14. Risking Women's Lives, Denying Women's Experiences: CDF Statements on Sterilization in Catholic Hospitals

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John Paul II's 1988 Apostolic Letter on the Dignity and Vocation of Women, *Mulieris Dignitatem* (MD) honors and praises the vocation of motherhood. "Through conceiving and giving birth to a child, a woman 'discovers herself through a sincere gift of self'" (no. 18). The document relates the motherhood of every woman with the motherhood of Mary and her participation in bringing the Son of God into the world. "Each and every time that motherhood is repeated in human history, it is always related to the Covenant which God established with the human race through the motherhood of the Mother of God" (no. 19). The letter only briefly mentions the difficulties that women undergo in childbearing. It makes reference to the transition from pain to joy of a mother giving birth described in the Gospel of John: "When a woman is in travail she has sorrow, because her hour has come; but when she is delivered of the child, she no longer remembers the anguish, for joy that a child is born into the world" (Jn 16: 21). The pain of childbirth is associated with the effects of original sin and is imagined as a mother's sharing in the Paschal Mystery, exemplified by Mary's sorrow at the foot of the cross.

On a spiritual level, comparing human motherhood with the motherhood of Mary can be a source of consolation and inspiration for some. On a practical level, however, such a comparison can be too idealized as it glosses over the risks and dangers that pregnant and would-be mothers face. The scriptural narrative of Mary's miraculous conception and birth of Jesus is far removed from the experiences of women who have to deal with absent, abusive, or irresponsible partners, difficulties with family planning, marital rape, domestic violence, life-threatening pregnancies, cesarean births, miscarriages, and so forth. While the apostolic letter

recognizes the "feminine genius," it gives little attention to the experiences of women who are often denied agency on matters of sexuality and reproduction. This disregard for women's experiences can lead to misguided and misinformed pastoral approaches that expose women and their children to grave harm.

This chapter explores one area of church teaching where women's contexts are disregarded. In the first three sections, I discuss three documents of the Congregation for the Doctrine of the Faith (CDF, later known as the Dicastery for the Doctrine of the Faith) on sterilization in Catholic hospitals. Spanning forty-three years, these documents neglected significant realities that affect the capacity of women to safeguard themselves, their children, and their marriages. In the fourth and final section of the essay, I retrieve a solidly probable opinion developed before Vatican II by moral theologians John Ford and Gerald Kelly, who used casuistry, moral principles, and pastoral approaches that are attentive to women who face the possibility of dangerous pregnancies. I argue that their probable opinion can be instructive for pastors and laity as they discern how to apply the church's teaching on sterilization. I conclude the essay by explaining how such a retrieval advances justice for women today.

The 1975 CDF Responses to Questions Concerning Sterilization in Catholic Hospitals

The encyclical *Humanae Vitae*, promulgated by Paul VI in 1968, reaffirmed the teaching of Pius XI in *Casti Connubii* (1930) prohibiting direct sterilization as a means of birth regulation. "Equally to be condemned, as the magisterium of the Church has affirmed on many occasions, is direct sterilization, whether of the man or of the woman, whether permanent or temporary" (*Humanae Vitae*, no. 14). Applying this prohibition to the context of Catholic hospitals, the bishops of the United States included in the 1971 edition of the *Ethical and Religious*

Directives (ERD) for Catholic Health Care Facilities the following directives:

> 18. Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception.
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> 20. Procedures that induce sterility, whether permanent or temporary, are permitted when (a) they are immediately directed to the cure, diminution, or prevention of a serious pathological condition and (b) a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradiating of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom and orchidectomy is permitted in the treatment of carcinoma of the prostate.[1]

In the mid-1970s, the uneven application of Directive 20 in Catholic hospitals become a concern of the US bishops' conference. Some bishops have allowed different interpretations of the directive and there were dissenting opinions from theologians. To prevent confusion and misunderstanding of the teaching of the Church, the National Conference of Catholic Bishops (NCCB, later to become the USCCB) sought clarification from the Vatican. Four questions were submitted to the CDF with the last question expressing the primary concern of the NCCB: "Can we accept the general prohibition of direct sterilization in Catholic hospitals and still make a number of exceptions in particular cases to solve pastoral problems?"[2]

The CDF addressed the questions of the NCCB in its 1975 document "Responses to Questions Concerning Sterilization in Catholic Hospitals." On the question of the liceity of contraceptive sterilization as

[1] Catholic Physicians' Guild, "Ethical and Religious Directives for Catholic Health Facilities," *The Linacre Quarterly* 39, no. 1 (1972): 9–12, 11.

[2] Eugene F. Diamond, "Sterilization in Catholic Hospitals," *The Linacre Quarterly* 55, no. 1 (1988): 57–66, 58, doi.org/10.1080/00243639.1988.11877938.

a means to cure, lessen, or prevent a pathological condition, the CDF gave a direct answer:

> 1. Any sterilization which of itself, that is, of its own nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation, is to be considered direct sterilization, as the term is understood in the declarations of the pontifical Magisterium, especially of Pius XII. Therefore, notwithstanding any subjectively right intention of those whose actions are prompted by the care or prevention of physical or mental illness which is foreseen or feared as a result of pregnancy, such sterilization remains absolutely forbidden according to the doctrine of the Church. And indeed the sterilization of the faculty itself is forbidden for an even graver reason than the sterilization of individual acts, since it induces a state of sterility in the person which is almost always irreversible.
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> Neither can any mandate of public authority, which would seek to impose direct sterilization as necessary for the common good, be invoked, for such sterilization damages the dignity and inviolability of the human person. Likewise, neither can one invoke the principle of totality in this case, in virtue of which principal interference with organs is justified for the greater good of the person; sterility intended in itself is not oriented to the integral good of the person as rightly pursued "the proper order of goods being preserved" inasmuch as it damages the ethical good of the person, which is the highest good, since it deliberately deprives foreseen and freely chosen sexual activity of an essential element. Thus article 20 of the medical-ethics code promulgated by the conference in 1971 faithfully reflects the doctrine which is to be held, and its observance should be urged.[3]

The document affirms the prohibition in Directive 20 of the ERD against medical procedures that are directly intended to sterilize a person

[3] Sacred Congregation for the Doctrine of the Faith, *Responses to Questions Concerning Sterilization in Catholic Hospitals*, www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19750313_quaecumque-sterilizatio_en.html.

temporarily or permanently to address a current or anticipated medical pathology. The CDF rejects the use of the principle of totality to justify sterilizing medical procedures for the sake of maintaining or protecting the overall physical and psychological health of a person. The document also prohibits the public's use of private theologians' dissenting opinions to contradict the magisterium's teaching.

The CDF document does not prohibit medical treatments that are directly intended to cure an existing pathology but have unintended contraceptive or sterilizing side effects. *Humanae Vitae* already permits such treatments: "The Church does not consider at all illicit the use of those therapeutic means necessary to cure bodily diseases, even if a foreseeable impediment to procreation should result there from—provided such impediment is not directly intended for any motive whatsoever" (*Humanae Vitae*, no. 15). For example, the treatment or removal of a cancerous uterus is allowed even if such a procedure has the unintended but foreseen result of impairing the patient's reproductive capacity. This is a recognized application of the principle of double effect. What the CDF had in mind in its prohibition are sterilizing procedures on healthy or currently non-threatening reproductive organs intended to prevent a future threat to the life, health, or well-being of the person due to pregnancy. For example, a tubal ligation to avoid future pregnancies that can worsen an existing heart or kidney condition is considered an illicit direct sterilization.

In a letter to all US bishops, the NCCB-USCCB president Cardinal Joseph Bernardin confirmed the magisterium's teaching on sterilization and the validity of Directive 20: "I am writing to give assurance that the 1971 guideline stands as written and that direct sterilization is not to be considered as justified by the common good, the principle of totality, the existence of contrary opinion, or any other argument. This means that Catholic hospitals, as a matter of institutional policy, may not authorize

sterilization procedures for reasons other than those contained in the guidelines."[4]

For married women whose life or health may be at risk in case of pregnancy, the pastoral advice that the Church gives them is to either abstain entirely from sexual relations or to use natural family planning. The Church presents sexual intercourse in marriage as a freely chosen act by consenting spouses who value each other's good and the good of their family and community. Spouses are expected to cooperate in living out marital chastity, especially in practicing natural family planning. Real situations on the ground contradict such an idealized expectation of the marriage life of couples. Pope Francis, in *Amoris Laetitia* (AL), urged for a realistic consideration of the situation of families and the challenges they face. He gave examples of the challenges women face in their marital relationships:

> The word of God constantly testifies to that somber dimension already present at the beginning, when, through sin, the relationship of love and purity between man and woman turns into domination: "Your desire shall be for your husband, and he shall rule over you" (Genesis 3:16). (no. 19)

> I think particularly of the shameful ill-treatment to which women are sometimes subjected, domestic violence and various forms of enslavement which, rather than a show of masculine power, are craven acts of cowardice. The verbal, physical, and sexual violence that women endure in some marriages contradicts the very nature of the conjugal union. (no. 54)

The presumption that married women can easily convince their husbands to practice natural family planning or to abstain from sex entirely to avoid life-threatening pregnancies is not only unrealistic but is also ignorant of the situation of women who are denied the ability to negotiate sexual

[4] Diamond, "Sterilization in Catholic Hospitals," 59.

relations with their spouses. The CDF document ignores the cultural and religious traditions and attitudes of many societies where women are not treated as equal to men in marriage and are obliged to provide sexual satisfaction for their husbands. Sexual violence against women by their partners or spouses is a grave problem in both developed and developing countries.

For example, the National Family Health Survey 5 conducted in India for the period 2019–2021 reveals that "29% of ever-married women had experienced some form of physical or sexual violence from their husbands."[5] and "of the 4,169 women who are (or used to be) married and have experienced sexual violence, 82% said that the perpetrator was their husbands. Of them, a large majority (84%) said that their husbands physically forced them to have sexual intercourse even when they did not want to.[6] The Center for Disease Control in the United States estimates that one in five women have had contact with sexual violence by an intimate partner, based on the 2015 National Intimate Partner and Sexual Violence Survey.[7] According to a UN Women 2020 campaign against gender–based violence, marital rape is not a crime in 34 countries.[8]

While the Church endorses natural family planning (NFP) as an effective and safe way for married couples to plan their families, its adoption and usage depend on the spouses' concrete situation and willingness to practice NFP consistently. Physical and sexual violence in

[5] Padma-Bhate Deosthali, Sangeeta Rege, and Sanjida Arora, "Women's Experiences of Marital Rape and Sexual Violence within Marriage in India: Evidence from Service Records," *Sex Reproduction Health Matters* 29, no. 2 (2022): doi.org/10.1080/26410397.2022.2048455.

[6] Parvati Bethu, "Marital Rape: Most Married Women are Sexually Abused by their Husbands, Says NFHS Data," *The Hindu Business Line*, May 16, 2022, www.thehindubusinessline.com/data-stories/data-focus/marital-rape-most-married-women-are-sexually-abused-by-their-husbands-says-nfhs-data/article65409875.ece.

[7] Center for Disease Control and Prevention, *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief-Updated Release*, November 2018, stacks.cdc.gov>cdc_60893_DS1.

[8] UN Women, *Ad Campaign: A Spotlight on Legal Gaps to End Violence against Women*, www.unwomen.org/en/digital-library/multimedia/2020/11/campaign-laws-endviolence.

marriage is a serious obstacle to NFP.[9] Married couples where one or both partners have physical, emotional, or psychological challenges that impair discipline and regularity in activities will find it difficult to use the modern NFP methods that require constant monitoring of signs of ovulation and consistent observance of abstinence during fertile periods. Circumstances that limit the sexual relations of couples only to prescribed times (e.g., conjugal visits in prisons, scheduled home visits of spouses working abroad, etc.) can also be obstacles to applying NFP. While modern methods of NFP are actively promoted by the Church, knowledge and usage of these methods can vary from country to country. In the Philippines, Catholics comprise around 85 percent of the population, but less than 1 percent of Filipino women use NFP.[10] It is estimated that approximately 1 percent of women in the United States use NFP, while globally, NFP usage is around 3.6 percent. Some women cannot identify their ovulation time using body temperature or cervical mucus monitoring due to irregular periods, abnormal uterine or cervical bleeding, temperature fluctuations from systemic illnesses, and cervical or vaginal infections. These women would be prevented from using various NFP methods effectively.[11]

While the 1975 CDF document seeks to provide clear guidance and prevent confusion regarding the meaning of direct and indirect sterilization in treating medical conditions, it focuses primarily on the reproductive organs and physical aspects of sterilization. The document disregards the concrete experiences of women and the multitude of social, marital, and biological factors that present difficulties in applying the teaching on sterilization without causing harm to the woman's health, her

[9] Susan Rakoczy, "A Gendered Critique of the Catholic Church's Teaching on Marriage and the Family: 1965–2016," *Scriptura* 115, no. 1 (2016): 1–19.

[10] Philippines Statistics Authority, *2017 National Demographic and Health Survey*, psa.gov.ph/sites/default/files/PHILIPPINE%20NATIONAL%20DEMOGRAPHIC%20AND%20HEALTH%20SURVEY%202017_new.pdf.

[11] Sharon Sung and Aaron Abromivitz, *Natural Family Planning*, www.ncbi.nlm.nih.gov/books/NBK546661/.

marriage, and the children to be born. The document presumes to address committed and highly motivated couples who can easily practice sexual abstinence to avoid a potentially dangerous pregnancy. Unfortunately, many couples cannot fit into this idealized image. The document fails to provide a humane and person-oriented response to real situations of women and married couples.

The 1993 CDF Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters

As early as the 1950s, Catholic ethicists have considered the case of a woman with a uterus scarred by repeated caesarian deliveries to the point of potentially failing in a subsequent pregnancy, with an accompanying risk to the lives of the mother and fetus. Can a hysterectomy remove the damaged uterus before another pregnancy occurs? As an alternative to a hysterectomy, can the damaged uterus be "isolated" through a less invasive tubal ligation during a caesarian delivery, wherein a woman's fallopian tubes are cut, tied, or blocked to prevent fertilization permanently? The Vatican had not yet made a declaration before 1993 on whether the removal of such a damaged uterus or uterine isolation would be licit medical interventions to prevent future harm.

The moral theologian Gerald Kelly used probabilism to address this specific case of sterilization. In moral theology, probabilism is applied to situations where there is doubt regarding the applicability of a law to a particular moral case. A law that is affected by doubt, either of its application or existence, cannot oblige a person's conscience.[12] A moral opinion of a theologian can rise to the level of a solidly probable opinion that the public can follow if it is held by a significant number of reputable theologians (extrinsic probability) and has an internal logic (intrinsic probability) that makes sense to moral experts. A probable opinion on a

[12] Eric Marcelo Genilo, SJ, *John Cuthbert Ford, SJ: Moral Theologian at the End of the Manualist Era* (Washington, DC: Georgetown University Press: 2007), 41.

moral case can guide pastoral practice if the magisterium has yet to give a definite response to the case and if the magisterium has not forbidden the application of the probable opinion.

Kelly proposed a "probable opinion" that a hysterectomy of a damaged uterus is an indirect sterilization and is thus licit.[13] In the influential moral manual *Contemporary Moral Theology: Marriage Questions*, Kelly and his fellow moralist John Ford argued that it was licit to allow the removal of a damaged uterus that was at risk of failing in a succeeding pregnancy.[14] Their opinion was deemed solidly probable to guide pastoral practice until the magisterium could make a definitive judgment on the matter. The reputations of Ford and Kelly gave their probable opinion sufficient credibility and weight that the 1971 Ethical and Religious Directives for Catholic Health Facilities made room for the possibility of a hysterectomy in an extraordinary medical situation:[15]

> 22. Hysterectomy is permitted when it is sincerely judged to be necessary to remove some serious uterine pathological condition. In these cases, the pathological condition of each patient must be considered individually, and care must be taken that a hysterectomy is not performed merely as a contraceptive measure or as a routine procedure after any definite number of Cesarean sections."[16]

Regarding uterine isolation, ethicists held that there is a moral difference between isolating a damaged uterus through tubal ligation and removing the same uterus through a hysterectomy. While both procedures can render a patient permanently sterilized, the former is considered an illicit direct sterilization while the latter can be justified in some instances as an

[13] Diamond, "Sterilization in Catholic Hospitals," 57.

[14] John Ford and Gerald Kelly, *Contemporary Moral Theology: Marriage Questions* (Westminster, MD: Newman Press, 1963) 328–337.

[15] Thomas O'Donnell, "'Uterine Isolation' Unacceptable in Catholic Teaching," *The Linacre Quarterly* 61, no. 3 (1994): 58–59.

[16] Catholic Physicians' Guild, "Ethical and Religious Directives for Catholic Health Facilities," 11.

indirect sterilization using the principle of double effect. The term "uterine isolation" might also be misused to justify other contraceptive acts, such as using a diaphragm or a cervical cap to prevent problematic pregnancies. For these reasons, uterine isolation was not included in Directive 22 as a permissible medical response to treating a uterus with a severe pathological condition.[17]

Persistent questions surrounding the scarred uterus case and uterine isolation led the CDF to issue the instruction *Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters* in 1993. The CDF made a distinction between the case of a damaged uterus, which poses an immediate threat to the life of a mother after delivery, and a weakened uterus that does not present an immediate danger to the life of a woman while she is not pregnant but can pose grave harm to her and her unborn child if she becomes pregnant. The CDF allowed the removal of the uterus in the former case but did not in the latter case. In the latter case, the CDF argued that removing the weak uterus did not have a proper therapeutic character but aimed to prevent future pregnancies and was, therefore, a direct sterilization. Such a procedure is not to be allowed in Catholic hospitals. The CDF also prohibited tubal ligation or "uterine isolation" to substitute for a hysterectomy of a uterus with a serious pathological condition.

> Q. 1. When the uterus becomes so seriously injured (e.g., during delivery or a Caesarian section) so as to render medically indicated even its total removal (*hysterectomy*) in order to counter an immediate serious threat to the life or health of the mother, is it licit to perform such a procedure notwithstanding the permanent sterility which will result for the woman?
> R. Affirmative.
> Q. 2. When the uterus (e.g., as a result of previous Caesarian sections) is in a state such that while not constituting in itself a present risk to the life or health of the woman, nevertheless is foreseeably incapable of carrying

[17] Diamond, "Sterilization in Catholic Hospitals," 62–64.

> a future pregnancy to term without danger to the mother, danger which in some cases could be serious, is it licit to remove the uterus (hysterectomy) in order to prevent a possible future danger deriving from conception?
> R. Negative.
> Q. 3. In the same situation as in no. 2, is it licit to substitute tubal ligation, also called "uterine isolation," for the hysterectomy, since the same end would be attained of averting the risks of a possible pregnancy by means of a procedure which is much simpler for the doctor and less serious for the woman, and since in addition, in some cases, the ensuing sterility might be reversible?
> R. Negative.[18]

The CDF's prohibition on sterilizations to prevent future dangerous pregnancies lacks an adequate consideration of the experience of women who face the risk of life-threatening pregnancies and miscarriages. The CDF refers to the marital acts that can lead to risky pregnancies as "sexual acts freely chosen" implying that affected couples should either avoid intercourse permanently or use NFP regularly. It appears that the CDF is blaming at-risk pregnant women for irresponsibly putting themselves in danger if they chose to have sex. As mentioned in the previous section, some women are in situations where they are not free to refuse sexual intercourse with their partners, and NFP is not possible for some couples due to their marital, physical, psychological, and social conditions. What should an at-risk married woman do if her husband lacks the capacity or desire for sexual abstinence, whether permanently or in the context of NFP? Does she refuse sex with her spouse and risk straining their marriage or provoking domestic violence? Does she wait until she gets pregnant, knowing she will likely lose her child and endanger her life before she can have the medical intervention the CDF allows? In effect, the CDF is asking

[18] Congregation for the Doctrine of the Faith, *Responses to Questions Proposed Concerning "Uterine Isolation" and Related Matters,* www.vatican.va/ roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_31071994_uterine-isolation_en.html.

at-risk women to place themselves in harm's way to preserve their reproductive organs until the last moment of functionality. For the CDF, real and present danger of death during pregnancy seems to be the only reason to remove a weakened or damaged uterus. Simply saying that there is no danger to the at-risk woman as long as she does not get pregnant is gravely insensitive to the experience of many women who cannot prevent their partners from forcing them to have sex.

The 1993 CDF response was integrated into the *2007 Ethical and Religious Directives for Catholic Health Facilities* of the US bishops' conference and is currently expressed in Directive 53:

> 53. Direct sterilization of either men or women, whether permanent or temporary, is prohibited in a Catholic healthcare institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present, and serious pathology and a simpler treatment is not available.[19]

Doctors working in Catholic hospitals in the United States face a difficult choice: whether to proceed with a medically-indicated sterilization for a woman whose health or life may be endangered in a future pregnancy and risk administrative sanctions from their Catholic facility (e.g., the loss of admitting privileges) or avoid violating the directives of their institution by having the patient transfer to a non-Catholic health facility to have the sterilizing procedure they need.

Transferring a patient can lead to delayed treatment that would be detrimental to the patient's health. A woman's health insurance may only apply to her local Catholic hospital and not to another hospital, resulting in onerous additional costs for her procedure. With the mergers of Catholic facilities with other medical institutions, a woman might find out too late about her hospital's religious directives when it is no longer

[19] United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Facilities Sixth Edition*, www.usccb.org/resources/ethical-and-religious-directives-catholic-healthcare-services.

medically advisable for her to be moved to a non-Catholic hospital.[20] The situation can be further complicated if the Catholic facility is the only hospital serving a remote area and the nearest non-Catholic health facility is not easily accessible. "Women who are on Medicaid or live in rural areas often have only one hospital they can go to—one-third of Catholic hospitals are rural community hospitals."[21] A 2020 US study identified fifty-two Catholic short-term acute care hospitals designated as their region's "sole community hospital" (located at least thirty-five miles from the nearest similar hospital).[22]

Many doctors believe that the Church's directive that prevents women from receiving medically-indicated sterilizations from Catholic facilities goes against the best interest of patients and "poses a 'risk of harm' to women by violating the accepted standard of care, especially for women who are already getting a C-section and would need an unnecessary second surgery."[23] There was a case where a patient sued a Catholic facility for denying medically-indicated sterilization that resulted in distress, delayed treatment, additional expenses, and new surgical risks because of the need to transfer to a non-Catholic facility for their procedure.[24]

A 2012 study of obstetrician-gynecologists working in religiously affiliated health facilities showed that those working in Catholic

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[20] Julia Kaye, Brigitte Amiri, Louise Melling, and Jennifer Daven, "Healthcare Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives," American Civil Liberties Union, www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied.

[21] Patricia Miller, "'A Risk of Harm': Catholic Hospital's Ban on Tube Tying," *The Atlantic*, January 2, 2015, www.theatlantic.com/health/archive/2015/01/a-risk-of-harm-catholic-hospitals-ban-on-tube-tying/383903/.

[22] Tess Solomon, Lois Uttley, Patty Hasbrouck, and Yoolim Jung, "Bigger and Bigger: The Growth of Catholic Health Systems," Community Catalyst 2020, www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf.

[23] Miller, "A Risk of Harm."

[24] Carrie Baker, "Catholic Hospital Denies Woman a Medically Necessary Sterilization, Putting Her Health and Well-Being at Risk: 'It's Wrong and It's Dangerous,'" *Ms. Magazine*, August 10, 2021, msmagazine.com/2021/08/10/catholic-hospital-woman-sterilization-health-care/.

institutions are most likely (52 percent) to report a conflict with their institution's religion-based policies on patient care.[25] The potentially harmful effect of strict implementation of Directive 53 on the life and health of at-risk women has led to inconsistencies in its application in Catholic facilities. A study in 2013 revealed wide diversity in the interpretation of Directive 53 in Catholic hospitals in seven US states. Out of 176 hospitals surveyed, "eighty-five or 48 percent of these hospitals provided a total of 20,073 direct sterilizations in violation of the ERDs."[26] A less strict interpretation of the directive was applied either by the Catholic facilities or by the bishops in whose jurisdiction the facilities were located.

The dangerous situations created by Directive 53 for at-risk women in the United States, where one out of six hospital beds is in a Catholic health facility, are a direct result of the 1993 CDF response that inadequately considered the experiences of women and the medical complications they face related to pregnancy. The CDF has placed women's lives and their unborn children in harm's way by simply focusing on precisely determining what constitutes direct or indirect sterilization without considering the human consequences of what is allowed or prohibited. The constant and unrelenting focus on preserving a woman's reproductive capacity even at the risk of her health shows a fragmented, disembodied, and inadequate view of women that does not respect their totality as integral persons deserving the best medical care available for themselves and their family. The CDF's moral stance on the plight of women who face the possibility of life-threatening pregnancies turns a blind eye to the realities of sexual violence and coercion in marriage and the social justice implications of limiting the healthcare options of persons dependent on Catholic medical institutions in their locality.

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[25] Debra Stulberg, Annie Dude, Irma Dahlquist, et al., "Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies," *American Journal of Obstetrics Gynecology* 207, no. 73 (2012): 1–5, doi.org/10.1016/j.ajog.2012.04.023.

[26] Sarah Hapenney, "Divergent practices among catholic hospitals in provision of direct sterilization," *Linacre Quarterly* 80, no. 1 (2013): 32.

The 2018 CDF Response to a Question on the Liceity of a Hysterectomy in Certain Cases

Twenty-five years after the publication of the 1993 CDF response, the magisterium deemed it necessary to return to the case of hysterectomy for women with a damaged uterus. The 2018 CDF response clarifies that it does not negate nor invalidate the teaching of the 1993 response. Instead, it aims to complete the previous document by addressing a case where a hysterectomy can be allowed.

> Question: When the uterus is found to be irreversibly in such a state that it is no longer suitable for procreation and medical experts have reached the certainty that an eventual pregnancy will bring about a spontaneous abortion before the fetus is able to arrive at a viable state, is it licit to remove it (hysterectomy)?
> Response: Yes, because it does not regard sterilization.[27]

The CDF argues that the above case differs from the cases addressed by the 1993 response. While the 1993 document dealt with cases where a damaged uterus can fail during pregnancy, the 2018 document described a case where medical experts have judged with certainty that a damaged uterus can no longer bring a pregnancy to term. In this case, the uterus can no longer fulfill its natural procreative function.[28] The removal of this non-functional uterus will not be sterilization, according to the CDF, because

[27] Congregation for the Doctrine of the Faith, "Response to a Question on the Liceity of a Hysterectomy in Certain Cases," press.vatican.va/content/salastampa/it/bollettino/pubblico/2019/01/03/0005/00014.html#en.

[28] The CDF approach to the damaged uterus case in both its 1993 and 2018 statements reflects a physicalist approach to sexual ethics that sees the human body as a blueprint of God's purpose for every human faculty, disregarding the importance of other dimensions of the human person for moral discernment. For a critique of this physicalist approach to the human person, see Charles Curran, "Catholic Social and Sexual Teaching: A Methodological Comparison," *Theology Today* 4, no. 4 (1988): 437–438.

there is no longer any procreative function to impede. "Removing a reproductive organ incapable of bringing a pregnancy to term should not therefore be qualified as direct sterilization, which is and remains intrinsically illicit as an end and as a means."

While the 2018 response intended to address a hysterectomy case not covered by the 1993 response, it provoked dissenting opinions claiming that this new document contradicts the 1993 response and the Church's teaching on sterilization.[29] The 2018 response states that "the objective of the procreative process is to bring a baby into the world, but here the birth of a living fetus is not biologically possible. Therefore, we are not dealing with a defective, or risky, functioning of the reproductive organs, but we are faced here with a situation in which the natural end of bringing a living child into the world is not attainable." Some object to this description of procreation as bringing a child into the world (live birth), pointing out that the magisterium has always treated the moment of fertilization as the moment of procreation and the start of human life. The National Catholic Bioethics Center (NCBC) raised the following concerns:

> While the response affirms that removing a uterus that is incapable of carrying a child to viability is not *per se* a direct sterilization, it does not offer a comprehensive rationale and explanation—including a full and specific medical scenario—under which performing such a hysterectomy would, in practice, be morally legitimate. . . . A matter of concern to some theologians, however, is how this response might be cited in the future, with its definition of procreation focused on live birth and its seeming opening of the door to a "pastoral" permission for women who can conceive children without being able to carry them to viability to procure hysterectomies to avoid further miscarriages.[30]

[29] Joshua Schulz and William Hamant, "Non-Sterilizing Hysterectomies: A Catholic Critique of the CDF," *Linacre Quarterly* 87, no. 2 (2020): 182–195.

[30] National Catholic Bioethics Center, "Commentary on the CDF Responsum of 10 December 2018," February 19, 2019, www.ncbcenter.org/resources-and-statements-cms/commentary-on-the-cdf-responsum-of-december-10-2018.

In the debate over the orthodoxy of the 2018 CDF response, the voices of women facing difficult choices regarding their reproductive health remain unheard. The language of the CDF and its critics show a narrow focus on children and childbearing while disregarding the women who have to face the effects and dangers of risky pregnancies. For example, the 2018 CDF response states, "the malice of sterilization consists in the refusal of children: it is an act against the *bonum prolis*." Such a description of the wrongness of sterilization seems to imply that those who seek sterilization do not want children, disregarding the fact that certain pregnancy situations carry severe risks to the health and life of both mother and child. Not all women who seek sterilization refuse to raise children; some desire children but cannot undergo pregnancy without risking harm to themselves and their unborn child.

In interpreting the CDF document, the National Catholic Bioethics Center declares that "any dangers to the health or life of the woman expected to arise as a result of future pregnancy, and any dangers to a potentially conceived child, should play no role in establishing a therapeutic rationale or 'proportionate reason' for performing a hysterectomy in the non-pregnant state."[31] To say that anticipated dangers to the mother or unborn child from a future risky pregnancy should not play any role in one's discernment over whether or not to have a sterilizing procedure goes against common sense, self-preservation, and Christian charity. Protecting human life and avoiding injury of both mother and child will always weigh more significantly in the decision-making of doctors, patients, and the patient's family than the strict adherence to church rules.

In the debate over the proper interpretation and application of the 2018 response to cases of hysterectomy, the final sentence in the document is barely accorded attention: "It is the decision of the spouses, in dialogue with doctors and their spiritual guide, to choose the path to follow, applying the general criteria of the gradualness of medical intervention to

[31] National Catholic Bioethics Center, "Commentary on the CDF Responsum."

their case and to their circumstances." This is a critical sentence highlighting the agency of those directly affected by risky pregnancies. Even if removing a defective uterus to prevent future harm is an illicit direct sterilization by church definition, a woman and her family's decision to proceed with this medical intervention to protect life and health should be respected and protected under the principle of the primacy of conscience.

A Way Forward: Retrieving the Probable Opinion of John Ford and Gerald Kelly

Before the 1993 CDF response, removing a damaged uterus to prevent a future risky pregnancy was justified by the solidly probable opinion of moral theologians John Ford and Gerald Kelly. John Ford and Gerald Kelly claimed that they had been consulted about the case of the scarred uterus at least a hundred times in twenty years.[32] Ford had previously held that the pre-emptive removal of a uterus scarred and weakened by repeated caesarian deliveries was direct sterilization. Still, he changed his position after studying medical data on maternal mortality. A study by Cornelius O'Connor, a medical doctor, showed that mothers who undergo an operation to remove their weakened uterus immediately after a cesarean operation have a 1 percent mortality rate compared to 2 percent mortality for mothers who, after a cesarean operation, do not have their weakened uterus removed.[33] This means there is a greater danger of death for a woman who retains a weakened uterus after a caesarian operation because of the possibility of a future pregnancy that can rupture the uterus. A woman who has her weakened uterus removed during her caesarian

[32] Ford and Kelly, *Marriage Questions*, 328.

[33] See, for example, Cornelius O'Connor, "The Problem of the Repeat Caesarean Section: A Preliminary Study," *American Journal of Obstetrics and Gynecology* 53, no. 6 (1947): 914–926. Ford does not provide a footnote reference to O'Connor's study. This article by O'Connor was published after Ford's article in *Theological Studies* that references O'Connor.

operation could face other life-threatening complications from her surgical procedure. Still, the danger of uterine rupture in a future pregnancy would no longer threaten her. For Ford, this 1 percent difference in mortality was sufficient reason to justify the removal of the weakened uterus both medically and theologically:[34]

> Is the difference between 2% mortality and 1% mortality a serious matter? If one were to look at the question from the opposite side, one might say: the conservative technique is 98% safe and the radical procedure is 99% safe. This very slight increase in safety is not enough to justify the sterilization. But to a surgeon the difference between 1% and 2% mortality is a very important, in fact, a decisive difference. "Twice as good a chance to survive" is a very big thing to a patient, and that is exactly what is represented by the difference between 1% and 2% mortality. Theologians recognize that a 1% danger of death is a very real danger and teach that persons who are undergoing an operation involving that amount of danger, or even less, are to be given the sacraments as persons who are truly in danger of death. Such persons are entitled to all the privileges which canon law allows *in periculo mortis*. Now, it seems to me that a danger of death twice as great as that is objectively a very important and serious matter, constituting a sufficient reason for permitting sterilization.[35]

Ford and Kelly, in their moral manual *Marriage Questions*, used the principle of double effect to justify cesarean hysterectomy, saying that it was licit to intend the good effect of preserving the health of the patient by removing a presently pathological uterus while at the same time not directly intending the resulting sterilization. To prove this point, Ford used a technique called "supposition."

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[34] John C. Ford, "Notes on Moral Theology," *Theological Studies* 5, no. 4 (1944): 495–538, 514-517, doi.org/10.1177/004056394400500405.

[35] Ford, "Notes on Moral Theology," 515.

> The supposition here would be that a woman has a double uterus (a condition that occasionally exists), one damaged, and one healthy. Granted the supposition, the removal of the damaged uterus would eliminate the source of danger without at the same time inducing sterility. This indicates very strongly that the damaged uterus is a separate cause of danger and that it may be made the precise object of surgical intervention even in the normal case without at the same time any direct intent of sterilization.[36]

Ford acknowledged that applying the principle of double effect was "notoriously slippery and open to dispute" in complicated cases such as the scarred uterus case. However, he believed there was less danger of abusing such a principle if its results coincided with common sense. Ford asked the rhetorical question: "Is it in accord with common sense to tell a woman who has had many cesareans: 'You have worn out this uterus in the service of motherhood. Nevertheless, you must keep it; and if you wish to protect yourself against the danger inherent in using it, you must abstain from marital intercourse'?"[37]

Ford's rhetorical question addressed the objection of some moralists that a present danger to the patient was needed to justify mutilation of an organ, such as the scarred uterus. Ford challenged such a view by quoting Pius XII's words on applying the principle of totality. Pius XII said that the principle of totality can be used to justify mutilations to preserve life, to repair damage, and to avoid damage.[38] Even if an existing danger was required, Ford asserted that the weakened uterus presented such a danger in the circumstances of normal married life. Ford and Kelly defined danger as "in a set of circumstances from which one can foresee with certainty or probability a future impending evil."[39] They considered the normal married

[36] John C. Ford and Gerald Kelly, "Notes on Moral Theology," *Theological Studies* 15, no. 1 (1954): 52–102, 70, doi.org/10.1177/004056395401500103.
[37] Ford and Kelly, "Notes on Moral Theology," 71.
[38] Ford and Kelly, *Marriage Questions*, 335.
[39] Ford and Kelly, *Marriage Questions*, 335.

life of a woman with such a damaged uterus and believed that such a woman was in danger of conceiving again. Ford and Kelly rendered this decisive judgment: "To say that she can avoid this danger by imposing perpetual abstinence on herself and her husband is to require a degree of heroism to which our moral principles do not oblige her."[40]

Ford and Kelly were able to propose their probable opinion because they viewed the circumstances of the case from the perspective of the woman who is forced to deal with the tension between the demands of her marital life and the potential dangers of her medical condition. By acknowledging the experience of these women and their right to avoid grave risks to themselves and their future children, Ford and Kelly fashioned a moral opinion that is attentive to the human condition of married women. This person-centric stance is more consistent with medical standards of care, Christian charity, and common sense than the impersonal moral calculation of the three CDF responses that focused only on reproductive organs and their functionality. This same person-centric stance presently influences some Catholic facilities to provide sterilization services in violation of the ERD so that the care of at-risk women will not be compromised. Unlike the CDF responses that focused on preserving women's childbearing capacity regardless of possible future harm, Ford and Kelly viewed women as integral human beings dealing with complex personal, marital, familial, and social relationships and responsibilities.

Conclusion

The 1975, 1993, and 2018 CDF documents on sterilization have created an unjust situation for women at risk of a future dangerous pregnancy. These documents limited the access of women to life-saving sterilizations in Catholic hospitals. Rather than listen to the experiences of women and

[40] Ford and Kelly, *Marriage Questions*, 335–336.

address the challenges they face with pastoral solicitude, the CDF documents placed on these women the burden of avoiding risky pregnancies even when they do not always have the agency to negotiate sexual relations in their marriage. The standard pastoral advice to abstain from marital intercourse or practice natural family planning is inapplicable in marriages where sexual coercion and domestic violence are present. While women may not always have the power to negotiate marital activity, they should have the capacity to protect themselves from harm that stems from their difficult marital and personal situations.

The physicalist focus of the magisterium on a woman's reproductive system prevents serious consideration of the social, cultural, religious, and personal factors that constrain marital sexual activity from being a free and loving act. The CDF documents contradict the personalist framework of Catholic social teaching that calls for adequate consideration of all dimensions of a person aimed at integral human development. John Paul II declares that "the Church's sole purpose has been care and responsibility for the human person, who has been entrusted to her by Christ himself" (*Centesimus Annus*, no. 53). Benedict XVI asserts that "authentic human development concerns the whole of the person in every single dimension" (*Caritas in Veritate*, no. 11). If the Church's teachings on sterilization are to be consistent with Catholic social teachings, it must adopt a personalist approach that considers the personhood of women in all dimensions and circumstances. To ignore the threats that women face in sexual relations and childbirth is to ignore the lived reality of many women and prevent them from receiving the care and protection that is due to them as human beings created in God's image.

The theologians Ford and Kelly have shown that a person-oriented approach is possible when analyzing the case of the scarred uterus. Using the resources of the moral manuals of their time, Ford and Kelly were able to argue that the removal of a severely weakened uterus in danger of failure in a future pregnancy is an indirect sterilization that can be licitly performed.

Still unrestricted by CDF directives, Ford and Kelly were able to navigate the church's norms on sterilization while paying serious attention to the challenges of marital life experienced by women. A retrieval and revival of their moral arguments and personalist approach can contribute to correcting the physicalism of the CDF statements and provide a more integral and humane solution to a dire situation many women face. The moral tradition has much to offer from its treasury of wisdom that can help the Church re-orient itself away from past moral statements that are unhelpful to vulnerable persons who deserve care, respect, attention, and fullness of life as God's children.

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