

## NOTE

### DEFINITIVE PELVIC SURGERY: A MORAL EVALUATION

The "definitive" concept of female pelvic surgery has provoked no little discussion among members of the medical profession and likewise raises some interesting questions for the theologian.

The need for a decision regarding what has been called "definitive pelvic surgery" arises when, due to some pathology of the uterus on the one hand or the ovaries on the other, it has become necessary to do a hysterectomy (removal of the uterus) or an oöphorectomy (removal of the ovaries). Since the removal of either of these entities necessarily destroys the generative function, some surgeons are reluctant, in some circumstances, to leave the remaining afore-mentioned tissues intact. They would sometimes prefer to remove the remaining ovaries or the remaining uterus, since they are a source of future possible complications, even though at present they are still unaffected by any pathology.

There are two questions which may arise in the moral evaluation of these procedures. The first question, less significant yet somehow persistent, regards the excision of nonpathological organs in general; the second question, more pertinent and somewhat more complicated, regards the excision of these particular organs under these particular circumstances.

First, with regard to the removal of nonpathological tissue, there was a fairly widespread opinion in the past (based perhaps on a misinterpretation of St. Thomas' treatment of mutilation<sup>1</sup>) which demanded that an organ be diseased before its removal was justified. This is incorrect. It is a distinction not even mentioned by many of the standard moral theologians, expressly denied by others,<sup>2</sup> and is clearly incompatible with the following statement of Pope Pius XII in his address to the Twenty-seventh Annual Convention of the Italian Society of Urologists:

The decisive point here is not that the organ that is removed or rendered functionless is itself diseased, but that its preservation or its function entails either directly or indirectly a serious threat to the whole body. It is quite possible that by its normal functioning a healthy organ may exercise an influence of such a nature on a diseased organ as to aggravate the disease and its consequences throughout the whole body. It can also happen that the removal of a healthy organ and the suppression of its normal functioning will remove from a disease, cancer for example, its field of growth, or, in any case, essentially change the

<sup>1</sup> Cf. *Sum. theol.* 2-2, q. 65, a. 1.

<sup>2</sup> Cf. Augustine Lehmkühl, S.J., *Theologia moralis* 1 (19th ed.; 1902) no. 57.

conditions of its existence. If there is no other means at our disposal, surgical intervention on the healthy organ is permitted in both cases.<sup>3</sup>

Secondly, granting that the question of whether or not the organs destined for elective surgery are diseased is not necessarily the deciding factor in the moral aspects of their ablation, the theologian may still retain some doubts about these two particular elective surgical procedures. Even though the fact that the remaining organs are not diseased does not necessarily preclude their removal, neither does it justify such elective surgery. The presence of any normal tissue in the human system is not without some significance nor is its removal achieved without some additional trauma and risk. Hence, a proportionate justification for such surgery is to be demonstrated rather than presumed.

#### ELECTIVE HYSTERECTOMY

Medical opinion will differ regarding the advantages of elective hysterectomy following oöphorectomy, depending upon the details of the individual case as well as the considered opinion of the individual gynecologist. From a moral viewpoint it is important to note that the elective removal of the uterus subsequent to bilateral oöphorectomy in no way affects the generative function, since this function has already been sacrificed with the removal of the ovaries. Thus purified of the generative implications which must be considered in most cases of hysterectomy and evaluated under the principle of double effect, the moral issue here becomes entirely a question of the proper application of the principle of totality. The importance of the medical indication for the hysterectomy must be evaluated in relation to the danger inherent in the procedure and the physiological and psychological significance of the sacrifice of the uterus in these circumstances.

A search of the current medical literature reveals very little comment on this aspect of gynecological surgery. This in itself, coupled with the fact that such elective hysterectomy is frequently done, is a strong indication that it is a medically acceptable and desirable procedure.

Moreover, in a discussion of distinguished panelists at a meeting of the New York Obstetrical Society (March 8, 1955), Dr. Norman Miller pointed out that it was not uncommon to find free cancer cells in the uterus in cases of ovarian cancer, and expressed his belief that hysterectomy should accompany oöphorectomy for ovarian cancer. At the same discussion Dr. Albert Aldridge advocated the same procedure when both ovaries had been removed because of even benign tumors, unless enough ovarian tissue could

<sup>3</sup> *Osservatore romano*, Oct. 10, 1953.

be left intact to maintain the childbearing function and/or menstruation.<sup>4</sup>

More recently Dr. Thaddeus Montgomery, on the occasion of his address to the Twenty-eighth Annual Meeting of the Central Association of Obstetricians and Gynecologists (October, 1960), made the following comment:

I really can't see much advantage in leaving the uterus in if the ovaries are removed. It is my feeling that if one is going to remove the ovaries one might as well remove the uterus also. The uterus does not appear to serve any purpose after removal of the ovaries, and it constitutes one of the areas in which trouble might occur in the future.<sup>5</sup>

It is true that the danger of future uterine cancer, apart from any positive indication, is neither proximate nor statistically alarming. Still, there are undesirable sequelae to the uterine atrophy which follows oöphorectomy (such as prolapse, etc.) which range from the uncomfortable to the distressing and even dangerous. Perhaps the best summation of the current medical opinion is offered by Dr. Andrew Marchetti, Chief of Obstetrics and Gynecology at the Georgetown Medical Center, when he comments: "After removal of the ovaries, the uterus is more of a liability than an asset."<sup>6</sup>

On the other hand, no one will deny that many women develop a certain psychic dependence on the uterus. They tend to identify its presence, to some extent, with their womanhood, sometimes to an exaggerated degree.

It is true that these fears are likely to be more common in cases where hysterectomy is responsible for the cessation of the childbearing function and the phenomenon of menstruation (which is not the case when a necessary oöphorectomy has already destroyed these functions), but even here many of the fears are grossly exaggerated or false. The dreaded obesity, masculinization, mental breakdown, and frigidity which supposedly are likely to follow any hysterectomy are based on the ever-present "they say" rather than on any scientific basis. Dr. Waverly Payne, in his presidential address to the South Atlantic Association of Obstetricians and Gynecologists (February 1, 1956), referred to such fears as "foolish misconceptions."<sup>7</sup> And this can be said without ignoring the real impact of the surgically induced menopause attendant upon early oöphorectomy. There seems to be no indication that concomitant elective hysterectomy changes this one way or the other.

<sup>4</sup> Cf. *American Journal of Obstetrics and Gynecology* 72 (1956) 534-43.

<sup>5</sup> *Ibid.* 81 (1961) 926-33.   <sup>6</sup> Private communication.

<sup>7</sup> *American Journal of Obstetrics and Gynecology* 72 (1956) 1166-70.

## ELECTIVE OÖPHORECTOMY

In contrast to the near unanimity of medical opinion regarding the removal of the grossly normal but now functionless uterus as an almost routine procedure after bilateral oöphorectomy, elective removal of the ovaries after a necessary hysterectomy is a more complex clinical question and admits a wider variation of medical judgment. This, of course, directly reflects the fact that the ovary is much more complex in its purpose and function than is the uterus. And although its function of ovulation is teleologically meaningless after hysterectomy, its function as an estrogen-secreting gland, varying in significance through the earlier and later decades of life, is neither destroyed by hysterectomy nor, on the other hand, totally unaffected by it. Moreover, there is less than unanimity of opinion among medical writers concerning either the significance of the waning ovarian endocrine function or the impact of hysterectomy on that function.

The question which finds the widest general agreement among the medical writers concerns elective oöphorectomy in the patient who is still some years away from her natural climacteric. There is a general reluctance to induce a surgically anticipated menopause and thus upset the natural endocrine balance (to which the ovaries so markedly contribute) much before the age of forty. But even this area has not been free from discussion. In 1960 H. K. Farrar, Jr., and R. Bryan, of the Northwestern University Medical Faculty, reviewed earlier recommendations by some that, in younger women, the left ovary be removed after hysterectomy. These recommendations had been based on statistical indication that cancer appears in the left ovary more frequently than in the right ovary. Farrar and Bryan, however, review these recommendations only to deny the validity of the data on which they are based, and conclude: "There appears to be no advantage in removal of one ovary over its opposite as a means of further decreasing the incidence of subsequent ovarian tumors."<sup>8</sup>

Another argument usually advanced in favor of elective oöphorectomy in the preclimacteric patient is an impression in some quarters that early hysterectomy tends to produce some degree of ovarian atrophy. The truth, however, or at least the clinical significance of this impression is by no means universally accepted.<sup>9</sup> Two of the most distinguished American gynecologists, Richard TeLinde and Lawrence Wharton of Johns Hopkins, recently made the following observation:

<sup>8</sup> H. K. Farrar, Jr., and R. Bryan, "Equilateral Distribution of Ovarian Tumors," *ibid.* 80 (1960) 1085-88.

<sup>9</sup> Cf. Robert G. Whitelaw, "Ovarian Activity Following Hysterectomy," *Journal of Obstetrics and Gynecology of the British Empire* 65 (1958) 917-32.

The uterus for many years, in numbers by now probably astronomical, has been removed in toto or in part. On some occasions the ovaries are also removed, at other times they are allowed to remain. One would think that by 1960 the effect of the removal of the uterus on the ovary and its function would be clear and not a subject of controversy; yet, this is not the case.<sup>10</sup>

In general, however, an inspection of the current medical literature leaves one with the impression that today it would be an unusual gynecologist who would think of removing nonpathologic ovaries of a woman much below the age of forty.

The matter becomes more complicated in the cases of patients who are approaching the climacteric or are already well within the period of waning ovarian function. In these circumstances many surgeons are likely to advocate the prophylactic removal of the remaining ovaries (with the possibility of controlling any ensuing estrogen-deficiency symptoms with synthetic hormones), in order to reduce the possibility of future pelvic complications and particularly to remove the site of possible future ovarian cancer.

Variations of medical opinion in this regard are due, of course, to the simple fact that the full story of estrogens is not yet fully known. New facts and sound assumptions are still coming piecemeal from the experimental laboratories and from clinical practice.

Generically, estrogen is a hormone, but the word itself is used to denote a number of compounds whose biologic activity is similar. While the most evident effect of these estrogenic substances is the modification and strengthening of the estrus (mating urge), it is clearly evident that a proper estrogen balance has far-reaching effects on the general well-being of the female. The little girl rides into womanhood on a gentle tide of estrogen, and many of the plaguing symptoms of the "change of life," as well as certain aspects of the subsequent female aging process, are attributed to the ebbing of estrogen secretion.

The two principal natural sources of estrogen in the nonpregnant female are the ovaries and the adrenal glands. The human system does, however, produce estrogen by metabolic conversion of other hormones to some degree, and likewise receives certain estrogenic substances in the ordinary diet. It is generally conceded, however, that the ovaries and the adrenals are the two most important sources of estrogen, and there is a constantly growing weight of authoritative evidence in favor of the opinion that although the cyclic secretion by the ovaries ceases at the menopause, significant secretion of estrogen by the postmenopausal ovary continues for some years, and pos-

<sup>10</sup> Richard W. TeLinde and Lawrence R. Wharton, "Ovarian Function Following Pelvic Operation," *American Journal of Obstetrics and Gynecology* 80 (1960) 844-62.

sibly for some decades. The current medical literature reflects a constantly increasing apprehension on the part of distinguished specialists that coronary heart disease, arteriosclerosis (degeneration of arterial connective tissue), osteoporosis (abnormal porousness of bone), and possibly other diseases occurring in middle-aged women may be related to too many ovaries being removed too soon.<sup>11</sup> Note the following quotation from Clyde Randall, who has done outstanding work on this question:

The advisability of conserving the ovary might be considered for some time to come. Before we advise women to have their ovaries removed, remember that only two generations ago no one knew that the ovary produced estrogens. Who can at this time say that women do not need ovaries, for they now seem to be destined to live at least a quarter of a century of life after the menopause. At least, in our experience, surgical castration results in demonstrable changes evidencing a deficiency of estrogenic effect in 40% of women within five years and in over 50% of women after ten years. It seems likely, therefore, that oophorectomy—when performed routinely whenever hysterectomy is indicated—could be contributing to the discomforts, disabilities, and eventual death of more women than now seem destined to develop malignancy of the ovary.<sup>12</sup>

#### MORAL CONSIDERATIONS

The moral considerations which arise from these clinical facts, assumptions, and impressions present problems whose answers must be found by interpreting the medical data of each individual case in the light of the principle of totality.

The physician's own professional orientation will alert him to seek the course of action which seems to contribute most to the over-all long-range greater good of his patient. The danger, present in some other cases of gynecological surgery, of so misconstruing the moral and ontological significance of the generative function itself as to essentially subordinate it to the patient's individual good, is not present here. The supposition here is that the generative function has already been sacrificed, indirectly, in the extirpation of some dangerously pathological tissue.

First, regarding elective hysterectomy in connection with necessary oophorectomy (bilateral), there would seem to be no moral objection to this

<sup>11</sup> Cf. G. C. Griffith, "Oophorectomy and Cardiovascular Tissues," *Obstetrics and Gynecology* 7 (1956) 479; Clyde L. Randall, "Conservation of the Ovary," *Illinois Medical Journal* 115 (1959) 187-91; Roger W. Robinson, Norio Higano, and William D. Cohen, "Increased Incidence of Coronary Heart Disease in Women Castrated Prior to the Menopause," *American Medical Association Archives of Internal Medicine* 104 (1959) 908-13.

<sup>12</sup> Clyde L. Randall, *art. cit.*

procedure if the physician should desire to do it—with, of course, the consent of his patient.

To identify a clear-cut defense of this procedure in the standard and traditional moral treatises is somewhat difficult, simply because this type of surgery was uncommon until relatively recent times. If the older authors' treatment of mutilation does not seem to cover some of the modern problems (as Gerald Kelly, S.J., judged in 1954<sup>13</sup>), it is only because these authors were concerned with the most common surgico-moral problems of their own and the immediately preceding times. Their primary concern with "direct" and "indirect" mutilation arose from the sterilization problem, and this indeed is still the pivotal distinction in the context of this increasingly common problem. But, aside from this, the only direct mutilation they seriously concerned themselves with in the medico-moral field was major surgical invasion to save life. Other minor modifications of the body, such as ear lobe piercing and even blood transfusion, were not, for the most part, looked upon as real mutilations.

The moral evaluation of some modern surgical procedures has, however, tended to give a new emphasis to the concept of "direct mutilation" under the principle of totality, with more explicit delineation of the proportionality involved in it. What was more often left implicit in the older authors is stated explicitly, for example, by Gerald Kelly:

Since mutilations vary in degree, the reasons justifying them must also vary. The cure of a slight danger may justify a slight mutilation, whereas the removal of an important part or the suppression of an important function requires a very serious reason.<sup>14</sup>

It is this type of extrapolation which covers such procedures as the removal of a healthy appendix incidental to other abdominal surgery<sup>15</sup> as well as hysterectomy in the present concept of definitive pelvic surgery. These two prophylactic measures have, incidentally, been recognized as related from a moral viewpoint<sup>16</sup> and also from a medical viewpoint.<sup>17</sup>

In each of these cases (incidental appendectomy and hysterectomy in definitive pelvic surgery) the abdomen is already open for other reasons, the

<sup>13</sup> Cf. Gerald Kelly, S.J., "The Morality of Mutilation: Towards a Revision of the Treatise," *THEOLOGICAL STUDIES* 17 (1956) 322-44.

<sup>14</sup> Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis, 1948) p. 36.

<sup>15</sup> Cf. Thomas J. O'Donnell, S.J., *Morals in Medicine* (2nd ed.; Westminster, Md., 1959) pp. 85-86.

<sup>16</sup> Cf. Kelly, *loc cit.*

<sup>17</sup> Cf. Clyde L. Randall, "Advantages and Risks of Preserving the Ovary," *Virginia Medical Monthly* 87 (1960) 366-71.

additional risk is minimal, there is no suppression of any known function, and the tissue in question is looked upon as a potential source of future danger which would require the further risks involved in possible serious pathology, general anesthesia, and future surgery. Other things being equal, there may arise the medical judgment that such tissue is now more of a liability than an asset and that the prudent provision for the future well-being of the patient dictates its removal. Such considerations would seem to dissipate any apparent moral difficulties in the matter.

Elective oöphorectomy following hysterectomy, on the other hand, presents quite a different problem. As previously pointed out, the full story of the postmenopausal ovarian function has not yet emerged, but the evidence for significant, if not cyclical, estrogen secretion for many years after the climacteric is too strong to be ignored. It is true that sometimes there might be positive reason to fear future ovarian carcinoma, and in such cases the physician must weigh the evidence and decide whether the ovaries should be removed or not, and here the theologian can reasonably accept the physician's judgment. But in the absence of positive indications, the mere statistical probability of future ovarian cancer could not justify the routine removal of ovaries simply because their generative role has been evacuated.

The death rate for cancer of the ovary, according to the 1956 reports of the Metropolitan Life Insurance Company, is 16 to 25 per 100,000 women between the ages of 45 and 64. Other studies indicate that about 3 per cent of these women would have had hysterectomies.<sup>18</sup> But, quite obviously, that does not mean that 3 per cent of hysterectomized women will develop ovarian cancer unless the ovaries are removed. There are too many unknown factors to judge that even a menopausal patient who is having a hysterectomy will be better off without her ovaries. The great weight of evidence is in the opposite direction.

Moreover, regarding the present possibility of supplying for the estrogen deficiency in the oöphorectomized female by means of hormone therapy, Culner has aptly pointed out:

As a point in favor of removing ovaries it is generally noted by proponents that menopausal symptoms which may ensue can be adequately controlled with preparations now available. The ability to control symptoms, however, is a far cry from being able to restore a distorted endocrine balance and few physicians, I am sure, would claim any great proficiency in this regard.<sup>19</sup>

Two conclusions, therefore, arise from this juxtaposition of current

<sup>18</sup> Cf. Alex Culner, "The Controversial Ovary," *California Medicine* 89 (1958) 30-32.

<sup>19</sup> *Ibid.*



medical impressions and moral principles. First, in the present concept of definitive pelvic surgery, the elective removal of the nonpathological uterus following oöphorectomy presents no moral difficulty; secondly, elective removal of the healthy ovaries after hysterectomy, even in the menopausal patient, is morally contraindicated except in those cases where sound clinical judgment recognizes a positive indication of future serious complications.

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