Abstract. Substantial medical evidence shows that about half of ovarian cancers originate in the fallopian tube. Some medical organizations and clinical articles have suggested opportunistic salpingectomy to reduce the risk of ovarian cancer in patients at average risk of developing it. This entails removing the fallopian tubes at the same time as another procedure that would occur anyway. The authors argue that the principles of totality and double effect can justify such salpingectomies, even though there is a low incidence of ovarian cancer. Since screening tools for ovarian cancer are ineffective and treatment options are poor, the good effect of reducing the risk of death from this type of ovarian cancer can be proportionate to the bad effects of the minor increase in surgical risk over the other procedure, the unintended side effect of infertility, and the removal of normally functioning tissue. The authors conclude that it is within the purview of a patient and physician to determine whether the benefits are proportionate to the risks in a particular case. National Catholic Bioethics Quarterly 16.1 (Spring 2016): 99–131.

Modern medicine presents a dilemma for classic moral reasoning regarding amputation and excision of body parts in the treatment of disease. Catholic moral theology has long recognized the legitimacy of amputating or removing one part of the body
to treat a pathology, as long as it is ordered to the benefit of the whole. A common understanding of this application of the principles of totality and double effect would hold that a pathology must be present in the tissue to be excised in order to justify the infringement of the body’s integrity. This understanding would apply even for procedures that involve removing reproductive organs.

To the contrary, however, Pope Pius XII taught that it is not necessary that the excised organ “be itself diseased, but that its retention or functioning either directly or indirectly brings about a serious threat for the whole body.” In cases involving the removal of life-threatening reproductive organs, he also distinguished between actions in which the agent directly intends sterilization as an end or means of removing the threat (which are not morally justified) and those actions that “will as a necessary consequence render procreation impossible, but this impossibility may not be desired either as an end or as a means” (which are morally justified). Combined, these two moral parameters provide a basis for distinguishing between morally justified procedures that prevent disease—yet result in sterilization as an indirect, unintended, but foreseen side effect—and those that intend sterilization as a means to achieve what would otherwise be a laudable goal of disease prevention.

Today, new diagnostic techniques, especially in genomic medicine, allow us to know that some people are predisposed to a disease long before it develops. Physicians and patients have used such knowledge to justify the removal of body parts before a pathology manifests itself. For example, risk-reducing surgery has become common practice with patients who are known to have an increased risk of developing a pathology. In some cases, these preventive measures involve removing reproductive organs, which consequently induces sterility in the patient.

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The views expressed in the NCBQ do not necessarily represent those of its editor or editorial board or those of the Ethicists or staff of The National Catholic Bioethics Center.


2. “Soit malade lui-même, mais que son maintien ou son fonctionnement entraîne directement ou indirectement pour tout le corps une menace sérieuse.” Pius XII, Address to Congress of Urology, 1953. English translations of this and other allocutions by Pius XII have been made by Becket Gremmels.

3. “Aura comme conséquence nécessaire de rendre impossible la procréation, mais cette impossibilité peut n’être pas vouée soit comme fin, soit comme moyen.” Pius XII, Address to Participants in the Seventh International Congress of Hematology (September 12, 1958).

4. This same basic moral reasoning is applied in Congregation for the Doctrine of the Faith (CDF), “Respons to Questions Proposed concerning ‘Uterine Isolation’ and Related Matters” (July 31, 1993).


frequency of this practice is increasing dramatically, to the degree that some physicians have argued that it has the potential to replace most if not all tubal ligations, where tubal ligations could become a thing of the past.8

Regardless of what one thinks about such a prediction, we conclude that such a procedure could be justified from a Catholic moral standpoint on the basis of the principles of totality and double effect, under certain conditions. We will first provide a medical overview of ovarian cancer and the recommendations themselves, then describe the relevant moral principles, and finally apply the latter to the former while laying out the conditions required for the procedure to be justified. In making this argument, we intend to use the available theological, philosophical, medical, and scientific evidence to think with the Church about complex bioethical issues. Faithful to the Church’s moral tradition, we propose an argument for discussion that may be subject to review by competent authority, that is, the magisterium. If, in its final judgment, the magisterium determines that this argument is not in accord with Church teaching, or if further medical research does not substantiate the medical facts or claims described in this article or uncovers new evidence of substantial burdens associated with salpingectomy under these conditions, we will faithfully submit to the magisterium and withdraw the argument. We hope that our analysis and conclusion will contribute to the fields of Catholic bioethics and Catholic health care.

Medical Overview

As cancer treatment has improved over the past few decades, the focus in oncology has broadened to include prevention as well as cure. One prophylactic option is simply to remove the tissue that has a chance of becoming malignant before it does so, thus lowering the risk of developing cancer. While it is considered the standard of care in a number of situations to offer the surgical removal of body parts to prevent cancer, and while we believe that the reasoning in those cases is generally analogous to the question at hand, we will address only one such intervention here: bilateral salpingectomy to reduce the risk of serous ovarian cancer in those at population (average) risk. We will discuss the epidemiology of ovarian cancer, its pathophysiology, and finally the medical rationale for offering such an intervention.

Epidemiology of Ovarian Cancer

In 2012, there were 239,000 diagnoses of ovarian cancer worldwide and 152,000 deaths.9 The lifetime risk of developing ovarian cancer in the United States is 1.3 percent, meaning that about one in seventy women will suffer from ovarian cancer by the age of seventy.10 In developed countries, ovarian cancer has an incidence of 9.4 per 100,000 women and a mortality rate of 5.1 per 100,000.11 A significant amount of this mortality is due to the late stage at which the average patient is diagnosed. Since ovarian cancer has few or no symptoms in its early stages, most patients are diagnosed when the disease is already advanced, meaning the cancer has already metastasized and spread to another site in the body.12 Only 15 percent of new diagnoses are localized, meaning the cancer is confined to the ovary itself. Slightly more are diagnosed with regional spread (19 percent), meaning the cancer has spread near the original site. However, the vast majority (60 percent) are diagnosed with metastatic disease distant from the original site, or stage IV.13

Two factors in particular make it difficult to detect ovarian cancer earlier in the disease process. First, symptoms of ovarian cancer usually involve “pelvic or abdominal pain, urinary frequency or urgency, increased abdominal size or bloating, and difficulty eating or feeling full.”14 Since these symptoms are vague and nonspecific, patients and physicians easily attribute them to menstruation or other causes. Certainly nothing in the list is particular to or suggestive of ovarian cancer. Consequently, neither patients nor providers have any reason to suspect any illness or malignancy until it is very serious. An early diagnosis “is often more a matter of chance than a triumph of the scientific method.”15 Yet it is incorrect to conclude from this that a late diagnosis results from a misdiagnosis of earlier symptoms, or that symptoms increase significantly in advanced stages of the illness. Rather, there appears to be little correlation between the type or duration of symptoms and the stage of the disease process.16

13. There are two methods of staging (FIGO and TNM) that do not always correspond, and few data on stage at time of diagnosis are available using the method we think most readers will know (FIGO) which uses stage I, stage II, stage III, and stage IV. However, the distant stage (TNM) and stage IV (FIGO) do correlate exactly. For a conversion between the two, see William Helm et al., “Ovarian Cancer Staging: TNM and FIGO Classifications for Ovarian Cancer,” Medscape.com, updated August 7, 2015, http://emedicine.medscape.com/
Second, no effective screening test currently exists for ovarian cancer. A number of methods exist, such as pelvic examination, transvaginal or transabdominal ultrasound, and blood tests for tumor markers like CA 125, yet they all carry a high rate of false-positive results, and evaluation of a false-positive result is associated with complications and unnecessary side effects from unnecessary follow-up procedures. While the sensitivity of these tests increases in later stages of ovarian cancer, the rates of false-positive results and follow-up complications are high enough that the tests are not recommended for routine use. Moreover, the majority of true positives occur at such an advanced stage that the likelihood of improving a patient’s chances of survival is very low. A definitive diagnosis, therefore, can only be made with exploratory surgery, typically done by laparoscopy. Thus, even if physicians suspect that a patient’s generic symptoms could be caused by ovarian cancer, they have no easy, accurate, or noninvasive means to determine whether that is actually the case.

Unfortunately, the mortality rates for ovarian cancer are skewed heavily toward the later stages, similar to the time of diagnosis. Five years after diagnosis, 92 percent of patients who had localized disease at diagnosis and 72 percent of those with regional metastases are still alive. Only 28 percent of patients diagnosed with distant metastases are alive five years later. Thus, while the incidence of ovarian cancer is rather small (lung cancer is found in 60 per 100,000 people), it is nonetheless quite concerning given its high mortality rate. For example, ovarian cancer accounts for about 3 percent of cancer diagnoses in women, yet it causes nearly 6 percent of cancer deaths among women. In comparison, breast cancer accounts for 26 percent of cancer diagnoses in women but only 15 percent of their cancer deaths. Therefore, the late stage of diagnosis and high degree of mortality make preventive steps for ovarian cancer particularly valuable.

### Ovarian Cancer

Ovarian cancer particularly valuable. This means that patients with this subtype are typically diagnosed at a later stage than those with other types of ovarian cancer, and consequently have a poorer prognosis.

A significant cause of this high mortality rate is the lack of effective treatment options. Some other subtypes of ovarian cancer carry a relatively good prognosis because they are more responsive to therapy—for example, endometrioid or clear cell carcinoma. Serous carcinoma, on the other hand, still has no good, consistently effective treatment regimen, which means that low-grade tumors carry a better prognosis because they grow more slowly, whereas high-grade ones have poorer prognosis because they grow faster. Sadly, high-grade serous carcinoma is also the most prevalent subtype of ovarian cancer. The vast majority (95 percent) of ovarian cancer is epithelial, and most (75 percent) are characterized as serous, 90 percent of which are high-grade. Thus, 64 percent of all ovarian cancer is of the high-grade serous type.

Historically, the origin of epithelial ovarian cancer was somewhat of a clinical mystery. While it was traditionally believed to originate from epithelial cells on the ovary (those that encompass its outermost layer), it has always been associated with cancer of the fallopian tube and peritoneum, since the three commonly appear together. It was originally thought that either this phenomenon was due to ovarian

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17. Eisenhauer et al., “Epithelial Ovarian Cancer”; 294; and Berek et al., “Ovarian, Fallopian Tube, and Peritoneal Cancer,” 446.
18. Saundra S. Buys et al., “Effect of Screening on Ovarian Cancer Mortality: The Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial,” *JAMA* 305.22 (June 8, 2011): 2295–2303. We believe this is also true for newer potential screening tools still in clinical trials. See Ian J. Jacobs et al., “Ovarian Cancer Screening and Mortality in the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS): A Randomized Controlled Trial,” *Lancet* 387.10022 (March 5, 2016): 945–956.
22. National Cancer Institute, “Ovary Cancer.”
cancer that spread to the tube and peritoneum, or that these three were separate cancers that just happened to develop simultaneously. Now it is thought that the three are actually one cancer that has a single etiology but has spread to different sites. This relatively recent concept seems very plausible for a number of reasons. First, all three bear a striking clinical resemblance to each other, both in their symptoms and treatment. In fact, it is recommended that they all be treated in the same manner, with the same medications and the same regimen. Second, recent findings indicate that a number of genetic markers in these cancer cells are the same as those found in epithelial cells of the fallopian tube. In particular, mutations in the TP53 gene, especially its inactivation, are indicative markers of cancer that originate in the epithelial cells of the fallopian tube.

Third, histological analyses show that anywhere from 35 to 64 percent of high-grade serous peritoneal cancers originate in the fallopian tubes. Several cellular features are indicative of tubal origin: the absence of cilia, cellular polarity (the unique structure and shape of cells as determined by their function), and cells undergoing mitosis, as well as numerous structural abnormalities in the nucleus, including increased size, less cytoplasm, irregular nuclear membranes, and irregular distribution of chromatin (the larger package that stores DNA while it forms chromosomes during mitosis). Since 64 percent of all ovarian cancer is of the high-grade serous type, at the very least 22 to 41 percent of all ovarian cancer is high-grade serous cancer that originates in the fallopian tubes. However, this latter number is probably higher, as it does not account for those that are not primarily peritoneal lesions. While further research could certainly expand the percentage of ovarian cancers that might be prevented by salpingectomy, it would not seem to add much to the discussion either way because, as mentioned above, the prognosis of other subtypes is much better given their slow rate of growth.

Fourth, all of this explains another lingering clinical mystery. Some patients at high risk for developing ovarian cancer, who had undergone a prophylactic ooph-

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30. Chen and Berek, “Epithelial Carcinoma;” and Crum, “Pathogenesis of Serous Carcinomas.”
34. Crum, “Pathogenesis of Serous Carcinomas.”
refers to the fact that the salpingectomy is only performed concurrent with another surgery in the pelvic or abdominal area. This substantially lowers the surgical risks of salpingectomy as the patient would otherwise be undergoing the general risks of anesthesia and infection anyway. Thus, the immediate risks added exclusively by the salpingectomy are minimal. However, even though the long-term risks of bilateral salpingectomy are not thought to be significant, they are not well established.

In fact, the standard of care appears to be changing to at least include offering bilateral salpingectomy as an option to all patients in these three circumstances. This fact is reflected by the increasing number of hysterectomies that are accompanied by bilateral salpingectomy (11 to 35 percent) and by the fact that many physicians (26 to 68 percent) now routinely remove both fallopian tubes with all hysterectomies. Previously, half to three-quarters of fallopian tubes were typically left in the body after a hysterectomy, as the intent was only to remove the uterus, not the tubes. A smaller but significant percentage of physicians (8 to 28 percent) perform salpingectomy instead of tubal ligation.45

To be clear, not everyone agrees with this approach. Some argue that the data are not sufficient to warrant such widespread use of salpingectomy and that what data we do have were not designed to state what proponents of opportunistic salpingectomy claim.46 Even though in theory it seems that salpingectomy would prevent serious ovarian cancer, this cannot be proved without prospective studies, which could take at least a decade. Some preliminary retrospective data do exist, and salpingectomy was found to reduce the occurrence of ovarian cancer by 42 percent.47 Certainly more research and data are needed before one can definitively say that opportunistic salpingectomy reduces the risk of ovarian cancer for women at average risk of developing it. That being said, the current debate and likely upcoming changes in the standard of care are forcing Catholic ethicists to assess whether these changes comport with Catholic moral theology. To make such an assessment, we must first identify and define the moral concepts and terminology that we will use in our analysis.

**Relevant Moral Concepts**

A number of moral principles are particularly relevant to arguing for the licitness of the above interventions, including the principle of totality, the principle of double effect, and the three classical fonts of morality: the object of the act, the intention of the agent, and the circumstances. We will identify and describe these principles before applying them to the questions described above.

**Principle of Totality**

As stated in the introduction to this paper, the primary operative principle for these interventions is the principle of totality, which holds that body parts cannot be removed, amputated, mutilated, or disfigured unless doing so benefits the whole body. This principle has both a theological and a philosophical basis. Theologically, the principle is based on the responsibility and obligation we all have as the stewards of our bodies. This account of stewardship recognizes that our bodies and our lives are gifts from God, who alone has full dominion over creation. As a result, we cannot dispose of them however we see fit, but instead we must respect the inherent dignity of our body. After all, “your body is a temple of the Holy Spirit . . . and . . . you are not your own” (1 Cor. 6:19). We do not have “unlimited power to perform acts of anatomical or functional destruction or mutilation.”48 We are free, however, to dispose of individual parts [of our body] for their destruction or mutilation, when and to the extent necessary for the good of [our] being as a whole.”49 This is typically done only in extreme cases in which the sacrifice of a lower function allows the whole person to continue to function.50

Philosophically, the principle is based on the metaphysical relationship of a part to the whole. Without the whole, a part cannot and would not exist; its existence is derived from and dependent on the existence of the whole. In turn, a part exists to benefit the whole; a part is ordered to the good of its whole. Thus, a part cannot be removed without harming the whole, since each part of the body is per se beneficial to the whole.51 However, if the part becomes a threat to the good or the health of the overall whole, then it can be sacrificed, since a part is subordinate to the whole.
The magisterium has confirmed the principle of totality on several occasions. Again, Pius XII articulates and clarifies the three conditions that are necessary to justify a surgical intervention that results in anatomic or functional mutilation:

1. The retention or function of a particular organ within the whole organism is causing serious damage or constitutes a threat to it.
2. The damage or threat cannot be avoided, or even notably diminished, except by a mutilation in question whose efficacy is well assured.
3. It is reasonable to expect that the negative effect will be compensated for by the positive effect.

Directive 29 of the Ethical and Religious Directives for Catholic Health Care Services (ERDs) also articulates this thinking: “All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.”

The differences between the principles of integrity and totality are important for understanding their application to the topic at hand. The principle of integrity refers to our obligation to “retain an understanding of the whole human person in which the values of intellect, will, conscience and fraternity are preeminent” within a hierarchy of values. The principle of totality, on the other hand, refers to our “duty to preserve intact the physical component of that integrated whole,” since it contributes to the realization of the whole person, as a means to that ultimate end.

Principle of Double Effect

The principle of double effect (PDE) is also applicable. In fact, Pius XII expressly mentions that these scenarios are permitted by “the general principles governing acts with a double effect.” Although an action involving the destruction of the reproductive faculties can be morally tolerated for its direct therapeutic effects, its contraceptive effects must also be indirect, that is, its contraceptive effects must be incidental to the direct therapeutic effects and cannot be directly intended. The PDE applies to actions which have two foreseeable effects, one that is good and one that is bad. Some actions can never be justified by the PDE, or by any other rationale, since they are immoral by reason of their immoral object; an example is contraceptive sterilization, articulated in our introduction. The fact that an agent has good intentions or will achieve a good outcome cannot morally justify an act that is immoral in its very object.

That being said, an action could be justified under certain conditions so long as it is not intrinsically immoral, even though it will result in a bad effect. If the bad effect is merely an unintended consequence of the agent’s action, it can justifiably be tolerated and the action morally justified under certain conditions. The PDE identifies four such conditions, or criteria, for assessing the moral standing of an action that carries both a good effect and an evil effect:

1. The object of the act (the finis operis) is good or at least morally neutral.
2. The agent’s direct intention (finis operantis) is only to bring about the good effect and not the evil effect.
3. The good effect is not achieved by means of the bad effect.
4. The good effect is proportionate to the bad effect.

If all these conditions are met, then the action can be justified. A physician ordering chemotherapy is a good example to illustrate the application of the PDE:

1. The object of the act of administering chemotherapy is for its curative effects, which is morally good.
2. The physician directly intends to cure the cancer and not to cause the foreseeable toxic side effects, like nausea, vomiting, infertility, cardiotoxicity, and nephrotoxicity.
3. Cancer is not cured by the bad side effects of chemotherapy but by the death of the cancer cells.

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54. “Le maintien ou le fonctionnement—d’un organe particulier dans l’ensemble de l’organisme provoque en celui-ci un dommage sérieux ou constitue une menace. Ensuite que ce dommage ne puisse être évité, ou du moins notablement diminué que par la mutilation en question et que l’efficacité de celle-ci soit bien assurée. Finalement, qu’on puisse raisonnablement escompter que l’effet négatif, c’est-à-dire la mutilation et ses conséquences, sera compensé par l’effet positif.” Pius XII, Address to Congress of Urology (1953).
56. Vatican Council II, Gaudium et spes (December 7, 1965), n. 61.
57. Orville N. Griese, Catholic Identity in Health Care: Principles and Practice (Philadelphia: Pope John XXIII Medical–Moral Research Center, 1987), 204–206, emphasis added; see also ST II-II.65.1 corpus.
58. “Qui reste permise selon le principe général des actions à double effet.” Pius XII, Address to Congress of Hematology (1958). For a discussion of this, see Griese, Catholic Identity, 219.
60. Catechism, nn. 1751–1761.
4. Curing the cancer and surviving outweigh the bad side effects of chemotherapy.
If possible, the physician would avoid the bad side effects. However, sometimes very toxic chemotherapies must be used because less toxic treatments have failed, do not exist, or are not as successful. From the physician’s perspective, the bad side effects are foreseen but indirect; they are not what she directly intends. Thus, while one can accurately say that the physician has sterilized a patient with chemotherapy, this is not the object of the physician’s action; neither is it the physician’s direct intention or the means used for curing the patient. Rather, it is an unfortunate consequence of an action undertaken solely for its directly curative effects.

In the current context of risk-reducing interventions for oncology, the PDE could justify removing reproductive organs that are cancerous in order to cure the cancer or prevent its spread. Pope Paul VI made this clear by saying that “the Church does not consider at all illicit the use of those therapeutic means necessary to cure bodily diseases, even if a foreseeable impediment to procreation should result there from.”

While this was made in the context of the removal of testicles to slow the spread of prostate cancer, the analogy still stands. This principle is also reflected in directive 29 of the ERDs, quoted above, and directive 53: “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.”

Thus, if an intervention meets the criteria of double effect, it can be morally justified even though it might induce sterility or compromise the functional integrity of a person’s organs.

The Object of the Act

The meaning of the term “object of the act” is key to understanding the moral assessment of an action within the Catholic moral tradition. Catholic theologians have long identified three aspects of an action as its “sources of morality”: the object, the intention, and the circumstances. The object of an action is described in the Catechism of the Catholic Church as follows: “The object of the act is a good toward which the will deliberately directs itself. It is the matter of a human act. The object chosen morally specifies the act of the will, insofar as reason recognizes and judges it to be or not to be in conformity with the true good. Objective norms of morality express the rational order of good and evil, attested to by conscience.”

For some actions, the object by itself can be enough to make the action morally unjustified. These actions “have been termed ‘intrinsically evil’ (intrinsece malum): they are such always and per se, in other words, on account of their very object, and

63. Catechism, n. 1751.
64. Ibid., n. 1755.
65. John Paul II, Veritatis splendor, nn. 79–82.
66. Catechism, n. 1756.
67. Ibid., nn. 1752, 1759, 1760; and Thomas Aquinas, Collationes in decem praeceptis, art. 1.
68. ST I-II.12.1 ad 4; and I-II.12.2 corpus.
69. ST I-II.19.1 corpus.
70. ST I-II.18.6 corpus.
71. 1 Sam. 16:7; 1 Kings 8:39; Prov. 16:2; 21:2; 1 Chron. 28:9; Jer. 17:9–10; and 1 Cor. 2:11.
observe what they are doing. Therefore, if the stated intention is not compatible with the observed actions, then it could be a sign of deceit by the agent. However, it could also be a sign of confusion by the agent or the observer. For example, it might appear to an observer that a driver ran a stop sign on purpose, but in reality the driver may have believed there was no stop sign because it was blocked by a tree. Similarly, the observer may have been incorrect in assuming that the driver was supposed to stop; there may have been no stop sign at all. Thus, perceived incompatibility between an agent’s action and stated intention does not necessarily indicate deceit by the agent.

The Circumstances of an Action

The third font of morality is the circumstances in which an action takes place. Using a metaphysical description, a circumstance is considered the “accident” of an action. A circumstance is not the action per se, such as the object described above; a circumstance surrounds the object, it might even touch the object, but it is definitively not the object. Aquinas lists seven types of circumstances: who, what, where, by what, why, how, and when. Clearly most of these are typically incidental to describing the object of an act, but they are all necessary to fully describe a particular action itself. For example, one does not need to know which hospital a patient is in (where), what time an IV bag was hung (when), or which nurse hung the bag (who) to know that a patient received chemotherapy (object). Not all circumstances are of equal relevance. Aquinas names why and what as the most important because they touch the intention and the object of an action respectively.

Circumstances are necessary for understanding and assessing the whole or complete morality of an action. No circumstance can make an action good if its object is evil, nor can circumstances make up for bad intentions, but a circumstance can turn an otherwise good action into a bad one. To continue with the chemotherapy analogy, an intentional overdose of chemotherapy is objectively wrong no matter where, when, or by whom it is given, because intentional overdoses are wrong by reason of their object. Additionally, circumstances can influence how good or bad an action is. For example, a massive overdose in chemotherapy that results in severe toxicity or even death is much worse than a slight overdose that causes little to no effect on the patient. Circumstances can also lessen the personal culpability or guilt of an agent. The Catechism points out that circumstances “can also diminish or increase the agent’s responsibility (such as acting out of fear of death).” Moreover, “the imputability or responsibility for an action can be diminished or nullified by ignorance, duress, fear, and other psychological or social factors.” For example, a nurse might be less culpable for giving an unintentional overdose of chemotherapy if the pharmacy filled the bag incorrectly, especially if the label reflects the correct dosage. Thus, while circumstances may not be the primary determinative factor in assessing the objective morality of an action, they are indispensable to a complete moral analysis.

The Concept of Pathology

While “pathology” is not actually a moral principle, an important caveat must be added here with regard to the understanding of pathology that is typically at work when the above moral principles are applied. The principle of totality is often (and erroneously, as we have explained) interpreted to mean that healthy body parts can never be amputated, removed, impaired, or rendered incapable of functioning. Similarly, the PDE is often intimately intertwined with the concept of pathology, so much so that one might think it cannot justify the removal of body part unless the removal directly cures a pathology. However, these interpretations are not complete in their understanding of these principles, as shown by the following four reasons.

First, the concept of pathology in medicine is broader than the narrow interpretation often offered by theologians and ethicists. Some pathologies involve an interplay of multiple areas in the body. For example, a patient with renal failure and heart failure has a different set of compounding problems that require different treatment than a patient with either disease in isolation. Yet a combined pathology like this can also involve healthy and pathological tissue. Normally functioning tissue can exacerbate problems elsewhere in the body, leading both tissues to be viewed as a joint or combined pathology. The removal or suppression of either tissue could be involved in treatment of the pathology. Pius XII’s example of a bilateral orchietomy (removal of both testicles) in a patient with prostate cancer is commonly used to illustrate this caveat. The hormones produced by the testicles, mostly testosterone, accelerate the growth and spread of the cancer. Modern medicine has discovered a and anxiety about the future. Such circumstances can mitigate even to a notable degree subjective responsibility and the consequent culpability of those who make these choices which in themselves are evil.”

less invasive, nonsurgical option to address this exacerbation, so orchietomies are not regularly performed in this situation. Yet before such treatment existed, or in cases of advanced cancer and in parts of the world today where medical therapy does not exist, orchietomy could be morally justified. Similarly, it could be justified to remove normally functioning tissue that presents a real threat for turning into a pathology in the future.

Second, and related to the first reason, Pius XII speaks directly to the fact that neither moral principle necessarily requires that the excised tissue itself be pathological. He notes that there are times when the normal functioning of a healthy organ or body part can threaten a person’s life or health. In these situations, it is justified to act on that otherwise healthy part, and even remove it if necessary to prevent harm to the body as a whole:

The decisive point here is not that the organ which is amputated or rendered incapable of functioning be itself diseased, but that its retention or functioning either directly or indirectly brings about a serious threat to the whole body. It is quite possible that, by its normal functioning, a healthy organ exerts a harmful action on a diseased organ that worsens the illness and its repercussions on the whole body. It could also be the case that the removal of a healthy organ and stopping its normal functioning relieves the illness, in cancer for example, its site of growth or, at least, essentially alters its conditions of existence. If one has no other means available, surgical intervention on the healthy organ is permitted in both cases.

Granted, in the example that Pius uses, the threat involves an exacerbation of a present, existing pathology and not the potential development of a future pathology. However, the criteria he lists for justifying the excision of a healthy but threatening organ do not limit themselves to a present, existing pathology.

Third, modern medicine has done wonders with disease management. Many diseases that were previously fatal are now considered chronic conditions because of the technology and expertise that physicians bring to the bedside. Examples include heart failure (often called chronic heart failure), diabetes, kidney failure, emphysema (now included in chronic obstructive pulmonary disease or COPD), HIV, and the like. Yet none of these diseases are curable. Even though physicians cannot cure these pathologies, they can be managed rather well. This important distinction is somewhat old for medicine but new for theology; only in the past six decades or so has it really become possible to make such a distinction. Thus, the concept of pathology, what that means, and what it means to treat or cure a pathology have changed drastically since the days of Aquinas. Consequently, the idea of “treating a pathology” and what it means for a pathology to be “current” or “imminent” have also changed.

Fourth, descriptions of the PDE do not mention the word “pathology,” whether in the early formulations of Aquinas or Jean-Pierre Gury or in more modern descriptions that apply to nonmedical scenarios like just-war theory. All that is required for the PDE to be applicable in these instances is that there are two effects: one good and one bad. It just so happens that when the PDE is applied to medicine it usually involves a pathology. Thus, even though the ERDs aptly discuss pathology in regard to the PDE, the broader moral tradition does not necessarily require it.

Therefore, based on this expanded understanding of pathology, an agent’s direct intention need not be to cure a pathology when performing a medical intervention that involves the removal or mutilation of a body part. Neither is it the case that the sole, immediate, direct effect of such an intervention be the cure of a pathology. Instead, such interventions can be performed on healthy, otherwise non-pathological tissue, if doing so removes or addresses a threat to the patient’s life, and this includes the prevention of a threat and not just its elimination. This broader reformulation of the object of such actions, and the agent’s direct intention, has clear implications for the questions at hand.

**Opportunistic Salpingectomy for Population Risk of Ovarian Cancer**

Keeping in mind the two preceding discussions, we will now apply the moral principles described above to the medical facts of the specific scenario of a bilateral salpingectomy for a patient with a normal (population) risk for ovarian cancer. At first glance, the proposed procedure might appear to violate the principle of totality, because the tissue being excised is not currently pathological. Moreover, it is entirely possible that it will never become pathological at all. However, the caveats mentioned above about the concept of pathology show this assessment to be flawed. Pius XII’s statement is clear that non-pathological tissue may be removed in certain situations.
assuming that its “retention or functioning either directly or indirectly brings about a serious threat to the whole body.”

His criteria do not require that the pathology be currently present. Some ethicists go even further, and explicitly consider prophylactic removal to a different kind of act from mutilation. The fact that the continued presence of the fallopian tubes presents a real (or possible) danger of developing a disease for which there is no good screening test or treatment, and a rather high mortality rate, means that removing the fallopian tubes to reduce the danger or risk of developing this disease is not a mutilation but a preventive healing procedure. As such, it does not necessarily violate the principle of totality, even though the risk is already quite small in the general population.

As for the principle of double effect, we believe that opportunistic salpingectomy meets all four of its criteria. The application of this principle is needed to make it clear that this procedure is morally good in respect to all three moral fonts: object, intention, and circumstances. In particular, we must show that the contraceptive effect of the salpingectomy is neither the proximate nor the remote intention of the procedure, and the circumstances must be right. First, salpingectomy is clearly justified in other areas, as in the treatment of cancer of the fallopian tube or treatment of an ectopic pregnancy. The procedure is performed very differently from a tubal ligation, the typical surgery used to sterilize women and, critically, for very distinct purposes. From a surgical standpoint, it is an altogether different kind of procedure. Tubal ligation involves simply cautering or clipping the tubes and interrupting the passageway between the ovary and uterus; salpingectomy, by contrast, removes the tubes entirely. The procedures are done for wholly different purposes, though both have a foreseen contraceptive effect.

Moreover, the circumstances of the two procedures are different. There are different procedure codes, the procedures are billed and explained differently, and the informed consent discussion is different, all of which helps to ensure that the concrete moral act is done for the right reasons and at the right time. None of these circumstances mean that a salpingectomy is inherently justified, and none are requirements for a particular salpingectomy to be justified, especially since billing and coding practices change regularly, but such circumstances differ in the first place only because salpingectomy can be substantially distinguished from tubal ligation.

Insofar as its object (its immediate purpose) is distinct from tubal ligation and can be rightly characterized as morally good as it derives its moral species from its end, opportunistic salpingectomy is not necessarily a direct sterilization or intrinsically evil. Thus, opportunistic salpingectomy meets the first criterion of the PDE.

Second, the current state of medical evidence suggests that the fallopian tube is a primary contributor to serous ovarian cancer, so it follows that removing the fallopian tubes before cancer is present would reduce the risk of ovarian cancer in general and likely prevent serous ovarian cancer. As mentioned above, a retrospective study already shows such benefits. Moreover, the differences between a salpingectomy and a tubal ligation, as clarified above, show that the objects of the actions are different, which in turn provide evidence that the intention of the physician and patient with respect to the salpingectomy is not for the bad effect of sterilization but only for the good effect of reducing the risk of developing ovarian cancer. If their intention were for the procedure’s permanent contraceptive effects (i.e., to sterilize the patient), one would wonder why they would bother to remove both tubes in their entirety rather than simply ligating them. After all, ligation is a much quicker, simpler, and less risky means to achieve the end of sterilization than removing the tubes entirely. Thus, a physician and patient typically choose opportunistic salpingectomy with the intention of reducing the risk of cancer and not directly for sterilization, meaning opportunistic salpingectomy can meet the second criterion of the PDE.

Third, as indicated above, the inability to reproduce is clearly not what reduces the risk of cancer; rather it is the lack of the presence of the fallopian epithelial cells. In fact, some patients who undergo opportunistic salpingectomy are postmenopausal and so are already infertile. For these patients, the procedure does not cause infertility, yet it still reduces their risk of ovarian cancer. Premenopausal patients could still become pregnant and reproduce through morally illicit procedures like in vitro fertilization or through procedures that some bioethicists consider morally justified, like low tubal ovum transfer or intrauterine insemination. In either case, one cannot argue reasonably that the patient’s infertility is what reduces her risk of ovarian cancer, especially since she may be infertile already or technically may be fertile even after the procedure. Thus, opportunistic salpingectomy meets the third criterion of the PDE.

Fourth, it may appear that the benefit of opportunistic salpingectomy is not proportionate to its risks. After all, the risks of anesthesia and surgery might seem high since the normal risk of developing ovarian cancer is quite small. However, the added risks of an opportunistic salpingectomy are also very small. For that reason, the clinical recommendation is only to remove the fallopian tubes in patients at average risk when

90. “Que l’organe amputé ou rendu incapable de fonctionner soit malade lui-même, mais que son maintien ou son fonctionnement entraîne directement ou indirectement pour tout le corps une menace sérieuse.” Pius XII, Address to the Congress of Urology (1953).


done concurrently with another procedure that the patient will otherwise undergo any-
way. In this manner, the only added risks of the salpingectomy are the few minutes of
extra time added to the surgery, a slightly increased risk of internal hemorrhaging, and
perhaps, but not necessarily, another surgical scar or laparoscopic incision. In contrast
to an opportunistic salpingectomy, an isolated salpingectomy, or salpingectomy by itself
without any other concurring procedure, would not seem to be morally justified by the
criteria we have identified above. Moreover, the Society of Gynecologic Oncology and
the American College of Obstetricians and Gynecologists recommend isolated salpin-
gectomy only as a replacement for tubal ligation in patients at average risk of ovarian
cancer. Thus, those performing an isolated salpingectomy on average-risk patients are
likely to almost always share the direct intention to sterilize the patient.

Furthermore, even though the population risk of developing ovarian cancer is
quite small, ovarian cancer has one of the highest mortality rates for cancer in women,
and high-grade serous ovarian cancer is the most common, most aggressive, and
most deadly of all its forms. Moreover, ovarian cancer has no recommended screen-
ing test to allow for early intervention, and late interventions are not very effective.
Therefore, we conclude that opportunistic salpingectomy for patients at population
risk of developing ovarian cancer can meet the fourth criterion of the PDE, and so
could be justified.

That being said, one might question whether the intended good effect is truly
proportionate (that is, sufficiently proportionate) to the unintended bad effects and
risks. We would argue on the basis of the reasons presented above that it is solidly
probable in principle that the good effect is proportionate to the bad effect. A moral
judgment that is solidly probable means that there are good moral grounds to concludethat the action in question is not morally prohibited and that a person in good con-
science may, considering the circumstances, decide either to perform the act or not.
Applying this point to the current question, no one outside of the physician–patient
relationship, whether an ethicist or a hospital, has generally sufficient grounds to
prohibit a patient from undergoing such a procedure if she determines that it is indeed
proportionate under her circumstances and if a physician is willing to perform it. It
is not the role of ethicists to prevent people from making an error in judgment or to
prevent them from making a mistake in their intention when the object of the act is
clearly licit. Rather, the ethicist’s role is to provide decision makers with principles
and tools of sound moral reasoning by which they can properly form their own
conscience, to provide an institution with appropriate guidelines and direction for
avoiding immoral actions, and to help ensure that procedures are performed under
the right circumstances, that good counsel is available, and that principles and tools
of sound moral reasoning are available and accessible to guide decision makers.

We qualify our conclusion in this way for two reasons. First, as we have shown,
the justification of an opportunistic salpingectomy hinges on whether or not it provides
a proportionate benefit. Any procedure that is “likely to cause harm or undesirable
side effects can be justified only by a proportionate benefit to the patient.” This
weighing of benefits and burdens properly occurs in the provider–patient relationship.

93. USCCB, Ethical and Religious Directives, dir. 33.
of the parents and physician, and still other professional organizations recommend exactly this approach.101

Our conclusion for opportunistic salpingectomy is similar. While we recognize that the benefits may not be proportionate to the burdens in a particular case, there is sufficient evidence in principle to obtain the solidly probable opinion that having an opportunistic salpingectomy is not objectively immoral and can be done for the right intentions in the right circumstances, and it therefore falls within the patient’s right to decide whether or not the procedure offers enough benefits so as to be justified in her case.

In sum, our analysis of the proposed scenario under the PDE is as follows:

1. Opportunistic salpingectomy per se is morally good or at least morally neutral.
2. The physician performs the salpingectomy to reduce the risk of cancer (the good effect), not to sterilize (the bad effect).
3. The loss of fertility is not what reduces the risk of ovarian cancer (the good effect is not achieved by means of the bad effect).
4. Reducing the risk of ovarian cancer and its high risk of mortality is proportionate to the removal of a healthy organ, the possible loss of fertility, and the risks of anesthesia and surgery.

Finally, the personal nature of this decision and the foreseen but unintended side effect of infertility carry implications for surrogate decision making. The question of surrogate consent could arise in at least two situations: an acute event that requires surgical intervention yet renders the patient incapacitated, and a case in which the patient has a chronic or permanent loss of decision-making capacity. In the first situation, appendicitis, cholecystitis, a ruptured ectopic pregnancy, or any number of other conditions could be severe enough to cause unconsciousness. Granted, such a scenario is unlikely, since if the patient is sick enough to need an operation, the physician might believe the added risks of salpingectomy, however small, might be unwarranted. Nevertheless, it is possible in theory. In the second situation, the patient might be elderly and suffer from dementia or be young and have a developmental disability severe enough that she cannot make her own medical decisions. These scenarios would not require an acute event and could occur with an elective intervention like cholecystectomy or appendectomy.

There are two possible circumstances in which we can envision permission for an opportunistic salpingectomy to be given appropriately by a surrogate decision maker. In the first situation, permission could be granted by an appropriate surrogate if the patient had already discussed the issue with her physician. If they have predetermined that she would want an opportunistic salpingectomy were she to have an incapacitating illness that required surgical intervention, surrogate consent might be justified.102 However, this would require that the physician provide the surrogate with reasonable evidence that the patient would want an opportunistic salpingectomy, for example a medical power of attorney in which the patient expresses such wishes or a note in the patient’s medical record from a previous discussion. Assuming that the physician still believes it is medically appropriate, without undue risk, and within the parameters of previous discussions with the patient, the surrogate could consent on the patient’s behalf, especially if the surrogate has medical power of attorney. This would be an appropriate application of substituted judgment.

In the second situation, there may be a patient who has always lacked decision-making capacity because of severe or profound developmental delay, where a best-interest standard would need to be applied because substituted judgment is not possible. Such a patient will always lack the capacity to consent to a medical procedure yet may require an abdominal surgery in which an opportunistic salpingectomy could be appropriate in the judgment of the surrogate, who is likely to be a parent. In patients who are at increased risk for ovarian cancer, the best-interest standard could justify a surrogate decision in favor of the procedure. In patients who are at average risk, we suggest requiring a review by the ethics committee in order to provide a check and balance on the surrogate and physician, especially given the historical problems of eugenics and involuntary sterilization.103 There may be other cases that would be analogous to these two.

**Considering Possible Objections**

A number of objections could be raised to our argument, but we will only consider the nine that we believe pose the most concern. First, it might appear that our conclusion runs contrary to well-established teaching of the magisterium regarding direct sterilization, especially as expressed by the Congregation for the Doctrine of the Faith. The Congregation is clear that any sterilizing procedure which “of its nature and condition, has the sole immediate effect of rendering the generative faculty incapable of procreation, is to be considered a direct sterilization.”104 This is true even when the procedure is done prophylactically to prevent a likely threat to the woman’s life from a future contingent pregnancy.105 If a prophylactic sterilizing procedure is unjustified in these cases, some might argue that it would also be unjustified to reduce the risk of ovarian cancer.

However, the Congregation is also clear that it condemns these actions not because of their sterilizing effects, but rather because the sole immediate effect of

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102. Admittedly, one could argue that in such a scenario the patient herself provided consent in the original discussion with the physician, but the surrogate would still be the one signing the form on the patient’s behalf.


104. CDF, Quaecumque sterilizatio (March 13, 1975), n. 1.

105. CDF, “Responses concerning ‘Uterine Isolation.’”
the procedure is sterility and the good effect ultimately intended by the physician and patient is only brought about by means of the patient’s sterility. This intention is praised as “subjectively right” because it stems from a desire to cure disease, but it is nevertheless rejected as flawed because the object of the act is defective, that is, sterility is the chosen means to achieve the ultimate end. Sterility is the proximate end, the immoral object of the act; the therapeutic effect, though laudable, is the remote end or subjective intention. Accordingly, it contravenes the first and third criteria of the PDE.

The same is not true for opportunistic salpingectomy to reduce the risk of ovarian cancer. As noted above, the fact that the patient cannot conceive is not what reduces her risk of cancer; rather, it is the lack of fallopian epithelial cells, which shows that the intent of the procedure is not sterility either as a means or an end. The Congregation’s references to pregnancy in its statements reinforce this point. Thus, our conclusion does not violate magisterial teaching regarding direct sterilization.

Second, one might object that the population risk of ovarian cancer is so small that it does not outweigh the burdens of the opportunistic salpingectomy. This line of thinking is appealing because the procedure does not eliminate the risk completely but only reduces it by about half, and it results in the permanent loss of the gift of fertility. Thus, the burdens and risks may appear to outweigh the benefits.

In response, the objection fails to account for three factors. First, as mentioned above, because the procedure is not intrinsically evil, a solidly probable opinion may be constructed that the patient has the authority to determine for herself whether or not the real burdens or benefits of a particular procedure are proportionate or disproportionate in her concrete circumstances. The objection may very well be true for many women, but it is not necessarily the case for all. Second, the loss of the gift of fertility is unquestionably of serious concern and cannot be taken lightly. The woman must understand the serious and irrevocable nature of her decision. Yet we have already shown that the gift is not necessarily directly rejected; rather, its loss is indirectly tolerated as a result of pursuing another legitimate good. Third, for ethicists, ethics committees, mission leaders, or hospital administrators to begin regulating what is and is not a proportionate medical benefit seems to contravene for ethicists, ethics committees, mission leaders, or hospital administrators to begin considering the procedure, should not be construed as a condition for the moral justification of the procedure under Catholic moral principles. If the intent not to have more children is held as a necessary moral condition, the procedure becomes the means by which that condition (intention) is achieved, in addition to being means by which reduction of the risk of death from ovarian cancer is achieved. All that is required from the Catholic moral perspective is that the woman understand that permanent infertility is an unintended side effect of the procedure and that the procedure’s benefits are proportionate to this side effect.

106. Statements from professional societies recommend that opportunistic salpingectomy should be pursued only when the woman has decided that she is no longer going to have any more children. This condition, as used in the medical evaluation of a woman considering the procedure, should not be construed as a condition for the moral justification of the procedure under Catholic moral principles. If the intent not to have more children is held as a necessary moral condition, the procedure becomes the means by which that condition (intention) is achieved, in addition to being means by which reduction of the risk of death from ovarian cancer is achieved. All that is required from the Catholic moral perspective is that the woman understand that permanent infertility is an unintended side effect of the procedure and that the procedure’s benefits are proportionate to this side effect.

107. Moreover, other procedures have more questionable benefit and entail significant risk, such as performing electroencephalography for headaches, imaging studies for nonspecific low back pain, or elective cesarean sections or inductions for patients less than thirty-nine weeks pregnant.

Third, one could object that this procedure defers too much to patient autonomy, so much so that it is at odds with the Catholic conception of medical decision making. Complete deference to patient autonomy might be acceptable in other moral frameworks, but in the Catholic moral tradition, the patient’s weighing of benefits and burdens is not always morally determinative. People, patients included, can choose to do things with their bodies that are not morally justified by reason of their inherent dignity, even if that action is freely chosen and they do so with full knowledge of the action’s nature and consequences. Thus, stewardship of one’s body is limited to the guide given to us by God as revealed in revelation and found in the natural law. Our bodies are not our own to do with as we please; they are gifts from God that “have been purchased at a great price” (I Cor. 6:20). Similarly, “we are not the owners of our lives.” In short, there are limits to what one can do to one’s body.

In response, we agree that the Catholic tradition of medical decision making does not defer entirely to patient autonomy. In fact, the idea that our conclusion defers entirely to patient autonomy is a mischaracterization. We set clear limits regarding when opportunistic salpingectomy could be chosen, namely, in concurrence with another procedure that will occur anyway for another medical reason. Moreover, it seems difficult to claim that we defer too much to patient autonomy, since we believe physicians retain the ability to refuse to perform an opportunistic salpingectomy if they believe the risks substantively outweigh the benefits in a particular case. Thus, we think our conclusion is consistent with the Catholic tradition’s understanding of the limits of patient autonomy.

Fourth, viewing the second objection through the lens of population health, it seems excessive to remove the tubes of hundreds of thousands of women in the United States each year only to prevent 4,800 to 9,000 (22 to 41 percent of 22,000) new diagnoses of ovarian cancer. At best one could argue that 55,000 to 102,000 diagnoses would be prevented each year on a global scale (22 to 41 percent of 250,000), but that would require performing the surgery on hundreds of millions of women, with the concomitant effects of sterilization. Moreover, as mentioned above, the long-term health effects of bilateral salpingectomy are not well known.

108. These and other recommendations for avoiding risks associated with unnecessary treatment can be found on the Choosing Wisely web site of the American Board of Internal Medicine, www.choosingwisely.org/clinician-lists.

109. USCCB, Ethical and Religious Directives, introduction to part 5.

110. Cronin, Ordinary and Extraordinary Means, 162–164.
However, these numbers are not much different from those for appendectomies to prevent death from appendicitis. The incidence rate of appendicitis is 11 per 10,000 (compared to 9.4 per 100,000 for ovarian cancer), and the lifetime risk is 8 percent for men and 6 percent for women (compared to 1.3 percent for women for ovarian cancer), and about half of those who have appendicitis would die if left untreated. It seems peculiar to object to “opportunist appendectomies,” yet they are relatively common (47 percent of all appendectomies are incidental) and used to be regularly offered with cesarean sections.112 Now they are rarely done with cesarean sections because the risk of complications was found to outweigh the benefits.113 Even so, about thirty-six incidental appendectomies (the analogous term for opportunistic salpingectomy) must be performed to prevent one case of appendicitis.114

Moreover, the number of cases prevented by salpingectomy could increase, since it is very possible that the fallopian tissue plays a necessary role in the development of other types of ovarian cancer. Up to 64 percent of all ovarian cancer could be prevented, which would amount to 14,000 fewer diagnoses in the United States and 160,000 fewer worldwide. The only study available is retrospective, but it found a decrease of 42 percent, which is slightly above what would be expected from the histopathological surveys cited above.115 Finally, even though the long-term effects of bilateral salpingectomy are not well known, this is not in itself sufficient reason to preclude the procedure at this time. It is, rather, important information for a woman to have when weighing risks and benefits as part of the informed consent process.

Fifth, one could object that our conclusion assumes that the fallopian tubes are inherently problematic or that their existence per se poses a threat to the patient’s life and health, but Aquinas says that body parts are per se “useful to the good of the whole body” and only happen to be hurtful to the body per accidens.116 Later in the same article he says that “so long as a member is healthy and retains its natural disposition, it cannot be cut off to the detriment of the whole.” The routine removal of healthy body parts to prevent illness seems to fly in the face of these metaphysical and moral points.

In response, Aquinas’s statement here does not account for the further development of the magisterium’s understanding of the principle of totality as articulated by Pius XII, nor does it take into account our expanded notion of pathology, which arises from the modern medical understanding of illness and anatomy and was not available in Aquinas’s day. Moreover, Pius XII and others who preceded him have further developed and clarified Aquinas’s thoughts. Thus, our conclusion does not necessitate a rejection of Aquinas’s metaphysical premise, especially since we readily acknowledge the vast majority of fallopian tubes do not and never will threaten the life of anyone. Our argument is based not on the claim that all or most tubes are ordered against the good of the body but rather that the lack of effective screening and treatment for ovarian cancer make opportunistic salpingectomy a morally legitimate option for those women who are at population risk and reasonably fear this low potential of developing such a dreaded disease.

Sixth, one could object that if opportunistic salpingectomy becomes widespread, many other body parts could also be removed under the same rationale. Why not offer prophylactic mastectomy to women of population risk of breast cancer after they finish nursing their youngest child, or prostatectomy or orchietomy to men at average risk of prostate or testicular cancer after they finish having children? After all, if cancer prevention is an end in itself, shouldn’t we also advocate for the bilateral mastectomy of female neonates?117

In response, breast cancer has a very good survival rate (90 percent) and an effective screening mechanism through self-examination and mammograms. Likewise, prostate and testicular cancer have some of the highest cure rates among cancers (over 95 percent for each), have a low incidence (similar to ovarian cancer), and have good screening mechanisms.119 In contrast, ovarian cancer has a very poor survival rate and cannot be screened for. Moreover, there are benefits to keeping the testicles and breasts besides reproduction and breast-feeding, but the only benefit to keeping the fallopian tubes is the ability to conceive naturally. Therefore, opportunistic salpingectomy falls into the middle of a scale between risks and benefits in comparison with other surgeries to prevent cancer in the general population.

Seventh, if the risks of ovarian cancer are so significant that one would undergo sterilization to reduce the risk by half, even if such sterilization were indirect, then it seems only logical to also undergo a bilateral oophorectomy in the hopes of completely preventing ovarian cancer altogether.

In response, this is neither a conclusion nor a recommendation from professional societies. Thus, while one might suspect that the intention behind opportunistic salpingectomy is actually to sterilize and not to reduce the risk of cancer, we would argue that the ultimate goal of opportunistic salpingectomy, beyond reducing the

116. ST II-II.65.1 corpus.
risk of ovarian cancer, is to prevent premature or untimely death in accordance with the goals of medical practice.120 Bilateral oophorectomy, however, is contrary to this ultimate goal, since early menopause caused by bilateral oophorectomy is known to shorten a woman’s life span overall because of a higher incidence of stroke, heart attack, and other health issues later in life.121 This increase is greater than the risk of ovarian cancer that remains after opportunistic salpingectomy. For this reason, the current recommendations are to leave the ovaries intact unless the patient has a significantly increased risk of ovarian cancer due to a genetic marker or family history.122 Since the ultimate goal is to reduce the risk of death, not cancer, the conclusion to leave the ovaries but remove the fallopian tubes is justified.

Eighth, there is the objection that if our conclusion is adopted, it could lead to sterilization becoming a routine. In a few decades, assuming opportunistic salpingectomy becomes widespread, the majority of women may very well lose their fertility surgically to prevent cancer many years before they undergo the natural decline in fertility that occurs with aging. Even if such sterilization is indirect, it is still concerning if the loss of natural fertility were to become so prevalent in the population. It perpetuates the cultural norm that fertility is a superfluous accessory or a burden rather than a gift, and reinforces the concept that the radical autonomy of the individual is the final arbiter of right and wrong. Moreover, the decline of birth rates is already worrisome and this procedure could accelerate it.123

In response, other surgeries are already just as common as this one might become. About 22 to 66 percent of people will have at least one wisdom tooth removed, and 50 percent of those over sixty years of age will need cataract surgery.124 Granted, both of these involve restoring divine gifts (eating and sight) rather than removing one (fertility), but opportunistic salpingectomy also serves to preserve the greatest gift of all: life itself. Wisdom teeth and cataracts are usually removed to increase the quality of life rather than to prevent death. Thus, even though salpingectomy removes fertility, it does so for a more serious benefit than other common

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122. ACOG Committee on Gynecologic Practice, “Salpingectomy for Ovarian Cancer Prevention.”


125. As stated above, the intent not to have more children cannot be a necessary condition of the procedure, the additional intent to prevent death from ovarian cancer notwithstanding. Doing so makes opportunistic salpingectomy the means by which one chooses to no longer have children, which renders it morally unjustifiable.

family members requesting a medically indicated withdrawal of a ventilator in a patient with widely metastatic colon cancer is generally not questioned. The same is true for a patient requesting a hysterectomy for abnormal uterine bleeding after less invasive treatments have failed. In both of these situations the agents could have subjectively bad intentions which would render their decision morally defective. Yet as stated above, only God knows someone’s thoughts and their true intentions. No one can know what is in someone’s heart unless that person declares it.

In the absence of evidence to the contrary, we must presume good intentions on the part of those requesting this procedure. To do otherwise would require a facility to constantly perform a policing function which runs afoul of values like trust, mutual respect, professional integrity, honesty, and appropriate confidentiality—values which are foundational to the professional–patient relationship. It is not our responsibility to police the consciences of patients, families, and clinicians. Rather, it is the responsibility and obligation of a Catholic facility to institute policies that are consistent with its identity as a healing ministry of the Church, but not to ensure that no one ever does anything that might be contrary to the Church’s teaching, especially when the act in question would be immoral solely because of the subjective intention of the acting agent. They must answer for themselves. Moreover, such a position could be construed as interfering with or controlling the practice of medicine. Thus, as long as a Catholic facility or physician takes these two steps, we believe that the risk of scandal will be sufficiently addressed to justify permitting opportunistic salpingectomy and avoid complicity with a “workaround” of the prohibition of direct sterilization.

**Opportunistic Salpingectomy Can Be Licit**

Recent medical evidence strongly suggests that opportunistic salpingectomy for women at average risk of developing ovarian cancer is likely to cut this risk in half. This has left some physicians asking, “Salpingectomy, why not?” We argue that offering bilateral salpingectomy to any woman who is at average risk of developing cancer and is already having an unrelated pelvic or abdominal surgery is morally justified by the principles of totality and double effect. Even though the fallopian tubes are not diseased at the time of removal, the salpingectomy is still directed at the good of the body as a whole. Pope Pius XII clarifies that the principles of totality and double effect morally justify the removal of non-diseased organs in analogous cases.

Opportunistic salpingectomy meets the criteria for the PDE. Salpingectomy is not intrinsically evil; it is justified in treatment of ectopic pregnancy and fallopian tube cancer. The agent’s intent in performing it is not to induce sterility but to reduce the risk of death from a very deadly form of cancer for which there is currently no screening available; if the intent were otherwise, the procedure would be a tubal ligation and not a salpingectomy. The patient’s inability to get pregnant is not what reduces the risk of cancer, but rather her lack of fallopian epithelial cells.

Finally, we believe that the benefit of reducing the risk of death from cancer is sufficiently proportionate to the added risks of opportunistic salpingectomy as to fall within the purview of the physician–patient relationship. We do not claim that the benefits are *always* proportionate to the risks involved, although they could be if future studies show that the procedure results in an extremely high reduction in the risk of ovarian cancer. At this point, however, we simply claim that the patient has the rightful authority to determine whether there is sufficient benefit to justify a potentially justifiable risk-reducing salpingectomy, because only patients or their rightful surrogates can determine if an intervention constitutes ethically ordinary means, and determinations of proportionate benefit must occur within the provider–patient relationship.
