An Ethical Dilemma in the Field of Gynecology

Un dilema ético en el campo de la ginecología

Um dilema ético no campo da ginecologia

Luca Valera[1]
Corrado Terranova[2]

Abstract
The aim of this paper is to assess a case report in the field of gynecology, starting from an ethical paradigm that relates primarily to the so-called "sources of morality" (objective structure, circumstances, aim). In order to do so, we first will present four ethical paradigms for the evaluation of clinical cases (preference utilitarianism, principlism, ontologically-grounded personalism and Aristotelian/Thomist objective ethics). After introducing the main aspects of these paradigms and pointing out that what matters in an ethical evaluation is not so much the final judgement, but rather the argument that leads to it, we will assess the case report in light of the chosen paradigm. Lastly, we will outline a possible solution to the problem, starting from the previous ethical evaluation.
Keywords: Objective ethics; bioethics; infertility; applied ethics; ethical evaluation; ontologically-grounded personalism; principlism; preference utilitarianism (Source: DeCS, Bireme).

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1 Pontificia Universidad Católica de Chile, Chile. luvalera@uc.cl
2 School of Philosophy and Center for Bioethics, Università Campus Bio-Medico di Roma, Unità di Ginecologia, Italia. c.terranova@unicampus.it

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Resumen

El objetivo de este texto es evaluar el informe de un caso clínico en el campo de la ginecología, a partir de un paradigma ético que se refiere principalmente a las denominadas "fuentes de la moral" (la estructura objetiva, las circunstancias, el objetivo). Primero se presentan cuatro paradigmas éticos para la evaluación de casos clínicos (utilitarismo de preferencia, principialismo, personalismo fundado ontológicamente y ética objetiva aristotélica/tomista). Después de la introducción de los aspectos principales de estos paradigmas y al señalar que lo que importa en una evaluación ética no es tanto el juicio final, sino más bien el argumento que conduce a ella, se evalúa el informe del caso a la luz del paradigma elegido. Por último, se esboza una posible solución al problema, a partir de la evaluación ética anterior.

Palabras clave: objetivo; ética; bioética; infertilidad; la ética aplicada; la evaluación ética; personalismo fundado ontológicamente; principialismo; el utilitarismo de preferencia (Fuente: DeCS, Bireme).

Resumo

O objetivo deste trabalho é avaliar o relatório de um caso clínico no campo da ginecologia a partir de um paradigma ético que se refere principalmente às denominadas "fontes da moral" (a estrutura objetiva, as circunstâncias, o objetivo). Nesse sentido, primeiramente apresentamos quatro paradigmas éticos para a avaliação de casos clínicos (utilitarismo de preferência, principialismo, personalismo fundado ontologicamente e ética objetiva aristotélica/tomista). Após introduzir os aspectos principais desses paradigmas e indicar que o importante numa avaliação ética não é tanto o julgamento final, mas sim o argumento de que conduz a ela, avaliamos o relatório do caso à luz do paradigma escolhido. Por último, esboçamos uma possível solução ao problema a partir da avaliação ética anterior.

Palavras-chave: objetivo; ética; bioética; infertilidade; ética aplicada; avaliação ética; personalismo fundado ontologicamente; principialismo; utilitarismo de preferência (Fonte: DeCS, Bireme).

INTRODUCTION

In this article, we will present an example of an ethical evaluation of a case report in the field of gynecology, starting from an ethical paradigm that relates primarily to the so-called "sources of morality". For this reason, our work will be structured as follows: 1) presentation of the case report; 2) ethical paradigms for the evaluation of clinical cases; 3) ethical evaluation of the case report in light of the chosen paradigm; 4) solution of the problem starting from the previous ethical evaluation; and 5) conclusions.

PRESENTATION OF THE CASE REPORT

A 29 year old lady was referred to our institution because of primary infertility. With her partner, the patient tried to conceive for 25 months without success. During that period, the patient underwent assisted reproductive technology procedures, which resulted in a miscarriage at seven weeks of gestation. The patient had a negative medical history and a normal menstrual cycle; ultrasound investigations showed normal ovarian function. A diagnostic hysteroscopy and laparoscopy, performed one year earlier, showed a normal endometrial cavity and no signs of tubal adhesion or endometriosis. Blood tests (including screening for thrombophilia and infectious diseases, thyroid function and karyotype) were within the normal range (except for Hb 11.8 g /dl). An evaluation of her husband revealed normal male factor and spermogram.

Given these premises, we are asked to analyze ethically the action to be taken. In other words, what should be done? A new IVF cycle, in order to give the couple the opportunity to have a child, once it is established that the desire to have a child is inherently good? Or, are the available data insufficient to assess the situation adequately?

SOME PARADIGMS OF ETHICAL EVALUATION OF CLINICAL CASES

Before assessing the case and introducing our system for ethical evaluation of clinical cases, it seems appropriate to outline the *status quaestionis* of the current theoretical paradigms in the so-called field of medical ethics – specifically those that ground the respective "clinical ethics paradigms" – so as to have an understanding of the main trends currently in play.[3] Due to the length of this paper, we will not delve into a criticism of the different ethical paradigms; rather, we will only present them to offer the reader a fairly complete background. We can outline four main ethical paradigms that are applicable to medical ethics: utilitarianism (particularly preference utilitarianism, as developed by Peter Singer) (3); ontologically-grounded personalism (developed by Elio Sgreccia) (4); principlism (developed by Tom Beauchamp and James Childress) and (5); Aristotelian/Thomist "objective" ethics (6-8).[4] In order to be as clear as possible and for the sake of schematization, we will present the main features of the four paradigms, knowing that this will not reveal the complexity of their approach.

Preference Utilitarianism

According to this paradigm, an ethical evaluation is carried out in light of four principles, the third of which

3 A good review also can be found in López Barreda (1). The necessity of "clinical ethics" is argued in Fox et al. (2).

4 With regard to this last paradigm, there is no single recognized reference, since the Aristotelian/Thomist tradition is quite broad.

(risks/benefits) is the most important in arriving at the final outcome through a calculation. There are no absolute values, and the only constant is the fact that every situation can be assessed according to the benefit (or harm). In this regard, the prevailing logic is the economic one; i.e., everything (and everyone) has a price. The four principles are:

1. The centrality of interest/preference. Each preference (or interest), when present, should be respected: the more preferences satisfied in the world, the better.
2. The equal consideration of preferences (we have to weigh preferences impartially): all preferences must be taken into account, regardless of whose preferences they are (3).
3. The risk/benefit calculation. In order to decide on the course of action, one has to assess the risks and benefits that every choice can bring about (the sum must always be positive).
4. The greater happiness principle. *It is the greatest happiness of the greatest number of people that is the measure of right and wrong*. It is always necessary to respect this principle: the greatest pleasure for the greatest number of people and at the least amount of pain.

Ontologically-grounded personalism

The evaluation, in this case, is based on the absolute value of the dignity of every human person, with no distinction whatsoever. With reference to bioethics, this value is guaranteed through the following four hierarchical principles (4):

1. The principle of defense of physical life. Life is the fundamental value and the source of all rights.
2. The principle of freedom and responsibility. Man's freedom is an inalienable good, one that pertains to genuine personal responsibility.
3. The principle of totality or the therapeutic principle. Any injury to the physical integrity (of the person) is acceptable in four conditions:
   a. It must be therapeutically rational.
   b. There should be no other less invasive ways to treat the disease.
   c. The risk/benefit ratio must be positive.
   d. It must have the consent of the patient or the authorized person.
4. The principle of subsidiarity and sociability. Everyone's life has value for society as well . This also means it is society's duty to take care of every individual.

These principles constitute the second step in a process of analysis conceived as the vertices of an ideal triangle, where data collection represents the cognitive level (first level), ethical analysis represents the justifying level (second level), and ethical evaluation and deliberation represent the deliberative level (third level) (9, 10).

Principlism

The evaluation is carried out in light of four principles, which are neither absolute nor hierarchical. In the event of conflict between two or more principles, the evaluator has to "balance" them, since the principles are neither absolute nor hierarchical. This balance (5) should be achieved on the basis of common morality, which also

will be used to define the meaning of "good," "bad" and "rights" in every situation. The four principles are (5):

1. The principle of autonomy. The subject is free to decide everything that concerns him/her and, therefore, the subject´s demands are also binding on the actions of the physician.
2. The principle of beneficence. The physician always must act for the good of the patient.
3. The principle of non-maleficence. The physician should never do the patient harm (*primum non nocere*).
4. The principle of Justice. We must always respect everyone's rights and do so impartially.

Aristotelian/Thomist "objective" ethics

Every human action must be assessed on the basis of certain criteria (the so-called "sources of morality"): the objective structure of the act, the circumstances and the motivation (or aim). These criteria, deliberately indeterminate, are useful in describing a situation and arriving at a decision, since human freedom is embodied in each concrete situation. To be clear, they constitute the answer to some crucial questions: "How is the action conducted?" (Objective structure); that is, "When?" "Where?" "How?" (Circumstances) and "Why?" (Aim) (6). In the clinical field, these criteria could be translated as follows:

1. Nosography. It is the objective structure of the act; i.e., a description of the state of existing things and possible cures to be undertaken.[5]
2. Gold standard. We need to compare the actual situation of the clinical case to the best chances of intervention. Within this assessment, it is also necessary to consider the proportionality (or less) and the ordinariness (or less) of the treatments being offered. This parameter interprets the idea of the circumstances, since it varies depending on the situation, the means, the time and place where the event occurs.
3. The intentions of the patient and the physician;[6] i.e., the "aim" in classical ethics. In this case, since the medical act is always an integrated act (there is no single subject acting on an object, but many people acting), it is necessary to balance the criteria in light of the final decision, taking into account the judgments expressed by different actors (the medical team, the patient, family members, etc.).

In order to assess the aforementioned case report, we will take into account mainly this latest paradigm, which allows us to develop an ethical evaluation of the case considering the main aspects of the action itself, and without necessarily using a term with numerous metaphysical and cultural implications, such as the concept of "person" (11).

ETHICAL EVALUATION OF THE CASE REPORT

The case we are considering could be solved through each of the four ethical paradigms presented herein, sometimes reaching different solutions and, other times, the

5 This dimension summarizes the parameters "medical indications" and "contextual features," as specified by many authors within the so-called "four quadrants approach" (12-14).

6 With this parameter, we hope to overcome the "individualistic" idea of "patient preferences" (12-14) so as to introduce a relational parameter.

THEREFORE, AN ADEQUATE NOSOGRAPHY AND A CLARIFICATION OF THE PURPOSE/GOALS THAT PROMPT THE ACTION ALLOW US TO ALSO UNDERSTAND THE CIRCUMSTANCES IN WHICH THE CLINICAL CASE OCCURS.

same ones. However, what matters here is not so much the final judgement, but the argument that leads to it. According to the paradigm we have chosen; i.e., Aristotelian/Thomist "objective" ethics, the first step is a nosography, which we explained at the very beginning of this article. What matters, in this case, is the health of both spouses, since the reproductive act is an essentially relational one and, therefore, fully involves both of them. It is also worth mentioning that the couple has already taken the path of assisted reproduction, with negative results. In this paper, we refrain from an ethical evaluation of IVF itself, since our purpose is a different one.

Before assessing the possible means available to the couple, we need to clarify the aim of the action, so as to identify the best way to accomplish their goal and to ensure that its purpose is good in itself. It is worth noting that, in this case, we do not have a unique purpose, but different goals that are intertwined. On the one hand, there is the couple, who are rightly moved by the desire to have a child; on the other, the doctor, whose goal is to cure a disease, or rather, to restore the patient's health. We highlight the fact that the doctor's aim is not grounded in his agreement with the couple's desire; his aim is purely to cure a disease or to recover a function fully or in part. This possibility, of course, cannot always be realized. Therefore, we should point out that medicine can be turned into "medicine of desires" and in vitro fertilization is a very effective example of "medicine of desires," since the patient does not reacquire a function, but only replaces it for a very short period of time.

Therefore, an adequate nosography and a clarification of the purpose/goals that prompt the action allow us to also understand the circumstances in which the clinical case occurs. This, in turn, sheds light on what might be the most appropriate means to use (15).[7] In this case, it seems the information we have does not help us to better understand what means are the most appropriate to fulfill both the purpose of the doctor (to cure) and that of the couple (to have a child). For this reason, we can no longer answer our previous question: "What should be done?"

A POSSIBLE SOLUTION IN LIGHT OF THE FOREGOING ETHICAL EVALUATION

After this analysis – which is already an ethical analysis, since it reveals the values in the given situation, it assesses the purposes and identifies the best means to achieve them – we can go back to the case report, which is a difficult one, since the available data do not indicate the best route to take. Due to a lack of the elements for an ethical evaluation (particularly with respect to the patient's condition), we decided to find out more about the patient's status. Accordingly, she is submitted to additional blood tests for autoimmunity, which highlight elevated tissue transglutaminase (tTG) IgA. A duodenal

7 This ability to evaluate, in concrete circumstances, what are the best means to achieve the good aim, is the virtue of prudence.

biopsy performed through esophagogastroduodenoscopy detects complete villous atrophy and crypt hyperplasia with leukocyte infiltration pathognomonic for celiac disease (CD). CD is common, with a prevalence of nearly 1% in Western populations. The symptoms are not only related to the gastrointestinal tract and several studies have linked CD to systemic manifestations. Data on the association between celiac disease and infertility are still considered contradictory and, at present, there are no recommendations to screen for CD in female patients with infertility. A recent meta-analysis (16) showed that women with infertility and with "unexplained infertility" are 3.5 and 6 times more likely to suffer from CD than fertile women. After 13 months of a gluten-free diet, the patient conceives naturally and gives birth to a healthy baby boy.

CONCLUSIONS

The present case report ends, therefore, with the pregnancy of the patient. In short, both the aim of the doctor and that of the couple were realized. Their goals were accomplished through good means and, above all, thanks to a broader knowledge and understanding of the situation. Of course, this presentation of a case report and its consequent ethical assessment were not done to demonstrate that the model we have chosen is the most effective or that it is the only one to lead to an optimal solution. The same purpose might also have been accomplished through a different system of evaluation. Therefore, we can say that what makes the course of action undertaken by the doctor a good one is not the final result, but the fact that all the criteria (object, circumstances and end) are good in themselves. Such action could subsequently lead to better consequences or greater respect for patient's autonomy and personality (as happened in this case), but this is only the consequence of the action itself and not its guiding principle. Our initial question: "What should be done?" could have found an adequate answer only by delving deeper into the patient's clinical condition. This highlights the fact that an ethical evaluation of a clinical case requires a properly done clinical analysis, if it is to be coherent, since the first objective of the action (*finis operis*) is the proper execution of the action itself.

The last element we want to highlight is the following: we have deliberately chosen a case of "ordinary" medicine, without presenting a "border case", in order to demonstrate that ethics should deal with ordinary life, as effectively pointed out by Toulmin (17).

REFERENCES

1. López Barreda R. Modelos de análisis de casos en ética clínica. Acta Bioethica. 2015; 21(2):281-90.
2. Fox M, McGee G, Caplan AL. Paradigms for Clinical Ethics Consultation Practice. Camb Q Healthc Ethics. 1998; 7(3):308-14.
3. Singer P. Practical Ethics. 3rd ed., Cambridge: Cambridge University Press; 2011.
4. Sgreccia E. Personalist Bioethics: Foundations and Applications. Philadelphia: The National Catholic Bioethics Center; 2012.
5. Beauchamp TL, Childress JC. Principles of Biomedical Ethics. Oxford: Oxford University Press; 2001.
6. Rhonheimer M. La prospettiva della morale. Fondamenti dell'etica filosofica. Roma: Armando; 1994.
7. Vendemiati A. In prima persona. Lineamenti di etica generale. Roma: Urbaniana University Press; 2008.

8. Premoli De Marchi P. Introduzione all'etica medica. Torino: Academia Universa Press; 2012.

9. Spagnolo AG, Refolo P, Sacchini D, Daloiso V. Health Technology Assessment Processes for Nanotechnologies: The Ethical Domain. Nanotechnology Development. 2011; 1(e1):1-3.

10. Sacchini D, Virdis A, Refolo P, Pennacchini M, Carrasco de Paula I. Health Technology Assessment (HTA): Ethical Aspects. Med Health Care and Philos. 2009; doi:10.1007/s11019-009-9206-y.

11. Pessina A. Bioetica. L'uomo sperimentale. Milano: Mondadori; 2000.

12. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. New York: McGraw-Hill; 2006.

13. Schumann JH, Alfandre D. Clinical Ethical Decision Making: The Four Topics Approach. Semin Med Pract. 2008; 11:36-42.

14. Sokol DK. The "Four Quadrants" Approach to Clinical Ethics Case Analysis: An application and Review. *J Med Ethics*. 2008; 34:513-6.

15. Russo MT, Valera L. Invito al Ben-Essere. Lineamenti di etica. Roma: Aracne; 2015.

16. Singh P, Arora S, Lal S, Strand TA, Makharia GK. Celiac Disease in Women With Infertility: A Meta-Analysis. *J Clin Gastroenterol*. 2016; 50(1):33-9.

17. Toulmin S. How Medicine Saved the Life of Ethics. Perspect Biol Med. 1982; 25(4):736-750.