FACT: Recent publicity concerning the successful gestation and birth of the first human baby conceived in vitro has once again brought to the public mind an awareness of the power of newly developed biomedical technologies. The possibility of in vitro fertilization has been widely discussed for several years, and there have been a number of unsubstantiated claims that the test had already been achieved. Nevertheless, the general consensus among researchers in the field is that the success of Drs. Robert Edwards and Patrick Steptoe is probably the first instance of in vitro fertilization followed by implantation, gestation, and birth. The parents of the baby girl are a British couple, Gilbert John and Lesley Brown, who had been unable to conceive a child in nine years of marriage because of an obstruction in Mrs. Brown's Fallopian tubes, a rather common cause of infertility. The technique consists in removing a mature ovum from the woman, fertilizing it ex utero, allowing the zygote to develop to the blastocyst stage, and then implanting the blastocyst in the uterus of the woman, thus bypassing her blocked tubes. Dr. John Dawson, secretary of the Central Ethics Committee of the British Medical Association, is quoted as having said that “the technique offers no ethical difficulties for doctors” if used “responsibly,” but that it would have been a “different matter” had the fertilized ovum been implanted in someone other than the biological mother. (St. Louis Post-Dispatch, June 11, 1978, p. 1A.)

COMMENTARY: There are a number of morally significant objections that can be made against the experimental procedure of in vitro fertilization, and these may be supplemented by Church teaching.

First, there is the problem of uninformed consent to experimentation. Edwards and Steptoe had been developing their techniques for almost twelve years before their success; this indicates that the problem they were working on was not an easy one. There is some reason to believe that the married couples who participated in their research were not adequately informed of the highly experimental nature of the procedures: the couples may have thought they were patients receiving treatment, when in fact they were subjects in an experiment. Edwards is quoted in Medical World News (April 4, 1969): “We tell women with blocked oviducts, Your only hope of having a child is to help us. Then maybe we can help you.” “It is questionable whether the offer of possible help was in any way honest in 1969. A news item appearing in the Washington Post for March 3, 1970 reported the hopes of a woman that a fertilized ovum would be implanted in her womb within the next several weeks, so that the world’s first test-tube baby would be born by the end of 1970. Although this unrealistic hope might not have been the responsibility of the experimenter, it remains true that the use of a couple’s strong desire for children might constitute an abuse of the experimental subject.

Second, there is the problem of the surplus and unwanted embryos. The process of acquiring a mature ovum, fertilizing it, and sustaining its development is a difficult one; it is most efficient to acquire a number of ova, attempt to fertilize all of them, develop them all, and choose from among them the most promising one for implantation. The rest are discarded or may be used for other research. The Catholic Church has not taught that these fertilized ova are persons possessing a rational and immortal soul, but she does teach that it is unjustifiable to act on the assumption that such beings are not persons: “it suffices that this presence of the soul be probable (and one can never prove the contrary) in order that the taking of life involves accepting the risk of killing a man, not only waiting for, but already in possession of his soul.” (“Declaration on Abortion,” November 18, 1974, footnote #19.) Edwards, Steptoe, and other researchers are not justified in acting on the assumption that what they are discarding is not a human person.

Third, there is the problem of the selected blastocyst and the resultant born child. The techniques involved in achieving the success are complex and involve considerable manipulation of the ovum, sperm, and developing zygote; at present there is no way of ruling out the possibility that the embryo will be damaged by the procedure. Our ability to test for defects is quite limited, and damage to the embryo may pass unnoticed. Even if damage is detected, “treatment” is likely to be an induced abortion. Some defects may not appear until long after birth. If we choose to conceive a child through artificial means and the child is born defective, we are particularly responsible for that defect. Some may wish to respond that the child has no basis for complaint even if he is born defective; he would not even have been conceived without these techniques. Such an argument should be rejected as a form of the doctrine that the end justifies the means: since the child is better off born defective than not born at all, it does not matter morally how that result was achieved.

Fourth, there is the problem of the violation of the marital relationship. The first three objections might be avoided were our technology to become sufficiently developed, but the fourth would remain regardless of the safety and efficacy of the procedure. The Church’s official position regarding in vitro fertilization based upon the marital relationship is contained in an allocution given to the Second World Congress on Fertility and Sterility by Pius XII on May 19, 1956.

...On the subject of the experiments in artificial human fecundation “in vitro,” let it suffice for us to observe that they must be rejected as immoral and absolutely illicit....

Artificial fecundation exceeds the limits of the right which spouses have acquired by the matrimonial contract, namely, that of fully exercising their natural sexual capacity in the natural accomplishment of the marital act. The contract in question does not confer on them a right to artificial fecundation, for such a right is not in any way expressed in the right to the natural conjugal act and cannot be deduced from it. Still less can one derive it from the right to the “child,” the primary “end” of marriage.

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A recent article appearing in Psychology Today (July, 1975, p. 88), “Why Some People Seek Revenge Against Doctors” by Louise Lander, provides an interesting insight into the malpractice problem. She notes that the vast majority of difficulties encountered in the practice of medicine, so-called “unusual incidents,” do not result in malpractice suits. Lander cites data collected by a hospital association risk-management program: over a twenty-year period, there were 700,000 unusual incidents reported, and only 15,000 malpractice claims; 85% of the latter involved incidents which had not been previously reported. Lander believes there is good evidence to support the contention that the key element in malpractice suits is not the presence of injury but patient anger with the physician or other health professional. She quotes the executive director of a federal commission investigating the problem of malpractice: “In this whole field of malpractice litigation there is a strong get-even, or revenge, factor. I have heard plaintiffs’ attorneys say that their clients did not really want to sue for money. What they really wanted was a chance to be alone in the room with the defendant for about 15 minutes.” (pp. 92-94.)

Lander believes that much of the problem can be traced to the impact of technology on the practice of medicine, an impact that in many ways is indirect. It is true that new procedures and machines increase the risk and seriousness of mishap, but they also serve to increase the psychological distance between the physician and his patients. It is this distance that contributes significantly to patient feelings of isolation, helplessness, frustration, and anger. The introduction of myriad new drugs into the physician’s array of treatments serves to compound the problem; writing a prescription can become an easy substitute for establishing a sound and understanding doctor/patient relationship.

Almost 60% of all malpractice claims result from surgical mishaps. This is, of course, partly explained by the nature of the procedures themselves: they are particularly serious matters and more likely to evoke anger if results are not satisfactory to the patient. Nevertheless, Lander believes this tells only part of the story: the risk inherent in surgical intervention is exacerbated by the surgeon’s common failure to deal with the psychological strains associated with undergoing surgery. The surgeon is in a position that enables him “to minimize both psychic and somatic problems by providing the patient with explanations, concern, and reassurance before surgery, and warmth and interest afterward.” But it all too frequently happens that the surgeon...

...regards the essentials of his work as taking place only when he is assuming an active, decisive stance above a supine, totally passive body, largely concealed by surgical draping—a person reduced to a thing. When that body regains consciousness and begins attempting to function as an active human being, the surgeon will probably continue to concern himself only with its thingness, attending to the state of the wound but hardly noticing the state of the person. If the state of the wound is not all that it should be, the state of the person—who might tolerate being treated like a thing if that guaranteed recovery—will predictably...

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Test Tube Fertilization (Concluded from Page Three)

The matrimonial contract does not give this right, because it has for its object not the “child,” but the “natural acts” which are capable of engendering new life and are destined to this end.... (Reprinted in The Human Body, Daughters of St. Paul, 1960, #59.)

The basis for the Church’s teaching is quite simple and was expressed by Pope Pius earlier in his address: it is the will of God that children should come into being within the union formed by the faithful and indissoluble love of husband and wife and through the act that fosters and expresses that love. The Church is thoroughly consistent (indeed, systematic) here. This principle excludes, in addition to in vitro fertilization, the use of donor sperm or donor ovum and the use of the husband’s sperm if the technique employed is not that of assisted intercourse.

Children come from the one-flesh unity of man and wife, and procreation must not be divorced from the act of union. The Church’s teaching here is the converse of her teaching on artificial contraception and sterilization: if the procreative aspect must not be separated from the unitive, neither may the unitive be separated from the procreative. Artificial contraception and in vitro fertilization appear to form a package: if one may have sex without babies, why not babies without sex? Once the connection is sundered between procreation and the physically embodied love of the spouses, how could one oppose the following uses of technology: sperm or ovum donated by a third (or fourth) party, embryo selection, surrogate or “host” mothers who would bear a child conceived in vitro and then at birth return the child to its biological parents, artificial insemination of single women, cloning of single men together, with use of host mothers. If the physical embodiment of our procreative power is rejected as unnecessary so that in vitro fertilization might thereby be found justifiable, there appears to be little firm basis upon which the above-mentioned possibilities could be rejected. What the Church finds reason to fear about artificial contraception and what is maybe more easily seen in the case of in vitro fertilization is the danger of the terribly dehumanizing power implicit in the artificial manipulation of the generative process, a danger which is no less real because the manipulation is accomplished for beneficent motives.

The Pope John Center hopes in the future to be able to publish a study on the moral and social implications of reproductive technologies.