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Secondary Causality and Defective Choices

Rev. Justin Kizewski

As a former high school teacher, it is not difficult for me to imagine a student asking, "What would you say to someone born of in vitro fertilization? That they should have never been born?" The question arises in reference to the Church's conviction that every person has the right to be conceived in the loving embrace of her parents, in the safe environment of her mother's body, under her mother's heart.[1] To protect the importance of the unitive and procreative end of marriage, the Church warns against severing the one from the other and anticipates the damage that such a wound causes. Contraceptive sexual relations intentionally damage the procreative logic and damage perhaps unintentionally the unitive by engaging in sex without openness to life, that is, without respect for the whole person. In vitro fertilization does the reverse, intentionally separating the procreative from the unitive, all the while carrying perhaps unintentional consequences wrapped up in the defective nature of such a choice. This separation is often felt in subsequent suffering.

While the clarity of the teaching is helpful, receiving the teaching can be hard. Consider someone who is a product of in vitro fertilization. How are they meant to feel? If their parents had followed the Church's teaching, they very well might not exist. Given the events of the past, ought they not exist now? Are they a mistake? These are real questions that must be answered with an absolute disavowal of the logic that would question the goodness of their existence. Existence is the most foundational good.[2] Every other good has as its prerequisite that we exist. No matter how you have come to exist, it is good that you are.[3]

What if the complicated and painful feelings experienced by a child produced through in vitro are themselves cast as the unintended but nevertheless understandable consequences of the lack of due order or deficiency in their parents' decisions? Even if untrue, questions about the validity of existence are painful. The questions exist not because the Church cautions against it but because the decision lacked a certain due order. The unknowns involved when someone's father is named donor are understandable.[4] Pains involved with custody battles surrounding IVF and surrogacy are easily discerned.[5] The Church as mother would have spared them these effects. She brings to bear a deep wisdom concerning what helps human beings flourish. To deviate from God's plan leads to pain, frustration, and an overall lack of flourishing. So much of the Church's teaching, if lived out, would result in sparing her children of much suffering. Can we recast the Church's teachings as expressive of the desire to spare all this unintended pain? If choices had been healthier, if they had been more in tune with God's will and Church teaching, many of the sufferings in these areas of life could have been avoided, or at least mitigated.

But what if they are not avoided? How can we respond to the struggling person who feels like a product? The *Catechism of the Catholic Church* comes to our aid in its section on Providence and secondary causes (nn. 306–308). Let us briefly discuss a bit of metaphysics: God is the First Cause. Humans act for the sake of an end. Between God and a person's end, the person is a secondary cause. Just as when one draws with a marker on a whiteboard, the marker is a secondary or intermediary cause to his or her writing on the board. Human actions are 1) sustained and so also caused by God and 2) caused by us. We are not caused in a way that would destroy our freedom. Writing with a marker entails the marker's capacity to write in accordance with its nature as blue or green. Likewise, God's causing us to act entails our capacity to act in accordance with our nature as free. In our case, our nature enables us to act freely not unlike the marker writes in green. God's causing us to cause entails our acting freely. This is true when we choose the good. It is also true when we choose evil.

St. Thomas Aquinas asks at various moments the confusing question of "Whether God causes our act of sin?"[6] Keeping in mind the distinctions made above, we might anticipate the answer he gives. Yes, God causes our act of sin. That is, he causes the being of our act. Just as being is good, our ability to act is a good even when our actions are not. Every being, every good is caused and sustained by God. The good implicated in my activity is meant to be directed toward goods that are conducive to my final end. The degree to which I defect from this end is the degree to which my act will lack goodness. This lack of goodness, lack of due order, and lack of being is the privation we call evil.

These paragraphs referenced above from the Catechism speak of secondary causes and the role they play in God's plan. The passage that is most helpful says: "God thus enables men to be intelligent and free causes in order to complete the work of creation, to perfect its harmony for their own good and that of their neighbors. Though often unconscious collaborators with God's will, they can also enter deliberately into the divine plan by their actions, their prayers, and their sufferings" (n. 307). Located under the providential governance of God, the work of secondary causes, collaborating even unconsciously, provides a helpful tool for understanding.

God can use even the sinful actions of some to bring about certain turns in his plan. Examples abound. Pontius Pilate helps bring about the means of our redemption: "You would have no power

if it were not given to you from on high" (John 19:11). The power of Pontius Pilate serves as a secondary cause to the First Cause's bestowal of that power. The necessary sin of Adam brings about Christ as our Redeemer.[7] Even the devil prompts the promise of a savior in his intent to mar God's creation (Gen. 3:15).

This umbrella of providence shelters each of us. Nothing is outside his providence, not even our poor choices. The defective choices that we have made may bring about opportunities for growth we would have found hard to come by without the consequent suffering wrought by our deficient acts. When we make a mess of things, we might gain the opportunity to experience someone's unconditional love and forgiveness. Or we can humble ourselves and offer our self-inflicted woundedness back to the One whose wounds still show.

This teaching allows us to say that even choices that lack due order regarding the begetting of a child do not fall outside of God's providence. God accounts for the defective choices of his creatures in bringing about his plan. We use defective choice because there may or may not be a sin on the part of parents who choose IVF, even though there is still a defection from the good.[8] It is still wrong and certainly attended by its unintended side effects such as the severing of the procreative and unitive character, feelings of remorse, and, depending on the degree of defection from the good, perhaps some psychological effects for the child. These effects arise if a child is conceived or gestated by a third party, a product of an unknown parent, or as the sole survivor among other siblings either destroyed or frozen. All these factors are often part of the picture in surrogate situations, donor parents, and IVF techniques.

Nevertheless, God can use the defective choices of parents to bring into the world someone that He wills. The child's coming-to-be is not outside of God's plan. Unconsciously, the parents of the child bring about the circumstances which allow for God's will to be done. God graciously sustains their misguided actions to bring a person into being.

No matter how a child comes to be, whether through IVF or outside of wedlock, the creation of each human person is God saying: "It is good that you are" or "I choose you." Every conceived child possesses the dignity of being affirmed, chosen, and called into existence by God. The unconscious collaborators participate in a plan of which they may not be fully aware. Keep in mind, none of this justifies a deficient action, but it does allow us to affirm absolutely the goodness of the child produced in such a way.

If deficient in some way toward our true flourishing, that is, if contrary to God's law or the perennially valid teaching of the Church, we will likely endure some unintended but nevertheless consequent suffering. Much of this suffering is wrapped up in the natural consequences of defective acts; however, this suffering is not directly intended by God, and the Church's desire is to spare us of it. None of this, however, is outside of God's providence, and his ultimate plans for us are for good (Jer. 29:11).

However, the second part of the quoted text is also important because it articulates the ideal. We "can also enter deliberately into the divine plan by [our] actions, [our] prayers, and [our] sufferings." Deliberately and consciously entering into this plan means following the Lord's commands, hearing the teaching of the Church as the Lord's own, accepting difficult circumstances as part of his providence, and offering our suffering in union with his as that which is lacking in the Body of Christ (Col. 1:24–29). By becoming full collaborators we avoid, as much as possible, a great deal of pain and suffering, share in his salvific work and glory of the Father, and are led little by little to the kind of peace and flourishing that He alone offers.

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Notes

1. Congregation for the Doctrine of the Faith, *Donum vitae: Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation – Replies to Certain Questions* (February 22, 1987), II.1: "The child has the right to be conceived, carried in the womb, brought into the world and brought up within marriage."
2. See Joseph Ratzinger, *'In the Beginning . . . : A Catholic Understanding of the Story of Creation and the Fall*, trans. by Boniface Ramsey, O.P. (Edinburgh: T&T Clark, 1990), 53. Ratzinger correctly points out that not all, particularly more and more young people, immediately intuit the goodness of existence; however, it is something knowable by reason and numbered in the classic lists of the "transcendentals." See also Thomas Aquinas, *De veritate*, q.1, a.1.
3. See Josef Pieper, *Faith, Hope, Love* (San Francisco: Ignatius Press, 1986), 164. Joseph Pieper associates this statement with basic affirmation of love.
4. Elizabeth Marquardt et al., *My Daddy's Name Is Donor* (West Chester, PA: Broadway Publications, 2010).
5. See *Michael H. v. Gerald D.*, 491 U.S. 110 (1989) in Jerry Menikoff, *Law and Bioethics: An Introduction* (Washington, D.C.: Georgetown University Press, 2001), 110.
6. Thomas Aquinas, *De malo*, q.3, a.2.
7. *Roman Missal*, 3rd ed. (Washington, DC: International Commission on English in the Liturgy, 2011), 355.
8. See Augustine, *83 Questions*, PL 40:46. Augustine characterizes sin as defecting from the good.

Reflections on Revising Part 4 of the *ERDs*

John F. Brehany

Fifth in a series that reviews the current ERDs *and reflects on what changes would be necessary or helpful in their next major revision.*[1]

ERD Part 4, "Issues in Care for the Beginning of Life," is the largest of the *ERDs*' six parts. This is not surprising, since it addresses both traditional ethical issues such as respect for human life in its origins and fertility, as well as more recent developments such as assisted reproduction, surrogacy, prenatal testing, and genetic counseling. It was advanced for its time, but new challenges and practices have arisen over the last three decades.

The introduction establishes a broad framework for its 17 directives by highlighting four major issues: (1) the Church's commitment to human dignity and the sanctity of human life, and its rejection of medical practices that undermine these goods; (2) the Church's understanding of the goods of marriage and marital love; (3) principles governing spouses' choices to space or limit the birth of children; and (4) the inadequacy of the technological imperative alone as a consideration in addressing infertility. Not to be missed is the final sentence of the introduction mentioning the moral (natural) law, which references a profound meditation on this topic in Saint John Paul II's 1993 encyclical, *Veritatis Splendor*.[2]

Part 4's directives cover a range of topics. One-third are devoted to issues surrounding infertility, including technology and techniques to achieve conception (38–41), surrogacy (42), and alternatives, such as adoption (43). Directive 44 calls for appropriate obstetric, pre- and post-natal care. Directives 45–49 cover critically important topics related to pregnancy, including abortion and its aftermath (45–46); treating serious pathologies experienced by women during pregnancy (47); ectopic pregnancy (48); and induction of labor (49). Directives 50 and 54 address two topics that were relatively new in the early 1990s—prenatal screening (50) and genetic counseling (54), whereas directives 52 (contraception) and 53 (sterilization) cover topics that have been in the ERDs since their inception.

Reflections on Revising *ERDs* Part 4

At least three considerations should shape efforts to update the guidance in Part 4: (1) incorporating relevant updates in magisterial teachings; (2) addressing new developments in clinical medicine, health care delivery, and society; and (3) improving the formulation or organization of directives.

The most important recent magisterial teachings to integrate are the encyclicals *Evangelium vitae* (1995), *Caritas in veritate* (2009) and, from the CDF, the instruction *Dignitas personae* (2008) and a Response to a Question on the Liceity of Hysterectomy in Certain Cases (2018). Important USCCB Committee on Doctrine guidance since 1995 includes Moral Principles Concerning Infants with Anencephaly (1996) and The Distinction Between Direct Abortion and Legitimate Medical Procedures (2010). Developments in medicine and recommendations regarding current directives are covered in the section below.

Reflections on Revising *ERD* Part 4 Directives

There are four major topics covered in Part 4: infertility and assisted procreation; abortion and medical interventions during pregnancy; prenatal screening and genetic counseling, and direct contraception and sterilization. For each topic I will provide suggestions for improving the current text and note new developments that should be addressed in a future revision.

The 1995 *ERDs* devote a great deal of attention to assisted reproduction at the start of Part 4. This topic was still relatively new at the time and, even after *Donum vitae*, some questions remained about what constituted licit interventions. Now, however, the overwhelming percentage of ART procedures involve in vitro fertilization (IVF). Alternative options once debated by Catholic scholars, such as GIFT and LTOT, have faded into obscurity if they are used at all. New practices before (intracytoplasmic sperm injection (ICSI)) and after IVF (selective reduction) have sprung up. The text of directives 38–41 should be distilled. It should suffice to specify that any interventions that utilize gametes or assistance outside of a marriage or that replace a specific conjugal act as the cause of conception are prohibited. This can create space to address other current reproductive interventions including gamete freezing, embryo freezing, preimplantation genetic diagnosis, and any form of cloning. Directive 42 should clarify that any gestational surrogacy is wrong, not merely that done for commercial consideration. Catholic hospitals should be counseled to avoid all cooperation in surrogacy arrangements, including participation in the handing over of a baby to the contracting parents after birth. Directive 43 should encourage the development and use of "restorative reproductive medicine" to help spouses overcome infertility with authentic healing.[3]

The next major set of issues addressed in the *ERDs* include abortion and interventions during pregnancy that may result in threats to the life or health of the mother, of unborn children, or of both. The Church's condemnation of all direct abortion has been consistent and was even strengthened by *Evangelium vitae* (which should be cited in the next *ERD* revision). Directive 45 provides a definition of abortion—"the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus." Directive 47 states that serious pathologies of a pregnant mother may be treated under certain conditions even if this would result in the death of the unborn child. And directive 49 notes that labor may be induced after viability for a proportionate reason. The text of these directives has remained consistent for decades. There are two particular challenges facing those who try to apply this framework in some "vital conflicts"[4] in contemporary medicine: there are some challenging conditions in pregnancy in which both lives of mother and unborn child are under direct threat and the only available intervention is induction of labor before viability (e.g., eclampsia). A more significant clinical and ethical challenge is posed by a small set of clinical conditions in which the life of the mother is threatened not by a disease (e.g., cancer) but by the stress caused by a normal previable pregnancy (e.g., peripartum cardiomyopathy during pregnancy). At issue is whether interventions that directly terminate the pregnancy (via early induction or by "deplantation" of the placenta) are consistent with the Church's teachings on direct abortion and directive 45. The issues are too complex to outline here.[5] Moreover, the dispute over interventions which qualify as direct abortion under directive 45's definition extends as well to the ethics of interventions for ectopic pregnancy (both surgical[6] and chemical[7]). The revision

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of directives 45, 47, and 48 might best be handled as a stand-alone project. However, if this is not done soon, then these directives should be addressed when the 1995 *ERDs* are revised in their entirety.

Directives 50 and 54 cover analogous topics. Each has aged relatively well. Of the two, directive 50, addressing prenatal testing or screening, most requires supplementation. Over time, the regime of proactively offering prenatal testing to all pregnant women has been exacerbated by increasing pressure to abort children with congenital conditions. And the traditional tools of prenatal testing, amniocentesis and chorionic villi sampling, have been surpassed in routine use by noninvasive tests of fetal DNA fragments found circulating in maternal blood. Given these additional pressures, directive 50 should be supplemented by calling for Catholic health care providers to be leaders in sensitively and effectively supporting parents who receive a positive diagnosis in prenatal testing.[8]

Directives 52 and 53 address the challenging topics of hormonal contraception and surgical sterilization, which have been covered in the ERDs from their inception. What distinguishes the 1995 directive 52 is a failure to clearly proscribe acts of direct contraception and cooperation by Catholic health care institutions and professionals in facilitating these. Rather, only efforts to "promote" or "condone" these are rejected. A revised directive 52 should clearly proscribe the provision of direct contraceptives, particularly the use of long-acting reversible contraceptives. It also should utilize more contemporary terminology, such as, "fertility awareness-based methods" instead of the antiquated term "NFP" and stress that FABMs are essential for promoting women's health beyond the spacing of children in marriage. An emphasis on the goodness of the human body and on women's health also could be incorporated into Part 4's introduction.

Directive 53 is relatively strong, in part because it has been supplemented with the text and endnote materials of directive 70, starting in 2001. The next revision should clarify how directive 53 should be applied to new clinical practices such as risk-reducing surgeries for cancer, particularly when there is no specific elevated risk for cancer.[9] It also should integrate the teachings in two important CDF *Responsa*, which address challenging medical conditions for which sterilizing surgery is a recommended clinical option.[10]

A final needed improvement would be to reorganize the topics. Moving the entire section regarding assisted reproduction to the back of Part 4 would allow issues of greater moral urgency (such as abortion) or that are more frequently encountered in Catholic health care (contraception and sterilization) to receive greater attention.

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Notes

1. See earlier articles in issues 46.8, 46.9, 46.10, and 46.11 of *Ethics & Medics*.
2. John Paul II, *Veritatis splendor* (August 6, 1993), n. 50.
3. International Institute for Restorative Reproductive Medicine at iirrm.org/.
4. See John A. Di Camillo, "Induction of Labor and Vital Conflicts," *Ethics & Medics* 40.5 (June 2015), doi: 10.5840/ncbq201616338.
5. See Ascension Health Colloquium, "Medical Intervention in Cases of Maternal–Fetal Vital Conflicts: A Statement of Consensus," *National Catholic Bioethics Quarterly* 14.3 (Autumn 2014), doi: 10.5840/ncbq20141439, and Jay J. Bringman and Robert B. Shabanowitz, "The Placenta as an Organ of the Fetus: A Response to the Consensus Statement on Maternal-Fetal Conflict," *National Catholic Bioethics Quarterly* 15.1 (Spring 2015), doi: 10.5840/ncbq20151514.
6. See Helen Watt and Anthony McCarthy, "Targeting the Fetal Body and/or Mother–Child Connection: Vital Conflicts and Abortion," *Linacre Quarterly* 85.3 (November 18, 2018): 241–51, doi: 10.1177/0024363919887613, responding to Maureen L. Condic and Donna Harrison, "Treatment of an Ectopic Pregnancy: An Ethical Reanalysis," *Linacre Quarterly* 85.3 (June 18, 2018): 147–60, doi: 10.1177/0024363918782417.
7. Benedict M. Guevin, OSB, "The Use of Methotrexate or Salpingostomy in the Treatment of Tubal Ectopic Pregnancies," *National Catholic Bioethics Quarterly* 7.2 (Summer 2007): 249–256, doi: 10.5840/ncbq20077253.
8. See Brian Skotko et al., "Prenatal Diagnosis of Down Syndrome: How Best to Deliver the News," *American Journal of Medical Genetics* 149a.11 (2009): 2361–2367, doi: 10.1002.ajmg.a.33082.
9. Becket Gremmels et al., "Opportunistic Salpingectomy to Reduce the Risk of Ovarian Cancer," *National Catholic Bioethics Quarterly* 16.1 (Spring 2016): 99–131, doi: 10.5840/ncbq201616110; and Jonathan Scrafford and Lisa Gilbert, "Opportunistic Salpingectomy during Cesarean Section," *National Catholic Bioethics Quarterly* 18.3 (Autumn 2018): 487–500, doi: 10.5840/ncbq201818348.
10. See Nicanor Austriaco et al., "Initial Reactions to the Recent CDF Responsum on Hysterectomy," *National Catholic Bioethics Quarterly* 18.4 (Winter 2018): 647–669; and Statement by NCBC Ethicists, "Commentary on the CDF Responsum of December 10, 2018," National Catholic Bioethics Center, February 15, 2019, available at https://www.ncbcenter.org/resources-and-statements-cms/commentary-on-the-cdf-responsum-of-december-10-2018.

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