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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Conscientious commitment to women's health

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ABSTRACT

Conscientious commitment, the reverse of conscientious objection, inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health. History shows social reformers experiencing religious condemnation and imprisonment for promoting means of birth control, until access became popularly accepted. Voluntary sterilization generally followed this pattern to acceptance, but overcoming resistance to voluntary abortion calls for courage and remains challenging. The challenge is aggravated by religious doctrines that view treatment of ectopic pregnancy, spontaneous abortion, and emergency contraception not by reference to women's healthcare needs, but through the lens of abortion. However, modern legal systems increasingly reject this myopic approach. Providers' conscientious commitment is to deliver treatments directed to women's healthcare needs, giving priority to patient care over adherence to conservative religious doctrines or religious self-interest. The development of in vitro fertilization to address childlessness further illustrates the inspiration of conscientious commitment over conservative objections.

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1. Introduction

The right to live according to one's conscience is a key human right. The United Nations (UN) International Covenant on Civil and Political Rights, giving legal effect to the UN's 1948 Universal Declaration of Human Rights, provides in Article 18(1) that "[e]veryone shall have the right to freedom of thought, conscience and religion. This right shall include [an individual's] freedom...in public or private, to manifest his religion or belief in worship, observance, practice and teaching." To preserve everyone's freedom of conscience against religious or other oppression, Article 18(3) provides that "[f]reedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others."

Recognition that the law may limit manifestations of conscience when "necessary to protect public...morals" was the basis on which laws in many countries historically prohibited many practices seen today as contributing to reproductive health, which includes the health of women liable to suffer unwanted burdens of repeated pregnancy and childbearing. Healthcare practitioners once almost uniformly faced legal constraints and punishments, instituted or supported by religious authorities, for advising and providing contraception, contraceptive sterilization, and abortion [1]. In the course of the twentieth century, these laws were challenged and eventually considerably liberalized,

particularly in westernized, democratic countries. However, some laws, particularly regarding abortion, are retained by independent countries in which they were introduced under European colonization, such as in Sub-Saharan Africa and Latin America.

The progressive relaxation of restrictive laws affecting women's reproductive health has generated a reaction, particularly among healthcare practitioners who hold conservative religious beliefs, of invoking rights of conscience to object to participation in such practices as prescribing or dispensing contraceptive products and undertaking contraceptive sterilization procedures and elective abortions. Their modern claims to conscientious objection, which may be required and/or channeled by religious institutions, reflect an earlier history of conscientious commitment to challenge the restrictive laws in regard to these practices and procedures that previously prevailed.

2. Historical conscientious commitment

Conscientious commitment to advocacy for means of birth control has a distinguished history [2]. The English philosopher and social reformer Jeremy Bentham advocated means of birth control as long ago as 1797, and in 1824 his follower and colleague the philosopher John Stuart Mill was arrested and briefly imprisoned for distributing birth control literature to the poor in London. Similarly, in 1886, the English secular politician Charles Bradlaugh was prosecuted, with the socialist activist Annie Besant, for republishing a pamphlet advocating birth control—the conviction subsequently being annulled on appeal.

Religious and conservative opposition to the promotion of birth control fuelled the prosecution of proponents of family planning well into the twentieth century. In 1914, Margaret Sanger, an American nurse

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working in the impoverished and overcrowded ghettos of New York, published a magazine that provided advice on contraception, and in 1916 founded the first American birth-control clinic in Brooklyn, New York City, for which she was prosecuted and imprisoned. The previous year, to forestall prosecution, she had travelled to England, where she met and motivated the botanist Marie Stopes. Appalled at the marital unhappiness caused by ignorance about sex and contraception, Marie Stopes began to disseminate information about these subjects. In 1918, she published her book *Married Love*, which caused great controversy and was banned in the USA.

The momentum toward public and political acceptance of family planning generated by these courageous pioneers, who defied the authority of organized religion, conservative convention, and at first the medical establishment, rewarded their conscientious commitment to serve women's health and reproductive self-determination. Nevertheless, until 1969, the Canadian Criminal Code reflected the history of earlier times in penalizing the spread of knowledge of contraceptive means as a "crime against morality." The courts had previously approved so many exceptions that the prohibition was effectively nullified, but family-planning initiatives remain under attack wherever they are proposed, particularly from the Roman Catholic Church hierarchy.

Voluntary sterilization was historically similarly contentious, although opposition declined with acceptance of contraceptive means. Involuntary, punitive sterilization, by castration of vanquished foes and later of sexual offenders, has a long history [3], and non-consensual eugenic sterilization has been approved by legislatures and courts since the 1920s, with continuing effect. The leading US Supreme Court decision of 1927 in *Buck v. Bell* [4], approving sterilization without her consent of an 18-year-old woman—the daughter of a mentally impaired mother and herself the mother of an allegedly impaired child—has never been reversed. However, the case remains highly controversial and it is commonly believed that it would not now be followed. In modern times, the legality of voluntary sterilization of mentally competent adult individuals is not generally doubted. An echo of earlier conservatism was heard in England in 1954, however, when a judge in a divorce case considering matrimonial cruelty described voluntary male sterilization as "degrading to the man himself and injurious to his wife and any woman whom he may marry" [5]. The other 2 judges in the case rejected this view, which was widely regarded as anachronistic at the time it was expressed.

Considerably greater conscientious commitment was required to liberalize restrictive abortion laws than to undertake voluntary sterilization. The incidence of deaths and injuries due to unskilled abortion among English families caused great concern in the mid-1930s, perhaps associated with economic depression and child-rearing costs. In 1938, the Ministry of Health and the Home Office, responsible for criminal law and its enforcement, set up the Interdepartmental (Birkett) Committee on Abortion to plan "the reduction of maternal mortality and morbidity arising from this cause."

A consultant obstetrician at a London hospital, Aleck Bourne, had terminated the early pregnancy of a 14-year-old gang-rape victim, to save her from becoming "a mental wreck," and informed the Birkett Committee of the realities of therapeutic abortion. For admitting to deliberately terminating a pregnancy, he was prosecuted for the crime of criminal abortion. The judge instructed the jury on the legal difference between the secretive actions of an unqualified person and a physician acting in a public hospital in good faith to preserve a patient's physical and/or mental health. This statement of the law in the Bourne case [6], distinguishing between criminal and lawful abortion, resulted in acquittal and remains an influential landmark in the laws of many countries inheriting English criminal law, establishing the legality of therapeutic abortion to preserve women's physical or mental health.

Conscientious commitment to the health of pregnant women is illustrated in the largely parallel careers of 2 physicians: the American William Harrison in Arkansas; and the Canadian Henry Morgentaler in

Quebec and later Ontario. Both were motivated by the plight of usually poor, vulnerable women who sought their help in the late 1960s. Dr. Harrison explained that he was affected by seeing in his hospital emergency room "girls and women with raging fevers, extraordinary uterine and pelvic infections, enormous blood loss and a multitude of serious injuries of the pelvic and intra-abdominal organs as a result of illegal and self-induced abortions" [7]. He set up the Fayetteville Women's Clinic in Arkansas in 1972, a year before the US Supreme Court recognized abortion as a constitutional right. Nevertheless, for many years, he faced fury, fire-bombing, and death threats from anti-abortion activists for providing safe, legal abortion care.

Henry Morgentaler, whose abortion clinic in Toronto was picketed and also fire-bombed, began his abortion practice in Montreal when, after speaking out against Canada's restrictive criminal abortion law, he felt conscientiously bound to assist the often desperate, disadvantaged women who then flocked to him for treatment. He opened his abortion clinic in 1969 but acted outside the restrictively demanding requirements for lawful performance of abortion. He was prosecuted in 1973 but his acquittal by jury was exceptionally reversed by the Quebec Court of Appeal, and in 1975 he was imprisoned for 10 months of an 18-month sentence. On relocating his clinic to Toronto, he was further prosecuted in 1984. When his case was decided by the Supreme Court of Canada in 1988, the Court accepted his argument that the criminal abortion law was unconstitutional. The Chief Justice of Canada condemned the provisions that made lawful abortion often inaccessible and observed that "[f]orcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person," which failed to conform to principles of fundamental justice [8]. Modern governments in Canada express no interest in recriminalizing abortion. In 2008, Dr Morgentaler was awarded the Order of Canada, the country's highest honor.

3. Modern conscientious commitment

The call for healthcare practitioners' conscientious commitment to undertake procedures to protect women's health often arises in response to other practitioners' failures or refusals to provide care. Refusals of care may be based on explicit claims of conscientious objection or on reasoning that affords priority to the perceived interests of embryos and/or fetuses over the rights and interests of the pregnant women who bear them. For instance, early in 2010, the Inter-American Commission on Human Rights required Nicaragua to act on a complaint arising from denial of indicated care to a 27-year-old, 10-week-pregnant woman, given the disguised name of Amelia. She suffered from life-endangering cancer, but physicians and the state-run hospital denied indicated cancer treatment such as chemotherapy and radiotherapy, for fear of causing spontaneous abortion and being accused of violating Nicaragua's extremely repressive abortion law [9]. Practitioners conscientiously committed to promoting the health of pregnant women would recognize that the women, rather than the fetuses, are their patients [10]. Accordingly, as patients, the women rather than their caregivers determine whether or not they receive available treatment indicated for their care, unrelated to pregnancy itself, that may affect the fetuses they bear or may bear in the future.

A similar concern has been observed regarding the treatment of women who experience spontaneous abortion. In hospitals owned or operated by Roman Catholic authorities, religious doctrines may be applied to prevent uterine evacuation in the event of threatened spontaneous abortion while a fetal heartbeat is detected. In a 2008 review of practice in the USA, cases were observed in which:

Catholic-owned hospital ethics committees denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients to non-

Catholic-owned facilities. Some physicians intentionally violated protocol because they felt patient safety was compromised. [11]

Protocols, ethics committee decisions on clinical cases, and rulings in such cases by religious office-holders that deny patients the available care their physicians consider to be in their best interests or that result in injury by delay of care or because of transportation of patients to other facilities raise serious concerns in law and in healthcare providers' professional ethics. Treating threatened spontaneous abortion via uterine evacuation is legally distinguishable from deliberately inducing abortion. Legal concerns about denying or delaying treatment involve liability for negligence, particularly due to failure to satisfy professional standards of timely care, possibly for breach of physician–patient contracts and breach of physicians' fiduciary duties to their patients, and criminal liability for negligence, reaching even as far as manslaughter. Liability, including criminal liability, may attach not only to individual physicians but also to third parties who intervene to obstruct indicated care, in addition to hospital institutions. Concerns in professional ethics include whether conscientious physicians can allow compromise of their judgment, and of their provision of best care to their patients, by third-party doctrinal intervention. Conscientious commitment to patients' safest care and healthcare providers' own safety from legal liability and professional censure may coincide.

Comparable concerns arise in the treatment of ectopic or “tubal” pregnancy. This is the leading cause of pregnancy-related death during the first trimester in the USA, and accounts for an estimated 9% of all pregnancy-related deaths. It also accounts for considerable morbidity in survivors, whose future ability to have children may be lost or severely compromised [12]. Treatment of this condition in the USA is aided by advances in anesthesia, antibiotics, and blood transfusion. In countries and regions where these means are not easily accessible or of a high standard, surgical interventions may be unavailable or unsuccessful. Fetal survival occurs rarely, if ever, and gestation to the point of rupture of the fallopian tube is hazardous to women's survival and to survivors' future health. After 1 ectopic pregnancy, evidence shows that a woman has a 7- to 13-fold increase in the likelihood of having another ectopic pregnancy [12].

Care guidelines for women with ectopic pregnancies are established by several specialist medical associations such as the American College (or Congress) of Obstetricians and Gynecologists [13] and the UK Royal College of Obstetricians and Gynaecologists [14]. In addition, the Cochrane Collaboration's review of evidence provides a synopsis of randomized controlled trials of treatment for tubal pregnancy and assessments of short-term and long-term outcome measures [15]. The range of treatment and management options for non-ruptured ectopic pregnancy includes salpingectomy, salpingostomy, medical treatment, and expectant management. Selection is based on the patient's clinical circumstances and future fertility intentions [16] (pp. 56–7).

Surgical and non-surgical management options are determined as a medical matter, directed to the woman's condition and taking account of her informed choice. By contrast, religious hierarchies, particularly those not including and explicitly excluding women, may direct their attention to the embryo or fetus, and whether its removal constitutes abortion. The Ethical and Religious Directives for Catholic Health Care Services, issued by the US Conference of Catholic Bishops, are ambivalent. Directive 48 provides that:

In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion. [16] (p. 58)

This is consistent with long-standing Catholic teaching but it follows a directive that appears more accommodating of physicians' conscientious commitment to women's health. Directive 47 provides that:

Operations, treatment, and medications that have as their direct purpose the cure of a proportionately serious pathological condition

of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child. [16] (p. 58)

From a medical perspective, the ectopic embryo or fetus may never be considered viable, but much turns on how the purpose of a treatment is characterized (e.g. whether by an attending physician, a hospital committee or chaplain, or a more senior church official such as a bishop) and by whom decision makers are influenced.

For instance, a leading Catholic healthcare theologian, Thomas O'Donnell, claims that no intervention is permissible unless, or until, the fallopian tube is so pathologically affected that ending the tubal pregnancy is justified. Further, he finds that removal of a non-viable fetus from the fallopian tube is not theologically different from its removal from the uterus, which is condemned as abortion [17]. However, the Catholic bioethicist Kevin O'Rourke claims that all treatment options are permissible. Removing the affected fallopian tube (salpingectomy) is justified because the direct intention is to save the mother's life—the fetal death being an unintended but unpreventable effect. Salpingostomy, in which the tube is not removed, is similarly defensible because the intention is to remove the woman's damaged tubal tissue and the damaging trophoblastic tissue (e.g. by use of methotrexate), not to kill or destroy the embryo [18].

Theologic analysis and debate are governed by their own principles, but what constitutes abortion is also a matter of law. This is shown in the context of emergency contraception [19], which allows conscientiously committed physicians scope to enjoy legal protection when they provide care (e.g. to women who have been raped) contrary to religious directives [20]. A judgment of the California Court of Appeal concerned a rape victim treated at a Catholic hospital, where she was not informed about emergency contraception. She sued, not for compensation, but for 2 judicial declarations. The first was that the hospital's failure “to provide information about and access to estrogen pregnancy prophylaxis to rape victims...constitutes a failure to provide optimal emergency treatment of rape victims in accordance with the [local] standard of good medical practice.” The second was that the hospital must “provide rape victims with information and access to estrogen pregnancy prophylaxis, including the morning-after pill,” or discontinue treatment and transport patients to the nearest facility that, within 72 hours of the sexual assault, would provide complete emergency medical treatment, including emergency contraception [21].

The hospital's defense was that these forms of emergency treatment would constitute abortion had fertilization occurred and that, as a non-profit religious institution, the hospital had legal protection against having to undertake such a procedure. However, the Court found that, as a matter of law, emergency contraception as described in the requested declarations does not constitute abortion because its purpose and effect are not to terminate but rather to avoid pregnancy by preventing fertilization or implantation. The Court followed earlier judgments that abortion, as it is commonly and legally understood, does not include intrauterine devices, the morning-after pill, or birth-control pills. The Court agreed with the contention that the rape victim's right to control her treatment must prevail over the moral and religious convictions under which a hospital is conducted and that, whether or not the hospital would transfer her care to another facility, failure to provide her with information of the emergency contraception option constitutes medical malpractice. Accordingly, even in a religiously run hospital, a conscientious physician is entitled, and perhaps obliged, to inform the patient about emergency contraception and, at her request, to administer such treatment if it is not feasible to transfer the patient to another facility in time for the treatment to be effective.

In view of the assertiveness of Roman Catholic leaders that treatments the law does not consider to be abortion remain condemned as such in their teachings, it is perhaps not surprising that they react strongly regarding treatments that laws clearly do characterize as

abortion. This creates the danger, however, of reacting too aggressively, even in ways that senior church officials themselves find excessive. This occurred in Recife, Brazil, in early 2009, when physicians conscientiously terminated the life-endangering twin pregnancy of a 9-year-old rape victim. The young girl's stepfather reportedly admitted sexually abusing her repeatedly since she was 6 years old, and was taken into police custody. The police had no interest in the abortion because this is lawful in Brazil when rape is proven [22].

However, Archbishop Sobrinho of Recife made public pronouncement of the resultant excommunication of the doctors involved in procuring the abortion and of the girl's mother, who requested it. The girl herself, being a minor, was not liable to excommunication and the church announced no ecclesiastic penalty regarding the stepfather. The Archbishop's requirement that this 9-year-old girl, whose pelvis was too small to accommodate even a single fetus, should continue a pregnancy imposed by rape and risk her life to become the mother of twins sadly reflects the insensitivity to the needs and feelings of children shown more widely in the inadequate, self-protective initial response of the church leadership to sexual depredations against children committed by their own priests.

Support for the physicians who were conscientiously committed to the young girl's survival, health, and wellbeing came from a bioethicist within the Vatican, Archbishop Fisichella, who was subsequently removed from his position as President of the Pontifical Academy for Life. Writing in the Vatican's newspaper *L'Osservatore Romano* on March 15, 2009, to express his dismay at the reaction of the Archbishop of Recife, he stressed that abortion is always bad but that the local prelate's apparent lack of compassion for the young girl's plight "hurts the credibility of our teaching, which appears in the eyes of many as insensitive, incomprehensible and lacking mercy" [22]. This marks the contrast with the compassion, sensitivity, and care shown by the physicians who lawfully terminated the pregnancy. Archbishop Fisichella's view proved controversial within the church, but political and popular sentiment in Brazil was that the physicians had acted conscientiously and humanely.

Conscientious commitment to assist infertile patients has been internationally acclaimed via the award of the 2010 Nobel Prize in Physiology or Medicine to Robert Edwards. His pioneering work with the late Patrick Steptoe resulted, in 1978, in the birth of the world's first infant from in vitro fertilization (IVF). He persevered to surmount the disappointments of denial of UK governmental research-funding support and of the lack of enthusiasm of peers in his commitment to overcome the childlessness of infertile patients. He also faced condemnation on some ethical and religious doctrinal grounds that continues to this day. Edwards himself was deeply involved in advancing the ethical analysis of IVF research and practice, however, and—as long ago as 1971—co-authored an important paper that initiated debate on many of the complex ethics and legal concerns to which IVF has given rise [23]. He proposed strict ethical guidelines for embryo research, acted with keen regard for the ethical propriety of IVF research and clinical practice, and ensured that an ethics committee for IVF was established at the clinic he founded with Steptoe at Bourne Hall, Cambridge, UK, which was the world's first IVF clinic [24].

4. Conclusion

The need has grown for physicians' and other healthcare providers' conscientious commitment to delivery of women's reproductive health services, to counter the rise of providers' religiously based claims to deny services on grounds of their conscientious objection. Conservative legislatures in many countries have enacted laws to protect such objection, publicly invoking the virtues of

conscience to pursue the sometimes less visible aim of reduction of women's reproductive choices. In the USA, for instance, the 2010 report of the National Health Law Program, entitled *Health Care Refusals: Undermining Quality Care for Women* [16], covers the spectrum of reproductive health services to show how women's care is denied or obstructed.

Respect for conscience requires accommodation of both objection to participation in services and commitment to their delivery. Conscientious commitment may call for courage when treatment is provided that contradicts non-medical directives such as those by religious institutions and officers. Healthcare providers' professional ethics require mutual tolerance and accommodation, however, and resistance to forces of intolerance. The FIGO Ethical Guidelines on Conscientious Objection provide, in Guideline 4, that "[p]ractitioners have a right to respect for their conscientious convictions in respect both of undertaking and not undertaking the delivery of lawful procedures, and not suffer discrimination on the basis of their convictions" [25]. Institutions that would apply punitive sanctions against those whose exercising of their rights to conscience the institutions disapprove weaken the justification for protection of the exercise of conscience they require or approve.

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