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Thomas W. Hilgers

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by

Thomas W. Hilgers, M.D., Dip. ABOG, ABLS, SRS

The author is Director, Pope Paul VI Institute for the Study of Human Reproduction, Omaha, Nebraska.

"Uterine Isolation" has been discussed, in one form or another, since the early 1940's by such notable American theologians as Fr. John C. Ford, SJ, Fr. Gerald Kelly, SJ; Fr. Francis J. Connell, C.SS.R.; Fr. L. Bender; Fr. John R. Connery; SJ, Fr. Edwin F. Healy, SJ; and Fr. Thomas J. O'Donnell, SJ.[1] The term "uterine isolation" originated with Fr. O'Donnell.

O'Donnell, who is personally convinced of the validity of the arguments for the solid probability of the "uterine isolation" view, was also responsible for having this *deleted* from the *"Ethical and Religious Directives for Catholic Health Facilities"* which were published and approved by the bishops in 1971. " 'Isolation of the uterus' or 'uterine isolation' " he says, "had taken root in the medical-moral community and, either through misunderstanding or deception, was being used as a presumably morally acceptable semantic for various forms of clearly contraceptive sterilization."[1]

O'Donnell states that the following three points need to be understood by Catholic hospital administration and staff with regard to the term "uterine isolation procedure":

1. Hysterectomy in the presence of a uterus which has been so damaged or weakened by multiple cesarean sections that it is judged to be incapable (because of the damage within the uterus itself) of safely supporting another pregnancy is, with solid probability, *not* a contraceptive sterilization and is permitted . . .

2. In this case, and only in this case, the isolation of such a uterus at its tubal adnexa, instead of its extirpation, if clinically indicated, is, with solid probability, not a contraceptive sterilization and thus may be permitted and practiced; *unless,* of course, this is disapproved by the bishop of the diocese who might well foresee greater harm in the danger of misunderstanding and morally unwarranted extension of the procedure as a semantic to conceal directly contraceptive sterilizations.

3. If, *after further study* and *investigation,* there would be a sufficient consensus of

theological opinion or a decision by the Congregation for the Doctrine of the Faith that either of the procedures described above (either the hysterectomy in this case or the isolation procedure) is indeed a direct sterilization (such as to discount the solid probability that it is not), *then neither of the procedures could be done* within the context of Catholic teaching. *The sole moral defense of either procedure is the solid probability of the moral opinion that it is not a directly contraceptive sterilization* (emphasis applied).[1]

I wish to emphasize the need for further study and investigation of this issue because the experience with "uterine isolation" is compelling and proves that the practice is nothing but *direct contraceptive sterilization.* It is also a practice with inappropriate medical justification . . . a practice which, in the 1990's, cannot be justified on medical moral grounds.

One of the most important questions that needs to be asked with regard to "uterine isolation" is "What are we isolating the uterus from?" It is clear that the uterus is not being isolated from either the sperm or the ovum since they present no potential of risk. It is equally clear that the isolation of the uterus, so proposed, is not isolating the uterus from any known disease condition. the only possible thing that this procedure could be isolating the uterus from is a pregnancy. Thus, it seems equally clear that the primary intent of such a "uterine isolation" is contraceptive sterilization. Furthermore, the actual application of "uterine isolation" policies in Catholic hospitals suggests that it is *direct* contraceptive sterilization.

Policy Attempted

I have had the opportunity to observe a number of Catholic health facilities that have tried to administer a policy of "uterine isolation". It is fair to say that in all circumstances, the policy has not worked. It has been almost impossible to implement and to monitor appropriately. It has been suggested, for example, that the photographs of the uterus or biopsies of the uterus be taken at the time of surgery or that a preoperative committee be used to review and evaluate each case. However, these have not been workable.

There appears to be a fundamental flaw in the argument that says "There is no moral difference between thus isolating the uterus and removing it. It was pointed out that the hysterectomy part of the surgical technique consists in the clamping and cutting of the fallopian tubes and the process of freeing the uterus. When this has been done the damaged uterus has already been functionally isolated and at that point one has already passed through the moral issue involved. Whether or not the uterus is now actually removed from the pelvic cavity is without moral significance."

While it is true to say that clamping, ligating and cutting the fallopian tubes is a part of an abdominal hysterectomy, it does not follow that such a division of the tubes is simply the beginning part of a hysterectomy which can be stopped at that point with the same intention and object as the hysterectomy itself. The hysterectomy is an operation of and by itself with a direct intention and object. A tubal ligation is also an operation of and by itself with its own direct intention and object. If one cuts, ligates and divides the fallopian tubes, one is doing a tubal

ligation, one is not doing either a hysterectomy or a first portion of a hysterectomy. To divide the tubes and stop the procedure at that point under the concept of the weakened uterus is an *incomplete hysterectomy* and if the medical justification exists to do a hysterectomy, then performing an incomplete hysterectomy is an unethical application of medical principle (and is an inadequate medical response to the problem which is being treated).

Rupture of the uterus is a rare but very serious complication of pregnancy. The incidence appears to have decreased over the past 20 years (0.04%) in spite of an increase in the number of cesarean sections.[2] Interestingly, nearly 80 percent of uterine ruptures are unassociated with previous cesarean section. The indications for cesarean hysterectomy (hysterectomy performed at the time of cesarean section) would *never* be solved by a "uterine isolation."[3]

There are a variety of medically indicated reasons for cesarean hysterectomy. These include such things as uterine artery laceration at cesarean section, placenta acreta, previa acreta, previa plus post-partum hemorrhage, abruptio plus post-partum hemorrhage, post-partum atonia at cesarean section, cervical intraepithelial neoplasia, microinvasive carcinoma, infection, uterine fibroids, menstrual aberrations, uterine rupture, broad ligament hematoma complicating cesarean delivery, disseminated intravascular coagulation, uterine prolapse, etc. This above list represents the majority of reasons for cesarean hysterectomy whether on an elective or an emergency basis. Only uterine rupture poses the possible concern over the capability of the uterus to carry a subsequent pregnancy.

While there are reports in the literature that relate to cesarean hysterectomies being done for rupture of a previous scar in the uterus most usually resulting from the woman having had a previous cesarean section, this situation is not corrected by tying and dividing the fallopian tubes.

At the time of cesarean section, if the previous scar has either ruptured or dehisced, the baby can still be delivered and that scar can be and should be revised and repaired at the time of that cesarean section leaving the uterus in an acceptable position to sustain a subsequent pregnancy. The appearance of the scar at the time of cesarean section cannot justify the performance of a hysterectomy unless the revision of the scar cannot be adequately treated at the time of the cesarean section and/or there is accompanying major hemorrhage.

Subsequent Pregnancy

If the patient becomes pregnant after such a repair has been made, obviously that pregnancy needs to be followed carefully. If the previous scar in the uterus is a low transverse segment incision, the chances that the scar will rupture in the subsequent pregnancy is extremely rare (about 0.3 percent). If the scar is from a classical, verticle incision, in the uterus and is subsequently repaired, the chances for rupture in a subsequent pregnancy do increase. However, with our ability to monitor such pregnancies by closely following that patient and her baby with frequent visits, educating the patient on the important signs to note, using ultrasound to monitor the thickness of the myometrium and its progressive

thinning, even those pregnancies can be expected to have a good outcome.

While it is true that classical cesarean section scars tend to rupture more frequently (than lower uterine segment scars) prior to the onset of labor, it is also true that most of these pregnancies can go to near term and that appropriate management can be expected to have an excellent outcome for both the mother and the child.

Thus, the physician's judgment that the scar from a previous cesarean section or a previous rupture of the uterus renders that uterus pathologic so that it cannot sustain a subsequent pregnancy is not predicated upon sound medical principles. In addition, and what is extremely important, it shies away from the physician's responsibility to take close care of that patient in subsequent pregnancies. The tremendous pressure that has been placed on physicians in the last 20 years with regard to malpractice has put an unnecessary fear into the physician's practice in situations such as this.

There are other cesarean hysterectomies that are reported in the medical literature but they are simply done for sterilization purposes. These would include such conditions as diabetes, RH sensitization, etc. In those cases, cesarean hysterectomy is clearly being performed for sterilization purposes so that the patient does not become pregnant in the future. Such hysterectomies have nothing to do with the apparent capability of the uterus to carry a subsequent pregnancy.

If one accepts the notion of "uterine isolation", then one could argue that one would not even have to surgically isolate the fallopian tubes at the time of the cesarean section but rather do it at a later time, for example, with the use of hysteroscopically implanted silastic implants placed into the internal ostia of the fallopian tubes. One could legitimately argue, as well, that the use of a diaphragm, cervical cap or condom could be legitimately described as a form of "uterine isolation". The extension of the concept of "uterine isolation" is predicated upon its basic principles and is very dangerous.

A fundamental test of the "uterine isolation" concept would be whether or not anyone would come, at a later time, to consider the reversal of such a "uterine isolation" because of desired pregnancy on the part of that couple or, in a divorce situation, a remarriage. In my own practice, in which I perform tubal reversals, I would not hesitate to consider reversal of that tubal ligation ("uterine isolation") given the circumstances of a previously ruptured Cesarean Section scar with subsequent repair. In addition, I wouldn't hesitate to take care of the woman who became pregnant after such a reversal. Thus, in looking at this, it would be difficult to put such "uterine isolations" to that test and have that test survive. This test, it seems to me, shows the directly sterilizing feature of "uterine isolation" most poignantly.

Ultimately, "uterine isolation" is being performed for strictly contraceptive purposes using repetitive cesarean sections as the excuse and the unfounded contention that the uterus is pathologic and cannot sustain a subsequent pregnancy. In one of the hospitals that I have observed, 47 out of 487 cesarean sections had "uterine isolations" performed in the year 1990, an incidence of 9.6 percent. In the first nine months of 1991, the incidence had increased to

11.5 percent. In this institution, as in others, the doctors talk freely about contraceptive tubal ligations and about discussing these procedures "in their offices" where the ultimate consent is obtained. Such obvious comments as "Do you want me to tie your tubes?" are frequently overheard by nurses in discussions between the doctor and the patient.

Personal Involvement

I would like to point out that I'm not necessarily distant from this whole discussion of the potentially damaged uterus from cesarean section. All of our children have been born by cesarean section. My wife has had five cesarean births. It is true that we took each pregnancy one at a time and, of course, presuming that each surgery went well, we could then make our decisions with regard to subsequent pregnancies. However, our decisions to prevent subsequent pregnancy and any subsequent potential problems that may result from damage to the lower uterine segment, was adequately managed, without difficulty, with the use of natural family planning. This is a critically important point to recognize in the overall discussion of this issue and a point that has, for the most part, been left unaddressed in the fifty-odd years of debate on this subject.

Perhaps this is because in the early days of discussion of this issue, modern methods of natural family planning were not available. Also, it should be pointed out, that the dangers of cesarean section and rupture of the uterus were much more significant in the 1940's and the 1950's than they are in the 1990's. Clearly, progress has been made in all of these areas reducing significantly the overall risks of these procedures.

But, within this context, one also needs to consider the value and the reliability of natural family planning if indeed one is serious with regard to subsequent pregnancies. Table 1 shows the results of three major studies of the Creighton Model Natural Family Planning System conducted in the 1980's. The method effectiveness, to avoid pregnancy, range from 99.1 to 99.9 percent. The use effectiveness to avoid pregnancy (which includes teaching and using error) range from 94.8 to 97.3 percent. This rate has improved in the last ten years mostly because of improvements in the educational technologies which support the delivery of service mechanisms. Indeed, these effectiveness ratings are as good as birth control pills or any other device on the market.

The Catholic institution is not without anything to offer the patient who does not wish a future pregnancy or in whom there are strong medical indications against a subsequent pregnancy. Natural family planning, taught by well-trained natural family planning teachers and applied by the couples with adherence to the instructions to avoid pregnancy, is highly reliable in seeing to it that the goal of avoiding pregnancy is achieved. It is critical, in my view, that in a Catholic institution, the institution not fail to recognize that morally acceptable options are available to these couples and that contortions in moral theology and bioethical positions or medical plans of action *need not be made* to resolve the dilemmas that these couples or their physicians are faced with.

In summary, it is not a "solid probability" that "Uterine Isolation" is not

direct contraceptive sterilization. In fact, it *is* "solidly probable", now that we have several decades of experience in trying to implement this policy, that, it is *direct contraceptive sterilization!* Thus, it is critical that Catholic institutions eliminate such policies and move towards the development of strong, professionally oriented natural family planning programs in all of their institutions.

It should be added, however, that most physicians around the United States and especially most obstetricians-gynecologists are ignorant with regard to the potential that natural family planning has for the solution of these problems. A monolithic attitude has developed amongst the obstetric and gynecologic community with regard to contraception. By that, I mean, contraception of almost any kind is an almost universally approved and accepted practice of obstetrics and gynecology whether one is Catholic or not Catholic. But it does not have to be that way! Since *Humane Vitae,* we have lost nearly two generations of doctors to the dissent that accompanied that encyclical. We can continue their ignorance by promoting programs which allow tubal ligations or we can stimulate them to loof further into natural family planning.

TABLE 1

METHOD AND USE—EFFECTIVENESS TO AVOID PREGNANCY OF THE CREIGHTON MODEL NATURAL FAMILY PLANNING SYSTEM BY ORDINAL MONTH AND CENTER CONDUCTING STUDY

ORDINAL	METHOD EFFECTIVENESS			USE-EFFECTIVENESS		
MONTH	CREIGHTON[1]	WICHITA[2]	HOUSTON[3]	CREIGHTON[1]	WICHITA[2]	HOUSTON[3]
6	99.6	99.4	100.0	95.8	97.3	98.6
12	99.6	99.1	99.9	94.8	96.2	97.3
18	99.6	N/A	99.9	94.6	N/A	97.0
Year of study	1980	1985	1989	-	-	-
Number of couples	559	376	697	-	-	-
Number of couples months	4.957	2,463	7,238	-	-	-

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