THE CENTRE FOR BIOETHICS
Improving health care through Bioethics

The Centre for Bioethics

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Editorial

In this issue we focus our attention on maternal-fetal conflict, an issue that sometimes is debated in the public arena and even becomes a factor in political campaigns in the West. It is a statement of the widespread ramifications of sin fragmenting human relationships, that it has not even spared a mother from her own baby. Sometimes the term maternal-fetal conflict might be an over-simplification for all that goes on there. It is a conflict within a human heart, between a man and his partner, between the woman and the members of her larger family and in-laws, between parents and the treating medical fraternity, between opposing worldviews... We hope that as you read these articles you will appreciate the difficulties and intricacies involved in this ethical dilemma.

Is it surprising that when God is not the foundation of ethics, then invariably ethics becomes a matter of convenience? And always, it is the defenseless and the voiceless who are the victims. As children of the Almighty who is always a defender of the defenseless, let us remember that our default position may be to fight for the rights of the unborn. As you will read on, you will recognize the myriad of fundamental values that are involved in this conflict – sanctity of life versus quality of life, might versus right, autonomy versus beneficence..... Have we as a human race moved on from defining ourselves as human "beings" to human "doings"? Is the worth of a human being arising from the fact that he is in the image of God or is it defined by abilities?

Dr Satish Thomas

Chairman's address

The current issue of the Bioethics Bulletin focuses on an important Bioethical area – the issue of Maternal –Foetal conflict. A long held concept was that the maternal foetal dyad was one complex patient and therefore the distribution of benefits and burden between the maternal and foetal components was not ethically relevant. However, this medical model of a dyad underwent a major shift from unity to duality thus raising several ethical issues and bringing in conflict. Foetal care has become complicated especially in situations where what is required to benefit one member of the dyad will cause an unacceptable harm to the other.

It has also raised questions about rights of both the foetus and the mother, the role of the courts in enforcing compliance and other equally complicated scenarios.

It is my hope that the articles in this bulletin will not just give clarity but also a Christian dimension to our response to this complex situation.

Dr. Sunil Anand
Executive Director, The Leprosy Mission India

ABORTION ETHICS

- Dr Beena Sam

Children are God's precious gifts to us.

Psalms 127.3 says, 'Behold, children are a gift of the Lord,
The fruit of the womb is a reward.' The unborn fetus has life from the time of fertilization and is therefore a life whose author and owner is God himself. And definitely He and He alone has the authority to take it.

In my 23 years of medical practice as an Obstetrician, countless couples have come to my outpatient department with the request for a termination of their pregnancy as it was unplanned and therefore unwanted. I have taken time to patiently counsel them regarding the sanctity of life and the equivalence to murder which this involves, if the pregnancy was aborted. I have encouraged them with my personal experience of the blessedness of being given a precious gift from God at the time that He thought fit, at forty when chances of chromosomal anomalies were quite high.

As a student of OBGYN in India, God gave me the courage to request my Professor to exclude me from the MTP clinic and God, honoring my decision, gave him the turn of mind to grant me such an 'unheard of' permission in a government college. But to my dismay at the viva exam, at the end of the postgraduate course, one of the questions asked me by the external examiner was, 'Now tell me how many MTPs have you done during your postgraduate course?' I was sure to fail my exam as I had not done any. Infuriated, he purposely asked me many more 'difficult to answer' questions, none of which I could answer. But God over ruled and I cleared the postgraduate exam.

Abortion is definitely never the right solution to an unplanned pregnancy. By offering compassionate, nonjudgmental support we can seek to bring Christ's love into a desperate situation and enable each woman to consider all her options. Often I have patients approach me, deeply distressed about terminations more than twenty years ago, unable to forgive themselves and living in guilt. We can only help them mourn the loss of their child, help them find forgiveness in Jesus Christ, keeping in mind that 'mercy triumphs over judgment.'

Quote from Triple Helix No 35, Spring 2006 –
"The serious, but usually treatable, acute complications of surgical abortion are haemorrhage (incidence0.1%) and uterine perforation (incidence 0.4 -2%). The risk of infection (incidence 10%) greatly increases when Chlamydia or Neisseria are present.- upto 23% develop pelvic inflammatory disease(PID) within four weeks. PID can cause infertility and future pregnancies have a greater risk of placenta praevia, about 7 to 15 times increased risk. The chances of preterm labor in the next pregnancy is increased which in turn can lead to chronic lung disease and cerebral palsy in the child.
Women who have abortions are much more likely to commit suicide within a year of the event than those that give birth. Thus abortion seriously threatens a woman's mental health whilst undisturbed pregnancy often improves it. Medical abortions have the risk of incomplete expulsion of the products of conception, sepsis and haemorrhage and also the aftermath of guilt and mental ill health."

Francis Schaeffer wrote, "Abortion does not end all the problems; it often exchanges one set for another".

There is another situation which often The Lord has let me be a part of. There have been occasions where I was faced with reported lethal anomalies in the baby, especially with previous caesarian sections, where further growth of the babies to term could necessitate repeat caesarian section without any hope of a viable baby. These same fetuses could have been delivered or aborted vaginally at an earlier gestational age especially in a scarred uterus.

Recently I was entrusted with the care of a mother with Monochorionic Diamniotic (MCDA) twins with severe Twin to Twin transfusion Syndrome (TTTS). At 20 weeks the fundal height was almost 36 weeks and a single deep pocket of the stuck twin was less than 0.5 cm and that of the other twin was more than 10 cm .Everyday the liquor kept on increasing causing respiratory embarrassment to the mother . The twins just 210 grams each would not survive outside nor inside. So the termination was indicated medically as is in the cases of severe preeclampsia before the period of viability. To save the life of the mother we were forced to terminate the pregnancy. In medically indicated instances we have to take the difficult decision to terminate live pregnancies for the sake of the mother.

The other situations that I come across are when imaging studies show a lethal anomaly incompatible with life. Termination becomes more and more hazardous as the gestational age increases. A year ago I had a patient who went through her pregnancy uneventfully and had a normal delivery, but the baby had multiple anomalies to which she succumbed after a month. The emotional trauma which the couple went through during the time they took care of the baby is indescribable. They had to daily see their newborn baby struggle to suck, had to see her aspirate whenever the baby tried to drink milk. Watching your baby struggle to live each moment without being able to help out even to breathe is an experience no parents would ever want to go through.

In instances of anencephaly, severe neural tube defects and in severe hydrocephalus with vaginal delivery becoming more and more difficult with the increasing diameter of the foetal head, one has to decide between destructive vaginal deliveries or even caesarian sections causing more morbidity to the mother than if the pregnancy were terminated at an earlier gestational age.

There also have been instances where some, who trusting in The Lord decided to continue the pregnancy in spite of the lethal anomaly. I have supported them with all my heart and have gone all the way with them. This was especially when the mother's life was by no means endangered.

As those entrusted with the wholesome care of those who are send to us, let us do His bidding not according to The Law but with grace and mercy. At a time when people go through such severe pregnancy crisis with difficult decisions, let us be with them and bring the comfort of God to them and be providers of medical care such that the very thing which came to crush them becomes an opportunity for the Lord to display His Glory. That was the case with the parents of the MCDA twins with Stage 3 TTTS. As Christians who wanted to follow The Lord all the way, their initial response on the heartbreaking news was not to interrupt the pregnancy even if it cost the life of the young mother with an older 5 year old. But with prayerful counseling, they could see the presence of God and the hand of God at every step in their 'fire'. It was amazing to see them go through their pregnancy crisis with courage and grace and be led to desire to adopt two children at the earliest.

As obstetricians working together with God and for the expansion of His kingdom, let us give ourselves to understand the mind of God as He entrusts each patient to us. He will give us His wisdom to give the best medical care and support to each of them.

Dr. Beena Sam is an Obstetrician in Tiruvalla.

Custom Made Babies?

Dr Roopa Jewel

A few weeks ago when I got an opportunity to attend a Gynecology conference there was a particular topic which caught my interest - latest trends and observations in the field of early trimester scanning. Almost 5 min into the talk I realized it was teaching us as to how easily we can detect simple abnormalities and document it so as to abort babies without much whims or fancies.

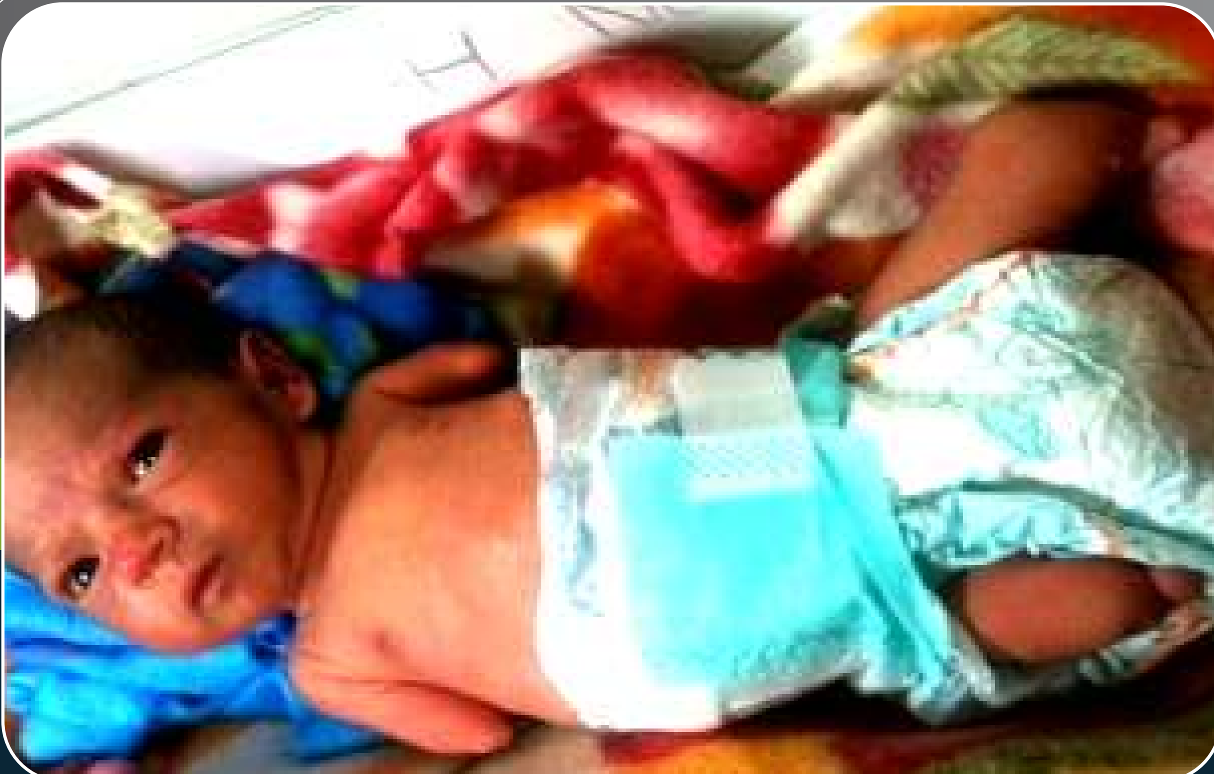
The field of prenatal Genetics has changed little over the past 25 years with regard to non-invasive tools available to assess the developing pre-born infant like ultrasonography, maternal triple hormone screening, and family histories. Even when used in combination, these methods lack specificity and sensitivity to the point of being almost worthless clinically. Attempts to clarify the results of these measures through invasive means have caused severe suffering, unneeded anxiety, and the destruction of untold numbers of normal children. Prenatal genetic testing allows scientists to test established pregnancies for genetic defects that then could be avoided by aborting the pregnancy. Pre-implantation genetic diagnosis allows multiple embryos to be tested and inserted into the mother only if certain desirable traits are present. This possibility noted that the time might soon arrive when pre-implantation screening will be used to pick desirable traits even in the absence of particular genetic disorders. In the coming years, human genome research will delineate gene clusters associated with increased intelligence, athletic ability, and musicality to name a few. "As the technology has developed, there are these really big ethical issues that are emerging and most clinicians are not ready to deal with them"

Our culture has generally considered parents to be the best judges of the welfare of their offspring, but even this has limits. Children are weak and vulnerable; they require protection from abuse and negligence. The ability for parents to choose which offspring die and which live and what traits they will manifest is an awesome responsibility. Innovations in maternal—fetal medicine must not only respect the autonomy of the woman but must also be beneficial and unlikely to cause serious harm. The balance between benefit and harm can be estimated prospectively but, very importantly, can also be measured retrospectively by the methods of audit that are part of evidence-based medicine. Discussion of ethical issues and legal regulation has followed rather than led the developments in maternal—fetal medicine. The autonomy of the woman and the moral status of the fetus are central to the debate. Western secular ethics gives priority to personal autonomy, but in matters of sex and reproduction society persists in assigning more autonomy to men than to women. Men often force their partners into undesired sexual activity. Unintended pregnancy is disproportionately harmful to women yet their default behavior is expected to be acceptance both of the pregnancy and of the obligation to care for the child. Full autonomy for women means equality in sexual behavior and complete personal authority over the fetus. There are practical difficulties in respecting the autonomy of the pregnant woman when providing the potential benefits of maternal-fetal medicine. The woman's view of pregnancy as a rewarding natural process differs from that of the health professionals who are primarily motivated to minimize the risks to her and her fetus. The offer of screening and antenatal diagnosis of fetal abnormality disturbs the woman's positive view of her pregnancy, but she may have difficulty in refusing what appears to her to be a routine part of antenatal care—something she does not fully understand, and that she cannot easily discuss in the crowded minutes she spends with the professionals in the antenatal clinic. She tends to accept the tests on offer and only later becomes truly aware of their positive and negative value for her. Techniques such as ultrasound imaging and fetal heart rate monitoring bond the clinicians to the fetus and create the illusion that the fetus is a person, a patient, for whom they are directly responsible. The clinicians' relationship with the woman can deteriorate and become adversarial when their view of what is good for the fetus differs from hers. Such disagreement has two causes: the first is correctable by effective education and results from lack of accurate knowledge and understanding by the woman; the second has to be accepted and is a consequence of deeply conditioned cultural differences between the woman and the healthcare providers. This may result in an adverse outcome that was potentially avoidable; but experienced obstetricians know that adverse prognoses are sometimes disproved—and that a woman who initially rejects necessary interventions will often accept the recommended management once time has passed and it has become clear that disaster looms. Ethical care should aim at ensuring that the woman remains responsible for herself and her fetus and that she retains her trust in the health professionals providing her care: it is not right to attempt to use the courts to force a competent woman to have treatment against her will.

This is a serious ethical concern. Should a child be created specifically to, or should a child be welcomed and loved unconditionally regardless of his or her instrumental value in helping someone else? This is important not just from a Christian perspective. Philosophers of rationalism, felt that human beings should always be treated as ends in themselves and not as the means for another person to attain his or her ends. But it goes beyond genetic abnormalities or gender, it's everything. What would you like to know about your baby – sports ability, physical appearance, intelligence? And what if your baby doesn't have the characteristics you had hoped for?
New screening tests have been developed that allow parents to find out their child's sex even earlier than with ultrasound. Some fetal DNA test-manufacturers are trying to discourage sex selection by not selling it in China and India, but the simplicity of the testing may make it tough to regulate. "If you can send off a blood sample to a laboratory and find out the sex of the baby and go somewhere else to request a pregnancy termination – no one will ask why"
Taking intentional measures to end the life of a newborn baby is commonly regarded as a violation of the duty to protect the life of the patient. This applies even when that baby's condition is intolerable, with no prospect of survival or improvement. The professional obligation of doctors is to preserve life where they can. To permit doctors actively to end the lives of seriously ill babies would compromise in a negative way the relationship between parents and doctors. In particular, parents may lose trust in the impartiality of the advice from doctors, which is central to the decision-making process.
The implications of this technology are likely to be profoundly troubling. The (always tragic) decision to have an abortion has most often been driven by the personal desire of one or both parents to end the pregnancy, with no serious regard for the potential of the child. The expanded ability to identify multiple variations within an individual's genetic makeup reverses this concept. That is to say, the decision to carry or abort a pregnancy will increasingly be based on an infant's ability to rise to a predetermined standard of acceptability, a standard that is determined either by the parents or society. The new view of abortion will be characterized as "prenatal euthanasia," carried out for the good of the parents, child, and society.
To be "fearfully and wonderfully made" (Ps.139:14) is not to be perfectly made. As finite beings, we cannot understand the breadth of God's creative abilities. Could it be that in His accounting, the character and gifts that are a part of the (for example) Down syndrome persona are especially precious to Him? It is easy to characterize those with obvious disabilities as less than normal. But in these characterizations, do we not promote elitism while carrying our own defects hidden from all but the Almighty? It is often argued that we should prize these individuals for what they can teach us. More importantly, however, they are precious if only for the reason that they represent another aspect of the Infinite Creator who formed us all. May we hold fast to this truth- and pray that others will be guided by it- as technology presents us with new temptations to destroy fellow human beings.
The temptation to redefine parenthood to include choosing particular characteristics in their children, as opposed to unconditionally accepting offspring as a gift of God, is something we all need to think and argue about not just as doctors who deal with it but also to put ourselves as individuals who might need to face it one day or the other.........I guess just a small thought to ponder upon.

Dr. Roopa Jewel is a Gynecologist working in Landour Community Hospital of Emmanuel Hospital Association

This is a photograph of a neonate born in ... hospital. The parents were advised to abort the child as the child looked abnormal in an ultrasound report ....They did not know what exactly was wrong with the child. They were told that the child was malformed and so cannot survive. The mother reached our hospital at 35weeks of gestation with abruptio (condition in which the patient has severe bleeding due to the placenta separating on its own). We treated her as we would treat any other patient and she delivered a live male child, 2.1 kg ....Yes the child had abnormalities, he did not have all 4 limbs but was defiantly a fighter for life ....in no way a person who does not deserve a chance to live and try life ....if only the people around him also understand the same concept.....



When does human life begin?

- Dr Jameela George

In 1983 the world was challenged in a new way. Mario and Elsa Rios who were millionaires died in a plane crash, leaving behind 2 frozen embryos. The question that arose was, “Did frozen embryos have property rights?” Do embryos have a right to life?

When does a “young one” come into existence? Is it at conception? at implantation? When the heart starts to beat at 22 days? When the embryo takes on a human form? When does the life of a new member of the species *Homo sapiens* begin? This is a frequently asked question which has led to numerous debates and arguments in Bioethics. This is very vital, as one's conviction about when a new human entity begins has its implications on a number of bioethical issues such as abortion, female feticide, infanticide, assisted reproductive technologies, human embryo experimentation, embryonic stem cell research, prenatal screening, cloning, contraception etc.

A number of terms are used to describe various stages of the intrauterine development of the human life. **Zygote** is the diploid cell, formed from the union of two haploid cells. **Embryo** refers to the stages from fertilization to the formation of the embryonic disc until 8 weeks after fertilization. This corresponds to 10 weeks of LMP. After 8 weeks of gestation, the entity is called a fetus. The transition from **zygote** to **embryo** to **foetus** is a matter of terminology. In addition to these, legal definitions include embryos as **persons**, embryos as **property or objects**, and embryos as a **unique category.**

It is strange that we can be so unsure about when and how we began. There are various theories put forward which explain when an embryo has moral status.

Self- Consciousness is an acute sense of self-awareness that one exists as an individual being. According to this, "an organism possesses a serious right to life only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity" Michael Tooley. According to contemporary ethicists (such as Peter Singer) human beings are nothing but the product of matter, chance and time; merely highly specialised animals. Life without consciousness is no worth at all. A period of 28 days should elapse before a new born is afforded a right to life. Developing embryo and foetus are non- persons because they lack consciousness of self. This theory condones abortions and research and procedures that destroy embryos

Potential for Self-Consciousness states that moral status ought to be based upon the mere *potential* for self-consciousness. So developing embryo and foetus would be extended the rights and privileges of a human adult, as the former *will be* the latter. The fertilized ovum maintains continuity of identity with the human adult that it is becoming. This theory supports acknowledging a human being's right to life from the moment of conception.

Sentience is the "capacity for feeling or perceiving". Sentience is acquired some time during the 2nd trimester. According to this theory, a foetus should be afforded moral standing late in the 2nd trimester or early 3rd trimester. Therefore, embryos would not have a right to life.

Viability

The unborn individual acquires a right to life at a stage when it can survive outside of the mother's womb, with some artificial means of assistance. Viability serves as the dividing line between a women's right to self-determination and the state's "compelling" interest in protecting the inborn individual's right to life. The fact is that viability depends on access to appropriate technology. So it is a measure of technology only.

Similarity

Carson Strong states that a right to life is *incrementally* conferred upon the developing embryo/foetus as it progressively attains an overall degree of physical similarity to normal adult human beings. Infant, advanced foetus, intermediate foetus, early foetus, embryo and early embryo – the entity is afforded a progressively lower moral status

Rationality states that human embryos are not human beings worthy of respect because they lack rationality or capacity for relationship

Scriptural Theories

One theory is that as Adam became "a living being" at the moment he received breath, so all humans gain a right to life at the moment they take their first breath – at birth. This cannot be accepted as Adam was an adult when he was formed, which is not the case since then. Also, since conception the new human life receives oxygen.

Another theory is that the embryo has the full moral status of a human being, complete with a right to life, from the moment of conception. The image of God is imparted to human beings at the beginning of the process of fertilization, and the right to life is, therefore conferred at the initial moment of conception. Human embryos possess the very nature, value and dignity of being the Image of God. They ought to be regarded as having a right to life.

Religious views

All major religions attach special meaning to embryos. Significant disagreement exists about the details of embryo status. The Vatican considers embryos to be persons from conception and it rejects IVF because it separates sex and reproduction. Conservative and Orthodox Judaism both attach greater but varying significance to embryos after the 40th day of conception (ensoulment)
According to the *Caraka Samhita*, (a Hindu medical text), the soul is already joined with matter in the act of conception. *Garbha Upanishad* claims that ensoulment takes place in the seventh month. Both the Sunni and Shia branches of Islam believe that ensoulment (the condition for being a person) occurs around the fourth month of gestation. Protestant Christian views vary widely, considering personhood to arise anywhere from conception to birth.

Equal moral status view of the human embryo

This is known among moral philosophers. According to this, all human beings are equal, and ought not to be harmed or considered to be less than human on the basis of age or size or stage of development or condition of dependency. Fertilization "produces a new and complete, though immature, organism" that possesses "the epigenetic primordia for self-directed growth into adulthood with its determinateness and identity fully intact". Although not all fertilization events lead to an adult, we were all once embryos in the blastocyst stage of development

Conclusion

Fertilization is a decisive process by which a new, genetically distinct human life is formed when the chromosomes of the male and female gametes blend in the oocyte (egg). As a result of this irreversible event, a new, genetically unique, single-celled entity, zygote, is created. It possesses all of the genetic materials needed to inform and organize growth. It is a human being at the earliest stage of its development which is a continuous process. There is no special moment when human life suddenly becomes worthy of respect and human rights. Humans, irrespective of their stages of development deserve full respect by virtue of the kind of entity they are – that worth is intrinsic. It is not determined by acquired characteristics or abilities, which we all hold in varying degrees even once fully grown. Hence it is fair to say that the fertilising ovum is the beginning of human life.

Dr. Jameela George is the Executive Director of the Centre for Bioethics

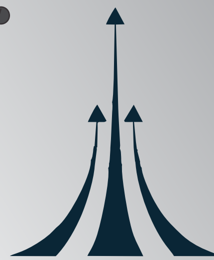
Aims & Objectives of TCB

1. To be a Christian voice on ethical issues based on Biblical values

2. To analyze, interpret and engage with the existing and emerging bioethical issues pertaining to health care and research

3. To facilitate upholding the sanctity of life and dignity of humans in medical practice and research

4. To promote ethical medical practice



5. To build leadership in the field of Bioethics, in the areas of Medical education, Medical practice and Medical research

Prayer support:

TCB needs constant prayer support of churches and individuals alike for the success of its mission and we request all our like-minded believers to kindly uphold us in prayers for God's leading and wisdom. We will appreciate you being in touch with us through face book, website, email or post.

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