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Abortion, Sterilization, and Physician Assisted Suicide: Moral Medical Decision Making Via the Discernment Theory

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**ABORTION, STERILIZATION, AND PHYSICIAN-ASSISTED SUICIDE: MORAL
MEDICAL DECISION MAKING VIA THE DISCERNMENT THEORY**

**A thesis submitted to
Regis College
The Honors Program
in partial fulfillment of the requirements
for Graduation with Honors**

by

Alexandra Lynch

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I. INTRODUCTION:

During my time at Regis, I have constantly revisited one question: how can I, as an aspiring physician of faith, balance my moral obligation—that which comes from the overall Catholic Church—with my medical obligation—that which comes with the territory of being a physician? I entered Regis fairly confident of my desire to become a physician, yet also fairly assertive of my religious and moral beliefs. I remember contemplating how I, as an aspiring physician of faith, could balance these two integral parts of myself as early as my freshman honors seminar. In fact, I wrote a paper suggesting that a Jesuit undergraduate university like Regis is the best undergraduate option for an aspiring physician of faith, due to its integration of science and faith. I discovered that I felt at peace at Regis—Regis enabled me to explore my passion for the sciences, while simultaneously exploring my faith.

As my time at Regis progressed, I found myself asking my initial question more frequently and ardently. During the summer following my freshman year, I began volunteering with the Denver Hospice. This involvement marked the first time I truly felt called to medicine, instead of simply pursuing an academic interest. At Denver Hospice, I discovered that I could explore my passion for medicine and the lives it touches while fulfilling the vocation I feel called to by God. Since this was my first true experience integrating faith and medicine, my initial question became even heavier on my heart. A year later, as I shadowed physicians in Lutheran Hospital's Emergency Room, my

question became more than theoretical—it became practical. I was forced to acknowledge that since these two parts of me exist, they must be reconciled somehow. Like Cook, author in the *American Journal of Bioethics*, I realized that my moral decision making as a physician is dependent upon two levels: “context and content of moral education in light of my own religious, philosophical, social and cultural beliefs, practices and outlooks” and “the professionalism that inevitably occurs when I become part of a professional group or institution such as a medical school or hospital” (Cook, 2007). Cook remarks that it is important for a physician to not only become a part of the institution, but also, remain true to her own background, maintaining integrity in her own person. Practically speaking, what does this look like? On a day-to-day basis, how does a physician of faith balance these two parts of herself in her medical practice? How do her actions differ from physicians who perhaps do not have moral obligation, in the way I have defined it here?

As I continued to engage in medical service endeavors—volunteering with Camp Wapiyapi (a childhood cancer camp), spending time in the oncology floor playroom at Children’s Hospital, and volunteering with the Rocky Mountain MS Center—and shadow physicians—shadowing, among others, a general surgeon at North Suburban Hospital, a pediatrician at Lutheran Hospital, and a pediatric oncologist at Children’s Hospital—I found that these questions were ones I could not ignore. I felt that I owed it to myself to truly explore these questions, finding some way to reconcile my moral and medical obligations. Then, in my junior honors seminar, “Justice for All”, I was given the opportunity to write a paper on the morality of physician assisted suicide. Initially, I saw

this as nothing more than a chance to explore a complex issue; over time, though, I realized this issue started to address my initial question: how does a physician of faith balance moral obligation with medical practice? Through this paper, I began to see where I personally draw the line between moral and medical obligations; I began to discover that moral obligation is of great importance to me. Similarly, Rawls, in *Justice: What's the Right Thing to do*, acknowledges that, “people often have affections, devotions, and loyalties that they believe they would not, indeed could and should not, stand apart from” (Sandel, 2009). For me, these loyalties can be traced to my moral obligation associated with my Catholic faith.

Yet, I also wondered if my moral obligation could take precedence in every medical situation, and if moral laws could truly account for the variety of nuanced cases I would encounter while practicing medicine? Are there certain situations that provide sufficient reason to deviate from moral law? If so, how do we differentiate these situations from others—what makes deviation from moral law acceptable in some cases and not others? Given the importance of these questions to my future, I decided to more fully explore them for my thesis project. I hoped to gain some clarity as to how I can, and perhaps should, balance my moral and medical obligations. Yet, before I could begin to answer these initial questions, I first had to determine a suitable approach to guide moral medical decision making.

II. DEONTOLOGICAL, TELEOLOGICAL AND DISCERNMENT THEORIES:

In order to make a moral decision, we must first decide how we would like to approach moral decision making. Initially, this task seems simple enough; in reality, it is much more involved. There are numerous approaches to moral decision making, each with its own stipulations as to what dictates, or how to best arrive at a moral decision. Given these various approaches and stipulations, it is not only possible, but probable, that different theories be in direct opposition to one another. This is certainly the case for the deontological theory and the teleological theory. The deontological approach “begins with the basic values of human life and holds that we cannot act directly against these values” (Overberg, 1998). According to the deontological theory, certain acts are blatantly right or wrong, regardless of circumstance. In order to fully understand this approach, its underlying principles and assumptions must first be defined.

A human act, according to the deontological approach, is one that is performed with intellect, will, knowledge, and consent. An act may be good or evil, and implies a choice between two alternatives. The components of this choice are the same for any act: object, intention, and circumstances. The object refers to the action itself, and ultimately, determines morality. The object determines morality because an action receives goodness from the morality of the act. Thus, when the moral object is in itself evil, the action is thereby evil, regardless of circumstances (Armenio, 2008). The intention refers to the motive for which a person commits an act. Yet, it is important to note that the result of an

action is not necessarily the product of the intention; it is possible to perform an act with a specific intention in mind, yet achieve a different result. This notion is particularly relevant within medicine.

Consider, for instance, the case of a pregnant woman who is extremely ill. Sometimes, in an attempt to save the mother, the fetus may indirectly be lost. In this case, the result of the action taken, loss of the fetus, is not the product of the intention, to save the mother's life. Since the intention of this act was not to abort the child but to save the mother, this act can still be morally good and permissible by way of the deontological theory. An act performed with a good intention can in fact decrease the guilt of a morally bad act. Thus, in the case described above, the good intention of saving the mother should decrease the guilt of a morally bad abortion (Armenio, 2008).

However, the deontological theory also maintains that a good intention cannot make an intrinsically evil act good. While the intention to save the mother can lessen the guilt associated with an accidental abortion, it does not actually make abortion good as an act. The circumstances occur with or around the act, and contribute to the morality of the act. There are six circumstances that are considered: who-the person acting, what-the act done, where-the place where the act occurs, why-the immediate situation of a particular action or additional reason for performing the act, how-the manner in which the act is done and when-the time of the act (Armenio, 2008). Not all of these circumstances influence the morality of the act in the same manner, or carry the same weight. Yet, regardless of each circumstance's influence, the circumstances of an act alone cannot

make an intrinsically evil action good. In this sense, circumstances are the least influential of the three components in determining whether an act is good or evil—ultimately, the divisions of good and evil are objective, as opposed to subjective, according to the deontological approach (Armenio, 2008).

Yet, what if the opposite were considered true? What if the divisions of good and evil were considered more subjective and context-based rather than objective? When good and evil are considered subjective divisions, the approach that ensues refers to the teleological theory. According to the teleological approach, the decision-maker should look at the goal or consequences of the decision, focusing on the particular situation (Overberg, 1998). Referring back to the abortion example, the teleological approach holds that circumstances alone can determine the morality of an abortion. The teleological approach argues that the end justifies the means, and may take on one of the following forms: situation ethics, consequentialism, or proportionalism (Armenio, 2008).

In situation ethics, it is believed that moral good and evil result from the situation involved. This form of ethics maintains that moral conduct cannot be guided by universal principles, but rather, an act can be judged only in light of the circumstances involved (Armenio, 2008). Consider, for instance, the following scenario: a frightened fifteen year old girl walks into the doctor's office. The look upon her face is one of sheer terror, and her lip trembles as she begins to explain: it was simply a mistake. She acknowledges her own part in the act, but also expresses that she is not yet ready to be a mother at fifteen. She has not finished high school, her family cannot financially support a child, and the

father is nowhere to be found. Consider, then, a different scenario: a thirty-five year old happily married woman walks into the same doctor's office. She explains that she and her husband simply do not want another child, and are content with their family as is. The teleological approach, by way of situation ethics, would allow that an abortion be granted to the desperate fifteen year old girl but not the content thirty-five year old woman, solely because of circumstances.

In consequentialism, moral concepts of good and evil are derived from the consequences of an action. This theory is similar to situational ethics, in that the act itself is not being judged (Armenio, 2008). In consequentialism, if the consequences that result from an abortion—happiness for the mother, burden removed from the mother, a sustained relationship for the mother and father—are good, then the act of abortion is thereby good. This theory is in direct conflict with the deontological approach—the deontological theory would hold that consequentialism can be used to incorrectly deem an evil act good or a good act evil (Armenio, 2008). Consider, for instance, a patient who has been involved in a car accident and is suffering blunt trauma. If a trauma surgeon tries her very best to save this man's life yet fails, consequentialism would claim her actions evil, since the consequence, losing a life, is evil. Thus, the deontological approach would take issue with this theory in that the effect of the action is overvalued while the principal set is ignored.

The theory of proportionalism is simply a variation of consequentialism. In proportionalism, the morality of an act is justified by the proportion of the effects that

follow (Armenio, 2008). Thus, if the evil that follows is less than the amount of good that results, the act is considered good. According to proportionalism, if the evil that results from an abortion is considered less than the amount of good that results for the mother, then the abortion is considered a good act. The difficulty with this theory, according to the deontological approach, is that seemingly any act may be justified or deemed permissible on these grounds. Proportionalism, by relying heavily upon subjective experience, makes it difficult to determine who decides what is “more” or “less” good in each situation (Armenio, 2008).

Situation ethics, consequentialism, and proportionalism are problematic as ethical frameworks—by viewing good and evil as primarily subjective, the teleological theory diminishes the role of law in morality, enabling a sense of moral relativism. Yet, is there also a flaw in viewing good and evil as entirely objective divisions? If good and evil are approached in an entirely objective manner, there seems to be little room for exception from moral laws. Is moral decision making really this black and white? Are there not particular instances in which deviations from the rule may be justified or even necessary? It seems that refusing to acknowledge such exceptions also implies a refusal to acknowledge the “ambiguity of moral issues and the dynamism of life” (Overberg, 1998). According to Overberg, this dynamism is linked to embodiment: the fact that we are “body” people. Acknowledging that we are “body” people means also acknowledging that we live in a particular time and culture—we cannot escape the influence of culture (Overberg, 1998). While culture does not define us, it does shape us. This shaping, then,

implies that we, as humans are open to change. An openness to change recognizes ambiguity within moral issues.

Embodiment is one of six intrinsic human qualities that Overberg argues all humans possess. Aside from body, we are also spirit; meaning, as humans, “we are reflective beings, persons who can think—even debate with ourselves—about our actions” (Overberg, 1998). If we as human beings possess the power to reflect upon our actions, perhaps we also have the ability to think critically about extenuating circumstances that may be exceptions to the normal rule. Overberg argues that as body-spirit people, we are social. We are interdependent, and thus, it is through discussion with others that we can arrive at a better sense of good and evil, reconciliation perhaps, in the most challenging of circumstances. In addition to these, Overberg argues that we are all also unique, implying that each individual possesses the ability to think critically, in his or her own way, regarding decision making. Along with this uniqueness, we are also free—free to choose to be truly human or not. Finally, as humans, we all have a capacity to be in relationship with God. However, this capacity does not guarantee fulfillment; freedom allows for each individual to decide whether or not to enter into this covenant with God (Overberg, 2008).

In explaining these six intrinsic human characteristics, Overberg is careful to note that while each individual does indeed possess the ability to decide, the decision does not determine the morality of the situation. For example, if a pregnant woman chooses to abort her fetus for financial reasons, her decision does not determine the morality of

having an abortion. Rather, reality is the basis of morality. The reality, “whether the act promotes or destroys the truly human,” determines morality (Overberg, 1998). Thus, when assessing whether an act promotes or destroys what it means to be truly human, perhaps the question is not “what ought I to do,” but rather “what ought I to be” (Overberg, 1998). Yet, even when framing decisions in the context of “what ought I to be,” each individual decision of “what ought I to do” is often times not an easy one. This difficulty can perhaps be partially attributed to the fact that few of our decisions are between absolute good and evil (Overberg, 1998). Rather, the majority of our decisions require us to think deeper, analyzing a somewhat ambiguous situation. How, then, should we resolve this ambiguity?

The deontological approach, instead of resolving the ambiguity associated with moral decision making, fails to address it altogether. This approach does not allow exceptions to a given moral law, even in particularly confusing or intricate circumstances. How practical is an approach that refuses to allow exceptions or acknowledge that different situations present different difficulties? Can the deontological approach truly account for the wide array of moral dilemmas that we encounter as humans? Is it possible for broad, over-arching laws to remain applicable for the myriad of situational possibilities surrounding the law? The deontological approach certainly does not seem adequate to account for the variety of moral dilemmas, in that it fails to acknowledge complicated ambiguities.

The teleological approach, on the other hand, perhaps addresses these ambiguities a little too well. While this approach can better account for confusing or intricate circumstances, it presents a new concern: teleology allows the end of an act to justify the means. If the teleological approach is followed, it seems that nearly any act could be justified, based upon the particular circumstances. Teleology overlooks the influence of reality in morality, and does not strive to uphold law.

If both of these extreme approaches, deontology and teleology, are inadequate and flawed for making decisions, perhaps a middle-ground approach should be employed: discernment theory. In discernment theory, the value and wisdom of law, firmly rooted in reality, is combined with the uniqueness of each situation (Overberg, 1998). Thus, the discernment approach suggests that law should indeed guide decision making, but should not, and perhaps cannot, hold true in every situation. Rather, law is an ideal to strive for, one that discernment followers realize must be broken in certain situations. By accepting the significance of the concrete situation, discernment avoids blind obedience to the law; by rooting itself in reality, discernment avoids relativism (Overberg, 1998). The discernment theory provides a law-based, yet comprehensive, approach to moral decision making.

Though the discernment theory allows exceptions to moral law in particular circumstances, it is important to note that not just any reason is sufficient to deviate from a given law. Rather, a reason is sufficient only when “the act supports the value in question and does not contradict or undermine it” (Overberg, 1998). To better illustrate

this principle, consider the act of an amputation. An amputation seems to be in conflict with the moral law that dictates we preserve and take care of our bodies (Overberg, 1998). By itself, an amputation is not a “good” act, and should not be performed under normal circumstances. Thus, in order to assess an amputation, we must know why it is being performed. An amputation may be necessary in order to save an individual’s life, in which case the greater value of life outweighs the value of having two arms (Overberg, 1998). In this case, an amputation actually supports the value of life at stake, rather than contradicting or destroying it.

Without knowing the context in which an amputation is performed, it may be considered evil. Yet, is it really fair to deem an amputation evil without knowing the circumstances surrounding the amputation? An act whose morality cannot be judged until knowing the surrounding circumstances is, according to Overberg, a premoral evil—pre-moral evil is “destructive of some aspect of who we are, of what it means to be truly human” (Overberg, 1998). An amputation, then, is considered a premoral evil according to Overberg: it is destructive of some aspect of who we are, but the morality cannot be judged until knowing the surrounding circumstances. If the amputation is life-saving, then it is committed with sufficient reason. A moral evil, on the other hand, is a “pre-moral evil that is committed without sufficient reason” (Overberg, 1998). Moral evil, instead of just destroying some aspect of who we are, destroys our actual humanity. Overberg distinguishes between these two to illustrate that the circumstances surrounding a premoral evil must be considered when determining if the act is a moral evil. In

determining whether an act is a moral evil, the reality (moral law) must first be considered, followed by the circumstances and intentions of the act.

According to the discernment theory, the reality that must first be considered involves three moral norms (or laws): the material, synthetic, and formal norm. A material norm is one that deals with our actions or doing (Overberg, 1998). An example of a material norm would be “do not kill,” in that this norm centers upon an action, killing. While material norms such as refraining from killing are generally applicable, there are instances in which deviation from this norm may be necessary. With this particular material norm, self-defense may be a sufficient reason for deviation. A synthetic norm, on the other hand, is one that seems to concern an action, but also includes a moral judgment (Overberg, 1998). An example of a synthetic norm in regards to the killing example would be “do not murder.” While this norm includes an action instructing not to kill, it also takes on a moral connotation, implying that there is no justified reason for the killing. Thus, the discernment theory could never be used to justify deviating from the synthetic norm, as a moral judgment is already implicit within the norm. Finally, a formal norm deals with essential human characteristics or our being (Overberg, 1998). A formal norm for the previous material norm may be “respect life.” In contrast to the material norm, the formal norm focuses upon a quality of the truly human. Thus, the formal norm does not have exceptions: life must be respected in all circumstances. However, the way in which life is respected may look different depending upon the circumstance. For instance, it is possible to respect life and uphold the formal norm, yet still kill someone in self-defense and make an exception to the material norm

(Overberg, 1998). Understanding these different norms is crucial to deciding whether a premoral act is actually an evil act. If a given circumstance perhaps violates the material but does not violate the formal and synthetic norms, then the act may simply be a premoral as opposed to evil one. In order to determine if this is really the case—if the situation provides sufficient reason to deviate from moral law, and thus, is morally permissible—we must now examine the particular circumstance.

Examining the particular circumstance, due to the countless circumstances that one may encounter, may be a quite subjective process. In order to reduce subjectivity, Richard McCormick, a moral theologian, has devised a six-step reflection process when deciding whether a situation provides sufficient reason to deviate from the moral laws (Overberg, 1998). First, the social implications of an act must be considered. The test of generalizability must also be employed: we must consider what the consequences would be if our choice were to become the norm or standard for all. Along with generalizability, cultural influences must be considered. What potential bias do we have in our decision making due to our culture? Is it culture that is making us think a particular way or deviate from law? Past experiences should also be considered, as we should be able to learn from our own past experiences and those of others too. When considering options, we should consult broadly with others, realizing that our own interests may be clouding our judgment. In the case of a physician, this may mean consulting with other physicians or other healthcare practitioners regarding a medical decision, consulting with patients, or consulting with those well-versed in moral laws. Finally, we need to make full use of our religious beliefs, allowing them to influence our decisions where necessary and relevant.

If this process is followed and the situation in question does not significantly violate any of McCormick's six criteria, sufficient reason for deviating from the moral laws may persist (Overberg, 1998).

Adhering to these six criteria allows the discernment theory to account for nuanced situations while still avoiding situational ethics. By requiring that a process be followed to determine if an act will result in a moral evil or provide sufficient reason for deviation, the discernment theory rejects situational ethics and the teleological theory. The discernment theory also rejects the deontological approach by allowing the end to justify the means to a certain extent. If the end or purpose of an act is not considered, it becomes difficult to judge the morality in especially nuanced cases. Thus, both the rooting of morality in reality and the end justifying the means (understood in the context of the six discernment theory criteria for sufficient reason) need be considered in decision making.

If a given situation does not improperly violate the three moral norms or McCormick's six discernment criteria, we must ensure that the situation does not violate a final discernment theory principle: the principle of double effect. The principle of double effect is employed in instances where good and evil effects occur, in order to determine if the act is morally permissible (Overberg, 1998). The first rule associated with the principle of double effect is that the action must be good in itself, or at least indifferent (Armenio, 2008). In the case of abortion, it is never permissible—even if it has a good effect—since the act itself is evil. (Abortion refers to a deliberate act and

killing of a fetus, which is different than if a fetus is accidentally or unintentionally lost while attempting to save the mother). The second rule is that the agent must have the right intention. The good effect must be directly intended, and the evil effect, although foreseen, must not be intended but only tolerated (Armenio, 2008). Thus, in the case of an extremely ill pregnant woman, the good effect, saving the mother, must be intended, while the evil effect, killing the fetus, must only be tolerated and not intended. This rule implies that the evil is allowed because it cannot be separated from the good. This is true for the case described, as the evil, killing the fetus, can sometimes not be separated from the good, saving the life of the mother, and therefore is permitted. The third rule is that the evil effect cannot be the means to the good effect; rather, the good effect must be the direct result of the action taken (Armenio, 2008). Thus, in the case of an ill pregnant woman, the killing of the fetus cannot be the means to saving the mother's life, but rather, only occur as a result. Since the good effect, saving the mother, must be the direct result of the action taken, the action must be performed to help heal the mother rather than to help destroy the fetus. The final rule of double effect is that the good effect must balance the evil effect. In other words, there must be a proportionately serious reason for tolerating the evil (Overberg, 1998). Thus, for an accidental abortion, the good effect, saving one life, is equal to the evil effect, losing another life. In this case, the act is permissible by way of the double effect.

While the teleological approach does not employ the principle of double effect at all and the deontological approach places equal weight upon each of the four aspects of double effect, the discernment theory focuses more upon the intention and the reason for

tolerating the evil, and less upon the evil effect being the means to the good effect (Overberg, 1998). This is consistent with the rest of the discernment theory in that even when applying the principle of double effect, discernment theory focuses upon whether there is sufficient reason to deviate from a given law. The discernment theory is complete and inclusive in this regard: the main focus is upon sufficient reason, which is evaluated by moral norms, McCormick's six discernment criteria, and principle of double-effect violation.

It is through the application of this exhaustive theory that moral decisions can be made in a variety of circumstances. The discernment theory accounts for finely nuanced situations and moral dilemmas, providing a comprehensive approach to making moral decisions in even the most difficult or complicated situations. These situations and dilemmas are perhaps the most prevalent within the practice of medicine, making the discernment theory the most reliable and exhaustive approach to medical decision making. It is through the implementation of the discernment theory that moral decisions can be made within medicine, regardless of varying circumstances.

Yet, while moral laws should definitely guide medical practice, where is this line drawn and where are the two separated? If an issue can be framed solely in a medical as opposed to moral context, can medical exceptions be made to moral laws? Are particular medical situations more likely to provide sufficient reason to deviate from moral laws than others? The discernment theory helps determine where moral laws should indeed guide medical practice, and where deviations from such laws may be justified and

necessary. The discernment theory is especially important in considering abortion, sterilization, and physician-assisted suicide.

III. ABORTION:

In order to properly understand abortion, embryonic stages, namely: fertilization, cleavage, compaction, implantation, gastrulation, and one post-embryonic stage (organogenesis) must first be understood from a biological perspective. Then, given this understanding, the beginning of life must be defined. When the sperm and egg meet, fertilization occurs. The sperm contributes twenty three chromosomes and the centrioles necessary for cell division, while the egg contributes its own set of twenty three chromosomes and mitochondria in cytoplasm necessary for embryonic development; together the new cell comprises a karyotype of forty six chromosomes. With this one fusion, the parents' genes are combined, and the egg is stimulated to begin development.

The processes that follow fertilization, prior to birth, are collectively referred to as embryogenesis, the first stage being cleavage. The cells divide by mitosis, dividing every twelve to eighteen hours following fertilization. The cells that result from cleavage are called blastomeres. Following the third cell division (eight cells), the blastomeres undergo a behavioral change—instead of continuing to be loosely connected, they become a compact ball of cells. These eight cells then divide to produce a sixteen cell morula at day four following fertilization. The morula is comprised of an inner and outer component: the outer cells become trophoblast cells and later form the chorion (the embryonic portion of the placenta), while the inner cells become the inner cell mass, which later generates the yolk sac, allantois, and amnion. This distinction between

trophoblast and inner cell mass marks the first differentiation event. The trophoblast must form first, as these are the cells that will allow the embryo to attach to the uterus during implantation. When the embryo has developed the trophoblast and inner cell mass, it is referred to as a blastocyst (Gilbert et al., 2005).

Prior to blastocyst formation, each of the blastomeres has the potential to form an entire embryo. If a single blastomere was isolated from others, it could generate a blastocyst, be inserted into a uterus, and create an entire embryo. Blastomeres are therefore totipotent in that they can make any cell; yet, upon blastocyst formation, inner cell mass cells cannot become trophoblast cells, making cells of the inner cell mass pluripotent. Monozygotic (identical) twins can either be formed from the separation of early blastomeres, or from the separation of the inner cell mass in the same blastocyst; about two thirds of identical twin formation occur at to the latter stage. The fact that twins can form from inner cell mass separation means that these cells are undifferentiated: although these cells are pluripotent and cannot become trophoblast cells, they can still form any cell in the embryo proper (Gilbert et al., 2005).

Once the blastocyst has formed, it continues to move through the oviduct on its way to the uterus. While doing so, the blastocyst grows in the zona pellucida, a protein coat that prevents the blastocyst from adhering to the oviduct walls (Gilbert et al., 2005). If the blastocyst escapes from the zona pellucida before reaching the uterus, the blastocyst may adhere to the walls, resulting in an ectopic pregnancy. Ideally, once the blastocyst reaches the uterus, an enzyme digests the zona pellucida, allowing the

blastocyst to come in contact with the uterus. The trophoblast cells begin to bury into the uterus, secreting human chorionic gonadotropin (the hormone tested for in pregnancy tests). Then, progesterone is secreted, creating the decidua, the maternal portion of the placenta; the decidua directs the embryonic trophoblast cells to become chorion. It is the decidua and chorion that make up the placenta.

Following blastocyst formation and implantation, gastrulation occurs about fourteen days post fertilization, and is about the time when a woman first misses her menstruation. At this point, embryonic cells are no longer pluripotent; thus, the embryo is committed to becoming a single organism (as opposed to becoming twins or other multiple births). It is also during gastrulation that the three germ layers form: ectoderm, endoderm, and mesoderm, each of which will give rise to different tissues or organs. The process in which these germ layers interact with one another and actually become different tissues or organs is called organogenesis. The first sign of organogenesis occurs during the third week of gestation: formation of the neural tube, which will later become the brain and spinal cord. The heart forms during week four, as do the limbs. During week five, eyes form, and by week eleven, the embryo is specifically male or female. By the twelfth week, the embryo has developed every organ, and, rather than develop anything new, will only continue to grow and mature in the months to come (Gilbert et al., 2005).

Given this biological context from the point of fertilization until birth, how then do we define when life begins? The Church (as in, the overall Catholic Church in

alignment with the deontological theory) insists that life begins upon fertilization. Considering the biological aspect of fertilization, this seems logical: when the sperm fuses with the egg, the egg now has all that it needs to begin development. This fusion marks karyotype creation; meaning forty six chromosomes are present to create a new life (normally and ideally). Even if all forty-six chromosomes are not present, this new entity now has the biological self-directedness of an organism (Fisher, 2012). Once fertilization occurs, the zygote undergoes chemical modifications that prevent penetration of additional sperm (Fisher, 2012). These chemical modifications give the zygote a new developmental trajectory: the gametes subsequently act together in a self-directed manner. If our criterion for life is acting in a self-directed manner, then fusion of egg and sperm certainly seems to mark the beginning of life. Yet, this explanation may not be as straight-forward as it appears: others argue that life cannot possibly begin at the point of conception since this life still has the possibility to become multiple lives. Thus, the concept of twinnability need be considered.

As previously stated in the biological context, an embryo has the ability to become twins or multiple lives until the point of gastrulation. The majority of twins are created when the inner cell mass divides, which can occur up until gastrulation; upon gastrulation, the embryo is committed to becoming a single organism. Thus, it is often wondered if something that has the potential to become multiple lives can truly be considered life prior to losing this potential. In fact, Father Norman Ford argues that in the case of monozygotic twins, “the first human individual ceases when it divides and two human individuals begin” (Fisher, 2012). If this is indeed the case, then how can

what existed prior to this division be considered life? If the original embryo does indeed die when twinning occurs, giving rise to two new individuals, then the original embryo cannot fully be considered life. In this view, the embryo prior to gastrulation is referred to as “potential” life.

Yet, if an embryo prior to gastrulation is simply potential life, how does life move from potentiality to actuality following gastrulation? It seems counterintuitive that a life merely possesses potential up until this point. If an embryo is only potential life prior to gastrulation, how can twinning even occur? Can additional life be formed from “potential” life? This, too, does not seem logical: rather, it logically follows that in order for additional life to be created, life must exist first, not potential life. The other issue regarding potentiality is how to measure or know when a potential life truly becomes life. Since there is no definitive way to know when this actually occurs, it makes more sense to consider life as having existed from the beginning. As Fisher claims, “either a substance is a unity or not, a human being or not” (Fisher, 2012). The idea of potential life seems to be in direct opposition to the fundamental definition of life. If an elderly man is dying from pancreatic cancer, and now has only the “potential” to live, would we consider this man a potential life? This very question sounds absurd; he is either alive or he is not—of course, we would still consider this man to be alive. Why, then, should we view life *in utero* any differently? By fusion of the egg and sperm during fertilization, an entity now exists that was not previously present. How can this be defined as anything other than life? Furthermore, this entity is self-directing, and will continue to develop and mature from this point on. This, the ability to self-direct and continue to develop, seems

to be the essence of life. Do we consider a five year old any less alive than a sixty-five year old?

Ironically, whether life begins upon fertilization or following gastrulation seems to be irrelevant when considering medical and surgical abortions. In order for a woman to discover she is pregnant, the embryo must have first begun to bury itself into the lining of the uterus, releasing human chorionic gonadotropin, the hormone tested for during pregnancy tests; thus, implantation must have occurred for a woman to discover she is pregnant. Directly after the embryo buries itself into the uterus, gastrulation begins. Gastrulation begins fourteen days after fertilization, and is usually the time when a woman misses her menstruation and may think to take a pregnancy test. If a woman takes a pregnancy test upon missing her menstruation, gastrulation will have already occurred, meaning that the embryo is committed to becoming a single organism. Thus, whether life begins at conception or following gastrulation, an abortion is taking life even if it is performed the day a woman discovers she is pregnant.

Most women do, in fact, discover that they are pregnant the week following their missed menstruation. At this point, a woman is considered to be five weeks along, as measured from the first day of her last menstrual period (LMP). If a woman discovers she is pregnant at this time, her only abortion option is a medical abortion (Dudley & Mueller, 2008). While medical abortions can be performed as soon as a woman discovers she is pregnant, a woman must be at least six to eight weeks pregnant to have a surgical abortion. Since surgical abortions require physical removal of the embryo, it is crucial

that the embryo be large enough (and therefore visible enough) to remove. This does not usually occur until a woman is at least six weeks pregnant; thus, if a woman prefers a surgical abortion and finds out she is pregnant directly following her missed menstruation, she must wait at least a week or two before the abortion can be performed (Dudley & Mueller, 2008).

For a medical abortion, there are two options for the initial drug: methotrexate or mifepristone (Dudley & Mueller, 2008). Both of these medications block progesterone, thinning the uterine lining, and causing the embryo to detach. Two to three days after administration of methotrexate or mifepristone, misoprostol pills are inserted into the woman's vagina, producing contractions, and causing a miscarriage (Dudley & Mueller, 2008). While medical abortions can be performed as soon as a woman discovers she is pregnant, they are only highly effective until the woman is nine weeks pregnant. Medical abortions account for only twenty five percent of all abortions before nine weeks, and thirty two percent of all first trimester abortions (Dudley & Mueller, 2008). Thus, the remaining seventy five percent of pre-nine week abortions, and remaining sixty-eight percent of all first trimester abortions are surgical abortions.

Surgical abortions in the United States are not only performed in the first trimester, but in the second and third trimesters too. When a surgical abortion is performed for a six week pregnant woman (first trimester), the fetus not only has a heartbeat, but detectable brain waves; when a surgical abortion is performed following the first trimester (twelve weeks), the fetus has every vital organ, and will only continue

to grow and develop in the coming months. During a surgical abortion, a speculum is placed into a woman's vagina, while a tenaculum is fastened onto the cervix. The dilators then go into the uterus in order to determine the depth and size of the uterus, and dilate the cervix. Once this is complete, a suction apparatus is inserted and used to puncture the amniotic sac surrounding the fetus. The suction is then hooked to a tube, and the suction tip removes the fetal tissue, tearing the fetus apart. The head, however, is too large and firm for the suction apparatus to be effective, so a polyp forcep is used to grasp and crush the head. The contents of the head are then removed, ensuring that the other bodily contents have all been removed as well (Nathanson, 1984).

Even though abortions at different time periods involve different fetal stages, all of these stages are nonetheless life. Is a twenty week fetus any more alive than a six week embryo? In fact, is a six week embryo any more alive than a two week embryo, following gastrulation? Can we really quantify life in this manner? If a two week old embryo following gastrulation is just as alive and destined to become a single organism as a twenty week fetus, then abortion, whether medical or surgical, regardless of when the procedure is performed, affects a life. If abortion always involves life, then we must consider the moral laws surrounding life, and if, accordingly to the discernment theory, abortion ever presents sufficient reason to deviate from these laws. In order to determine if sufficient reason for deviation exists, the material, synthetic, and formal moral norms of the discernment theory regarding life need be considered.

The material norm regarding life is “do not kill.” There is, in fact, an exception to this norm in cases of self-defense; aside from instances of self-defense, the material norm is not to be violated. Thus, the only way that abortion can be justified under the material norm is if a woman is acting out of self-defense. Let us, then, consider the role of self-defense when an otherwise healthy woman has an abortion for elective reasons: emotional, psychological, or financial to name a few. Morgentaler argues that a woman choosing to have an abortion for non-medical reasons is “protecting” herself from the life that is growing inside her, and the ramifications that may ensue (Hurley, 2001). Yet, can this really be considered self-defense? What did the innocent life growing inside the woman do to warrant the woman acting out in “self-defense” and justify killing of the embryo or fetus? Since no one more innocent than a fetus can possibly be imagined, this human being cannot possibly be considered an aggressor (Hurley, 2001). While it may be true that the life was conceived accidentally, under non-ideal conditions, or at an inopportune time, this is certainly not the fault or choice of the new life. In cases where the mother is otherwise healthy and makes an elective choice to have an abortion, the issue of self-defense is irrelevant. Since self-defense is not a consideration in these cases, the material norm cannot be violated.

An inability to violate the material norm “do not kill” also implies an inability to violate the synthetic norm “do not murder.” The synthetic norm contains a moral judgment: murder, or the deliberate taking of an innocent life, is never permissible. Killing and murder are different in that killing can be morally sound in cases of self-defense, whereas murder can never be morally sound, regardless of the circumstance. If

someone were to randomly shoot an innocent twenty year old woman walking down the street, we would surely consider this murder and impermissible. Why, then, should making an elective choice to claim a life *in utero* be considered anything other than murder? If abortion for elective reasons is indeed murder, then it violates the synthetic norm and can never be allowed in an otherwise healthy mother.

The final norm that needs to be considered, the formal norm, is similar to the synthetic norm in that it too can never be violated. The formal norm is “respect life.” Obviously, respecting life may look different depending upon the situation, but ultimately, life must still be respected regardless of the situation. When a woman has an abortion for elective reasons, the embryo or fetus is not respected, and an innocent life is claimed. If an abortion was permitted for a fifteen year old girl who felt she was too young to mother a child and could not financially support a child, but refused for a thirty-five year old mother who simply wished to not have any additional children, teleology would ensue. Teleology, by focusing on the goal, allows the end of an act to justify the means. Under this approach, nearly any abortion case could be justified or refused, based upon the particular circumstance. Teleology overlooks the influence of reality in morality, and does not strive to uphold law.

How, then, would we justify allowing an abortion in one case and not another? If an abortion for elective reasons fails to uphold all three moral norms, then it cannot possibly be permissible, making the particular situation irrelevant. These moral norms are fairly straight-forward and easily applied to abortion in elective cases, but how do we

apply these norms in the more ambiguous cases? How should abortion be approached when the fetus is diagnosed with a prenatal disease, when the mother is deathly ill and curing her will likely kill the baby, or in cases of rape? Are these moral norms still as clear, or is it possible to deviate from them? These moral norms and the six guidelines for determining sufficient reason for deviation in the discernment theory are useful in addressing these nuanced situations.

Abortion in cases where a fetus has received a moderately severe prenatal disease diagnosis—where the fetus will likely survive but be difficult to raise—is certainly more nuanced and less straight-forward than abortion for elective or extraneous reasons. With the ever-increasing use of genetic testing, more genetic disorders are constantly being diagnosed prenatally. Providing such information to parents presents them with a decision: continue or terminate the pregnancy. Today, there are numerous genetic tests that can be run with the fetus *in utero*: aneuploidy, a type of chromosomal abnormality that results in an abnormal number of chromosomes, is one of the most common prenatal disease diagnoses. This includes Down Syndrome (Trisomy 21), Edwards Syndrome (Trisomy 18), and Patau Syndrome (Trisomy 13), as well as other more rare aneuploidies (Hurley, 2001). Of all the prenatal Down syndrome diagnoses in the United States each year, only eight percent of these mothers choose to continue the pregnancy, carrying the fetus to full term (Hurley, 2001). It can be argued that a woman choosing to have an abortion under these circumstances is completely within her right as a woman and future mother. In fact, a woman may even feel as though carrying a handicapped fetus to term

and then subsequently raising the child is unfair, as this is not what she anticipated or perhaps wanted (Hurley, 2001).

Yet, how often is life “fair?” How often in life are we actually given exactly what we wanted or anticipated? Is the possibility for error and surprise not a reality of life? While the situation is indeed unfair to the mother, it must also be considered unfair to the fetus: it is not as though the fetus chose this unfavorable outcome either. How, then, do we reconcile this situation? Given the moral laws and guidelines for determining sufficient reason for deviation from moral law in the discernment theory, what is permissible?

As previously mentioned, the material norm says “do not kill.” If killing is impermissible according to the material norm, how can an abortion be justified even when the fetus has received a prenatal disease diagnosis? If abortion is considered an act of killing in elective cases, then surely it is still an act of killing in moderately severe disease diagnosis cases. It almost seems illogical to claim that abortion in the case of an unfortunate prenatal diagnosis is no longer an act of killing; thus, how can it be considered morally permissible? Exceptions are, however, permissible to the material norm in cases of self-defense. Some argue that abortion in this case is perhaps self-defense, as the mother is protecting herself from possibly having to take care of a difficult child (Hurley, 2001). Yet, “difficult” certainly seems to be subjective. A mother may indeed be worried about the difficulty of raising a diseased child, but isn’t raising a child difficult even with a healthy child at times? Even with a healthy child, it is impossible to

know or predict if the child will have severe behavioral issues, also making raising the child difficult. Given this ambiguity, how can we allow abortions in cases where a prenatal diagnosis may mean the mother has difficulty raising the child?

Others also argue that abortion, in these cases, is an act of self-defense not only insofar as the mother is protecting herself from something she may not have been prepared for, but that the mother is also protecting the fetus from what could be a painful or difficult life (Huxley, 2001). Yet, this potential difficulty can be neither officially confirmed nor officially denied prior to birth; additionally, it does not provide sufficient justification for an abortion to be performed and prevent the life from living at all. To a certain extent, deciding whether a fetus can live with a particular diagnosis or would be better off not living is reflective of what we consider “normal.” If a mother or we as a society (medical society and otherwise) think that a certain livable diagnosis or handicap is tolerable, then the pregnancy may be carried to full-term; if the livable diagnosis or handicap is considered intolerable, the pregnancy may be terminated. Yet, who are we to make this judgment call? Who are we to define what is “normal” and what is not? Is normal truly a “one size fits all” standard or can there be variations in how different people define “normal?”

Consider, for instance, the case of a deaf community. A non-deaf individual may consider this community “abnormal,” and perhaps even take pity on the deaf persons for not being able to hear like normal individuals. Yet, is it the perception of the non-deaf that takes precedence, or is it that of the deaf? To certain individuals in the deaf

community, deaf is not only entirely normal, this way of life is preferable and worth defending (Gilbert et al, 2005). If people living with deafness or other disabilities can indeed live happy lives, aside from our own standards of what this may mean, how can we determine whether their life is worth living? Rather than be forced to become “normal” through medicine or other means, disabled individuals often report that they would rather be accepted as they are than society attempt to “fix” their disabilities (Gilbert et al, 2005). Thus, if our concern is truly to “protect the fetus” from living a potentially difficult life, then our efforts should focus on addressing the difficulties that these individuals face, not simply choosing to prevent them from living altogether (Fisher, 2012). Aside from whether it is within our right to deem a life normal or abnormal in the first place, there are other issues with attempting to define normality: norms are often determined by functional ability and yet these definitions sometimes contradict those determined by statistics, genetic prenatal testing stresses that the disability, rather than the social response to the disability, is the issue, and parents often receive the impression that this disability will decrease their parental joy (Gilbert et al, 2005).

The material norm, as demonstrated, is violated by a prenatal disease diagnosis abortion regardless of the circumstance. Abortion in these situations can definitely not be justified as an act of self-defense by defending the mother or fetus, either. Violation of the material norm in all cases also implies violation of the synthetic norm to abstain from murder. If abortion in these cases is an act of killing and cannot be considered a form of self-defense, then it must be considered murder—a killing that affects the innocent, a life

that cannot possibly be an aggressor or defend itself. Since both the material and synthetic norms are violated by abortion in these cases, so, too, is the formal norm to respect life. Since abortion is still an act of killing and murder, surely life is not respected. It seems hard to refute that an abortion in prenatal disease diagnoses fails to respect life; an abortion for a moderately severe prenatal diseased fetus is still a destruction of life.

An abortion in the case of a prenatal disease diagnosis does indeed violate all three moral norms of the discernment theory; however, we must now evaluate whether McCormick's discernment criteria provide sufficient reason to deviate from the moral norms. The first criterion states that we must weigh the social implications of the act we are considering. What are the social implications of aborting a fetus solely because of a diagnosed (or predicted) disease? The social implications of this act are both broad and detrimental: abortion in these cases deals with the issue of normality already discussed. Socially, having an abortion for a diseased fetus sends the message that this life is somehow worth less than a "normal" life, and that the mother decided she would only like to carry a pregnancy to full-term if the baby is entirely healthy. Rather than focusing on how we as a society can better address the difficulties such an individual may face, or working to become more accepting of those with diseases or disabilities, abortion implicitly suggests that these lives are not worth living. Choosing an abortion in these cases may be the "easier" option, as opposed to raising a child with a disability or disease, but if we choose this option, what else does this say about our society? Making this decision because we think it may be easier has its own social implications,

suggesting that we can not only determine what is normal and deserving of life, but also can eliminate potential struggle and hardship for our own convenience.

The next criterion for discernment that must be considered is the test of generalizability: what are the implications if every prenatal disease diagnosis, including moderately severe but livable diagnoses, resulted in an abortion? If every pregnant woman whose child was diagnosed with a disease or disability did indeed choose to abort, this would become a significant issue. Not only would a plethora of lives be lost, some of these lives may not have even been affected by the predicted disease or disability in actuality. While testing for certain diseases *in utero* is highly reliable, testing for others may not be so reliable or an absolute guarantee (Fisher, 2011). Thus, if abortion in these cases was to become the norm for all, how many lives would be lost that would have actually been “normal” and not diseased or disabled? Yet, aside from the margin of error present in prenatal diagnoses, abortion in prenatal disease diagnosis cases violates the test of generalizability for another reason: if this is to become the norm for all, where, then, do we draw the line for what constitutes a significant enough medical disease or disability for abortion? There may be certain diseases that, because of their severity, individuals agree can justify abortion, but what about those that are more ambiguous? How can we allow abortion for a couple that considers Down syndrome a severe disease, and yet another who considers celiac disease a severe disease? Though these two diseases certainly differ in terms of lifestyle management for the individual, both couples may view their child’s condition as equally severe. If this is the case, how do we differentiate

between diseases? Does justifying abortion on these grounds not create risk that more and more genetic diseases or disabilities will be considered severe enough to justify abortion?

Next, we must reflect on cultural influences, and how these influences might bias our judgment. Once again, in this case, cultural influences are most evident in our perception of normality. Culture has conditioned us to believe that certain conditions are more normal than others, and thus, we cannot allow these cultural influences to cloud our judgment in aborting “abnormal” lives. Despite the role of cultural influences for this issue now and in the past, wisdom of past human experiences must be taken into consideration. Unfortunately, in this case, there are not too many past human experiences to draw from, due to the newness of genetic testing *in utero*. Also, wisdom from past experiences regarding this matter is conflicting: one woman may urge that carrying a diseased pregnancy to full-term and subsequently raising the child has proved to be extremely rewarding and fulfilling, while another may urge that she found justice for both herself and the diseased life by choosing abortion.

Given this ambiguity and differing perceptions based upon the particular woman and particular situation, McCormick’s criteria to consult broadly and make full use of our religious beliefs become even more important. McCormick’s criterion to consult broadly, in the case of a prenatal disease diagnosis, means consulting with experts in the field such as physicians or nurses who may be conducting abortions under these circumstances, mothers who have either chosen to abort or to continue to carry the pregnancy, and theologians who are experts on application of moral laws. Aside from consulting broadly,

we must make full use of our religious beliefs: since abortion in these cases violates the moral norms, we must consider this when making our decision. Not only does abortion in these cases violate the moral norms, sufficient reason for deviation cannot even be justified by applying McCormick's discernment criteria, making abortion for moderately severe prenatal disease diagnoses unjustified.

Yet, perhaps even more nuanced than prenatal disease diagnosis situations are cases where a mother's life may be in jeopardy, either due to her own medical condition or as a direct result of the pregnancy. Let us first examine cases where a mother's life is in jeopardy due to her own medical condition. For the sake of this illustration, let us assume that the mother may lose her life if she does not receive treatment and that by receiving treatment, the fetus will die. A suitable example for this illustration is if the mother has cancer: the mother has just been diagnosed with a type of leukemia. If the mother does not receive treatment, she will surely die; yet, if the mother does receive treatment, the fetus will not survive the administration of methotrexate, a common chemotherapy agent. (In fact, as previously mentioned, methotrexate is one of the drugs administered when a woman receives a medical abortion; thus, there is no hope for the fetus to survive). This situation differs from the case of moderately severe prenatal disease diagnoses, as the moderately severe cases we analyzed were ones where the fetus would likely survive until birth, but subsequently be difficult to raise. In this case, it is almost a guarantee that the fetus will die *in utero* upon administration of methotrexate. What, then, is the moral course of action in this instance? In order to put this situation

into moral context, let us examine the situation *in lieu* of the discernment theory moral norms.

Is the material norm “do not kill” violated in this instance? While the fetus will indeed die as a result of the chemotherapy treatment, killing of the fetus is not the primary intent. Rather, the primary intent is to save the mother’s life; thus, loss of the fetus occurs as an unintended consequence of the treatment. Also, the material norm allows for deviation in cases of self-defense: the unintended killing of the fetus can indeed be considered an act of self-defense on the mother’s part, in an attempt to save her own life. While the fetus can still not be considered an aggressor, it is nonetheless morally sound for a mother to choose to receive treatment in order to save her own life. Since the killing is an unintended consequence of an attempt to save the mother’s life, the synthetic norm “do not murder” is not violated: this situation cannot possibly be considered an act of murder. In this regard, the formal norm “respect life” is still upheld: by choosing to receive treatment, the mother’s life is respected, and the life of the fetus, however adversely affected, is not intentionally disrespected.

Since the moral norms are not violated in this instance, McCormick’s discernment theory criteria need be applied in order to determine whether there is sufficient reason to deviate from moral laws regarding abortion. First, we must consider the social implications of this decision. What are the effects of indirectly killing a fetus when the mother has a potentially life-threatening medical condition? The social implications for the life of the fetus are drastic in that a life is lost; however, we must also consider the

social implications if the mother's life is lost. If the woman is married, what are the effects of this loss on the woman's husband? More importantly, if the woman already has children, what are the effects of this loss on the children? It seems unfair and perhaps even unjust for these children to be raised without a mother in a situation that could have been avoided. Though losing a new child is indeed a great loss and difficult situation, it seems that the effect of this situation on the family would be much more severe if the mother, as opposed to the new child, is lost. Thus, when we consider the social implications of this dilemma, it seems that there is sufficient reason for deviation, in that the social implications are worse if the mother does not receive treatment and subsequently loses her life.

The next criterion that must be considered is the test of generalizability: if a woman choosing to receive treatment for a life-threatening medical condition, indirectly taking the life of the fetus, was to become the norm, what would the implications be? If every woman in this situation did indeed choose to receive treatment and lose the fetus, there do not seem to be any major unforeseen consequences; thus, it seems logical to conclude that every woman in this situation should be able to choose the treatment option if she so desires. Yet, we must also consider cultural influences in this decision making process—what are the cultural influences that may persuade us toward choosing the treatment option? Yes, the mother's life is often times more valued than that of the fetus in our culture, but this decision is not necessarily based on which life is valued more; rather, the decision is based on the mother wishing to receive treatment for the sake of her own life. Despite how much she may value the life of the fetus, the mother may still

make this decision for herself. Thus, cultural influence regarding whose life is more valuable—the mother or the fetus—does not seem to be a major contributor in deciding the treatment option.

Aside from cultural influences, we must also consider any wisdom obtained from past human experience. Since past human experience on this matter is conflicting—some women who were in this situation may argue that abstaining from treatment and putting the well-being of the fetus before her own was extremely rewarding, while others may argue that choosing treatment was the best option for the rest of her family—wisdom from these experiences cannot reliably be used to assess this situation. Thus, similar to prenatal disease diagnosis cases, extra emphasis must be placed upon McCormick's criteria to consult broadly and make use of religious beliefs. When a pregnant woman is faced with this difficult situation, she should consult with others who were previously in this situation, read any available literature on the matter, and discuss her thoughts with family, friends, or physicians. While doing so, the woman should make full use of religious moral law. Since none of the discernment theory moral norms are violated by choosing treatment, the woman should find consolation in this, understanding that her choice is morally sound.

Since there is sufficient reason for deviation from moral law according to McCormick's discernment criteria in this case, the principle of double effect should also be applied. The first principle of double effect, that the action must be good or at least indifferent, is upheld in this situation: the action involved, giving the woman necessary

medical treatment, is by itself a good act. The second principle, that the good effect must be directly intended and the evil effect only tolerated, is also upheld: the good effect, the treatment that the mother receives and hopefully saves her life is directly intended, while the evil effect, killing the fetus, only occurs a foreseen, but unintended, consequence. The third principle, that the evil cannot be the means to the good effect, but rather the good effect must be the direct result of the action taken, is also upheld: in this case, the evil of losing the fetus is not the means to the good of saving the mother's life; instead, the good effect is the direct result of the medical treatment that the woman receives. Finally, the last principle, that the good must balance the evil, is upheld in that the woman's life is saved (ideally), while the fetus' life is lost; in this regard, the good and evil effects are balanced: one life is gained or maintained, while another is lost. Thus, indirect killing of a fetus by a mother receiving necessary and life-saving medical treatment is morally permissible in that it does not violate the discernment theory moral norms, provides sufficient reason for deviation according to McCormick's discernment criteria, and is justified by way of the principle of double effect.

If indirectly killing the fetus in an attempt to save the mother's life is morally permissible in cases where the mother's own health condition is threatening her life, what, then, is the moral course of action in cases where the mother's life is directly threatened by the pregnancy? This case is perhaps best illustrated through discussing ectopic pregnancy. During an ectopic pregnancy, the embryo implants outside of the uterus; for example, in the mother's fallopian tube. If the embryo is permitted to grow in the fallopian tube, there will come a point when the embryo grows too large for the

fallopian tube to sustain the life. If this point is succeeded, the embryo will rupture the fallopian tube: this causes not only severe hemorrhaging for the mother, but loss of the embryo since it is not longer implanted and is now floating around the abdominal cavity. This case is similar to the leukemia onset one discussed earlier; in both cases, the embryo or fetus will eventually die. These cases differ from the moderately severe prenatal disease diagnosis cases, as it is almost a guarantee that the life will die. If both the embryo and mother's lives are in jeopardy when an ectopic pregnancy is allowed to continue, how should we best address this issue? It seems that in order to prevent the loss of two lives, action should be taken earlier during the pregnancy. What, then, is the moral course of action to resolve this pregnancy?

In the case of a fallopian tube ectopic pregnancy, a woman has three options to terminate the pregnancy: salpingectomy, salpingostomy, and methotrexate. The first, salpingectomy, refers to removal of a portion of the fallopian tube, allowing the embryo to die on its own having been removed from the woman's body. The second, salpingostomy, refers to an incision being made in the fallopian tube, and direct embryo removal. The third, methotrexate, refers to the drug that is administered to induce a spontaneous miscarriage; this is the same drug that is administered in the case of a medical abortion (Nathanson, 1984). According to the discernment theory, which of these three options is preferable to terminate the pregnancy? Since we have already proven that indirectly killing a fetus in an attempt to save the mother's life is not a violation of discernment theory moral norms or McCormick's discernment criteria, let us focus on the principle of double effect application for each of these termination options.

In the case of a salpingectomy, the faulty organ (the portion of the fallopian tube containing the embryo) is removed, and the embryo is then allowed to die outside of the body. This action, removing a portion of the fallopian tube, is morally indifferent, upholding the first principle of double effect. This action is also indicative of the right intention: the good effect, removing a fallopian tube that would otherwise burst, is directly intended, while the evil effect, killing the embryo, is not directly intended, but rather, tolerated. Also, the evil effect is not the means to the good effect: the good effect, saving the life of the mother, is the direct result of the action taken. Finally, as seen in the case of a woman with leukemia, the good effect balances the evil effect: the life of the embryo is lost, but the life of the mother is maintained. Thus, a salpingectomy does not violate the principle of double effect, making this procedure preferable and morally permissible when terminating a fallopian tube ectopic pregnancy.

A salpingostomy and methotrexate, on the other hand, seem to violate the principle of double effect, making them morally impermissible options to terminate an ectopic pregnancy, according to the discernment theory. These procedures both violate the first double effect principle, in that the action, either directly removing an embryo or administering a drug to terminate the embryo's life, is evil in itself. Also, the evil effect, killing of the embryo, is the means to the good effect, saving the mother's life, violating the third principle of double effect. While these two procedures may indeed have the right intention to save the mother's life and the good effect may balance the evil effect, the means to which the good effect is achieved is a violation of the principle of double

effect; therefore, a salpingostomy and methotrexate are not morally permissible options to terminate an ectopic pregnancy.

Deciding which of these three fallopian tube ectopic pregnancy termination procedures is the most morally permissible is certainly challenging, yet the principle of double effect application makes the morality of these procedures fairly clear; principle of double effect application is not so clear, however, in cases of rape: cases of rape are perhaps the most difficult abortion types. Abortion in cases of rape constitutes perhaps the greatest gray area of abortion for pro-choice and pro-life individuals alike. Adamantly pro-life individuals often have a difficult time stating that abortion is still morally impermissible in cases of rape. To further complicate matters, women who have been raped and chosen to have or not have an abortion often times tell conflicting stories: some women who choose to have an abortion following rape feel as though they received healing from the experience, while others feel more hurt. The women who receive healing from the abortion feel healed because the event is now one they can officially put behind them, and not be reminded of again: they will not be reminded of a child that was conceived in an act of violence out of their control (Fisher, 2012). However, some women do not feel relief but rather, remorse following the abortion. These women claim that just as the rape was not their fault it was not the baby's fault for being conceived this way: they claim that it is actually not fair for them to punish the baby. These women sometimes claim that they could have received counseling and therapy to recover from being a victim of rape, but that they cannot receive adequate counseling for choosing to abort the child; they can't undo their dead baby. Some women who choose to carry the

pregnancy following a rape claim that doing so actually brought them healing and redemption: they claim that continuing to love the child despite the circumstance actually brought them empowerment (Fisher, 2012). Given this ambiguity and often times conflicting stories of women in this situation, how can we determine the morality of abortion in cases of rape? Similar to the other abortion cases we have examined, we can apply the moral norms of the discernment theory in hopes of better understanding the morality involved.

The material norm “do not kill” seems to still be violated by abortion in the case of rape, in that an innocent life is still claimed. Yet, can abortion in this case be considered an act of self-defense on the mother’s part, and therefore justifiable? The fetus did not choose to be conceived in this way, just as a fetus never chooses its means of conceptions, and therefore can still not be considered an aggressor; however, cases of rape differ from the rest in that the mother did not partake in the conception, and thus, did not choose for the baby to be conceived either. If the mother did not choose for this situation to occur, or partake in the conception, can she truly be held responsible? If the woman wishes to protect herself from living with additional repercussions (possible emotional and psychological trauma from raising a child that is the product of violence) from an act that she did not personally partake in, is she acting in self-defense? Yes, the woman’s physical well-being may not be in danger as a result of the pregnancy, which is typically how we define acting in self-defense; yet, if her emotional and psychological well-being is in jeopardy through no fault of her own, can we now consider this an act of self-defense? Whether abortion in these cases can be considered an act of self-defense,

thereby providing an acceptable exception to the material norm, is quite unclear; thus, we must now turn to the other two moral norms.

Since it is difficult to ascertain whether abortion in these cases can be considered self-defense, it is also difficult to determine whether the synthetic norm “do not murder” is violated. If this is truly an act of self-defense on the mother’s part, then killing is justifiable, and the act cannot possibly be one of murder. If, however, this is not an act of self-defense, killing is still immoral, and must be considered an act of murder. Thus, since violation of the material norm is ambiguous in this case, so, too, is violation of the synthetic norm. Unfortunately, this ambiguity carries over to the formal norm “respect life.” In this case, life seems to be respected in both scenarios: if the woman has an abortion, she is respecting her own life since she was violated by a man; if the woman does not have an abortion, she is respecting the life that is growing inside her. It seems that all three of the discernment theory moral norms are somewhat ambiguous for abortion in cases of rape, making it difficult to determine whether these norms are truly violated.

Since it is unclear whether these norms are violated, it is perhaps not possible to officially determine the moral course of action in these cases. Given this ambiguity, perhaps it is best for each woman in this situation to use McCormick’s six discernment criteria to decide, for herself, whether there is sufficient reason for deviation from moral law. Since I personally have never been in this situation, it is difficult for me to assert how a woman should react, or which course of action I find to be the best. Ideally, in my

mind, a woman should go to the doctor's office and receive the morning after pill as a preventative measure. This way, it is possible that the woman would not be directly taking life since it would be impossible to know at that point whether she was pregnant. This would eliminate the need for an abortion if she were to discover she was indeed pregnant later down the road. This appears sound in theory, but how feasible is this course of action in actuality? It seems to me that upon getting raped, a woman's first thought may not be to seek medical attention and receive the morning after pill; rather, a woman may be emotionally and psychologically disturbed, preventing her from immediately taking action. She may be hurt, confused, and even ashamed; these feelings will of course only be amplified if the rape was by someone she knew or even trusted. How, then, can we expect every woman who has been raped to rush into the doctor's office the day after she has been raped? If the woman is ashamed, she may have a difficult time admitting to herself that she has been raped, yet alone to a healthcare professional. Consider, also, if the woman is poor and does not have insurance or access to healthcare. Of course, the woman would not be denied access to healthcare in an emergency room in this situation; yet, this woman may feel less comfortable seeking healthcare than someone more accustomed to having ample access to healthcare and visiting doctors when medical issues arise. How, then, can we expect this woman to rush into a doctor's office or the emergency room directly following an incident as traumatic as a rape?

Given this limitation, it is best if each woman uses the discernment theory criteria to make the best decision for herself. This is, in fact, a fine illustration of the discernment

theory at work. The discernment theory is designed to be a reflective, individualistic process that one can use to determine whether there is sufficient reason for deviation. I feel comfortable applying the discernment theory to other cases of abortion, but do not feel comfortable doing so and determining an absolute ruling in this situation; thus, I am advocating that each woman in this situation apply McCormick's criteria to the best of her ability in order to make a moral decision.

This individualistic application of McCormick's discernment theory criteria is especially important in cases where the rape is also an act of incest. Since these women may experience additional emotional and psychological trauma by being raped by a man in their family, they may be even more hesitant to confess the act to a healthcare professional or seek medical attention. If the man has threatened her to not tell anyone, she will be even more hesitant to speak out or seek help. Thus, women who have been raped, especially those whose rape is an act of incest, should apply McCormick's discernment theory criteria to make the most moral decision in their case.

IV. STERILIZATION:

Sterilization is a procedure in which reproductive organs are either modified or removed with the intention for the individual to no longer be able to reproduce. For a male, this means a modification *via* vasectomy: the vas deferens is severed, preventing sperm from traveling to the ejaculatory duct and being released. For a female, sterilization may mean a modification via tubal ligation: the fallopian tubes are tied so as to not allow the passing of eggs, thereby preventing fertilization; this is considered a direct sterilization in that reproductive organs (the fallopian tubes) are not allowed to function as intended, and sterilization is a direct intention (Cowdin and Tuohey, 1998). Alternatively, a female may undergo a removal procedure via hysterectomy: the uterus is removed, or in the case of a full hysterectomy, both the uterus and cervix are removed; this is considered an indirect sterilization because the uterus is deemed a faulty organ—a weak uterus or uterine cancer, for example—and thus, is removed first and foremost because it is not functioning properly. In this regard, the hysterectomy is simply the removal of a faulty organ, and the sterilization that occurs is a side-effect but not a directly intended result (Cowdin and Tuohey, 1998). For the sake of this discussion, female sterilizations will be the emphasis. We will determine whether an indirect or direct sterilization should be performed, according to moral laws. Yet, this distinction is irrelevant if we do not also determine whether elective or medically necessary

sterilization, if either, is morally permissible according to the moral norms, McCormick's discernment theory criteria, and the principle of double effect.

Currently, the Church, in alignment with the deontological approach, is against sterilization on the grounds that this procedure prevents the possibility of new life, the purpose of marriage. The Church is adamantly against sterilization for elective purposes: couples who simply do not wish to have any, or additional, children. (Recall that in the deontological approach exceptions to a rule are not permitted regardless of circumstance; thus, sterilizations can never be performed for solely elective purposes). The Church justifies this teaching on the grounds that the purpose of uniting a man and a woman through marriage is procreation, and therefore violation of this purpose is morally impermissible. Since the Church is consistently against elective sterilizations, the Church makes a distinction between direct and indirect sterilizations, rejecting one and supporting the other. The Church is adamantly against direct sterilization procedures: because sterilization is the main intention of this procedure, it is never morally permissible. In this regard, a direct sterilization is always considered elective in the eyes of the Church—the procedure does not serve a medical benefit outside of this intention. An indirect sterilization, on the other hand, is a morally permissible sterilization procedure according to the Church, as sterilization is simply a side-effect of removing a faulty organ. Removing a faulty uterus serves an additional medical benefit outside of the unintended sterilization, contrary to a direct sterilization procedure. Thus, the deontological approach deems an indirect sterilization morally permissible in cases of a

faulty organ, but direct and elective sterilizations never morally permissible, regardless of circumstance.

Interestingly, the deontological approach maintains this view of sterilization even in instances where it may be medically unsafe for a woman to become pregnant or carry a baby to full-term, deeming that sterilizations in these instances are still elective, and thus, impermissible. This ruling seems counterintuitive, as the deontological approach also upholds the principle of Totality: the destruction of one organ or smaller part of the whole in medicine for the promotion of the greater overall being. For instance, the principle of Totality allows for the amputation of a leg that is infected with *Necrotizing fasciitis* since the leg is causing harm to the overall body or being. If this is the case, why wouldn't the principle of Totality apply to reproductive organs: if a woman's health may be in jeopardy due to a pregnancy, why can't the organ that would aid in causing the harm, her uterus, be removed just as a leg infected with *Necrotizing fasciitis* is removed? Does destruction of this one organ not promote the greater overall being in these instances? If removal of a reproductive organ falls within the principle of Totality, how can sterilizations in these instances be considered elective?

According to Pope Pius XII, the principle of Totality does not apply to reproductive organs, as "reproductive organs, having their own (reproductive) finality, were not bodily parts (like a liver or kidney) presupposed by the principle of Totality" (Crosby, 1998). Since reproductive organs have finality of their own—to bring forth additional life—a sterilization that destroys the finality of these organs cannot possibly

promote the greater overall being. The main purpose of marriage is procreation; therefore, a procedure that removes this possibility fails to promote the greater overall being by hindering the couple emotionally and spiritually. Though the physical well-being of the woman may be improved or restored, her emotional and spiritual well-being is of greater importance (Crosby, 1998). Thus, sterilization in these instances falls outside the principle of Totality and is still considered an elective procedure, making it impermissible.

As further proof that sterilizations in these instances are an elective procedure, deontological approach supporters argue that they “have heard physicians say that there is no woman that they cannot get safely through a pregnancy,” urging that “modern medicine has the means to overcome those dangers and risks” (Smith, 1998). The Church argues that women, regardless of their situation or health complications, may successfully complete a pregnancy with the aid of physicians and technology available in modern medicine. Thus, if these women still desire a sterilization procedure, it would be for elective reasons, and not because the pregnancy would have been dangerous or life-threatening.

Yet, what about women who (despite knowledge of current medicine and technology available) do not wish to become pregnant and take the risk? For these women, the deontological approach suggests Natural Family Planning. This encouragement of Natural Family Planning stems from the Church’s view against the use of artificial contraceptives to prevent life (Smith, 1998). Since the Church is against

contraceptives, a couple should instead practice Natural Family Planning when they do not wish to become pregnant. The Church is confident in the ability of Natural Family Planning to achieve this end, arguing that “a woman diligently using Natural Family Planning would be assured that she would be safe from pregnancy” (Smith, 1998).

The Church does not express any hesitations about the effectiveness of Natural Family Planning, but how extensively can Natural Family Planning truly be relied upon, especially in cases where a pregnancy may be life-threatening for the woman involved? Consider, for instance, a woman who is not only obese, but severely diabetic. Even if this woman diligently practices Natural Family Planning, there is still a margin of error for her to become pregnant. Natural Family Planning involves scheduling intercourse around a woman’s menstrual cycle: even if a couple strives to be mindfully aware, there is still room for human error. In addition to human error, a woman’s menstrual cycle and body does not always function as planned or expected. If a couple is tracking the woman’s menstrual cycle on a calendar, yet the woman is irregular, or for some reason spontaneously becomes irregular, there is an even bigger margin for error. If an unwanted pregnancy for this woman could be life-threatening, she may not want to take this risk.

The deontological approach may argue that modern medicine can successfully get any woman through a pregnancy, but is this really the case? Surely, different women with different circumstances or health issues present a different risk in becoming pregnant, some more so than others. If this is the case, may it not be potentially life-threatening for

certain women to become pregnant or complete a pregnancy? Since the Church also does not support artificial contraceptives such as condoms or birth control, what options is this woman left with? It seems that if the woman is not confident in Natural Family Planning as a preventative pregnancy measure, this woman's only option would then be abstinence.

Choosing abstinence may seem like a simple solution, but this choice would also have consequences, ones that could even be considered detrimental to a marriage in the eyes of the Church. If a married couple feels as though their only option is to abstain, what are the effects of this choice upon the marriage? In addition to procreation, the "unitive good of marriage also has its own integrity, and this integrity holds true regardless of how one orders the goods of marriage" (McKenny, 1998). Thus, if this unitive good also carries weight, it seems unfit that a couple whose pregnancy could be life-threatening be forced to abstain simply because this is the surest way to prevent a dangerous pregnancy. In this case, the married couple would not only miss out on the procreative goods of marriage, but also the unitive goods of marriage. If procreation and unity are the main purposes of marriage, it seems that this couple, if also forced to abstain, may experience detrimental effects to their marriage. Perhaps, then, in cases where a potentially life-threatening pregnancy is concerned, sterilization should be re-considered.

In cases where a woman's life may medically be in danger by becoming pregnant, sterilization should be viewed in a different light, with aid of the discernment theory. If

the question of whether or not a woman should receive a sterilization procedure can be framed entirely in a medical, as opposed to moral, context, then perhaps medical needs should take precedence. This approach does not seem entirely contrary to teachings of the Church, as even Pope Pius XII acknowledged that “the risks involved in a pregnancy can demand a no to motherhood,” and that this “is a question of concrete facts and therefore a medical, not a theological question” (Cowdin and Tuohey, 1998). It seems that medicine (more so in alignment with the discernment theory) as opposed to moral theology (more so in alignment with the deontological theory) would be best fit to judge the permissibility of sterilization in cases where the procedure may be deemed medically necessary and safe for a woman (McKenny, 1998). Medicine should, at the very least, “enjoy the technical competence to state a woman should not get pregnant” (Cowdin and Tuohey, 1998). If medicine can deem that a given woman should not become pregnant, it seems logical that medicine should also be allowed to conduct sterilizations in these special instances. In these cases, morality is not directly concerned in deciding whether or not a sterilization procedure is permitted. Rather, medicine should determine whether or not the procedure is permitted, and if medicine decides to permit the procedure, morality should determine which kind of procedure is permissible.

Since indirect sterilizations (hysterectomy) are currently allowed for biomedical issues such as a weak uterus or uterine cancer, it seems logical that indirect sterilizations also be permissible for biomedical issues that could threaten a woman’s life should she become pregnant, such as diabetes, asthma, or kidney issues. If an indirect, as opposed to direct, sterilization is performed, it seems that a moral decision is still being made in the

context of a medical question. In cases where sterilization is a medical as opposed to elective concern, medical authority should take precedence in terms of granting sterilization, but moral law should be incorporated by choosing indirect sterilization. In cases where sterilization is not a medical concern but simply an elective procedure, moral law takes precedence over medical authority, as this question is primarily a moral one. This balance is indeed a fine illustration of the discernment theory, incorporating both moral law and medical concerns. The teleological approach, on the other hand, would suggest that the circumstance must be heavily weighted in determining whether sterilization should be performed, even in elective cases. The main issue here is that elective sterilizations primarily concern a moral question, and thus, cannot result in relativistic thinking; in these cases, even indirect sterilization should not be permissible.

Yet, in order to truly ascertain whether indirect sterilization is morally permissible in cases where a woman's life may be threatened should she become pregnant, we must determine whether the discernment theory moral norms are violated. The first norm, the material norm "do not kill," is not violated, in that life is being prevented and not directly taken. In this regard, the synthetic norm "do not murder" is not violated either; if no life is being taken murder is not even a consideration. Since life is not taken, differentiating sterilization from abortion and rendering the material and synthetic norms irrelevant, the formal norm "respect life" is especially important. While it can be argued that the life of a potential fetus is not respected by performing sterilization, the life of the mother is certainly respected. It is important to recall that while the formal norm "respect life" cannot be directly violated, the manner in which this is upheld can look different

depending upon the situation. Thus, while the potential for life may not be respected in this case, the already present life of the mother is respected. One could argue that in cases of abortion, the already present life of the mother is respected while the life of the fetus is not respected; however, sterilization differs from abortion in that sterilization affects the potential for life, while abortion affects an actual life. Failing to respect the potential for life, for medical reasons, is a very different situation than failing to respect an actual life. Thus, allowing indirect sterilization in cases where pregnancy may be life-threatening for a woman does not violate any of the discernment theory moral norms.

Since the discernment theory moral norms are not violated in this case, we must now consider whether we have sufficient reason to deviate from moral law according to McCormick's six criteria. The first criterion we must consider is the social implications of the act: the most obvious social implication is that the couple would no longer possess the ability to procreate or bring forth life. Yet, sparing the couple the stress and intensity of a possibly life-threatening pregnancy is also a social implication that must be considered. As far as social implications are concerned, the effects of this procedure seem to balance each other out. The couple's inability to procreate seems to be a negative social implication, but removing the possibility of a dangerous pregnancy seems to be a positive social implication. Thus, we must now look to McCormick's next criterion, the test of generalizability: if sterilizations in cases where it is medically dangerous for a woman to become pregnant were to become the norm for all, are there any unforeseen consequences? It seems that if all women in this situation received an indirect sterilization, there would not be any substantial negative consequences. The one caveat to

this would be that a “medically dangerous pregnancy” needs to be medically determined by a physician. If this is upheld, it is not risky for sterilizations in medically necessary cases to become the norm for all.

The next criterion, culture, evaluates whether cultural factors influence this desire to deviate from moral law. In this case, it is not culture but a medical risk that is the main propelling factor. If sterilizations were permitted for strictly elective purposes, this would be an example of culture influencing or biasing deviation from moral law. Since this is not the case, deviation can be considered independent of culture. We must now consider past experiences, both within literature and personal experiences: since sterilization is a fairly new procedure and is more commonly performed for elective as opposed to medical reasons, there are not too many past experiences to draw from. Thus, these sterilization cases provide sufficient reason to deviate from moral law when considering past experiences. Furthermore, we must consult with others when we want to deviate from moral law. In these cases, a physician must first discuss possible options with the family, other physicians, or other medical staff. If a physician discusses other options with a woman and her husband, yet the couple still decides sterilization is the safest option, then the physician is sound in her judgment. Similarly, if the physician discusses her thinking and reasons for granting sterilization with other physicians or medical staff, then she has done her part in consulting with others. In this way, the couple should also consult broadly with others: seeking advice from not only medical staff, but friends, family, theologians, or priests. Finally, sterilization in these cases must meet the last criterion: make full use of religious beliefs. These cases make use of religious beliefs in

that life is being prevented rather than directly taken, and a direct sterilization is certainly morally preferable to an indirect one. Thus, sterilization in cases where it is medically dangerous for a woman to become pregnant meet McCormick's six discernment criteria, alluding to the notion that these sterilizations provide sufficient reason to deviate from moral law.

Yet, in order to fully determine whether there is sufficient reason to deviate from moral law in these cases, we must ensure that these sterilizations are consistent with the principle of double effect. The first principle of double effect, that the action must be good or at least indifferent, is upheld in this situation: the action involved, giving the woman medical treatment in the hopes of preventing a future medical danger, is by itself a good act. The second principle, that the good effect must be directly intended and the evil effect only tolerated, is also upheld: the good effect, the treatment that the mother receives in order to prevent a life-threatening situation is directly intended, while the evil effect, preventing life, only occurs a foreseen but unintended consequence. The third principle, that the evil cannot be the means to the good effect, but rather the good effect must be the direct result of the action taken, is also upheld: in this case, the evil of preventing life is not the means to the good of preventatively saving the mother's life; instead, the good effect is the direct result of the medical treatment that the woman receives. Finally, the last principle, that the good must balance the evil, is upheld in that the woman's life is saved, while the potential for life is lost; in this regard, the good and evil effects are balanced: one life is maintained, while the potential for another is lost. In this regard, sterilization in these cases does not violate the principle of double effect.

Thus, preventing future life by a mother receiving a possibly life-saving medical treatment is morally permissible in that it does not violate the discernment theory moral norms, provides sufficient reason for deviation according to McCormick's discernment criteria, and is justified by way of the principle of double effect; indirect sterilizations can morally be performed in instances where it would be medically dangerous for a woman to become pregnant.

V. PHYSICIAN ASSISTED SUICIDE:

Janet Adkins, a fifty-four year old woman suffering from Alzheimer's disease, lived in fear of memory loss and an impaired ability to engage in everyday activities. Most of all, she feared the thought of one day being unable to make a rational decision. In a desire to end her life before this dreaded day became a reality, Adkins contacted Dr. Jack Kevorkian, a retired pathologist. Dr. Kevorkian fulfilled Adkins' wish, starting a saline IV, and then instructing Adkins to initiate a flow of barbiturates and potassium chloride, resulting in death. Adkins was Dr. Kevorkian's first physician assisted suicide (PAS), but she was certainly not his last. Dr. Kevorkian continued to assist in suicide even once his medical license was revoked, switching to carbon monoxide as his drug of choice (Darr, 2007). Prior to his sentence of ten to twenty five years in prison, Dr. Kevorkian assisted in about one hundred and thirty suicides. Of these, only approximately forty percent were officially diagnosed terminally ill. To some, Dr. Kevorkian seems unqualified to even make such diagnoses, considering his pathologist specialty. Furthermore, Dr. Kevorkian failed to consider the mental state or competence of each patient, a significant oversight (Darr, 2007).

This oversight, among others, appears quite glaring—it is easy to look at Dr. Kevorkian's significant shortcomings and immediately assert that he acted in an immoral manner. In fact, the Church, consistent with the deontological approach, would maintain that Dr. Kevorkian's actions were undoubtedly immoral: taking life, regardless of the

method and situation, cannot possibly reflect accordance to moral laws. The teleological approach, on the other hand, would assert that the morality of Dr. Kevorkian's actions is dependent upon each patient and corresponding situation. According to the teleological approach, whether or not PAS is indeed morally permissible differs with each differing circumstance: it can be morally justified in certain situations, but not in others. For instance, PAS may be morally justified for a seventy-seven year old man dying of lung cancer, but not for a thirty-four year old man diagnosed with celiac disease. Yet, how can PAS possibly be "more morally sound" in some situations than in others? How is taking life seen as moral in one situation and immoral in another? Given the vast discrepancy between the deontological and teleological approaches for PAS, perhaps we should now look to the discernment theory for guidance. In all fairness, Dr. Kevorkian's shortcomings must be considered in context of the discernment theory moral norms in order to truly determine the morality of PAS.

The first moral norm, the material norm "do not kill," is blatantly violated by PAS. While perception of the beginning of life is central to determining whether abortion is killing, PAS has no such ambiguity: PAS involves individuals who have already been born and lived some portion of their life. If PAS involves a life that is definitively alive, how can it possibly be considered anything other than killing? Is a sixty year old man dying from lung cancer any "more alive" than a twenty year old healthy man? Can we really quantify life in this way? Since a sixty year old terminally ill man is still, by definition, alive, PAS must be considered killing in the same way that taking the life of the healthy twenty year old man is considered killing. Viewing PAS as killing and

therefore in violation of the material norm is quite unambiguous; discerning whether PAS violates the synthetic norm to not murder and the formal norm to respect life, on the other hand, presents ambiguity.

Certainly, there is ambiguity in evaluating whether the synthetic norm “do not murder” is violated in the case of PAS. Typically, murder occurs when a victim is killed against their will. If, however, an individual requests for someone to aid them in ending their life, does this still qualify as murder? If PAS patients are requesting that their life be taken, can PAS be considered murder? Moreover, if patients are aiding in the act (by initiating a flow of barbiturates that has simply been prepared by the physician, as in the case of Adkins), who is responsible for the death? Can such an ambiguity truly qualify as murder? It is difficult to ascertain whether PAS can be considered an act of murder, or if it is solely an act of killing—to some extent, the answer is perspective dependent. There is similar ambiguity present in evaluating whether the formal norm “respect life” is violated by PAS. Like the synthetic norm, the formal norm seems to be dependent upon perspective. In order to determine whether PAS violates this norm, we must first consider the true role of a physician in respecting life.

The role of a physician, in its most basic form, is to heal and treat patients (McLachlan, 2010). According to this definition, PAS—assisting in actively administering a lethal drug to a patient—violates the role of a physician. Assistance in committing suicide is not a form of healthcare treatment; rather, it is just the opposite (McLachlan, 2010). Instead of attempting to heal or preserve life, PAS aims to end life.

How can a “treatment” that aims to end life possibly fulfill the healing role of a physician? Interestingly, a PAS request normally does not come from the physician, but rather, the patient. (In the Netherlands, however, it is fairly common PAS practice for the physician to initiate the request). If PAS violates the role of a physician yet is requested by the patient, it is also possible that a patient may present other requests to physicians that are not focused upon healing. Thus, all physical, psychological or other wants of a patient cannot be met by healthcare, yet alone be appropriate for a physician to fulfill (McLachlan, 2010). Physical or psychological patient desires that are not directly related to “healing” lie outside of the responsibilities or duties of a physician. Since PAS fails to address the role of a physician as a healer, PAS conflicts with a physician’s central role and perhaps the burden cannot be placed upon the physician. Moreover, PAS seems to conflict with the role of a physician as a “comforter” (Darr, 2007). If the role of a physician is to comfort always, how can PAS possibly be in alignment with this role—how can a physician comfort a life that she ends?

Yet, in considering the role of a physician as a comforter, a different perspective on comfort need be considered. Consider, for instance, a patient who has been given two months to live, diagnosed with an inoperable brain tumor. If this patient continually requests death, and feels as though he would find comfort in death (by no longer experiencing physical, emotional, or spiritual distress), does a physician who assists the patient in suicide fulfill her role as a comforter? In this sense, it seems as though a physician’s role as a comforter may be subjective. Is comfort defined by the patient, or by the physician who is supposedly providing the comfort? From the patient’s

perspective, a physician's refusal to assist in suicide when death itself may bring comfort is indicative of a physician not acting in accordance with the role of a comforter. Also, if a physician's assistance is acquired, the patient may feel safer than if he were to attempt the suicide by himself or through another means, again achieving a sense of comfort (Parpa et al., 2010). The physician, however, may feel as though she is violating her fundamental role as a comforter by assisting the patient in suicide as opposed to pain management or other options. The role of a physician as a comforter seems to be subjective, depending upon whether the perspective of the patient or physician is considered. If the perception of comfort differs based upon perspective, how, then, can we unambiguously determine whether the physician is fulfilling her role as a comforter, thereby respecting life?

Perhaps, in order to assess whether PAS violates this fundamental role of a physician, we must first assess whether a physician views her patients in a maternal or autonomous manner. If a physician views herself as protector of her patients, acting in a maternal manner, she would most likely not favor PAS. Although a patient may adamantly request assistance in suicide, this physician would likely uphold what she personally thinks to be in the patient's best interest. She might worry that the patient is not mentally sound to make this decision or that the patient may not consider the complete ramifications of his actions. Yet, aside from the patient's ability to make this decision, the physician may also question the accuracy of her own prognosis: how certain is she regarding the predicted amount of life remaining? If she were to fulfill the patient's wish, would she then wonder if the patient would have indeed died within the

projected time frame? Unfortunately, with such prognoses there is certainly a margin of error and element of uncertainty (Darr, 2007). Would this physician struggle afterwards, wondering if the patient could have possibly survived otherwise?

To highlight this element of uncertainty, consider the case of my grandma, who was extremely sick with uterine cancer seven years ago. Following her cancer treatments, my grandma was taking copious medications, in order to address multiple issues. In an attempt to balance out her medications, her doctor removed her from Librium, a medication she had been taking ever since entering menopause some thirty years earlier. As a direct result, my grandma began to die. The effects of this withdrawal upon her body were drastic; we were told that abruptly removing her from this medication was more severe than removing a heroin addict from heroin. She had become completely unresponsive, was receiving the maximum allowed amount of Dopamine, and was having an evolving heart attack. The doctors informed us that she would not survive through the night. She had previously been given only a few months to live, but now, less than a day.

When we gathered around her hospital bed, saying our goodbyes, a nun walked into the room and asked if we would like her to pray with us. We accepted her offer, and formed a circle around my grandma's hospital bed to say the "Our Father." Three words into the prayer, after being completely unresponsive for three days, my grandma opened her eyes, and said the entire prayer. The doctors were astonished. My grandma not only survived through the night, but for a few years afterwards. The doctors still do not have a

medical explanation for this occurrence, and maintain the belief that she should not have survived through the night.

If these sorts of uncertainties exist and do indeed occur within medicine, how can a practicing physician ever be completely positive of a prognosis for a given patient? Given this uncertainty, how can a physician reconcile assisting a patient in suicide? Might there not be times that a physician assists a patient in suicide without knowing that the patient could have possibly lived longer? Due to these uncertainties, a physician who values acting maternally may not support PAS. However, a physician may, instead, place higher value on the autonomy of the patient, and thus view PAS differently.

A physician who respects the autonomy of a patient above all else may view PAS as the patient's right to make an autonomous, liberty-driven decision (Darr, 2007). By respecting the autonomy of patients, this physician advocates for her patients' personal beliefs and desires. If she truly advocates for her patients' desires, does this not then apply to PAS? Where is the line drawn for a physician who advocates for her patients; to what length will this physician go in order to ensure this goal is achieved? If a physician desires to uphold her patients' wishes, regardless of what the wish may be, it seems that this would apply to PAS. Thus, this physician would likely assist a patient in suicide in order to fulfill the patient's personal wish and maintain his autonomy.

Yet, at what cost is this autonomy granted? Does granting a patient this level of autonomy come at the cost of dignity? If upholding the dignity of a patient means preserving and respecting each individual life, then this certainly seems to be the case. If,

instead, PAS is not granted and life is maintained, perhaps dignity is upheld in that life is preserved (Darr, 2007). Yet, depending upon perspective, the opposite may be true: perhaps, in order for a patient's dignity to be upheld, he should still be able to live a redeeming life, performing everyday tasks and enjoying simple pleasures. If a patient no longer possesses a certain quality of life, either by his or the physician's standards, is the dignity of the patient in jeopardy?

The case of Elizabeth Bouvia clearly exemplifies these differing perspectives regarding dignity. A twenty-six year old suffering from cerebral palsy, Bouvia entered Riverside General Hospital in California in 1983, requesting that the hospital aid her in fasting until her death. Since she was unable to move, Bouvia requested that the hospital provide her with hygienic care, as well as any medications necessary to ensure a painless death by starvation. The hospital, however, informed Bouvia that they had no option but to force feed her if she chose to stay. Against her wishes, a permanent feeding tube was inserted, until Bouvia renounced suicide. Although she officially renounced suicide, it was reported that she still welcomed death (Darr, 2007).

How does the hospital's decision ultimately affect Bouvia's dignity, both according to the hospital and according to Bouvia? Given Bouvia's poor quality of life, does forcing her to live instead of supporting her death wish fail to maintain her dignity? According to Bouvia, her dignity was not upheld and she was disrespected. In refusing to help her fast, the hospital did not respect her wishes, and forced her to live in an

unpleasant state, one in which her dignity was diminished. Yet, according to the hospital, her dignity was upheld, in that she lived and continued to live for some time thereafter.

Whether or not Bouvia's dignity was upheld depends, once again, on perspective: according to Bouvia, her dignity was not upheld; yet, according to the hospital, her dignity was upheld. In this case, it seems that the hospital acted in a paternalistic manner, choosing the option that they thought to be in the patient's best interest and ignoring Bouvia's wishes. This decision resulted in differences in opinion regarding whether or not Bouvia's dignity was upheld. Yet, what if the hospital had acted in an autonomic manner, fulfilling her desire to simply be made comfortable while she starved to death? In this case, Bouvia would have felt that her dignity was upheld, in that she was allowed to die a comfortable death by her own standards. The hospital, on the other hand, would have felt that they failed to uphold Bouvia's dignity by failing to save her life.

It seems that whether the physician acts in a paternalistic or autonomic manner is unhelpful in determining whether a physician fulfills her role as a comforter: in both cases, the assertion differs depending on perspective. Thus, whether PAS violates the role of a physician as a comforter remains subjective even when the paternalistic or autonomic approach of the physician is considered. This subjectivity extends to whether PAS respects or fails to respect life. If we cannot determine whether the physician acts as a comforter, how can we determine whether she is respecting life? Whether the physician is respecting life, too, is dependent upon perspective; therefore, we cannot objectively evaluate whether the formal norm to respect life is violated by PAS. Given the

subjectivity and ambiguity associated with both the synthetic and formal norms for PAS, we must now turn to McCormick's six discernment theory criteria in order to determine if there is sufficient reason to deviate from moral law, making PAS morally permissible.

The first discernment criterion we must consider is the social implications: what are the social implications of permitting PAS? Most obviously, an individual who was previously alive is now dead due to his personal choice, and through the assistance of a physician. In this regard, there are social implications for the physician, as she is responsible for setting the patient's wish in motion. Is the physician now viewed by some as a killer, rather than a healer? Is the physician resented by some of the patient's family members who perhaps do not understand the patient's decision or why a physician would grant such a decision? In addition to there being negative social implications for the physician, these family members may also experience negative social implications. Whenever a life is lost, even by natural means, countless other lives are affected. Often times, there is confusion, anger, and despair for those who experience the loss; these feelings are likely only magnified in cases where the individual chooses to end his life, either on his own accord or through the aid of a physician. Thus, in PAS cases, there may be negative implications for family members and other lives of the patient, in that they may not understand the patient's decision, only increasing their confusion and anger in grieving the death. The social implications surrounding PAS are quite broad, and certainly present multi-faceted concerns.

The next criterion that must be considered is the test of generalizability: if PAS were to become permissible for any patient who wishes to end his life, what are the implications? In the case of Bouvia, it is difficult upon hearing her story to not sympathize with her and want to help her maintain a sense of dignity by her own standards. Yet, what if instead the patient was one with dementia, who perhaps could not make a coherent decision? How do we distinguish between these different cases—where do we draw the line between which PAS wishes can be granted and which cannot? Ultimately, which patients are “qualified” to make this decision by themselves? Would we consider a seventy-year old man dying a slow, painful death from cancer and a thirty-year old woman suffering from a mental illness equally qualified to make this decision? If we would consider this decision permissible for some yet not others, how do we reconcile these cases? It seems that PAS presents significant issues with the test of generalizability, and cannot objectively be applied to all cases.

In addition to generalizability, we must also consider culture: is our culture a driving force for wanting to partake in PAS? Since some individuals would consider PAS while others certainly would not, making PAS a very individualistic contemplation that differs from person to person, it is difficult to objectively determine whether culture is responsible; however, we can objectively state that our culture is very much one of instant gratification. In society today, people are often taught the simplest or quickest way to fulfill their needs. Would it not be fair, then, to say that this same mentality could certainly apply to our perception of death? If we could die on our own terms, sooner rather than later when terminally ill, wouldn't culture support us in this mode of

thinking? Our culture also urges to keep suffering at a minimum. If PAS achieves this by ending a patient's suffering, it seems that PAS would be supported by culture. While it is difficult to determine to what extent PAS is driven by culture, it is also difficult to deny that culture is indeed a driving factor.

Next, we must look to our past experiences: what do past experiences with PAS suggest regarding the moral permissibility? Do past experiences raise concerns that suggest there is not sufficient reason to deviate from moral law? When considering past experiences, we must look to the legalization of PAS in Oregon, and PAS use in the Netherlands. PAS was legalized in Oregon in 1997, under quite strict guidelines, including: a fully informed, voluntary patient decision, availability to only the patient's last six months of life, two patient oral requests, one patient written request, psychological patient counseling if deemed necessary, availability only to physicians licensed in Oregon, and prohibiting nonresidents of Oregon from partaking (Lachman, 2010). Since PAS legalization, "approximately 1 of 1,000 dying Oregonians obtain and use a lethal dose of medication," a seemingly small percentage (Lachman, 2010). Such patients were reportedly concerned with a loss of autonomy, as well as a loss of dignity (Darr, 2007). The willingness of physicians to partake in PAS was dependent upon context, as opposed to rule based: these physicians aimed to assess the individual patient's situation. The physicians most likely to participate in PAS, in decreasing order, were: family medicine physicians, oncologists, and internal medicine physicians (Darr, 2007). This data suggests that PAS can perhaps be controlled and used in moderation if legalized; however, is this true of other past experiences with PAS legalization?

Legalization of PAS in the Netherlands, for instance, seems to have taken a quite different course.

The practice of PAS in the Netherlands, legal since the 1980's, looks much different than what is currently practiced in Oregon. A study conducted in 1990 showed that of the 8,100 patients who received assistance in suicide, consent was obtained from only 3,100 (Darr, 2007). Furthermore, under Dutch law, "children as young as sixteen may request termination of life in writing," and "children as young as twelve may request and receive assisted suicide with agreement of parents or guardians" (Darr, 2007). Shocking as this stipulation may be, perhaps even more shocking is that the law allows physicians to "exclusively judge that a patient's suffering is lasting and unbearable" (Darr, 2007). This allowance is of great concern: if a key role of PAS is preservation of patient autonomy, does allowing physicians to make this judgment call negate autonomy considerations? If a physician no longer needs to justify the need to end life, where is the line drawn between what is acceptable and what is not? The line becomes entirely blurred. Thus, patients at risk in the Netherlands now fear that their lives will be ended without their consent. As a result of this fear, patients carry cards specifying their desire to continue living (Darr, 2007). This fear instilled within patients seems to be a result of the common misuse of PAS within the Netherlands.

It seems concerning that PAS has such a broad application in the Netherlands, and that various extremes are permitted without much consideration. Is this, then, the fate of Oregon and the two other states that have recently legalized PAS? Currently, PAS in

Oregon seems fairly controlled, but what about the more ambiguous cases? PAS in the Netherlands is concerning, and suggests that society is not well-equipped to handle these ambiguities; thus, past PAS experiences definitely do not provide sufficient reason to deviate from moral law.

In addition to past experiences, we must also consult broadly with others. For PAS, this means that a participating physician should consult broadly with the patient's family, as well as other physicians and medical staff. This also means that the patient desiring PAS should consult broadly with his family, medical staff, theologians, or priests. In the case of PAS, consulting broadly may result in ambiguity: some individuals may advocate for PAS, while others may urge against it. Given this ambiguity, the individual seeking PAS must look to the final discernment criterion: make full use of religious beliefs. What do religious beliefs suggest about PAS; would religious beliefs and PAS complement each other or be in stark contradiction? In other words, would God support our decision to end our life, or would He feel that this decision was not ours to make? It seems that when we consult our religious beliefs in regards to PAS, we find them to be in direct opposition to one another; thus, we do not have sufficient reason to deviate from moral law.

All of McCormick's discernment theory criteria suggest that PAS does not provide sufficient reason to deviate from moral laws; yet, in order to be absolutely positive of this determination, we must ensure that PAS also violates the principle of double effect. The first principle of double effect, the action must be good or at least

indifferent, is violated in this situation: the action involved, actively ending a life, is by itself an evil act. The second principle, that the good effect must be directly intended and the evil effect only tolerated, is also violated: while the good effect, ending suffering per an individual request, is directly intended, the evil effect, taking life, is also directly intended. The third principle, that the evil cannot be the means to the good effect, but rather the good effect must be the direct result of the action taken, is likewise violated: in this case, the evil of taking life is the means to the good of ending the individual's suffering. Finally, the last principle, that the good must balance the evil, is not upheld in that the suffering is ended but the life is lost; in this regard, the evil effect outweighs any potential good effect. By violating all four principles, PAS is in direct violation of the principle of double effect. Thus, PAS is morally impermissible in that it violates the discernment theory moral norms, does not provide sufficient reason for deviation according to McCormick's discernment criteria, and cannot be justified by the principle of double effect; PAS is not morally permissible in any circumstance.

VI. CONCLUSION:

The discernment theory is particularly helpful in determining the moral course of action for abortion, sterilization, and physician assisted suicide. By accepting the significance of the concrete situation, discernment avoids blind obedience to the law; by rooting itself in reality, discernment avoids relativism (Overberg, 1998). The discernment theory provides a law-based, yet comprehensive, approach to moral decision making. This comprehensive approach is well-suited to account for a variety of nuanced situations encountered in medicine. It is through application of the discernment theory that moral decisions can be made in a variety of medical situations.

Yet, the moral course of action—whether there is sufficient reason to deviate from moral law—sometimes cannot be fully determined, even in light of the discernment theory. For me, this major point of contention arises for abortion in cases of rape or incest. In these cases, it is difficult for me to ascertain whether the moral norms are violated, making it difficult to determine the moral course of action. I suggested that women in this circumstance apply McCormick's six discernment criteria to the best of their ability, in light of their own situation. This is, in fact, a fine discernment theory application—the discernment theory is an individualistic, reflective process, one that each individual should reconcile on a personal level.

How, then, do I as an aspiring physician of faith reconcile the perhaps irreconcilable? Unfortunately, I do not yet have all the answers. I am unable to reconcile

abortion in cases of rape, and thus, there are likely others issues I did not explore here that I would be unable to reconcile at this time. However, despite not having an answer to each particular situation, I do have a more general answer: I now know that for me, my moral obligation will take precedence over my medical obligation. Ultimately, I will remain true to myself and my own beliefs while practicing medicine. Sometimes, this may mean referring a patient to another physician if I am morally uncomfortable with a particular treatment. This way, I remain true to my own beliefs while simultaneously respecting the patient's wishes. If I am discerning the moral course of action as a physician, the patient may be doing some discerning of his own. Since this discerning may be present on both ends, and both of us may come to a different moral conclusion, the best thing I can do as a physician is remain true to my own beliefs yet also respect the patient's decision. I must act in accordance to my own moral code, and the patient must act in accordance to his. Even if I think my decision is the "more moral" one, I must still respect the patient's wishes and way of thinking. At the end of the day, I must only be concerned with my own decisions, as I must reconcile them with myself and with God.

Upon completing this project, I now know that my moral obligation is of greater importance to me than my medical obligation. Through this project, I started to answer my initial question: how can I, as an aspiring physician of faith, balance my moral and medical obligations? Since I by no means have all the answers at this time, I plan to apply discernment theory concepts to the best of my ability when I enter medical school. I plan to give precedence to my moral beliefs, while still acknowledging the particular situation at hand. I hope to further explore the integration of moral and medical obligations during

medical school. To achieve this end, I hope to attend a Jesuit medical school to guide me in exploring my initial question, one that will teach me how to effectively integrate my moral and medical obligations, and ultimately, help me make moral medical decisions in a variety of nuanced situations.

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