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## Editorial: New ABA Board

On the top of the page you will find the logo of Eubios Ethics Institute, representing the three countries from which we operate. Of course it reaches out across the world in a large network. This is the last issue of the 20<sup>th</sup> year, next year starts the 21<sup>st</sup> year. Asian bioethics is certainly coming of age in its reflection, and the first issue of 2011 will be a double issue containing a detailed analysis of Japanese bioethics. On the last page of this issue are the results of the 2010 Asian Bioethics Association (ABA) elections, which see almost an entirely new board of members, which start in principle the fourth new board of the ABA. I also

congratulate the new president of ABA, Anoja Fernando, the first woman president of ABA, who takes over from Leonardo de Castro. Thanks to those who have renewed their membership of ABA, and to all the previous board members – who we hope continue like those before to develop bioethical reflection and research in Asia and the Pacific.\*

This issue of *EJAIB* includes six papers exploring themes relevant to the theory of bioethics, as well as the practice of Asian bioethics. Delport and Pollard review obesity which is an epidemic in the region, with a number of causative factors. It can be expected to contribute to even more health problems in the future than today. Education to empower citizens to make good choices can overcome this, though we still

Brannigan explores Buddhist understandings of “presence”, through suffering. He considers how U.S. health care may not treat pain well. The same could be said for many systems, including those in Buddhist countries. There are also papers in this issue by Grinvoll, and Chaipraditkul, which present results of interviews and review of abortion, and sex selection, in Thailand with references to Buddhist thinking. A number of stereotypes found in their research may apply across the world also, and women’s health is a very important and still neglected issue in many countries.

Moorthy and Selvadurai look at ethical worldviews from an Indian tradition, largely from Hinduism but with multicultural undertones which are across religions found in Indian culture. Cattorini examines ethics and advanced medicine. On the web two supplementary issues for November 2010 are books of abstracts from UNESCO-UKM conferences being held 29 November – 3 December in KL, Malaysia.

For those readers interested in Ethics and Industrial Meat Production, the major source of greenhouse gas emissions, please visit the new website of [www.unescobkk.org/rushsap](http://www.unescobkk.org/rushsap) to download a new book publication from ECCAP working group 13.

-Darryl Macer

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# Changing Perspective on Obesity: Genetic and Environmental Health Consequences in the Offspring

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## Abstract

The prevalence of obesity and overweight has reached epidemic proportions with globally more than 1 billion adults being overweight and an estimated 400 million clinically obese with a projected rise to over 700 million by 2015<sup>1</sup>. The condition – once affecting only high-income countries – is now a major global health concern touching all communities across all ages and socioeconomic groups. The traditional view that overweight and obesity is exclusively the result of over-indulgence in energy-dense, nutrient-poor foods with high levels of sugar and saturated fats is widespread. This is not necessarily the case promoting an urgent need to raise awareness about the multidisciplinary origins of this condition. For example; maternal exposure to a variety of fat-dense diets under differing environmental conditions and fetal developmental phases may adversely impact upon metabolic parameters predisposing the infant to an increased risk of overweight and obesity in early childhood, and reduced fertility later in adult life. By emphasizing that the condition maybe the product of both past and present circumstance, we are challenging contemporary food security improvements. It is for this reason that the present review focuses on both the science and the ethics. Bioscience ethics can usefully be linked to the discipline of epigenetics – namely environmentally triggered changes in gene expression promoting lasting legacies in subsequent generations. Importantly, epigenetic insights reveal how positive or negative environmental influences may promote resilience, or otherwise, in the offspring. By integrating ethics and the life sciences, unique educational opportunities for advancing biological understanding within the scaffolding of ethics can be created.

**Keywords:** Obesity, fetal metabolic programming, epigenetics/epigenome, bioscience ethics, addiction, stress.

## Introductory Background

Obesity, the prevalence of which has seen an almost exponential rise, is an “energy imbalance” disorder resulting in excess fat accumulation in the body, mostly within the subcutaneous tissues. The

accumulation of fat, stored mostly as triglycerides in adipose tissue, is caused by a greater caloric ingestion than is required for producing energy needed in daily activities. The most widely used measure to indicate the presence of this condition is body mass index (BMI), which, by comparative analysis of an individual's weight to height ratio, determines a range of adaptive body fat percentages. A BMI of 25-30kg/m<sup>2</sup> is defined as a state of overweight, whereas a state of clinical obesity is represented by a BMI of greater than 30kg/m<sup>2</sup> [1]. When body mass indices are referred to in this review, obesity is defined as a body mass index of  $\geq 30\text{kg/m}^2$ . It is important that attention be drawn to the fact that this body index does not take into account individual body characteristics such as differing body type morphologies, athletic versus shapely, nor does it allow for measurements of weight to specify bone and muscle density. By considering only total individual mass and excluding metabolic efficiency, obesity simply highlights a condition of over-consumption. While it is undeniable that obesity is a result of energy intake and expenditure imbalance, underlying aetiologies may suggest, for example, alteration in glucose and lipid metabolism [2] or vascular dysfunction [3].

An appetite for foods dense in fats and sugars is the result of selection of adaptive physiological characteristics that evolved in our distant hunter-gatherer ancestors. During that phase of our evolution the ability to store energy reserves in the form of adipose tissue was adaptive in seasonal environments where periods of limited food availability – starvation even – was predictable [4,5]. Since then our physiology has remained little unchanged; thus, in contemporary society where foods are abundant, individuals are ill adapted to this newfound bounty currently triggering a global epidemic of morbidity and ill health [6,7,8].

## Obesity in Pregnancy and Early Infancy: Long-Term Metabolic Consequences

There exist periods of vulnerability during fetal development where the types of foods the mother eats may increase the risk of overweight and obesity in the offspring. For example, during the third trimester of pregnancy, epigenetic drivers in the form of increased portions of processed, energy-dense maternal food intake, will up-regulate the transport of lipids as free fatty acids across the placenta which, in turn, will accelerate the generation of fat cells within fetal adipose tissue [9,10]. Development of additional fat cells, in unison with increased fetal/placental circulating levels of leptin, is likely to predispose the offspring to a larger than average gestational weight and increased appetite during childhood; thus, perpetuating the trans-generational effects of overweight and obesity [11]. Leptin, the hormonal product of the OB (obesity) gene, is produced in adipose tissue and plays a significant role in the central regulation of energy expenditure (including appetite and metabolism) as monitored by the ‘appetite centre’ of the brain's hypothalamus [4,12]. Under normal adult conditions, leptin acts as an endocrine signal on the hypothalamic receptors

<sup>1</sup>World Health Organization. Fact Sheet no. 311. Geneva: WHO; 2006

where it inhibits appetite; however, consistently elevated leptin levels, as in obesity, may impair this function. On the other hand, leptin – also widespread in fetal and placental tissues – acts as a potent fetal growth factor [9]. Before birth, leptin production promotes growth by increasing the mobilization of maternal fat stores in order to further support fetal growth. It should be noted that towards term, a number of structural and functional maturational changes occur in the fetus in preparation for the transition from intrauterine to extrauterine life. Particularly relevant to the present discussion is that during the last trimester's growth phase, fat represents over 50% of fetal caloric accretion.

Maternal 'flavour preference' can also be passed on to the offspring during the period of breastfeeding, as well as during third trimester gestation. Clinical trials monitoring possible periods of flavour development preferences identified a critical period spanning 3-4 months postnatally [13]. Infants were exposed to two baby formulae with differing flavour characteristics; cow's milk-based and hydrolysed protein-based milk. Despite a sour, bitter taste and unpleasant odour, infants that were previously exposed to the hydrolysed protein-based formula over the four month course of the trial, became more accepting of the unpalatable formula [13]. Similarly, exposure to specific nutrient-dense foods during breastfeeding can result in infant preference to this specific food type. For example, earlier clinical trials found that the type of formula fed during infancy influenced taste preference at ages 4-5 years [14].

These and similar findings demonstrate that early exposure to specific 'flavours' does impact upon learned food preference where behavioural association with energy-dense foods established during critical developmental periods, may affect certain neurological adaptations that increases a distinctive pleasant reinforcement response, when the food is consumed later in life. As a consequence, the beginnings of overweight and obesity are partly contributed to by intrauterine conditions during development, as well as infancy and dietary choices made in later life. For this reason, it is crucial that informed parental behaviours associated with food intake are established prior to gamete formation and conception, as well as during pregnancy and breastfeeding. Parents, who are better informed about reproductive physiology [15], become more responsible behaviourally, reducing the risk of their offspring developing obesity or overweight [16]. Awareness of how individual choice and circumstance can influence both individual and generational health, through the advancement of biological knowledge of both the genetic and epigenetic contributors to a high body mass index, will improve societal and individual understanding of obesity.

### **Obesity and Fertility Outcome**

Individuals who are more vulnerable to a genetic predisposition of higher body weight often experience reduced reproductive fitness. A greater weight,

especially distributed around the abdominal region, is associated with reduced fertility in both women and men. Fertility irregularities can be identified early via changes to the balance of circulating hormones; such as leptin, which can result in adverse effects controlling normal regulation of neuroendocrine function driving maturational changes towards the attainment of puberty [17]. As described above, leptin (part of the adipokine regulating system) is a product of adipose tissue so circulates in the body at a higher concentration in obese or overweight persons, compared to those of lesser mass. The adipokine system is central in the adjustment and timing of the onset of gonadotropin-releasing hormone (GnRH) secretion that drives the hypothalamic-pituitary-gonadal axis to initiate the processes that culminate in puberty [18]. Owing to high circulating levels of leptin in overweight young girls, the onset of puberty is premature compared to their lesser weight associates. With the occurrence of the first menses at an earlier age, it is also predicted that this group of women will experience menopause at an earlier age [19,20]. In any event, it has been well established that a state of obesity influences fertility in reproductively active women by adversely affecting the development of gametes (eggs) that may then contribute to the trans-generational effect of obesity and possible reduced fertility in turn [21]. Decreased reproductive capability, or fitness of offspring, is further enhanced when the gamete is fertilized by a male partner who is also overweight or obese.

Male infertility has been little discussed until recently with the primary focus for its cause attributed to an imbalance of hormone concentrations. As a greater weight reduces metabolism essential for sperm serum production, men who are overweight or obese often have decreased plasma levels of sex hormone-binding globulin (SHBG), which lowers the level of circulating steroid hormones [22, 23]. Men with a body mass index exceeding 30kg/m<sup>2</sup>, with a large proportion of adipose tissue distributed around the abdominal region, are further likely to experience lower levels of total testosterone and free testosterone due to the enzyme aromatase in fat tissue, which aromatizes testosterone to estrogen [24]. The combination of reduced semen quality and low testosterone, progressively result in lower sperm count, increased sperm with abnormal morphology and decreased fertilizability [25]. Overweight or obese individuals are approximately three times more likely to develop these fertility anomalies than men with a body mass index of less than 30kg/m<sup>2</sup> [26]. As a result, clinically obese men are more likely to have greater fertility difficulties that may adversely affect the next generation of infants: hence, further contributing to the trans-generational effects of obesity.

As many individuals are unaware of the progressive generational predisposition to inherit reduced fertility status, it is crucial that information regarding the influence of obesity and overweight on future generations be made available. By distributing knowledge of the applied science through bioethics

education, individuals can be made more aware of their choices and provide better long-term health in offspring by reducing their vulnerability to develop the basis of adult disease *in utero*.

### Sedentary Lifestyle and Increased Food Availability

Since the beginnings of human evolution, we have adapted physiological mechanisms to cope with daily requirements of physical exertion and the storage of energy reserves for periods of starvation. Progressively leading into the 21<sup>st</sup> century, lifestyles have adapted to become more sedentary with a lessened physical role in both the workforce and traditional home functions. As technological advances have allowed us to become more efficient in daily processes, the energy requirement for daily function is much lower now than a century ago. Hypothetical models of energy requirement have estimated total daily expenditure a century ago to be around 3000 kcal/day whilst under modern living conditions, daily energy requirement for physical activity is estimated around 500-1000 kcal/day; 30-60% lower than past decades [27]. In addition, total body fat composition is negatively correlated with basal metabolic rate (BMR) because fat consumes lower energy per unit weight compared with muscle [28]. For this reason, individuals with an inherited predisposition to store excess fat may, involuntarily, be more likely to gain weight as a result of a sedentary lifestyle. Further, as a result of physiological adaptation to a higher daily caloric intake and levels of circulating dopamine – the feel good neuro-hormone – individuals can develop an addiction to our primordial taste preference, increasing the risk of developing overweight or clinical obesity. However, despite the nature of the workforce changing, there still remain numerous opportunities to exercise and consume foods lower in saturated fats and sugars, suggesting that progression from overweight to obesity is, to a great extent, determined by individual lifestyle choices. As many of the outcomes of compulsive consumption of fast-foods, such as reduction in basal metabolic rate and potential addiction, are largely unknown by many members of contemporary society, it is crucial that this knowledge be made easily accessible in order to heighten individual and community awareness.

### Summing up: The Ethics of Science

From the biological perspective, health and ill-health are not alternative states; rather they are part of the same continuum where genetic and epigenetic influences sustain, or derail, normal reproductive processes triggering lasting legacies in the next and subsequent generations. As described in this review, we inherit more than just our genes from our ancestors. Inadequate control over the decision-making in one's life generates a destructive interplay of social, physical, economic and environmental (epigenetic) factors that undermine the determinants shaping the wellbeing continuum. Like all of us, fetuses have mechanisms by which they adapt to deteriorating environmental conditions brought about by parental distress, drug abuse, disease, nutritional

excess or deprivation, and non-adaptive lifestyles. In essence, normal development is disrupted by harmful influences and for those surviving their prenatal challenges, the cost maybe a struggle with long-term health consequences [29]. By facilitating information transfer based on biology relevant to contemporary society, future studies will, progressively over time, provide a basis for individual knowledge and the opportunity for the establishment of informed decisions associated with food intake. As obesity is the second most common cause of morbidity and mortality in modern times, it is crucial that further work also focuses upon the fetal origins of obesity and its trans-generational occurrence. Figure 1 allows the reader to see the rapidity of weight increase as measured in some selected OECD countries. The hoped for outcome is that with ready access to ongoing scientific investigations, existing societal mores will change and facilitate informed individual choice supporting the development of a positive foundation to maximize trans-generational health.

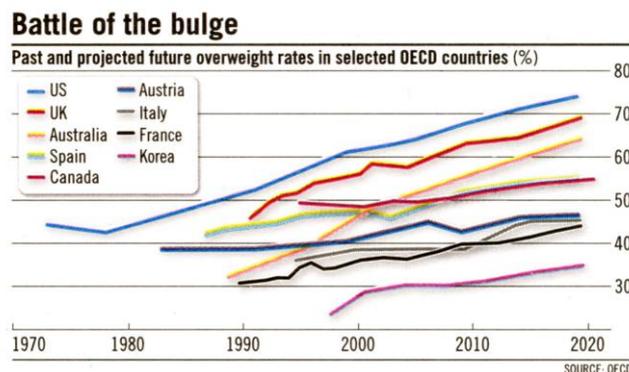


Figure 1: Published in *The Weekend Australian Financial Review* 9-10 October, 2010, p. 27. (Source <http://economix.blogs.nytimes.com/2010/09/23/the-world-is-fat/>)

### References

1. Waterland R, Michels K. Epigenetic epidemiology of the developmental origins hypothesis. *Annual Review of Nutrition* 2007; **27**:363-388.
2. Vasquez G, Duval S, Jacobs Jr D, Silventoinen K. Comparison of body mass index, waist circumference and waist/hip ratio in predicting incident diabetes: a meta-analysis. *Epidemiology Review* 2007; **29**:115-28.
3. Romero-Corral A, Montori V, Somers V *et al*. Association of bodyweight with total mortality and with cardiovascular events in coronary artery disease: a systematic review of cohort studies. *Lancet* 2006; **368**(9536):666-78.
4. Cripps R, Martin-Gronert M, Ozanne S. Fetal and perinatal programming of appetite. *Clinical Science* 2005; **109**:1-11.
5. Philipson T, Posner R. The long-run growth in obesity as a function of technological change. *Perspectives in Biology & Medicine* 2003; **46**:87-107.
6. Lehrke M, Lazar M. Inflamed about obesity. *Nature Medicine* 2004; **10**: 6-7.
7. Walley A, Blakemore A, Froguel P. Genetics of obesity and the prediction of risk for health. *Human Molecular Genetics* 2006; **15**:124-130.
8. Wang Y, Lobstein T. Worldwide trends in childhood overweight and obesity. *International Journal of Pediatric Obesity* 2006; **1**:11-25.

9. Forhead A, Fowden A. The hungry fetus? Role of leptin as a nutritional signal before birth. *Journal of Physiology* 2009;**587**:1145-52.
10. Jones H, Woollett L, Barbour N, Prasad P, Powell T, Jansson T. High-fat diet before and during pregnancy causes marked up-regulation of placental nutrient transport and fetal overgrowth in C57/BL6 mice. *The Federation of American Societies for Experimental Biology Journal* 2009;**33**:271-278.
11. Stoger R. Epigenetics and obesity. *Pharmacogenomics* 2008;**9**:1851-60.
12. Oken E, Gillman M. Fetal origins of obesity. *Obesity Research* 2003;**11**:496-506.
13. Mennella J, Griffin C, Beauchamp G. Flavor programming during infancy. *Pediatrics* 2004;**113**: 840-845.
14. Mennella J, Beauchamp G. Flavor Experiences during formula feeding are related to preferences during childhood. *Early Human Development* 2002;**68**: 71-82.
15. Pollard I. Bioscience-bioethics and life factors in reproduction with special reference to the Indigenous Australian population. *Reproduction* 2005;**129**:391-402.
16. Huda S, Brodie L, Sattar N. Obesity in pregnancy: prevalence and metabolic consequences. *Seminars in Fetal & Neonatal Medicine* 2010;**15**:70-76.
17. Pasquali R, Pelusi C, Genghini S, Cacciari M, Gambineri A. Obesity and reproductive disorders in women. *Human Reproduction Update* 2003;**9**:359-372.
18. Mitchell M, Armstrong D, Robker R, Norman R. Adipokines: implications for female fertility and obesity. *Reproduction* 2005;**130**:583-597.
19. Ali A, Crowther N. Factors predisposing to obesity: A review of the literature. *Journal of Endocrinology, Metabolism & Diabetes of South Africa* 2009;**14**:81-84.
20. Wardle J, Carnell S, Haworth C, Plomin R. Evidence of a strong genetic influence on childhood adiposity despite the force of the obesogenic environment. *American Journal of Clinical Nutrition* 2008;**87**:398-404.
21. Catalano P, Ehrenberg H. The short- and long-term implications of maternal obesity on the mother and her offspring. *International Journal of Obstetrics & Gynaecology* 2006;**10**:1-8.
22. Hammoud A, Wilde N, Gibson M, Parks A, Carrell D, Meikle A. Male obesity and alteration in sperm parameters. *Fertility and Sterility* 2008;**90**:2222-2225.
23. Hammoud A, Gibson M, Peterson C, Meikle A, Carrell D. Impact of male obesity on infertility: A critical review of the current literature. *Fertility and Sterility* 2008;**90**:897-904.
24. Frey K, Navarro S, Kotelchuck M, Lu M. The clinical content of preconception care: Preconception care for men. *American Journal of Obstetrics & Gynecology* 2008;**10**:389-395.
25. Hamilton M, Gazvani M. ICSI: What are we doing to our gene pool? *The Obstetrician & Gynaecologist* 2000;**2**:11-15.
26. Magnúsdóttir E, Thorsteinsson T, Thorsteinsdóttir S, Hemisdóttir M, Ólafsdóttir K. Persistent organochlorines, sedentary occupation, obesity and human male subfertility. *Human Reproduction* 2004;**20**:208-215.
27. Leonard W, Robertson M. Nutritional requirements and human evolution: A bioenergetics model. *American Journal of Human Biology* 2005;**4**:179-195.
28. Hewitt J. The genetics of human obesity: What have genetic studies told us about the environment? *Behavior Genetics* 1997;**27**:353-358.
29. Pollard I. Bioscience Ethics. Cambridge, Cambridge University Press 2009.

## Presence in Suffering: Lessons from the Buddhist Four Noble Truths

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### Abstract

The core of Buddhist teaching compels us to address and relieve the suffering of sentient creatures in the best ways we can. However, U.S. healthcare has not sufficiently faced this challenge. Despite undeniable progress in efforts to medically control pain, U.S. healthcare delivery still struggles in coming to terms with fundamental aspects of pain and suffering, for instance in chronic and terminal illness. I argue that one major factor lies in an increasing forgetfulness of what I consider the "virtue of presence" and its associated distinction between curing (treating) and healing. Within this context, I will more closely examine Buddhist views of suffering, healing, and presence, focusing particularly upon the Buddhist Four Noble Truths. Although the Truths date back over two millennia, certain teachings resonate in our ongoing clinical encounter with pain and suffering. Buddhist insights help to reaffirm necessary ingredients in genuine presence. Moreover, they lend weight to the proposition that U.S. healthcare has much to learn from other traditions and perspectives. I conclude by reasserting our need, more so today than ever, to cultivate presence.

### Introduction – Western Medicine's Pyrrhic Victory

In *The Worst of Evils*, a brilliant tour de force recounting the cultural struggle against pain, chemical pathologist Thomas Dormandy describes the ordeal of the impressionist painter Pierre-Auguste Renoir (1841-1919) whose bicycle injury, rheumatoid arthritis, and later paralysis of arms and legs left him wheelchair-bound during his last nine years [1]. At that time in the early 1900s, Western medicine met with little success in treating the type of unrelenting, chronic pain that Renoir endured. After the reputed Viennese Professor Rudolf Schade treated the painter for two weeks with a steady diet of herbal medicines, he assured him he could now walk. Renoir's son Jean, the celebrated film director, recounts the episode in his biography, *Renoir, My Father*. He describes how his father, to others' astonishment, arose tentatively from his wheelchair, and found strength to walk slowly across the room [2]. Upon returning to his chair, utterly exhausted, the painter realized that walking would entirely consume any energy left for painting. But at least he

now had the choice. He chose to remain in his chair, and despite his deformed hands and crippled fingers, he painted masterpieces like *A bunch of roses* (in memory of his wife who died in 1915) and *Portrait of Madam de Galea*. With the help of Richard Guino, he even sculpted pieces such as *Venus Victrix*. Although his physical pain persisted, his suffering was in a sense relieved. Whereas prior to Schade's urging, the painter felt inescapably imprisoned in the wheelchair, he now had some semblance of control.

When it comes to pain and suffering, we are engaged in a domain of meanings. Whereas physicians imprint an objectivity through assigning medical meaning to a patient's condition, the patient lives out that condition in a subjectivity that is engulfed within an intimately personal, familial, social, religious, and cultural web. Renoir's domain of meaning centered around his passion for his art. The patient's subjective domain of meaning underscores the phenomenological distinction between pain and suffering. However my pain is labeled, it remains *my* pain. How I perceive and understand my pain becomes *my* suffering. Moreover, my meanings affect the course of my illness, which in essence remains a personal interpretation of a condition just as suffering is a personal rendition of personal pain. For instance, meanings that I bestow upon my chronic headaches no doubt change if my physician discloses a tumor in my brain. And my meanings are further altered upon disclosure that my tumor is inoperable. My suffering rests upon the meanings I give to such 'facts' and ultimately remains *my* suffering.

None of this is novel. Over six decades earlier French philosopher Maurice Merleau-Ponty offered his penetrating incision into the existential nature of illness, reminding us that, though a disease may be ascertained as an objective entity, a person's lived experience of that pathology is entirely subjective and constitutes the real meaning of illness [3]. Theologian Paul Ramsey reached further though less deeply, lamenting the disappearance of the "person" who, once institutionalized and objectified, becomes stamped a "patient" [4]. The metamorphosis is deceptive, for the patient is always first and foremost a person.

Not long after Renoir, Western medicine achieved a remarkable string of victories in ways to medically control pain. Landmarks include discovering both the role of neurotransmitters in conveying signals, and effective agents in treating pain such as norepinephrine, dopamine, serotonin, Nembutal, amphetamines, metamphetamines, and aspirin. In due course the triumph of *penicillin* and general anesthesia empowered Western medicine to gain the upper hand in controlling acute pain [1]. Yet, medical conquest of acute pain undermined efforts to address chronic conditions such as rheumatoid arthritis, Parkinson's Disease, deafferentiation (the phantom limb in Merleau-Ponty's *Phénoménologie de la Perception*), and "non-specific" ailments like lower back pain as well as those associated with terminal illness. Equally significant, medical control over pain meant less attention to the personal suffering induced by the pain. During Renoir's time, prior to

successful pain-control, it was the obverse. Physicians, more or less helpless in assuaging physical pain, could at least offer solace and comfort in addressing their patients' suffering [1].

Western medicine's Pyrrhic victory – improved pain control accompanied by diminished interest in suffering – reflects medical attentiveness to what is *visible* and *known*. Whereas a disease category is grasped, measured, and objectified, a patient's lived experience of his or her illness remains invisible to medical inspection, less measurable during the medical interview, and entirely subjective. What is less visible becomes less "real." For instance, a patient's personal narration has less fact-value than the disease category of hypertension, which, as a visible and known category, can at least be addressed through typical drug regimen. My lived experience of my hypertension however is of less account. What matters is known etiology.

Despite its continuing conquest of pain, healthcare's perennial challenge lies in its struggle to come to terms with pain and suffering. This constitutes the litmus test of medicine. Furthermore, this compels medicine to acknowledge its limits in treating persons, for persons suffer, whereas bodies do not.

### Aim

All this is a roundabout way of introducing my purpose in this essay, which is to travel back in time and revisit leading ideas from millennia-old Buddhist Four Noble Truths to assess their applicability to twenty-first century Western medicine. My reason is straightforward. The Four Noble Truths form the heart of Buddhism in that they directly address suffering as a universal truth and propose ways to alleviate not just one's own and other human suffering, but that of all sentient beings. Along the way, we have much to learn from the Buddhist prescription. One prominent lesson centers around a notion which I believe represents a chasm in our current healthcare delivery – a commitment to the exercise of active presence. Through Buddhist insights, I underscore the importance of presence so that we may cultivate it within healthcare in ways that become through force of habit second-nature.

Buddhists scholars may disapprove of my simplified exegesis. Nonetheless, in the spirit of Buddhism, the text, like diagnostic technique, is a tool, not an end-in-itself. As the Buddha instructs the monk Malunkyaputta, one who is shot with a poisoned arrow is not concerned with the make-up of the arrow, but with being free from the arrow [5]. As a tool to help us free ourselves and others from suffering, the Buddhist Four Noble Truths, as applied to our current U.S. medical climate, contributes to an ethics of presence.

### Back to the Living Past – The Four Noble Truths

What makes the Four Noble Truths "noble"? These truths lay bare the nature, origin, and relief of suffering. Given the centrality and misery induced by suffering, the question is all the more fitting. According to the *Majjhima Nikaya*, the "Middle

Length Discourses” of the Buddha, their nobility lies in their undeniable facticity.

These Four Noble Truths, monks, are actual, unerring, not otherwise. Therefore, they are called noble truths [6].

In addition, philologist K. R. Norman, who admits that the translation “noble” lends itself to misinterpretation, asserts that these truths are *espoused by the noble one*, the Buddha. Furthermore, through acknowledging and embracing such truths, *we in turn become noble* [7].

For our purposes, Norman’s analysis is instructive. The Truths correspond to a medical diagnosis in that they point to a particular condition (suffering, or *dukkha*), specify the cause of that condition (*trsa*), indicate that we can be relieved from the condition (*nirodha*), and prescribe the way to relief (*marga*). It is not surprising that the Buddha is also referred to as the Great Physician, the Healer. He embodies what healing is all about. Physicians, by virtue of their commitment to relieve pain and suffering, are ennobled. In turn, medicine is a noble profession.

Let us further explore these ennobling truths by using as our centerpiece the parable of Kisagotami, described by the fifth century Buddhist commentator Buddhaghosa in his *Vissudhi Magga* (Path of Purification).

Kisagotami became in the family way, and when the ten months were completed, gave birth to a son. When the boy was able to walk by himself, he died. The young girl, in her love for it, carried the dead child clasped to her bosom, and went about from house to house asking if anyone would give her some medicine for it. When the neighbours saw this, they said, “Is the young girl mad that she carries about on her breast the dead body of her son!” But a wise man thinking to himself, “Alas! this Kisagotami does not understand the law of death, I must comfort her,” said to her, “My good girl, I cannot myself give medicine for it, but I know of a doctor who can attend to it.” The young girl said, “If so, tell me who it is.” The wise man continued, “Gautama can give medicine, you must go to him.”

Kisagotami went to Gautama, and doing homage to him, said, “Lord and master, do you know of any medicine that will be good for my body?” Gautama replied, “I know of some.” She asked, “What medicine do you require” [8]?

Gautama, the Buddha (literally “awakened one”), then instructed her to go to each neighbor and collect a mustard seed from every household that has not faced death. She did as instructed, hearing different responses from villagers, some having lost a child, some lost parents, and some lost slaves. In sharing with Kisagotami their own personal stories, they offered a common response, “The living are few, but the dead are many.”

At last, not being able to find a single house where no one had died, from which to procure the mustard seed, she began to think, “This is a heavy task that I am engaged in. I am not the only one whose son is dead [8].”

With this realization, she then left the body of her dead in the forest and returned to Gautama. Though empty-handed, she was now filled with insight having learned the law of death.

Gautama said to her, “You thought that you alone had lost a son; the law of death is that among all living creatures, there is no permanence [8].”

### **Noble Truth One - *Dukkha***

Kisagotami acquired insight into the law of death and, in doing so, realized the First Noble Truth - that pain and suffering, *dukkha*, permeates existence. Although the Pali term *dukkha* is typically translated as “suffering,” it literally means “dislocation,” an unease, a ‘dis-ease’ that more profoundly embodies Kisagotami’s predicament.

Her visits with each household – the text leaves it to us to imagine the details – must have gradually impressed upon her the full scope of *dukkha*, not only its utter pervasiveness, but that it is life’s impermanent nature itself which generates suffering. The painful memory of her son’s death rouses her sense of dislocation, his dis-ease. Furthermore, since nothing is permanent, then neither is his or her entity called “I”. For Buddhists, this “I” or “self” simply supplies an anchor of security in this ocean of transience, and we have no real grounds to confirm that “I” exists without begging the question. This latter aspect of suffering (*sankhara-dukkhata*), evoked by the “I” illusion, is exceedingly difficult for those of us conditioned to believe in a separate, independent, and permanent self. Buddhists challenge our ontic bias by reducing who we are to five components, or *skandhas*: form (body), sensation, perception, mental constructs, and consciousness. These represent our physical and mental states, and together, they comprise our individual being and identity; there is no separate self as overseer, no “ghost in the machine.”

In all this, it is crucial to appreciate that Kisagotami’s insight into the law of death comes about through her person-to-person encounter and engagement with others who shared her suffering. Through her neighbors, in a sense her medical team, she gradually recognizes that in her suffering she is not alone. Hers is thus a parable of recognition, and *presence* plays a major role. She also recognizes that through shared suffering, “she” is not independent and separate from “them.” She eventually awakens to her oneness with her neighbors, indelibly linked through suffering. Herein lies the key. Recognition can only come about through presence, indeed a reciprocal presence of each person to the other, an inter-presence. This inter-presence is strong medicine and leads to Kisagotami’s awakening, which in turn leads to her healing. Through the medicine of recognition and presence, and in turn inter-presence, “I” can now more easily enter into the suffering of the “other” and vice versa.

This is also a parable of healing, for healing means to restore what is broken, to repair what is torn apart, to make whole. The ultimate aim in

medicine is to heal. And healing clearly requires presence. Gautama's medicine consists in prescribing to Kisagotami a face-to-face encounter with her neighbors. He instructs her *to present herself to them*, and in doing so, they *present themselves to her and with her*. And with each encounter, each inter-presence, she ultimately realizes the fundamental truth that she is not, never was, nor ever will be alone.

### Noble Truth Two - *Trsna*

In the course of our diagnosis, the second Noble Truth underscores the root cause of our suffering, *trsna*, usually translated as "desire." I prefer the translation "craving," the extreme form of desire. Craving occurs when our desires, most notably the desire for permanence, overcome us, as was clearly the case with Kisagotami who desired medicine for her dead son. Unable to let go of her son's death, clinging to a past in which her son was alive, Kisagotami was attached to the idea of permanence. She was further attached to the illusion of a separate identity, the idea that she alone was suffering, that "she" was different and apart from any "other."

Again, through her inter-presence with her 'medical team,' she in time recognized the shared nature of her plight, that she was not alone in her suffering. In the classic Mahayana text *Vimalakirti Sutra*, the enlightened disciple Vimalakirti instructs us that our personal suffering enables us to enter into the suffering of others. The suffering of her neighbours enabled them to enter into her personal plight. By virtue of their presence to her and with her, she entered into their suffering as well, recognized her oneness with them, and thus awakened to the illusion of separation between her and all others.

### Noble Truth Three - *Nirodha*

The Third Noble Truth represents the turning point in the Buddhist diagnosis and sets the Buddhist approach apart from the current state of much of Western medical science. It tells us that, as in the case of Kisagotami, we can indeed be relieved from suffering. Suffering is not cast into the category of "untreatable condition." As healers, we must recognize suffering, address it, and work to alleviate it.

The Buddhist prognosis is thoroughly optimistic. Because suffering permeates one's being, medicine not only strives to relieve it, but it *can*. Kisagotami's encounter with her neighbors treats and relieves her suffering. Their mutual presence, inter-presence, each being open to and present with the other, enables her healing. Although the medical prescription for healing in most cases requires more than simply presence, presence is a necessary condition.

### Noble Truth Four – the Eightfold Path

Because suffering is treatable, the fourth noble truth provides a detailed treatment regimen. This prescription, the Eightfold Path, consists of steps all of which interact with each other. It is important to note that these eight paths are not separate. As with

multiple drug treatments, they all interact. The seventh path in particular - right mindfulness – directly focuses upon the need for presence. At the same time, presence assumes significance in each of the others.

**Path One Right understanding**, embracing Buddhist teachings as a necessary means to relieve suffering, requires that one must be *present* to these teachings, open to them in a way that allows their insights to penetrate.

**Path Two Right intention** demands that we cultivate the proper attitude, to be free from self-centeredness and from the delusion of duality between "me" and the "other." Kisagotami's willingness to listen to her neighbors and to be open to whatever they had to share with her, allowed for inter-presence, their mutual openness to each other.

**Path Three Right speech** means what it says. In the *Samyutta-nikaya*, the Buddha warns his monks:

*"In sooth to every man that's born  
A hatchet grows within his mouth,  
Wherewith the fool, whene'er he speaks  
And speak amiss, doth cut himself..."*[9]

Right speech thus illustrates the force of karma, that principle of moral causality in which every action with moral weight inevitably produces consequences that are either productive or destructive, so that our character affects and is affected by our speech.

This is especially germane in terms of how I interact with a patient. Right speech involves a twofold presence. It requires self-presence in that I am *present to myself*, aware of my inner state in the company of others. It also requires that I be *present to and for* the other whom I am with. Right speech demands that I actively listen and reflect before speaking, a hard lesson in our excessively noisy and chatty culture, absorbed much of the time in what German philosopher Martin Heidegger referred to as "idle talk" [10].

**Path Four Right action** means selfless behavior. It therefore proscribes lying, stealing, behaving unchastely, wrongful killing, etc. And selfless action certainly requires being *present to, for, and with* others, for it demands placing the needs of other living beings first.

**Path Five Right livelihood** requires that we engage in occupations that nurture selflessness. In so doing, right livelihood demands a similar *presence to, for, and with* others, especially with our co-workers throughout our eight, ten, twelve, fourteen or more work-hours per day.

**Path Six Right effort** beckons us to develop the discipline to always act in selfless ways. As with right speech, discipline is not a popular term in our public lexicon, but it is vital in Buddhist practice. For example, Buddhist meditation requires our mental discipline to be totally present to ourselves in both body and mind. *Self-presence* is a prerequisite to discipline and demonstrates right effort.

**Path Seven Right mindfulness** speaks directly to the meaning of presence, insisting that we be fully attentive, aware of where we are, how we are, when we are, and with whom we are. As I see it, right mindfulness sums up the essence of Buddhist

teaching, that is, *to be where we are when we are there*. This is absolutely imperative in the clinical setting where the patient, already physically and emotionally compromised, is situated within an institutional context that appears highly impersonal. *Being-there*, as simple as this seems, is profoundly difficult.

*Path Eight Right meditation* represents the ideal state in which, via presence and all of the prior steps, I transcend the conventional duality between “I” and “other” and awaken to the truth that there is no separate “I” nor “non-I.” As long as Kisagotami assumes that “she” is separate from her neighbors, her suffering is all the more agonizing. Her gradual realization that her suffering is shared dissolves the protective wall she had built between herself and the world. Inter-presence and the realization of non-duality leads to healing.

### Back to the Present

With this snapshot view of Buddhist teachings, let us now apply the above notions of presence to contemporary healthcare. In the process, what more can we assert about presence? The clue lies in the word’s existential, spatial, and temporal bearings. Presence means “being present,” and to “be present” one must “*be there* in the *present*,” not somewhere else other than where one is, not stuck in some past nor playing out some scene in the future. This is what right mindfulness is all about. To be present with one who is suffering is exceptionally challenging since suffering entails anguish over loss of what was past as well as fear towards some future. Being present requires securing ourselves in the present, wherever that present takes us.

### Medical Interview

One of the most important and, from the patient’s point of view, most impressionable encounters between physician and patient is the initial medical interview. The medical interview consists in figuring out what is wrong with the patient. It requires knowing the complaint, understanding the complaint within the broader contexts of the patient’s medical and personal history, and getting a good pulse on the patient’s perspectives, concerns, and expectations [11]. Here, presence is undeniably crucial.

Figuring out what is wrong with the patient takes time, not necessarily lots of time, but time that is well-spent. Time is the scarcest medical resource for health professionals under the gun of fiscal and professional pressures. I continue to hear an ongoing litany from providers and nurses that they simply do not have lots of time to spend with each of their patients. In many cases, they have good reasons, given institutional constraints, recurring systemic dysfunction, and a lack of care-continuity. In some cases, however, such reasoning can be an expedient excuse for insufficient and improper attention to patients. In all cases, as I have regularly stressed in numerous meetings with medical staff, it is not the amount of time that matters, but *how* that time is used, or wasted. Presence is the key. And

unless we can learn to better cultivate presence, we ourselves will continue to hinder healing and, for that matter, treatment.

In Margaret Edson’s 1999 Pulitzer Prize winning play *Wit*, Chief of Medical Oncology Harvey Kelekian and others transform Vivian Bearing, Professor of English with a specialty in the metaphysical poetry of John Donne, by objectifying her into the disease she bears, late stage metastatic ovarian cancer. As clinical Fellow Jason Posner conducts his medical interview with her, he awkwardly demonstrates a near total absence of presence. The fact that he is a former student of the patient adds further insult [12]. A cold detachment occurs in the clinical encounter when the health professional is more attentive to the medical data, the “facts,” than to the person before him. This takes on a special cruelty when that person is dying. Contrast this with the inter-presence that must have eventually developed between Kisagotami and her neighbors. So, what in particular does this presence require?

### Ingredients in the Virtue of Presence

#### *Active listening*

The medical interview prompts us that presence needs to be established from the start. Active listening provides the key. Active listening engages the whole person. We convey our messages in three ways: the words we use, our tone of voice, and nonverbally, for instance through body language. Communication studies reveal that we are much more attentive, and thus attribute more importance, to both nonverbal cues and tone of voice than to the words themselves. Clinical oncology consultant Elisabeth Macdonald rates this attentiveness at 60% for nonverbal cues, 35% for tone of voice, and 5% to the spoken words [11]. Bodily presence is no doubt indispensable. With our socio-cultural infatuation with mobile phones and text messaging, think of how we might feel if physicians text-messaged to us our diagnoses. Active listening therefore requires that we listen to both what is not said and what is said, along with how all of this is conveyed. As we described above, the Buddhist path of right speech is not only about what is spoken, but how it is said, and especially what is left unsaid.

Silence is its own voice, so that presence must allow silence to have a ‘say’ in the encounter. This is difficult in a culture that thrives on noise and talk. Yet, according to the Swiss philosopher Max Picard, silence is the ground of speech, without which speech is incomprehensible [13]. Silence is thereby its own profound language. Indeed the language of silence is the most difficult to learn. Active listening requires listening to this language, especially in the clinical setting where patients are exceptionally vulnerable and their suffering is intensely intimate. While we may control the agenda by filling in the cavities of silence with speech, our effort oppresses the truths which only silence can convey.

*The small truth has words that are clear; the great truth has great silence.* (Rabindranath Tagore, *Stray Birds*, CLXXVI)

### *Pace*

An inherent power-imbalance in the clinical encounter between physician and patient requires that we empower the patient by allowing the patient to set the pace. Although the physician necessarily pursues an agenda, provides direction, and guides the patient along the way, the physician can also control the agenda through interruptions and closed questions that may discourage the patient from revealing more of the important context behind the initial complaint. The Buddhist path of right action underscores acting selflessly, in that we put aside our own agenda, our own narrative, in order to be genuinely present to, for, and with the other and fully listen to his story, and not our own. The physician can further control the agenda by focusing solely upon the presenting complaint so that the complaint becomes *the* problem, apart from the broader context of the patient's personal, familial, and social history and habits.

Medical tests to ascertain diagnoses are no doubt invaluable. As Public Health expert Eric Cassell points out, assurances provided through medical techniques, diagnostic procedures, and tests may help soothe the discomfort of uncertainty given the fact that each patient responds to his or her condition and treatments in unique ways [14]. Yet a moral turning point occurs when reliance on technique and procedure supersedes interpersonal engagement with the patient. For instance, a pivotal scene in the classic Japanese film *Ikiru* (To Live), directed by Akira Kurasawa, depicts two physicians seemingly fixated on the x-ray image of the patient Kenji Watanabe's malignant stomach tumor [15]. Watanabe's suffering is profoundly and indelibly real. Yet images threaten to replace the patient in the hierarchy of importance, perniciously becoming more real than the reality they depict. When faith in technique trumps faith in what we can learn from our encounter with the patient, medical intervention undercuts the healing power of presence.

### *Reciprocity*

The primordial premise in the Buddhist Noble Truths highlights the intimate and synergistic interconnectedness among all living beings. This is the teaching of *pratityasamutpada*, co-dependent origination. All actions, particularly interpersonal, are thereby cause and effect. We see this in the path of right livelihood, which encourages us to engage in occupations that cultivate selfless action, and which can be further nurtured through selfless encounter with others.

This presents a special challenge in the noble profession of medicine. An authentic relationship between the professional caregiver and the patient can only unfold in a climate of trust. Without trust, a relationship of potential healing risks becoming one of suspicion, doubt, and adversity, a climate ripe for medical litigation. Since by its nature presence tends to be reciprocated, presence helps to establish and ensure trust. That is, the medical team's proactive presence often evokes presence on the part of the patient and family. This reciprocity is the inter-presence I alluded to above in the story of

Kisagotami. The physician's genuine and felt presence sends the most important message to the patient – that he or she is valued. The patient naturally responds more openly.

To summarize, through active listening, pace, and reciprocity, presence embodies the fundamental condition of "being present." This sets in motion "being-present-to." The healer is a professional who, in the desire to heal, presents his or her competence and expertise to the patient. Presence is also "being-present-for," in that the healer's commitment to the patient's well-being operates on a more humane, covenantal level that goes beyond a relationship that is minimalist, impersonal, and merely contractual [16]. Moreover, presence is "being-present-with." The healer does not work alone, but works together with the patient and the medical team in partnership with the patient, and at the same time seeks to sustain a bond of trust with the patient and family. Finally, presence includes "being-present-in-transcendence." The quality of the healer/patient relationship transcends its immanence in a way that reflects the deeper mystery of their unique encounter in which matters of faith and deep-rooted spirituality occupy a privileged place, embodying in the deepest sense the nobility of the medical profession,

### **Conclusion - Presence as release from the tyranny of time and mind**

It is enormously difficult to cultivate these ingredients of presence - active listening, pace, and reciprocity - within our U.S. healthcare system, principally because our health system reflects deep-rooted cultural values. The healthcare provider's quandary represents a socio-cultural predicament. We are increasingly consumed by an incessant need to accomplish as much as we can in less time. With information technologies that enable us to "stay connected" and "plugged in," we find ourselves ensnared in a range of diverse contexts that require never-ending responses through speedy and convenient digital communications and multi-tasking, in turn elevating these to a level of virtue. The ability to stay focused on single tasks, one-at-a-time, is not only becoming a rare species but even regarded as a hindrance to moving forward and keeping pace with the traffic. We have come to believe that we have no time for one-at-a-time thinking, reflection, and response. Likewise, medicine moves forward in multiple contexts, appearing increasingly disjointed and without a coordinating center, a symphony orchestra without a conductor. As a result, our health system is dangerously fragmented in ways that threaten both continuity and quality of patient care.

On account of two culprits, Time and Mind, providers encounter extreme difficulty *embodying* presence with their patients. Under the pressure of time, within a context of medical uncertainty in view of each patient's uniqueness, the patient's problem stands in danger of being defined strictly within diagnostic categories that objectify the patient's subjective experience of illness. Lack of sufficient time requires that we efficiently get to the complaint, figure out the problem, and resolve *it*, the operative

term noting "it" as the problem. Within this densely multi-directional system, providers understandably find themselves under the axe of time and institutional pressure to perform in cost-effective ways that not only sustain the system, but protect their job security within the system. Yet this comes at a cost, and the patient, who in principle should always occupy the moral center of their professional concern, pays the price, for the patient's problem or complaint has been transformed and translated as *the problem*.

Presence, being where-we-are-and-with-whom-we-are, is also profoundly difficult, not only for physicians but for all of us, because, as the Buddhist text *Dhammapada* reminds us, the mind is like an elephant. Tamed, it quietly makes its way through the forest. Untamed and unrestrained, it rampages through our mental terrain taking us in different directions at once, so that we become easily distracted from where we happen to be. In our encounter with patients, distraction exacts a high toll for the stakes are high. Instead of listening to what is said, how it is said, and what is left unsaid, we let our own agendas speak to us and allow our minds to pull us away from being-present to, for, and with our patient. This means rewinding to the complaint which translates into *the problem*, reviewing different treatment regimens, considering additional tests to confirm (and to protect ourselves down the line).

The Buddhist philosopher Nagarajuna, in his brilliant *Mulamadhyamikakarika*, cautioned us against becoming fixed to ideas, concepts, and other mental baggage. Fixation to what is not real (our thoughts) pulls us away from our lived presence in our interaction with the other, who is real. Fixation provides us with a safe detour away from the reality of the suffering patient before us. Yet how we are present to the one who suffers will shape the extent and degree of that sufferer's healing.

One of the many invaluable lessons that I have learned from my work with patients, particularly hospice patients, is that patients themselves detect whether or not we-are-there-with-them. Our body language gives it away: eye contact, where our eyes go, what we do with our hands, the way we fidget, looking at our watch, whether and where we stand or sit, whether we write more or listen. How we maneuver our physical environment also gives it away. Is there sufficient privacy and quiet? Have we turned off our pagers? Are there physical barriers such as tables, desks, chairs, notes, clipboards, etc. between physician and patient? For the patient, these physical barriers represent significant meaning-filled walls. These add up to that less visible quality known as sincerity. I suspect that our own personal experiences as patients would confirm this. Those in vulnerable circumstances are especially sensitive to, alert, and intuitive regarding the visitor, whether neighbor, hospice nurse, volunteer, or physician. It seems as if our vulnerability somehow unveils our intuitiveness to the vulnerabilities of others and their discomfort with or expression of sincerity and presence.

In conclusion, what I consider to be the virtue of presence requires that we cultivate the skill and the art of using the little time we have, which may be all the time we really need, in the best way we can. It goes without saying that we bring our experience, expertise, and competence to the encounter. Yet presence demands much more. How we manifest our presence forms the vital condition for healing. On our part, this requires patience, attentiveness, mindfulness, active listening, reassurance, and care. It entails being-there-with-our-patient. *How we are with the patient*, the person before us, not only makes a difference; it *is* the difference.

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### References

1. Dormandy T: *The Worst of Evils: The Fight against Pain*. New Haven and London: Yale University Press; 2006.
2. Renoir J: *Renoir, My Father*. Translated by Weaver R and D. London: Collins; 1962: 445-446.
3. Merleau-Ponty M: *Phénoménologie de la Perception*. Paris: Gallimard; 1945.
4. Ramsey P: *The Patient as Person*. New Haven: Yale University Press; 1970.
5. Rahula W: *What the Buddha Taught*. Rev. ed. New York: Grove Press; 1974.
6. The Middle Length Discourses of the Buddha: A New Translation of the Majjhima Nikaya. Translated by Nanamoli B. Boston: Wisdom Publications; 1995.
7. Norman KR: *A Philological Approach to Buddhism*. Lancaster: The Pali Text Society; 2006.
8. Brannigan MC: In *Striking a Balance: A Primer in Traditional Asian Values*. New York: Seven Bridges Press, LLC; 2000: 66-67.
9. Birnbaum R: *The Healing Buddha*. Rev. ed. Boston: Shambhala; 1989.
10. Heidegger M: *Being and Time (Sein und Zeit)*. Translated by Macquarrie J and Robinson E. Oxford: Basil Blackwell; 1978.
11. Macdonald E, ed: *Difficult Conversations in Medicine*. Oxford: Oxford University Press; 2004: 6-7.
12. Edson M: *Wit: A Play*. New York: Faber and Faber; 1999.
13. Picard M: *The World of Silence*. Translated by Godman S. Washington, DC: Regnery Gateway; 1988.
14. Cassell EJ: *The Nature of Suffering and the Goals of Medicine*. New York: Oxford University Press; 1991.
15. Brannigan M: *Ikiru and Net-Casting in Intercultural Bioethics*. In *Bioethics at the Movies*. Edited by Shapshay S. Baltimore, MD: Johns Hopkins University Press; 2008: 345-365.

16. May W: *The Physician's Covenant: Images of the Healer in Medical Ethics*. Philadelphia: Westminster Press; 1983.

## Some Ethical Thoughts from the Indian Tradition

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### Abstract

In the pre-World War II era, Western powers colonized many countries in different regions of the world. In the greater Asia region, Western powers like the Portuguese, British, Dutch and the American divided the region into their own sphere of influence. Through centuries of occupation, the occupiers managed to introduce certain way of life, conducts, norms and values into the local population. Slowly, Western precepts began to be embraced as superior and preferred models of thinking and conduct. Nevertheless, in the modern day, human and environmental problems have been blamed, to large extent, on the anthropocentric worldviews of the West. This paper explores alternative perspectives from the Indian tradition to arrest some of these problems. The East is no stranger to ethics; the Indian (mainly Hinduism, Buddhism and Jainism) and Sino (mainly Confucianism and Taoism) traditions have strived for centuries in the Asian societies. The paper attempts to show the relevancy of certain ethical precepts from the Hindu-Buddhist tradition to provide guiding principles and alternative explanations on matters that affect humanity and the environment

### 1. Introduction

There is a preconceive notion that bioethics is a product of Western thinkers, especially stemming out from the modern philosophers in the likes of Locke, Kant and others. Their thoughts frame the nature of social, political and ethical dimensions of philosophy in the modern era, eventually being prescribed as global values for humankind. Through trading activities, occupations and later diplomatic relations, Western philosophy and ethics spread rather aggressively into societies of the East. However, the East is no alien to philosophy and worldviews either, the Hindu-Buddhist faiths and Confucianism have existed in the Asian societies for centuries. Bioethics principles can be seen in the discourse and teaching of Confucius, Buddha and other Hindu thinkers. These Eastern discourses are rarely known to the West. It should be noted that Western prescription of bioethics is not always congruent with the Eastern societies. Western constructions of ideas can be

problematic in explaining phenomena in the Eastern cultures. The paper attempts to show the relevancy of certain ethical precepts from the Hindu-Buddhist tradition in providing guiding principles and alternative explanations on matters that affect humanity and the environment

### 2. The Indian Alternatives

Can ethical precepts from the Indian traditions provide alternative perspectives to address contemporary human and environmental problems? The answer to this question appears to be complex. This is because the Indian tradition is not free from problems concerning humanity. For example, the caste system practiced by the Hindus for thousands of years has been blamed for rampant human rights abuses. In reality, Hindu societies appear to endorse these abuses as a form of pecking order in societal hierarchy and classification, which leads to society imposing different levels of dignity to different groups of people, usually on the basis of their colour, creed and professions. As such, it can be argued whether the Indian tradition can offer any significant alternatives to address current concerns. Compared to the West, the Indian tradition has been in existence longer than any other tradition in the world and its ethical precepts have evolved over centuries through dynamic interactions between fellow religionists, the nature and with other interacting worldviews. The faith systems, as in the Hindu-Buddhist belief, are mostly interwoven with societal values and norms, making it somewhat difficult to differentiate whether the ethical precepts are faith-origin or cultural-origin. In the Indian tradition, humanity and human dignity are expressed differently from the Western tradition. For example, in the Indian tradition, the sanctity of all form of life and the preservation of that life is central to the Hindu-Buddhist belief. This concept is somewhat foreign to the Western societies, which, in the post industrial revolution period began to see humans as a factor of production, with an economic value tag. On the matter of environmental sustainability, ecological consciousness is far more expressed in the Indian tradition as compared to the West.

The last several decades has witnessed the reemergence of the discourse on human dignity amongst scholars, analyst and the civil society. Although the concept had regularly appeared in several United Nations documents, especially in the Universal Declaration of Human Rights (UDHR) and the European Convention on Human Rights and Biomedicine, it was only recently, after the declaration of the Millennium Development Goals (MDGs) and the 1994 United Nations Human Development (UNDP) report of human security, the concept took center stage in the thinking of the international community. Philosopher, Immanuel Kant (1724–1804) argues that dignity or human dignity is enshrined in the rudiments of human autonomy. For Kant, dignity falls neatly into an ethical category, where humans are said to be born equal in dignity, in spite of their colour, creed and origin. Kant's perspective on human dignity is also shared by the framers of the UDHR (Miguel, 2004).

The various principles in UDHR are in actual fact manifestations of the spirit of human rights, his dignity and his wellbeing, which also relates to his environment. In the Hindu-Buddhist tradition, human dignity has a very high priority in the Indian mindset. Humans are integral to community and therefore place community interests and wellbeing before individual-centric egoism. Humans are seen a vital constituent of family and community, and endowed with dignity, value and responsibility to safeguard all God's creation. Even though the hierarchical Hindu caste system has been criticized for a variety of human rights abuses over centuries, Hinduism do provide elaborate accommodation for human dignity expression. On the other hand, Buddhism rejects the caste system and focuses on efforts to liberate humans from worldly suffering, which is an eventual consequence of human greed. In Hinduism, some gods are projected in human forms, and Buddhism claims that humans have the intellectual and spiritual capacity to achieve superhuman wisdom and release themselves from the worldly cycle of birth and death (Anonymous, 2002). Human life is sacred and the whole passage of life is to seek divine truth.

In the Indian tradition human life and other forms of life are considered divine. By putting the divinity tag, the Hindu-Buddhist faiths place all living beings in the highest regards. Therefore, hurting or abusing all forms of life is considered unholy and disrespectful. This notion is somewhat different in the Western tradition, which has the tendency to look at human life and other forms of life for utilitarian and economic perspectives. The 'soul' is integral to the existence of all life forms, having similar qualities of the Creator, and thus suggesting that all beings as divine. Hinduism is also called *Sanatana Dharma*, which literally means the 'eternal religion'. It is eternal because unlike other religions, there is no specific time in history to trace its origin and its magnanimous capacity to embrace the diversities of all other religions. The Sanskrit word *dharma* means both man's nature and his faith. To a Hindu, *dharma* is the pursuit towards the fulfillment of the divinity of humankind, where we are in inner harmony with the world where we belong (Chakravarti, 1994). The concepts of *samsara*, *moksha* and *karma* are also central to the faiths of the Indian tradition (Hinduism, Buddhism and Jainism). *Samsara* is the cycle of birth and death, and as such the very purpose of life is to escape from this cycle of suffering through liberation or *moksha* (also called *nirvana* in Buddhism). All souls are said to be reincarnated according to the law of *karma* (which literally translated as the principle of cause and effect, action and reaction). Dead people are usually cremated so that the soul is totally liberated from its previous body (Cordeiro & Ochoa, n.d.). The Indian traditions promote inner harmony with the surroundings.

Another principle that refers to the inviolability of life is the concept of *ahimsa* or non-violence. *Ahimsa* promotes sanctity and harmony of life with itself, others and nature (Jayaram, 2010). Humanity is not devoid of violence behaviours and acts, as history

has shown us that humans are capable of creating harm and destruction to others and the nature. Violence has become a serious menace worldwide, and continues to devastate lives and societies all over the world. *Ahimsa* does not refer to non-violence alone; it also refers to the love for all forms lives, with no exception made for animals or other living beings. This concept claims that all life forms are divine, whether human or otherwise. Thus, it is not surprising that the Indian faiths promote vegetarianism amongst its followers. Nonetheless, the Indian tradition is not free of violence conflicts. The father of India, Mahatma Gandhi, who is famous for his pacifism and non-violence resistance against the British, did not entirely reject violence. Gandhi claims that "where there is a choice between cowardice and violence, I would advise violence. But I believe that non-violence is infinitely superior to violence." (as cited in Appleby, 2000). The Ramayana and Mahabharata have also depicted wars in their texts. These texts have suggested war only as last resort in the pursuit to defend virtue, after exhausting all other peaceful means. Even Buddhist priests have said to have persuaded Emperor Asoka to relinquish his throne despite his victory in war. The message here is that waging war may conquer the world but not the mind and inner peace (Paneerselvam, 2010).

Mahatma Gandhi views *ahimsa* not merely as a political tactic but as an effective way to liberate the Indian people from colonial rule and securing its national identity. Nevertheless, the strength of *ahimsa* generates from inner consciousness of spiritual unity within the people. The Gandhian concept of non-violence action and *satyagraha* is incomprehensible if it is viewed as a means of attaining unity rather than as the ends of inner unity already attained (Merton, 1964, p.6). Gandhi asserts that non-violence should be the basic principle guiding human existence. As such, *ahimsa* can be utilized as an efficient mechanism for social action and change, since it coheres with the man's intrinsic nature and the desire for peace, justice, orders, freedom, and personal dignity. In contrast *himsa* or violence devalues and corrupts man, where power reciprocates power and likewise hatred reciprocates hatred, thus leading towards humans' gradual value degeneration. In this light, *ahimsa* has the capacity to cure and restore human nature, bring about social order and justice. *Ahimsa* is not an instrument to seize power, but as a means of altering relationships that can bring about harmonious transfer of power. This is because non-violence is voluntarily accepted by all parties and has been recognized as a right in itself (Merton, 1964, p.23). Human conflicts arose from the inability of humans to resolve their differences amicably. As a result, humans may resort to abrupt and violent responses to manage their differences. The practice of *ahimsa* provides a natural resource for individuals to address their differences through examining their disputes collaboratively and seeking harmonious conflict resolutions approaches. The *ahimsa* approach may

provide durable alternative resolution methodology for much of current day human conflicts.

On the matter of sustainability, Indian tradition has long embraced ecological friendly values. For example, the Hindus believe that the material world may comprise of numerous life forms, but the ultimate sustaining force rests wholly on spirituality. Thus, all forms of life are viewed as divine and humans are duty bound to protect them. This pantheistic belief in their value system provides a rich resource for the respect for nature. Earth is often viewed as 'mother', whilst the mountains as abodes of god and rivers, trees, animals and vegetation as sacred and holy. Humans are integral part of nature, as they are interconnected with other life forms and non-life forms to form one whole unity. This mindset promotes sustainable actions, as humans have long co-existed with other life forms on Earth, sharing scarce resource. The Indian tradition promotes simple and sustainable ways of living with basic levels of consumption, without abusing the limited resources. Equitable sharing forms its core value and thus restraining unlimited individual desires. Buddhism also advocates its followers to reduce excessive consumption practices and to adhere to an ethical lifestyle through basic and simple living, and empathy for the needs of others (Siwatibau Suliana, 2008). The idea of sustainable development entails the adoption of a sufficiency model, which means humans should lead a lifestyle that ensures the succeeding generations will be able sustain a living with the same resources. In other words, it promotes the conservation of natural resources to prevent further deterioration of the environment.

Elements of nature are often celebrated and even revered in the Indian traditions. The forces of nature have been sanctified in early Hindu scriptures, thus prompting protection and conservation practices amongst its followers. The Riga Veda, for example, the earliest scriptural text of Hinduism, contains textual hymns glorifying the deities like *Agni* (Fire), *Indra* (Storm & Rainfall), *Surya* (Sun), *Soma* (Moon) and *Usha* (Dawn) (Nevatia, 2006). Mahatma Gandhi also spoke about environmental sustainability. He argued that there are no limits to the desire of humans, and arbitrary quests for achievement and satisfaction have brought about environmental degradation in the West. Gandhi makes a clear distinction between the concepts of 'needs' and 'wants' in explaining human nature. For him, 'needs' refer to the fulfillment of basic requirements of life, which is to survive and grow. Meanwhile, 'wants' is the human wish to fulfill desires. Several decades ago, Mahatma Gandhi warned Indian not to imitate the living standards of the West. He claimed that the scarce resources of India simply cannot accommodate India's large populace if they decide to consume and live like the Westerners. It should be noted that his warnings are still relevant to the present day consumerist culture and waste-centric society (Pravin Sheth, n.d.). He also advised the present generation to take on the responsibility to use the resources succinctly, while considering the needs of the future generations who will inhabit the same mother Earth. This idea is embedded in the

notion of trusteeship ethics. Humans have the sacred duty to safeguard nature not only for their own use but also for future generations. Gandhi's popular quote, "the Earth has enough to satisfy the need of all the people, but not for satisfying the greed of some," will be of significant relevance in contemporary discourse on environment, sustainability and climate change.

### 3. Conclusion

Can Indian tradition suggest alternatives principles to guide humans in dealing with other humans, other species and his environment? While it is difficult to provide an outright answer, it will be pertinent to note that in addressing current day problems, as argued earlier, Western precepts have failed to provide meaningful solutions to many of these problems. However, it will be erroneous to suggest that all from the East is good and all in the West is bad, as principles such as love, compassion, nobility and duty exist in all cultures in spite of geographical, political and religious differences. Nonetheless, as suggested earlier, Indian precepts can offer some meaningful alternative perspectives in addressing the said issues and dilemmas.

The principle of collectivism is one of the central themes of the Indian tradition. It encourages unselfish attitudes towards oneself, others and nature, and thus instilling the understanding that oneself is essentially a part of a bigger whole. Therefore, one's actions ought to be mutually dependent and harmonious to the interests of others. Such values are often lacking in Western ways of thinking. The principle of non-violence is a central principle of the Indian thinking. This principle promotes harmonious and peaceful co-existence with all beings, the nature and the universe. Nature is vital for the existence of species, and without it, there will be no life on earth. Therefore, safeguarding the environment for present and future use becomes the central responsibility of humans. The Indian tradition ethical principles can offer alternatives but it requires rethinking and embracing of new sets values.

### 4. References

1. Anonymous. (2002). *Hinduism and Buddhism. A Comparison*. Retrieved 27 July 2010, from [http://sc.essortment.com/hinduismandbud\\_rtgs.htm](http://sc.essortment.com/hinduismandbud_rtgs.htm)
2. Appleby, R. S. (2000). *The Ambivalence of the sacred: religion, violence, and reconciliation*. (The Sacred and The Sovereign, University of Chicago). Lanham, MD: Rowman & Littlefield. Retrieved 20 August 2010, from <http://sacred-sovereign.uchicago.edu/rsa-ambivalence.html>
3. Chakravarti, S.S. (1994). *Hinduism: A way of life*. [e-book] Delhi: Motilal Banarsidass. p.23-24. Retrieved 23 August 2010, from [http://books.google.com.my/books?id=J\\_rASTqw8wC&printsec=frontcover&dq=Chakravarti,+S+S,+Hinduism+A+Way+of+Life.&source=bl&ots=IDclxSn6X&sig=qp1F8zjWP9NUEDNYQ\\_K3UJ7vRkM&hl=en&ei=gzOETMiSA5HGvQO4soGUBA&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CUBYQ6AEwAA#v=onepage&q&f=false](http://books.google.com.my/books?id=J_rASTqw8wC&printsec=frontcover&dq=Chakravarti,+S+S,+Hinduism+A+Way+of+Life.&source=bl&ots=IDclxSn6X&sig=qp1F8zjWP9NUEDNYQ_K3UJ7vRkM&hl=en&ei=gzOETMiSA5HGvQO4soGUBA&sa=X&oi=book_result&ct=result&resnum=1&ved=0CUBYQ6AEwAA#v=onepage&q&f=false)

4. Cordeiro, J. and Ochoa, S. (n.d.). Religion, science and immortality. Retrieved 21 August 2010, from <http://www.transhumanism.org/tv/2004/Cordeiro.pdf>
5. Jayaram, V. (2010). The concepts of Ahimsa or non-violence. Retrieved 23 August 2010, from <http://www.hinduwebsite.com/hinduism/concepts/ahimsa.asp>
6. Merton, T. ed. (1964). *Gandhi on non-violence: a selection from the writings of Mahatma Gandhi*, New York: New Directions.
7. Miguel, C.R. (2004). Human dignity: History of an Idea, *Dictionary of the History of Ideas*, [online] 28 September 2004, p.3–14, Retrieved 26 July 2010, from <http://etext.lib.virginia.edu/cgi-local/DHI/dhi.cgi?id=dv4-20>
8. Nevatia, H (2006). Hinduism and the environment: The Pagan element in Hinduism advocated sustainable development as evidenced in The Riga Veda and The Bhagavata Purana, (update 14 Oct 2006). Retrieved 20 August 2010, from [http://hinduism.suite101.com/article.cfm/hinduism\\_sustainable\\_development](http://hinduism.suite101.com/article.cfm/hinduism_sustainable_development)
9. Paneerselvam, S. (2010). The use of non-violence in war and peace. In D. R.J. Macer and Souria Saad-Zoy (Eds.). *Asian-Arab philosophical dialogues on war and peace*. Bangkok: UNESCO.
10. Pravin Sheth (n.d.) The Eco-Gandhi and ecological movements. Retrieved 3 August 2010, from <http://www.gandhimuseum.org/sarvodaya/articles/ecogandhi.htm>
11. Siwatibau Suliana (2008). Ethical dimension for sustain our environment: A Pacific island perspective. In D. R.J. Macer (ed.). *Asia Pacific perspectives on environmental ethics*. Bangkok: UNESCO.

## The Winter of Clinic? Advanced Ethical Dilemmas for an Advanced Medicine

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### Abstract

Scholars in narrative bioethics, all over the world, are confronting some key questions. Which medicine will survive? What kind of promise, of covenant, of alliance will be signed between the professional power and the society? Three controversial ethical issues, among others, stir the debate: persistent vegetative states, artificial procreation, individual requests for reshaping an healthy body (doping included). Dealing with these dilemmas, typical of advanced medical science and technological practice, implies not only balancing carefully the burdens and benefits (in an utilitarian way) for suffering persons, families, equipment, hospitals, cultural and religious communities, but also imaging and realizing new visions of a just society, of a

beneficent (without paternalism) medicine and generally of a good life, where each moral agent could write in worthy and convincing ways the next chapter of the book of his/her own life. Both literary tools and intellectual concepts give resources to the same intriguing research.

### Winter, snows and cultural death

A suffering man. A frightened woman, unable to help him. And above all, the snows of Kilimanjaro. *The Snows of Kilimanjaro* is the famous novel by Ernest Hemingway<sup>2</sup> and an eloquent metaphor of the doubtful identity of the healing professions, which make diagnose much more than they can cure, and whose social aims are largely confused and sometimes expressed in embarrassing, contradictory, illusory promises.

"The marvellous thing is that it's painless," he said.

"That's how you know when it starts".

"Is it really?"

"Absolutely. I'm awfully sorry about the odour, though. That must bother you".

"Don't! Please don't." [...]

"Please tell me what I can do. There must be something I can do."

"You can take the leg off and that might stop it, though I doubt it. Or you can shoot me. You are a good shot now. I taught you to shoot didn't I?"

"Please don't talk that way. Couldn't I read to you?"

"Read what?"

Reading something. The value of narrative in medicine (the so called narrative medicine) and in ethics (the stream of narrative ethics) might offer a safety anchor for scholars reflecting upon the future role of biomedical practice. That's what we are going to explore in the next pages.

### Visions of medicine

What will be the Hippocratic heritage in this new century<sup>3</sup>? Which moral dilemmas will provoke that legacy and challenge its primary duty of beneficence: to act in the interest of the patient, by preventing harm, promoting good, removing evil? This article tries to underline three problematic areas and some theoretical issues at stake. The main thesis, we defend, is that we need to rebuild medical ethics, beyond the so called "principlism"<sup>4</sup>, taking in account

<sup>2</sup> Ital. transl. *Le nevi del Kilimangiaro*, Milano, Mondadori, 1992.

<sup>3</sup> This article extends the text sent in 2009 to an Italian Journal, *Medicina nei Secoli - Journal of History of Medicine* (Rome), with the title "Shall I become a Zombie? Storied of Illness, Ethical Dilemmas and Visions of Society", by maintaining the previous structure, and simply adding some new comments and literary references. Our aim is to analyze and compare the reactions by readers belonging to a wider, Asian and international context. We thank the Direction of *Medicina nei Secoli*, who gave the permission.

<sup>4</sup> The famous book *Principles of Biomedical Ethics*, by T.L. Beauchamp and J.F. Childress, Oxford, Oxford Univ. Press, 1979, 2001 (5th ed.), has raised several

the role of emotions, of moral symbols and leading narratives. Narrative ethics is not the trendy hobby of some tired moral philosophers, but it represents the perennial dimension of Western thought, since its Socratic beginning.

The analysis of important moral dilemmas (as the ones presented in the following pages) will show the importance of an interdisciplinary, pluralistic and socially constructive dialogue and it will display the key role of the ethical evaluation, that is the effort to rationally justify hard decisions in health care policy and at the patient's bedside. In this reflective work, visions - as we have said - play a crucial role. As the philosopher Plato has explained once and for all, the myths are not the tomb, but rather the ground of the reason. Philosophical and especially ethical interpretations have in *mythos* and *logos* their systole and diastole, the double wing of the same passionate search for truth. *Logos* critically reflects upon the *mythos*, which we believe in, and reshapes such narratives, but in no way it can replace or get rid of them. The truth-search, we have mentioned, takes each time the form of thinking by means of concepts (theories) or by means of images (metaphors, tales). To decide the right way of dying, of procreating, of practicing medicine, we need not only a logically coherent use of intellectual concepts, but also a convincing, enchanting, promising and leading vision of a good personal and societal life. As Karl Jaspers has written, any world-vision has an objective side (the world-image) and a subjective one (the attitude toward the world).

#### At the beginning of life

The topic of assisted procreation produced a cultural turmoil in Italian society, since a very restricted law has been approved by the Parliament in 2004. The prohibition of gamete donation, of embryo freezing and of preimplantation genetic diagnosis, prompted libertarian associations to demand a public referendum in order to amend the law. The referendum took place but did not reach the quorum required to be effective. In the meantime, the Supreme Court named Corte Costituzionale has declared unconstitutional some important articles, so that a deep fissure is impairing the law's application.

Beyond the result, what astonished and disappointed several expert of bioethics was the atmosphere and style of the debate: wall against wall, slogan against slogan, parody of adverse positions. A grotesque tug-of-war was played between some embryo life defenders and procreative rights supporters. A liberal Catholic standpoint like mine was widely ruled out and obscured. The most amazing show was the recourse to embryologists in television talk programmes: some of them claimed to demonstrate or exclude the personal identity of the zygote on a mere genetic or biological basis, without analysing the philosophical dimensions of the terms (such as individual) they used.

Not to imitate this simplistic fight, advanced ethical issue, as the one regarding the nature of embryo, has to be dealt with a more correct *interdisciplinary approach*. Neither embryologists alone nor philosophers or theologians alone can solve, and even understand a question like that: "is an embryo a person?". The reason is that in the same sentence two terms appear, belonging to different disciplines: embryologists know well what can be seen at a microscope in the phase of morula, but they ignore what the word person means (and usually no biological handbook offers a definition). Person is indeed a classic key word of philosophy and theology, but their initiates don't have conceptual tools by themselves, if they do not previously attend biomedical lessons, to deal with the scientific side of the issue, for example to explain which are the unifying/growing factors of an human fertilized egg.

Interdisciplinarity, one essential feature of bioethics<sup>5</sup>, implies that different disciplines should sit at the same table, dialogue each other, mutually translate their languages, look for bridge-concepts (the concept of individual, for example, in the case of embryo debate), which enable a cognitive exchange. In the next years, it will be more and more important the effort to interpret another science or practice from our own disciplinary point of view, and, reciprocally, to let another scholar to read our data from his/her own perspective and to force us to rethink our conclusions in the light of discoveries made within another scientific domain. Neurosciences and "neuroethics" could be an excellent test bench of this challenge. Interdisciplinarity is a more difficult enterprise than *multidisciplinarity*, that simply collect the different perspectives, coming from multiple point of view, which regard the same complex object of study.

Another essential methodological premise for dealing with ethical dilemmas is taking seriously the *pluralistic arena* that we live and work in. As in the case of procreation law, it may happen that almost all the citizens see the necessity of a law, to avoid the so called "tube-babies Far West", but their opinions diverge about the legal contents: admitting or prohibiting insemination from donors, surrogate motherhood, embryo selection and so on. If a debate becomes a war based on the principle "nothing or all", whoever wins (libertarian or conservative wings) will prevent the losers from following coherently their moral supreme values in such an intimate and private field like the procreative decision. The minority opinion, not being legally recognized at all in its requests, will suffer a deep wound (whose consequences are likely to disturb and hinder the future dialogue on similar topics), and it will be tempted to sabotage the implementation of the bill, to conceal forbidden behaviours or to find alternative solution, like procreative tourism. Even for people believing in a universally knowable ethical truth, pluralism may be a positive condition to foster dialogue and to deepen one's own position. Pluralism does not necessarily lead to the heavy, paralysing

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disappointments over the last years. See for example E.R.DuBose-R.Hamel-L.J.O'Connell, Eds., *A Matter of Principles? Ferment in U.S. Bioethics*, Valley Forge, Trinity Press Int., 1994.

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<sup>5</sup> See our book *Bioetica. Metodo ed elementi di base per affrontare problemi clinici*, Milano, Elsevier, 3rd Ed., 2006.

consequences of the extreme skepticism or relativism<sup>6</sup>, which affirm that moral values are nothing but the private, unquestionable expressions of emotional drives, that are disconnected from rational reasoning.

Now, if a mature society liked to frame *common criteria* for promulgating a new law in a controversial matter, it should abandon fanatical and fundamentalist hypothesis and ask each "thinking-family" to rank the priority of its own moral points, by distinguishing what can't be renounced (its moral "core") from those demands that might be negotiated or even delayed and postponed. In Italian law, the Catholic position, in some way, has prevailed, but, as a Catholic thinker, I have been asking the following question: what would happen if my religion were *minority* in a Huxley's State<sup>7</sup>, where only extreme forms of artificial reproduction took place, and if the right of naturally procreating within an religious heterosexual marriage were neglected or fought? Wouldn't we Christian families oppose such a law? Wouldn't we ask an abrogative referendum? Wouldn't we judge as an unfair offense the decision of the presumed majority not to participate in the vote and to recommend the abstention? The Italian results of the wrong strategy of inviting to escape the polls are serious: a bargaining atmosphere has been darkened and we still don't know if the greater part of Italian people actually favour the present law in a convinced and informed way. In fact, in the large portion of abstentionists there have been also lazy, misinformed, indifferent citizens. The hypothesis of a "veil of ignorance" should work in moulding our future laws: if you don't know who will win the election, what do you think it is right to previously agree with your opponents<sup>8</sup>?

As you see, dealing with this kind of problems entails not only that we deepen our personal ethical position, but also that we image and trust a *vision of a just society*, where minorities and vulnerable people rights are protected, and where - at the same time - conditions are set for an open, transparent, respectful debate, in the hope that the best solution will persuade reluctant interlocutors, instead of imposing them heavy forms of veto. An example concerns our position. A religious person, who is morally against in vitro fertilization from donor (for the reason that a stranger gets in an intimate loving story of a couple, gives birth to someone, and then completely disappears without bearing any responsibility for what has happened), might nevertheless oppose a prohibitionist law. We have got no sociological evidence that children born from

an heterologous insemination suffer severe mental disorders or that family institutions are destroyed. Therefore, at least one kind of Christian position could limit to bet that its vision of a worthy "coming into the world" would convince, day by day, social experiment after social experiment, the supporters of a different cause. Generally speaking, moral traditions have to put themselves to the test of the new technological alternatives and historical choices, just to know in which sense their ethical heritage is still rich of fruitful perspectives.

#### At the end of life

A common front, established among secular and religious moral traditions, can oppose - we hope - medical overtreatment, improve advance directives, prevent paternalistic attitudes, implement hospice solutions for poor and lonely terminal patients, defend terminal palliative sedation. But an hard point of disagreement remains and it regards ill persons in persistent vegetative state (PVS), that we define, in the context of this article and for the benefit of a clearer discussion, as the condition where no awareness (no sentience, no feeling of pleasure, pain, thirst, hunger and so on) is anymore possible, forever.

We would like to ask ourselves: is it possible, even in this topic, to follow the recommendation by the Italian Conference of Bishops, *Communicating the Gospel in a Changing World*, June 2001, when they remember that non believers might have something to teach us believers, regarding the understanding of life, so that, in unexpected ways, the Lord can make His voice be heard thanks to them<sup>9</sup>?

Some ethical agencies affirm that artificial nutrition and hydration (AHN) are always morally proportionate and ordinary (in the sense that it is morally wrong to withdraw or withhold them), if they produce the foreseen nutritional results, if economic resources exist and if no adverse effect or physical inconvenience arise. This is also the conclusion of the Congregation for the Doctrine of Faith, responding (on Aug. 1, 2007) to some U.S. Bishops' questions. Even if this position underlines correctly a presumption in favour of life, defends the personal dignity of disabled patients, recommends a just allocation of resources for ill persons and their families, and gives voice to the weakest members of our human family, its peremptory style and brief final statements have caused some perplexities in several ethicists. We summarize here the main critiques<sup>10</sup>.

First of all, it is impossible to ethically evaluate a moral action, without taking in account *its meaning* and such a meaning can be understood only within a human story, the story of a moral agent with his/her values, feelings, style of living, relationships, ideas of

<sup>6</sup> See this distinction in S. Veca, *Etica e verità. Saggi brevi*, Fondaz. Europea G. Venosta - G. Casagrande Publ., Milano- Lugano, 2009, p. 37

<sup>7</sup> A. Huxley, *Brave New World*, 1932; Id., *Brave New World Rvisited*, 1958 (Ital. transl.: Milano, Mondadori, 1971).

<sup>8</sup> I have in mind for example the precious ethical experiment outlined by R. A. McCormick, "Abortion: the unexplored middle ground", *Second Opinion*, 10, March 1989, pp. 41-50.

<sup>9</sup> See p. 28.

<sup>10</sup> The literary genre itself of the Document hasn't been quite helpful in order to deepen the ethical reasoning. See our Editorial "La professione medica oggi. Dilemmi etici", in the Journal *Riv. Ital. Med. Leg.*, 2008, n.6, pp. 1205-1225.

beauty, vision of a good life<sup>11</sup>. Precedent events, consequences, cultural background, subjective affections and intentions, all this cluster of ingredients make up the *context*, that guarantees a faithful interpretation of the *text*, represented by each human deed<sup>12</sup>. The same kind of action, as described from an external, detached and impersonal point of view, might have different and even opposite meanings, if it is seen in the concrete light of specifically different situations and stories. Meaning depends on stories, stories depend on characters, and characters are defined by the promises they make to themselves and to others.

Now, PVS is a tremendously new condition, usually created in the last decades by intensive care unit, a condition that legitimately receives *different interpretations* and therefore reveals *different meanings*. Some people would like to be indefinitely sustained by ANH, if they fell in PVS, because they recognize this condition as not particularly repugnant, but rather an amplified, extreme figure of the weakness and dependency, that mark every limited human life and that needs an adequate respect, care, attention by the entourage. Other people, who treat as well patients in PVS as living persons, having the same right to care of every other patient, think notwithstanding of this condition as a painless torture, an artificial stop of the dying process (caused by a severe encephalic injury), an invisible prison, a defacement of personal dignity, an exile in which a person is confined, without the possibility of even expressing the primary message "please let me go".

Let me go, let me die. This last position - we think - can be rightfully taken also by Christian and even Catholic believers, because it is *not* equivalent to a *suicidal attitude*. They rather make a discernment and consequently balance benefits and burdens of the life sustaining treatments, to conclude (signing a specific advance directive) that their life has not to be prolonged at any cost, not at the cost of this kind of survival. As you know, in Christian moral tradition, life is a fundamental, basic, but not a supreme or absolute value, so that the main duty is living a good life (good in a Christian sense) and not expanding it as more as possible. Life has rather to be spent for just causes and in the effort of achieving supreme values, even if that implies putting life at risk. This is

<sup>11</sup> For the notions of biographical unity and vision of a good life see A.C. MacIntyre, *After Virtue. A Study in Moral Theory*, Notre Dame, Univ. Notre Dame Press, 1981. We have rethought this book referring to end-of-life clinical cases in P. Cattorini, *La morte offesa. Espropriazione del morire ed etica della resistenza al male*, Bologna, Dehoniane, (2nd ed. with a new Afterword), 2007. For the problem of PVS see: P. Cattorini-M. Reichlin, "Introduction", e "Persistent Vegetative State: A Presumption to Treat", in *Theoretical Medicine*, Issue on "Decisions of Medicine at the End of Life" edited by P. Cattorini - M. Reichlin, v.18, n.3, Sept. 1997, pp.217-219, 263-281.

<sup>12</sup> For the notion of action as a text, see Paul Ricoeur's philosophical researches, for example P. Ricoeur, *Soi-même comme un autre*, Paris, Seuil, 1990; Ital. transl. *Sè come un altro*, Milano, Jaca Book, 1993.

the only way of honouring and not morally impoverishing its dignity.

*"In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case."*<sup>13</sup>

If we don't recognize and respect both these different personal evaluations of ANH in PVS, we stifle one original vision of world and suffocate one kind of religious spirituality. It is not an overtreatment if we sustain for years and years people who need and want ANH and it is not a passive euthanasia<sup>14</sup> stopping such a treatment, if the patient had beforehand requested it in an informed, free and competent act of will, and if the society has freely offered all the services and resources needed in both cases.

Unfortunately, the "winter of clinic" (in the sense that clinicians surrender to the technical injunction to repair the broken gear) ties up with neo-paternalism, by expropriating moral autonomy. It is an amazing vice to shift *from a personal dimension to a professional one*, giving the physicians the last word in the matter, and asking healthcare professionals to decide if a treatment (in this case ANH) is or not a proportionate one. The only thing that a technician may evaluate is the efficacy of a therapeutic mean, that is the capacity to obtain some biological results. But when we use the term "proportionate" (an aesthetic term, one of the classic necessary features of a beautiful work of art), it means the congruity, the fitness, the harmony existing between that form of care and the human world, the personal values, the existential style of a patient. It is neither a physical nor a psychological matter: it is an ethical one, and no technical expertise or scientific knowledge could transform a doctor in a moral judge. If this shortcircuit sometimes happens, due to social or ideological pressures or to professional arrogance, technicians usually cast their moral shadow in the bedside situation and substitute their own ethical stance for the patient's one.

We deeply worsen the quality of reasoning if we define ANH not a medical treatment but a daily, *elementary form of caring*<sup>15</sup>. If you attend a symposium about artificial nutrition (a kind of treatment originally thought to aid transient digestive diseases), you have to realize that an entire staff of technical competences is needed (surgeon, internist, gastroscopist, nutritionist, specialized nurses and so on) to position, control, monitor and periodically

<sup>13</sup> Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Vatican City, 1980, pp. 9-10.

<sup>14</sup> Catholic moral tradition condemns both active and passive euthanasia, as they are both seen as forms of rational assisted suicide.

<sup>15</sup> Against the thesis affirmed by the "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the PVS", *Neurology*, XXXIX, 1989, pp. 125-126.

evaluate the efficiency of the device and its biological consequences. Relatives or friends of the patient may learn and implement some manoeuvres (as it happens also for artificial ventilation at home), but the methodology needs a technological leadership and responsibility. It is something completely different from keeping a body warm, clean and dry or from making sweetly a bed. The term “elementary” itself has several meanings: elementary for whom? Compared to what? At which level? And for what reasons? One boy may find it elementary to learn tennis, another may find terribly difficult to hold the racket.

As we have shown in other texts, metaphors and narratives interweave ethical and even clinical reasoning<sup>16</sup>. Then it does not astonish us that *rhetorical figures* connote both daily and scientific discourses. But this dimension has to be critically analyzed, not to become a subtle form of propaganda. “Giving water and food” or “offering somebody something to drink and eat” is quite diverse from artificially nourishing a comatose patient. Daily language words are stripped out from their authentic use and twisted to normalize something that is morally controversial. This linguistic tactics hides an ethical evaluation, that rather would deserve to be rationally justified and debated. “Eating” is voluntarily putting something in our mouth, tasting and usually enjoying it, chewing and swallowing it, and then feeling a sense of satiety. “Giving something to eat” usually means helping someone to make such an experience, filled with perceivable psychological, cultural and moral significance. Is this what happen in ANH? We understand the usual ethical importance of feeding someone, that is expressing, in an elementary way, the respect and care we owe to every member of our society, especially to the weakest and most vulnerable ones. But this respect, not to fall into a paternalistic bias, has to be thought and revealed through the interpretation of the *meaning* of the action, and some people, who thank anyhow the social helpfulness shown toward them (the readiness to hydrate them with devotion and skill), have the right to tell anyone in advance that they consider a wrong decision the choice of prolonging artificially and endlessly a sort of “dreamless sleeping”. Caressing a child is normally a tender act, but in some situations and for some children it might sound as a dangerous omen of violence.

Finally, it is bizarre to redefine these life sustaining procedures as “natural” instead of “artificial”, stating that they would guarantee the normal alimentary

needs, by giving stability to the nutritional functioning of a non terminal patient. If “natural” is used in a medical sense, it sharply contrasts the scientific consensus statements, that actually talk of “artificial” NH<sup>17</sup>. If “natural” is used in a *prescriptive* sense<sup>18</sup>, it presupposes the ethical conclusion that rather should still be demonstrated: the conclusion that is always a moral duty prolonging ANH in PVS. In this case some ethical questions have to be raised: why such a primary importance is given to the digestive system? Its functioning is of course essential for life, but the same thing could be said of the respiratory, cardiac or urinary systems. In the condition of PVS, should all these biological systems, in case of their failure, be indefinitely replaced by artificial devices (artificial ventilation, dialysis, and so on), for the reason that the patient is not strictly terminal (in the sense that his life may go on, if medically assisted)? Wouldn't this attitude lead us to the so called technological imperative: “apply any available technological resource to keep life at any cost!”, an imperative that sounds terrifying even in a science fiction tale? Furthermore, if the word “natural” or “normal” is identified with “proportionate” (in the sense that ANH reach its biological aim), you give rise to an ethical misunderstanding, because the proportionality of a treatment has not to be referred to the homeostasis of the living organism and it is not measured with reference to the hydrosalty equilibrium, but to the global interest of a person, with his/her values, beliefs and preferences. It would be “unnatural” and “abnormal” ignoring this anthropological dimension.

Instead of building rigid decision-charts, hard medical dilemmas have to be prepared through an advanced, informed, competent and non-directive communication, that takes in account the critical, general interest of a person, who is shooting (in the sense of cinema) something like the final sequence of the precious film of his/her life, looking for an happy, just and worthy end<sup>19</sup>. Such a dialogue might be improved by the presence of an *ethics consultant*, not to deprive patients, families, health operators and psychologists of their voices and responsibilities, but to facilitate the interdisciplinary debate and deepen the ethical nuances of the decision. Consultation is a frontier-land, at least in our European Countries, and sometimes it is burdened by vices and naivetè, but the challenge has to be taken up, not to leave the matter in the hands of charlatans, of frauds, uninformed dogmatizers, or of primitive and savage moral gamblers<sup>20</sup>.

<sup>16</sup> P. Cattorini, *Un buon racconto. Etica, teologia, narrazione*, Bologna, Dehoniane, 2008. See also our articles: “The Desire for Children and the Experience of Illness. A Christian Ethical Perspective”, *I supplementi di Tumori*, v.3, n.3, S171-S175, 2004; “Narrating Pain: The Role of Medical Humanities”, *Eubios Journal of Asian and International Bioethics*, v. 16 (6), Nov. 2006, pp. 177-181; “Aesthetics in Ethics: Narrative and Theoretical Dimensions of Moral Evaluation”, *Eubios. Journal of Asian and International Bioethics*, 19, March 2009, pp. 47-53.

<sup>17</sup> To deepen these aspects, read C. Tollefsen, Ed., *Artificial Nutrition and Hydration. The New Catholic Debate*, Springer, Dordrecht, 2008.

<sup>18</sup> In a descriptive sense, it merely means that a event usually (*ut in pluribus*, in Latin words) happens.

<sup>19</sup> See. R. Dworkin, *Life's Dominion. An Argument about Abortion, Euthanasia, and Individual Freedom*, 1993 (Ital. transl. *Il dominio della vita*, Milano, Ed. Comunità, 1994).

<sup>20</sup> P. Cattorini, *Bioetica clinica e consulenza filosofica*, Milano, Apogeo, 2008.

### Reshaping the body

Another important issue, which ethics in advanced medicine deals with, refers to the aims, scopes and limits of medicine<sup>21</sup>. Waiting? Or shooting the patient? Or taking the leg off? – to use Hemingway's words. Medicine has become a sort of secular religion and questions, that traditionally had been addressed to priests or philosophers, are now the matter of medical or psychotherapeutic decisions. At the same time, ethics (generally, the philosophical consultation movement) is fortunately regaining some of what has been expropriated by science, but the fight for independency is quite hard and some people have difficulty in understanding the difference between *how* questions (how to manage this disease? how prolonging the life? how in vitro inseminating an infertile woman?), and *why* questions (why looking for a delayed but worse death? what is the moral meaning in generating a child? why telling patients the truth?). With the excited complicity of some pharmaceutical market, of powerful health care institutions and of celebrated specialists, medical knowledge has settled regions of life and of ordinary experience, that common people were used to live, handle, share and administer with their own wisdom, practical skill and mutual cooperation.

One of the most impressive example of "cultural iatrogenesis", to use Illich's words<sup>22</sup>, is the *palliative myth*, the illusion of a pain free world and of a suffering free life, under the governance of anaesthesia vestals, who declare pointless bearing with full awareness the pain and living crisis situations, instead of taking off consciousness by artificial means. Fostering the moral strength to keep own's one feeling power, in spite of pain and through suffering phases, is deemed a primitive, out of fashion, foolish masochism, when sedative medical devices are available (drugs, Caesarean section delivery, epidural anaesthesia, and so on). Beyond what line technical progress becomes a tempting, unreasonable fashion?

What scope the medicine should have? Our opinion is quite simple: it is *properly medicine* every act who tries to heal a sick person, using scientific competence, technical skills and/or empirical knowledge. The reason is that, in our philosophy of medicine, the core of medicine is the *clinic*, that is the moral enterprise of caring for an ill person. In this sense medicine is not, first of all, an applied science, but a covenant between a suffering person and a caring expert (an individual or a team): two allies who decide how much knowing and doing for the benefit of the weaker. As you can see, the heart of the matter is the *intention*, along the Hippocratic tradition

(but avoiding any past paternalism<sup>23</sup>) of healing the sick, in the different directions that the purpose of beneficence can take: to cure, to care for, to sedate, to prevent, to rehabilitate someone who suffers for an illness. The clinic is the core, but it seems to be in winter, hidden by the snow of controversy. Let's draw the consequences of our thesis.

What exceeds the *caring field* does not deserve, in a strict sense, the title of *medicine*, even if it possesses some material elements belonging to medicine: technological competences, for example, or scientific doctrine. If an unjust government causes social malaise, this is not a medical problem (the ideological use of psychiatry in totalitarian regimes was unfortunately an eloquent example of this confusion). If a technically skilful dentist drills the teeth of a *marathon man* (as in the movie picture directed by Schlesinger in 1976) not to cure his caries, but to torture him in order to obtain some information regarding diamonds, that dentist is not practicing medicine, but simply making use of medical expertise. Another instance: some kind of aesthetic surgery (the *Hastings Report* says) are *non medical*, but socially acceptable *use of medical knowledge*. Take for example a television star, who asks for a surgical intervention of breast reshaping, neither because of some somatic disease nor anxiety disorders, but - she confesses - because she needs new contracts and her beautiful and healthy breast forms are out of fashion. Well, this desire (from our point of view) is not a medical need and a physician should decline, on principle and generally speaking, to satisfy the request.

The same thing might be maintained about granting the demand of a body artist, who needs an abdominal incision for his next performance: a public exhibition in a well known museum. Not even the desire of a deep, invasive piercing can justify a medical intervention. The physicians' duties are not to make everything that might have serious psychophysical consequences, if it is done by an incompetent layman (like a piercing inserted in septic and antihygienic manners), but to follow the social promise of acting in the interest of the patients, and not to serve other aims: economical, scientific, political or whatever else. This is the basis of a beneficent profession and of its code of ethics. On the contrary, if advanced society needs a technician, ready to fulfil every desire formulated by informed, free, competent, paying clients or by customers associations, then medical schools will have to create (besides the traditional figure of physician) a second kind of profession, free from Hippocratic Oaths and from ethical boundaries. We suggest to call *iatrotechnicians* these new kinds of body-rebuilders.

In the first legal trial, where I have been invited, as an ethicist, to act in front of an Italian Court as an expert appointed by the lawyer for the defence, the prosecutor asked the conviction of an African woman for complicity in abuse of medical profession. The woman was a Catholic one, but she wanted her son

<sup>21</sup> A famous international Report by Hastings Center is devoted to the issue. We have read it in the Italian translation "Gli scopi della medicina: nuove priorità", appeared in *Notizie di Politeia* (Milan), 13, n.45, 1997.

<sup>22</sup> I. Illich, *Limits to Medicine – Medical Nemesis: the Expropriation of Health*, London, Marion Boyars Publ., 1976.

<sup>23</sup> E.D. Pellegrino – D.C. Thomasma, *For the Patient's Good*, New York, Oxford Univ. Press, 1988.

be circumcised, one month after his birth, for ethnical reasons, as a sign of their cultural and geographic origin. Such a practice was still quite common, and even known and tolerated by the Catholic priest, an African himself, pastor of that Afro-Italian spiritual community. Unfortunately something went wrong: another woman, a friend of the mother, who was used to make this kind of interventions in a private flat and in hidden ways, made the child bleeding. He was brought to an emergency department and the visiting doctor reported the fact to the police. The public defender (the mother had no money for private lawyers) asked my help because he found out that, some years before, I had written an opinion dissent in a statement by the Italian Committee for Bioethics<sup>24</sup>.

My dissent was quite simple: a *religious* male circumcision is not justified on a clinical basis<sup>25</sup>, but on ritual grounds. Therefore the intention is not a therapeutic one and the act doesn't deserve the label of "medical" in the strict sense we have explained above. In other words, I cannot see ethical reason to qualify as clinical intervention a religious act that generates a (even though little) physical breach, generally produces some discomfort in the child and leaves indelible and irreversible bodily marks (I'm translating some Committee Document's terms), even if no impairment of sexual and reproductive functions is created. An act, I would like to add, that obviously cannot be approved by the informed consent of the (under age) citizen involved.

Moreover, I can see no substantial difference between religious, ethnical or simply *private* bodily injuries ("private" means: based on the individual, secular value preference of someone). To avoid any sort of discrimination, the consequence of our point of view is that no physician (working in public or private institution: it doesn't make difference) has a duty to perform such kind of gestures. What's more, an health care professional should not violate the social promise, that he will act only for the good of ill

<sup>24</sup> Comitato Nazionale per la Bioetica (CNB) (Roma), *La circoncisione: problemi bioetici*, Sept. 25, 1998, Presidency of Council of Ministers. Beyond my dissent, within the Committee the positions were not unanimous. All the experts condemned female infibulations, but for some members, the male religious (ritual) circumcision in a newborn (usually Jewish children are circumcised at the 8th day; later on for Islamic ones), could be made by religious ministers specialized in the practice and having trained an appropriate and acknowledged competence (even if they are not health care professionals), because the intervention is deemed quite simple. The ministers should also warrant the assistance that might become necessary, if something goes wrong after the rite. The reason of this tolerance is expressed in the Document: those members evaluated as inopportune the medicalization of religious practices. I completely agree with this concern. These paragraphs are nothing but the paraphrase (translated in English) of my disagreement.

<sup>25</sup> The premise of my statement is that, as I know, there is no certain, complete and final epidemiological evidence that circumcisions prevent genital diseases, in such a way that it should be universally recommended by pediatricians.

people. Religious circumcision should remain *out of the medical sphere*, unless a specific article in the professional code of ethics and an explicit state law require physicians' help, for the sake of public order, but these exceptions must remain few, democratically approved and transitory. We can allow a surgeon to heal the broken wing of an eagle, if no veterinary is available. But it must be clear that this is not a medical duty.

To avoid interferences between religions and medicine, to prevent undue medicalization of cultural traditions and to oppose dramatic collusions between medical power and arbitrary individual desires, medical ethics should defend its beneficent intention. In the case of male circumcision, my proposal was that it is administered by imam, rabbis, generally speaking by religious ministers, who will bear the legal and moral responsibility of their performances. Of course, it would be useful (and perhaps legally required) that they attend preliminary lessons and make a good training, under the supervision by medical experts, to assure a satisfying level of hygienic and sanitary safety (as it happens for piercing offices). When the circumcision is performed in adult people and the intervention becomes quite similar to an invasive surgical intervention, the only solution I see is to require that the religious minister is a medical doctor in every respect.

Let us take an other debated example. It is quite easy and common to criticize the *doping* in sports and to establish punitive rules for physicians found guilty of complicity. It is less easy to offer ethical reasons supporting such blame. If medicine extends its domain by including any kind of invasive body reshaping, if no professional moral promise exists but following the competent, free and informed desire of a paying client, if the quality of life (interpreted as the arbitrary, boundless customers' desire of a better existence, even in the absence of any diagnosed physical disease or mental disorder) is the only criteria to define the proportionality of a biomedical treatment, then it is time to say farewell to codes of ethics prohibiting the use of some performance-enhancing substances. The difference itself between use and abuse would be fated to disappear. The movie picture *Any Given Sunday* directed by Oliver Stone (Usa 2000) is a faithful, upsetting portrait of this moral storm.

The economic market pressures, the managers' ambitions, the advertising allurements and the cruel competitive atmosphere, we all know, will create dangerous slippery slopes. But dangerous for whom? An athlete might evaluate as minimal or tolerable risk a drug adverse effect, because he/she evaluates some sport results as a primary end of his/her own life and he/she would judge *paternalistic* any refusal of cooperating with such a project. Even the objection of *unfairness* has received coherent replies: if all the sportsmen (in either agonistic, professional, or amateur-practices) were allowed to get the drug (and even gene-doping) they need or want, in a transparent and libertarian way, this technical manipulation wouldn't contradict the gentlemen

agreement of loyalty and of an equal starting-point, that the contest requires. Who can and want to take a substance or to use a prosthesis, he/she would be allowed to do it: personal will is respected and the starting point simply reset. Isn't sometimes the natural lottery itself a more scandalous discrimination among runners?

How could we solve the dilemma? Lists of banished products are based upon agreed rules of conduct, and the rules upon ethical principles and theories, but - last of all - ground narratives and visions of a good life (of a fair sport, of a beneficent medicine, of an healthy body) give the philosophical framework, the convincing language and the leading metaphor, by which individual and societies might mould together an ideal and a treaty about what represents a worthy and happy mutual respect and aid. We need parables, rooted in religious or secular environments, to draw an universal contract of giving and receiving, in the world of sports, too.

### Conclusions: what metaphors, what tales of care?

Sometimes the ethical heart of clinical enterprise seems so confused, ambiguous and anaemic as the scared, chilly, tired body of a rash beast of prey, which has lost its own way. In the three contexts we have examined, it is clear that advanced medical science and practice require a *new ethics*, which is not based upon abstract, impersonal and general principles, whose meaning may seem *prima facie* univocal, but admits, in a hidden way, so many different points of view, that the theoretical structure and the intellectual coherence of the syllogistic moral deduction collapse in front of the relevant dilemmas, we have to face in our society. To make an effective use of terms like "proportionate care", "responsible desire of child", "properly medical scope", "fair sport", we have to rediscover the stories of origin, the mythical narrative, the visions of just society, where theories, concepts and principles take roots.

An *hermeneutical-narrative ethics*, that recognizes the symbolic dimension of our thinking, the generating metaphors of our language, and the aesthetic feature of our decision-making framework (also in the medical field), cannot be explained in this article<sup>26</sup>. We have just the room to say that the good action (and also the good medical decision) is like a well-made work of art, that is, at the same time, absolutely original (because it is created once and forever by an individual artist) and universal

(because it claims the approval of all the audience)<sup>27</sup>. In a similar way, a good action deserves to be made unconditionally, for the reason that it honours the moral agent's desire both of happiness (the old Greek people would have said "of *eudaimonia*") and of justice (by opening a world, where everyone might be treated with equal compassionate care).

Advanced medicine needs these symbols of solidarity and the strength of an ethical vision (about the beginning and the end of life, the meaning of care, the value of body, the scope of sport-performances), not to stumble in an embarrassing humanistic stammer. Acting for the good of suffering persons requires a rationally justified synthesis of scientific knowledge, technical expertise, sense of justice, moral integrity and sensitive style of relationship. There has to be *aesthetics in medical ethics*, because there is creativity, emotional involvement and perception of elegance in medical practice. A novel can help us again.

"Can't you let a man die as comfortably as he can without calling him names? What's the use of slanging me?" "You're not going to die."

Upon Kilimanjaro, close to one of its summit, there is the dried and frozen carcass of a leopard. No one has explained what the leopard was seeking at that altitude.

When we rightly oppose the evil of death and of malignant diseases, we make a promise, which is worthy, even if we have no guarantee to realize our desire. Something might go wrong and make us loose the way, like that frozen leopard carcass. But we must not give up the pleasure and the duty of narrating the stories and the worlds, that feed our hope as caring individuals and institutions. This is one side of the work of ethics.

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## Sex Selection in Asia, with a focus on Thailand

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### 1. Introduction

Humans are capable of many actions, and also have moral responsibility for their choices and actions. One of the dominant ideas to all living beings is "the continuation of species", or simply reproduction. What makes reproduction so important? Reproduction helps to continue the species and through it inheritable physical and mental characteristics are passed from parents to child. Among humans, there is segregation between two sexes, males and females. In some countries, infants especially females are rejected, avoided or even not allowed to be born by their parents, because of prejudice against girls and women. In this

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<sup>26</sup> See for example our book *Bioetica e cinema. Racconti di malattia e dilemmi morali*, Milan, FrancoAngeli, 2006 (2nd Ed.) and our articles: "Application or Interpretation? The Role of Clinical Bioethics Between Moral Principles and Concrete Situations", *Analecta Husserliana*, LXXII, 2001, pp. 99-115; "Clinical Bioethics. Identity, Role, Aims", *Medicina nei Secoli - Journal of History of Medicine*, 13/1, 2001, pp. 187-197; "Moral Norms and Hermeneutics in Clinical Bioethics", *Medicina nei Secoli - Journal of History of Medicine*, 13/1, 2001, pp.199-209.

<sup>27</sup> *Estetica nell'etica. La forma di un'esistenza degna* is the title of the book we are now preparing.

paper, I will examine the biological aspects of gender differences, methods of sex selection, and some associated ethical and social issues.

## 2. Biological understandings of males and females, and reproduction

Reproduction of all living creatures is divided into two main types - sexual and asexual. Humans use sexual reproduction with males and females. The human genome has 23 pairs of chromosomes<sup>28</sup>, with one pair, the sex chromosomes (X and Y), which determine sexual features biologically, and 22 pairs of autosomes<sup>29</sup> that do not determine sex. The female has a pair of X chromosomes whereas the male has one X and one Y chromosomes.

The process of reproduction is that males produce spermatozoa, which contain XY chromosomes whereas female's produce ovum with XX sex chromosomes. The fastest (and/or strongest) sperms have more chance to fertilize the ovum than weaker sperm. If there is a Y chromosome the embryo formed will be male. The sperm will determine the gender of the offspring, not the egg.<sup>30</sup> In nature, humans cannot predict the gender of the unborn child or fetus, until the time when the mother delivers the child.

## 3. Sex determination of the embryo

Some parents would not be satisfied if the child who is born is not what they wanted or expected. In the past, parents also couldn't take precautions against the defects that the child might inherit from the parents. Nowadays, the world has changed and medical technology has advanced. Biotechnology has been used to provide benefit to society throughout history, but there are also risks that it will be misused. As our knowledge has grown about the stages of pregnancy, reproduction, sex determination and abortion, couples can learn what to expect and can try to avoid the unwanted. The couples who cannot conceive their own children are considered infertile, and some attempt to use assisted reproductive technologies, such as in vitro fertilization [IVF]<sup>31</sup>. Although, IVF is very useful for many infertile couples, gestation is not always successful and being costly could lead the couple to be in a great debt. There is only a 20 percent

success rate for implanted embryos to be born as a baby each cycle (Engelen and Vendevelde, 2004). Some married couples who are experiencing the decline of age and infertility can be desperate to have a child. Other couples may also have the idea of perfection and how their child would be. IVF can be considered as a standard alternative for reproduction for infertile couples. In fact, technology has its way to make our lives easier, yet the technology does have some flaws as well. It leads to new alternatives for human choice and while conception of babies for infertile couples is possible it could lead to discrimination if embryos are selected due to their sex.

There are several alternatives for gender selection for couples. First, preimplantation genetic diagnosis (PGD) is primarily developed for tracking genetic disorders or defects, however it can be also used to practice sex selection. PGD helps to prevent unwanted fetuses who are at risk of inheriting sex-linked hereditary abnormalities from the parents; for example, congenital diseases, Down syndrome, and thalassemias. In the case of autism, some parents may choose girls over boys because there is a reported increased chance of autism in boys (Savulescu, 1999). Consequently, PGD seems to be an appealing decision for the couples who do not feel that they could raise a child with a serious handicap, or else those who think it is painful for the children with these diseases. Of course there are many ethical debates over the ethics of PGD.

The screening of the DNA for physical anomalies or genetic defects usually uses Fluorescence *in situ* Hybridization (FISH) (Malpani and Modi, 2002). It can be used as a screening device for defects that might be inherited or pose a threat to the embryos. However, apart from the reason that has been mentioned, some couples wish to use PGD to select the gender of their infants. Due to the advances of modern technology the sex of the embryo can be detected by a maternal blood sample within 6 weeks of gestation whether, they are female or male (Macer, 2009). Ultrasound can be used from 11 to 13 weeks of fetal growth (Macer, 2009).

The cell or tissue samples from fetuses can be taken through amniocentesis or chorionic villi sampling, and then these samples can be screened by FISH. Ultrasound is widely used, since it is non-invasive, and it allows us to visualise some physical traits of the fetus. Any of the regular methods for prenatal diagnosis can be used for sex selection.

Prior to conception, sperm selection can be used before artificial insemination, where the sperm is injected into the vagina. There are several techniques which separate sperm, either based on their density or swimming ability of those who carry two X or XY (lighter) chromosomes (Parliamentary Office of Science and Technology, July 2003).

There are even more simple methods from popular beliefs that are said to assist as preconception methods for fertilization of particular genders. Some may agree to dieting to increase the possibility of conceiving a particular sex, for example, bananas,

<sup>28</sup> *Chromosomes FAQ*, Genomic.Energy.Gov, Genome programs of the U.S. Department of Energy Office of Science, Founder of the Human Genome project and leader in systems biology research, 12 September 2003 [http://www.ornl.gov/sci/techresources/Human\\_Genome/po\\_sters/chromosome/faqs.shtml](http://www.ornl.gov/sci/techresources/Human_Genome/po_sters/chromosome/faqs.shtml)> Accessed 19<sup>th</sup> April 2010

<sup>29</sup> Griffiths, Anthony J.F., *Sex Chromosome and Sex-Linked Inheritance*, <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=iga&part=A222>> Accessed 19<sup>th</sup> April 19, 2010

<sup>30</sup> *Cell Reproduction*, 4<sup>th</sup> February 2010 [http://anthro.palomar.edu/biobasis/bio\\_2.htm](http://anthro.palomar.edu/biobasis/bio_2.htm) Accessed 18<sup>th</sup> April 2010

<sup>31</sup> What is in vitro fertilization [IVF] and how does it work?, retrieved from <http://www.hfea.gov.uk/IVF.html> Accessed in 20<sup>th</sup> April 2010

grapes, and beans are said to help conceiving male embryo (Liao, 2005).

#### 4. Physical Differences between Sexes

People are judged by their physical appearance everywhere. The first aspect that people see of others is their physical features such as race, skin colour, height. Men and women are judged by their physical structure as well.

It is a universal belief that men are physically stronger than women, what make us different. Basically except for the changes induced by the Y chromosome, women and men are identical having the same genetic structure. The 23rd pair of chromosomes define the sex of an individual. Besides genetics, the feature that separates gender are hormones that controls male and female behavior and emotions. Testosterone is the so-called male hormone, and estrogen is the female hormone. There are variations in the amounts between every individual in a gradient. The hormones influence physical characteristics, for example, comparing male and female voices, the pitch of a women's voice is higher than men due to higher levels of estrogen. It controls voice production features which clearly separate men from women. Not only do these hormones control the brains of males and females during early physical development and later on. Many would say that men and women have different ways of thinking that depend on their brains. A person's behavior is affected by growth hormones, sex hormones and stress, which are also related to the brain's anatomy. "Males and females look different, we act different, so of course our brains are different," said Tracey Shor, a Rutgers University psychologist.<sup>32</sup>

The sex hormones dominate sexual behavior from the age of puberty. The sexual identity of the brain is determined by hormones. In research on animals, an experiment to extract testosterone out of the male animals had the result that the male tend to behave like females despite of their gender. The physical characteristics of males and females are influenced by testosterone and estrogen, respectively. It is generally believed that the sex hormones don't take action until the age of puberty, which is when a person's body will be ready for reproduction. Estrogen and testosterone are both produced in the hypothalamus.

A neurobiologist, Larry Cahill,<sup>33</sup> conducted an experiment in which the subjects were men and women who watched the same emotional film. It the result shows that men were more stimulated on the right side of the amygdala, while women were emotionally aroused by the left side (The amygdala is a brain organ in the limbic system which controls emotion and reactions). The right and the left hand sides don't work the same in both sexes, the left side of the amygdala is stimulated by the outer environment and visual stimuli, and connected with

the visual cortex. The left side focuses on the inner atmosphere of the body producing emotion by senses and experiences. There are some sex-linked tendencies, for example, males are more prone to alcohol and substance abuse, but women are more prone to their depressive and unpredicted emotion. However, we should not stereotype traits to gender.

#### 5. Social construction of gender

##### *Gender and Social Roles*

Most societies divide humans into two main groups by their sexual appearances. Society also determines the genders roles. In every society there are rules that manage everything. There are roles for different people and roles are given such as occupation, titles, and family members. Humans also create that role for each individual, men and women. Throughout history humans have been taking the same path of aggression, war and strife. Men and women have been the victims in the times of conflict, and also in domestic affairs.

The simplest way to categorize males and females is their physical features and behavior. Men are known as being independent, strong, reasonable, smart, yet aggressive, but women are assumed to be dependent, weak, gentle, and passive. Males and females are even stereotyped by their choice of toys during their childhood. Boys play with robots and girls play with dolls. While boys are encouraged to express thoughts and given more freedom, when girls grow up, often they are expected to be responsible for traditional practices. Girls are usually responsible for preserving cultural values and burdens instead of showing their individuality. Males and females have different responsibilities in response to social demands. For example, in tradition, men go to war and fight for their nation, while women look after their husband and children. We could assume that each is responsible for certain duties but why do we keep on encourage competition among males and females, instead of supporting compassion and admiration, and welcoming new changes of social roles among both sexes?

Obviously, males and females are responsible for different tasks, but in many cultures males are considered superior to female. Women have always been portrayed as an object in the family. For instance, there is a saying that "*There are three non-filial acts: the greatest of these is the failure to produce sons.*" (Confucius).<sup>34</sup> Women are simply a tool for reproducing male infants to serve male-oriented social expectations. Eventually women are obliged to have a son to achieve a better family hierarchy and societal status, whereas those who don't produce a son face ignorance and discrimination. Women themselves also struggle for a better status in the family. In the same way, the Chinese prefer a boy over a girl because of their male supremacy beliefs which have continued in Chinese families for many centuries. A son means the survival of the family line, whereas daughters are

<sup>32</sup> Kotulak Ronald, *Tribune science reporter*, 30<sup>th</sup> April 2006, Accessed 20th May 2010

<sup>33</sup> Kotulak Ronald, *Tribune science reporter*, 30<sup>th</sup> April 2006, Accessed 20th May 2010

<sup>34</sup> Retrieved from <http://www.womeninworldhistory.com/lesson3.html>

married out and have male children. The borrowing of Chinese characters in Korea, for example, affected Confucius male preference, when it was first spread and adopted at the beginning up to the middle reign of the Choson dynasty which still exists in Korean society and culture until now. The strong kinship is linked to male preference, where the roles of family members are fixed traditions of authority kinship (Chung and Das Gupta, 2007). Men and women through the centuries have been given roles as a part of a patrilineal social structure. Consequently, the strong preference for males by people was followed and implicitly agreed upon, with corresponding assignment of roles. This is maintained perpetually.

To conclude, we can see three general reasons for male child preference. First, the symbolic significant of continuing the family line. Second, they inherit power status from adults. Third, sons were financially empowered by being responsible for their parents, whereas daughters do not hold much power or authority in their household (Bélanger, 2002). All in all, since the domestic role of women in a family is disvalued and not appreciated, therefore, they are dependent. Many years of constant stereotyping may lead to serious practices against women. From these ideas the perspective of desiring sex determination is more understandable.

#### *Gender-based stereotyping*

Stereotyping is a generalization of some aspects of certain issues. The perception of gender is determined by socio-cultural norms. There are rules for social conduct for each gender which are intrinsically practiced by people in each society and culture, and among specific groups. I would like to focus on gender stereotypes, which are reinforced in our mind as soon as we are born.

Men are expected to be strongly independent and unemotional. They are encouraged to be involved in sports and competition. Men are generalized as a leader and risk taker. However, in one study, where the subjects were male patients with cancer for one to five years, it was shown that had experienced nervousness and anxiety. They were allowed to choose a place of their own. Men were told to abstain from the liberty of personal expression, many of them had never sought assistance and a few of them privately cuddled stuffed toys, wept in their cars, or even took time away from their family in order to seek their own comfort. They followed the concept of "self control" which is expected of men (Moynihan, 1998). Men are forbidden to show their frustration and fear. Men are highly regarded because they withstand the pressure by their high social standing in a so called patriarchal society, which ironically forces them to suffocate their own freedom, and even though at times men are weak, and need an opportunity to show grief as a right of expression and comfort. Compared to women, they have more advantages for seeking shelter, being protected, giving and getting emotional support from both sexes while men are hiding and suppress their grief.

What are stereotypes of women and the prejudice against them? Women are emotional, compassionate, sensitive and gullible. The ability of understanding mathematics of women is considered inferior compared to men by some psychologists and biologist (Fausto-Sterling, 1985), due to the difficulty of having menstruation and having a different brain structure to men. Normally, most women have experienced menstruation which is linked to their biological roles for ensuring future generations. This illustrates that women may be discriminated in their whole being, in a sense judged as "guilty" from their age of puberty. However, men also are biologically designed for reproduction, and have particular issues from puberty onwards such as production of sperm, in the same way. Stereotyping gender roles will not have positive consequences to end misogyny. New techniques of sex selection using assisted reproduction have led to further serious gender discrimination.

#### **6. Traditional practices against women's rights and freedom**

India has a practice called the rite of Sati (Machacek and Wilcox, 2008). The sati rites originate from the story of a chaste lady called Sati, who cremated herself for her husband Siva, because she could not stand her father's humiliation of her husband. The rite itself is known as a ceremony in which a wife is willing to die by being burnt on the funeral pyre to follow her dead husband after his death. If a wife complies to the ceremony she will be considered as a goddess; therefore, the death of willing or unwilling wives causes the expectations of women which is at the same time against human rights and sovereignty. The rite of Sati lessens the women's worth in Hindu society. For example, in the epic of Ramayana, Meghanatha's wife, Sulochana<sup>35</sup>, cremated herself to death in honoring her dead husband.

These traditions all contribute to the social preferences of the gender of infants? A woman who delivers a female infant is considerably wronged or mistreated by not giving birth to a boy due to the financial burden that would be coming later on because the parents of a woman have to have pay a dowry to the groom's parents. These cultural practices illustrate how the child being born as a girl has to experience many challenges. With this line of thinking, some Indian people don't want to have a baby girl. Women will be a burden on the family. Once they get married, the dowry is paid to the groom's family. There are also some cases of bride burning as a consequence of low dowry payment. The family of the bride must pay the dowry for the groom's family, and if the payment is not as high as they wanted, the bride may feel that she should commit sati practice. The social system has worked its way to develop a great deal of discrimination

<sup>35</sup> Indian epic values: Rāmāyaṇa and its impact: *Proceedings of the 8th International Rāmāyaṇa Conference*, Leuven, 6-8 July 1991, Gilber Pollet, Peeterspublisher, pg.63, retrieved on 11 August 2010.

against women, and also to high levels of physically abuse and even death to women. The repeated scenarios of abuse against women can be seen in many societies.

Hofstede<sup>36</sup> has categorized what people value in groups in their society around 50 countries, and divided between collectivism and individualism. A collectivist society focuses on the entire society, is family oriented, community-based, promotes interpersonal harmony, and avoids conflict. While the second type, individualistic societies tend to value self-respect, freedom of speech, be liberal, promoting self-fulfillment, individual needs and satisfaction. Collectivist culture is seen in countries such as India and China, mentioned above. They are ones where people agree on consensus, whether people in the society are valued on any matter.

One of the famous Chinese philosophers, Confucius said that *"disorder is not sent down by Heaven, it is produced by women."* We can see this when an infant is born with defects or deformities, the mother is the first one to blame. This attitude not only affects the discrimination of female fetus but the female in general as well. Where does this idea come from? Is it appropriate to put the blame on patriarchal collectivistic societies?

India also highly values men similar to China and Thailand as collectivistic cultures. Due to the fact that India is also a collectivistic society this practice is commonly practiced among many Indians. This practice devalues females in the society thus contributing to female infanticide. In one study of a group of 450 women in India who went to an urban clinic, 430 women aborted their female babies (Malpani, 2002). Another paper examined preferences for boys in Northern Vietnam. In families of four persons or more, the families try to reduce their girl members, and continuously, having boys, they are affected by having small land ownership which causes poverty. Married women without sons are blamed by the family that they do not have sons (Bélanger, 2002).

Imagine if more than half the women in a country have experienced sex selective abortion. The sex ratio would obviously become imbalanced and this would be followed by a drastic change in the society. What type of changes would this make in society? Nathan Keifitz, a demographer claimed that sex selection abortion may change gender inequality because it reduces the proportion of women, and therefore this could even make the remaining women potentially more powerful (Bélanger, 2002). On the other hand, there is an estimate that if there are too many males, the rate of prostitution will be increased. The scarcity of women may make it even more harder to find mates leading to polygamous marriage, in addition to higher rape rate, abduction and incest (Macklin, 2009). There could also be increased homosexuality. The ratio of males to females is very important to maintain, as we can imagine what could happen in the future if the ratio of

both sexes is greatly imbalanced? The ratio of males and females in the population should be equal. If women are the majority, the male would not find a difficulty in finding their mates; on the other hand, some women could not find a mate. We shouldn't ignore the social consequences of imbalanced sex ratio in the population.

## 7. Parental rights and limitations on gender selection

"Why can't we get what we want?", this classical question leads to a further discussion on rights and limitations. This question has been asked by many people in every class and society. In the case of sex selection, why cannot we decide the sex of our baby, and who would be troubled by our decision? On the other hand, why we attempt to design our daughters and sons lives? There are no parental rights to end sons or daughters' life. This should be a clear limit on parental rights. We still, however, have to consider what can be rights and limitations of parents. Basically, parents hold the rights of parenthood which decide a number of things for their offspring. There are many possible ways of making a decision in parenting which are conveyed by cultural norms and social contract, in a form of sex preference. For instance, India is economically and socially supportive of boys, while girls are the victim of the mainstream culture and so on. The notion of autonomy of parental gender based selection seems to be choice of the couples. As many studies mentioned, the mothers appear to choose sex selective abortion by their choice, however, in a deeper aspect the choices made were strongly influenced by their mates, parents and in-laws in response to the threats of physical abuse, for women to deliver male infants (Oomman and Ganatra 2002). The decisions to abort or kill their own sons or daughter is not an easy one to make, and the practice was somehow associated with the low income of families, economics, and the failure of contraception and family planning. We can see the cultural influences and societal pressure. The smaller scale of society is looking at each household and within each household consists of persons with specific roles. The roles of family members can also be influential in decisions to abort or not to abort the child. Nonetheless, abortion after sex selection is not a decision made solely by the family but includes the wider socio-environmental surroundings.

## 8. Religious laws or doctrines

Some religious scriptures and customs include discrimination against females. For instance, according to Manusmriti of Indian Hinduism, [or as known as the laws or ordinances of Manu], apart from the caste system, it is also included the female-biased ideas which mentions Hindu women are restricted to live their lives and survive, namely, *"In her childhood, a girl should be under the will of her father. In her youth, of her husband. Her husband*

<sup>36</sup> Larry D. Samovar, Richard E. Portor, Edwin R. McDaniel, *Communication between cultures*. 6<sup>th</sup> edition, Thomson Wadworth.

being dead, of her sons. A woman should never enjoy her own will." [Laws of Manu c. 200 B.C.]<sup>37</sup>

In the Christian Bible and Jewish Torah, it mentions that the women will be unclean after delivering a boy for one week, but if she delivers a girl, she will be unclean for two weeks. This illustrates a form of gender discrimination towards female babies (Leviticus 12: 2-5).<sup>38</sup> Christianity regarded women as neither pious nor evil. However, the exaggerated image of being virtuous or despicable distorts the image of women in reality, who are simply human. For instance, in medieval Europe, where Christianity spread, idealistic pious women were compared to the Virgin Mary, while some other women who were perceived by intolerant judgment were considered as witches, temptress or Eve, the culprit for the original sin.<sup>39</sup> In the Bible, at the beginning of humanity, God in Heaven creates man in the same image of himself, then God creates woman out of Adam's ribs. Eve was easily lured by the serpent to take forbidden fruit. Eve lose her faith in God, and decided to trust the serpent instead. As a result humankind is banished from the Garden of Eden. Accordingly, in this tradition women are untrustable, maleficent, and greedy. Women are blamed for such act. This belief has been taught through generations in western world. The image of Mary is a perfect female model. Thus the expectation of women in a male dominant perspective will mean that there is less freedom. This makes the status of women inferior to men, while men are in the same image of God himself. In most religious traditions around the world the Earth is associated with mother, and God with a father. This suggests intrinsic female discrimination.

All in all, the devaluing of females is the cause of female feticide and infanticide. The level of women's virtue was lifted so high that women have lost their rights to live their own lives, and to be themselves under the high societal norms. Therefore, women are often treated immorally. According to religious laws, those who don't comply with the law will be punished by detested people in society empowered by gods or religious ordinance.

### 9. Infant Fertility and Mortality Rates

From the infant mortality rate calculated for different ages of children we may find signs relating to severe neglect or abuse of children. The infant mortality rate in Thailand compared to India for 2009 is in Table 1.

Table 1: Comparisons of India and Thailand<sup>40, 41</sup>

Thailand	India
<i>Infant mortality rate:</i>	<i>Infant mortality rate:</i>
total: 17.48 deaths/1,000 live births	total: 50.78 deaths/1,000 live births
country comparison to the world: 114	country comparison to the world: 51
Male: 18.48 deaths/1,000 live births	Male: 49.33 deaths/1,000 live births
Female: 16.43 deaths/1,000 live births (2009 est.)	Female: 52.4 deaths/1,000 live births (2009 est.)

The rates show significant differences between Thailand and India, but the Thai population is much smaller than India. One comparison shows that the mortality rate of female infants in India is greater than males, but in Thailand males have a higher rate than females. The ranking doesn't indicate the cause of the mortality of infants. India is infamous for its male linear dominated society and there has been a problem with the sex ratio demographics of the male and female birth rate because of sex selective abortion. In the case of India, in Maharashtra, according to a report, the figure shows that from a group of 1,409 women who had an abortion in Maharashtra in India, all 253 women who were interviewed said that they had an abortion because they don't want to have girls, i.e. they wanted to abort the female fetuses.<sup>42</sup>

If we compare the number of infant's born in Thailand in 2007, there were 417,783 males for 393,601 females, meaning an excess of 24,182 extra males.<sup>43</sup> When we consider the mortality rates of infants in the world, the highest rate of infant mortality in the world is Angola, with 180.21 (deaths/1,000 live births) in 2009. India held 51st place in the ranking of infant mortality (50.78) while Thailand held 114<sup>th</sup> place with (17.48).

### 10. Interview Research among the Thai public

The parents themselves are one of the main reasons for gender determination, and in the case of Thailand, I conducted interview research to ask some questions regarding gender preferences with 65 people from June-July 2010. The average age of respondents was 30 years, ranging from 20 to 49 years of age. Within the respondents there were both Chinese-Thai and indigenous Thai.

<sup>37</sup> *Laws of Manu*, retrieved from <http://www.duhaime.org/LawMuseum/LawArticle-297/200-BC--Laws-of-Manu.aspx>, retrieved on 16 June 2010.

<sup>38</sup> Leviticus 12:2-5, *the Holy Bible*, New International Version, 1988 printing International Bible Society. Retrieved on 18 June 2010.

<sup>39</sup> Josie P Campbell, *Popular culture in the Middle Ages*, Popular Press, page 48-49. Accessed in 27 September ,2010

<sup>40</sup> The Central Intelligence Agency, *The World Factbook*, 22 April 2010 <https://www.cia.gov/library/publications/the-world-factbook/geos/th.html> Accessed 26th April 2010.

<sup>41</sup> The Central Intelligence Agency, *The World Factbook*, 21 April 2010 <https://www.cia.gov/library/publications/the-world-factbook/geos/in.html> Accessed 26th April 2010.

<sup>42</sup> Bela Ganatra, Siddhi Hirve, V. N. Rao, *Sex-Selective Abortion: Evidence from a Community-based Study in Western India*, page 4, accessed 6<sup>th</sup> May 2010.

<sup>43</sup> Department of Provincial Administration of Thailand, retrieved from [http://dopa.go.th/xstat/tran/birth50\\_1.html](http://dopa.go.th/xstat/tran/birth50_1.html) accessed 9<sup>th</sup> June, 2010.

Of the 65, 35 persons said they preferred boys, 18 persons said they preferred girls, and 12 persons said they had no preference. They gave a variety of reasons for their gender preference for babies, as open comments written on the questionnaire. These include:

- Boys are easy to raise as they do not need too much attention and caring.
- Baby girls are more adorable than baby boys
- Boys are cute
- There is no point having girls, nowadays the cost of living is so high, boys are the better choice
- When a woman got married, she can no longer use her family last name, and therefore she will face disadvantages in her working life. It is hard for a married woman to pursue her career.
- It's better to have a boy from the beginning since woman cannot continue the family name.
- Girls, when grown up can take care of their family, but boys will take care of their wives and children, they will no longer support their parents.
- Boys don't talk too much, they are not whiney. They are the leader.
- Boys or girls, it really doesn't matter, they have differences and similarities; good or bad such as they are. No one can say which is the best.

### 11. Interviews with medical professionals

I conducted interviews with health professionals in Bangkok about sex selection. Let me begin with quotes from three doctors' interviews regarding gender selection.

*"There is an alternative for the couple who could not accept the sex of the fertilized embryo in case of a particular unwanted gender. Secretly, they would try to ask the doctor for a new appointment for new fertilization and have the new fertilized embryo."* Telephone interview [anonymous 1]

The doctor however did not explain what actually happens to those unwanted embryos. Is the fertilized embryo considered as a human being although they are not human-like at that stage? Do they have rights to be born, this will always a question that has different answers.

*"I do not believe that Thailand has a strong gender preference on boys or girls, we don't have that kind of tension to pick the gender of the baby. Although, we have Chinese-Thai families in this country. For example, in China the one child policy made a dramatic imbalance gender ratio where boys outnumber girls. The root of gender selection is mainly in China, not Thailand."* Telephone interview [anonymous 2]

He does not believe that sex selection and preference has played a part in Thailand and strongly mentioned China and the one child policy.

A third doctor said:

*"Sadly, most parents that came to this hospital prefer boys to girl. The parents preferred to have baby girls rather than boys, because they once had a very talented woman in their family. She was very successful in her career. So, in this case girls are more preferable than boys."*

The doctor did give an interesting point of why some parents prefer boys to girls, if they have a talented female in their family in response to the social and economical status of a woman; therefore, she will be valued by such attributes and qualities. In this certain aspects female infant are more desirable and needed (Sen, 1992). The doctor even claimed a case that girls are more preferable if she is expected to be talented. Otherwise she would be neglected by her parents. The case of Thailand still needs to be investigated. The three interviews, and the comments from the public suggest a preference for boys in Thailand, greater than that for girls.

### 12. Discussion

We have examined biological, physical and social aspects that are linked to gender discrimination which may lead to sex selection abortion. In conclusion, biological factors do not cause gender based selection. Biologically, human reproduction has its own way of determining the gender by the standards of perfection that work in nature, without human notions of perfection or preference. Although, sex chromosomes, X and Y, ensure the continuation of the human species, the differences don't lessen or increase the value of being a female or male human being. Babies are born to continue humankind; therefore, there is no discrimination or segregation against sexes. When a human is born he or she will usually differentiate into a particular gender, and be stated as a particular gender.<sup>44</sup> Consequently persons are categorized by social roles.

Most males and females are capable of reproducing their future generations. South East Asian women are trying to overcome sexual inequality and degradation of women, and the fact that men and women are treated by different standards. Men and women are supposed to be treated with arbitrary standards of masculinity and femininity, which can be accepted and agreed on by their preference, and which are also sometimes protected by legal instruments. Female feticide and infanticide should be stopped if the specialists are not willing to comply with the parental choices of gender, except for medical reasons. Medical doctors should not comply with the parents' desires. Ironically they often provide the alternatives for their patients to abort female fetuses. Parents should give unconditional love towards their children whether they have a boy or girl. Doctors should be ethical in making a certain decision as well as parents. We cannot simply judge who is responsible for all of these abortions, the medical specialist or the parents, but we should consider that we are humans and what makes the fetus, at least a person-to-be, deserve lesser kinds of protection. Do embryos have the right to live on as persons with legal rights and human dignity, even though the parents may have chosen

<sup>44</sup> This paper does not consider transgender persons, and those who seek sex change operations. It is the topic for a further paper to examine sex selection and transgender issues, and many arguments that apply to the preferences for females or males, would also apply to transgender identities.

for them to be disposed of because they are female? Who can be an arbiter of deciding which sex is more valuable, and thus which person is more valuable, and who deserves to be able to be born or to live in this world?

There has been a lot of discussion in the literature about the possible reasons for female fetal discrimination or infanticide. Socially, females are burdened with domestic affairs, which disable women from expressing as much autonomously fulfilling their own needs and satisfaction. Women are bound to cultural norms and practices, which they need to cling on to for social survival. If not they are considered as an outcast. This is universally acknowledged.

Some people even say that girls are not needed unless there are some reasons behind conceiving a baby girl. Should a specific reason be given for people who are born or are they supposed to serve a certain purpose, if not should they be eliminated? Is it ethical to kill innocent babies because of their being?

Religiously, women are either defined as objects to be possessed, portrayed as either pious or despicable beings. Women may not necessarily be recognized as an inferior gender. In some religions there are bipolar images of women, from piety to evil, which has created stereotypes of women. Stereotyping leads to discrimination and prejudice. More importantly, the concept of a perfect woman to a number of men should be one who is submissive and even willing to sacrifice all of her being for her given role. This often also includes abstaining from freedom of expression and liberation after centuries of forcing women to be submissive. Determining how women should serve society, women in many cultures have been cornered into roles of those who cannot defend themselves. On the other hand, men have been put into position of leadership which we can readily see in business and political communities today, men are expected to take the lead yet they are also told they should abstain from the sense of love and belonging as a generalization of being masculine.

The portrayal of gender discrimination is found in many forms. A good example is the social struggle of women as day-by-day survival. In this modern world, there are many forms of female discrimination in existence, and women perceive society pressure through culture, mainstream beliefs, or daily media. Women must follow the path that society gives. One common classical trait used for discrimination is perceptions of beauty. Beauty is also considered to be one of the factors that discriminate women. Many women try to make themselves attractive according to stereotypic forms. Perceptions from everyday media are that beautiful persons are welcomed and adored. Women also often do cosmetic surgery, for example, rhinoplastic surgery, or liposuction. Beauty, perfection and expectations made us forget compassion and sympathy. On the contrary, if humans rigidly differentiate themselves by gender differences, there would be no peace and harmony since we are all individuals with distinct essentialities.

There are many broader questions, such as why do we have prejudice against others, why women are exploited and why do we tolerate the loss of freedom of others? Does it really matter what makes us a real human, male or female?

Protection of gender equality and humanity has a long way to go. Where people are judging others by races, skin colour, and sexes. Male and female infants cannot be valued as equal, they are different in many ways yet they are the same. The identical feature is that they are humans who need simply love, nurturing, a sense of belonging, and chances. Patriarchal oriented society might be a possible causal effect on female discrimination yet it isn't; on the other hand, the notion of being physically strong made men receive less nurture and caring for example reasons such as because they are boys, they can take care of themselves. In conclusion, the true reason that causes female infanticide is hatred and prejudice against an alienated group - women. Misogyny and hatred might be possible threats against females, not solely the patriarchal society as we understand. We cannot change things which have happened, but we can change society by teaching the value of lives to children at all ages, supporting the promotion of inner-value and embracing people from all genders, classes and every corner of society and eliminating ignorance.

### 13. References

- Bélanger, D. (2002) "Sex Selective Abortion: Short-term and Long term Perspectives." Roundtable / *Reproductive Health Matters* 10 (19): 194-196.
- Chung, W. & Das Gupta, M. (2007) *Why is Son Preference Declining in South Korea. The role of development and public policy, and the implications for China and India*. Policy Research Working Paper. The World Bank Development Research Group Human Development and Public Service Team October 2007 pp. 1-30
- Engelen, B. & Vandeveld, A (2004) "Commentary: A Defence of Common sense. A reply to David Heyd's "The ethics of sex selection for non medical reasons"", *Ethische Perspectieven* 11 (1): 84-87.
- Liao, Matthew S. (2005). "The Ethics of Using Genetic Engineering for Sex Selection", *J Med Ethics* 31: 116-118.
- Macer, D. (2009) "Efforts to overcome sex selection in reproduction in Asia", *J. International Biotechnology Law* 6: 44-55.
- Machacek, Wayne D. (2003) "The place of women in Hinduism", pp.110-113 in Wilcox, Melissa M., eds., *Sexuality and the world's religions*, ABC-CLIO.
- Macklin, R. (1995) "The Ethics of Sex Selection" *Indian J. Medical Ethics* Oct-Dec 3 (4).
- Malpani, A (2002) "Why Shouldn't Couples be Free to Choose the Sex of Their Baby" *Reproductive Health Matters* 10 (19): 192-193.
- Malpani, A & Modi, D (2002) "Pre-implantation Sex Selection for Family Balancing in India" *European society of Human Reproduction and Embryology* 17(1): 11-13.
- Moynihan, C (1998) "Theories of Masculinity" *BMJ* 317: 1072-1074.
- Oomma, N & R. Ganatra, B (2002). "Sex Selection: The Systemic Elimination of Girls" *Reproductive Health Matters* 10 (19): 184-188.

Parliamentary Office of Science and Technology, U.K. (2003) "Sex Selection" *Postnote* July 2003 Number 198 pp. 1-4.

Savulescu, J (1999) "Sex Selection: The Case For" pp. 145-149 in Kuhse, H & Singer, P. eds. *Bioethics An Anthology* second edition, Oxford: Blackwell Publishing.

Sen, A. (1992) "Missing Women" *BMJ* 304: 586-7.

## Thai perspectives on abortion

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### Introduction

Abortion in Thailand is formally illegal except for the reasons of rape, damage of the fetus or mental health grounds. Despite restrictive abortion laws, an estimated two to three hundred thousands abortions take place in Thailand every year. A significant number of these are performed in illegal clinics which have no legally enforced standards, and often by untrained practitioners. The illegality forces prices to be high, treatment to be rushed, as well as stressful and of poor quality. The necessary follow up of the patient after the abortion to make sure the abortion is complete a week or two after may fall through with the illegal clinics. This is the first ethical issue, that many abortions are performed with unsafe methods, and continues to be an issue requiring policy review.

As a result of this, many pregnant mothers experience injury, infections, infertility and even maternal death. The current abortion law in Thailand has been the focus of public and political debate a few times in the last decades, however those opposed to liberalization of the law have managed every time to let it remain as it is. What are the reasons for this and what is the view on abortion in Thai society?

The issue of abortion remains crucial in terms of Thai women's health and women's rights. It also demonstrates how women's bodies are used to represent and affirm the nation's cultural values. The government thinks liberalized abortion is a threat to Thai culture and the gendered narratives it creates about the nation.

### Facts of abortions

Studies of abortion rates in Thailand are scarce as most women do not admit to having had induced abortions due to the illegality and social sanctions of having abortions. A major hospital study was carried out by The Ministry of Public Health in Thailand in 1999. This study was carried out among 787 public hospitals, while the private hospitals declined being a part of the study due to the illegality of abortions (Warakamin et al., 2004). Socio-economic reasons were reported in 60.2 % of the induced abortion cases, while the rest were medically related such as fetal anomalies (15.4%), intrauterine death (13.5%), health reasons (7.8%), HIV infection (2.2%), rubella (0.3%) and rape (0.6%). Half of the induced

abortions were performed on young women under the age of 25. The study also showed that as much as 46.8 % of the abortions carried out by hospital personnel complied with the abortion law regulations.

A study of abortions carried out outside hospitals shows that one-third of the abortion cases, women had serious complications due to having undergone abortions performed by non-health personnel. A contributing factor to an increase in the number of illegal abortions is the country's national development plans to reduce population growth and rapid modernization (Lerdmaleewong, 1998).

### Thai society's view on abortion

Thailand is a country where Buddhist thought is highly influential and where 96 per cent of the population claim to be practicing Buddhists. According to Buddhist belief, to abort is seen as a sin, as it is killing of lives. It is such a sin that leads to serious karmic consequences or demerit for the mother, the fetus and even for those involved in the act of abort. The beginning of a human life, according to Buddhist belief begins at the moment of conception. Thus it is also argued that the later the stages in the development of the fetus that the abortion takes place, the stronger the negative karmic consequences to the mother. Therefore, to abort at an early stage in pregnancy is most common, followed by merit making afterwards (Lerdmaleewong, 1998).

Motherhood and reproduction remain a primary source of female power and prestige in Thai society. By giving birth a woman demonstrates her merit and as well as she improves her merit by providing the opportunity for the reincarnation of a life principle. Abortion thus interferes with the karmic cycle and births and deaths by not allowing the rebirth of a being. In so, Buddhism teaches that a woman will inevitably suffer karmic retribution for her actions. The women who reject pregnancy are also seen as of being not a real woman and are depicted as a selfish being (Whittaker, 2004).

Also it is deeply rooted in Thai culture that abortion is felt as a national "loss of face" which is a very strong notion of Thai culture which cannot be ignored. Abortion is therefore seen as un-Buddhist, anti-religious and therefore also un-Thai. In fact the issue is a critical point to the national identity of the nation. The political opposition led by Chamlong Srimuang against amending the abortion law was in the 1980s quoted in saying that "*we need to avoid abortion in order to uphold and maintain Thai-ness*".<sup>45</sup>

A female pharmacist (45) at a Bangkok based pharmacy had this to say about the abortion pill:

*"This pill is dangerous and I don't think you should try to buy it either. I have experience with this pill, as I used it for abortion myself. I will tell you about it. I had to cut off my uterus because of the bleedings the pill caused. It is the worst thing that has ever happened to me and my life. If you are considering*

<sup>45</sup> *Matichon* (Thai newspaper) (2 April 1988) "Chamlong joins with four religious leaders for the second wave of abortion law opposition".

*having an abortion I think you should stop thinking about it. We Thai's are Buddhists and it's sinful to abort babies. It's killing lives. It gives bad karma that will follow you everywhere you go. You won't succeed in anything, not in work, marriage or nothing. It will also ruin your health. I tell you, you should not do it. I do not recommend it. It is better to keep the baby."*

### Who are these women who have abortions?

In the media, during the times when focus was strong on the abortion issue the females who underwent abortions were often portrayed as 'loose', immoral, party and fun seeking girls. Abortion was portrayed as an immoral act by immoral people with immoral lifestyles. TV programmes and media coverage of the abortion issue tended to show western images as abortion was associated with Western values. Parliament representative Chamlong Srimuang who was strongly on the opposition side to the reform claimed abortion was an evil influenced by the West, which was not fit for Thai society. He blamed the call for reform on Thailand becoming more globalized and westernized. Chamlong further suggested that rather than liberalise the law Thai people should focus on the five pillars of Buddhism.<sup>46</sup>

About the women who aborted not much were mentioned about the problems of the other groups including school girls, women with financial problems, deserted wives, those whose contraception failed, and married women. However, studies about abortion have showed that 75 per cent of the women who seek abortion are married and primarily motivated by economic or family reasons as well as contraceptive failure (Koetsawang, 1993). Another study that was undertaken by the Thai Health Department in 2001 reported that 25 per cent of the abortionists were students.

Thai law prohibits young girls who are still students (at any level) to become pregnant. Therefore, a persistent social problem is that pregnant young girls desperately seek abortion to retain their student status, otherwise they will be ordered to leave their educational institution. A 19 year old student who underwent an abortion for those reasons was caught under a police raid on Pattanawet Hospital in Bangkok on 26<sup>th</sup> May 1994. Together with doctors and other patients she was sentenced for the crime of having had an abortion. The student however was sentenced the longest, two years compared to the elder women who aborted for other reasons who were sentenced for a few months, according to national newspapers at the time.<sup>47</sup>

### Attempted reforms of the current abortion law

The peak times of the abortion debate in Thailand took place in the 1980's and 1990's when the issues of reforming the abortion law as of 1957 was brought

to public awareness.<sup>48</sup> Many publications can be found that are pro-reform published detailing legal and medical arguments about the adverse social consequences of the restrictive law, as well as the social problems and the lack of women's rights to decide over their own bodies. A group of pro-reformers such as physicians, lawyers and women activists came with one proposal, that pregnant women should have more rights than the fetus before 12 weeks of pregnancy and that the fetus should have more rights after 12 weeks. This however, did not have any success (Warakamin et al. 2004).

Again, in 2001 the issue of abortion was brought up for discussion but was soon ended when the story known as "Hell clinic" reached the front pages of the national media. An 18 year old school girl had gone to a Bangkok clinic to have an abortion in her 8th month of pregnancy. Despite the late stage of pregnancy the untrained doctor agreed to perform the abortion for a large amount of money, which ended in a tragic case where the Doctor had to cut off the baby's arm due to complications. Further complications followed and the girl had to be transported to a hospital, which immediately gave her a cesarean section.<sup>49</sup> In the aftermath of this the Public Health Minister Sudarat suggested that to "*focus on ethics and correct behavior in adolescents is better than changing the law*". The issue of abortion was again closed and a following up and crack down on illegal abortion clinics throughout the country with penalties followed<sup>50</sup> (Bamber, S. 1997).

### Results of interviews

Wanting to find out more on the accessibility of having an abortion in Thailand I conducted an interview with Dr. Kamthorn from Chulalongkorn Hospital. He had the following to say regarding the abortion issue:

*"Most of the patients that come to our hospital to have an abortion are married women, women with problems with the fetus or who come with excessive bleedings due to self induced abortions. School girls also come here a lot. These are patients I want to help. We have seen a decrease in the abortion rate at this hospital the last 4-5 years due to the easy access to the pill Prostaglandins, actually a pill used for peptic ulcer but which is now used as a pill to abort. It is cheap and can be purchased without a prescription anywhere at a pharmacy. We also recommend our patients to use this."*

Upon hearing that abortion is easy to attain in Thailand with the pill available on the market nowadays, we decided to try and buy the abortion pill. We went to 15 pharmacies around Bangkok without being able to buy it at all. Many of the pharmacists looked at us as they did not want

<sup>46</sup> *Matichon*, (14 April 1988) "All religions must strengthen to oppose free abortion law"

<sup>47</sup> *The Nation* (English language newspaper) (4 Sept. 2001) "Police charge abortion girl"

<sup>48</sup> *The Nation* (newspaper) (28<sup>th</sup> August 1997) "Call made for update of abortion law"

<sup>49</sup> *Thai Rath* (1 September 2001) "Abortion in the 8<sup>th</sup> month"

<sup>50</sup> *The Nation* (English language newspaper) (9 September 2001) "Horror abortion raises key questions".

anything to do with this illegal matter, and one even discouraged us from attempting to abort due to karmic reasons.

In conclusion, having an abortion in Thailand is still a sensitive issue which needs to be given some attention to. The decision whether to have an abortion or not should not be reasoned on the government policies. Women need to be given a free will to decide over their bodies. Perhaps as some have said: *"Laws against abortion does not stop it from happening, they simply make it unsafe"*.

## References

- Bamber, Scott (1997) 'The Thai medical profession and political activism', *Political change in Thailand* (p. 233-250) Routledge.
- Banhart, Michael G. (1998) 'Buddhism and the morality of abortion', *Journal of Buddhist Ethics*.
- Bell, Peter (1992) *Gender and economic development in Thailand*.
- Lerdmaleewong, Malee (1998) "Abortion in Thailand: A feminist perspective" *Journal of Buddhist Ethics*, Vol 5 1998: p. 22-48
- Warakamin, S., Boonthai N., Tangcharoensathien V., (2004) 'Induced Abortion in Thailand: Current situation in public hospitals and legal perspectives', *Reproductive Health Matters* (24 Supplement): p. 147-156.
- Whittaker, Andrea M. (2004) *Abortion, sin and the state in Thailand*, Routledge Curzon.
- Whittaker, Andrea M. (2002) 'The struggle for abortion law reform in Thailand', *Reproductive Health Matters* 10 (19): 45-53.
- Other newspaper articles:**
- Bangkok Post* (15 March 1978) "200,000 abortions a year in Thailand".
- Bangkok World* (25 March 1978) "Three alleged abortionists arrested".
- Naew Na* (Thai newspaper) (10 April 1988) "Abortion law crushes every religion?".
- Matichon*, (14 April 1988) "All religions must strengthen to oppose free abortion law".
- The Nation* (newspaper) (28<sup>th</sup> August 1997) "Call made for update of abortion law".
- The Nation* (English language paper) (10 November 2001) "New abortion bill: Sex law stirs an uproar".
- Bangkok Post* (3 February 2001) "Abortion law likely to be amended" by: Bhatiasavi, Aphiluck.
- The Nation* (14 November 2001) "Battle of the sexes all over again".
- Thai Rath* (Thai newspaper) (26 April 1997) "Surprise attack catching 7 clinics doing abortions".
- The Nation* (English language newspaper) (4 Sept. 2001) "Police charge abortion girl".
- The Nation* (English language newspaper) (9 September 2001) "Horror abortion raises key questions".
- Krungthep Thurakit* (Thai newspaper) (28 August 2001) "300,000 Thai women have abortions each year".

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