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Contents

	page
Editorial: Dignity, Respect and Love	129
- Darryl Macer	
Should a Brain-dead pregnant woman be provided somatic support to save the life of the fetus?	130
- Sakiko Masaki, Hiroko Ishimoto, Yasuhiro Kadooka, Atsushi Asai	
Compassion in medical ethics of traditional Mongolian medicine	137
-Dashjamts Shagdarsuren and Battogtokh Gerelmaa	
Framing Assumptions in Teaching Ethics Using Case Studies	140
- Ann Boyd	
Internal Evaluation of Subject Ethics in Health Care: My Experience of MS Nursing Students at a Pakistani Nursing Institute	144
- Zoheb Rafique	
The Patterns of Social Stigma among the Rural Women in Bangladesh: A Sociological Study	146
- Sumana Akter, Wardatul Akmam, Md. Nazmul Hoque	
Would we leave our ageing parent or grandparent in the care of a robot? – A perspective from Islam	153
- Sibtain Panjwani	
HESC to IPSC: Prohibition to Controlled Permissiveness to ethical panacea	155
- Intekhab Islam, Vinicius Rosa, Raymond Wong	
ABA Renewal and EJAIB Subscription	159

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Editorial: Dignity, Respect & Love

This issue includes 7 papers that could be grouped as commentaries on different aspects of promotion of dignity, respect, compassion and love. These are all critical in our treatment of others, and our ourselves, and successful societies and institutions must promote these. We could add honesty and not bearing false witness as additional requirements. There are numerous discussions of these over history and they are very relevant to bioethics.

The first article by Masaki et al. reviews the arguments over the continuation of life sustaining support for pregnant women when they have entered the phase of brain death – which is the widely accepted end of life. How do we balance the life of the fetus, and her mother? Does this balance change when the mother dies leaving the fetus a passenger in a living corpse? Her mother is clearly not a corpse to a vital fetus, and often not to the bereaved partner, parents and surviving children. While many may rejoice in the options presented by modern “life”-sustaining technology, as will likely any baby born after such gestation, others attempt to limit its use.

Compassion can assist us in medical decisions, as Dashjamts Shagdarsuren and Battogtokh Gerelmaa argue from a Mongolian perspective. Sibtain Panjwani argues that there may be limits on the use of a robot in elderly care. Aging societies face dilemmas of shortage of care, and robotic surgery is becoming routine. Robots may shake less and do a better job in delicate treatments, or through telemedicine.

Social stigma in Bangladesh is reported in an extensive article by Sumana Akter, Wardatul Akmam, and Md. Nazmul Hoque. There are clearly some urban-rural gaps in many countries, but stigma is common. Two papers on teaching ethics, by Ann Boyd and by Zoheb Rafique, offer some clues to explore how we can assist in formation of social values. Finally there is paper from Intekhab Islam, Vinicius Rosa, and Raymond Wong exploring the use of HESC and IPSC stem cells, and whether these can be an ethical panacea. At least love, dignity and respect, universally can help us.

- Darryl Macer

Should a Brain-dead pregnant woman be provided somatic support to save the life of the fetus?

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Abstract

In recent years, a number of news stories were reported worldwide involving brain-dead pregnant women. Debates over providing life support to brain-dead pregnant women and delivery of their children have been around for some decades. Maintaining a woman's life solely for fetal viability has become a major controversial social issue. Opposing opinions exist where one side supports the woman and her child should be left to die in dignity and the other side claims to protect the unborn child's right to live. Each group has strong beliefs. This paper addresses main aspects when considering the continuation of somatic support to the brain-dead pregnant woman for the purpose of fetus delivery including; human death, dignity of the woman, rights of the fetus, proportionality of acts, and the woman's donor status, and independence of mother and fetus. Then, the authors present several diverse opinions and positions concerning the legitimacy of life support for brain-dead women based on them and critically evaluate them. We show that each and every claim can be ethically refuted. This paper also approaches to those claims from three different points of views, which are that of the brain-dead woman, her fetus and her family. We believe that the brain-dead woman's wish and dignity, the child's predicted wellbeing after birth, and the family's beliefs and welfare should all be counted equally when making the final decision. In conclusion, we argue that the decision can be ethically justified only when the interests of all parties are appropriately taken into consideration and protected.

1. Introduction

A number of news related to delivery of a baby born from brain-dead pregnant women were presented

worldwide between 2013 to 2014. In Japan, three brain-dead pregnant women's cases were reported in 2014 (1, 2). These women were brought to a university hospital and became brain-dead. Two of the three women had delivered their babies. One family wanted to save the fetus, the other remained uncertain until the contraction of the woman began, and the third had no desire for the baby in the first place (1, 2). Similar cases were reported from Canada, Hungary and the United States, too. A Canadian woman was just 22 weeks pregnant when she was declared brain dead. Doctors in charge kept her alive at her husband's request so that their unborn baby would have a better chance of survival. She was on life support for six weeks before she gave birth to her child (3). The Hungarian was 15 weeks pregnant and she was on life support for 3 months before she delivered a healthy baby boy (4). In the USA, a pregnant woman who lapsed into a brain-dead state was removed from life support after a hospital complied with a judge's order to disconnect her from the machines keeping her alive. Her husband wanted to have his wife die with dignity. The fetus, which was at 23 weeks' gestation, was not delivered (5, 6).

Debates over a brain-dead pregnant women's life support and their child birth have been around for some decades. Esmaeilzadeh et al found 30 cases reported between 1982 and 2010. Twelve viable infants were born and survived the neonatal period (7). Various countries, including Japan have reported different cases (2, 8-16). For example, a woman's organs were donated to others post-delivery and, in another case the mother's life support was maintained even after the child-birth (4, 9, 10, 11). It is claimed that an especially significant ethical problem arises if a pregnant woman is declared "brain dead" before the age of fetal viability. Should she be maintained on life support for the sole purpose of allowing fetal maturation to occur before delivery? (14)

Both pros and cons towards maintaining woman's life when it is done only for the fetal viability became a major controversial social issue although an international specialist group in Obstetrics and Gynecology has already published comprehensive recommendations concerning brain death and pregnancy (17). In the Canadian case, contributions were gathered for the husband's solicit donation. In the US case, anti-abortion groups insisted that the infant should have given a chance to live, whereas pro-abortion parties supported that the woman's desire for dying with dignity should be kept (18-22). In 1993, the similar case was reported in Germany. The situation became a public question that split the nation in two. One side demanded that the young woman and her child be left to die in dignity. The other side referred to the unborn child's right to live and therefore wanted the body of the woman maintained until the fetus could be born (12). Gostin questioned that how should society reconcile these two interests that stand in such stark tension. He argued that there are no clear answers, but only questions: when does life begin, how should it be valued, and whose choice should prevail between

the woman's and state's. The answers to these questions have seriously divided the medical and political communities and the public (23).

Given the conflicting claims about the justifiability of somatic support of brain-dead pregnant woman to save the fetus, in this paper, we would consider whether a brain-dead woman should be provided somatic support to save the life of the fetus. We would present several diverse opinions and positions concerning the legitimacy of the life support for brain-dead women and give them our critical evaluations. It will be shown that each and every claim, regardless of its side, can be ethically refuted. Finally, we would suggest that the brain-dead woman's wish and dignity, the child's wellbeing after the birth, and the family's belief and welfare should all be counted equally when making the final decision. In conclusions, we would argue that the decision can be ethically justified only when the interests of all parties are appropriately taken into consideration and protected. We would also present unresolved issues that require further consideration.

2. Critical considerations towards main views about the continuation of somatic support to the brain-dead pregnant woman for the purpose of fetus delivery.

2-1 Opinions based on the death of pregnant women

One opinion stands that the brain-dead woman is no longer alive, likewise, the deceased body is no longer for medical objectives, either. Hence it is meaningless to use any life-supports for sustaining her physical ability (24,25). However, not all the countries have laws or regulations for brain-death as a man's death. A certain number of laws in different countries state that brain-death is the definition of the death. In Japan, on the other hand, under the organ transplant law, someone would be pronounced dead by brain death criteria only when it directly relates to organ transplantation. For the rest, normally cardiac death is a definition of death in Japan (26). Besides legal death does not necessarily correspond to biological death. Sometimes, even if the brain is actually dead, other body parts are still normally functioning. Some Japanese Shinto adherents insist that cardiac death is desirable even when transplants are performed because cardiac death is perceived as the time of a soul's separation from a body and a natural death, but a warm death, or an unseen death, is considered unnatural (27, 28).

2-2 Opinions based on necessity of dignity towards the deceased

When brain-death is considered as one's death, it becomes important how to handle the body with certain dignity. The body must be carefully treated with great respect. Therefore when treating the body, we should always be honorable to it and should not fail to lose its integrity at any time (29). Generally these are common attitudes for handling deceased bodies. Hence if we were forced to maintain physical capacity

of the brain-dead pregnant woman, it could have spoilt her dignity. However, we could refute this opposition based on her dignity by arguing that the position lacks due consideration for the existence of the fetus in the woman's body. It can be dangerous to treat pregnant woman's body equal to a usual deceased body, because even if she is dead, a fetus is still surviving in her womb. Additionally we should take the pregnant woman's wish about child birth into consideration as latter mentioned.

Conversely, some argue that the claim that use of the pregnant mother as an incubator would violate her right to autonomy and bodily integrity is irrelevant because the patient is already dead. In ethical deliberations of obstetric interventions on behalf of the fetus, one has to consider the risks to the mother and there is no maternal risk in this case (12, 15). Nonetheless, we should suggest that it would be quite narrow minded medical remarks if they do not count one's interest only because she is no longer alive. Even if keeping the maternal womb is the only life-saving method to the fetus, continuing life support to the pregnant woman against to her and her family's wishes would be totally unacceptable, because it would be adverse to both family and social interests. Using a dead woman's body as an incubator against her wishes, as interpreted by her family, should be of grave concern to everyone who cares for and about both women and our nation's moral health (24). The psychological grief of the family will get stronger when the loved-one's dead body gets hurt.

2-3 Opinions based on significance of dying with dignity

It is argued that where brain-death is regarded as a terminal stage, the priority should be focused on making one's death be one with as much dignity as possible. In the same token, when a brain-dead pregnant woman clearly voiced her wish to have death with dignity, her will should be protected and conveyed as it is. Also for the brain-dead patients, continuous life-support would have no meaning to themselves. In another words, exposure to medically futile interventions leads to take a contrary position from having a dignified death. Moreover, some suggest that it is unacceptable to keep the brain-dead mother's body only for the childbirth, since that practice reaches to the sexual discrimination by demeaning and degrading women, because it is treating her body as a 'delivery machine', 'container for fetus' or 'incubator' (7, 12).

Nevertheless, there are the arguments against those who oppose somatic support of brain-dead pregnant women on the grounds that they had advance directive indicating their wishes for dignified death. We would argue that there must be some conditions for their argument to be accepted. In our opinions, the woman should have been refusing to give a birth to her baby, or she had written an advance directive expressing her wish to have dignified death at the cost of her fetus's life. What matters most is that her previous statement clearly specifies what she

would want to do when she lapsed into brain death during her pregnancy. Advance directives which just mention about her wishes for delivery or death with dignity are not good enough as guiding evidence. Conversely, when it is known that the pregnant woman was eager to sacrifice herself for the purpose of childbirth, then her dignified attitudes and actions would be worth giving for. That is one of the forms of transferring her love. Thus when the woman is clearing craving for her baby to be alive, helping out alongside with her wishes is protecting her dignity. Therefore, continuous somatic support of the brain dead pregnant woman for childbirth in this situation would not constitute exploiting her as a mere delivery-machine.

However, disagreement could exist over how to handle the brain-dead woman's wish to become a mother, to raise a child, or to have a new family. This is because the fulfillment of these wishes is completely impossible due to the fact that she is brain-dead and has no chance of recovery. The authors have no idea about what the woman would want concerning childbirth in the situation where she became brain-dead and had no chance to live with her baby. It is also anticipated that there must be very few women who express their desires about child and family in advance, after assuming that they become brain-dead during their pregnancy. It may be especially true when they are young and full of hope of the future and about to start a new family and new life with a baby. For them, picturing themselves in such situation is highly unrealistic and bizarre. Moreover, it would be unacceptable to make the final decision unconditionally and automatically by using the brain-dead woman's advance directive because there are also other conditions to take into account including the interests of the fetus and the family as described later. Finally, we should also consider the possibility that, for some women, their affections to their own babies have already started developing during pregnancy and it may lead a strong desire to the baby to be born and be alive even without their existence. In such a case, the agenda regarding how to deal with the mother's decent affection would emerge for the bereaved family.

2-4 Opinions based on the rights of the fetus

When both the interests of a brain-dead pregnant woman and that of a fetus are taken into consideration, some argues that the latter is given priority. If the mother is to be considered a "cadaveric incubator" with no autonomous rights, the rights of the fetus should legally prevail (7). It is also claimed that, from the medical point of view, the preponderance of argument is that it is acceptable to strive to resuscitate the fetus by maintaining life support if there is a reasonable chance the pregnancy will continue at least until fetal lung maturity is achieved (13). There also exist the claims that physicians must primarily focus on saving the life of the fetus, and that therefore the treatment protocol should give special recommendations on how to support the mother in a way that she can deliver a viable and healthy child (7).

However those who prioritize the birth of fetus seem to have a firm premise to their argument. That is that being born is better and more beneficial for the baby itself than being unborn and non-existent. It is possible that we recognize the right to be born and the right to live for the fetus in order not to deprive it of something valuable such as life. From a secular viewpoint, since life itself is worthwhile, a life-to-be certainly has essential values in it in order to lead a personal life. The authors believe, however, that life merely exists each moment as value-neutral position where we cannot judge whether life is good or bad. At the end of life, we believe it comes out even after all ups and downs. Therefore, no harm would be inflicted in an unborn child by remaining non-existent. Yet to be born is value-neutral position and consciously nothing. Nobody receives any disadvantages by not being born. Fear of death and sadness of separation come from life experiences, thus it is extremely awful when a living human-being including the authors dies. We belt our personalities, self-consciousness and relations with others through our life, which all together cause fear of death because we were born. A fetus has nothing.

In Christianity, abortion is strictly forbidden because they believe the same right to live is equally given to all human-beings including a life just begun after a moment of fertilization. On the other hand, in Japanese folk religion, Shinto suggests that our soul gradually grows over time and the growth of each soul closely relates to his/her social roles thus the soul is not stable or unchangeable from the moment of fertilization. From that belief, under seven-year-old children's immature souls had been treated exceptionally for a long time (30). Before the age of seven, those children are not included in the human society, therefore even if the life was taken it regarded as returning to the original world where they came from rather than a murder (31, 32). As seen above different religious thoughts can be opposed to each other and each claim can be conflicting. The authors suggest that the belief of the value of life which based on a specific religion does not have huge influence in the ethical judgment of the person who does not believe in it. Hence we should not ignore any advance directive from a pregnant woman, refusal of life-support by family members or when handling the deceased body with dignity, just because there is a fetus

2-5 Opinions based on proportionality of somatic life support

Some argue that it is proportional to perform medical interventions for continuing life-support on a brain-dead pregnant woman in order to save a fetus (33). This opinion based on the proportionality of act emphasizes that spoiling the woman's dignity, integrity and/or privacy by keeping brain-dead pregnant woman alive can be justified because the life of the fetus is extremely important. However, judgmental criterion for proportionality varies among people. Both medical professionals whose mission are saving lives and antiabortionists stand their position as it is acceptable

to sacrifice most for the fetus life. On the other hand, death-with-dignity supporters differ in their opinions from above. They put high values on dignity, integrity and privacy of a brain-dead pregnant woman and would be willing to sacrifice other things they think less important. Also, even for a fetus delivery promotion group the question may arise whether to aim a goal for fetus delivery when the cost for both maintaining life-support for a brain-dead woman and for post-delivery child care will be excessively high. As just described, the concept of proportionality is quite arbitrary and unstable. This argument can be used to support both pros and cons.

2-6 Opinion based on the fact that the brain-dead pregnant woman is an organ donor

One of the determinant factors in this decision-making process is a prior statement by the mother with respect to organ donation. If the deceased mother is an organ donor, then prolongation of her vital function is more easily justified from an ethical point of view, since the fetus would be the first to benefit from receiving the donation of the mother's organic function (14, 15). However, continuing somatic support for organ donation is one thing and the support for childbirth is completely other. First, this somatic support for fetal delivery would possibly continue for weeks or more. Thus both the psychological and financial strain for the family would grow stronger. Secondly we should pay attention to the differences between continuing somatic support for existing people and for a new life to be born. As mentioned previously, there are big differences between someone who has already existed will continue to live and someone who is not yet to be born will become part of the world. Thirdly, the consent for organ donation has to be separated from the consent for giving a birth to the world where the mother herself will not exist. Additionally, we have to review the point whether a brain-dead pregnant woman's intention for the organ donation remain unchanged when the fetus is in her uterus. Moreover when thinking about the family's following life without the brain-dead pregnant woman, implementing of organ donation may have little influence on it whereas delivering a baby gives directly the opposite effects on the family's future.

2-7 Opinion based on independency of the mother and the fetus

It is argued that both the mother and the fetus are two distinctive organisms, and, hence the fetus should be saved. If the mother and the fetus are regarded as two distinct organisms, maintaining the vital functions of a brain-dead pregnant patient may be ethically justifiable to support both the birth of a child and possible organ donation (7). However, this claim is not plausible because, in order a fetus to survive, it must be dependent upon its brain-dead mother. It is impossible for the fetus to survive without the mother's body functions and the concurrent death of the fetus would ensue as soon as the deterioration of its mother's condition would happen. This total

dependency state of the fetus makes the fore-mentioned argument based on the fetus as an independent organism quite strange and weak. The fetus is not self-independent until at least it acquires viability outside of the mother's body. On the other hand, even legal abortion is accepted in some societies including Japan now, so all abortions would be forbidden once the total independency of fetus is accepted.

3. The diversity of the brain-dead pregnant woman family's hopes and their situations

So far, we have reviewed many important conflicting opinions concerning maintaining the life support on a brain-dead pregnant woman in order to deliver a fetus and we have found a way to refute each and every argument. In this section, we are going to discuss about the third important party, the bereaved family. We have to learn about the family's situation and carefully consider their intentions as a substitute decision maker. A family judgment would widely vary due to the love from a husband to his wife, his love for the fetus, affordability and positive attitudes towards child-rearing, and attitude towards the fetus's handicap. For instance, if the family has no financial capacity for the childcare, they may have to give up on the childbirth. On the other hand, even the fetus has some handicaps the bereaved family may wish the brain-dead mother to deliver a baby. Also the decision making may be influenced by the husband's age, whether he has the opportunity of redo his life or not, the level of anxiety towards child-bearing, the relative's intentions and how much support the husband can get from them. Sometimes parents cannot accept the brain-dead daughter's baby simply because she is not married (1). The decision may differ from the first and multipara pregnancy. Sometimes the national attitude towards abortion can be an influence factor. The gestation stage may affect the family's preparation for the baby. Some family may wish to keep the baby alive as a keepsake of a wife/daughter. A husband and/or his relatives may wish to save the baby for the sake of keeping the blood line of their own family root. There may also be different attitudes of the pre-existing children in the family. Circumstances and psychological status of the family vary in each case, thus the final decisions naturally differ from each individual situation.

4. The authors' positions: Love, happiness, responsibility, privacy, and tolerance

There are a great number of variables to consider in the judgment of the right or wrong about keeping brain-dead pregnant woman alive for the purpose of a fetus delivery. Significant medical uncertainty also exists. Additionally, the family's psychological status and circumstances are multifarious. All of them would make the judgment of this matter extremely difficult. The authors would argue that it would be nearly impossible to determine right or wrong of maintaining life support for brain-dead pregnant patients just for the

childbirth, because any pros and cons do not have decisive strength to it as mentioned previously.

Using the diagram of the benefits of brain-dead pregnant woman vs. fetus is too simple in deliberating on this issue since the family circumstances and intentions are important and deserve being taken into account as well. Of course, it would be insufficient to focus only on the family's intention, either. The reason for this includes that some family's decisions would be unacceptable from the ethical point of view. Some family's intentions may focus on their own benefit by using the brain-dead pregnant patient as a mere means. Then, what do we have to do? The authors would argue that our decision regarding this dilemma should always cover all three parties' benefits including the woman, her fetus, and her family. The only judgment will be ethically justified when those three parties' circumstances are equally considered; the brain-dead pregnant woman's dignity and wishes, the child's welfare after birth and the family's belief and happiness. Specifically, some important points are described as below.

At first, the situation should include the brain-dead patient to have strong love and desire to deliver her baby into this world even without her existence as a mother, and her family to have strong beliefs in the patient's wishes. The most important point is the family's genuine beliefs in her wishes based on long-standing communication between the patient and her family and mutual understanding among them. There should not be any mistrust about the brain-dead patient's intention and desire concerning delivery of her baby. Secondly, at least, either the father or the patient's parents has firm intention to nurture the child and develop a new family. That is; the bereaved family expresses a strong urge for the childbirth, they have sense of love to the baby and they are willing to take all responsibilities for bringing-up her baby. The childbirth should be the expression of their pure love.

Thirdly, a child-to-be-born should be able to find happiness with secure enough possibility in its life. When the baby's life is full of love, dedication and various pleasant experiences from the family, even without the mother, it may be good to be born. Of course nobody knows what the future is like, but it would be far better to have fewer disturbing factors to find happiness. The child needs to have positive prospect that the life will be decent enough to enjoy even if it would not be the best. Fourthly, both society and health professionals should not force any specific judgment for a bereaved family. Both extremes - "The patient must deliver the baby" or "The patient should give up the childbirth" should be prohibited. The main focus should be on the patient and the family side; "I do want to give a birth" and/or "We want the babe to be born". Because having a baby and making new family is an extremely private issue.

5. Conclusions

In summary, it would be acceptable to maintain brain-dead pregnant woman's somatic function in order to deliver her baby only when the bereaved-

family-to-be will care for the baby with decent love and have responsibility to that child and when the family firmly believed that their choices would fulfill the patient's wish. What are crucial are to love, not to coerce, to aim for happiness and to have long-term responsibility for our own acts to the others including the child and its mother. Otherwise, maintaining life support to the brain-dead pregnant woman should not be performed. Patients should be free from any medical procedures unless there are good therapeutic reasons for them (34). We are aware that both love between the couple or among family members and happiness of the child could be temporary and fragile and they might be too unstable to be a legitimate reason for serious life and death decisions. Nevertheless, we argue that only love and prospect of happiness can justify such interventions.

The authors would argue that it is not be justifiable to maintain the brain-dead pregnant woman's somatic function for the child delivery in the following situations: A state compels the family to continue the pregnancy of brain-dead woman to increase the state population; the radical pro-life individuals physically threaten either the family or the hospital to force it based on their own beliefs against abortion; a pro-choice group puts pressures on the family or the hospital to discontinue the woman's life-support in the name of protecting her right and dignity; the family or physician maintains the woman's somatic support to develop and deliver the fetus who has serious congenital disorders and is likely to lead only a short and painful life after birth; and the physician would conduct experimental somatic supports for the purpose of making the new record of the longest physical maintenance of brain-dead woman and/or the minimum weight delivery.

Furthermore, in the majority of cases, the brain-dead pregnant women had actually delivered their babies (16). However, there are also some cases in which the fetus reportedly died along with the mother (5, 12). It is possible that cases involving somatically supported brain-dead women who had failed to deliver their babies alive were not reported. In the same vein, cases involving the families of brain-dead women who had refused to have their babies delivered might not have been reported either. In Japan, the following reports have been published between 2012 and 2013: a case in which the family of a brain-dead pregnant woman did not want her baby delivered, even though the fetus was at 34 weeks' gestation (1); a case in which the family did not want the baby to be delivered initially, after the declaration of brain-death of the mother, but finally gave the medical team their consent to have the mother undergo cesarean section after consultations with the medical team. (2); and a case in which the family wished to continue the mother's life support, but without delivering the baby (35).

Only one report published by Kinoshita et al. describes the details of decision-making processes concerning the delivery of brain-dead pregnant women's babies in Japan. Thus, detailed interactions and communications among those concerned in their decision-making processes, and how the decision to

maintain the brain-dead pregnant woman's somatic function for the sake of child delivery has been reached, remain uncovered.

However, it would certainly be unacceptable for a responsible physician to coerce or demand the family to maintain the brain-dead pregnant woman's somatic function. Such action would clearly disregard the woman's dignity, her family's emotion, and their financial concerns. In the Kinoshita's case, the medical team in charge of the care of the brain-dead pregnant woman convened an ethics conference involving various healthcare professionals to discuss relevant moral issues. The team had consultations with the woman's family members and provided them with necessary information, but without giving a specific recommendation. Finally, her family gave the medical team their consent to have the mother undergo a cesarean section.

The above-mentioned cases are unacceptable because these cases lack in respect for the woman's decision, protection of her dignity, the love in personal relations, the responsibility for the happiness of the child, the consideration to her physical privacy or the generosity for others. Of course, timely interventions by ethical committee would be beneficial in order to avoid these clear abuses. However, decisions concerning somatic support of brain-dead pregnant woman and subsequent delivery of the fetus are an extremely private and delicate matter. The tasks of the ethical committee should, therefore, focus on providing sufficient objective information to the patient's family as a third party and preventing the abuses from happening. For anyone it is extremely difficult to make any decision in a cool-headed way under one's family member's life and death situation. Therefore it is necessary for both medical professionals and the ethical committee to provide enough support to the family so that they can realistically imagine their future with the child and avoid being confronted by the situation that the family regrets their choices afterwards. The patient family should be the final decision-maker to choose a course of action because they are the very persons who would have to live with the consequences of their own choices. Their determination should be given a top priority unless there are any irrefutable reasons to repel it.

6. Unanswered questions

Finally, we would consider the following two scenarios and issues concerning just resource allocation. The first scenario is that the brain-dead pregnant woman's husband and/or parents are eager to request maintaining the patient's somatic support due to the desire for keeping their blood-stream or having their heir, even if the patient's intention is unclear. The family may claim that the expectant mother would rejoice her genes being left. It is in a sense a common sense in society, and it is also understandable for some extent that they argue that the continuation of a family-tree has great meaning for them. However the authors would conclude that the family's intention expressed in the above-mentioned

scenario is unacceptable. This is because the family's motive lacks affections to the patient or the baby and considerations to the patient's dignity do not exist. It is doubtful that the family intends to use the patient as a mere means for their own contentment.

The second scenario is that the husband wishes to have their baby as a keepsake of his wife yet the patient's intention remains unsure. His desire of having their baby as his wife's memento may be considered as the pure expression of his love to his wife. This is because his love to his wife is the foundation of his wish to want his wife to give a birth and he wants a baby on the ground that the baby is her baby. In this case, it might be acceptable to maintain the patient's somatic support until the delivery if there was the husband and the parents' affections to the patient; if the baby had a sufficient chance of happy life; and if the family has firm commitments to child rearing. However, as mentioned in the conclusion, love and happiness may be too unstable to be a legitimate reason for serious life and death decisions. Moreover the opinion has validity that the decision to maintain the pregnant woman's somatic support to have a baby cannot be justified when the wife's intention is unclear. Thus, in this case, the authors cannot determine the appropriate course of action for the present.

Finally, it is necessary to discuss whether maintaining the brain-dead pregnant woman's somatic function for the purpose of child delivery is justifiable or not, from the perspective of healthcare resource allocation alone. Worldwide, when a patient is declared brain-dead, one is legally declared dead, and therefore, public or private health insurances do not usually cover services after death is declared (17). Moreover, some people doubt that allocating scarce medical resources to maintain the "dead body" is justifiable (36). On the other hand, current situations in Japan are quite different, for example, the cost of medical care for brain-dead patients is completely covered by the national healthcare insurance. Furthermore, as previously mentioned, Japanese public opinions predominantly support continuation of life support immediately after brain-death diagnosis, because brain death has yet to be socially acknowledged as human death (26). A nationwide survey of physicians specialized in emergency medicine and intensive care revealed that only 2% of these physicians would discontinue life support for brain-dead patients; in fact, many were afraid that withdrawal of life support from brain-dead patients might constitute homicide, and that they would be sued as a murderer (37). Thus, there have been no social discussions on the appropriateness of use or complete public coverage of medical resources for these patients, regardless of whether the patient is pregnant or not.

Nonetheless, issues concerning the allocation of limited healthcare resources and national healthcare costs are becoming more and more serious in Japan, which has entered the era of "super-aged" society earlier than any other countries. In addition, advancements of medical technology would make it

possible to sustain the somatic function of brain-dead pregnant women for a prolonged period, and to increase the chance of their babies being delivered. Healthcare costs required for somatic support of such patients would simultaneously increase, and this situation would attract public attention, possibly initiating a social debate on this matter in near future. However, we would argue that, for the time being, the criticism towards maintaining the brain-dead pregnant woman's somatic function to deliver her child will likely remain suppressed, because, as mentioned above, sustaining the somatic function of brain-dead patient who is not pregnant has not even led to a heated social debate from the viewpoint of medical cost and justice. Furthermore, it can be argued that an attempt to save and deliver the baby would be regarded as a worthy goal to pursue, or a good enough reason to justify the use of public funds and precious medical resources for the brain-dead patient. Even if the family wishes to maintain the brain-dead pregnant woman's life support without wishing the fetus delivery, it would not be different from other ordinary life support for brain-dead patients and would not bring about a major dubious issue. Therefore, in Japan at least for the time being, we would argue that it is unacceptable for healthcare professionals to unilaterally limit or discontinue somatic support of a brain-dead pregnant woman by declaring that such use of medical resources is not justifiable from the viewpoint of fair resource allocation.

For future consideration, we believe that an urgent discussion should be carried out from the macro level regarding whether or not it is appropriate to use healthcare resources to maintain a brain-dead pregnant woman's somatic function for child delivery. There is a need to clarify if "together all, let's save the fetus" is a social consensus or not. Of course, in this debate, serious deliberation should also be given to consider the appropriateness to use healthcare resources for the woman and her fetus itself, no matter who pays the bill. Finally, discussions concerning the priority of use of limited health resources between brain-dead pregnant woman and other patients requiring intensive care would also be necessary. We need to make explicit policies regarding this matter in each institution urgently.

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Compassion in medical ethics of traditional Mongolian medicine

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Abstract

In traditional medicine of Tibet and Mongolia where Mahayana buddhism prevails, a physician is seen as an enlightened person who had been trained thoughtfully in Buddhist phylosophy. In order to become a physician one should develop compassion which is considered as a path to enlightenment. Compassion is not a characteristic, but it is a skill used for therapetic purpose which should be mastered through training and meditation stage by stage.

This research puts forward hypothesis that quantum physics can explain the therapeutic

effect of physician's compassion toward the patient. Meditating on compassion can result in stimulated photon emission. These emmitted photons through quantum entanglement serve as an invisible connection between physician and patient, improving the treatment results significantly.

Introduction

Medical ethics in present day Mongolia is shaped by Western medicine developed since the socialist era under influence of Soviet Union, and traditional Mongolian medicine which has roots in Buddhist philosophy. Compassion is considered as a main determinant in both Eastern and Western medical ethics. In Western medical ethics compassion is seen as a conduct of the physician and emphasized significantly in rules, regulations, codices, and oaths. In this context, compassion in developed western countries defines the responsibilities and duties of medical professionals [Ngandajina Silva, 2007]. In contrast, medical ethics of Mongolian traditional medicine based on Mahayana Tibetan Buddhism consider compassion as prerequisite to become a physician. Compassion is a womb of enlightenment and should be developed by physician to comprehend fully the nature and causality of the illness.

Importance of compassion in treatment

In the famous traditional medicine scripture of Mongolia "Four principles of medicine" physician's compassion is equaled to "bodhicitta" (Figure 1).

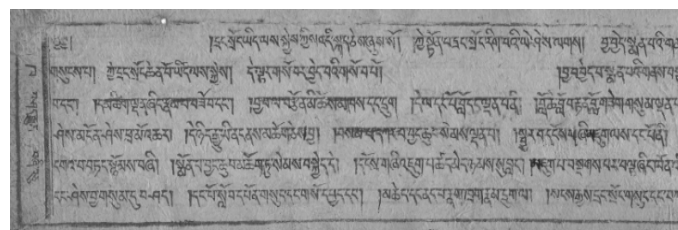


Figure 1. The first page of 31st chapter of "Four principles of medicine" (from author's personal archive)

The famous Mongolian physician and scholar of Traditional medicine Lunregdandar, who wrote an interpretation to the "bible" of Mongolian traditional medicine, "Four principles of medicine" emphasized that enlightenment and compassion are in the essence of the treatment. In his book *"Introduction to Tajod and fundamentals of secret theory of eight collars of holy elixir"*, Lunregdandar wrote "Bodhisatvas should learn how to cure same as one who learning to become a physician should learn the bodhisatva way." According to teachings of Traditional medicine, anger, ignorance and lust are the main causes of all illnesses and are named as "three poisons". To treat illnesses the physician should get rid off himself of these "three poisons" through practicing and meditation of Medicine buddha Manla and then prepare the medication mastering the professional knowledge and talent [Lunregdandar, 2005]. Here the logic is same to the

example of smoking physician who may not be able to help the smoking patient to quit the bad habit.

Through history physicians were Buddhist monks that had been trained in medicine. By mastering Buddhist philosophy at first physician learns to see his patient's illness not only as a physical sickness but in whole picture of cause and effect. His goal is not limited to treatment the particular ill organ of the human body but in liquidating the seed of cause of illness. In a Buddhist view all living beings should be treated and loved as someone's own mother [Shantidewa, 1997]. This comes from belief in incarnation of the soul and life after death. Each soul is born and dies limitless times and through these countless lives every being had been mother or child of other's. Therefore, a physician should be able to love every living being as his own mother and this achieved through developing compassion. In this way the sincere desire to cure "his own mother" boosts the treatment effect.

The 9th Jebtsundamba Khutugtu (1932-2012), the spiritual leader of Mongolia taught, *"Physician is a person who serves others with compassion... He should be someone with compassion and should be trained professionally upon it. In such way the physician treats people not only with professional knowledge and skills but also with compassionate soul... Inside, he should follow buddha footsteps, while outside he should master his medical profession. Compassion as well as medication helps the living beings to get through illness suffering"*¹.

In "Four principles of medicine", the causes of all illnesses are summarized into 404 types from which 101 can be cured by medicine, 101 can be cured by rituals and tantras, 101 can be cured by itself without any intervention, 101 are incurable due to karma and causality effect. Such classification indicates that illnesses traditionally were treated not only by medicine but also by physician's desire and wish for wellbeing of his patient coming from his compassionate soul.

Dr. Adrian Feldmann, an Australian doctor who later become a Buddhist monk, describes his encounter with a Tibetan doctor which medical practice he finds completely different from his Western experience *"I was deeply impressed by the emphasis on compassion as being the main therapeutic power of a doctor; this had not been mentioned at my medical school. A doctor only became fully qualified when he or she was well advanced on the bodhisattva's path of wisdom and compassion based upon perfect concentration and renunciation – subjects also missing from the syllabus at medical school. A Tibetan doctor's day begins while asleep: dreams are observed and certain signs of success or failure of treatments are recognised. Then, before breakfast, meditation on the Medicine Buddha practice is performed, and medicines are blessed through the power of compassion and mantra."* [Feldmann, 2005]

Stages of developing compassion

The famous script of Mongolian traditional

medicine "Four principles of medicine" equals compassion to bodhicitta or enlightened mind. It can be achieved through following four stages [Lunregdandar, 2005]

1. Equal mind
2. Joyfull mind
3. Caring mind
4. Compassionate mind

At first a physician should understand that all sentient beings are the same and treat them equally as his own mother. He should not make distinction between his own and others'. This stage comes upon understanding the karma and causality. As soul incarnates numerous times every being is born as one other's mother and has been other's child. So one should see all beings as his own mother. However, seeing every being as equal is not enough for compassion because equality can be easily turned to neglect and ignorance. Therefore after treating every being equally a physician should have emotional sharing with his patients. She should feel the joy when the patient is joyful and feel the pain when the patient is in pain. Like a radio-receiver the physician must adapt his soul mode to emotional wave frequency coming from his patient or other's being. However, feeling the emotions of the others does not always translate into action. A person can be overwhelmed by his emotions but still can be passive and refrain from providing needed care. Thus the emotional sharing should be translated into genuine care. Treating equally, feeling the patient's pain, caring for him in this and next lifetime translates into compassion.

Compassion in the sense of bodhicitta should be trained, mastered and reached by attentive meditation. Buddha Manla is meditated on for this purpose. The medicine Buddha turned blue as it treats the suffering of the patient through compassionate mind.

The common depiction of Compassion Buddha Avalokitesvara (the Dalai Lama is regarded as a manifestation of Compassion Buddha) is thousand armed and multiple headed buddha. Meditation on this Buddha helps to unleash the soul stuck inside one's physical body, a fragile temporary shell but hard enough for soul to be shaped by and strained within it in this lifetime [Thurman, 2007].

Compassion and quantum physics

Albert Einstein insisted that fundamental quantum theory is incomplete since it fails to describe the quantum entanglement of photons, which they referred as "spooky action at a distance" (Einstein, Podolsky, & Rosen, Can Quantum-Mechanical Description of Physical Reality be Considered Complete?, 1935). Quantum entanglement of photons is observed when photons obtained from a particle can instantly affect each other even separated by long distances and since referred as EPR paradox. When movement of one photon found to be clockwise spin on a certain axis, the polarization spin of the other's is measured to be complete an opposite. Einstein disagreed N.Bohr who maintained that these photons immediately transfer the information and share single quantum

state even if they separated physically (Bohr, 1935). According to Einstein such instant communication is impossible because it will exceed the speed of light.

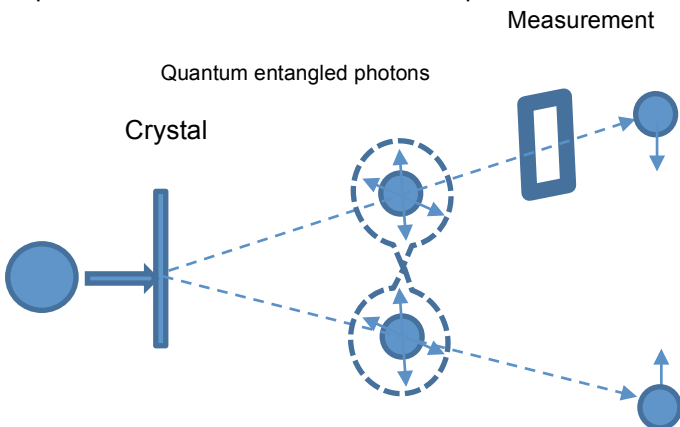


Figure 1. Quantum entanglement of photons

Since then numerous tests (Bell, 1964) (Hensen, et al., 2015) indeed proved existence of “spooky action at a distance” rejecting possibility of predetermined entanglement. The recent explanation for EPR paradox came from L. Susskind and J. Maldacena who proposed that entangled particles are connected by wormhole or Einstein-Rosen bridge (Maldacena & Susskind, 2013). Einstein-Rosen bridge is a tunnel with two ends in two different places of universe which was used to explain the black holes (Einstein & Rosen, The Particle Problem in the General Theory of Relativity, 1935). According to L. Susskind and J. Maldacena instant communication of entangled particles can be made possible by shortcut tunnel created by spacetime curvature (Figure 2)

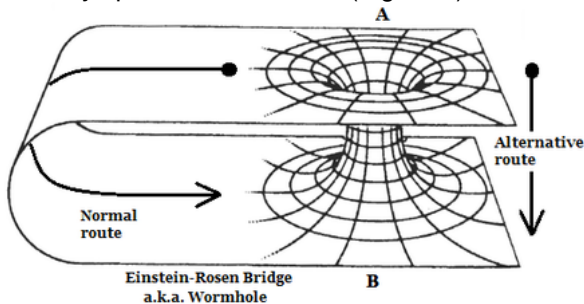


Figure 2. Einstein-Rosenhole bridge created by spacetime curvature

It is known that human bodies emits biophotons. Research has been done on detection and measurement of these biophotons (Cohen & Popp, 2003). Physician's meditation on compassion can result in stimulated emission of biophotons. Stimulated emission of photons which is contrast to spontaneous emission was theoretically discovered by A.Einstein (Einstein, Strahlungs-emission und -absorption nach der Quantentheorie, 1916). These emitted biophotons through quantum entanglement can enhance the therapy by creating spacetime curvature or shortcut between the doctor and his patient. In this way compassion entangles the doctor and his patient and can have significant therapeutic power.

Conclusions

The traditional medicine of Mongolia is based on Mahayana buddhism transmitted from Tibet. In a Buddhist view compassion equals to enlightened mind and is regarded as the main therapeutic power of a physician which should be achieved through meticulous training and meditation stage by stage. Accordingly, illnesses are classified by their causes into several groups, with some of them being treated by compassion as well as by medicine. Our hypothesis is that the therapeutic effect of compassion can be explained by recent breakthrough in quantum physics. Photon emission of human bodies might be stimulated by compassion meditation. The space-time shortcut tunnel established by physician's compassion toward his patient might have significantly boosting the effect of the therapy.

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Framing Assumptions in Teaching Ethics Using Case Studies

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Introduction

Teaching ethics is both challenging and intellectually fulfilling when the students and instructor are engaged in open mutually respectful dialogue. Over the past twenty years the shape of the bioethics course has changed both in content and pedagogy. The constant has been the centrality of case studies and moral deliberation. Seeking to help students identify ethical issues within a case and understand several philosophical claims of what is good, four moral theories were introduced for case analysis: utilitarian, respect for persons, egoism and natural law. Students worked each case within the framework of a moral theory and rotated through all four theories in four separate case studies. Groups representing students within the same moral theory discussed the moral rule and moral judgment of the case. The

instructor facilitated feedback from each group comparing and contrasting wherein there was agreement and disagreement within and between moral theories. Over time, it became clear that some students were forming an intuitive response to the case study and cleverly framing the analysis using the guidelines of the moral theory, to support his/her judgment, rather than allowing the normative claims of the theory to guide ethical analysis. Intuition supported by moral theory was not one of the objective of the course. In evaluating the course at the end of the semester individual students claimed to prefer one theory for a particular type of case and another for a different ethical issue because utilitarian or egoism would allow them to make a good justification for something they approved personally and natural law and respect for persons would prohibit an issue they opposed. This outcome was disappointing and led to revisions. By adding virtue ethics and removing both egoism and natural law, and increasing the number of case studies used, students dig deeper into literature in support of their ethical analysis. Choosing and presenting the case for ethical deliberation is not a completely objective process. Cases are chosen because they invite examination of values in a specific context. Each case has within it particular facts and details, abstract issues and concepts. When and why a particular case is chosen helps frame ethical questions for deliberative dialogue.

Framing assumptions of cases

Teaching ethics with the aid of cases helps focus discussion, highlight particular issues and concepts and test various normative values. Most cases have a factual foundation: the situation happened and was repeated by someone involved. Why that case was memorable or shared in order to make its way into a course suggests it offers an opportunity to evaluate ethical values through critical thinking. In selecting a case, several questions are considered. What community is represented? What values does the case suggest? Is the story intuitively or emotionally stirring? Is the case presented as normal, abnormal, ordinary, or unusual?

Students are aware of making ethical choices. They have decided to tell the truth or not. They know that taking what does not belong to them is wrong. They have over time developed a code of conduct that reflects their culture and tradition. Why they tell the truth, or refrain from taking what is another person's property may be less well developed. Why one action is good and an alternative bad may rest on a belief that to obey rules helps avoid trouble or punishment. Explaining why telling the truth is good is more difficult because most students can think of times when not disclosing all information was protective. Students may lack philosophical language to articulate why specific values are good.

A historical summary is given for each theory used with an outline for ethical analysis modified from C.E. Harris, *Applying Moral Theories* (Harris, 2007). Students diligently applied the testing rules and

evaluative process, but struggled with creating a moral rule that was specific enough to direct action and general enough to apply to a variety of similar situations. Interestingly, after each student had prepared his/her analysis, they discovered divergent views from other class members within the same moral theory, a good outcome because it encourages deliberative dialogue. Asking for a consensus in group discussion stimulates a search for common ground and illustrates that the theory is a guiding normative framework but not a prescription for a "right answer." Students often disagreed about which issues and concepts were most important, why one action or rule was good and why leading to compromise and synthesis. They discovered that the views of others often strengthened their own position, and occasionally inspired a change of mind. Diversity of values discussed within the platform was beneficial.

After introducing moral theories and some examples of cases analyzed by each theory, the remainder of the course in bioethics moves through a series of conceptual issues: health professional-patient relationships, health policy, life-sustaining treatment and end of life choice, life and death, reproduction, genetic medicine, each of which is covered with a variety of ethics articles on the concepts and issues (Steinbock, et al., 2013) supplemented with other journal articles.

Choosing a case generally reflects the unit focus, for example in the Doctor-Patient relationship unit, autonomy of doctor and patient is stressed along with the presumed intent of health care professionals to help a patient achieve better health. The Steinbock text offers cases within each unit. Some are discussed in class as a prelude to their first written case assignment such as, "Beneficence Today, or Autonomy (maybe) Tomorrow, Antihypertensives and the risk of temporary impotence: A case study in Informed Consent" (Steinbock, 2013, p 68). Whereas the principles of autonomy, beneficence, non-maleficence, and justice are conceptually important they are used to support the ethical analysis within the moral theory rather than as an independent framework. Agreeing with Callahan, principles should be considered but not used as "moral trump cards" (Callahan, 2012).

Conceptual development of autonomy, paternalism, Hippocratic tradition, is developed with material from the text and other journal articles. The first case to be written, discussed in discussion groups, and evaluated by various theories is an opportunity to test each student's ability to apply moral theory, extract issues and concepts from the case that require analysis, and deliberate within small groups. Prompt grading with liberal annotation is necessary for students to get feedback on their effort and to inform the instructor of what is understood and where additional explanation may be needed. The philosophical understanding of autonomy within the doctor-patient relationship is critical because it is much more than an individual wish. Patients may be influenced by family relationships that are contrary to

their individual wishes. Patients may hold religious views about what can and cannot be done.

The first case assigned for analysis and group deliberation to be graded brings out all of these variables that affect how a person exercises autonomy: "Devotion or Disease?" (*Hastings Center Report*, March-April 2011). In summary, the case involves MV a fifty-year-old woman who called 911 for help. Her husband would not admit emergency responders but police gained entrance. She was minimally communicative. A packed suitcase was on her bed. When asked if she was trying to leave her husband she would not answer. She was transported to the emergency room because she was emaciated and intermittently mute. MV's medical records reveal MV has schizophrenia. She is admitted but the only treatment she and her husband will accept are vitamins because they believe in Scientology. MV is admitted to the psychiatry unit as an involuntary patient. While a patient, her health improved but she denies any psychiatric problem and will not take antipsychotics. Should the health care team accept her treatment refusal?

Some of the framing assumptions of this case are the concepts of competency and vulnerability in patient's exercise of autonomy, the doctor-patient relationship, and the role of the physician to act in the best interest of the patient. Students discuss the competency and vulnerability of MV, and the duty of the physicians to do what they can to improve her health. Should she be declared incompetent in order to treat? Should they allow her to return to the family physician who was willing to accept her beliefs? Is MV competent to decide? If the doctors treat her based on her incompetence and she is mentally stable, is she at that point competent to reject further treatment? Should they ignore her Scientology beliefs? If her husband is abusive should he be a surrogate decision maker? What is in the best interest of MV? One of the complications of this case is whether or not it is possible to separate MV's capacity to make decisions because of her psychiatric disease is causing her to deny her schizophrenia or if the Scientology beliefs are prompting her to deny treatment. The challenge to separate these is vital to analysis of the case. If she cannot understand her illness due to delusional phase of her schizophrenia, paternalistic treatment may be justified. If she will not accept the diagnosis or accept treatment because of her religious convictions, treating her against her will is a violation of her autonomy and a lack of tolerance for her religious convictions. Giving MV the right of self-determination involves some risks.

The second unit deals with allocation, social justice and health policy, and uses articles about ethical framework for access to health care and the cost of care in relationship to social justice. Students read a variety of articles about the cost of care especially regarding technological interventions. The text includes a few cases alongside articles selected from the literature to explore the complexities of social justice and health. One example is "Bone Marrow Transplants for Advanced Breast Cancer: the story of Christine

Demeurers” (Steinbock, 2013, pp 223-239). Discussion includes an expanded understanding that health care in the US has been subject to market forces for a long time. The Affordable Care Act seeks to make insurance coverage available to everyone. While the law has increased coverage there are significant numbers of residents lacking insurance either by personal choice or their status as undocumented resident aliens. Is it a social or individual obligation to ensure health care coverage? How much care is enough? Are the costs and benefits proportional? Is health care a right? Should all types of treatment be covered? Are there limits and if so what are the guiding parameters? What rationing system is fair if rationing is necessary? Who decides?

The case assigned for student analysis is “Undocumented Patients” (*Hastings Center Report*, 2012). Briefly, Mr. A was admitted to the emergency department at a Catholic hospital complaining of fatigue. He is a thirty-five-year-old African male from Tanzania. He complains of headache, no appetite and nausea, and has swelling in feet and hands. After testing, the physician informs Mr. A that he has end-stage renal disease and he needs dialysis or a kidney transplant to live. The physician recommends dialysis but the man is living in the US illegally, and has no job or family in the area. The Emergency Medical Treatment and Labor Act (EMTALA) requires the hospital to examine and stabilize the patient. To stabilize Mr. A, the physician admits him and starts dialysis. Administratively, the hospital is concerned that a non-paying patient could compromise quality of care for other patients and that his long term dialysis required to prevent Mr. A’s death would involve substantial costs. Should Mr. A be discharged once stable? If you were a member of the hospital ethics committee what would you recommend?

Complexities in this case include the legal requirements of EMTALA: is this an emergency medical condition? If so, it is not only this current treatment that is at issue but the continuing legal duty after he is stabilized. Furthermore, this is a Catholic hospital with religious normative guidelines for health care. “In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination” (p16 *HCR*, Jan-Feb 2012). The hospital needs a policy to deal with cases like this so that the mission of the hospital does not put the facility in financial jeopardy while being responsive to patients.

Framing assumptions for this case are the influence of law and institutional mission on health care access. Finance and legal concerns are obvious but how either should impact access to health care is a broader and deeper question. What ethical values guide health care availability? Is the current system just? Does it provide equality of opportunity? Must there be limits for the system to be sustainable? What is the responsibility of each stakeholder? The overall

objective is to get students to read and think deeply about health care as a justice issue.

Selecting the case should reflect the teaching objective within the spectrum of ethical thinking, deliberation, and analysis. It is difficult to present the case in a completely neutral way. Often a case is recorded because it is emotionally stirring, unusual, or presents an opportunity to uncover multiple ethical norms. Using a case such as “A Case of Dwarfism” first recorded by *Science News* in 1994 could be used to explore reproductive freedom.

The case is included in the “Genetics, Birth and the Biological Revolution” (Veatch, 2010, pp 233-236). The obstetrician requests a bioethics consultation to consider the request from a pregnant woman and her husband wanting genetic testing for achondroplasia (dwarfism). The woman is three months into the pregnancy. She and her husband are achondroplastic dwarfs. The condition is caused by a mutation in one gene, the FGFR3 (fibroblast growth factor 3) gene which is recessive. If both parents are dwarfs each is heterozygous for the gene (+/-) since the homozygous (-/-) genotype is lethal, and homozygous wild type (+/+) will produce normal stature individual. The chance the child will be dwarf is 2 in 4, and one in four for a normal stature child. It would be reasonable to test for the -/- genotype and abort since the fetus is not likely to survive. But it is their intent to abort if the fetus is +/- and not a dwarf. “If the fetus was not achondroplastic, they would have the pregnancy aborted because they did not want to rear a child obviously different from themselves” (Veatch et al., 2010, p 236).

It is clear that this case could be inflammatory, or presented in such a way that the community of Little People could take offense. The thought that a “normal” child is not desirable could be surprising to student hearing the case, thus, inviting a discussion of the perspectives of “normal” intelligence, height, eye color, hair and where the line between trait and disease might be drawn. Is abortion restricted to disease based justification or is the full range of reproductive choices dependent on the will of the parent(s)?

Holly Gooding and coauthors warn that this case risks stigmatizing one group of people (Gooding, et al., 2002). Interestingly a survey of the “Little People of America” revealed that they “value the opportunity to contribute a unique perspective to the diversity of society” (Rinker, 1995). The value of the case is that it draws attention to deeper questions and fuels discussions about reproductive autonomy, genetic determinism, environmental influences, social values, genetic testing, in so far as the introduction of it is made clear, that it is an unusual request because only 2% of persons with achondroplasia would consider terminating a fetus because it would be average in stature.

Framing questions help to avoid a biased reading and analysis of cases. What will future technology allow in selection of embryos? Will the “best” embryo be an individual free choice or will a more equality based policy limit such decisions? When it is possible

to reliably edit embryos to correct genes will there be agreement on a liberal ideal of respecting any and all individual choices or will there be a more egalitarian conservative norm of editing to correct conditions for which a consensus exists that such conditions are harmful or deleterious to the future child? Will the ideal embryo be the same for everyone? While it is not helpful to try to suppress the intuitive or emotional response to a case. It does require overcoming those initial reactions in order to engage in reasonable, critical dialogue for why something is moral and how it can be explained in a reasonable and logical way. The goal is why something that is called good can be shown to be so (Giubilini, 2015).

Objectivity: Kathryn Montgomery warns against the idea that cases can be presented neutrally. "There is no pure, objective presentation of a case, and, although there may be a cultural or national or professional consensus on the values engaged by a case and the principles that apply to it, consensus never forecloses further examination, reinterpretation, and retelling. The medical ethicist's case, far from being a piece of reality isolated for the testing of assumptions and hypotheses, has been constructed from the very materials it purports to test" (Montgomery, 2001). Recognizing the limitations, using cases does help to focus discussion and help students learn to engage in deliberation and critical thinking. To science majors who want the one and only right answer to a problem, it is a surprise that deductive reasoning is not critical thinking. The temptation for many students is trying to solve the dilemma posed by the case, rather than evaluating the various normative guidelines: what is this case about? What values and issues are relevant? What concept(s) is/are involved?

Narrow framing of issues undercuts critical analysis. What assumptions do we have, individually, as members of one culture, and collectively as humans sharing a planet? What do we know that is empirically rooted about a subject? Are we biased for one theory over others? Do we challenge a theory from within? Are we reflexive as teachers always looking for new ways to shape questions to produce the most open deliberative and dialogical exchange of ideas? Narrow frames emerge from uncritical belief in one tradition over another or putting a higher value on one or a few norms. How questions emerge and are discussed should produce reasons all can accept or at least understand as reasonable. The direction of the field of bioethics seems to be driven at times by the beneficence of therapeutic medicine rather than the deeper generative question of what is good health care.

Framing Effect

There is a "framing effect" in the way a case is described that influences how it is evaluated. Critical bioethics calls for a polite informed skepticism, informed dialogue, civil disagreement because truth is often more complex than people claim (Arnason, 2015). The course moves deliberately from individual

choice to communal impacting policies. An end of life choice highlights autonomy. To the extent that the techniques are available and affordable, these individual choices within the "market of medicine" should be respected. However, when the community collectively pays for health care, limits may be imposed for how allocations are made in end of life care situations. Public health includes the setting of priorities, equal, fair, and just contours of health care financing, aims at the conceptual understanding of justice. What is fair? How broad must the defining community be to encompass the fair distribution of resources? When a new technology emerges anywhere in the world, how does it become the "standard of care" in particular locations? Pursuing social justice in public health should expand the horizon to global dimensions. Few issues in public health are restricted to a particular time and place. Certainly for infectious diseases the ability of people to travel is the open avenue for distribution of infectious agent. Larger issues of justice emerge from expensive treatments available in one geographical location but absent in another and the idea that people with equal needs being treated equally. Because of the absence of a universal system of financing health care globally, the issues get parsed into individual goals each under its own banner of appeal as is evident in both the Millennium Development Goals and its successor, the Sustainable Development Goals.

Appeal of Socratic Debate

Reading the dialogues of Plato introduces the reader to Socrates, a person who never wrote a book, in part because he was never sure he had reached a final conclusion. Socrates did not indoctrinate his students and neither should professors seek to do so today. The good dialogue partners of Socrates engaged in deliberative dialogue circling around and around the subject of virtue. Refuting negative examples of character only confirms what virtue is not, and stops short of defining what virtue is. The Socratic Method examines questions and answers, without assuming any answers will be or should be the same for everyone. The goal is to evaluate how reasonable and rational a position may be.

Teaching students the art of deliberation requires having certain virtues: the ability to think the "other" may be right, that another person's views can help move me in a direction that is more wise and prudent. Without the ability to listen to diverse views the deliberative approach cannot succeed. Each person should be able and free to articulate his/her position without fear (Gracia, 2016).

Professional Modeling

If an instructor exposes a preference for values or methods early in a course, students may seek to align themselves seeking to please which defeats the purpose of the opportunity to exercise and develop moral analytical thinking. If the instructor is overly neutral on all issues and methods, students may conclude prematurely that all moral reasoning is simply

relative. Disclosure of why a particular case or article is assigned helps to avoid either entrapment. Sadly, some students care more about making a good grade than taking the opportunity for moral development. Persuading students to enter into dialogue with an open mind is best achieved by modeling. When a student expresses an opinion, asks a question designed to pontificate a particular value the instructor has an opportunity to take the statement seriously, calmly counter with questions or alternative considerations. Remaining neutral means respectful treatment of students with divergent views and values. It is helpful to explain why particular cases or articles are being used to explore specific ideas, concepts, and values. The classroom is then a microcosm of the larger social context and the exercises in deliberation within the small group prepares students for critical thinking, and engagement in the world. The one critique that remains to be addressed in future revisions is a move from an almost exclusive Greek Philosophical ethics to a more global approach.

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Internal Evaluation of Subject Ethics in Health Care: My Experience of MS Nursing Students at a Pakistani Nursing Institute

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Abstract

This article shares my experience of internal evaluation of bioethics at postgraduate level at a nursing institute of Pakistan. Bioethics is included in the MS Nursing student's curriculum as a subject "Ethics in Health Care". In this article I will focus on internal evaluation and also put some light on curriculum design of MS Nursing students.

Introduction

The MS Nursing program at the public school of Nursing LUMHS (Liaquat University of Medical and Health sciences) Jamshoro started in 2016 and the subject Ethics in Health Care is also included in the curriculum. This subject is being taught in the 1st semester of MS Nursing and the degree comprises of two years. Like other specialties related to health care, nursing discipline also needs Ethics because Nurses are experiencing ethical and moral issues as a result of contemporary global developments and new changes in health care (1). In the past few years, nurses were expected to behave obediently without question and they did not participate in decision making of ethical issues (2), but now the nursing students are given training in ethics to recognize and resolve ethical dilemmas in the field of nursing and also to face the situations where ethical analysis is a compulsion (3). The Ethics in Health Care curriculum is recognized by the Pakistan Nursing Council denoted as PNC and also by the Higher Education Commission Pakistan denoted by HEC.

This master's degree program of MS Nursing students is designed like any other modern program and the students are assigned various tasks during their semester. The teaching of ethics is included from start to finish in 1st semester and it includes various units and students are given home assignments, group presentations, debates, summaries of various units to write up and also internal evaluation class test and all these assignments comprises internal evaluation which includes 20% marks and semester exam will cover 80% marks. In this paper I will share my experience of internal evaluation of master's students and also their Course contents and how students performed in internal evaluation before final exam which is scheduled in August 2016 as semester was started in 1st week of March 2016.

The students are taught for 16 weeks (2 hour/week) and the subject holds a weightage of 2 credit hours. The students are given preparation time of 2 weeks before their final exam and in between they are given 5 weeks summer holidays and this period covers our Holy Month of Ramadan and Eid festival. I completed the Internal Evaluation of students on 25th May 2016 (13th week of Teaching) before the summer vacation.

Discussion

The MS Nursing program at LUMHS is a modern program and its curriculum includes the essential ingredients of contemporary bioethics. This course has philosophical ethics as its major component which is practiced in the health care setting. It develops philosophical and ethical knowledge, ethical awareness and skills. Patient care is a compulsory aspect and component of nursing education that students have to master in to graduate (4).

The course has different units and it comprises of unit 1 which focuses on social, philosophical, and other historical forces which has influence on the development of nursing. Ethical theories are covered in unit 2 and they include Utilitarianism, Kantianism, Liberal Individualism (Rights based theory), Communitarianism (Community based theory), Character ethics (virtue based theory), Ethics of care (Relationship based theory), and Casuistry (case based reasoning). Unit 3 includes Ethical principles which include all fundamental principles and they are elaborated, discussed and analyzed. This unit also includes Professional Patient Relationship and demonstration of Professional behavior.

Unit 4 focuses on value clarification and development i.e. what is value process and how values are acquired. Values conflict and its implications in nursing care are also highlighted. Ethical Dilemmas are taught in unit 5 and includes various examples of ethical dilemmas and ways of thinking to solve them. Professional Ethics and Institutional Constraints in Nursing Practice are discussed in unit 6 and multiple ethical obligations and responsibilities of nurses are elaborated, the nurse doctor relationship is also discussed and importance of nursing is also highlighted. Rights, obligations and health care are taught in unit 7 and it includes the concepts of rights. The last unit 8 includes Policy, Ethics, and Health Care. In this unit ethical dimensions of health policy are discussed, health care policy in recent decades is analyzed and its historical, legislative and political background is discussed. Now coming to internal evaluation and as per our university policy 20% marks are assigned for internal evaluation before the final semester exam.

As discussed earlier students are obliged to give presentations, debates, write summaries and make home assignments and also have to appear in class test, so therefore it was not possible to mark every assignment in internal evaluation. To solve this problem I assigned marks to 4 of the components and made other assignments unmarked. The first

assignment that I assigned to students was to make summary of unit 1 which comprises of social, philosophical, and other historical forces influences on the development of nursing. The students have to write summary of minimum 500 words and one week was given for each and every assignment except the class test, which was announced 2 weeks before to give ample time to students to prepare. The first assignment was not marked in internal evaluation. The second assignment was given as group presentations on the topic fundamental principles of bioethics. There are 15 students in our class and I made 4 groups (3 group each having 4 members and one group having 3 members). Each group was assigned one fundamental principle and all four principles i.e. Autonomy, Beneficence, Justice and Non-maleficence were presented. 5% marks of internal evaluation were added through this presentation. This happened in 3rd week after teaching those principles. The students performed better and majority got 80% marks in that. The third assignment was given as "To develop informed consent form" and it was given in the 5th week after teaching the concept. This assignment also comprises of 5% marks in internal evaluation and the students took marks in the range of 60 to 90 percent.

The 4th assignment was again a write up summary of the topic values clarification and development from unit 4. This summary of 500 words was also unmarked and not included in internal evaluation. The summary assignment was a group activity from each of 5 members and the consent form assignment was individual work. This was done in 6th week. The students were informed 2 weeks before of the class test and as per rule it was taken in 9th week (mid term). The class test was also given 5% marks in internal evaluation. It comprised of SBQS (single best questions) and SEQs (short essay questions). The test was of 1 hour duration and having 13 SBQS (26 marks and 20 minutes) and 4 SEQs (24 marks and 40 minutes duration). The students performed in the range of 40% to 78%. Out of a total 15 students, one was absent and one failed (less than 50% marks) while the highest marks were obtained 39/50 (78 % marks). The other 13 students passed the test. The 5% of internal evaluation was taken accordingly from the total of 50 score. The next assignment was also one of group presentations and the group comprised each of 3 students. This assignment was unmarked and the students had to present ethical theories and the 5 groups were assigned 5 main ethical theories (one each). The presentations were good and students presented better arguments. The groups were assigned topics by small slip as one member from each group has to take one piece of paper (folded slip having the name of topic written) to choose his/her topic through luck. All the slips were folded and put on the table). The last assignment was marked and it happened in 13th week of semester. This was a debate on various contemporary bioethics issues. This debate was also a group activity and 6 groups were made to handle 6 topics. This was included as 5% marks in internal evaluation and each group had either 2 or 3

members. The topic was included after they had been taught in the course, and included issues: Organ donation (pro and con groups), Euthanasia (con group), In Vitro Fertilization (IVF) or assisted reproduction (Pro and Con group) and Abortion. The students performed well in the debate and the majority got 80% marks (4/5). This last assignment concluded the 20% percent marks of internal evaluation and they are finalized before the final exam which has weightage of 80% marks. The final exam will be on the pattern of class test and having both SBQS and SEQS. The students performed in the range of 70 to 85% in internal evaluation (20 marks). One student left the MS program. The performance of students was very satisfactory for me as a facilitator and they worked very hard throughout the semester and for almost every week they got home assignment in the form of summaries, presentations and other such as debates, class test. The students were provided articles, notes, presentation material and the book (Beauchamp and Childress, *Principles of Biomedical Ethics*) for reference and preparation.

Conclusion

In conclusion I want to state that the experience of teaching at masters level (MS Nursing) was very good and it was first time for me to teach at the postgraduate level. I already had experience of teaching bioethics at undergraduate level at many institutes and programs, but this exposure was far more satisfactory because the students were more mature and qualified (Masters level). Because of their field and expertise (Nursing care), they are always active members of the health care team as they have to provide critical care, face ethical dilemmas, resolve the critical ethical conflicts and now they are also involved in more formal ethical decision making. I tried my best to achieve my target of completing the ethics course in one semester and to put all my efforts to teach those things in one semester which I learned in two years in my master of bioethics. In my opinion and as per the feedback given to me by nursing institute administration I have achieved my target and it was not possible without constant hard work of MS Students.

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The Patterns of Social Stigma among the Rural Women in Bangladesh: A Sociological Study

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Abstract

A pattern of social behavior usually refers to the relatively permanent, recurrent and objective social behavior of human beings that emerge as a reality in interacting with one another as members of society. However, it is not possible for all human beings to be the same regarding age, gender, taste, physical structure, face and appearance, personality, skin color, intellectual and social characteristics, etc. Although people in general realize their situation and characters, some characteristics become justified by them as undesirable and social stigmas appear. This study was conducted in Gopalpur village of Natore district. The objective of this study was to explore the patterns of social stigma among rural women in Bangladesh. Several methods such as social survey method through scheduled interview, focus group discussions (FGD), informal meetings, spot observations have been used to explore and gain a critical view of overall aspects of social stigma in the study area. The study found that all of the women were stigmatized on the basis of one issue or another. Social stigma may occur in many different forms. The most common forms that occur are related to socio-cultural identity, family, poverty, ignorance, physical structure, gender, skin color, disease etc. In this study women who had been stigmatized felt as if they had been transformed from a whole person into a tainted one. They felt themselves as different and devalued by others. Social policies should promote inclusion of all people in socio-economic activities and prevent the processes of stigmatization and social exclusion.

1. Introduction

A pattern, originating from the French word "patron", is a type of theme referring to recurring events or objects, sometimes taken as elements of a set of objects.¹ It denotes a social construction of ordered social behavior in a social milieu. Social

¹ http://en.wikipedia.org/wiki/Geometric_patterns Accessed on 22/02/2011

stigma is also a social construct. Expected and unexpected attributes are always dependent on social atmosphere. Such atmosphere emphasizes wealth, material prosperity, sociability, educational qualification, health status and physical beauty, youth, competence, independence, productivity, and achievement. Deficiency in exposition of such values can import social stigma.²

The totality of beliefs and sentiments common to the average members of a society forms a determinate system with a life of its own. It can be termed "collective" or "common" conscience.³

According to the model prescribed by Bruce Link and Jo Phelan, stigma exists when—

- (a) social groups differentiate and label human variations,
- (b) prevailing cultural beliefs tie those labeled to adverse attributes,
- (c) labeled individuals are placed in distinguished categories that establish a sense of separation wall between "us" and "them" and finally
- (d) labeled individuals experience "status loss and discrimination" that lead to unequal circumstances.⁴

2. Methods

The study is exploratory in nature. Blending of several methods such as social survey method through scheduled interview, informal meeting, spot observation, and non-participant observation have been and were used to explore and to gain critical overview of overall aspects of social stigma in the study area.

Sampling and Sample Size: Gopalpur village under Baraigram *thana* (a local administrative unit) of Natore district was selected purposively as the locale of this study. After conducting a preliminary baseline survey, it was found that the total number of households in the study locale was 1309 and the total number of married women was 1519. For this study, 218 married women from 218 households have been selected through simple random sampling.

Unit of Analysis: The household was considered the unit of analysis in this study.

Sources and Techniques of Data: Both qualitative and quantitative data were gathered for the study. Primary data were collected from the respondents in relation to the objectives of the study. Techniques such as face-to-face interview using a schedule, spot observation, and non-participant observation, compilation of personal and family profiles through informal meetings were used. Both open-ended and closed-ended questions were incorporated in the schedule. In addition, focus group discussions using a

checklist were carried out with people belonging to different social strata. Moreover, secondary information from books, journals, documents were also put to use.

Data Analysis and Presentation: Data were analyzed through simple statistical tools and techniques using inductive logic to draw inference. Analyses were presented in a narrative form along with tables and graphs.

3. Patterns of Social Stigma

Goffman has categorized social stigma into three categories- a) overt or external deformities as can be exemplified by leprosy, polio etc. b) known deviations in personal traits as can be exemplified by ill motivated persons, drug addicts, those with suicidal tendency, dementia, etc. c) tribal stigma as can be exemplified by the Afghan *madrassa* students (known as Taliban), or Pakistan as a place of religious extremism, race such as Bantu,⁵ as examples.

Falk classified stigma into two classes, namely a) existential stigma- deriving from a condition which the target of the stigma either did not cause or over which she/he has little control and b) achieved stigma – stigma that is achieved through behavior.⁶ Social stigma may occur in many different forms. The most common forms occur with socio-cultural identity, family, poverty, ignorance, physical structure, gender, skin color, and disease etc. In this study, women who had been stigmatized felt as if they had been transformed from a whole person into a tainted one. They felt themselves as different and devalued by others. These things took place in their workplaces, educational settings, and mostly in their own families, neighborhoods and community as well.

4. Results

4.1 Age distribution of the respondents

Social perception of age is important in shaping and coping with social stigma in society. Fig. 1 showing age distribution of the respondents reveals that most of the stigmatized women (69%) were aged between 21 and 50 years. Only 20% of them were aged above 50 years. It is also notable that 11% of the respondents were aged below 20 years. Thus it is clear that more than 80% of the stigmatized women were in their working age.

4.2 Religious identity and stigmatization

Religious identity can mould social stigma at various levels. Originally, the study village was dominated by Hindu people, but since 1947 the number of Muslims in the area increased and it became Muslim dominated. In the present study, 86% (n=188) of the respondents were Muslims, 4.6% (n=10) were Hindus and 9.2% (n=20) of the respondents were Christians (Fig. 2).

² L M Coleman, "Stigma: An Enigma Demystified" in *The Dilemma of Differences*, eds. S C Ainlay, G Becker, and L M Coleman (New York: Plenum Press, 1986), pp. 211-232.

³ Emile Durkheim, *The Division of Labor in Society* (New York: The Free Press, 1984), pp. 31-149.

⁴ B G Link & Jo C Phelan, "Conceptualizing Stigma", *Annu. Rev. Sociol.*, vol. 27, (2001), p.363.

⁵ Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon & Schuster, Inc., 1963), pp. 32-123.

⁶ Gerhard Falk, *Stigma: How We Treat Outsiders* (New York: Prometheus Press, 2001), p.11.

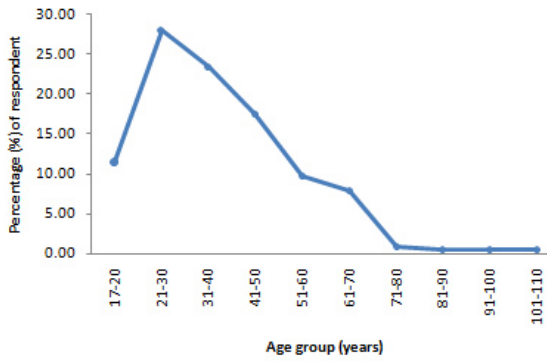


Figure 1: Age distribution of the respondents

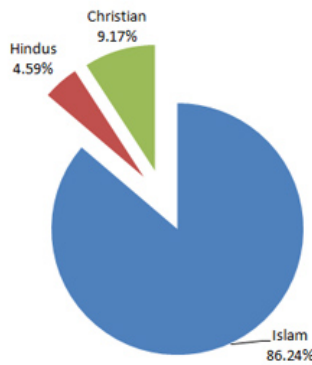


Figure 2: Distribution of religious identity of the respondents

Religious identity can stigmatize people. In the study area, were Hindus. But they had lower caste status in their own religion, and lived in the *khas* (land owned by the government) land in the study area. For their drinking habits, they were always stigmatized. Converted Santal Christians were habituated to drinking locally made alcohol from the palm trees. For their drinking habits and food consumption pattern such as eating meat of pigs, tortoises, snakes, frogs etc., they were highly stigmatized.

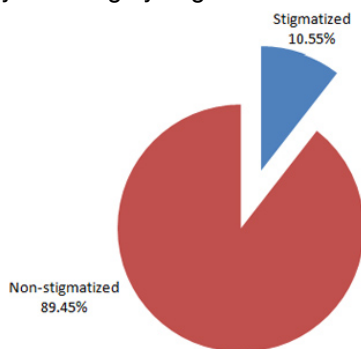


Figure 3: Stigma for religious identity

Religion played an important role in rural social life. Everything related to religion carried deep emotion and a sense of sacredness.⁷ Arabic is seen as very sacred for among the Muslims as it is the language of their holy book, 'the Quran'. Hindus and Christians who could not read the Gita and the Bible were

stigmatized just like the Muslims who could not read the Quran written in Arabic.

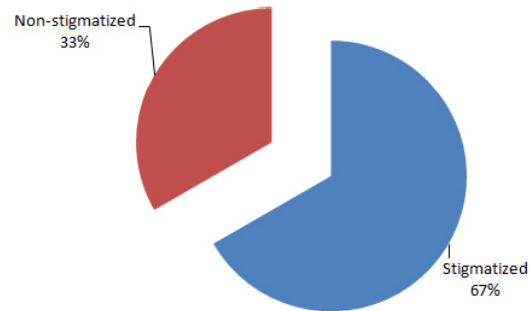


Figure 4: Stigmatization status for not being able to read the Quran

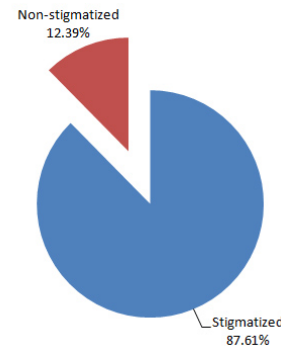


Figure 5: Stigmatization status due to education

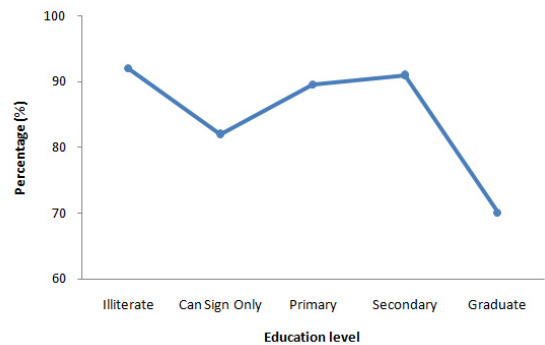


Figure 6: Association between stigma and levels of education

4.3. Education and stigmatization

Women in the study village were expected to work only as housewives and they were not allowed to pursue formal education. It is seen from this study that 88% of the respondents were socially stigmatized for either both, acquisition of education and for not being able to do so (Fig. 5). All the levels of education brought about stigma for them at the same time though the general public assumption is was that illiteracy is was relatively more stigma prone.

⁷ Emile Durkheim, *The Elementary Forms of the Religious Life* (London: George Allen & Unwin Ltd., 1915), pp. 219-230.

4.4. Physiological factors of women and social stigmatization

Traditionally, people in rural areas in Bangladesh like a fat body and educated people in urban areas try to be slim. Again, people of the developed world prefer to be slim whereas people of the poverty ridden world favor fattening of the body. It has been observed among the respondents that 13.3% were fat and only about 1% women were unusually thin.

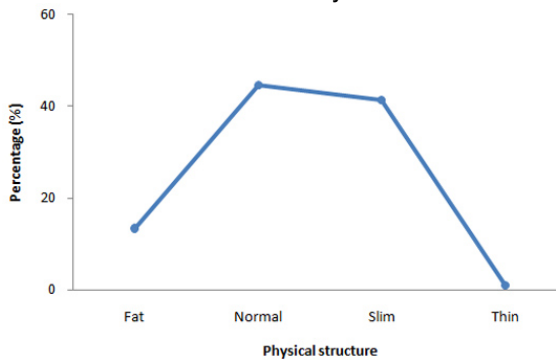


Figure 7: Physical structure of the respondents

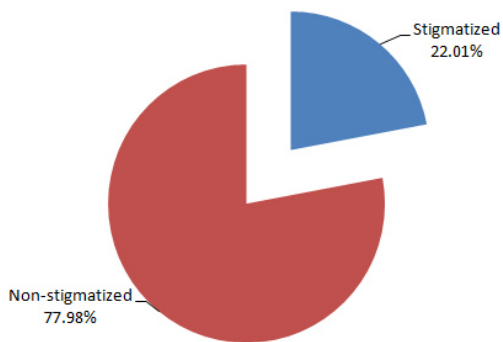


Figure 8: Stigmatization status due to physical structures

In this situation, fat, thin and a portion of physically “normal” women were stigmatized in the study area. Even slimming efforts are stigmatized by traditional rural society of Bangladesh.

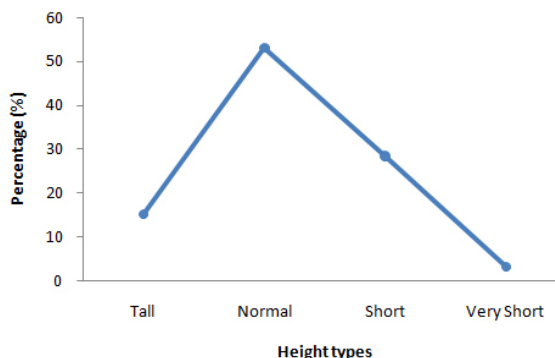


Figure 9: Height of the respondents

Too tall and too short women have always been stigmatized. In the current study, 15% of the women were ‘very tall’ and about 32% of them were ‘very short’. Figure 10 portrays that 66% of the respondents were stigmatized for their height. However, this caused serious obstacles in women’s social life, especially regarding marriage. Women were stigmatized by calling names, such as *Bantu* (referring to a tribe in

Africa, members of which were very short), *Gattu/Bamun* (very short/ dwarf) etc. If women were very tall, then they were called *Hati* (elephant), *Talgach* (palm tree), etc.

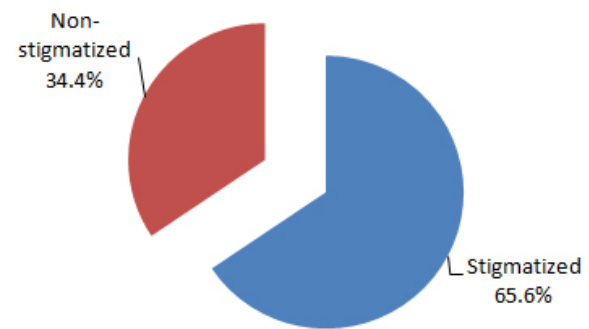


Figure 10: Stigma due to height

Skin color is a vital factor in stigmatizing. In Bangladesh, white skin is always appreciable albeit European whites are always under fire. In the present study, 33% of the respondents were fair skinned whereas 44% were blackish and 24% of them were dark skinned (Fig. 11).

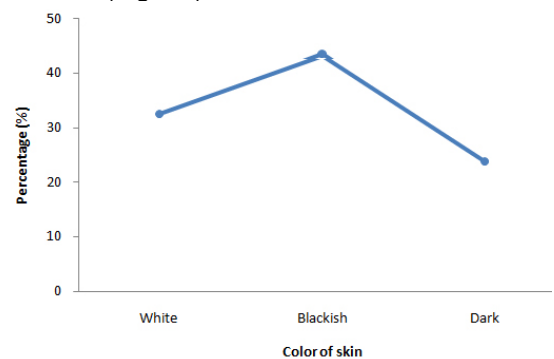


Figure 11: Skin color of the respondents

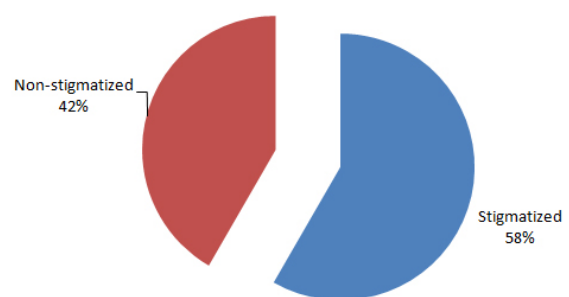


Figure 12: Stigmatization status due to skin color

It is seen in Figure 12 that 58% of the respondent women were stigmatized and often they were stigmatized by the name *Kalti*, which meant abominably black or *Ma Kali* (a deity of the Hindus who is black), *petni* (female ghost). Black skinned girls are considered burdens to their parents, as it is an impediment in being selected as a bride for marriage.

This often leads to a greater amount of dowry being needed, and low quality groom if parents are poor.

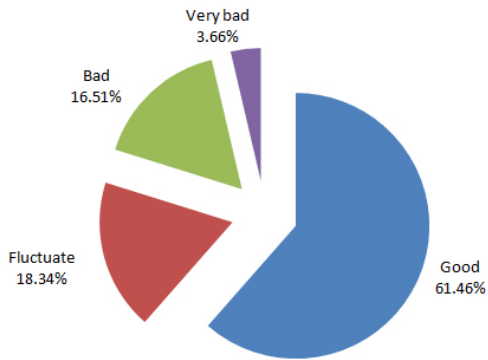


Figure 13: Physical condition of the respondents

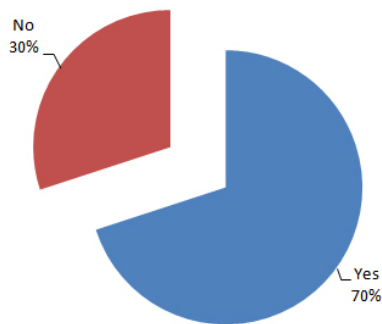


Figure 14: Burdened by illness

Physical condition of the respondents shows that 61% of the women were in good health condition, 18% fluctuated, 17% were in poor health and 4% were very sick in this study (Fig. 13). Male dominant society looks at women as dependent members as women’s contribution to household works are unpaid.⁸ When women are in a physically vulnerable situation, it can foster stigmatization to the apex.

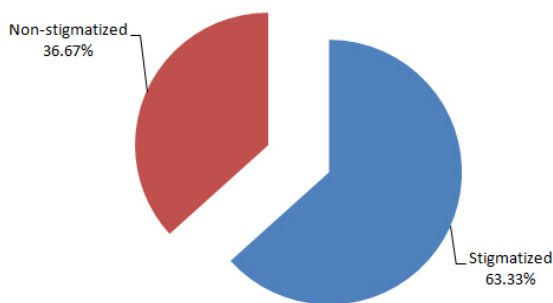


Figure 15: Stigma for sickness

Among those whose health conditions fluctuated, or were in bad or very bad condition respondents in the study, 70% felt that they were a burden to their families for illness where as 30% of them did not think so. Among those respondents who thought they were burdens for their illness, 63% felt stigmatized for their poor health. Respondents spontaneously said that if a woman remains ill for long days or plunges into illness very often, she is highly stigmatized in

⁸ibid, p.39.

comparison to those who rarely become ill for a few days.

4.5. Family and stigmatization

Women were stigmatized for the behavior of their family members. The present study shows that 60% of the respondent women were stigmatized for their husbands’ activities as an induction rule. An example is a proverb that says “A man is best known by the company he keeps”. A number of open ended responses have been collected from the respondents in this study. These are given in Table 1.



Figure 16: Stigmatization status due to husband’s activity

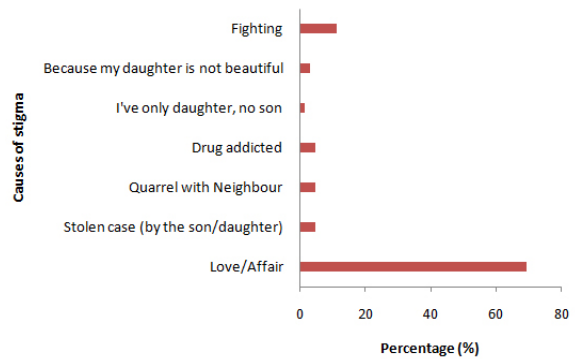


Figure 17: Causes of stigmatization by the children

Table 1: Activities of husbands for which wives are stigmatized (%)

Husband doesn't want to work	1.4
Husband is not clever enough	1.4
Quarrels with neighbor	11
Husband bought necessary commodities for wife	1.4
Drug addicted husband	12
Illegal relation with other women	19
Stolen case	18
Fighting	23
Husband got married to another woman	4.1
Husband is a mental patient	1.4
Husband is a member of Bangladesh Rifles	1.4
Business problem	4.1
For playing cards	1.4

People generally relate children’s behavior with their parents, especially with their mother. Among the causes of such stigma, an ‘affair’ case alone

represented 69% of the respondents, who said that a daughter's affair is much more disastrous than a son's affair and that rural people often blamed her mother--as--"she the daughter is like that because of her mother" and even husbands also blamed their wives, often ordering, "Control your daughter!" etc.

4.6. Personality traits and social stigma

Ideally, extramarital attraction for other males is strictly forbidden in Bangladesh. From time immemorial, extramarital relations are considered strong sources for stigmatizing. 5 Five (2.3%) of the respondents confessed that they were stigmatized for being attracted to other males (Fig. 18). Respondents also said that if male members are were involved in such activities community people does--did not stigmatize them as harshly as they stigmatized women.

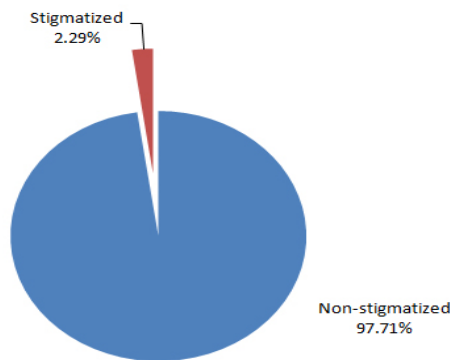


Figure 18: Stigmatization status due to attraction to another male

4.7. Social, political, cultural and economic conditions in stigmatizing women

Sex refers to physical differences of the body but gender is concerned with the psychological, social and cultural differences between the male and female in society.⁹ Every society has different views on gender identity. Gender and gender relations are the social norms in societies and stigmatization mechanism lies in the gender expectations of society. These norms set up appropriate behavior of the male and female and crystallize them.¹⁰ In the study area, 15% of the respondents thought that society looked at their gender identity negatively. Again, 45% of the respondents thought that society's judgment on the gender identity was a situational one. Situational categories were exemplified easily by the respondents in from the informal discussions. They said that if gender identity favors someone, then it was justified as right by that person. If it did not favor their her/his interest, people he/she justified that gender identity as a wrong one. 'Positive attitude' of community denotes that gender roles as fixed by the society are justified and 'negative attitude' denotes that the roles are not justified.

⁹ Anthony Giddens, *Sociology* 2nd edition (Oxford: Polity Press, 1993), p.162.

¹⁰ Ranna Haider, *A Perspective in Development: Gender Focus* (Dhaka: UPL, 2000), p.35.

Prevalence of stigma emanating from negligence and gender identity was alarmingly high in the study area. Among the respondents, 67% informed that they were victims of negligence and stigmatized for their role in family and society at large. Male members of their families and community at large regarded women's role in family and community as trivial.

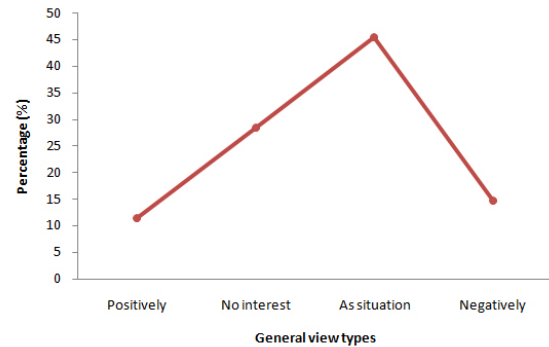


Figure 19: Society's view on gender identity

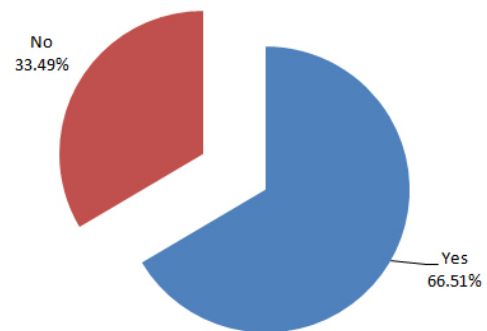


Figure 20: Negligence for gender identity

Widowed and divorced women, and those who were married more than once, were stigmatized in the study area. Society generally has a negative attitude towards them. Data show that 5.3% of the respondents of this category did not get proper treatment, 87% of the respondents said that society took them negatively and only 7.9% were viewed normally. When a husband passes away, it is said that the wife has taken him away. Divorced and remarried women were stigmatized by the community. They considered women of bad character. If they were not, such calamities would not have happened in their lives.

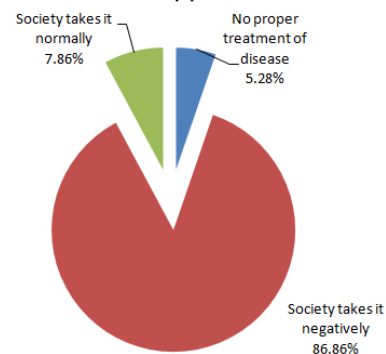


Figure 21: Society's outlook about widow, divorced and married more than once

Poverty is a fundamental cause of social stigma in the study area. Financially weak persons can be easily

stigmatized by the powerful ones. This, of course, requires a discussion on power and economic dimension in social stigma.¹¹ Data show that 83.43% of the respondents among the poor realized that they were stigmatized for their poverty (Fig. 22).

Sterile women are stigmatized highly in Bangladesh society. Women who had failed to give birth to child even after five years of their marriage were severely criticized. Respondents of the present study have shared that it was always women who were stigmatized for this. Among the childless women, 35% were stigmatized and blamed for not issuing a child. Women who never became a mother were stigmatized by formidable words such as *apaya* (bearing bearer of a bad omen), *alaxmi* (a woman with bad luck), *banja* (sterile womb) etc. Besides, many women are were physically tortured by their husbands for this reason. In many cases, people avoided meeting them when they started their journey on a fishing endeavor, a business, or to attend an inauguration ceremony etc. If unconsciously or accidentally met, people think negatively about their lot.

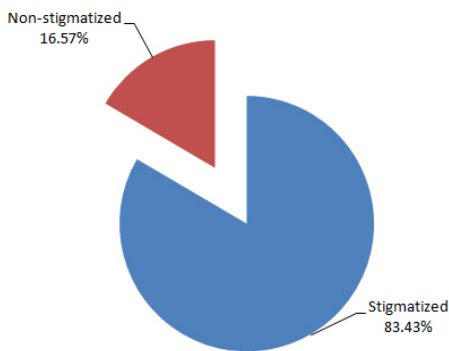


Figure 22: Stigmatization for poverty

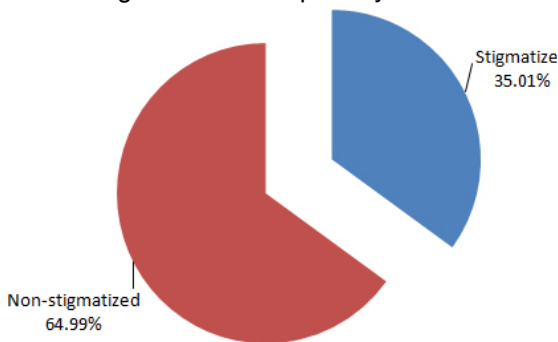


Figure 23: Stigma for having no children

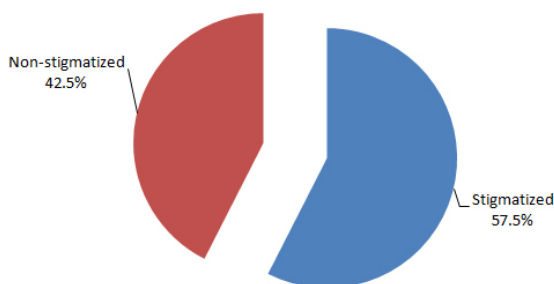


Figure 24: Stigma for having only son/daughter

The importance of son in all religions and rituals can be an important source for stigma. In Hinduism, a son is needed to burn-cremate his father's dead body. In Islam, a daughter cannot take part in the funeral of her parents. Sons are income earners and decision makers in family and resultantly they are very much desired in families. Owing to all these facts mentioned above, most of the respondents who had no sons were stigmatized in the rural areas like in the area of the current study. Women who had only sons (and no daughters) were stigmatized but less in comparison to those who had no sons. Data show that 58% of the women having sons only or daughters only were stigmatized in the study locality.

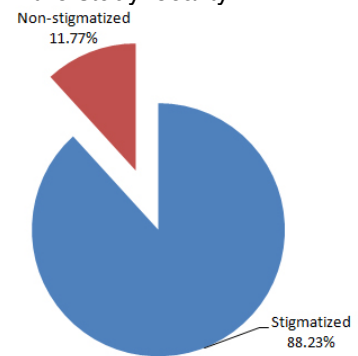


Figure 25: Stigma caused for not putting on nose pin/wedding ring

Ornament norms are maintained by the rural people of Bangladesh irrespective of religion. *Nakful* (ornament for nose) is such an ornament. Normally, women are expected to wear it after their marriage in Muslim and Hindu communities. If the married women of these two major religions did not wear the *nakful*, it is thought that either they desire to do harm to their husbands' or their husbands were dead. The study shows that 88% of the respondents who did not wear *nakfuls*/wedding rings were stigmatized (Fig. 25).

5. Conclusion

Social stigma among the rural women in Bangladesh is almost entirely molded by long cherished socio-cultural patterns. Patterns of social stigma in the study area embrace physical and socio-cultural domains. Women are stigmatized nearly in all spheres of their lives. It is understood from the respondents that patriarchy is the root of all such stigma. Once women are socialized in patriarchy, their views become the same those of the male members of society. Women are stigmatized by their husbands and by other family members including female members. Full participation in all social domains to unfold their potential is still a far cry. This leads to their social exclusion. Further research endeavor is needed to explore the complicated nexus of social stigma in Bangladesh.

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Would we leave our ageing parent or grandparent in the care of a robot? – A perspective from Islam.

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You may think this question is far-fetched. It is not. Just look at what the social/economic trends tell us. In Western Europe and Japan, there is ageing population and shrinking population size. In the long term, it is estimated that by 2050, all the continents except for Africa will have increased ageing population and shrinking general population. Two important challenges among others, for the world in 2050, are:

1. Demands of the Ageing population
2. Limited human resources available from the declining general population.

In the UK, there are 11 million people aged 65 or over with 3 million people aged 80 or over. By 2050, estimates predict that the elderly will account for 16 percent of the global population. Research suggests that about three in four of elderly people will develop a social care need such as assistance getting up in the morning to all day support for physical, emotional and mental care. With declining population generally

throughout the world, there will be shortage of human resource willing to take on the responsibility. Families that traditionally look after the elderly will also come under pressure due to much social and economic pressure.

In the last 500 years, technology has come to the rescue of humanity to solve some of our challenges. It is said that, in the last 100 years, more knowledge is discovered than ever before. It is increasingly likely that robots and artificial intelligence (AI) assisted appliances will take on the part of the role of care providers, including, meeting practical care needs, providing round-the-clock support and even providing a form of companionship. Over 22 per cent of Japan's population is currently aged 65 or older and many companies are working on robots that can assist the elderly, ranging from those which offer therapeutic care to those which can help move and carry objects. Within the next 20 years, it is increasingly likely that (AI) robots will be used in the care of older adults throughout the developed world. What are the implications for human society as a whole of this intervention in our social relationships? What ought to be the Muslims perspective on Artificial Intelligence (AI) assisted appliances?

As part of larger global society, Muslim communities are also undergoing increasing ageing population. The community needs to deliberate upon the key ethical and social implications on the use of this technology; implications it will have, on the family life, social life as well as on individual identity. I am expressing a reflection from an Islamic perspective on this topic briefly, hopefully, to encourage deeper deliberations on this topic among bioethics and religious scholars:

Metaphysical perspective

Though there is little work, if any, done in the aforementioned subject, there is one major issue which runs throughout Islamic metaphysical and philosophical literature – the soul (nafs). There is no indication in the Qur'an or hadith that a being higher than the human being would possess something like the complexity of the human soul – both in terms of its intellect, desires, capacity, emotion and transcendental yearning. For this reason, a robot would not be able to replace the human soul but only resemble it. We have to ask, is this resemblance enough for communication with an elderly person? It is possible that in cases where an elderly person has no one at all, a highly developed robot with some human-type personality possessing self-awareness could be programmed to communicate with the elderly person. It is up to an elderly person to accept such an entity. However, from the Islamic viewpoint, this does not replace the soul which is the basis for human identity, emotional capacity and spiritual, ethical and transcendental growth. This complexity allows for deeper intuitions which the robot may not be aware of. Therefore, one may argue that the use of robots in absolutely replacing humans (from a metaphysical point of view) is not only counter-human but dangerous as it reduces

human beings to nothing more than mechanical beings who require mechanical communication. There would be no room for deep human communication or flourishing. However, the use of robots in aiding human beings to perform certain services like cleaning or the such would be permissible as the role of human identity is not threatened in a major way.

Scriptural perspective

There is nothing in the Qur'an and ahadith which explicitly talks about A.I or robot. Even if so, it has to be interpreted a great deal. From a purely textualist angle, one may argue there is no prohibition on using robots to communicate with the elderly but this is a limited angle requiring a greater ethical and metaphysical framework which is not present in Islamic theory.

Legal viewpoint

This depends on the judgment of a jurist with his own *ijtihad*. Again, this is subjective as no overall framework exists with regards to bioethical issues. Usually *ihtiyat* or *bara'ah* (exemption) is used in the face of bioethical issues unless some verses and hadith is found which contain some sort of order prohibiting or permitting the technology or action in question.

The Islamic viewpoint may, at present, utilize a mixture of principles from metaphysics, philosophy and ethics with a broad reference to scripture to argue for the protection of human identity. This would position the soul as the basis of human identity requires cultivation rather than hindrance. If robots hinder the transcendental and ethical cultivation of the elderly, even at the time of death, this is against the spirit of journeying towards God. It is possible that robots aiding human beings in their services to the elderly would be allowed and as a last resort, to allow robots to replace a human in the case of truly isolated and alone elderly persons (as some movies have suggested). But the thumb-rule is one of prohibition and caution as from a metaphysical viewpoint, it renders human beings like machines which is not their purpose in accordance with Islamic scripture and metaphysics.

What do you think about this question?

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HESC to iPSC: Prohibition to Controlled Permissiveness to ethical panacea

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Abstract

Human Embryonic stem cell (HESC) research was replete with controversies involving the origin of these cells and the moral status of the embryo. The emergence of Induced Pluripotent stem cells (iPSC) was heralded by many as the solution to the controversy. It was believed by proponents of Induced Pluripotent Stem cell research that finally the fruits of the technology could be cherished without the dilemma of research involving human embryos. However, Induced Pluripotent stem cells are not the quick fix solution to the ethical issues of Human Embryonic Stem cells research as was made out to be. They come with their own ethical implications and the most glaring of them is the downstream applications of these cells. Regulations need to be formulated with these downstream applications in mind. The problem to define the moral status of IPS cells will become unavoidable as will research involving zygotes and embryos. Urgent international regulation is required for harmonization and proper advancement of the field.

1. Introduction

It is widely recognized that stem cell research has the potential to transform modern clinical medicine. The potential ability of stem cells to drive transplantation therapy as well as to serve as models for drug discovery and testing drove stem cell research in spite of wide spread controversy and opposition. The array of Pluripotent stem cells now contains embryonic stem cells, induced pluripotent stem cells and amniotic fluid stem cells. Pluripotent cells are those that are able to proliferate indefinitely, express pluripotent cell markers and are able to differentiate into all three germ layers [1].

Embryonic stem cells are isolated from the Inner Cell Mass (ICM) of the blastocyst stage embryo. These cells demonstrate the unique property of pluripotency, which is the ability to form any specialized differentiated cell types of the organs from which they are derived.

The derivation of pluripotent human stem cell lines from oocytes and embryos is intertwined with disputes regarding the onset of human personhood and human reproduction. A major objection to the generation of Human Embryonic Stem Cells is that it requires destruction of fertilized eggs which raises ethical concerns. The alternative established methods of deriving stem cells such as reprogramming of cells to produce induced pluripotent stem cells (iPS) avoids the ethical problems specific to embryonic stem cells.

The works of Takahashi and Yamanaka caused a paradigm shift in stem cell research as they demonstrated the forced expression of four transcription factors was sufficient to convert mouse fibroblast cells into embryonic stem cell like cells [2]. The resulting cells were called Induced Pluripotent stem cells (iPSC) and these cells are regarded as pluripotent as they display characteristics of pluripotency, which include ability to express multiple stem cell genes and the ability to differentiate into tissues representative of all three germ layers. The new method was revolutionary as it provided the means of generating pluripotent cells without embryonic tissue.

However, is it possible that iPSC cells will erase all the ethical dilemmas that Human Embryonic Stem cell research raises? There are problems with Induced Pluripotent Stem cell research that goes beyond the origin of these cells. The downstream applications of stem cells derived from both Human Embryonic stem cells and Induced Pluripotent stem cells raise similar concerns. This paper will address some of these concerns that the downstream applications of these cells raise and how the existing regulatory frameworks may be applied to guide such research.

2. HESC Research: Ethical Quandaries and Objections

A major ethical concern pertaining to research involving Human Embryonic Stem cells was the creation of human embryos for research and destruction of embryos for such research. This of course is based on the assumption that human embryos have moral status.

Some consider the fertilized ovum to have full moral status and that it should not be subject to research and or destruction. Others argue that the embryo is merely a ball of cells with no moral status. Most however take a middle ground that the zygote has a moral status but many only become deserving at a later stage of development [3].

Some advocate full moral status of the embryo from fertilization; that personhood begins at conception. They believe development from a fertilized egg to a baby is a continuous process and any attempt to pinpoint an arbitrary period when personhood begins is wrong [4, 5]. They believe that the embryos should not be viewed as means to an end and should be valued as human beings with moral status and human rights. The embryo is thus supposed to have the same set of basic moral rights, claims or interests as an ordinary human being and should be afforded the same dignity and respect as a person. Thus creating and using embryos for research is impermissible even if it saves lives [6]. Others however advocate full moral status only from the fourteenth day onwards. The Warnock Report [7] stated that no live embryo derived from in vitro fertilization maybe kept alive beyond fourteen days after fertilization nor may it be used as a research subject beyond fourteen days after fertilization. This formed the basis for the cut-off point being fourteen days. Although the fourteen day

has been criticized as being quite arbitrary. Other institutes such as the Royal College of Obstetricians and Gynaecologists had suggested seventeen days as a cut off period at which early neural development begins. Many believe this to be a slippery slope where embryos will be created to fuel such research. There was a dilemma to choose between the duty to prevent or alleviate suffering and the duty to respect the value of human life for those who viewed the embryo as human. In the case of Human Embryonic Stem Cell research, it was impossible to respect both these moral principles for those viewing the embryo as human life with moral standing. The early embryo had to be destroyed to obtain embryonic stem cells. This meant destroying a potential human life according to opponents of this research. However, it was accepted that Embryonic Stem Cell Research would lead to the alleviation of suffering of a lot of peoples. One view was that use of discarded IVF Embryos to obtain stem cells was compatible with the respect due to embryos, whereas the creation and used of cloned embryos was not. The argument was that cloned embryos are created for instrumental use only as a mere means[8]. The main issue was the moral status of the embryo. There was also debate about the intentionality and whether it was permissible to create embryos for research[9].

From a human rights perspective, the key is respect for individual human rights[10]. The theory claims that humans have rights and these rights must be taken seriously, but it is imperative to understand who qualifies for such protection. It is debated whether this protection applies and extends to unborn human beings. From the viewpoint of dignity based theories, the dignitarian perspective condemns any practice, process or product which will compromise human dignity. Originating in Kantian principles, the actions or omissions that could compromise human dignity are to be avoided.

3. The Ethical Panacea of IPSC

This possibility of creating pluripotent stem cells without “destroying a human embryo” in the process has been welcomed by scientists and bioethicists, policy makers as well as the scientific community. The words of Thomas Berg, Archdiocese of New York and Professor of Moral Theology, that “*The work of Yamanaka has put Human Embryonic Stem cell research largely out of business*” summarizes the view that Induced Pluripotent Stem cell are said to bypass ethical problems with research on embryonic tissue.

The production of Induced Pluripotent Stem cell eliminated the problem opponents of stem cell research had with the origin of the cells. It was assumed that embryos were suddenly not needed for such research. The new method was potentially revolutionary as it provided the means of generating pluripotent cells without embryonic tissue and was widely accepted as an end to the controversy surrounding Human Embryonic Stem Cell research.

However, with any stem cell research there are questions that go beyond the origin of the cells.

4. Ethical Issues raised by IPSC research

Stem cell research whether embryonic or induced poses unique ethical and moral questions and challenges. The rapidity with which research is expanding has made the emerging issues even more challenging. Induced Pluripotent Stem cell research raises the question of complicity as it was derived from technology based on Human Embryonic Stem Cell research. There are also questions about the technical issues concerning research involving Induced Pluripotent Stem cells. There are issues pertaining to consent, discrepancies in regulation, and conflicting legal and ethical standards across national boundaries. There is also the matter of ownership of these cells as well as privacy infringements. The most pressing of these issues is the downstream use of these cells. This section will try to address some of these issues.

4.1 Complicity

When raised with two conflicting alternatives, prudence dictates choosing the morally unobjectionable means and IPSC seems to be the morally less objectionable means. However, the problem of moral status of the embryo re-emerges as moral complicity in the development and progress of Induced Pluripotent Stem cell research. Complicity refers to the collaboration or collusion with a morally wrong act. Induced Pluripotent Stem cell research technology originated in human embryonic stem cell research and subsequent advancements in the field depended directly or indirectly on human embryonic stem cell research. Some argued that participation and advocacy of Induced Pluripotent Stem cell research implicates proponents in being morally complicit in causing harm to embryos. Apart from complicity there are other aspects of this research that raises unique questions and dilemmas.

4.2 Scientific and Technical Challenges

As with all research, there are existing scientific challenges. It is well accepted that there are known disagreements, knowledge gaps and uncertainties pertaining to research involving Induced Pluripotent stem cells. These include patient safety, treatment efficacy, and suitability of these cells for drug testing and disease studied or their theoretical ability to contribute to a human embryo under suitable conditions [11]. It is well accepted that advances in reprogramming technology will require parallel Human Embryonic stem cell research [12].

Both Human Embryonic Stem Cells and Induced Pluripotent Stem cells have the potential to form teratomas, and carry the risk of tumorigenesis. The Induced Pluripotent Stem cell in addition are at risk of alteration from age or toxins. There were also initial objections to the use of viral vectors for creation of these cells but advancement and refinement in production methods have eliminated that issue. Induced Pluripotent Stem cells also permit creation of patient specific histocompatible pluripotent stem cells

and can be directed towards production of tissue specific progenitors.

4.3 Potentiality and Downstream applications

However, the similarities in the issues that Induced Pluripotent Stem cell research and HESC research raises go beyond moral complicity and donor and consent issues. The major concern with Induced Pluripotent Stem cell research is the potentiality of this research. Stem cell research and treatment are entangled in ethical issues that now go beyond the questions related to the destruction of the embryo. Induced Pluripotent Stem cell and Human Embryonic Stem Cell are very similar in potential. Thus the downstream application of both groups of cells raise similar concerns. All the concerns regarding the problems arising from the applications of Human Embryonic Stem Cell were applicable to Induced Pluripotent Stem cell as well.

Moreover, the field advanced very rapidly and with it the potential implications grew as well. In the words of Peter Singer, the Australian philosopher and Professor of Bioethics, "more often than not there is a compromise between ethics and expediency". This was very pertinent to the advancing field of Induced Pluripotent Stem Cell research. There was an urgent call to proclaim Induced Pluripotent stem cells as the solution to all ethical issues raised by embryonic stem cells by proponents of the technology. The ethical issues that Induced Pluripotent stem cells themselves raise were not considered and merely the origin of these cells formed the basis of such an argument.

The ethical issues in Stem cell research starts from informed and voluntary consent during donation of biological materials. The risk and benefits of experimental intervention and informed consent is a recurring issue when it comes to clinical trials involving stem cells.

A study conducted in the Berman Institute of Bioethics looked at patient's perspectives and attitudes towards donating materials for Induced Pluripotent Stem cell research[13]. The most common reason for supporting Induced Pluripotent Stem cell research was altruism and the desire to help others. There was also the question of personal benefit with people believing that such research could benefit them in future. Despite broad endorsements, there were also concerns about privacy, immortalization and the creation of gametes. There is great concern that donation of materials could lead to invasion of privacy. Some were worried whether genetic information obtained from their tissues could preclude them from obtaining insurance. There was also concerns about the immortalization of the cell lines. The concerns not only stemmed from the potential inappropriate use of these cells but also about the profit that future technologies will produce.

There are concerns with the process and control of the original tissue donation and the purposes to which it is applied. There is a major concern with privacy. If these cells are to be used to study disease processes or to treat diseases like Parkinson's or Alzheimer's, it

will be important to know the donors history and it may make it impossible to maintain donor privacy.

Moreover, can consent be modified to track every new and potential use of the cells? If a person does not consent to say use for chimera research, will they have rights to withhold use for similar but undefined research.

There is also the concern regarding patentability and profitability. Will a donor be privy to the profits arising from commercial products derived from their cells? There is also the question of distributive justice. Will such treatment be available for all, or will it be available to only the privileged few in society? Thus it was clear that not only with the scientific community but also with donors and patients there are dilemmas pertaining to consent for donation of materials for stem cell research, early clinical trials for translational therapy and oversight and progress of stem cell research.

The most disconcerting thought was the production of gametes from Induced Pluripotent Stem cells. Derivation of male germ cells from induced pluripotent stem cells in vitro and in reconstituted seminiferous tubules were demonstrated in mice[14]. Equizanal et al. showed complete differentiation of human induced pluripotent stem cells to postmeiotic cells. They also obtained haploid cells from human iPSC of different origins and of both genetic sexes[15]. Panula et al. demonstrated that human iPSCs derived from reprogramming of adult somatic cells can form germline cells[16]. It was also shown that Human iPSC's could differentiate directly into male germ cell lineages including postmeiotic spermatid like cells[17]. Easley in a review states that Spermatozoa with full reproductive viability establishing multiple generations of seemingly normal offspring have been reported in mice and, in humans, haploid spermatids with correct parent-of-origin imprints have been obtained[18]. The production of oocytes is proving challenging at present.

Although a myriad of ethical issues surround Induced Pluripotent Stem Cell research, there is none as controversial as the generation of gametes and subsequently life from this technology. There is a universally accepted norm that entities with intrinsic potential to become full grown humans should not be used for research. However, there are proponents that believe Ethical conduct is justifiable by reasons that go beyond prudence to "something bigger than the individual". These cells can be used for cloning purposes and have been proved to be able to generate gametes for IVF in animal models. There is no scientific difference between Human Embryonic Stem cells and Induced Pluripotent Stem cell based therapies concerning the theoretical possibility of these cells to contribute to a human embryo. The most obvious ethical objection stems from the ability of Induced Pluripotent Stem cell to form tetraploid complementation, the ability to form a health and fertile animal with no contribution from cells other than the Induced Pluripotent Stem cells themselves [19].

In July 2009, two independent research groups reported the first successful generation of human mice from induced pluripotent stem cells [19, 20]. They used a technique called tetraploid complementation and involved creating tetraploid embryos by fusing the blastomeres of two cell stage embryos. They have twice the number of chromosomes. They tetraploid embryos are grown to the blastocyst stage, injected with mouse ESC and injected into the uterus of a surrogate mouse. The resulting pups are derived solely from the ESC with the tetraploid embryos contributing to the tissues that form the placenta and membranes that nourish and protect the growing organism.

Although these experiments have not been carried out in humans, there is the inherent possibility that these cells may be used for creation of organisms or the pursuit of reproductive technologies from cells made into sperm and egg. Although the possibility is distant, it is very real. Ethical and legal concerns exist about ownership and about publishing and sequencing the entire genome. At present human reproductive cloning is banned in all countries and therapeutic cloning is banned in several. However ethical environments may change or may differ across international borders. There would be serious concerns over aspects of patentability.

The derivation of gametes is a distinct possibility. While fraught with controversies it is accepted universally that there is considerable scientific value and potential for both understanding basic mechanisms of gamete biology and for overcoming clinical problems in translational research. While the development of a human gamete from a Pluripotent stem cells may not be fully conceivable yet, the scientific community firmly believes that technology is advancing rapidly and the fructification of this reality is closer than it seems. The production of gametes and the potential ability to create life has been frowned upon in all circles. Once gametes are created, determining the functional potential of these gametes will require and necessitate production of an embryo to establish their capacity for fertilization and early embryogenesis. This will be morally objectionable to factions who afford full moral status to human embryos. It will also be against policies where it is illegal to create embryos exclusively for research purposes.

Thus although we may have potentially circumvented the issue of status of the embryo by producing induced pluripotent stem cells, these cells themselves may bring the research to a full circle and present the same ethical quandaries.

If life were to be created via this technology, what sort of dignity would that life form have? Would they be treated as a means to further research? There are fears that the identity and individuality of the created life form would be threatened thus reducing autonomy [21, 22].

4.4 Human Dignity

Human dignity is the value by virtue of which we are what we are. It is the very basis of all human rights and interpersonal morality. Are we prepared to answer questions about the dignity and rights of the created life forms? There are also concerns about prejudices and respect for such life forms. Will there be fear for such created life forms or will there develop a new form of discrimination against such life forms. UNESCO's Universal Declaration on the Human Genome and Human Rights (1997) was the first international instrument to condemn human reproductive cloning as a practice against human dignity. Article 11 of the declaration states that "Practices which are contrary to human dignity such as reproductive cloning of human beings shall not be permitted". This position was shared by the World Health Organization and the European Parliament. This stance can be extrapolated to life forms created via iPSC technology. Allowing iPSC technology to proceed with production of gametes is also contrary to human dignity. Human dignity is related to Kant's categorical imperative that a person should not be used as a means to an end and opponents of Human Embryonic Stem cell research who believe that using Embryos for research is contrary to Kant's imperative should be wary that downstream applications of iPSC research are also contrary to Kant's that a person should not be used as means to an end.

Different societies will respond differently to regulate and oversee research with such potential. As of now there are vast discrepancies in regulations and policies.

4.5 Discrepancies in Regulations

There is a lot of discrepancy between regulations and guidelines for Induced Pluripotent stem cell research in Canada, UK, US, Japan and the ISSCR. The US and Japan allows use of identifiable cells with IRB approval or notification to a designated committee but Canada requires anonymity and does not allow use of identifiable cells [23]. The emerging themes in these regulations from different countries is that derivation of germ cells or transplantation into humans or grafting into animals requires additional approval or review and monitoring.

It is generally accepted that research should avoid the creation of entities in which human sentience or consciousness might be expected to occur and animals into which human embryonic stem cells, induced pluripotent stem cells, or any other kind of pluripotent stem cells have been introduced should not be allowed to breed.

The use of stem cells derived from other countries or institutions places the user at crossroads of conflicting legal and ethical standards. While medical tourism remains a distinct possibility, it is imperative to recognize that there will be jurisdictions where research with gametes is permitted or will be permitted. Scientists and policy makers will have to consider a variety of issues as the science progresses.

Though social issues should form a part of any policy decision, scientific inquiry should not be restricted simply because of divergent views in society. Instead safeguards should be built to direct and guide such research.

4.6 Consent, Privacy, Patenting and Ownership

Some bioethicists have advocated that donor consent processes should include the disclosure of the possibility that their cells could be used in human/animal chimera research. They should also be informed that the research was based on cells derived from human embryos. Several iPSC lines have been derived from commercial tissue banks presumably without informing donors that they may be morally complicit in research that derived its base from embryo research. There are also concerns about re-identification of the donor leading to privacy infringements and potential for information to be used in an unfair and discriminatory manner. The major concern stems from the inability to control the downstream use of cells and prevent their inappropriate use. This includes concerns about the commercial aspects of cell use and the question of patentability and ownership. The ownership could rest with universities or industries or iPSC banks and repositories. There is also concern about cells derived from stored specimens.

These future concerns can be addressed by mitigating factors like proper consent, transparency and trust. Informed consent is a means of safeguarding violations of autonomy. A robust informed consent process along with transparency about potential uses and commercialization and close attention to policy.

While issues regarding the moral status of the embryo still remains relevant and is debated politically and scientifically, the field is constantly evolving and extending its consideration to current and emerging policies and issues including procurement of embryos, patenting, stem cell tourism and new sources of stem cells among others[24].

It has been argued that stem cell based produces are considered somatic cellular therapies that do not warrant a distinct regulatory approach[25].

When it comes to translational stem cell research, autonomy and safety of research subjects as well as patients are recognized as intrinsic value. Respect for individuals, reciprocity, proportionality, justice and sustainability form the basis of the future of stem cell research. From this stems debates and proposals and resolutions on informed consent and voluntary participation.

Most regulating authorities now reiterate that there is a need to keep a keen eye on whether stem cell research is conducted in an ethically defensible way with consistency and transparency. What is necessary is regulation that promotes greater safety, efficacy, and greater accessibility for larger number of patients. Scientific advancement and query will necessitate continuity of HESC and iPSC research.

5. Conclusion

The problem of how to define the moral status of IPS cells will become unavoidable. It is imperative to recognize that regulations should be formulated with the future in mind.

Research should be regulated the same way as research involving embryos and zygotes. International regulation is required for harmonization and is required urgently. iPSC is not the quick fix solution to ethical controversies of HESC research. It carries its own ethical quandaries. iPSC cells present with unique potentials and corresponding ethical concerns, policy should come closer to reflect public opinion and should involve researchers, regulators, patients and organizations. Only then will the potential be fulfilled and will allow society to reap benefits of research progress. Lines and limits must be drawn to prevent abuse and focal consideration is vital for efficient and ethical development of the field.

When compared to HESC, the methods used to create iPSC's may not be ethically problematic or socially controversial, however the downstream uses most certainly are and require immediate regulatory responses.

Conflict of Interest:

The Authors declare no conflict of interest

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