cannot carry her child to term.  After all, sexual intercourse, which begins the procreative process, *also* has live birth as its objective end or purpose; this does not mean that a couple has not truly had sexual intercourse if due to medical problems their sexual union cannot result in live birth. And if couples become parents at conception, then it seems that respect for fertility is inevitably engaged also by those who can conceive but cannot have a live-born child. For a discussion of these issues, see the Winter 2018 issue of the *National Catholic Bioethics Quarterly*. [↑](#footnote-ref-33)
34. The assumption here is that the child has *implanted* in the ectopic site rather than being simply placed there, perhaps moments ago. In contrast, even *pre-*implantation a woman is pregnant if she has a child in her reproductive tract, even if she is not the genetic mother. Her teleology is immediately engaged by the presence of such an embryo, in a way the non-reproductive teleology of the abdomen is not. [↑](#footnote-ref-34)
35. In contrast, if an IVF embryo were to implant in a man’s abdomen or a donor womb he would not be the father (unless he was already the genetic father). [↑](#footnote-ref-35)
36. For more on the moral importance of teleology see McCarthy 2016, chap. 2. [↑](#footnote-ref-36)
37. Watt 2016, 81-83. A similar thought is offered by O.E.Worcester, a female physician writing in 1894: "I would as soon take a child from its crib and dash its brains out, as to destroy the youngest fetus... This is my plea: 'What God hath joined together let not man put asunder,' in the medical profession or elsewhere." (Worcester 1894, 599) [↑](#footnote-ref-37)