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should be able to discuss her fears and anxieties with a physician who demonstrates to her the interest and understanding needed. It is frequently noticed that following one such visit, the anxiety is allayed and the patient becomes pregnant before the next visit. Confidence must be instilled, and once the psychic origin of the trouble has been determined there should be minimization of involved laboratory procedures, etc. which in themselves frequently exaggerate the existing anxiety. Sex instruction for both partners is often important along with creation of newer and wider outside interests.

If, however, the fundamental emotional problem lies deep within the unconscious, then psychotherapy in a psychiatric clinic should be instituted.

It is not the purpose here to discuss the more involved dynamics and therapeutic approaches, but rather it is intended to introduce the concept of psychical influences into the study and investigations of the problem of infertility.

Some Moral Phases of Infertility Problems

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[The moralist's contribution to a symposium on fertility aids cannot at this date profess to be entirely original. Most of the ethical problems inherent in the subject have long since been discussed by the most competent of theologians, whose resultant conclusions will continue to be recognized as standard until such time as either the advance of medical science creates substantially new moral problems in the field or the Church sees fit to resolve certain remnants of doubt which she alone can clarify authentically. However, in order to provide for doctors the convenience of having within a single volume both the medical and moral data pertinent to the subject, it has been suggested that this series conclude with a synopsis of its principal moral aspects, together with references to the more readily accessible literature which treats those ethical phases at greater length. That is the primary raison d'être of the comments to follow.]

Confronted with the fact of a barren marriage, the partners to which are desirous of offspring, the physician must conjure with a problem which is potentially as complex morally as it is medically. As diagnostician he must first ascertain the cause(s) of infertility; and thorough investigation to that end often necessitates procurement and examination of the male sperm. How may medically satisfactory seminal specimens be obtained without prejudice to the law of chastity? With that hurdle cleared, and on the supposition that sperm fertility is established, the more complicated process of discovering female generative deficiencies may not be entirely void of moral question marks, at least in cases involving surgery or other diagnostic techniques which might be classified as notably dangerous according to medical standards. And finally as therapist, the physician must choose corrective measures with due regard for any surgical risk entailed and mindful of moral teaching on the question of artificial insemination. Those are the generic moral problems which suggest themselves immediately upon any mention of fertility aids; and while the major issues of male sterility tests and artificial insemination have been thoroughly aired by moralists, especially
in more recent years, a summary of their conclusions may not be entirely superfluous here.

MALE STERILITY TESTS

[For a doctor’s purpose, perhaps the most satisfactory expression of moral teaching on the subject of both male sterility tests and artificial insemination is that of Fr. Gerald Kelly, S.J., in MEDICO-MORAL PROBLEMS (II, pp. 14-22), a series, incidentally, which should be a staple in every Catholic doctor’s library.1 I refer to it as most satisfactory for several reasons: it is most conveniently available to medical men; it is concise and eminently clear; and it confines itself chiefly to reasoned conclusions without confusing the practical medico-moral issue with the speculative controversies of theologians. (Important as those controversies may be to ourselves, they are understandably of minor interest to the physician.) The bibliography appended to this article of Fr. Kelly’s provides ample reading matter for anyone interested in pursuing the moral questions further. The following outline is based largely on his presentation.]

Once semen has been licitly obtained, there is no ethical objection to whatever standard tests may be necessary to determine its fertility. Prescinding momentarily from the medical impracticality of some means of procuring sperm, we can speak in general of (1) methods which are certainly illicit, (2) those which are certainly licit, and (3) those which are probably licit and which therefore may in good conscience be employed until such time as theologians may prove them to be certain unlawful or the Church declares them so.2

(1) Certainly Illicit are those methods of procuring semen which require intentional excitation of the generative faculty in any act other than natural intercourse (between husband and wife) consummated intravaginally. Hence the following possibilities are NOT permissible:

- a) masturbation;
- b) intercourse which involves the use of an intact condom, or a vaginal sheath equivalent to a condom;
- c) intercourse which terminates in extravaginal semination.

Because Catholic doctors generally are not inclined to question the immorality of these practices, it seems unnecessary to substantiate the above statement except by reference to Fr. Kelly (op. cit., p. 15) and the explanation presented there.

(2) Certainly Licit are those methods of procuring semen which either are subsequent to unintended excitation of the generative faculty, or which follow upon natural intercourse (between husband and wife) consummated intravaginally and do not notably interfere with natural post-coital spermigration. Therefore the following possibilities are certainly lawful, although not all of them would appeal to the doctor as being medically practical:

- a) semen obtained as the result of spontaneous or involuntary emission;
- b) extraction of seminal remnants from the vagina about an hour after normal conjugal intercourse;
- c) expression from the male urethra of semen remaining there after the completion of normal conjugal intercourse;
- d) collection of sperm, which would otherwise be lost, in a vaginal cup which is inserted into the vagina after marital relations.

(3) Probably Licit, and hence permissible until proven certainly wrong either by irrefutable theological reasoning or by future ecclesiastical pronouncement, are those methods which either do not involve excitation of the generative faculty, or which interfere only to some negligible extent with natural post-coital spermigration. Accordingly the following are probably objectively licit, and in practice would certainly be permissible as of now:

- a) collection of semen, during marital intercourse, in a condom so perforated as to allow passage of most sperm while retaining sufficient for laboratory tests;3

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1 The 4-volume set, plus Code of Ethical and Religious Directives for Catholic Hospitals, may be obtained from Catholic Hospital Association, 1438 So. Grand Blvd., St. Louis 4, Mo. ($2).
2 It is not a theological lyric leap from “probably licit” to “certainly permissible in practice.” Moral obligation to act in a certain way necessarily presupposes certain that the contrary mode of action is illicit. Hence a moralist cannot legitimately say “You must not use this or that fertility test,” until all genuine objective probability alleged for the lawfulness of that procedure has been validly disproven. (Cf. Kelly, op. cit., p. 15.)
3 See above, p. 48. Even though some excellent theologians defend the lawfulness of procuring seminal specimens (cf. Kelly, op. cit., pp. 15-16), all doubtlessly would advise against the perforated condom technique. As Fr. Kelly notes, the danger is that people will misunderstand, i.e. either suspect the doctor of suggesting something immoral, or get the mistaken impression that an exception is being made to the natural law prohibition against contraceptive devices.
b) removal of a seminal sample from the vagina very soon after conjugal relations;

c) direct aspiration of sperm from testicles or epididymes.

Note that in the second and third categories of the preceding outline (2b and 3b) a distinction is made between a seminal sample extracted from the vagina about an hour after normal intercourse, and one which would be so obtained within a substantially shorter period. The first method is declared to be **certainly** licit when legitimate reason prompts it: and the vast majority, if not all, of theologians have long agreed with that conclusion. The latter method, however, has not been so clearly evident as lawful, and many moralists would be inclined to argue against the morality of the practice. This insistence on a time interval is not an instance of theological hair-splitting, but only a conscientious attempt to abide by the prime principle that deliberate interference with natural post-coital processes is morally reprehensible. It is only on condition that nature be left substantially unimpeded in the normal process of spermigration that moral theology can countenance any method of seminal sampling after coitus.

Here is another instance where moralists are dependent on medical data for their own practical conclusions. Is migration of sperm notably impeded if, very soon after intercourse, an amount of ejaculate sufficient for testing purposes is extracted from the vagina? Up to recent times, moralists generally had been given to understand that only after the lapse of an hour or so from the time of coitus could fair certainty be had that spermigration to the cervix had been substantially completed to the degree which nature intends. For that reason many have been unwilling, or at least very reluctant, to sanction any removal of semen within a markedly shorter period, lest chances of fecundation be thereby notably lessened and the sampling thus qualify as interference with natural post-coital processes. However, it may be that more recent and more exact medical evidence now calls for a revision of the moralists' estimate of the minimum time interval required between deposition of sperm in the vagina and removal of semen for fertility tests.

For it seems to have been established that sperm deposited in the acid vagina will normally die there rather quickly unless contact is made with the alkaline cervical mucus. In fact, it has been estimated that in normal intercourse 80% of the sperm do for that reason perish intravaginally, and that it is the vanguard 20% upon which nature depends for conception. If, however, the seminal pool can be protected from vaginal acidity and at the same time be brought into closer contact with cervical mucus, spermigration is allegedly so improved that within 15-30 minutes more sperm will have penetrated the cervix than would ordinarily ever survive the vaginal acid bath in normal circumstances. That appears to be the basic principle underlying the cervical spoon:4 and if the theory is medically sound, there seems to be no theological reason for insisting upon an hour's interval before allowing the spoon to be withdrawn and its residual contents subjected to fertility tests.

The crux of the practical moral question in this instance is a point of medical fact. It would be hard to find valid moral objection to seminal sampling which does not interfere substantially with the degree of spermigration normally intended by nature. And it is the prerogative of conscientious physicians to demonstrate that withdrawal of seminal remnants, even relatively soon after intercourse, can satisfy that condition.

One brief concluding word on testicular biopsy as a sterility test. The reason for mentioning this procedure is not to cast doubt upon its moral permissibility, but merely to state expressly that there are no particular moral problem involved in the technique. Its sole purpose and effect would seem to be the removal of a relatively minute specimen of testicular tissue in order to determine possible spermatogenic defects. No reason occurs for even suspecting its lawfulness; nor has any moralist, to this writer's knowledge, ever questioned the procedure.

**DIAGNOSIS OF FEMALE STERILITY**

Ordinarily in manuals of medical ethics, discussion of sterility tests is restricted to the question of seminal specimens, and the diagnosis of female sterility is more often than not passed over in silence. For it is a fact, scarcely deserving of more than passing statement, that no particular moral problem attaches to what gynecologists probably consider routine diagnostic procedures in this field, such as cervical smears, tubal insufflation, endometrial biopsies, etc. (with emphasis, however, on the caution mentioned by Dr. Doyle with regard to the last procedure).5 And there the case might also rest in this discussion if it were not for a doubt, conceived not by theologians but by some doctors, with regard to the more recent use of culdoscopy and/or culdotomy in the diagnosis and correction of infertility in women.

If I understand correctly both procedures, culdoscopy entails a simple puncture of the vaginal wall sufficient to allow introduction of the culdoscope into the peritoneal cavity where ovarian structure and

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4 See above, pp. 40 and 41.

5 "... unless the patient has been instructed not to attempt pregnancy that month, it is best to wait for the first day of the cycle to avoid interruption of a pregnancy (by endometrial biopsy)." Cf. above, p. 44.
activity may be observed to some limited degree. Culdotomy requires
more extensive vaginal incision, and permits more complete investigatio
of the same area with or without the aid of a telescope. It has the sur-
gical advantage. I am informed, of being a careful, layer-by-layer
section after the pelvic cavity has been identified by aspirating peri
toneal fluid with a hollow needle.

One impression resulting from inquiries made of doctors is that of
certain lack of enthusiasm on the part of some for either culdoscopy o
culdotomy as a means of detecting functional generative deficiencies
Their chief difficulty appears to be the surgical risk entailed: and the
allege, for instance, the fact that the puncture of the vaginal wall
required for culdoscopy is a blind one, in which miscalculation can resul
in serious damage to internal organs, e.g. in perforation of the bowel

According to the testimony of other doctors, those risks simply do not
exist to any degree worthy of medical note when an experienced
operator is performing. In fact, preference for culdotomy is not infre-
quently expressed in terms of its relative simplicity and greater safety as
compared with laparotomy.

Now if and when such differences of medical opinion exist, the
moralist as such is not qualified to settle them. If he finds that doctors
themselves are as yet unable to agree completely on a question of
surgical risk, then not only is he ineligible as a medical arbiter, but he is
also unable to give an unqualified moral decision until the surgical
question is settled to the satisfaction of doctors themselves. If therefore
legitimate medical doubt, on grounds of surgical risk, can be cast upon
culdotomy in this connection, the moralist must first make these conces-
sions to reality:

1) The individual doctor is infinitely more capable than the theolo-
gian of calculating surgical risk; and no reputable physician would wan-
tonly ignore the element of possible danger or fail to take adequate
precaution against it;

2) certain doctors may develop such skill in performing operations
which other doctors would hesitate to attempt, that at the hands of the
former the element of danger is perhaps so minimized as to be practi-
cably negligible;

3) such a doctor is fully justified in calculating risk, or the lack of
it, in the light of his own personal experience and technical proficiency.

With these points in mind, a conditioned moral solution can be given
which should prove acceptable to any extant school of medical thought
on the question of surgical diagnosis of female infertility:

1) If no notable risk can be prudently anticipated, there is no moral
problem.

2) If medically notable risk can be legitimately alleged, then it is up
to the prudent doctor to decide whether, in view of his own experience
and proficiency, his choice of such a procedure is medically sound. A
medically prudent decision will of necessity be a morally good decision.

Doctors will doubtless agree quite readily that explicit consent of
the patient should be had if, either according to medical standards or in
the patient’s estimation, any contemplated treatment would be properly
ruled very unusual. And that consent should be based on at least a
general understanding on the patient’s part of what the treatment
entails. It is a cardinal principle of both medicine and morals that “the
physician has no other rights over the patient than those which the latter

gives him explicitly or implicitly and tacitly.”

permission to use very

unusual measures cannot ordinarily be presumed. Doctors will also, of
course, be careful not to give a patient the impression that she is in any
way obliged to take what she may consider extraordinary measures in
order to discover or to correct organic disorders of a generative nature.
But apart from those routine cautions, recognized to be part and parcel
of any good doctor’s habitual way of thinking and acting, the principle
stated above represents the moral state of the question as it presently
stands. Granted a good probability of achieving a worthwhile result,
together with the patient’s knowledgeable consent to a medically prudent
procedure, it is extremely unlikely that any moralist would challenge a
conscientious doctor’s decision to employ culdoscopy or culdotomy when
lesser diagnostic measures have proven ineffective.

ARTIFICIAL INSEMINATION

[For the theological evolution of this question, see Fr. Kelly’s article already
cited, and the bibliography there

provided.]

PASSING from the diagnostic to the therapeutic phase of sterility
problems, the basic moral question first encountered is that of
artificial insemination, which is now well established in some medi-
cal quarters as a standard corrective for some failures to conceive.6
Catholic doctors generally are already quite aware that moral theology

6Pope Pius XII, Allocatio to First International Congress on the Histopathology
of the Nervous System, Sept. 1952. The entire text of this discourse was printed in

7 For some rather significant complications involved in donor insemination, see a
report from Denmark in JAMA, 154: 779.
definitely precludes from their armamentarium any artificial insemination truly worthy of the name; and they are also familiar with the statement of Pius XII which now provides the standard theological reference on the subject. A brief summary of that papal pronouncement will more than suffice for our purposes here.

Explicit in the Pope's treatment of this question (which he discussed at the express request of the physicians in attendance at the time) was a confirmation of traditional theological teaching regarding the immorality of all "donor insemination" and of any artificial fecundation achieved with semen obtained by immoral methods. Scarcely ever had there been less than unanimous agreement among moralists that these forms of insemination could not be reconciled with natural law principles; and hence from the beginning informed and conscientious Catholic doctors had rejected them. But then His Holiness took up a phase of the question which previously had been open to debate, and by implication apparently resolved a doubt which had been discussed by moralists for some thirty years. His statement regarding "new methods" of insemination has since induced moralists to conclude that only through the medium of natural coitus can human procreation be licitly effected; an opinion which the majority had maintained even prior to the pronouncement of Pius X. Hence the minority, who had previously held as errors the extension of the word, could be termed "artificial." This method presumes always, in accordance with the allocation, natural coitus and cannot be regarded with extreme reserve, but it must be utterly rejected. With such a pronouncement, one does not necessarily preclude the use of certain artificial methods intended simply to facilitate the natural act or to enable the natural act, effected in a normal manner, to attain its end—LQ, loc. cit., p. 5.

PSYCHOTHERAPY OF INFERTILITY

If there had previously been any doubt among doctors as to the Church's stand on general psychotherapeutic methods, it should certainly have been dispelled by Fr. John C. Ford's thoughtful and informative article reprinted in LINACRE QUARTERLY, August, 1953. Any attempt to summarize his entire treatment of the question would exceed the limits of the present discussion; but doctors might find it profitable to read or re-read it with the following points especially in mind:

1) There is no essential incompatibility between psychotherapy and morality. Doctors may rest assured that we do not consider the psychiatrist to be engaged in a morally shady business, and that we do not discourage from seeking proper psychiatric treatment those of the faithful who may seem to require it.

2) Among the dangers to be recognized and avoided in psychoanalytical treatment of sterility problems is that involved in any discussion concerning the intimacies of another's conjugal life. As a professional man, the doctor will have schooled himself towards sexual details. Nevertheless, he should not allow himself to forget that the subject remains an essentially delicate one which can be disturbing in various ways for his patients. Hence a Christian reverence towards sexual details. Nevertheless, he should not allow himself to forget that the subject remains an essentially delicate one which can be disturbing in various ways for his patients. Hence a Christian reverence for matters sexual should habitually constitute an integral part of his professional attitude in this sphere.

3) This does not mean, however, that the subject of sex must be excluded from the psychiatric interview. Moralists do not have to be convinced of the existence of infertility problems which are totally or partially psychological; nor of the necessity of attacking those problems at their psychological roots; nor of the competency of Christian psychology to cope with them. And nobody is more willing than ourselves to defer in this matter to the doctor whose professional skill is further
enhanced by recognition of and respect for truly Christian attitudes towards the functions of sex.

With those generic points in mind, what specifically Catholic contribution can be made towards the satisfactory solution of this type of problem as encountered in the infertility clinic? It is but stating the obvious to assert that many of our young Catholic people approach and enter marriage with a totally inadequate concept of its physical implications. But it is an infinitely sadder fact that they are even more likely to be unaware of the intimate relationship of physical to spiritual. Without pretense of more than a gentleman’s reading knowledge of psychiatry as such, it can be safely said that among our married people many maladjustments to matters sexual are traceable to a poor educated conscience which erroneously regards and regrets the physical side of conjugal life as something less than virtuous. Call the result guilt complex or what you will—the symptoms are unmistakable and the diagnosis is substantially the same whether made by priest or psychologist.

Proper sex instruction for some such individuals is important; and all too often it is the doctor who must assume the duty of imparting it, either to avert marital tragedy or in an attempt to repair it. But physical details alone were always sufficient, the Catholic doctor could claim no special competence, by mere reason of his faith, as a therapist in this field. The fact of the matter is that, to a Catholic conscience improperly educated, those details alone may sometimes be psychologically harmful, unless they are enhanced by reference to the Christian concept of marriage and thus revealed in their true dignity and sublimity. Granted the fact of a Catholic conscience as yet unadjusted, or maladjusted, to the physical aspects of conjugal life, proper spiritual education is but a corollary of sound psychology. Here is an area where not only the professed psychiatrist but the Catholic doctor in genera has a tremendous opportunity for good, both medical and spiritual—and one might add, a tremendous responsibility. For too often, in the regrettable defect of proper instruction from other sources, he alone is in a position to detect the individual need for enlightenment and to supply it.

It may well be that a Catholic physician, despite personal awareness and appreciation of the Christian design for sex and marriage, will find himself less than fluent when he attempts to convey those convictions to others. Yet there is no insurmountable reason why any doctor, who is sufficiently articulate to conduct successfully the purely medical matters of his office, should be less than capable in this regard. Without professing to have discovered a panacea for this species of timidity, I would suggest that any physician who is not already acquainted with the Christopher Recordings on Sex Instruction would find eminently profitable the thirty minutes required to hear them. Produced originally as guides for parents in the sex instruction of their children, they consist of four dramatized scenes in which father or mother, or both, undertake to give suitable and adequate answers to a child’s natural curiosity concerning the origin of babies, menstruation, problems of adolescent boyhood, and the marriage union. Doctors may benefit from them in two respects: they reveal the ease and naturalness with which sexual functions can be realistically but reverently explained in matters essentially Christian context; and, incidentally, they might also serve as a demonstration in the art of expressing anatomical data accurately in a language easily understood by the layman—in this case, even by a child. (It was the death of a state medical school who, during a public lecture, was once interrupted by the physician chairman with the admonition, “Please put that into English for the audience, Doctor.”) The records are available either in a single LP ($1.50) or in four standard disks ($3) from The Christophers, 18 E. 48th St., New York 17, N. Y. In the opinion of many well qualified to judge, they provide the best available means of demonstrating an ideal way of truly educating others, either children or uninformed adults, in the divine plan of procreation.

Another recommendation which seems a propos is a series of articles in GP by Ian P. Stevenson, M.D., Associate Professor in Neuropsychiatry and Medicine at Louisiana State University School of Medicine. The basic supposition which inspired the series is the doctor’s conviction that any medical practitioner must, can, and does give effective psychotherapy to many of his patients in the course of his ordinary work. His remarks, therefore, are directed to general practitioners and to specialists in fields other than psychiatry, all of whom should find much that is informative and reassuring in what strikes even the unprofessional eye as a deal of eminently good sense and sound psychology. Applied to the psychological problems which almost any doctor is likely to encounter in patients with infertility complaints, the basic techniques discussed by Dr. Stevenson should prove immensely helpful to the physician whose preferences have not led him to specialize in psychotherapy. In fact, professors of pastoral theology, if they are listening in, might find in these articles impressive corroboration of many of the practical principles and suggestions commonly proposed to future confessors.