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4. The Ethics of Therapeutic Abortion and an American Catholic Medical School
Charles Coppens, S.J. and the Creighton Medical College
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Introduction
[1] In 1897, the Jesuit priest Charles Coppens published the lecture notes for his course in medical jurisprudence at the new John A. Creighton Medical College in Omaha, Nebraska. Coppens’ work, entitled Moral Principles and Medical Practice, was the first American Roman Catholic textbook in a discipline that would later come to be known as medical ethics (on the historical significance of Coppens’ volume, see Kelly: 110). Explaining the purpose of the course in his opening lecture, the Jesuit remarks:
The principal reason why I have undertaken to deliver this course of lectures – the chief reason, in fact, why the Creighton University has assumed the management of this Medical College – is that we wish to provide for the West, as far as we are able, a goodly supply of conscientious physicians, who shall be as faithful and reliable as they will be able and well informed; whose solid principles and sterling integrity shall be guarantees of upright and virtuous conduct (36).

[2] One of the most challenging ethical questions facing “upright and virtuous” physicians at the end of nineteenth century concerned the use of emergency obstetrical procedures that could be lifesaving for the mother, yet fatal for her unborn child. The most controversial of these practices, which we might regard today as instances of therapeutic abortion, provoked serious analysis and debate among physicians and Catholic theologians during this period. Charles Coppens, who was neither a doctor of medicine nor a doctor of theology, addressed these sensitive issues from an unusual vantage point: as a priest teaching in the pluralistic context of an American Catholic medical school. By relying primarily upon medical (rather than theological or ecclesiastical) authorities to support his ethical arguments, the Jesuit translated the Catholic ethical tradition for a predominantly non-Catholic audience of aspiring scientific professionals. Although Coppens does not adequately acknowledge the range of contemporary medical opinions regarding these issues, his work nevertheless models the importance of engaging physicians’ ethical conclusions about moral problems, and not simply their technical expertise regarding medical procedures, within religious ethics.

[3] To understand Coppens’ arguments and contribution, it is critical to set his work in context. First, one must consider why craniotomy and similar procedures posed such an important challenge for medical practice (especially in the United States) and for Roman Catholic theology at the end of the nineteenth century, and how the debates within the medical community and within the Church influenced one another. Second, one must consider Catholic medical education in the United States, and examine how the controversies over obstetrical ethics affected American Catholic medical schools. In light of this general history, one is better prepared to appreciate the significance of Coppens’ role as an instructor in medical jurisprudence at Creighton, and to recognize how the context in which he was teaching seems to have influenced his approach to obstetrical ethics. Finally, these investigations of background – medical, theological, and institutional – illuminate Coppens’ approach to obstetrical controversies within Moral Principles and Medical Practice.

Therapeutic Abortion as a Medical and Theological Issue

[4] “In the period from 1880 to 1900,” explains James Mohr, “the United States completed its transition from a nation without abortion laws of any sort [as it had been in 1800] to a nation where abortion was legally and officially proscribed” (Mohr: 226, 3). The majority of state anti-abortion laws (including Nebraska’s) were adopted between 1860-1880, in

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1 At the time when Coppens was writing, “abortion” referred to the termination of the pregnancy before the fetus became viable. Hence, craniotomy and embryotomy (when these procedures were performed on a living child) were not “abortions,” in the technical sense, unlike the premature delivery of a not-yet-viable fetus. For a basic definition of abortion in this sense, see Williams: 338.
response to campaigns against elective abortion spearheaded by the young American Medical Association (Joyce 2002: 95; Brown and Wheeler: 1000). Yet these laws (again, including Nebraska’s) established an explicit exception for procedures intended to save the life of the mother. Legislators generally did not specify what circumstances or medical criteria had to be present to justify a therapeutic abortion, leaving such determinations to the physician’s conscience and professional expertise (Joyce 2002: 95-96; Reagan: 61-62; Louisell and Noonan: 230-31).

[5] For the medical community, one particularly contentious issue in obstetrical ethics during this period concerned the appropriate response to life-threatening complications during childbirth, such a disproportion in size between the mother’s pelvis and the baby’s head (Dixon; Van Fleet; Leavitt: 236-37, 239-41, 244; Reagan: 63-69; Imber: 38; Ryan 2002: 467-74, 478-81, 484-91). While surgical developments during the nineteenth century gave doctors – at least in theory – an expanding range of options for confronting such problems, the practical realities were often much more circumscribed (on the various procedures available, see Leavitt: 233-36). At a time when most births occurred in the home, and family members often summoned a doctor only when it was clear that an extended labor had become an emergency (see Hardy: 263-64), conditions were hardly ideal for a caesarean section or other surgical approach, even for a practitioner with the appropriate skills to provide such treatments (Leavitt: 234-35, 237, 242). When forceps delivery was impossible, an alternative to a surgical intervention was craniotomy, i.e. perforating and crushing the baby’s head to allow its extraction. Although the more common use of this procedure was to remove a dead fetus, some doctors also performed it on the living as an “emergency last resort to save the mother’s life” (Leavitt: 235). Heated medical debates over legitimacy of craniotomy – an act that no doctor desired to perform, but one that many believed was sometimes tragically unavoidable (e.g., see Shrady 1885; the comments of Dr. Fifield, reported in Dixon: 278; Barnes: 624) – and over the comparative risks of the various options, extended through the late nineteenth and into the early twentieth centuries (Leavitt: 236-37; Ryan 2002: 472-73, 478-81, 488-90, 492-93; Barnes; Ashby).

[6] During the same period, moral theologians were also analyzing the appropriate ethical response for obstetrical emergencies, not only in light of the contemporary medical developments, but also in light of longstanding tradition. In fact, theological justifications (under certain circumstances) for some acts intended to save the life of a pregnant woman, even if they inadvertently resulted in the death of her unborn child, extended back to the early fourteenth century (Connery: 114-16). By the mid-1900s, much of the Catholic theological debate centered around two questions. First, could the fetus (inadvertently of

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2 On the limitations of the practitioner as a consideration, see Barnes; Shrady 1889: 324; the comments of Richardson in Dixon: 279; Grandin, 641; Ryan 2002: 464, 467-68, 479-80, 481, 487.

3 For a description of the various procedures from a textbook used in Coppens’s time, see Cameron: 926-41. Cf. Cameron’s emphasis on the dangers for the mother of another such procedure, embryotomy (the mutilation of the trunk of the child’s body) with his comments on craniotomy and caesarean section (926-27, 941).

4 For examples of debates over these issues at the meetings of medical societies, see Dixon; Van Fleet: 391-94; Leavitt: 236-37; Barnes.
course) threaten the mother’s life in such a way that she was entitled to defend herself against it, just as she could defend herself against an assailant who was not morally responsible for the assault? Second, could certain obstetrical procedures fatal to the unborn child meet the criteria for classification as indirect rather than direct taking of innocent human life, since Catholic tradition regarded the former (but not the latter) as acceptable under limited conditions? Some theologians invoked these arguments to justify particular procedures, e.g., craniotomy, premature delivery, or surgical removal of an extrauterine fetus that could not survive outside of the mother’s body, while others rejected such acts as direct killing of the innocent (Connery: 214-303; Rhonheimer: 57-81). Moreover, individual theologians sometimes agreed on the moral assessment of a procedure, without agreeing on the grounds for its justification (see Connery: 301-302).

[7] This lively discussion was, in many ways, merely the continuation of a debate that had already been going on for some time, and in fact, continues today (Rhonheimer; Shaw). Two factors, however, were new in the late nineteenth century. The first was the development of academic and pastoral journals that “allowed for a much faster exchange between proponents of different and especially opposing opinions” (Connery: 226). The second was the intervention of ecclesiastical authorities. By the end of the nineteenth century, it was becoming increasingly common for Vatican officials to offer direct answers to complex ethical questions, instead of advising the perplexed to consult the approved authors (Connery: 226-27, 255, 291-94; Ryan 2002: 471; on the eventual significance of this change in the twentieth century, see Keenan: 18-19).

[8] In the thirteen years before Charles Coppens published his Moral Principles and Medical Practice, the Holy Office issued responses to questions surrounding obstetrical emergencies, the first two concerning craniotomy and the third, premature delivery of a not-yet-viable fetus (ASS 1884; ASS 1889; ASS 1895). Not surprisingly, these responda addressed cases that had been the topic of intense debate in the professional literature: in fact, two of the public defenders of craniotomy had served as editors of the Acta Sanctorum Sedis, a monthly journal that disseminated major church documents, including statements of the Holy Office and the other Roman Congregations (Connery: 232, 256). Additional rulings regarding premature delivery in particular cases would come from the Vatican in 1898 and 1902 (ASS 1898; ASS 1902).

[9] As harbingers of an increasing involvement in ethical controversies, these Vatican interventions represent a very important development in the history of Catholic moral thought. However, the particular responda themselves are terse answers to specific questions rather than developed ethical analyses. For example, to the Archbishop of Lyon’s inquiry about whether Catholic schools could teach that craniotomy was licit as a means of saving the mother, when the alternative would be the death of both mother and child, the Congregation instructed: “it cannot be taught safely [tuto doceri non posse]” (ASS 1884: 556). Only occasionally do the responda mention ethical principles that ground their decisions: in general, they respond to the original questioner’s “doubt [dubium]” with a brief

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5 Another author willing to accept craniotomy was the bishop of Alton, Illinois (see Connery: 267; Ryan 2002: 474-78). The defense of premature delivery of an unviable fetus had first been raised in Revue théologique in 1857 (Connery: 214).
pronouncement on the proposed action’s legitimacy. There is no resolution of the underlying ethical debates, e.g., whether one can reasonably describe a fetus as a materially unjust aggressor. (Direct response to that question would only come much later in a encyclical of 1930 primarily devoted to marriage and contraception, Pius XI’s *Casti Connubii* [562-63]).6 The Vatican resolutions of the late nineteenth century were practical rulings that left the foundational ethical questions unanswered.

[10] In their own professional literature, physicians made many references to the evolving Church teaching on obstetrical questions (e.g., Dixon: 279; *JAMA*: 405-406). The Roman *responsum* of 1884 gained particular attention, eventually provoking editorials or other notices in a number of American medical journals, such as the *Eastern Medical Journal*, *The Atlanta Medical and Surgical Journal*, *The Peoria Medical Monthly*, *The Southern California Practitioner*, *The Eclectic Medical Journal*, the *Kansas City Medical Index*, the *Detroit Lancet*, *The Mississippi Valley Medical Monthly*, the *Virginia Medical Monthly*, and *The Saint Louis Medical and Surgical Journal* ([Marston], *Atlanta*, [McIlvaine], *Southern*, [Scudder], Lanphear, [Connor], [Neely], [Edwards], James; some of these sources quote, paraphrase, or reprint material that appears in others). An important source for a number of these commentaries (either directly or indirectly) was a letter to the *American Israelite* from Moses Mielziner, professor of Talmud and rabbinical literature (and later president) of Cincinnati’s Hebrew Union College, entitled “Papal and Talmudic Opinion of Craniotomy.”7 While Mielziner’s letter contrasted the Vatican’s position with the treatment of similar problems in the Mishna, the medical journals devote less attention to his effort in comparative religious ethics than to his report that every Catholic doctor in New York City had received a circular outlining the Vatican’s decision.8

[11] Not surprisingly, late nineteenth-century medical journals were very interested in the potential impact of the Vatican ruling upon Catholic doctors. The *Southern California Practitioner*, for example, suggested that this “promulgation from the Popal [sic] throne” would “cause a revival of Caesarean section” (61; on the debate over the safety of Caesarean section, see Leavitt: 235-36; Ryan 1997). Other editors expressed skepticism that the pronouncement would have any impact upon medical practitioners, including Roman Catholic physicians. A particularly harsh editorial in the *Saint Louis Medical and Surgical Journal* argued that any Catholic doctor who allowed the mother to die in such emergency circumstances “should be indicted for homicide, or the grossest of criminal malpractice” (390).9

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6 Although this version of the text contains no paragraph numbers, this is Paragraph 64 in later editions.

7 Direct references to and in some cases lengthy citations from Mielziner’s work appear in the editorials from *The Mississippi Valley Medical Monthly*, the *Virginia Medical Monthly*, the *Kansas City Medical Index*, and *The Atlanta Medical and Surgical Journal* (see [Neely], [Edwards], Lanphear, *Atlanta*). It is impossible to tell which of these sources are citing Mielziner directly, and which are relying on each other. Some of the other editorials mention information that seems to come from Mielziner’s work without making an explicit reference to it.

8 Mielziner says that the distribution of this circular was reported in the daily papers and that New York’s archbishop (whom Mielziner calls *Carrigan* rather than *Corrigan*) denied that the chancery was responsible. I have not yet been able to identify the paper or papers to which Mielziner is referring.

9 This journal, which by 1900 was the oldest surviving medical monthly in the United States, had been founded by M. L. Linton, an early faculty member at St. Louis University (see Goldstein: 206; see also the similar
The most interesting exchanges regarding Church teaching on craniotomy appeared in the influential *Medical Record*, where Jesuit moral theologian Aloysius Sabetti twice responded to editorials published by the journal’s long-time editor, George Shrady. In October of 1885, in “The Ethics of Craniotomy,” Shrady reported on the recent Holy Office responsum, and included an English translation of the text within his editorial. Concluding that this ruling would prohibit Catholic obstetricians from performing craniotomy while the child was still alive, even to save the mother, Shrady argued: “This view is a logical and consistent one from the Catholic standpoint. It is not, however, that which physicians have always been taught, nor does it seem to us to be in harmony with the best and broadest ethical instincts” (1885: 492).

Apparently, Shrady also wrote to the archbishop of New York directly on this subject, for less than a month later, the *Medical Record* published a response composed by Sabetti at the archbishop’s request. Sabetti explained the grounds for the Church’s teaching on craniotomy, including an overview of the recent debate in Europe and the historical context for the Congregation’s responsum. (He also corrected one element of *The Medical Record*’s responsum, by pointing out that the original text contained no reference to Catholic medical schools, since the Archbishop of Lyon’s question concerned teaching in his diocesan seminary.) This published exchange was exceedingly respectful on both sides, with Sabetti expressing his joy that the medical profession was approaching the question “in so commendable a spirit” (Sabetti 1885: 606-607).

The second exchange in 1895, while still civil, was less eirenic. In “The Catholic Church and Obstetrical Science,” Shrady summarized a *Münchener medicinische Wochenschrift* article written in response to a pastoral letter from the Bishop of Augsburg regarding premature delivery. Pointing to the limits of the bishop’s authority, the anonymous author invoked several prominent moral theologians’ questions about craniotomy, and finally cited a ruling of the Holy Office that simply advised the questioner to consult the approved authorities before acting. Shrady’s report on the article ends with the following observation: “This is certainly a logical as well as conservative opinion, for if it is wrong to take one life to save another, it cannot be lawful to suffer two lives to be destroyed when one can be saved” (1895: 148). Sabetti, responding to the “loose and misleading statements” in Shrady’s article, explained that his German source had apparently ignored the development of both Church teaching and theological opinion: the 1872 responsum it cited preceded the Holy Office’s later resolution of the problem, and Catholic theologians had adjusted their views accordingly (Sabetti 1895: 799-800). Yet just as interesting as the evident disagreement between the authors is the seriousness with which they regarded each other’s disciplines, so that Shrady was willing to translate an essentially theological argument for his medical audience, and Sabetti took the time to correct theological mistakes in the *Medical Record*.
If some medical scholars kept an eye on theological developments related to obstetric ethics, some Catholic publications followed medical developments with no less interest. In 1893 and 1894, the *American Ecclesiastical Review*, after presenting a debate between three prominent theologians on the proper response to ectopic pregnancy, published the responses of thirty-seven medical professors and physicians to related questions about the condition and possible interventions. The respondents included several professors from Georgetown, but most necessarily came from non-Catholic institutions (Holaind 1893, 1894: 18-20). Catholic moralists understood that they would need the insights and expertise of physicians to resolve these complex ethical questions. Moreover, as Sabetti’s responses to Shrady illustrate, they recognized the importance of addressing the questions and objections that doctors raised (for another interesting account of a discussion between several seminary faculty members and a Boston professor of obstetrics, see *JAMA* 1885: 405-406).

All this had important potential consequences for a Catholic medical school, especially in the United States. First, because the theological debate was ongoing, and because the Holy Office might intervene again at any point, it was hard to be sure what the Catholic teaching ultimately would or would not approve as acceptable responses to obstetric emergency. Second, because the presumption in favor of preserving the life of the mother in conflict situations was so strongly ingrained in the standards of medical practice, a Catholic institution could not necessarily assume that its professional faculty would accept the rulings of the Holy Office. After all, the medical debates were largely centered upon the safety of surgical alternatives to craniotomy and whether they had advanced to the point that sacrificing the child was no longer justifiable. Many physicians shared Shrady’s view that it was wrong to allow two deaths when one could be avoided. The negative response to the 1884 *responsum* in many American medical journals reflected the gap between Catholic theological assumptions and common medical standards. Thus, a Catholic institution faced a possible discrepancy between official Church teaching and what its faculty members were lecturing about in their classrooms, advocating in medical societies, and employing in the treatment of their patients.

According to Joseph Ryan, “correspondence between the Jesuit president of Georgetown University and his superior in New York” in 1888 “revealed the reluctance of some Jesuit officials to advertise the [university’s] medical program,” because of concerns about its faculty members’ views on craniotomy (Ryan 2002: 481-82; 1997: 105). Although Georgetown apparently resolved the matter amicably, a debate in 1920 over therapeutic abortion at Marquette resulted in the resignation of five faculty members and a great deal of negative publicity for the university (Joyce 2002: 106-108). That event was far in the future at the time that Creighton founded its Medical College in 1892, but it demonstrates that concern about possible conflicts over obstetrical ethics was hardly farfetched for a Catholic institution. More importantly, the Georgetown exchanges suggest that the wider Jesuit

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11 Nor did the journal’s compiler publish responses representing only a single point of view, although he sometimes chose to include his own ethical reaction to the doctors’ arguments in the footnotes.

12 In fact, a Protestant physician at Georgetown, Samuel Busey, became one of the leading opponents of craniotomy (see Imber: 31-40; Ryan 2002: 483).
community was already considering the problem at the time that the Creighton’s Medical College came into existence.

The Context of Catholic Medical Education in the United States

[18] The John A. Creighton Medical College was the third medical school to be associated with a Roman Catholic institution of higher learning in the United States. Each of them (St. Louis University, Georgetown, and Creighton, respectively) had a Jesuit foundation, yet the early histories of their medical colleges were quite distinct from one another. Although St. Louis University’s associated medical school was founded early in the institution’s history, it became separated from the University in 1855, in response to pressures from the anti-Catholic nativist movement. Creighton’s more immediate predecessor was Georgetown’s medical college, founded in 1851. However, that institution (like most American medical schools at the time) was initially a proprietary academy owned and administered by its faculty, with minimal connections to Georgetown (Curran: 145-50). Only in 1876 did it become “an integral department of the university” (Curran: 309).

[19] During the last decades of the nineteenth century, American medical education in general was in the early stages of a transition that would eventually embrace the research and clinically oriented university medical school as its paradigm (Starr: 112-16, 118-119, 122-23). For most of the 1800s, however, the situation had been very different. The abolition of medical licensing during the middle decades of the century led to an unrestricted market, in which “whether or not a physician went to medical school and if he did, for how long and with what general education, were all variable” (Starr: 58, 89). The plethora of medical schools that came into existence during this period – so many of them that, by 1850, the United States had fourteen times the number of medical schools that France had – were characterized by their wide accessibility and their low quality (Starr: 42, 63-64, 113-114). The fears of losing students in a competitive market kept schools from raising entrance or graduation standards. But with the return of licensing in the 1870s and 1880s, and with the general reform movement in American higher education in light of the German university model, competition between American medical schools began to shift in the other direction, so that schools with longer academic terms, more extensive requirements regarding years of study, laboratory work, and clinical preparation could offer their students a growing professional advantage. Since the number of commercial medical schools was still growing during the 1890s, the reform-minded, university-based medical schools were not yet numerically dominant, but they anticipated what would eventually become the norm in medical education (Starr: 102-16).

[20] The founders of Creighton’s medical college clearly created their institution with an eye towards this reform agenda. Organized as a department within the University rather than as a proprietary institution, the College of Medicine began with a three-year curriculum and quickly expanded to four. In 1900, less than a decade after the medical college opened,

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13 On the date for the foundation of a medical college at St. Louis University (i.e., 1842 versus 1836), compare Power: 206-208, with Schvitalla: 269-70. St. Louis University would have no medical school again until the twentieth century (Power: 208-209). On the significance of nativism, see Ryan 2002: 466-67, n. 25.

14 Harvard’s medical school, for example, was a proprietary institution until 1871 (see Starr: 114).
Coppens would describe in glowing terms its endowment with “the latest and most improved styles of scientific instruments,” and its (eventual) attainment of a $70,000 medical building (Coppens 1900: 43, 45). Like his colleague at Georgetown after its medical school’s reorganization in 1876, Creighton’s Jesuit president James F. X. Hoeffer enjoyed administrative control over the medical college, but he was also a member of its faculty as a lecturer in Medical Jurisprudence (Curran: 309; Boro and Mead: 45). The second role was the position that Charles Coppens would assume in 1894.

The Career of Charles Coppens

[21] Charles Coppens was born in Turnhout, Belgium in 1835. The child of a master builder, Charles was admitted to a Jesuit college at the age of twelve (see Woodstock Letters: 198). In 1853, Peter DeSmet, the famous Jesuit missionary, visited the college on a recruiting mission for the Missouri Province, and Coppens volunteered to come to America. By late December of that year, Coppens had survived a steamboat wreck and reached his new home in the Jesuit novitiate in Florissant, Missouri, where the prospective Jesuit missionaries had come to learn English and to prepare for their work in the society (Woodstock Letters: 198-99).

[22] “When I look back to the days of my novitiate,” Coppens wrote many years later, “I cannot help realizing how unfit I was for the career on which I had entered” (Woodstock Letters: 200). The victim of ill health since early childhood, he developed lung problems in Florissant, and his novice master told him that he would probably die within the year. Because expectations for his survival were so low, Coppens did not receive “the thorough education customary” in the Society of Jesus, and in fact, by his own admission, he “never had but two years of regular studies in a scholasticate.” Delighted at the omission, since he too assumed that his life would be short, Coppens moved straight into teaching. Ironically, by the time that ill health finally forced him out of the classroom in the year of his death (1920), he had been at work for almost sixty years, a service record that the author of his obituary characterizes as “longer than any other teacher in the history of the province” (Woodstock Letters: 199, 200, 202).

[23] During the course of his long career, Coppens had taught a variety of subjects, from Latin and Greek to rhetoric, philosophy, religion, and medical jurisprudence. In 1885-86, he published his first textbooks (on oratory and rhetoric), and then produced three philosophy texts before his work on the ethics of medical practice appeared (see Woodstock Letters: 200-201). In his later years, Coppens also produced a number of encyclopedia, journal, and periodical articles, some of which were reprinted in pamphlet form. His intellectual interests, like his teaching responsibilities, were extensive and wide-ranging.

[24] Coppens spent eleven years at Creighton, between 1894 and 1905, a period that also included the golden jubilee of his entry into the Jesuits (Dowling: 269-70; CUArchive). During these years, he taught philosophy and religion at Creighton and served on the medical faculty as its lecturer in medical jurisprudence. In 1897, Coppens published his

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15 The college faced many financial hardships in its opening years (see Mihelich: 75-76).

16 This obituary includes a short autobiographical account of his life that Coppens had written at his superior’s request (see also Dowling: 143, 267-70).
Religion, Health, and Healing

lecture notes for that course as *Moral Principles and Medical Practice: The Basis of Medical Jurisprudence* and dedicated the volume to the college’s founder, John A. Creighton (Coppens 1897: 5). Translated into German, Spanish, and French, Coppens’ text continued to be in use for many years, and was “often quoted by other moralists” (Kelly: 116). Three chapters (out of nine) concern craniotomy and abortion (Coppens 1897: 37-103). Coppens would later contribute the article on “abortion” (which included both “criminal” and “obstetrical” abortion) to *The Catholic Encyclopedia* (Coppens 1907). To begin an analysis of the therapeutic abortion debate’s significance for an American Catholic medical school, however, the most useful of Coppens’ writings is a report he produced in 1900 concerning the foundation and progress of Creighton’s medical college for the Jesuits’ private serial, *The Woodstock Letters* (Coppens 1900).

[25] Since Coppens did not come to Creighton until 1894, two years after the foundation of its medical college, his report concerning its origins is less valuable as a historical record than as a witness to the concerns he might have expected his fellow Jesuits to share. Coppens asserts that the medical college came into existence to “provide a worthy staff of attending physicians” for St. Joseph’s Hospital, in its new building that had also been provided by the Creighton family (1900: 41). Although physicians from the Omaha Medical College had served the hospital in the past, Coppens gives three reasons why this arrangement was no longer satisfactory. First, “the virus of the American Protective Association had infected many of them,” creating tensions with the sisters who administered and provided nursing care at St. Joseph’s.17 Second, the doctors “had committed themselves to principles and medical practices which no Catholic could tolerate,” and were performing unacceptable operations in the hospital. The third reason seems to be a corollary of the second: Coppens invokes the “urgent need of providing some institution in the West where Catholic young men could study medicine . . . without being exposed to proximate danger of having their morals ruined and their religious principles blasted by agnosticism and infidelity” (1900: 42). Thus, Coppens grounds the creation of the medical college in the need to protect Catholics, from the sisters and patients in the hospital to the medical students whose faith was potentially at risk.

[26] However, careful reading of Coppens’ letter reveals an interesting dichotomy between his explicit *raison d’être* for the Medical College and his description of the College itself. Although Coppens argues that the Medical College was meant to protect Catholics from a hostile environment, the institution, by his own admission, included very few Catholics, either on the faculty or among the students. In 1900, only five of Creighton’s forty medical professors and approximately 24 of its 134 students belonged to the Church (1900: 43, 46). If Creighton’s medical school was intended to be a haven for Catholics, it had not yet found many Catholics to shelter!

[27] In fact, Michael Dowling, S. J., twice president of Creighton during its first quarter-century, provides a different picture of the University’s original desires regarding the Medical

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17 The American Protective Association was an anti-Catholic and anti-immigrant movement of the 1890s. For the reaction from Creighton to the efforts of the APA in Omaha, see Dowling, 131-37. It is not clear whether Coppens means that these doctors had joined the APA, or simply that they had anti-Catholic prejudices (1900: 42).
College’s status as a Catholic institution. In a volume of his “reminiscences” on the University’s first years, Dowling writes:

Professors and students of every creed have found a welcome in the Medical College, without any attempt being made to restrict, in the least, their liberty of religious belief and practice. Animated by that broad Catholic spirit which adopts the best talent, wherever found, the Trustees have never allowed denominational differences to stand in the way of their securing the best professors . . . The sole wish of the founder, whose desires the Board of Trustees have loyally endeavored to carry out, has been to form Doctors, who, while eminently equipped for the duties of their profession, will pride themselves on being conscientious, upright, honorable and willing to act according to the principles of sound morality. Medical science can be taught without setting at naught the Christian religion, making light of divine revelation or inculcating a baleful materialism. However divergent their religious views in other respects, the professors unanimously approve a system carried along on these broad lines (143).

Dowling’s emphasis on the ethical qualities of a Creighton doctor, published a few years after Moral Principles and Medical Practice, obviously parallels the textbook’s statements (and even its language) about the goals of the Medical College. This theme also plays an important role in Coppens’ 1900 contribution to Woodstock Letters. In distinguishing Creighton’s medical school from its Omaha Medical College, Coppens insists repeatedly upon the Jesuit College’s ethical character, and the witness to moral principles by non-Catholics as well as Catholics within the institution (1900: 43, 44).

[28] It would be interesting to know, of course, whether the operations that had roused controversy at St. Joseph’s Hospital included craniotomy and obstetrical abortion, but Coppens does not tell us. However, he does invoke these issues when highlighting the virtues of his non-Catholic colleagues. To illustrate the willingness of these faculty members to “conform to our moral teachings,” Coppens describes a conversation with the Jewish professor of obstetrics, who visited him “to learn what moral principles I maintained on the matters of his specialty, in order that ‘all might say the same thing,’ as our rules so wisely direct.” Coppens next explains: “I lent him an article of the American Ecclesiastical Review on the subject. He not only studied it with care, but also read it to his class, and laid it down as the basis of his moral teachings: for lecturers on medicine will teach moral and religious principles, or immorality and irreligion” (1900: 43-44).18

[29] The most interesting point about the reported conversation is that the various parties have identified obstetrical practice as a potential source of tension. Coppens’ colleague wants to know what he will be teaching the students, to make sure that there is no discrepancy in their positions. And Coppens apparently recognizes that reporting on this exchange will reassure his fellow Jesuits about the catholicity of Creighton’s medical college, despite its

18 Since American Ecclesiastical Review published its first volume in 1889, and was still publishing its casus conscientiae in Latin at the time that Coppens came to Creighton, the article that Coppens gave to his colleague was probably Dissez, O’Hara, Parish, or perhaps the introduction to Holaind 1894.
dearth of Catholic faculty or students. This demonstration of success in negotiating the divisive issues of obstetrical morality augured well for success of a religiously diverse Jesuit institution.

[30] Finally, Coppens’ letter tells us something important about his famous book: the first American Roman Catholic textbook of medical ethics was written for a student body that was overwhelmingly non-Catholic. The need to address controversial ethical questions in a religiously pluralistic setting would influence the structure of Coppens’ arguments on therapeutic abortion.

Moral Principles and Medical Practice

[31] Although the term medical ethics existed in the nineteenth century, it primarily referred to the regulation of physicians’ professional rights and responsibilities rather than to the moral evaluation of medical procedures (see Kelly: 81-94). The American Medical Association’s original code of ethics, for example, devotes eleven sections to physicians’ duties to their patients and the public, ten to patients’ responsibilities to their doctors, and twenty-nine to physicians’ relationships with one another, as fellow members of the profession (American Medical Association). While Coppens’ book addresses some of these issues of professional etiquette, it was written to serve as a textbook in medical jurisprudence, a field that addressed the intersection between law and medicine, since doctors might be called as expert witnesses regarding the competency of or injuries to their patients. Thus Wharton and Stillé’s Medical Jurisprudence, a standard treatise to which Coppens repeatedly refers, discusses insanity, poisons, violent injuries, and other similar topics. Coppens addresses a few of these problems (notably, insanity) but he redefines medical jurisprudence as “the study of the principles on which . . . [laws concerning medical practice] are founded, and from which they derive their binding power on human conscience” (1897: 17). Thus, he begins his analysis from the perspective of foundational ethics, even though the book considers many practical moral problems that the doctor might encounter (see Kelly: 113-115).

[32] Within Coppens’ text, chapters two and three consider craniotomy and abortion respectively, while chapter four, entitled “Views of Scientists and Sciolists,” expands his consideration of craniotomy by citing at length or responding to medical writers on the subject. That Coppens makes these issues the headings for three of his nine chapters testifies to his view of their importance, although the chapters themselves sometimes address other topics than the issue indicated in the title. Readers of a conventional text in medical jurisprudence would have expected a discussion of criminal abortion, but not of obstetrical emergency procedures such as craniotomy (cf. for example, the discussion of abortion by

19 There is also a short section on the duties of the public toward physicians. The code does deal with some issues that would fall under contemporary bioethics, such as confidentiality (see pages 1-2).

20 Coppens uses the term medical law for the traditional content of medical jurisprudence.

21 Sciolists are those who pretend to be learned, but whose knowledge is actually superficial.

22 Chapter two, for example, discusses vivisection, physician assisted suicide, and self-defense at some length before it ever gets to craniotomy (37-50). Coppens also raises obstetrical issues in other chapters.
Wharton and Stillé: 3.61-78). That Coppens includes this question indicates the ethical rather than legal focus of his work.

[33] One of the most interesting elements of Coppens’ arguments regarding obstetric emergencies concerns his sources. Because Moral Principles and Medical Practice represents a published version of his lecture notes, it provides no bibliography or extensive documentation, yet Coppens does quote some sources at length and makes explicit reference to the others. These authorities are almost all doctors: prominent physicians whose ethical assessments correspond with Coppens’ views, or medical witnesses whose counterarguments he must overcome to make his case (e.g., 1897: 73-77; 81-96). More importantly, Coppens does not rely upon these professionals only for medical information: instead he often cites them (either positively or negatively) for their moral arguments. Chapter four, for example, includes a very long extract from an attack upon craniotomy composed by Dr. L. Charles Boislinière, which rejects the identification of the child as a materially unjust aggressor by comparing obstetric emergency to the case of two shipwrecked British sailors convicted for killing and eating their companion in a lifeboat. Boislinière (as cited by Coppens) argues:

The child is not an unjust aggressor against the mother. It is placed in the womb without its consent and is defenceless. It is the mother who is, as it were, the aggressor from the obstacles caused by a deformed pelvis, tumors, etc.; and she has not the right to ask or consent to the killing of the child who does not attack her (1897: 87).

[34] Coppens certainly could have used theological sources to make the same point: in fact, one of the participants in the American Ecclesiastical Review’s theological discussion of ectopic pregnancy to which Coppens refers in the previous chapter similarly insists on the innocence of the fetus (Aertnys: 354). Yet this approach gives Coppens an ecumenical advantage, for he can also quote Boislinière as saying: “In a subject of such delicacy and importance I have avoided all argument based upon the doctrines of any particular religion, and considered the subject upon its purely ethical and scientific basis” (1897: 89-90). Thus a position regarding obstetrical crisis that many doctors regarded as a Catholic peculiarity could be presented instead as the logical conclusion of human reason and scientific progress (see the discussion of the Suffolk District Medical Society, reported in Dixon; and of the New York Medical Association, reported in Van Fleet: 391-94.).

[35] To argue on the basis of moral knowledge available to human reason was, of course, absolutely typical of Catholic moral theology during this period, and Coppens’ use of Catholic moral principles and concepts (e.g., the direct/indirect distinction, the understanding of the relationship between rights and duties) is quite consistent with their discussion in the standard manuals (i.e., the textbooks used to train seminarians) (1897: 66, 41-42). Where Coppens differs from these sources is in his lack of explicit appeals to theological authority. Particularly when discussing controversial issues, moral theologians of this period typically made many references to the opinions of their predecessors and contemporaries, so that it is usually easy to identify the major influences upon a particular author. Coppens does not identify his theological sources for us. The only clear reference to particular theologians in these chapters of the book concerns the theological debate on
[36] Though it might seem unsurprising that a text written for medical students would downplay theological references, Coppens' approach was not the only way that Catholic authors chose to approach these subjects. In this regard, it is interesting to compare Coppens' book to the only other Roman Catholic text on moral dilemmas and medical practice then available in English, Dr. Carl Capellmann's *Pastoral Medicine*, which had been translated from the original German in 1878 (on Capellmann, see Kelly: 70-74; Imber: 26-31). Capellmann, a physician very interested in the ethics of obstetrical emergency, wrote to instruct priests and doctors, respectively, in what they needed to understand about medicine and moral theology to carry out their duties (Capellmann: 1-2). Although his text was intended for physicians as well as pastors, its structure parallels the manuals of moral theology, organizing material according to the commandments, the precepts of the Church, and the sacraments. Capellmann also quotes (in Latin) or refers to the views of specific theologians within his text (e.g., see pages 11, 15, 22). Thus, the doctor's work is far more conventional in genre as a Roman Catholic moral treatise than the text of the Jesuit Charles Coppens.

[37] Even more striking in Coppens' work than his theological reticence, however, is the paucity of references in these chapters to magisterial interventions. Coppens mentions the decisions of the Holy Office only once, at the end of his discussion of the ongoing debate over ectopic pregnancy. Declining to posit an answer in the face of such disagreements among the authorities, Coppens advises his students that, under such circumstances, “we act prudently by invoking the authority of wiser minds . . .” He then explains:

> A Catholic physician has here a special advantage; for he has in cases of great difficulty the decisions of Roman tribunals, composed of most learned men, and renowned for the thoroughness of their investigations and the prudence of their verdicts, to serve as guides and vouchers for his conduct. Although these tribunals claim no infallibility, yet they offer all the advantages that we look for, with regard to civil matters, in the decisions of our Supreme Court (1897: 80).

[38] After calling his readers’ attention to reports of the pertinent decisions in *American Ecclesiastical Review*, Coppens next comments on the significance of these decisions for those outside the Catholic Church:

> Non-Catholics are, of course, not obliged to obey such pronouncements; yet, even for them, it cannot be injurious, but rather very useful, to know the views of so competent a court on matters of the most vital interest in their learned profession. This is the reason why the “Medical Record” has published of late so many articles on the teachings of the Catholic authorities with regard to craniotomy and abortion (Ibid.).

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23 The only theologian that Coppens quotes at length and names in these chapters is John Henry Newman, and that citation concerns the first principles of morality rather than specific ethical questions (102-103).
[39] Since the texts that Coppens cites are the Shrady’s summary of the German article, Sabetti’s objection, and subsequent responses to each of them in the letters to the editor (see paragraphs 12-14), one can argue that the Medical Record was doing far more than providing general information for its readership about these magisterial decisions, and that the discussion was less harmonious than Coppens’ description would suggest. However, the central point of these paragraphs is to explain the significance of the magisterial rulings for a religiously diverse audience, many of whose members were unlikely to assign great weight to the pronouncements of the Holy Office. Coppens appeals to his non-Catholic students’ interest in attaining competency in their “learned profession” by describing these rulings as developments of which educated physicians should be aware.

[40] Coppens’ major argumentative strategy therefore relies upon Catholic principles articulated in terms of natural law (e.g., the fundamental right to life) and medical conclusions about the progress of obstetrics. Sometimes, however, these two elements stand in uneasy relationship with one another. Early in his treatment of craniotomy, for example, Coppens asks his students to imagine a scenario so dire that all of the possible surgical interventions would be fatal to the mother. After some consideration of the possible arguments in favor craniotomy, he asserts that it is never acceptable to kill the child directly, even to save the mother’s life (51-54). Yet within the same passage, he approaches the issue from a different direction: “Of late, however, the practice of craniotomy and all equivalent operations upon living subjects has gone almost entirely out of fashion among the better class of physicians” (1897: 64). Then he offers two long quotations from doctors arguing that surgical procedures have advanced to the point that they are as safe for the mother as craniotomy; and as a result, craniotomy can no longer be justified (54-57).

[41] Coppens acknowledges that this conclusion drawn from medical progress is not the same as his original argument: “when this distinguished Doctor said, ‘We are not now justified in destroying a living child,’ he was speaking from a medical standpoint. . . From a moral point of view, it is not only now, but it was always, unjustifiable to slay a child as a means to save the mother’s life” (1897: 57). Thus, Coppens’ medical source is offering a moral argument against craniotomy that is similar in its practical consequences, but grounded in a very different ethical assumption, than Coppens’ natural law analysis.

[42] Indeed, Coppens’ argument vacillates between suggesting that medical consensus has rejected interventions such as craniotomy and acknowledging (sometimes indirectly) the existence of a medical debate over these practices. Coppens clearly recognizes that the absolute proscription of therapeutic abortion demands something very difficult of his students, not only as compassionate persons anxious to help a suffering woman, but also as practitioners influenced by the common standards and concerns of their profession. Coppens asks his students to imagine the following scenario:

You are called to attend a mother, who, you think, must die if you do not bring on a miscarriage. You are urged to do it by herself and her husband,

24 Here, Coppens is referring to a citation from Dr. James Murphy, as cited by O’Hara: 362.
and perhaps by other physicians. There are money considerations too, and the possible loss of practice. Will you yield to temptation? (1897: 71).  

[43] As Leslie Reagan points out, the professional and financial consequences for refusing to perform a therapeutic abortion during this period could be quite serious for a general practitioner (Reagan: 67). In 1904, ministers enjoyed a slightly higher average annual income than doctors and, with the exception of the medical elites; physicians often began their careers in an extremely precarious financial situation (Starr: 85, 89). Young doctors who adopted Coppens’ standard might well have faced not only the ire of their patients’ families, but also the disapproval of some of their colleagues. Despite his assertions that “there is no longer any estrangement between Ethics and Medical Practice,” and more specifically, that “the better class of physicians” has rejected craniotomy, Coppens’ references to various articles from the “ estimable” Medical Record indicate that he was well aware of divisions among the doctors regarding these practices (1897: 20, 54, 25).

[44] In fact, a Creighton medical student during this period would not have needed national publications to come into contact with the controversy over craniotomy. Shrady’s 1895 article on the Church and craniotomy had been paraphrased without attribution in the Omaha Clinic, the first medical journal in the state of Nebraska. In the same year that Coppens’ textbook was published, physician J. M. Hardy of Cairo, Nebraska, published an account of a craniotomy that he had performed in the middle of the night, during a heavy snowstorm, fourteen miles from his nearest colleague, for a rural patient whose family had delayed calling him in for many hours. Reflecting on his experience, Hardy observes: “Some of my brethren may think it would have been preferable to have performed the Caesarian section or Porro’s operation, but after these months, I think that under like circumstances I should do the same thing again” (Hardy: 263, 264).  

[45] Coppens makes no direct reference to these Nebraska publications. But he certainly knew that any students who rejected his position would have the law on their side. The Jesuit explicitly invokes craniotomy to prove to his students that they need medical jurisprudence as well as medical law, since doctors are accountable to a higher law than those imposed by the state (1897: 32). Coppens movingly describes the privacy (and hence, the loneliness) of the doctor’s ethical decision. Unlike a judge, a lawyer, a politician, or a civil servant, a doctor “on very many occasions, can be morally sure that his conduct will never be publicly scrutinized” (33). In light of these observations, it is reasonable to assume that Coppens recognized just how challenging the standard he was advocating might become, even for graduates of a Catholic medical school.

25 Coppens here employs a slippery slope argument, suggesting that giving in to this desperate family will leave the doctor no grounds to refuse an adulterous woman who fears her husband’s vengeance, or a prominent unmarried girl who wishes to protect her family’s reputation (71-72).

26 Hardy had presented this paper at a meeting of the Nebraska State Medical Society in Lincoln. On Porro’s operation, see Ryan 1997: 158-59.
Conclusions

[46] Charles Coppens’ analysis of therapeutic abortion is original not for its arguments or its conclusions, but for its context. Outlined in the first American Catholic textbook designed to train doctors in the ethics of their profession, Coppens’ approach addresses the needs of his primarily non-Catholic students by drawing heavily upon the moral witness of physicians. At times, the discrepancy between the medical debate over the progress in surgical alternatives and the Church’s absolute prohibition of the direct taking of innocent human life creates a tension in his argument – a tension that poses an important challenge for contemporary moral theology. Coppens reminds us of the ever-present danger of proof-texting medicine (and science, in general), by glossing over disagreements within a discipline. When specialists disagree about the interpretation of scientific evidence, it will always be tempting for ethicists to rely upon those who support the position we wish to prove. More positively, however, Coppens provides a valuable example of the need for moral theology to engage science and medicine, and to draw on those disciplines’ practitioners’ moral (and not simply their technical) expertise. Ethics, Coppens reminds us, is not simply a supplement to science; rather, morality is imbedded in the grain of every human activity, including medical practice. Medical decisions involve ethical choices, whether one recognizes them as such or not. For that reason, the goal of the Catholic medical school, as Coppens explained to his students at Creighton, must always be the training of conscientious physicians, whose character matches and supports their professional skills.27

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27 I am very grateful to the staff of the Midwest Jesuit Archives and especially to the Creighton University Archivist, David E. Crawford, for assistance in finding material regarding Father Coppens.

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