The Linacre Quarterly

Volume 68 | Number 3 Article 5

August 2001

Methotrexate, Character, and Casuistry: A Lesson from Machiavelli

Daniel P. Maher

Follow this and additional works at: http://epublications.marquette.edu/lnq

Recommended Citation

Maher, Daniel P. (2001) "Methotrexate, Character, and Casuistry: A Lesson from Machiavelli," *The Linacre Quarterly*: Vol. 68: No. 3, Article 5.
Available at: http://epublications.marquette.edu/lnq/vol68/iss3/5

Methotrexate, Character, and Casuistry: A Lesson from Machiavelli

by

Prof. Daniel P. Maher

The author is Assistant Professor of Philosophy at the Catholic University of America. He has served as editor of Ethics and Medics.

Various recent articles have addressed the morality of the use of methotrexate for the treatment of tubal pregnancies.[1] Authors disagree insofar as they emphasize different features and arrive at different conclusions regarding whether methotrexate treatment for tubal pregnancies is appropriate in Catholic hospitals. Despite their differences, most authors display a remarkable agreement about *what* the fundamental issues are. Typically, an author begins by describing the diagnosis and prognosis of tubal pregnancy and the basic treatment options: expectant management, salpingectomy, salpingostomy, and methotrexate.[2] The morality of each approach is assessed, then, in light of the distinction between direct and indirect abortions. Methotrexate receives extended attention because of its technical advantages over the surgical options and because it is not obvious how to apply to this medical approach moral principles first articulated for surgical procedures. In particular, authors discuss the pharmacology of methotrexate, its relation to the distinction between direct and indirect abortion, the formulation of the *Ethical and Religious Directives for Catholic Health Care Facilities*, the diagnosis of ectopic implantation as itself pathological, and the status of the trophoblastic tissue.

The purpose of this article is twofold: (1) to state the fundamental difficulties of the moral dimension of this problem with somewhat greater concision than has appeared in one place so far; (2) to open an avenue to a solution that is different in kind from any that has appeared so far. For the former, it is sufficient to bring attention succinctly to what has been noted in various places. For the latter, it is necessary to approach the question in a manner completely unlike that adopted by most authors. Most authors

approach the question in a casuistic manner. This means that they try to apply general moral principles to real or imagined cases or situations. The principles, usually drawn at least in part from the *Ethical and Religious Directives*, tend to be conceived legalistically in the sense that they are taken to permit or forbid certain actions, with the result that different treatment modalities are judged "licit" or "illicit." Catholic faith, through the *Ethical and Religious Directives*, is understood to present limitations on the freedom both of patients and of medical personnel within Catholic hospitals. Almost nothing is said about the character of life toward which Catholic faith urges us. Casuistry tends to frame moral phenomena as arising in tension between liberty and obligation or law. In other words, the emphasis of the casuistic approach falls upon whether a particular procedure is proscribed or permitted, not upon the moral character of the person who makes one decision or another in a medical context. This article suggests that it is helpful to look less closely at the law and more closely at the reason for the law. This different approach is not a way of diminishing the significance of moral obligation. Rather, it is a recognition that our moral lives involve more than simply fulfilling the "moral law" in much the same way that raising our children amounts to a good deal more than fulfilling an obligation to provide for offspring.

A Paradigmatic Case

Recently in these pages Peter A. Clark, S.J., Ph.D., has provided an instructive discussion of methotrexate and tubal pregnancies.[3] His essay reviews the medical features of the situation and summarizes the arguments that others have offered both for and against methotrexate. He presents the matter as arising for him in the form of the case of "Judy and Ray." If one were inventing a case in order to present the issue with sharp clarity, one could scarcely do better than Fr. Clark's case. Judy, in her thirties, has one blocked fallopian tube and has just been diagnosed with a tubal ectopic pregnancy. Expectant management may resolve the matter, but runs the risk of tubal rupture and the loss of her functioning fallopian tube. Salpingectomy, full or partial removal of the tube, is also supposed to leave her infertile. Fr. Clark says that salpingostomy is direct abortion, which renders it incompatible with the Catholic faith.[4] Methotrexate, administered systemically or injected directly into the fallopian tube, appears to be the best way to allow her to preserve her fertility. The question that Fr. Clark confronts as a bioethicist is whether methotrexate is "morally justifiable by the Catholic Church."

In this case, the difficulty appears in the confrontation between the noble hopes and desires of Judy and Ray, on the one hand, and the "moral

law" as articulated by the Catholic Church, on the other. Judy and Ray "very much want to have children," but have had difficulty conceiving. Now they find themselves threatened not only with the loss of this pregnancy, but also with the loss of Judy's fertility, if her fallopian tube cannot be preserved. We read that, due to their circumstances, their chances of adoption are "slim." If they very much want children, they very much want to find a way to preserve Judy's fertility. On the other side, Catholic moral teaching, as expressed in the *Ethical and Religious Directives*, is presented as a source of limitations on their therapeutic options. Fr. Clark presents us, then, with an exceptionally pure confrontation between freedom and law: Does the moral law forbidding direct abortion prohibit Judy and Ray from the use of methotrexate or are they free to employ it in an effort to preserve their future fertility?

Four Difficulties

The various articles already published on tubal pregnancy review the clinical details and include references to the medical literature for additional information. It is not necessary to recount that information here. Instead, it is appropriate to draw attention to four areas in which there is some uncertainty that is morally relevant.

First, there is some disagreement about the best way to understand the trophoblastic tissue and placenta. One view is that after conception the early cellular division that results in the differentiation of the cytoblast (or inner cell mass) from the trophoblast should be understood as the emergence of what will yield the embryo proper from tissue or cellular material upon which the embryo is biologically dependent, but from which it is ontologically distinct. On this view, the placenta, too, is understood to be something instrumentally necessary for the fetus, but not an integral part of it. The alternative view asserts that the placenta is an organ of the fetus and that, similarly, the trophoblastic tissue and cytoblast constitute one whole. The fact that the placenta is discarded at birth should not prevent us from recognizing that the placenta develops from the chorionic membrane of the embryo and is significantly (though not exclusively) composed of tissue that is genetically identical to the child. Because the placenta is essential to the child's ability to carry on the processes of acquiring nutrition and eliminating waste (which are necessary for any living being), the placenta must be understood as an organ integral to the fetus. Attention is focused on this disagreement because it can be argued that if the placenta and the trophoblastic tissue from which it arises are integral to the embryo or fetus, then any deliberate destruction of this tissue (medically or surgically) amounts to a direct assault on the life, even the very body of the child.

Alternatively, if it can be convincingly maintained that these tissues are distinct from the child, this may help support the argument that in some circumstances the destruction of these tissues may be fairly cast as only indirectly harmful to the child. This argument would be drawn on the model of the classic case of the removal of a pregnant woman's cancerous uterus. If sufficiently serious reasons can be advanced for the destruction of the placenta or trophoblast, despite the foreseeable consequences for the child, the argument is that this amounts only to an indirect abortion.

Second, there is some uncertainty about the pharmacology of methotrexate. We know that the effect of methotrexate (MTX) is to prevent cellular division by inhibiting DNA replication. "Actively proliferating tissues, such as malignant cells, bone marrow, fetal and trophoblastic cells, dermal epithelium, buccal and intestinal mucosa, and the urinary bladder epithelium, are most susceptible."[5] However, "It is still largely unknown how MTX affects the invasive property of the trophoblast and the growth of placental chorionic villi and why some EPs [ectopic pregnancies] fail to respond to MTX, why tubal ruptures occur, and whether the inflammatory response is influenced by MTX."[6] This makes it unclear whether the effect of the administration of methotrexate is necessarily directly destructive of the embryo proper[7] or it is instead plausible to argue that methotrexate operates only or primarily upon the trophoblastic cells and the maternal cells at the site of implantation.[8] It is easy to see connections between this difficulty and the preceding one regarding the status of the trophoblast or placenta as integral to the developing child. It also bears a relation to the difficulty that will be discussed next.

Third, it can be argued that in the case of a tubal ectopic pregnancy, implantation in the tube amounts to a pathological condition that is life-threatening for both mother and child.[9] As a result, inhibiting or undoing the process of implantation is best understood not as abortion (termination of pregnancy prior to viability) but as a therapeutic intervention to halt and reverse a destructive process that will ultimately lead to the death of the embryo and possibly the mother. In other words, medically (or for that matter surgically) interfering with implantation in the tube has a different clinical meaning than would the same action directed against implantation in the uterus. The eventual death of the child is an indirect result of a directly therapeutic intervention of a serious pathology. The alternative view maintains that the preceding assessment involves a misunderstanding either of the biological facts or of the moral situation. To put it simply we might say that what has just been said to be a therapeutic intervention is in fact the termination of the life of the embryo or of the trophoblastic tissue on which its life depends. In other words, there is no "pathology" here that is independent of the developing child. To characterize the embryo or the

trophoblastic tissue on which it depends as a pathology is an abstraction, ignoring that this is some part of the growing child. Or it is a mistaken view of how methotrexate operates, which does not merely protect or restore to health maternal tissue, but directly destroys fetal tissue, the embryo and/or the tissue on which its life depends.[10]

Fourth, there is some doubt about how to understand the significance of the reformulation of the guidance offered by *The Ethical and Religious Directives for Catholic Health Care Services*. The 1971 version of this document offered a detailed version of the conditions required for intervention relative to ectopic pregnancy.

> In extrauterine pregnancy the affected part of the mother (e.g., cervix, ovary, or fallopian tube) may be removed, even though fetal death is foreseen, provided that:
> (a) the affected part is presumed already to be so damaged and dangerously affected as to warrant its removal, and that
> (b) the operation is not just a separation of the embryo or fetus from its site within the part (which would be a direct abortion from a uterine appendage) and that
> (c) the operation cannot be postponed without notably increasing the danger to the mother.[11]

This version of the *Directives* would appear to require that the mother suffer rather extensive bodily damage or at least be in serious danger of such damage before anything can be done. Methotrexate and some other conservative medical and surgical options are desirable in part precisely because they can be used before the degree of damage described above has occurred. This version of the *Directives* inclines us to believe that acting significantly before serious harm occurs is morally suspect at the least. However that may be, this version has been superseded by the 1994 version, stating succinctly: "In case of an extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."[12] One might argue that the absence of specific prohibitions means that the bishops no longer teach that such prohibitions hold. Obviously, this is not to say that the teaching is reversed, but only to suggest the possibility of applying casuistic reasoning to an area in which Church teaching is not fully explicit or is open to theological dispute.[13] The reformulation in favor of vagueness is taken to invite theological speculation about the moral significance of various treatment options that are available now, when ectopic pregnancy is diagnosable very soon after implantation and before significant damage has been done to the mother's body. Alternatively, one can say that the proper way to read the current version of the *Directives* is in the light of the previous version. The reformulation has no teaching significance and does

not cast doubt on what was taught in the preceding version for more than twenty years. The change could perhaps be explained in other ways besides alleging a specific intention on the part of the bishops no longer to teach what used to be taught.

The need to cope with these four areas of uncertainty simultaneously makes it difficult to see one's way clear to a solution. It is unsurprising to find that people hold divergent views on this complex matter and persist in their disagreement. We will now turn directly to Fr. Clark's handling of this question in order to point the way to a different kind of solution.

Fr. Clark's Analysis

Fr. Clark's analysis is preceded by a summary description of the biology of tubal pregnancy, the action of methotrexate, and then a review of the main features of arguments in favor of and against the use of methotrexate. Both sides of the debate are framed in the traditional moral categories of the "three fonts" (object, intention, and circumstances) and both utilize the principle of double effect. These argument summaries reflect the various sides of the difficulties discussed above. Fr. Clark's own analysis consists of articulating his agreement with the argument in favor of the use of methotrexate. He does not resolve the conflict between the divergent parties of the dispute but allies himself with one side.[14] His analysis does not refute the alternative view, a fact Clark himself acknowledges by turning to the casuistic tradition, specifically *probabilism*, which his paper explains is appropriate when one is in doubt about the lawfulness or lawlessness of an action. Ultimately, Clark concludes that the intrinsic strength of the arguments in favor of the use of methotrexate, which are characterized as "cogent but not conclusive," coupled with the endorsement of these arguments by eminent theologians render "solidly probable" the opinion that one may act in accordance with this opinion, despite the persistence of arguments in favor of the alternative view.[15]

There are limitations to this approach. Objections concerning the quality of his casuistry and of the argumentation in support of the probability of his position have already appeared in these pages.[16] The decisive point, according to the casuists, is that probabilism does not apply in the case under discussion.

> . . . [A]ll the "moral systems" tolerated in the Church (equi-probabalism, probabilism, probabiliorism) agree that the area of application of the rules of prudence has definite limits. It may not be extended so far beyond the sphere of legal obligation as to jeopardize any good essential for salvation. In all cases of doubt, if no other good is at stake

beyond the rectitude of conscience (*honestas agentis*) the rules of prudence may be applied. But if a good transcending the subjective correctness of conscience is placed in jeopardy, a good which we must safeguard, or there is menace of an evil we must shun, the safer way is to be followed in all doubtful cases. The reason is evident. Moral conduct is not to be considered solely in the light of its inner rectitude, but also in its bearing and influence on the order of existence. Because the effects of an act quite frequently do not depend exclusively on the sincere conviction of the agent, it follows that in many cases the safe view (*sententia tutior*, not *sententia certior*) must be followed, even though the opposite position is more probable. this holds good for all in the following instances: if there is question of the valid administration of the sacraments; if one's own salvation is at stake; if the following of a merely probable opinion might result in temporal or spiritual damage to one's neighbor, which we are obliged to avoid.[17]

The import of this for the case at hand is that if one uses methotrexate when one is only probably certain that this is not a direct abortion, one runs the risk of doing just that, bringing about the death of the child directly. To put it bluntly, one does not gamble what one cannot afford to lose. It is not just that "someone" might die as a result of this course of action, but the child, whom both mother and physician have a certain obligation to protect, may die. According to casuistic tradition, the doubts attendant to the case do not support the use ofmethotrexate on the basis ofprobabilism.

Even admitting the central point of the above passage, we are left with the difficulties with which we started. We are left with a practical resolution (different from that of Fr. Clark) in the presence of the uncertainty of our understanding of the situation. In other words, rather than resolving our doubt in favor of freedom, we are doing so in favor of the law or our obligation to avoid possibly becoming responsible for a direct abortion. The persistence of the difficulties reviewed above invites further discussion of these same issues in the light of additional experience with and reflection on these same matters. In other words, the meaning of the result of casuistic reflection is that we know by following this course of action we will not commit a bad action, a violation of the moral law, or a failure in our responsibility. Nevertheless, we do not on this basis understand our action as positively good, noble, or admirable. We know our action as a non-violation of the law. Yet the text quoted above indicates that it is crucial to pay attention to the real world significance of the reasons for the moral law.

The characteristic defect of the casuistic approach is that it embodies

a legalistic understanding of moral good and bad. Even when casuistry shows us the way to what we ought to do, it is difficult to resist the impression that this achievement is akin to following the tax code correctly, taking advantage of those and only those exemptions and deductions allowed to us, but dutifully paying what is required. In casuistry, the emphasis falls on the laws we should obey (or, just possibly, might not have to obey), not on the character of the life we lead by the choices we make. As we all know, following laws is not a complete description of how we should live. A different approach would pay more attention to character of life and less to a narrow focus on fulfilling obligations.

A Different Approach: Emphasizing Character

Machiavelli, who knew something about the difference between the way we should live and the way we actually do live, knew also about the power of seeming to be other than we are. Although most people judge others by appearances, our character (or what we are) is more fundamental than what we seem to be. Few people are nothing more than what they seem to be at first sight and we can come to much more adequate assessments of others by examining what they say and do, which are indications of character. Machiavelli illustrates this in his play *Mahdragola*, in which one character, Ligurio, tries to assess another, Timoteo, who is a priest. Ligurio asks the priest to help his friend (Nicia) with a "strange case," in which Nicia's relative—a young, unmarried woman in the care of a convent—has become pregnant. Ligurio explains that the woman's family is prepared to grant Fr. Timoteo a large sum of money for charitable works if the priest can "remedy" this situation. Timoteo has been predisposed to assist and when he learns that his role would consist of "persuading the abbess to give the girl a potion to make her miscarry," he responds that this is "something to be thought over." Ligurio helps him to think it over by stating the situation with exceptional clarity:

> Keep in mind, in doing this, how many goods will result from it; you maintain the honor of the convent, of the girl, of her relatives; you restore a daughter to her father; you satisfy [Nicia] here, and so many of his relatives; you do as much charity as you can with these three hundred ducats; and on the other side, you don't offend anything but a piece of unborn flesh, without sense, which could be dispersed in a thousand ways.[18]

Ligurio describes a situation and supports his proposal with a textbook-quality utilitarian calculation. If we are offended by Ligurio's proposal and

dispirited by Timoteo's acceptance of it, we can remind ourselves that, according to the play, the girl and the situation are complete fictions. Ligurio invents this case in order to see what kind of priest Timoteo is.[19] Not the case, but the priest's character is the central concern. Timoteo is not a scoundrel; he apparently is genuinely interested in performing charitable deeds. Nevertheless, his zeal for good works renders him willing to overlook some significant points of theology and to be used by the crafty Ligurio. Timoteo is not a crude hypocrite with a hidden life that is completely inconsistent with his priesthood. Timoteo needs to be able to make his actions appear *to himself* to be consistent with his priesthood. When Timoteo assents to Ligurio's proposal in the strange case, he reveals his character and Ligurio knows he has found the kind of priest he needs.

Timoteo's character is important to Ligurio because he wants the priest to persuade an overtly pious woman that it is no sin for her to commit adultery in order to become pregnant. Ligurio's scheme is complicated. It involves giving the woman what is supposed to be a fertility potion, one consequence of which is said to be that the first man to have sexual relations with her will die. The remedy for this is to substitute someone besides her husband, who agrees with the scheme because he desperately wants a child. At first the woman recoils from the manifest immorality of the plan, but in conversation with Fr. Timoteo she is or appears to be easily confused. She can be led to rely not upon her own judgment or conscience, but upon that of the priest. Ligurio enlists also the aid of the woman's mother, who assures her daughter: "I have told you and tell you again that if Frate Timoteo tells you that there's no burden of conscience here, you may do it without thinking about it."[20] Fr. Timoteo is confident that he can convince the woman because her goodness will incline her to trust him and his greater expertise in complex moral theology will enable him to recast her strange case. He tells her that he spent hours at his books studying her case and found that "As to the conscience, you have to take this general principle: that where there is a certain good and an uncertain evil, one should never leave that good for fear of that evil." So she ought to pursue what is certain (pregnancy) over what the priest says is doubtful (the death of her partner in adultery). Fr. Timoteo swears to her by his consecrated heart that she should obey her husband and she finally agrees.[21]

It is useful to consider this portion of *Mandragola* because it clearly illustrates both why casuistry tends to arise and its limitations. In addition to the limitations already mentioned, it is important to recognize another, the significance of which is not often appreciated. The difficulty involved with correctly interpreting, applying, and following complex moral laws that admit extensive and subtle distinctions (not to mention the importance of doing so correctly) leads to the reliance of ordinary people upon experts.

This is one important reason that casuistry tends to arise. Ordinary people, who must execute decisions, come to disbelieve in their ability to understand the moral dimension of their actions. They rely more or less blindly upon experts in the law, those who are skilled with the terminology of reflex principles, kinds of conscience, degrees of probability, and so on. This opens the space for "experts," like Fr. Timoteo, who are able to lead people (who may well be innocent) into perverse interpretations of the moral law. Alternatively, it opens the space for less innocent people like Ligurio to "shop around" for a priest who will tell them that something they want to do is "no burden of conscience."

Resolution

Looking, then, at Fr. Clark's case, not through the lens of casuistry's rules for resolution of doubt, but with an eye attentive to the moral features of actions, we notice that it reduces to this: A woman wishes to have a child; she is in fact pregnant, but there is no reason to suppose that this child will survive to term.[22] Moreover, there is good reason to think that the use of methotrexate offers the best if not the only chance of her ever giving birth to a child in the future. Even if we allow the controversial or problematic belief that methotrexate brings about the death of the embryo only indirectly,[23] we must recognize that the child will die as a result of this intervention. In the absence of an immediate threat to the mother's life, what justifies an intervention with fatal consequences for the embryo? The answer can only be the goal of protecting the mother's fertility so that she might later satisfy her wish to give birth. In other words, faced with this situation, the woman who elects to use methotrexate determines that that desire is the paramount concern. To the extent that methotrexate is desirable because it offers the best hope for future fertility, despite its possible or probable abortifacient quality, the decision to use methotrexate in this situation amounts to a willingness to cause the death of *this child*, at least indirectly, not because one's own life is in danger, but because one's own desire is in danger of being frustrated. The woman's character as revealed or constituted by such a decision is not so much a matter of the contradiction between a desire for a child and the destruction of a child. Instead, the woman's character is established in the pursuit of her desire for a child despite the presence of this other child, who does not apparently satisfy her desire and who presents an obstacle to the satisfaction of her desire. Her attachment to her noble and generous concern for a child obscures her appreciation of the cost of satisfying that concern in her unfortunate circumstances, that is, it makes her less than generously protective of the life of the child within her.

The focus on character may seem to amount to an effort to pass

judgment on people who are forced by circumstances to make difficult decisions under great strain, which passing of judgment is understood to be objectionable in principle. In a sense this is true, but not in a sense that makes it objectionable. To pass judgment on the type of character revealed or constituted by the type of decision under discussion is not to make a personal condemnation of the individual involved. The subjective moral dimension (the personal responsibility of the mother, physician, and various others and their moral standing in the eyes of God) is not here at issue.[24] All of this means that to reject the use of methotrexate in the situation under discussion on the basis of the character its use forms is akin to condemning as bad the kinds of acts that make people cowardly, self-indulgent, or selfish or to praising as good the kinds of acts that make people courageous, moderate, or gentle. We can and must pass this sort of judgment without assessing the subjective moral standing of individuals and the various mitigating circumstances that can be expected to modify the moral responsibility of people who make serious decisions in difficult situations. It is incomparably easier to analyze the moral features of this sort of situation in advance than it is to make a good decision in a clinical setting. It is for this reason that we try to identify what action is best before we face the pressure of the clinical setting. In other words, the tensions that might exculpate an individual who makes a decision under pressure are not necessarily relevant to those who must say, under a cooler light and free of pressure, what decision would be best and what action they would hope to have the strength to perform.

It is probably helpful to state more directly the conclusion of this line of reasoning. In the case of Judy and Ray methotrexate offers hope of preserving Judy's life and health (i.e., future fertility) although it will also result in the death of the embryo within her. This latter consequence is justifiable, if it is justifiable, because something equally serious, Judy's life, is at stake and the embryo's death results indirectly from the protection of Judy's life. But Judy's life is not at stake. She would not be a candidate for methotrexate treatment if her life were in any serious danger; medical treatment is pursued when other considerations are more important (cost, surgical risks, etc.).[25] As the case is described to us, the paramount concern is the preservation of her future fertility. More precisely, it is not her fertility in the abstract that is at issue, but her stated desire to have a child. The argument is based upon the wish to be able to satisfy her desire. The impulse to avoid the stern possibility that the satisfaction of her desire might not be available is the basis for the argument in favor of methotrexate in this case. Rather than allowing this impulse to govern our view of what should be done, it is appropriate to look at the action to which this thinking leads. Just as any mother would sacrifice her future fertility to save the life of her living

child, Judy should be encouraged to accept that she is already a mother and must face the possibility that responsible care for the life within her might have serious consequences for her.[26]

Fr. Clark implies but does not state explicitly that Judy and Ray are Catholic and that they are married. If they are, perhaps they can be persuaded to recognize that the goodness or nobility of their desire to have children is not due to the fact that it is their fervent desire, but because of its coherence with their state of life and the life to which God calls them. The pain of their situation, and the possibility that they will never raise children of their own, suggests that God's plan for them may not be what they thought it was. They display and constitute their character as good parents when they generously accept the child that they actually have without allowing their wish for a different child to cause them to overlook the significance of this life. The character of the action that they take reveals its goodness or its badness when we look at it from this perspective much more clearly than when we look primarily to the terms and technicalities of the law.

Concluding Statement

In the approach offered here, actions are assessed not merely for their conformity to law but primarily for what they determine us to be. It may seem that this perspective is too global or vague and that it lacks the sophistication or precision that seems to be necessary for appreciating the many intricacies of this issue. It may seem that this approach renders the matter too simply without coming to terms with the doubts and difficulties reviewed above. On the contrary, excessive attention to the technicalities of the medical[27] and casuistic dimensions of this matter has drawn attention away from the primary moral features, which are visible especially, if not exclusively, from this perspective. The point is that actions are good or bad based upon what they are and what kind of life is embraced by performing those actions. Some actions are incongruent with a noble, good, or holy life. It is for this reason that people speak of moral laws forbidding them. In order to evaluate courses of action, it is the real-world meaning of those actions to which we must primarily appeal, not to the terms and technicalities of the law.

It might also seem that this approach is equally open to the kind of abuse of moral reasoning that Machiavelli portrays. It might seem that the approach presented here amounts to no more than casting decisions in good light or bad light and that the same decision can easily be cast in both ways. This may perhaps be true and may be an inescapable feature of all moral reasoning. There remains, however, this advantage over the casuistic

approach. Here, our attention is drawn to the primary moral phenomena, not to the formulations of the law. The difference between a good and bad appraisal of the moral character of an action will be established by its adequacy in dealing with all of the moral features of the action. Even in Machiavelli's case, we are forced to take Fr. Timoteo's word for what he has found in his books, but the moral corruption of the various characters in the play is manifestly clear. We do best to attend to the moral phenomena in the world.

Interest in using methotrexate to treat ectopic pregnancy has been growing for the past twenty years. Salpingostomy is still the "gold standard," but methotrexate is increasingly common in some places for selected patients.[28] There is reason to expect that methotrexate and other forms of medical management will become more widespread in the future, considering the enthusiasm with which it has been received by some: "The use of methotrexate for the treatment of EP may be one of the greatest advances in gynecology in this century."[29] Plainly, this evaluation is possible only for someone who is indifferent to the significance of this treatment for the unfortunate but not yet irrelevant developing embryo. Concern for this life must be displayed, if it is not to be extinguished entirely, primarily by noble and generous actions of people in difficult circumstances and secondarily by prudent counsel from those who advise them.

References

1. Peter A. Clark, S.J., "Methotrexate and Tubal Pregnancies: Direct or Indirect Abortion?" *Linacre Quarterly* 67:1 (February 2000): 7-24; John Foran, "Ectopic Pregnancy: Current Treatment Options, deja vu Humanae Vitae," *Linacre Quarterly* 66:1 (January 1999): 21-28; William E. May, "Methotrexate and Ectopic Pregnancy," *Ethics & Medics* 23:3 (March 1998): 1-3; William E. May, "The Management of Ectopic Pregnancies: A Moral Analysis," *The Fetal Tissue Issue: Medical and Ethical Aspects*, ed. Peter J. Cataldo and Albert S. Moraczewski, O.P., (Braintree, Mass.: Pope John Center, 1994), 121-47; Albert S. Moraczewski, O.P., "Ectopic Pregnancy Revisited," *Ethics & Medics* 23:3 (March 1998): 3-4; Albert S. Moraczewski, O.P., "Tubal Pregnancies: Part I," *Ethics & Medics* 21:6 (June 1996): 3-4; Albert S. Moraczewski, O.P., "Tubal Pregnancies: Part II," *Ethics & Medics* 21:8 (August 1996): 3-4; Jack Healy, "Ectopic Pregnancy and Methotrexate," *Linacre Quarterly* 63:3 (August 1996): 95-96; John F. Tuohey, "The Implications of the *Ethical and Religious Directives for Catholic Health Care Services* on the Clinical Practice of Resolving Ectopic Pregnancies," *Louvain*

Studies 20 (1995): 41-57.

2. For descriptions and variations of these procedures see: Togas Tulandi, "New Protocols for Ectopic Pregnancy," *Contemporary OB/GYN* 44:10 (1999): 42-55; Susie Lau and Togas Tulandi, "Conservative Medical and Surgical Management of Interstitial Ectopic Pregnancy," *Fertility and Sterility* 72:2 (August 1999): 207-215; a collection of articles under the general title "Modern Diagnosis and Management of Ectopic Pregnancy," ed. Sandra Ann Carson, *Clinical Obstetrics and Gynecology* 42:1 (March 1999): 1-56; LaRynda D. Thoen and Mitchell D. Creinin, "Medical Treatment of Ectopic Pregnancy with Methotrexate," *Fertility and Sterility* 68:4 (October 1997): 727-30; Mylene Yao and Togas Tulandi, "Current Status of Surgical and Nonsurgical Management of Ectopic Pregnancy," *Fertility and Sterility* 67 (March 1997): 421–33; Charlotte Floridon, *et al.*, "Ectopic Pregnancy: Histopathology and Assessment of Cell Proliferation with and without Methotrexate Treatment," *Fertility and Sterility* 65:4 (April 1996): 730-738; Sandra A. Carson and John E. Buster, "Ectopic Pregnancy," *The New England Journal of Medicine* 329:16 (14 Oct. 1993): 1174-81.

3. Peter A. Clark, S.J., Ph.D., "Methotrexate and Tubal Pregnancies: Direct or Indirect Abortion?" *Linacre Quarterly* 67:1 (February 2000): 7–24

4. Ibid., 10.

5. Rebeccca Rogers Prevost, Thomas G. Stovall, and Frank W. Ling, "Methotrexate for Treatment of Unruptured Ectopic Pregnancy," *Clinical Pharmacy* 11 (June 1992): p. 529.

6. Charlotte Floridon *et al*. "Ectopic Pregnancy: Histopathology and Assessment of Cell Proliferation with and without Methotrexate Treatment," *Fertility and Sterility* 65:4 (April 1996) 736.

7. It almost surely must be directly destructive of the embryo proper when it is injected directly into the gestational sac (a method mentioned occasionally in the medical literature), as distinct from being administered systemically, intramuscularly, or by direct injection into the affected fallopian tube. See Sandra A. Carson and John E. Buster, "Ectopic Pregnancy," *The New England Journal of Medicine* 329:16 (14 Oct. 1993): 1174-81.

8. See, for instance, Albert S. Moraczewski, O.P., "Managing Tubal Pregnancies: Part II," *Ethics & Medics* 21:8 (August 1996): 3-4 and "Ectopic Pregnancy Revisited," *Ethics & Medics* 23:3 (March 1998) 3-4.

9. Albert S. Moraczewski, O.P., "Managing Tubal Pregnancies: Part I," *Ethics & Medics* 21:6 (June 1996): 3-4.

10. See William E. May, "Methotrexate and Ectopic Pregnancy," *Ethics & Medics*, 23:3 (March 1998): 1-3.

11. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, D.C.: United States Catholic Conference, 1971), directive 16.

12. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, D.C.: United States Catholic Conference, 1994), directive 48.

13. See John F. Tuohey, "The Implications of the *Ethical and Religious Directives for Catholic Health Care Services* on the Clinical Practice of Resolving Ectopic Pregnancies," *Louvain Studies* 20 (1995) 42.

14. It seems that the only new element in Clark's analysis is his interpretation of the proportionate reason clause of the principle of double effect according to Richard McCormick's criteria for determining "whether the value of preserving the health and life of the mother outweighs the premoral evil of the foreseen but unintended death of the nonviable human embryo" (Clark, p. 16).

15. Ibid., p. 18.

16. See the letter to the editor by Karen D. Pochailos in *Linacre Quarterly* 67:1 (February 2000): 4-6; and three separate letters from Fr. Anthony Zimmerman, Eugene F. Diamond, and John E. Foran in *Linacre Quarterly* 67:3 (August 2000): 4-7.

17. Bernard Häring, C.SS.R., *The Law of Christ*, vol. 1, tr. Edwin G. Kaiser, C.PP.S., (Westminster, Md.: The Newman Press, 1961), 183. One finds similar restrictions on probabilism in other casuists. See Henry Davis, S.J., *Moral and Pastoral Theology*, 3rd ed., vol. 1 (New York: Sheed and Ward, 1938), esp. 96-100; John A. McHugh, O.P., and Charles J. Callan, O.P., *Moral Theology*, vol. 1 (New York: Joseph F. Wagner, Inc., 1929), esp. 237-40 and 252. Additionally, see the letter of Fr. Anthony Zimmerman in *Linacre Quarterly* 67:3 (August 2000): 4.

18. Machiavelli, *Mandragola* trans. Mera J. Flaumenhaft (Prospect Heights, Ill.: Waveland Press, 1981), Act III, scene 5.

19. Fr. Timoteo himself announces that he realizes this in Act III, scene 9

20. Act III, scene 10.

21. Act III, scene 11.

22. This euphemistic formulation is not meant to deny the nearly absolute certainty

of the death of the embryo in cases of tubal pregnancy. The point, rather, is to emphasize that death is a certainty for all of us, so that for each of us the outcome is already assured and it is always only a matter of time. It should perhaps be emphasized that in the course of this analysis of the use of methotrexate we assume that the case includes a living human embryo. Without this assumption, the case loses its moral significance. Diagnosing embryonic death removes the moral problem.

23. One might offer the argument that embryonic death is indirect either because the trophoblast is understood not to be a part of the embryo or because methotrexate is understood to constitute a therapeutic treatment addressed to a pathological site of implantation (assuming, again, something uncertain, viz., that this interpretation is consistent with Catholic faith).

24. It is appropriate at this stage to point out that this is a matter pertaining not only to the woman, but also or especially to the moral character of the physician and those who cooperate in whatever decision is taken and to the moral character of those who advise one course of action or another (albeit, not subjectively, but objectively).

25. "Technologic advances now allow routine diagnosis of ectopic pregnancy before clinical symptoms. Although early diagnosis may contribute to a higher incidence, it also has contributed to a concomitant decline in morbidity, deaths, and treatment costs. Further, timely and early diagnosis has made this disorder amenable to medical therapy with success rates similar to traditional surgical management with lower rates of persistence and lower cost. Ectopic pregnancy, when it is managed correctly, clearly has evolved into a medical disease where surgery should be required only for delayed diagnosis or complications." John E. Buster and Margareta D. Pisarska, "Medical Management of Ectopic Pregnancy," *Clinical Obstetrics and Gynecology* 42:1 (March 1999): 29.

26. It is worth calling to mind again that there is no guarantee that Judy will have to sacrifice anything. The embryo within her might well die of natural causes, which would make it appropriate to remove any remaining tissue by whatever means is judged medically appropriate. Salpingectomy is not the only alternative to medical treatment. There is also expectant management. See Matthew A. Cohen and Mark V. Sauer, "Expectant Management of Ectopic Pregnancy," *Clinical Obstetrics and Gynecology* 42:1 (March 1999): 48-54

27. It should be noted in passing that there are other medical treatments for ectopic pregnancy and that subtle differences in their various modes of action do not alter the fundamental moral meaning of their use. That is to say, the argument of this paper is not limited to methotrexate. See Sophie Christin-Maitre, Philippe Bouchard, and Irving M. Spitz, "Medical Termination of Pregnancy," *The New England Journal of Medicine* 342:13 (30 March 2000): 946-956.

28. "In women who wish to preserve their fertility, conservative surgery by linear salpingostomy is considered the gold standard for the management of ectopic pregnancy," Togas Tulandi and Ahmed Saleh, "Surgical Management of Ectopic Pregnancy," *Clinical Obstetrics and Gynecology* 42:1 (March 1999): 32. In the same issue of that journal see also John E. Buster and Margareta D. Pisarska, "Medical Management of Ectopic Pregnancy," 24.

29. LaRynda D. Thoen and Mitchell D. Creinin, "Medical Treatment of Ectopic Pregnancy with Methotrexate," *Fertility and Sterility* 68:4 (October 1997): 730.