ETHICS IN REPRODUCTIVE MEDICINE IN THE GERMAN DEMOCRATIC REPUBLIC

ABSTRACT. The paper discusses the practice of genetic counseling and elective abortion in the German Democratic Republic.

Key Words: elective abortion, embryo transfer, in vitro fertilization, protection of human life, reproductive ethics, German Democratic Republic, bioethics

Progress in medicine has been accompanied by the emergence of new possibilities and freedom in the field of human reproduction which give rise to ethical problems in balancing risks against rewards and in determining the appropriate course of action. A detailed assessment is quite often made of possible devices for increasing human happiness and the social quality of life. These same devices, however, have frequently been rejected out of philosophical bias or a realization of the risks they pose. Differences in value orientation and legislation are particularly conspicuous in international comparisons, due to cultural traditions, philosophical positions, and socio-economic conditions. In this context, substantial importance is attributed to the ethical positions on the purpose and value of human life (Koerner et al., 1984; Koerner, 1986a; Koerner, 1986b).

POLICY ISSUES OF REPRODUCTIVE MEDICINE AND ETHICAL STANDARDS

Problems relating to medical ethics generally exist at the following two levels: The first is associated with demands made on the

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medical profession by society and by the professionals themselves. These are demands on doctors' conscience and commitment in the context of balancing individual interests with objectively existing social conditions and requirements. The second is associated with the rules and criteria that should be observed for the best possible service to the patient, including good choice of adequate and tolerable medical means and approaches.

Controversial positions are strongly pronounced regarding the second level in reproductive medicine. Some of the demands made on medical doctors are diametrically opposed to each other. The demand for termination of an undesired, perhaps carefree pregnancy (without previous contraceptive attempt) is contradicted by calls for expensive, invasive sterility therapy such as in vitro fertilization (IVF). The request by the woman concerned for destruction of a clinically intact embryo (prior to the twelfth week of pregnancy) is contradicted by enormous efforts undertaken to save even a deformed fetus that is borne as a planned child. A severely malformed fetus may be destroyed even beyond the 24th week of pregnancy, whereas everything possible may be done for the survival of a newborn with the same or even worse malformations.

All problems of human reproduction are located between two poles, the desire to have children and the desire not to have children. Medical doctors and nurses frequently find themselves confronted with problems of value orientation and may also be faced with the disapprobation of society when they have to take action. Very great efforts are made, on the one hand, to induce pregnancy, while on the other, the demand is often honored simply to disrupt otherwise intact development. Another problem may result from social disorder caused by the malformation of a fetus which potentially impedes the expected social quality of life of parents and child. In the face of these types of problems, the following three responsibilities should be primarily assigned to reproductive medicine: (1) remedial action on biologically and psycho-socially determined reproductive disorders; (2) assurance of good health and quality of life by adequate diagnosis and counselling prior to and during pregnancy, including possible termination of pregnancy or prenatal therapy; and (3) control of biologically intact reproduction by contraception and, if advisable, termination of pregnancy on the pregnant woman's socially substantiated request.
It is part of human freedom and of the deliberate building of social life to have important common standards of general validity along with their corresponding values, codes, and norms. These function in the various spheres of life despite their contradictions and sometimes conflicting aspirations and requirements. However, when the twin goals of reproductive medicine are carried to their full extent in the ethical debate on life saving, it is obvious that they are diametrically opposed. Each side argues for their criteria to be applied across the board to all human life. On the one side, the ban on homicide, valid for the human individual as a subject of law, is applied to all prenatal life (Stoll, 1982). On the other, reference to permissibility of destruction of prenatal life might imply a right to euthanasia in cases of advanced senility and severe diseases (Fletcher, 1975).

The practical upshot of persistence in such extremes is often the rejection of the nuanced differentiation necessary for adequate social standards. The background of this persistence may be formed by a dogmatic-religious position; but it quite frequently emerges from a philosophico-theoretical helplessness in handling normative limitations and the boundary area of existing norms, which is, to be sure, a philosophically intricate subject. Another extreme, the situation-ethical negation of standards, has been occurring with increasing frequency recently and at least deserves mention.

When it comes to international discussion, particular attention should be given to the interrelations between ethical positions, on the one hand, and the diversity of social conditions, legal arrangements, and cultural traditions, on the other. There are certain notions on issues of reproductive medicine which we reject for ethical reasons. One of them is a fairly cautious orientation which has been formulated by Stoll (1982): "We ought to be fully aware, also in family planning, that the birth of a healthy child is a gift of heaven rather than a command game". The opposite attitude is characterized by a deficit in moral scruples and is oriented to technical feasibility, such as commercial surrogate motherhood. It has been formulated as follows: "What is the point of taking offence with the hiring of a person in need of cash for surrogate parent services? Why should this be indecent, as compared to employing a miner for underground work or a mason for the completion of a high-rise structure? Poor people and women may be employed for high-risk jobs, provided that they are clearly
briefed of the risks beforehand and that precautions are taken to avoid accidents" (Engelhardt, 1988).

The debate on these different ethical positions and our assessment of them cannot be made by criteria of general validity in a vacuum, but only as determined by reference to national values, cultural tradition, and objective conditions. In the sphere of ethics decisions cannot be made simply by objective criteria of right and wrong. Rather, there must be negotiable yardsticks and rules, defined with due consideration of social reality and social interests and on the basis of value orientations and ideals which have grown in the process of history.

COMMENTS ON STANDARDS OF MEDICAL LIFE-SAVING DUTY IN THE GDR

It is a matter of principle that any kind of legally permitted termination of pregnancy is associated with a differentiation between absolute and relative protection of human life, regardless of whether the intervention is based on timing or on a stringently limited medical indication (Koerner, 1984; Henning, 1984). Under GDR law, the medical life-saving duty is subdivided into four different phases of life, which are defined also by the ethical positions predominant in this society:

1. Homocide is absolutely impermissible, and the life-saving duty applies without any restriction up to the ultimate limits of medical life-saving capacity for all individuals from birth and throughout life. Therapeutic action up to those ultimate limits is increasingly characterized by a weighing of risks and burdens against the chances for a restoration of health and preservation of life. Hence, aspects relating to quality of life and to the patient's own decision-making are necessarily assuming growing importance in medical decision-making.

2. The same principles of saving lives and prohibiting homocides basically apply to the neonatal period. Yet, in the boundary case of severe damage there is room for medical discretion. Resuscitation and other extraordinary therapeutic measures should be renounced in cases in which maximum viability of a newborn is clearly limited, because of severe damage, to a few weeks or months, or in which, for the same reasons, a development of conscious human life and active involvement in society cannot be expected (Grauel et al., 1981).
3. Medical life-saving duties with regard to all prenatal life are characteristically subordinated to the responsibility for preserving the life of the pregnant woman and her adequate health and social interests. Should a high-risk situation endanger the lives of both mother and child in the process of labor, the life of the mother has to be saved as the first priority, even at the expense of the child’s life. During pregnancy, the woman is free to decide on medical abortion, following medical advice or consent by an interdisciplinary commission, on account of fetal malformation or risk to her own health.

4. Prior to the twelfth week of pregnancy, the woman concerned is legally entitled to take absolutely independent decisions on prenatal life, including premature termination of pregnancy. This would then be performed by a physician in a hospital (GDR Gazette, 1972). Medical advice is compulsory even under these conditions, but only as an accompanying measure. It is, nevertheless, intended to help explore possible ways and means by which to preserve the embryonic life envisaged for destruction by the pregnant woman.

THE JUNCTURE FROM WHICH TO PROTECT HUMAN LIFE

Whenever it comes to decision making on prenatal life and abortion or remedial action on fertility disorders, the assumption must be made that individual human life is extremely valuable, and deserves protection from the moment of conception and in all phases. The question “When does human life begin?” is often, and wrongly, thought to be simply a quest for a biotically demarcated point in the course of an individual’s development. There can be no doubt that the development of the human organism and the individual actually begins with the fusion of oocyte and spermatocyte. Rather, the question should be about the point at which and the mechanism through which social dignity, value, and relevance ought to be attributed to a developing organism, since human nature is defined as such in virtue of the attribution of social or philosophical importance to the developing organism.

For two millenia of European history the definitions of personhood and a human being have hinged on a certain fixed point, with examples ranging from the child aged two to three years, to the zygote. In current discussion, zygotism, nidation, the end of postembryony, and the onset of neuronal brain stem activity or
completion of organ formation have each been defined as points at which personal human development begins, and thus as initial thresholds for compulsory protection (with separate explanations being offered for each of these points). This is a biologistic approach in which the social level is ignored, even though it is essential to the human nature.

The nature and value of prenatal human life are in any case issues of culturally and socially determined interpretation, and the point chosen is of a fairly random character. Therefore, in materialistic philosophy we are not trying to construe an abstract principle of being as a defined biotic phase, as if it were given by nature and begun at that particular juncture by nature or as a divine gift. The human individual emerges and grows in a unity of biotic, psychic, and social determinants and manifestations of life. That unity does not originate from one single point in ontogenesis. To us, the beginning of the human being, with its intrinsic social value and dignity, can be defined, but not in a way which fixes its beginning at one stationary biotic point in prenatal development. That beginning is strongly influenced and determined by the act of social acceptance, reflected in the wishes and expectations of parents and society. (Such a nature-determining act can be implied in the act of procreation proper).

Human life is highly valuable and ought to be protected at all stages of ontogenesis. Consequently, every pregnancy and every embryo is a treasure that calls for protection and shelter by society. In a society orientated to humanist values and to providing more freedom and development for all its members, legal coercion would be absolutely inappropriate against women with undesired pregnancies. In these cases protection of prenatal life can be accomplished only in relative terms, subject to the given conditions of socio-economic existence, the established way of life, and the individual values which all influence, but are in turn influenced by, the woman's free decision. It is a challenge to society to develop living conditions, values and behaviors which discourage the termination of pregnancy.

Translated by W. Ghantus, Berlin, GDR.
REFERENCES


