Gynaecology and ethics

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Summary

The link between gynaecology and ethics, one time neglected, turns out to be inevitable. The gynaecologist's work has to be oriented to the highest value on the earth, i.e., to the human person, considered in both its developmental and social dimensions. The task of a doctor (physician) is to further the health of the human person, and the specific task of the gynaecologist and obstetrician is to help professionally in the transmission of human life. To fulfill this task, they have to know the correct answer to the question when human life begins, the answer given by embryology and medical thermodynamics. The human embryo has to be considered and treated as a human person. This includes the exclusion of such acts as direct or indirect abortion, experimental use of embryos, and all kinds of genetic manipulation. The right ways of human fertilization are a consequence of the dignity of the child and of the married couple, as well as of their right to love and to be loved. It excludes the insemination, the homogeneous and heterogeneous fertilization in vitro, and the surrogate motherhood. The gynaecologists, obstetricians and midwives have to refuse to perform the nocive or immoral interventions. They should be ready to do their best in helping people in the right transmission of human life.

Gynecology; Ethics

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It is a characteristic fact that in recent years, ethical questions – concerning moral rules – in gynaecology and obstetrics have been cropping up quite frequently in the professional literature and at scientific conferences on gynaecology. This is a new phenomenon. Until recently it seemed that the traditional rules of conduct in gynaecology, going back to ancient times, were sufficient, although many gynaecologists were not observing the principle of 'respect for human life'. Also it seemed that the rapid progress in science and technology had confirmed the nineteenth-century scientistic tendency of ignoring questions of ethical considerations and tackling all problems from the point of view of the technical effectiveness of the methods used. However, precisely the opening up by technological developments of tremendous

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possibilities in the field of experimentation on the human embryo and in genetic manipulation has made us aware of the need for clear and stable moral guidelines.

I. The principal criterion in the ethics of gynaecology

The criterion proposed by several interested parties that any act, the accomplishment of which is possible thanks to technology, is morally good, is a consequence of an erroneous concept of science and ethics: the belief that only the experimental and technical sciences are 'scientific', and hence there would be an opposition between science and ethics. The predominance of technology which would result from this is unacceptable because it would imply the objectification of man, who would thus gradually become the slave of technological progress and the object of manipulation. It is not man who is to serve technology, but technology that is to serve man.

When we pose questions about the criterion of ethics, we are speaking about the highest early value that should regulate human activities. With the experience of thousands of years in mind, and especially of our own twentieth century, we do not hesitate to reply that this highest value is man himself, and his well-being. Man, who differs from his environment of matter and energy by his inner life, which cannot be reduced to, or explained by matter, even as an expression of energy.

Of course, I do not mean 'man' in general here, since this is merely a concept which may easily provide a smoke screen for the domination of certain people by other people. I mean that the principal earthly value is man as a person, in other words each and every particular individual, since humans live as individual persons. It is the individual person that medicine – and hence gynaecology and gynaecologists – are to help.

Man as an individual person is a being subject to development. Physically he develops in a certain period of time, a number of years which differs from person to person on the conditions of climate, radiation, nourishment and housing facilities. Psychologically, however, the individual person may undergo development right up to the moment of death, providing this development is not restricted by any pathological changes independent of him. Here I mean intensive development in the sense of the individual's spiritual awareness and reception of intrinsic values, for of course extensive psychological development becomes restricted by the ageing of body. One of the chief aims of the medical profession is the assistence in the struggle against the influence of ageing and the procuring of preventive measures securing the best possible physical and psychological development for patients. The gynaecologists and obstetricians should never forget this aspect of their task, both with reference to the developing person in the womb and also to his parents.

The individual person is thus not an isolated individual: he is born thanks to the interactions in the society in which he lives and is educated; for his spiritual development he needs to live in a society. By his very nature the human person is a social being. A doctor, and especially a gynaecologist or an obstetrician, must always bear in mind that he will never be asked to treat a patient in social isolation, but that his task is to help individual human beings within their social context. This social aspect of medicine is particularly visible in preventive medicine, which from

the social point of view may be more important than therapeutics, and the success of which depends primarily on the efficient organisation of research and on the cooperation of medical practitioners.

II. Particular criterion in gynaecological ethics: the beginnings of the life of the human being

As the science and technology associated with gynaecology and obstetrics are interested in the initial stage of human life, the first question that should be put is when does the life of a human being begin. The answer to this question will determine many of the ethical principles in gynaecology and obstetrics, both in the field of research and in therapeutics.

We have long passed the times when man was thought to be a person only after birth, and the prenatal stage of his life was neglected. The question remains, however, does human life begin at the moment of conception or at some later time; in other words when an independently existing zygote is formed.

The hypothesis that human life begins at some later stage in the embryo's life was said to be supported by two facts. The first was that about three-quarters of all zygotes perish almost immediately, leaving more or less a quarter surviving. The second was the fact that the distinction of twins appears later than the emergence of the zygote. Hence the hypothesis of 'successive animation', put forward by some philosophers referring to St Thomas Aquinas, who thought that the 'form' of existence known in man as the 'soul', *anima*, could only appear in matter once it was ready, *apta*, for the soul. The theory of successive animation was taken up by some ethicists who were looking for a moral justification for the use of IUDs, pills and injections that produce early miscarriage by disturbing the endometrium. The theory's weakness is the impossibility of an accurate definition of the exact time of animation, in other words on what day or in which week of the human embryo's existence does it become a human person. But even if we accepted the theory of successive animation, the life of the human zygote and embryo would still be entitled to respect and a guarantee of inviolability (integrality), since it would constitute a preliminary stage of human life.

However, biology has not confirmed the theory of successive animation. First, we do not know whether the zygotes which perish at conception are already new, independent thermodynamic systems, the emergence of which denotes the initiation of new human lives. Moreover, the fact that we can observe cell division into twins only at a later stage does not mean that its causes were not present at the moment the zygote was formed, the more so as we now know that the emergence of new thermodynamic branches is dependent not so much on the cell's nucleus as on the plasma. Finally, despite the use of numerous terms for the various prenatal stages in man – zygote, embryo, foetus – no qualitative changes have been observed from stage to stage. It is confirmed, however, that when a human zygote is formed that is capable of survival, the existence is initiated of a new thermodynamic branch that determines the genetic and biological independence of a new human individual, and hence also that individual's personal subjectivity. The life of the human zygote is

thus already a human life. It is the life of a human person who, as we have said above, by his very nature is a developing being.

III. Moral conclusions concerning human prenatal life

Certain important moral conclusions regarding human prenatal life result from the above observations. Human zygotes, embryos and foetuses have the right for respect of their personal dignity, and hence also the right to life and integrality, and medical care should be provided for them by doctors and society. They may be, and even – conditions permitting – should be given therapy providing the following are observed:
(a) that their integrality is respected.
(b) that they are not exposed to an inordinately large risk.
(c) that their parents have received adequate information.
(d) that harmless methods of prenatal diagnosis are used.

On the other hand, the following are unacceptable from the moral point of view:
(1) the performance of prenatal diagnoses which directly or indirectly risk the damaging of the zygote, embryo or foetus; the performance of prenatal diagnosis, when there is no moral certainty that the method used for research or observation will not bring harm to life and integrality; and also the undertaking of diagnoses with a possible view to abortion;
(2) abortion, either by direct means or indirectly, e.g. by methods or devices making implantation of the embryo in the womb impossible or causing the eviction of the embryo from the mother's body;
(3) experimentation on the human zygote, embryo or foetus, unless such experimentation is intended to save life and health in an otherwise hopeless situation when there are no other methods of treatment available and the parents have given their consent to such life-saving experimentation;
(4) manipulation interfering with the genetic (chromosome) heritage; the effecting of cloning, parthenogenesis and twin-cell division;
(5) all other manipulative operations, such as the conjugation of human and animal gametes, the placing of human gametes or embryos in animal or artificial wombs; the freezing of zygotes or embryos', and the killing of so-called 'excessive' zygotes or embryos.

IV. The tasks of gynaecologists, obstetricians and midwives in the light of ethics

We have already said that it is the task of gynaecologists and obstetricians – and undoubtedly also of midwives – to help people in their personal and social development. There is no cause more noble than this, although this task may be performed in various dimensions: religious, educational, political, medical. Throughout history this kind of duty has been considered not an ordinary profession, but a vocation, a calling to a special kind of social service. The Polish medical code, *Zbiórzzasad etyczno-deontologicznych polskiego lekarza (The Polish Doctor's Collection of Ethical and Deontological Principles)*, authorized by the Polish Medical Association in 1977 and published in 1978, states that "at the start of his practice a

doctor makes a conscious and voluntary decision to serve his patients and to care for the health of society through his observance of the ethical and deontological principles".

This feature of service is perhaps particularly evident in the performance of their vocation by gynaecologists, obstetricians and midwives. A number of moral postulates results from this.

(1) Gynaecologists, obstetricians and midwives are to manage clinics and their equipment, but they may not exert an arbitrary rule over the women and children in these clinics. On the contrary, they should serve them, keeping to the ethical principles. A doctor is not the creator of human life and may not usurp the right to make decisions as to a person's life, integrality and development. He should endeavour to help every mother to successfully bear her conceived child. It is inadmissible to terminate the life of the baby in the mother's womb, regardless of whether it is at the zygote, embryo or foetus stage. It is also morally inadmissible to mutilate a person by sterilization; people have the duty to control their reproductive instinct, but not by interfering with the work of the Creator and depriving themselves of the powers which He has given them. It is a still more serious crime to sterilize a person without his or her consent. It is a tragic paradox that many gynaecologists, whose job is to save lives and preserve health, are, by performing abortions and sterilizations, destroying new human life and mutilating healthy men and women.

(2) To be able to carry out their duties well, gynaecologists, obstetricians and midwives should possess adequate knowledge, not only in the field of gynaecology and obstetrics, but also in other branches of medicine, and to keep improving and perfecting their professional qualifications throughout their careers. It is certainly not to contemporary doctors' credit that they are ready to consent to abortion 'on medical and health grounds', and that they are willing to have such a clause in the legislature, when it has been known for many years that, with the exception of extra-uterine pregnancy, in a well-organized clinic every pregnancy can in principle be brought to a successful birth and every mother's life saved, providing she contacts the clinic in time. In reality there are no longer any absolute 'medical indications' today for the termination of pregnancy through abortion; one may say that only there are some backward clinics and incompetent doctors.

(3) In their professional training, gynaecologists, obstetricians and midwives should not restrict themselves to medicine only, but should also take into account knowledge in the fields of biology, ethnology, sociology, psychology, even educational studies, and in particular prenatal psychology. For instance, it has been well known for a long time that successful parturition or treatment is determined to a large extent, and sometimes crucially, by the psychological readiness of the parturient or patient. As far back as over 60 years ago Axel Munthe campaigned for recognition and acceptance of this simple truth by the medical world.

However, it seems that it has still not been fully acknowledged in European gynaecology. In many European countries one hears complaints against doctors, midwives and nurses in gynaecological clinics, whose approach to pregnancy and childbirth is purely technical and sometimes downright brutal. It is a regrettable fact that obstetrics, which in German carries the beautiful name of 'help in childbirth' –

Geburtshilfe – may too often become, as a result of this brutality or lack of sympathy on the part of the staff of some clinics, an outright obstacle to childbirth.
(4) The duty to help every person needing assistance in his or her personal or social development does not permit the limiting of medical care to certain groups of people or dispensing such assistance at the cost of other persons or groups. For gynaecologists this means the duty to refrain from any activities or programmes of eugenics which follow discriminative, racist or exclusivist principles – regardless of whether such policies are based on political, economic, ideological or religious grounds.
(5) In accordance with the nature of their profession as a vocation to public service, and also with the Polish doctor's ethical and deontological principles described above, gynaecologists, obstetricians and midwives should never put their own material gains or careers (promotion and fame) before the duty to help persons in need, especially where procreation is concerned.

V. Gynaecological ethics and human procreation

It is precisely this assistance in procreation, in the giving of life, that is the most important task for gynaecologists, obstetricians and midwives. There can be no more wonderful achievement for man than the bringing about of the existence of a new human person and his or her upbringing and education. Hence the assistance carried by gynaecologists, obstetricians and midwives in procreation and the handing down of life is a great task: it is a service rendered to human life and society. We are talking about the handing on of life here, and not about 'human reproduction', since the term 'reproduction' is too close in meaning to the technical sense of the 'production' of material goods. Although the term 'reproductive biology' had become accepted as a general term, gynaecology and obstetrics deal nevertheless not with the production of man, but with a phenomenon which is unique in the world, the transfer of human life, which is at the same time the bringing about of the existence of a new person. This great and mysterious work is a continuation of the work of creation, and hence it deserves its traditional name of 'procreation'. It is for this reason that the bringing into the world of a new person by marriage partners, co-operators with the Creator who created man out of love and on each occasion breathes His spirit into the life transferred by the parents – should be a result of the married couples' mutual giving of themselves in love. The greatness of the gynaecologist's, obstetrician's and midwife's calling lies in the fact that it is their task to assist in the great and unique work of bringing new human persons into the world. By assisting married couples in passing on life, they help a new person to come into the world, they contribute to human progress and they become the collaborators of God in the work of creation. This is why their attitude to their professional duties should be one of great care and respect for the persons involved – the parents and the child, and his or her life and integrality. Their task is to assist, not to try to act as substitutes for the parents, the chief partners of the Creator; thus they may not provide a technological substitute for the loving conjugal act. In their research and therapeutic activities to treat and prevent infertility, gynaecologists should respect

the personal dignity of the married couple and their children. Finally, they should refuse to conduct harmful or immoral practices.

We have already discussed the necessity of abstaining from practices that are the very opposite of the handing down of human life, that is abortion and sterilization. We now have to consider those activities which might appear to promote the passing on of life, but are in fact at variance with the criteria of morality and should be refrained from by gynaecologists and all their associates.

In view of the fact that a child has the right to receive life as a result of the personal loving union of his or her parents, artificial insemination, including homogeneous insemination (by the husband's sperm), and in vitro fertilization are ruled out. These interventional biological and medical techniques – insemination and IVF – reduce the child, who is a subject with his or her own personal dignity, to the role of an object of scientific technology. Additional arguments against IVF are first, the death of 'excessive' embryos, and secondly, the lack of an appropriate environment – the mother's womb – during the initial stage in the life of the child, who is a new biological system. We do not know yet what will be the result of this, but we do know that a biological system constitutes a certain kind of unity in coexistence with its appropriate environment.

Heterogeneous fertilization where at least one of the gametes is extramarital, and surrogate motherhood, must be ruled out all the more, emphatically. These forms of parenthood introduce discrepancies between the family relationships that are result of pregnancy and of genetic relationships; they confuse the situation regarding parental duties in bringing up offspring, they threaten the unity and permanence of the family and they infringe the rights of the child, depriving him of an appropriate relationship with his parents and hampering the development of his personal identity. A child has the right to be conceived and carried in the womb of his mother, and to be born and cared for and brought up by a married couple, including the extremely important prenatal stage of his life, and parents should see in their child a living reflection of their love and a permanent sign of their conjugal unity.

Neither a married couple, nor indeed anyone else, has the right to 'have' – 'possess' or 'own' – a baby, since a child is a person and cannot be 'owned' by anyone. A married couple has the right only to perform the conjugal act, which may initiate the life of a child, a new human person, and the right to rear that child.

Conclusion

Our reflections have concentrated on the greatness of the gynaecologist's, obstetrician's and midwife's calling, and on the difficulty of the tasks facing them. They can accomplish them adequately only if they combine high professional qualifications with an awareness of and respect for intrinsic moral values and with a sense of service to the human person and to humanity in general.

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