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Contents

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Editorial: Cross-cultural bioethics discourse

This May 2013 issue of *EJAIB* includes further papers from the Sixth Joint UNESCO-Kumamoto University Bioethics Roundtable, held in December 2012. The 2013 roundtable will be held 7-9 December 2013, as a joint UNU-IAS and University of Kumamoto Bioethics Roundtable, following my departure from UNESCO Bangkok. From 8-10 May there was a joint UNU-Kumamoto University Workshop on Finding Future Visions of our World: A Sustainable Japan and the World ---Dialogue Methodology for Social Change for A Sustainable Future at UNU-IAS in Yokohama, Japan. The 60 participants discussed a variety of approaches to consensus building, include a day long workshop by Drs Amy and Arno Mindell on process work. Those readers who are interested in the ongoing trials of peace building and conflict resolution on difficult issues of bioethics can contact the editor.

In this issue of *EJAIB* there is a paper discussing medicalization of fatique, and Living with a Misunderstood Disease: Myalgic Encephalomyelitis / Chronic Fatigue Syndrome in Japan, by Miwako Hosoda. There have been failures of medical systems to recognize certain persons as sick. The condition also has some implications for the way our society makes people too tired.

Two papers discussing controversial topics to which there are many sides to debate are, Right to Abortion under International Law by Stellina Jolly, and Is Non-procreation the Solution to Human Suffering? which is an analysis of David Benatar's book by Karori Mbugua.

The real qualification of professionals in rehabilitation medicine in Japan, that gain people's trust, is discussed by Katsuaki Yamano. Empathy to help persons come back to real life was praised as a reason for building turst between patients and doctors.

Abdul Wahab Suri discusses the Right without Choice and the Future of Bioethics Discourse in Post-Colonial Society, in the case of Pakistan. Masayuki Kodama reviews the state of Surrogacy in Thailand and work of Dr. Somboon Kunathikom by Means of a Three-Layer Structural Analysis. There will be further papers on cross-cultural themes in the next issue.

We need more submissions for the ABC and APSAFE conferences, which is a convenient trip for those coming from overseas, being 19-23 November in Chennai, and 27-30 November in Bangkok. Both will be significant gatherings of researchers and policy makers, and please check the websites for conference details.

14th Asian Bioethics Conference (ABC14), 19-23 November, Loyola College, Chennai, India, with Asian Bioethics Association (ABA). Contact: selvam.mariadoss@gmail.com

APSAFE1- The First International Conference of the Asia-Pacific Society for Agricultural and Food Ethics: "Food Safety and Security for the Twenty-first Century", 28-30 Nov., 2013. Chulalongkorn University, Bangkok, Thailand. See website http://www.apsafe2013.org/

– Darryl Macer

Living with a Misunderstood Disease: Myalgic Encephalomyelitis / Chronic Fatigue Syndrome in Japan

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Introduction

There are 340,000 people suffering from Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS) in Japan, and 17 million people in the world. Despite the great number of people affected by the disease, there are still uncertainties surrounding ME/CFS. Of the four million Americans who have ME/CFS, for instance, fewer than 20% have been diagnosed. Even one is diagnosed with ME/CFS, few medical and social service is provided, because ME/CFS has not been considered a critical illness or a responsible disease for severe disability.

In most cases, people are diagnosed with ME/CFS when they feel long-term fatigue without any physical abnormalities recognized by medical examinations, such as blood test, CT, or MRI. The US Center for Disease Control (CDC) developed this definition in 1988. However, long-lasting fatigue is also a symptom of other diseases. For this reason, Post-viral fatigue syndrome (PVFS) or Chronic Fatigue and Immune Dysfunction Syndrome （CFIDS） has recently been used as an alternate name to distinguish it from simple fatigue.

As of today, the causes of ME/CFS have not been identified, and no specific diagnostic tests are available. However according to the international criteria, it is known that people with ME/CFS are so run down that the syndrome interferes with their lives and can make them dysfunctional at all. Furthermore, they are not just dealing with extreme fatigue but with a wide range of other symptoms, which include sudden severe fatigue, sleep without refreshing, muscle and joint aches without swelling, intense or changing patterns of headaches, sore throat, swollen lymph glands in the neck or armpits, and memory problems/inability to concentrate.

Despite of the definition, many people including doctors think that ME/CFS patients are only complaining their fatigue. Even ME/CFS "specialists" adhere to the stress theory, which suggests that great amounts of stress cause ME/CFS, and these specialists thus diagnose patients with mood disorders or somatic disorders. As a result, patients have been forced to overcome the illness through their own efforts. Many patients have complained about this situation, both in the US and Japan:

"Physicians did not want to understand my physical pain and seemed to deny my personality, which greatly saddened me." (Ms. A, a ME/CFS patient)

"You see in this country, ME/CFS was not accepted as a legitimate illness. It was thought to be psychological and placed in the category of psychosomatic diseases." (Mr. C, a ME/CFS patient)

Finding themselves without full sympathy from doctors, family members, and acquaintances, some ME/CFS patients have created associations to share their emotions and experiences. They have also approached medical and biomedical scientists asking for further biomedical research to discover the causes of ME/CFS and more effective treatment options. In addition, patients and patient groups have asked insurance and administrative agencies, as well as politicians, for better medical and social services.

People with ME/CFS have refused being called "lazy" and as having "mood disorders". They have wanted diagnoses to justify their physical symptoms and their pain. This change in status from "lazy person" and/or "social deviant" to "patient" is a process that Conrad and Snyder (1980) referred to as medicalization.

It is somehow true that medicalization provides positive outcomes for patients. For example, people are likely to be considered sick and to avoid criticism that they are unable to engage in expected social activities (Parsons 1951). Once the ME/CFS sufferers are provided with a legitimate reason for their physical difficulty, they could obtain the designated treatment, which is covered by health insurance and the social services for the person with disabilities. However, it will take a great effort to "medicalize" ME/CFS patients (Clark 2003). Therefore, Dumit (2006) called ME/CFS "the illness you have to fight to get".

A survey on the people with ME/CFS

In this manuscript, I explore the real life with a lot of difficulties of the people with ME/CFS by conducting a questionnaire survey targeting them. Participants were collected through the Japan ME/CFS Association and other ME/CFS patients. Two hundred fifty six questionnaire sheets were distributed from March 2012 to October 2012, and 135 sheets were returned (responded rate was 53%). This survey was reviewed by the Harvard School of Public Health and approved as an IRB Exemption (Protocol Number 21687-101).

Half of the participants were in their 40's and 50's. And 7% of the participants were teenagers. 78% percent of the participants were female. As for the marital status, 45% of the participants were non-married, while 37% were married. 49% of the participants received university and higher education, 22% were high school graduates, and 19% finished occupational school.

Results

Living with never-ending fatigue and pain

Almost all participants felt severe fatigue all the time; 49% of the participants felt fatigue and extreme tiredness all the time, 31% did most of the time, and 14% about half of the time, while only 6% suffered a little of the time.

In addition, the participants were suffering from the next day soreness or fatigue after non-strenuous daily activities; 61% of the participants felt next day fatigue all the time and most of the time, 27% felt about half the time, and seven percent did a little of the time. Exactly a half of the patients were bothered by severe pain or

aching muscles throughout the past six months, and 38% got moderate or mild pain and aching. Because of the onset of the problems with fatigue/energy, 82% of the participants had symptoms caused a 50% or greater reduction in the activity level.

Participants described their physical condition as follows: I am living with severe pain; I want to die because of extreme fatigue; I am afraid to die of difficulty in breathing; I will not be able to visit my primary care physician (PCP) when my symptoms get worse; My PCP does not see me as a patient.

Limited Healthcare and social services

Even though the ME/CFS patients have extreme fatigue and/or pain to spend their daily life or do not extra energy to work, they do not receive enough medical and social service to support them. In terms of the social status/occupation, 29% of the participants were unemployed. This unemployment rate is much higher compared to the Japanese average of 7%.

The access to social services is very limited so that patients have been forced to stay home and isolated from the society. Recently, some patients started to raise their voice to get appropriate social services to live their social life. For example, Ms. A had negotiated with local government officers for a mobile stretcher free-rent service for people with disabilities and eventually achieved this goal. Ms. A now appeals to the national officers to ensure that ME/CFS patients are eligible for appropriate medical and social services without being designated as disabled.

In many cases, however, they are still unable to receive appropriate social service. They said as follows: my activity range is decreasing. I cannot work anymore; I was fired. I have no money to live on; I need a helper to spend daily life, but it costs a lot; ME/CFS is not considered as a disease, so I cannot receive any social services.

Expectations for social awareness

The ME/CFS patients are also suffering from stigma and social discrimination caused by their disease. When Ms. A visited a ME/CFS specialist three years ago, she was told that, "you have pain because you think you have pain. Your toothache will not disappear if you just lie on bed. If you remain in bed because of the pain, you will not be able to sit in a chair. You have to change your cognition. Try to think you can sit in a chair, then your pain will disappear." Ms. A was very disappointed to hear this advice.

Many physicians believe that the causal factor of ME/CFS is psychiatric, and ME/CFS patients are sometimes diagnosed with a "somatic disorder". However, according to the survey, 65% of the participants believed that the cause of ME/CFS is a physical problem, not a psychological or psychiatric factor.

Participants felt that were losing their social trust due to ME/CFS. The following statements were seen among the open answers of the survey: I got this disease when I was a high school student. I was so sad because my teacher and doctor did not understand my severe physical condition and thought that I did not like school; The name CFS is very stigmatized; I visited an agency hoping to find a job, but the agent did not recognize me as a person with a disease.

In response, people with ME/CFS have attempted to raise awareness amongst medical professionals and the general public and to inform them that ME/CFS is not a psychiatric disease but is caused by an external factor, such as virus.

People with ME/CFS have been contesting clinical diagnoses and expect that biomedical research on ME/CFS will uncover the real causal factor of ME/CFS (Crossley 2005). Importantly, the people with ME/CFS pin their hopes not on medical research as such, but on biomedical research.

Discussion

The survey shows that the people with ME/CFS were suffering from many aspects of life; medical, social welfare, and society. The sense of total isolation sometimes makes them feel their lives are useless (Hosoda 2010b). It can be said a "structural isolation". They cannot work so that they lose their friends at their workplace. They cannot go out so that they lose their private friends. They can sometimes move so that their family does not understand their terrible physical condition. Even more, when their physical condition allows them to try to have fun, they are blamed for dishonesty. Once they contribute to the support group activities, people outside of the group expect them to work instead.

The association of people with ME/CFS has already made a lot of activities to live through, such as translating international documents and information written in English into Japanese, screening of a documentary film on ME/CFS, holding meetings for general public, spreading awareness of the disease to medical professionals, hosting lectures by specialists on ME/CFS, advocacy to seek for social services, and scheduling patients' meetings. This could be said to be a strategy for the people with ME/CFS to live and an important theme of sociology (Brown 2005, Kuhmann 2009).

Additionally, these activities would become a connector among many stakeholders, such as government officials, medical professionals, clinical practitioners and lab researchers (Hosoda 2010a). Now would be the time for bioethicists and social science researchers to pay attention to the patients in such condition. Those researchers can also appear as a stakeholder of the ME/CFS world.

References

Brown, P., Zavestoski, S. (2005) *Social movements in Health: An introduction, Social Movement in Health,* Oxford, Blackwell, 1-16.

Clark, A. et al. (2003), Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine, *American Sociological Review*, Vol.68, 161-194.

Conrad, P & J W Schneider, (1980), *Deviance and Medicalization: From Badness to Sickness,* expanded ed, Philadelphia: Temple University Press

Dumit J, (2006), Illnesses you have to fight to get: Fact as forces in uncertain, emergent illness, S*ocial Science and Medicine*, 62(3), 577-9-.

Hosoda, M. (2010a) Social Movement against the revision of the Social Health Insurance Fee for Rehabilitation Therapy, *The Japanese Journal of Health and Medical Sociology*, 20(2), 64-73.(Japanese)

Hosoda, M. (2010b) Hansen's Disease Recoverers as Agents of Change: A Case Study in Japan, *Leprosy Review*, 81, pp.5-16.

Kuhlmann E., Allsop J., and Sacs M. (2009) Professional Governance and Public Control: A Comparison of Healthcare in the United Kingdom and Germany, *Current Sociology*, 57(4), 511-528.

Parsons, T., (1951), *The Social System,* Routledge.

Right to Abortion under International Law

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Abstract

The recent horrendous death of Savita Halappanavar in Ireland after the doctors there refused to conduct abortion has evoked fierce, ethical, legal and human rights debate. The Irish government reacted swiftly with an assurance that a bill will be introduced allowing limited abortion right to women. Women's organisations and feminists have long argued that the denial of access to safe abortion is a flagrant violation of human right. This paper tries to analyse whether there exists a right to abortion under international human rights law. It recapitulates and highlights relevant progresses if any within the international legal systems in support of abortion and protection of women's reproductive autonomy. The paper points that denial of legal and safe abortion procedures forces women to obtain unsafe and often traditional methods of abortions, threatening their lives and health. The paper tries to see how the issue of abortion can be approached in a balanced way.

Keywords: Abortion, Human Rights, Unborn, International law, Reproduction

Introduction

*"Abortion is a moral right—which should be left to the sole discretion of the woman involved; morally, nothing other than her wish in the matter is to be considered. Who can conceivably have the right to dictate to her what disposition she is to make of the functions of her body?" (*Ayn Rand).

The famous quote by Ayn Rand grants a complete prerogative to women regarding the utilization and functions of her body and aptly sums up the basis of a clear and strong argument in support of abortion making one wonder if abortion was such a straight forward sole concern of female why has it become the leading concern of many jurisdictions. Unfortunately the concerns surrounding abortion are far from the simple uni-dimensional view expressed by Ayn Rand. It is a serious emotive issue bringing forth vehement moral, ethical, social, religious, legal and human right arguments. According to the World Health Organization (WHO), about 21.6 million women had unsafe abortions in 2008.[1] These unsafe abortions were responsible for the deaths of nearly 47,000 women.[2] This paper attempts to analyse whether there exists a legal or ethical right to abortion under international human right law. It recapitulates and highlights germane progresses if any within the international legal systems in support of abortion and protection of women's life and health. The paper contends that denial of legal and safe abortion procedures forces women to obtain unsafe traditional abortions, threatening their life and health.

Abortion: Ethical and Legal Arguments

Abortion may have become easier as well as controversial with the rapid rise in technology, but as a technique to thwart the unwanted pregnancy it can be traced as far back as culture and civilisation of humankind. Writings on abortion suggest that induced abortions in China dating back –to even 5000 years.[3] A typical case of abortion revolves around three or four parties, pregnant women, unborn child, and society, and in some cases, father. A catenna of legal and ethical arguments have been raised from all the sides in support and opposition of their positions. The major support for abortion has come from the feminist literature and writers.[4]

The first argument is of bodily sovereignty.[5] With regard to abortion it is argued that bodily sovereignty dictates that there should not be any compulsion or force explicit or implicit on females to become pregnant, nor to carry on her pregnancy to the complete term. The development of the principle of self-autonomy can be attributed to the writings of John Stuart Mill. He conceded, 'Over himself, over his own body and mind the individual is sovereign.'[6] State should accept as lawful any activity unless it causes harm to others, even if it is regarded as immoral. But this viewpoint can be counterproductive in the abortion debate if we accept a fetus as a legal person. In such a scenario allowing abortion will not only be immoral but will be harmful to fetus. As an argument, the principle of bodily sovereignty has limited application today. Most legal systems prescribe it as offence to attempt to commit

[1] World Health Organisation, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, (2011) pp 1-8.

[2] Op.cit., p 4

[3] Eduardo Díaz Amado, Abortion Legally and politically feasible, *BIoEthica,* 9/ 1(2009), pp. 114-123. <http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S1657-47022009000100011&lng=en&nrm=iso>. accessed on 08 Jan. 2013.

[4] Julie Loesch, Our Bodies, Their Lives, in *Pro-life Feminism: Different Voices* ed. G. G. Sweet (Lewiston, New York: Life Cycle Books; 1985), p 186.

[5] J. Herring, *Medical law and Ethics, (3rd ed., Oxford University Press 2010) p.* 270-350.

[6] J Mil, *Liberty*, (4th Edition, London: Longman, Roberts & Green, 1869), p 14.

suicide and do not accept the absolute liberty of individual over himself.

Feminists have considered laws against abortion as a violation of various human rights including privacy and health.[7] The famous case of Roe v. Wade [8] relied on the concept of privacy in its support for abortion**.** Recent times there have been efforts to include reproductive dimension albeit precisely to the right to health.[9] The UN Committee on Economic, Social and Cultural Rights recognized that the right to health includes 'the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference.' [10] Freedom to abort or access to safe abortion can easily be included here as the absence of which will dangerously hamper the health of women. Abortion also has a major social dimension revealing an acute face of poverty. Vast majority of women resorting to unsafe abortions procedure are drawn from the poorer sections of developing nations.

Many consider it unethical to force someone to carry forward and complete her pregnancy. This becomes an imperative given the fact that the primary responsibility of a child remains with the parents and not with the state. So once the state does not permit abortion it does not end there and in fact it is only the beginning for parents who has to incur huge financial, physical and emotional burden of taking care of the chid. This dilemma has been brought clearly in the case of Niketa in India where the Bombay High Court refused permission to abort a 26-week fetus with a serious heart defect.[11] Niketa and her husband have approached the court for medically terminating her pregnancy when it was detected in the 24th week of her pregnancy that the child she carries suffers from congenital heart disorder. Under the Indian law termination of pregnancy can be undertaken on medical grounds but not after 20th week of pregnancy.[12]

Critics of abortion points that permitting abortion on the basis of fetus abnormality and medical grounds depicts the outlook of society towards disability/differently abled people. [13] They argue that what is a normal and healthy child is a societal construction and permitting abortion on the basis that the child in the womb does not satisfy the requirement of 'normal' will encourage parents to seek more frequent abortion. But a women who desires a child and is happy with her pregnancy, but changes her attitude on finding fetal abnormality, is not making a negative/positive statement about disability or disabled people.[14] She is just expressing her personal sovereignty about her desires and limitations. The abortion decision is not about disability status but about giving choices, women should be given the freedom to choose, freedom to abort an unwanted pregnancy. This argument has been influenced mainly by the fact that in most of the society women has no control on reproductive issues like when to have child, spacing between children and even refusal to have physical intimacy with the husband. Marital rape is not made punishable in many societies including India. [15]A pregnancy can be the result of even marital rape. These issues are influenced and shaped by highly patriarchal set of political, economic and social ideologies of society.

A major objection against abortion seems to have originated from the moral view that abortion is a murder of a being or a being who has the potential to be a full grown human being.[16] The question of abortion cannot be answered without looking into two fundamental questions what is life and when does it begin? [17] Biologically" life" can be defined as the quality which differentiate living being from others. The distinguishing features can be growth, pain, feelings, metabolism etc.[18] The momentous judicial verdict in Roe v Wade [19] in USA made the issue of abortion to prominence but fell short of ruling on when life begins. Religious views do not offer much assistance here.[20] Some of the scientific authorities and treaties suggest that life begins after 14 days of conception.[21] This can be discerned from the stemcell research controversy where many legal systems have banned embryonic stem cell research after 14 days of conception.[22] The question in such cases will be whether to disallow all abortion after 14 days of conception to be

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[7] R. Tong, Feminist *Approaches to Bioethics: Theoretical Reflections and Practical Applications* (Boulder, Colarado Westview Press 1997) p 152.

[8] 410 U.S 113(1973).

[9] A Rahman & R.I Pine, *An International Human Right to Reproductive Health Care*, 1 *Health and Human Rights,* 1 (1995), p 405-418.

[10] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003).

[11] S. Kher. Niketa's Miscarriage Brings Back Focus on Legal Cut off for Abortion. *Indian Express* 2008 Aug 15 (online edition) Available from: http://www.expressindia.com/latest-news/Niketas-miscarriage-brings-focus-back-on-legal-cutoff-for-abortion/349199 accessed Dec 15 2012.

[12] Medical Termination of Pregnancy Act 1971, India.

[13] N Madhiwalla, "The Niketa Mehta Case: Does the Right to Abortion Threaten Disability Rights?"*Indian Journal Of medical Ethics,* 5/4 Oct-Dec 2008, pp 152-153.

[14] Op.cit., p 152

[15] Indian penal Code Art 375 Art 375, Exception.—Sexual intercourse by a man with his own wife, the wife not being under fifteen years of age, is not rape

[16] F. J. Beckwith, *Defending Life: A Moral and Legal Case Against Abortion Rights*, (Cambridge University Press, 2007) p236.

[17] Op.cit., p 236.

[18] *Merriam-Webster's collegiate dictionary* (11th ed 2005). Springfield, MA: Merriam-Webster.

[19] See note 13, Roe

[20] J.J Lipner, The Classical Hindu View on Abortion and the Moral Status of the unbom, Hindu *Ethics: Puriry, Ahortion and Euthanasia.* Ed. H G. Coward, J J. Lipner, Katherine K. Young, (Albany: State University of New York Press, 1989) p 43. Demirel, Serdar, *Abortion from an Islamic Ethical Point of View.* International Journal of Business and Social Science, 2 (1) 2011), p. 230-237.

[21] E.Chemerinsky, 'Rationalising the Abortion Debate Legal Rheotoric and the Abortion Controversy, *'Buffalo Law Review,* Vol 31, 1982, p 107-164.

[22] Michael Ruse, Christopher A. Pynes, The Stem Cell Controversy: Debating the Issues (Prometheus Books, 2006), p 117.

illegal. Such rule does not have much practical application as it almost amount to blanket prohibition. In most cases people become aware of pregnancy only after 14 days. Here the important consideration can be on the meaning of life and value of life.[23] In case of complications at the time of delivery medical practitioners and society gives priority to the life of mother over the unborn. Dworkin can be of assistance when he argues whether abortion is against the interest of fetus must depend on whether the fetus has interests at the time abortion is performed and not whether interests will develop if abortion takes place.[24]

Those who oppose abortion also point out that a women's psychological state undergoes tremendous change before, during and after pregnancy. Women who want an abortion may change her opinion and even regret the decision when she will develop an attachment with the baby. This happens even in the case of surrogate mother, as revealed in the famous Baby M case.[25] But on the other hand it may be countered by arguing that should a question of magnitude like abortion be left to a possible uncertain change of mind. What if mother eventually does not develop that feelingness of love and affection with the new born. The arguments and counter points amply prove the inherent and intrinsic difficulty associated with the issue.

Is abortion a human right under international law?

International law list out treaties, customs, general principles of law recognised by civilised nations and judicial decisions as the sources of international law. For abortion to qualify as a legal and human right it has to satisfy the test and requirement of any of these sources.

To analyse the legal position of abortion under international treaties or declarations it is imperative to have a look at the various human right documents. The modern human right is said to have made a beginning after the Second World War. The atrocities and gross human sufferings witnessed during the war led to the realisation that protection and preservation of rights are absolutely essential for the dignity of human being. The robust effort got culminated with the Universal Declaration of Human Rights (UDHR) in 1948, considered as the magna carta of human rights.[26] Right to abortion does not find a mention in the entire document. Article **12 of the UDHR, provides that** no one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence.[27]Article 25 of the UDHR states that motherhood and childhood are entitled to special care and assistance.[28] It is been asserted that these rights especially privacy can be interpreted to include right to abortion.[29] The argument follows mainly on the line that the since the declaration does not define the contours of privacy and other rights. Abortion is a personal issue and hence a private matter. The declaration is worded in a gender neutral manner**.** This was understandable given the fact that women's affairs started gaining attention only in the 1960s after critical legal studies thinkers highlighted the social, political, economic and legal discrimination faced by women across the globe.

Women's issues gained a major boost with the adoption of convention on elimination of all discrimination against women (CEDAW) described as an international bill of rights for women in 1979.[30] The Convention affirms women's right to reproductive choice.[31] The biological features of reproduction and division of labour where women are entrusted with the primary responsibility of rearing and caring for children places women at the center stage of reproduction. The right to abortion as a subset of reproductive rights got further enshrined in the 1975 UN International Women's Year Conference in Cairo.[32] On abortion, the Cairo document states that 'Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning.'[33] It also stated that 'where abortion is not against the law, such abortion should be safe' it affirms that 'Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process.'[34] It is to be noted that none of these declarations pertaining to women impose an obligation on states to legalise and legislate on abortion. To complicate the matter further, even if abortion is read as part of reproductive rights which is a recognised human right, many of these conventions and declarations fall under the category of soft laws meaning they are not enforceable.[35]

Regarding abortion there exists no global convention or treaties which explicitly recognise the right to abortion. When most of these documents were negotiated, many nations had legislation outlawing abortion and they

[23] R. M. Baird ,S. E. Rosenbaum, ed., *The Ethics of Abortion : Pro-Life Vs. Pro-Choice Contemporary Issues* (3rd ed Prometheus Books, New York, 2011) p 236..

[24] R Dworkin, 'Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom, 'Campbell *CS.Camb Q Health Ethics.* 3/2 (1994).pp.303-6.

[25] In Re Baby M, 537 A.2d 1227 (N.J. 1988).

[26] Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., at 71, U.N. Doc. A/810, 1948., Article 25.1 of the Universal Declaration of Human Rights affirms.

[27] Op. cit., Art X11

[28] Op. cit., Art XXV

[29] D. Shaw, Abortion and Human Rights, Best *Practice & Research Clinical Obstetrics and Gynaecology,* Vol. 24 (2010), p 633-646

[30] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 1, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

[31] Op. cit., Art 14.

[32] *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, 5-13 September 1994, para. 8.25, U.N. Doc.A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].

[33] Op.Cit., ICPD Programme of Action 8.25.

[34] Op.Cit., ICPD Programme of Action 8.25.

[35] K. W. Abbott, D Snidal 'Hard and Soft Law, in International Governance,' *International Organization,* Vol. 54 (2000), p 421 Soft laws are forms of legalization that is, various combinations of reduced precision, less stringent obligation, and weaker delegation

intended to leave those laws unaffected [36] What is noticeable is that there is a constant endeavour to elevate abortion to the level of human right Firstly it was done through multitude of feminist writings making a case for implied human right to abortion derived from right to life and health. According to Zampas and Gher, "women's right to abortion is bolstered by the broad constellation of human rights that support it, such as the rights to privacy, liberty, physical integrity and non-discrimination. [37] Secondly human rights compliance committees of various conventions has been advocating and interpreting convention provisions to include right to abortion. [38] At the other end of spectrum, states also tried to avoid the liberal approach towards abortion by invoking reservation as they accede to the conventions. For instance CEDAW Convention permits reservations, which are not incompatible with the object and purpose of the convention. Monaco and Malta made specific reservations on abortion and reproductive rights.[39]

With respect to abortion, there is definitely a move to liberalise abortion across the jurisdictions but it cannot be taken as a clear indication for the formation of a custom. The approach of the states shows a wide range from liberal, restrictive to absolute prohibition. In the case of *Roe* vs. *Wade* [40] The Court ruled that the state cannot restrict a woman's right to an abortion during the first trimester, the state can regulate the abortion procedure during the second trimester 'in ways that are reasonably related to maternal health,' and in the third trimester, demarcating the viability of the fetus, a **s**tate can choose to restrict or even to proscribe abortion as it sees fit.[41] In India, The Medical Termination of Pregnancy Act provides for abortion generally on medical grounds.[42] A similar approach is seen in other south Asian nations including Afghanistan, Bangladesh, Bhutan, Sri lanka etc.[43] The right to abortion has never been contested before the international court of justice. There exist some decisions directly on the point by the European Court of Justice but it declared that there is no right for women to abortion.[44]

Any discussion on abortion cannot be complete without looking at the legal position ascribed to the unborn child. Rights of unborn received some attention from the very beginning of bill of right in the form Universal Declaration of Human Rights 1948 and carried further in ICCPR 1966. Both UDHR and ICCPR declare that, "Every human being has the inherent right to life.[45] This affirmation is not qualified as to age or limited to the born, and it would be difficult to understand them as no*t* including the living but- not-yet-born. The interest of unborn got specific prominence with the adoption of Convention on the rights of the child (CRC).[46] During the negotiations leading to CRC the representative of Italy observed that no State was manifestly opposed to the principles contained in the Declaration of the Rights of the Child and, therefore, according to the Vienna Convention on the Law of Treaties, the rule regarding the protection of life before birth could be considered as "jus cogens" since it formed part of the common conscience of members of the international community.[47] For the furtherance of their arguments support has been sought from the rule which requires execution to be postponed till the delivery in case of pregnant women. In comparison existing human rights documents and declarations clearly shows a preference for the protection of unborn and hence pro life over right to abortion.[48] They add up to a decided preference for life, even in provisions where unborn children are not mentioned directly but are inevitably among the beneficiaries.[49]

Discussion

The survey of legal and human right documents suggests that the right to abortion is not mentioned as a human right under international law. In the absence of clear cut explicit right recognising right to female autonomy of abortion it is imperative that a balanced interpretation is the need of the hour if we have to avoid most unfortunate situation like that of Savita and protect the health of millions of other women. Any discourse on abortion needs to bear in mind that society is dynamic in nature. Changing times and situations may require alterations, modifications and even creation of new perspectives and laws in society.

[36] A.P Tozzi, 'International Law and the Right to Abortion,' (New York, Catholic Family and Human Rights Institute, 2010) p 866.

[37] C Zampas & J. M. Gher, Abortion as a Human Right – International and Regional Standards,' *Hum. Rts. L. Rev.* 2 (2008) p 252.

[38] Compliance committee under CEDAW told Zimbabwe to "reappraise the law on abortion with a view to its liberalization and decriminalization. WendyWright, CEDAWCommittee Rulings, http://www.cwfa.org/articledisplay.asp?id=1870

[39] The Principality of Monaco does not consider itself bound by Article 16, paragraph 1 (e), to the extent that the latter can be interpreted as forcing the legalization of abortion or sterilization. Declarations, Reservations and Objections to CEDAW, available at http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm, accessed on 4-12-2012. M A. Freeman, Reservations to CEDAW: An Analysis for UNICEF, Discussion Paper, Policy and Practice, New York December 2009, p31.

[40] See note 8, Roe

[41] Op.cit.,

[42] See note 12, Medical Termination of Pregnancy Act 1971.

[43] R. J. Cook & B. M. Dickens, 'International Developments in Abortion Law:', AM*. J. PUB. HEALTH,* 78, (1998), p1305–11.

[44] *A, B and C v Ireland* [2010] ECHR 2032

[45] See note 26 UDHR & ICCPR.

[46] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990).

[47] S Detrick, *The United Nations Convention on the Rights of the Child, A Guide to the "Travaux Préparatoires*", (Dordrecht: Martinus Nijhoff Publishers, 1992), p 109.

[48] B.K.Rothman, Redefining Abortion, *Ethics in Practice,* ed H. LaFollette. M Blackwell, (1997), p103-111, P Lee, *Abortion and the Unborn life,* (Washington, Catholic University of America Press, 2010), p7.

[49] P J. Flood, Does International Law Protect the Unborn Child?, available at http://www.uffl.org/vol16/flood06.pdf,accessed on 3-12-2012.

To make any progress in the abortion dilemma, the debate about abortion should not be considered as an issue where the interest and rights of unborn comes in conflicts with that of mother. Generally the issue of abortion is based on certain pre-assumptions: in the first position, the premise is that life is the most important value while in the second it is freedom. The debate should not be about whose rights are protected under international human right documents. The debate should not merely focus on the beginning of life. In the absence of a consensus it will only lead to another controversy whether to give priority to religious beliefs, social morals or science. The requirement is to understand the inimitability and uniqueness of pregnancy and secondly to reason out why a female desires abortion. Kingston rightly points that both prochoice and pro-life group 'often fail **to recognise the unique notion of pregnancy and the relationship between woman and fetus.'**[50]

When a women desires abortion, she simply expresses what she wants about herself and how much suffering she can undergo as a human being. This may be due to medical grounds or non-medical grounds. Most of the jurisdiction that permits restricted right to abortion, usually confines the grounds of abortion to medical reasons. Owing to fact that the society and its structure have undergone considerable change. Women may desire abortion not merely on health grounds.

• The family may not be financially secure to look for an additional member. This is important in many of the developing nations as the primary responsibility of taking care of the children remains with the parents. In addition most of these societies the accessible, affordable contraceptives and family planning may not be available. Adding to it religious believes many times stand in the way of family planning.[51]

• Live–in relationships are on the rise and any young women find themselves pregnant before entering into matrimony and don't have the means to raise and support a child.

Society has to respond to these situations in a practical way. To argue that these grounds are flimsy and it cannot be morally sustained may not be the most desirable. Any discussion on abortion needs to keep in mind that it is not simply an issue of ethics but one with significant practical consequences. Everyday doctors and women have to make practical decisions regarding abortion that involve not only socio-political institutions but also and legal rules.[52] We need to "remember" that practical problems have to be solved not only by appealing to ethical arguments, but also by implementing political actions and stating legal boundaries.[53] This may not be the most desirable situation, but all arguments against abortion cannot ignore the very facts and data presented by various world bodies on unsafe abortion.[54]

The paper while arguing for liberalised abortion rule does not advocate a stand that gives women absolute liberty over abortion choices, or even claim that right to abortion is a human right or argue for its interpretation as a human right. This paper considers it as a practical problem for the society to react and respond to in a practical way. In many of the societal issues ranging from prostitution and homosexuality etc., legal systems have responded in a pragmatic way even though these are core moral issues with significant societal implications. A practical approach to abortion is already discernible from the fact that most of the jurisdictions give reproductive choice to women on medical grounds as well as where the pregnancy is a result of sexual assault. In such scenarios, society already exhibits a tolerance and preference for the interests of women over the interests of unborn.

This paper argues for a more liberalised look at abortion. In the first and second trimester women should be given the absolute liberty to decide about abortion. It is the woman who must decide whether her relationship with the fetus is so valuable enough that she really wants to see it developing it. [55] Provisions for multiple counselling can be introduced so that the demand for abortion is not made in a fit of emotion. In addition counselling will also help to understand whether the demand for abortion is not under any pressure or coercion. This liberal approach will be reflective of the changing requirements and realities of society. In the third semester in the eventuality of any detection of serious medical grounds abortion can be allowed looking at the viability of fetus. If scientific opinion and technology makes the independent existence of the fetus outside womb possible then I do not think abortion in the late stage should not be allowed. A separate body consisting of judicial and scientific experts can be set up and they should have the exclusive jurisdiction to hear any plea regarding abortion in third semesters. The focus should be on the viability of fetus and note on the beginning of life. When medical and technological progress enables the survival of fetus outside the womb even in earlier stage of pregnancy abortion should not be permitted. The need is to look at abortion as a dynamic issue.

Conclusions

To conclude any approach to this conflicting issue should bear in mind that right to life qualifies as the supreme right and encompasses all other rights. Both women and unborn fetus have a genuine claim to right to life. But when both their interests appear to be in conflict with each other it is the paramount consideration of the policy makers to keep in mind certain fundamental principles. There is no confusion regarding the sanctity and certainty of a mother's life. But there appears different religious and scientific version regarding the beginning and existence of life in the womb. Michael Meslin has shown that 'the concept of person is one of

[50] Op.cit.,

[51] V.O.Otiode, F.Oronsaye.et.all, 'Why Nigerians Adolescents seek Abortion than Contraceptives, Evidence From Focus Group Discussions, 'International Family Planning Perspective, 27(2) (2001), p77-81.

[52] See note 3 Amado, Abortion, p116.

[53] Op.Cit.,

[54] See note 1 WHO., Unsafe Abortion, p 3.

[55] See note 7 Tong, Feminist Approach*es*, p 152.

the most difficult concepts to define.[56] There is no agreement in science or philosophy about when personhood begins, or where it ends, or how it should be defined. This should act as the guiding factor for states to follow a policy that gives priority to women's decision to abortion as an unwanted pregnancy changes the entire course of her life.

Is Non-procreation the Solution to Human Suffering?

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Abstract

In his controversial book titled *Better Never to Have Been*, the South African philosopher David Benatar advances the thesis that creating people seriously harms them. To ensure that no more people are harmed, he calls for the extinction of the human species through non-procreation. In this paper, I will argue that although those who exist suffer harm, existence in itself does not cause harm. Consequently, even if we grant that Benatar is right about the harms that characterize all conscious existence, eradicating the human race by ceasing to procreate is not a morally acceptable way of getting rid of these harms. A more *realistic* way of resolving this problem is to try to make the world a better place so that no more people are harmed. I further argue that contrary to what Benatar would have us believe, the degree of human suffering is not so great as to make non-existence a preferable option. Furthermore, there is evidence to suggest that life is getting better in most societies. Nevertheless, I conclude that Benatar is to be commended for challenging us to rethink the ethics of procreation

Introduction

In his controversial book, *Better Never to Have Been*, Benatar defends the thesis that every person is gravely harmed by being brought into existence. He further argues that we have a moral duty not to procreate and recommends that the human species should be phased out of existence as soon as possible so that no more people are harmed.

By advancing and defending unpopular and counter-intuitive views, Benatar has ruffled the feathers of a great many people both within and outside the philosophical community as evidenced by the many articles and reviews in philosophical journals, and commentaries on web logs and YouTube. Sami Pihlström, for example, has argued that Benatar's ideas are too dangerous and culturally harmful to be discussed philosophically (Philström 2009). Yujin Nagasawa reaches a similar conclusion when he says that Benatar's claims 'are dreadful and possibly dangerous' (Nagasawa 2008, 675).

I will begin by giving a summary of Benatar's two main arguments for antinatalism: namely, the formal and the material arguments. I will then show that Benatar fails to clearly distinguish between existence (which in itself is not bad) and the harm that those who exist suffer. I further argue that he has grossly exaggerated the harms that characterize existence. Given the insurmountable difficulties that the implementation of Benatar's anti-procreation policy would face, I argue that the most realistic way of ensuring that humanity does not continue to suffer is to seek to eliminate the cause of suffering itself and not to extinguish the human species. I believe that this is possible because we already have evidence suggesting that life is getting better and people are happier.

The case against conscious human existence

Benatar has two independent but complimentary arguments for antinatalism: the formal and the material argument. Whereas the former, which is commonly referred to as the asymmetry argument, uses logic to demonstrate that creating people harms them, the latter largely appeals to empirical evidence to demonstrate that our lives are *very* bad and were therefore not worth creating.

Most critics of Benatar have focused on the formal argument, which is found in the first chapter of his book. This argument proceeds from the following two premises, which are asymmetrical:

- The absence of pain is good even if that good is not enjoyed by anyone.
- The absence of pleasure is not bad unless there is somebody for whom this pleasure is a deprivation (Benatar 2006, 30).

Benatar's point is that pain is intrinsically bad but there is nothing bad about the absence of pleasure so long as no-one is deprived of it. Given this asymmetry and considering that human existence entails harm while non-existence does not, Benatar draws the nihilistic conclusion that it is better not to exist. As he forcefully puts it '…the avoidance of the bad by never existing is a real advantage over existence, whereas the loss of certain goods by not existing is not a real advantage over never-existing' (Benatar 2006, 14).

Benatar further argues that all suffering, however small (including a pin-prick), is sufficient to make coming into existence undesirable. It is useful to point out at the outset that Benatar is not claiming that the non-existent are better off. To say so would be to attribute a property to a non-existent thing. All what he is saying is that coming into existence is harms those who come into existence (Benatar 2006, 4)

The second argument for anti-natalism that Benatar proposes is the material argument, Here Benatar seeks to show that even the best lives are *very* bad and although some are worth continuing, no life is worth starting in the first place. He appeals to three

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[56] M Meslin, Religious traditions and the Human Person, *Concepts of Person in Religion and Thought*, H G. Kippenberg, Y B. Kuiper, and Ay F. Sanders eds., (Berlin: Mouton de Gruyter, 1990), p67.

psychological theories to explain why people tend to over-estimate the good in their lives. The first is Polyannaism, which states that humans are predisposed to optimism and tend to remember the good things in their lives and repress bad memories. The second theory is adaptation, which is the capacity to adjust to new experiences and adopt new behaviors. The third is the social comparison theory, which is the tendency to focus on comparative rather than an actual self-assessment of well-being (Benatar 2006; 65-68). He suggests that these psychological traits may have been favored by Darwinian selection because they helped militate against suicide and hence promoted the survival of the species. Benatar goes on to give a catalogue of miseries to demonstrate the magnitude of harm in the world. These include ill health, hunger, anxiety and death that are caused by disease and wars and natural calamities such as earthquakes, volcano eruptions and flooding. He maintains that all humans will experience at least one of these harms in their lives, which means that the probability of exposure to harm is certain.

From the two arguments Benatar has drawn a number of conclusions. The first one is that since human existence entails harm and this harm is more severe than most people realize, procreation is always immoral. He maintains that not only do we have no moral duty procreate; we have a moral duty not to procreate. According to this view, sex can only be morally acceptable if it is not reproductive.

A second consequence of Benatar's argument is the assertion that pregnant women have a moral duty to abort during the early days of gestation. His justification for this is that during the early stages of gestation a fetus will not yet have come into existence in the *morally relevant sense*.

Even more disturbing is Benatar's recommendation that the human species should be extinguished. He thinks that the best way to achieve this goal is not by mass murder or suicide but through non-procreation. And since coitus is possible without bringing anybody into existence, he maintains that non-procreation need not come at the expense of frustrating coital needs. But he cautions that such a moral duty should not lead to the abolition of legal procreative rights because of the immense harm the enforcement of such a law would bring to those who already exist.

It is important to point out at the outset that Benatar is not saying that those who don't exist are better-off than those who exist. The non-existent 'are not' and cannot therefore be benefited or harmed by our actions. What he simply means is that coming into existence is bad for *those* who come into existence and it is preferable if they never existed at all (Benatar 2006: 4).

An interesting twist in Benatar's anti-natalist argument is that whereas coming into existence harms the "exister", once a life is started it would be worth continuing because terminating it would prevent the person from having future goods. This in essence means that decisions about the creation of life and decisions about its continuance must be handled differently.

Weird, as they may sound, Benatar's anti-natalist views are not entirely new. As he has pointed out, a number of people throughout history have alluded to or explicitly expressed similar anti-natalist views. These include philosopher Arthur Schopenhauer and prophets Job and Jeremiah and the writer of Ecclesiastes in the Bible. Interestingly today there exists an organization calling itself the 'Voluntary Human Extinction Movement' whose agenda, as its name suggests, is the extinction of the human race. This movement was founded by Les Knight in 1996 and his deep convictions led him to have a vasectomy at the age of 25.

However, whereas Benatar's antinatalism is primarily motivated by the desire to save mankind from avoidable and needless suffering, Knight's motivation is to prevent the further degradation of the environment. For Knight, eradicating the human race is the panacea to the environmental problems besetting the world today. As he forcefully puts it: *"If you haven't given voluntary human extinction much thought before, the idea of a world with no people in it may seem strange. But, if you have given it a chance, I think you might agree that the extinction of Homo sapiens would mean survival for million, if not billions, of Earth-dwelling species…..Phasing out the human race will solve every problem on earth, social and environmental"* (Knight 1991, 72).

Another writer who shares Benatar's views is Jimmy Crawford. As he puts it, *"as far as philosophies go, mine is pretty and dry. I simply believe that human beings should stop breeding and let the race die out through attrition"* (Crawford 2011, 13). Indeed, he believes that anti-natalism is a logical extension of normative human sensibilities and any person with some degree of empathy for the suffering of others would agree with him.

Is life really that bad?

The problem with Benatar is his tendency to exaggerate the enormity of the harm that accompanies existence. He does this in his second argument where he gives a catalogue of the sufferings that those who exist undergo. The truth of the matter is that although no life is without its own challenges, most lives are reasonably good and devoid of intolerable suffering. That is why once started, as Benatar acknowledges, most lives are worth continuing.

But if most lives once created are worth continuing, as Len Doyle has rightly pointed out, one could as well take the risk of bringing forth a child with the hope that its life will turn out to be worth continuing (Doyle 2007: 474-575). If all lives are *very* bad, as Benatar seems to suggest, then all lives would be wrongful lives and our courts would be inundated with wrongful life cases. The fact that we are able to distinguish between wrongful lives and normal lives is a clear indication that most lives are not as bad as Benatar would have us believe.

Furthermore, some lives may be worth starting even though this may predispose to harm the being whose life is. Take the life of Nelson Mandela, the anti-apartheid icon, as an example. We certainly can say that even though his life was characterized by pain and suffering, the world would be worse of today had Mandela not come into existence. His life is therefore not only worth continuing (his death would cause pain to many) but was also worth starting in the first place. The same can be

said of the many heroes and heroines who sacrifice their lives in order to make this world a better place, not to mention the many scientists, inventors and poets who have made discoveries, invented gadgets and written poems, all of which have made our lives better than they otherwise would have been.

What Benatar fails to realize is that some pleasures may outweigh any possible harm. A good example is the pain that a mother undergoes during labor and the overwhelming joy and happiness that follows the birth of the baby. Pain may also be necessary and beneficial for the achievement of other values. As the saying goes 'there is no gain without pain'. Without pain we would never know when our bodies are in trouble. Indeed, even if the non-existent are not deprived the joys of existence, conscious existence is an experience that those who already exist rarely regret. Furthermore, even if existence is always characterized by harms, these harms are temporary since all lives end in death. One could therefore argue that it is better to have lived and suffered rather than to have failed to exist at all.

Benatar's attempt to bolster his antinatalist thesis in the final chapter of his book by showing that it is compatible with religion, and especially Christianity, is not successful. Whereas it is true that at one point in their lives prophets Job and Jeremiah lamented their coming into existence, their lives are not representative of most peoples' lives. The truth of the matter is that the two prophets' lives were characterized by immense suffering but *most* of us enjoy worthwhile lives. It is also useful to note that in the Bible man is the highest achievement of God's creation and is commanded to be fruitful and multiply. The concept of life after death is also testimony to the reverence that most religions have for human life. For most religions, death is not the end of life but the beginning of another life. It should therefore be no surprise that religious people find antinatalism unappealing.

Should humanity be phased out of existence?

Benatar's suggestion that the human existence should be brought to an end strikes me as very odd way of resolving a problem. Given our strong biological drive to pass on our genes to the next generation, his call for the eradication of humanity is not likely to have an impact on pro-creation as he himself acknowledges (Benatar 2006: vii). Although if implemented his anti-procreation policy would no doubt ensure an end to all human suffering, it is not practically implementable. It is highly unlikely that the seven billion people who currently inhabit our planet will one day unanimously agree not to procreate. In any case, even if they were to agree, there is no guarantee that some of them will not break the promise. The point is that moral philosophy cannot afford to be a mere academic exercise; it should help us make practical choices regarding our lives and wellbeing.

Benatar's argues that women have a moral duty to abort during the early days of gestation. His reasoning is that the moral status of an embryo increases with age and that before the 28th to the 30th week it is morally acceptable to carry out an abortion. This argument will no doubt be resisted by those who believe that the embryo has a moral status, equivalent to that of an adult human being from the moment of conception.

There is also a very real possibility that once we allow women to abort during the early stages of gestation some will be tempted to abort during the later stages. Setting aside the question of an embryo's moral status, Benatar will also have to contend with question of abortion's harm to women. Empirical studies have consistently shown that abortion harms women psychologically (Fergusson et al., 2006, Mota et al., 2010). Moreover if all pregnant women were to abort today, as Benatar suggests, this will greatly harm the young as there will be no-one to take care of them in their old age.

As I see it, the problem with Benatar is that he fails to make a clear distinction between *existence* and *harm*. Although existence predisposes one to harm, existence is not a harm and neither does it cause harm or suffering. Indeed, we can imagine a world in which there is no suffering. Accordingly what humans should do, and they have always done this with some measure of success, is to try to eliminate the causes of human suffering. Our job should be to prevent future persons from suffering and not to frustrate their coming into existence.

Benatar is advancing a very strange kind of utilitarianism. He not only seeks to eliminate pain, he also wants to ensure that those who are to suffer this pain don't come into existence. Eradicating the human race in order to eliminate suffering is like burning your own house in order to get rid of a rat. This is a very defeatist and cowardly way of resolving a problem. The best way to deal with such a problem is to kill the rat itself and not to burn the house. Benatar's proposal would only make sense if life was characterized by nothing but pure suffering.

The good news is that science and technology are continuously improving the quality of human life. Advances in the field of obstetrics and gynecology, for example, have reduced the amount of pain and suffering that women go through during childbirth, not to mention the pain killers that have improved the quality of life of those who are terminally ill.

A recent study by Ruut Veenhoven suggests over the last ten years the quality of life in most nations has improved. In these countries happiness and longevity have increased (Veenhoven 2010). Instead of bringing humanity to an end, we should continue to strive to make the world a better place. We have done this in the past (with a measure of success) and there is no reason why we should not continue to do it now. Of course one way of ensuring this happens is by cutting the number of births as our planet has a limited carrying capacity.

It is important to note that there already exists a movement called transhumanism, which seeks to understand and evaluate the opportunities for improving human life. Some of the enhancement possibilities being proposed include the extension of human life through the eradication of disease, unnecessary suffering and augmentation of human intellectual, emotional and physical capabilities. Although these objectives may take a long time to be realized, there is no good reason to believe that they cannot be realized. Benatar is wrong to imagine that humanity will never be able to overcome the

harms that accompany conscious existence. As I have just pointed out, technology has already improved the living standards of humans by making life easy and fast.

At the risk of being accused of *ad hominem* attacks, I cannot help but wonder what has motivated Benatar to entertain such pessimistic views about human existence. People don't theorize in a vacuum. What has life done to Benatar to embitter him this way? Why is he not polyannaish like most of us? These are not idle rhetorical questions. A psychoanalytic study involving a follower of the Voluntary Extinction Movement (Vhement) mentioned earlier revealed that the activist had a disturbed childhood full of violence and neglect (Ormrod 2011). And a perusal of *The Confessions of an anti-natalist,* by Jimmy Crowford, an admirer of Benatar, whose work he quotes *in extensa*, reveals that the author's life (i.e. Crowford) was characterized by joblessness, drug abuse, and ill health (Crawford 2011).

I fear that Benatar's anti-natalist arguments will provide additional ammunition to the likes of Jimmy Crawford and antinatalist cults such as the Vhement group and the Church of Euthanasia, which have been calling for the annihilation of the human species. An ethics that calls for the eradication of all conscious life goes against ethics itself. Ethics, as Albert Schweitzer once said, is nothing but a "reverence for life' (Schweitzer 1987, 309). Any attempt to eradicate life is to be resisted.

Conclusion

In this paper I have argued that although Benatar is correct in saying that conscious existence is always characterized by pain and suffering, he has grossly exaggerated these harms. Furthermore, his suggestion that humans should stop procreating so that no more people are harmed is too unrealistic to be taken seriously. A more realistic solution to this problem is to strive to eliminate these harms. However, in spite of my criticism of Benatar, I think he is to be commended for challenging us to rethink the morality of procreation and parenting. There are many people who believe that they have a moral duty to reproduce regardless of whether they can guarantee their offspring a decent life. Furthermore, as Benatar rightly notes, in most cases procreation is the consequence sex rather than the result of an informed or rational decision to bring someone onto existence. I agree with him when he says that the welfare/interests of future children must be taken into account when deciding whether or not to bring them into existence. A lot of needless suffering could be avoided if people ensured that they only create children whom they are able to take care of and who don't have debilitating diseases or inherited conditions.

References

Benatar, David. 2006. *Better Not to Have Been: the Harm of Coming into Existence*. Oxford: Claredon Press.

Doyle, L. 2007. "Is Human Existence Worth Its Consequent Harm?" *Journal of Medical Ethics* 33(10): 573-576.

Crawford, Jim. 2010. *Confessions of an Antinatalist*. Charleston: Nine-Banded-Books.

Fergusson, D. M., Horwood. I. J and Ridder, E. M. 2006. "Abortion in Young Women and Subsequent Mental Health", *Journal of Child Psychology and Psychiatry* 47:16-24.

Mota, N., Burnett, M. and Sareen, J. 2010. "Associations between Abortion, Mental Disorders, and Suicidal Behaviors in a Nationally Representative Sample". *The Canadian Journal of Psychiatry*, 55 (4), 239-246.

Knight, Les U (pseudonym). 1991. "Voluntary Human Extinction," *Wild Earth,* 1(2), 72.

Nagasawa, Yujin. 2008. 'Review of David Benatar's *Better Never to Have Been: the Harm of Coming into Existence*. *Mind*, 117 (July), 117:674-677.

Ormrod, James S. 2011. "Making Room for the Tigers and Polar Bears: Biography, Phantasy and Ideology in the Voluntary Human Extinction Movement". *Psychoanalysis, Culture and Society",* 16(2), 142-161.

Pihlström, Sami. 2009. "Ethical Unthinkabilities and Philosophical Seriousness". *Metaphilosophy*, (40) 5: 656-670.

Schweitzer, A. 1987. *The Philosophy of Civilization*, trans. C. T. Campion. Amherst, New York: Prometheus Books.

Veenhoven, Runt. 2010. "Life is Getting Better: Societal Evolution and Fit with Human Nature". *Soc. Indic Res*, 97: 105-122.

What are the real qualifycations of professionals? Consideration from the Point of View of the Patients in the Practice of Rehabilitation Medicine in Japan

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1. Introduction

Most therapists (Physical therapists, Occupational therapists, Speech-Language-Hearing Therapists, etc.) belong to many types of organization. The physiatrist[1)] bosses the therapists in the position of general manager. Fundamentally, therapists should evaluate, assess and make plans for the patients as professionals. However, some of the physiatrists often fulfill a role, and prescribe to therapists (Yamano, 2012, p.83). Most of the therapists think they must practice therapy with complying prescriptions, because they are not established to practice in therapy without a physician's prescription, and without direct guidance of the physician, by regulations in Japan. Thus, they have thought the prescription is an "absolute order" (Yamano, 2012, p.83).

It is able to build a relationship of trust between physiatrists and patients. The patients are able to regard the physiatrist as a professional. Meanwhile, from the standpoint of view of regulation, therapist's role is only practicing evaluation and therapy for patient by physiatrist's prescription. Therefore, the therapists may not be able to have a trusting relationship with patients. If it is fully true, the therapists may be lying if they told their profession. However, from the point of view of the patients, he or she may put their trust in therapists. The subject in medical care must be the patients, and they

must decide whether the caretakers are professionals. The therapists may be able to build up a trusting relationship with the patients. If they do, we will accept that the therapists have the real qualifications of professionals. The purpose of this study is to clearly identify what the real qualifications of professionals are in rehabilitation medicine from the point of view of the patients.

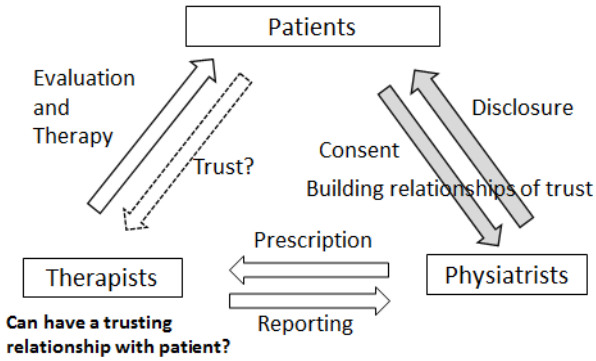

Figure 1: The relationship of trust among the physiatrists, the therapists and the patients

2. The preceding study

Hosoda investigated 27 patients by interviews from 2000 to 2004 (Hosoda 2006). She described the results of interviews with two patients that met with professionals and transfigured themselves with their progression. Hosoda mentioned that one of the patients received a shock because the patient was explained from the physician, "There is no hope concerning recovery from dysfunction (Hosoda 2006, p.183). However, the patient had a relationship with a speech therapist for four years, and the patient answered that they were able to build relationships with the speech-language-hearing therapist, for example, respecting each other, discuss life for the future, and accept each other on equal grounds (Hosoda 2006, pp.323-4).

In the case of another patient, Hosoda mentioned that through the meeting and relationship with the physical therapist, their relationship became specialized and informal because the therapist practiced therapy over the institution and responded individually to the patient (Hosoda 2006, pp. 325-6). Hosoda's position is very interesting because it is not always that the patients trust only the physiatrists. It is beneficial to sustain her position from the point of view of the other patients.

3. Materials and method

In this research, four writings which were written by the patients who received rehabilitation medicine were selected and used (Tsurumi 1998, Tada 2007, Ikenoue 2009, Hayama 2012). I (1) followed their progress from each of the writings, and (2) picked out the various types of professionals who had trusting relationship with the patients or not from them.

4. The four patient's writings

4-1. Kazuko Tsurumi

Kazuko Tsurumi was a sociologist who had a left hemiplegia with intracelebral hemorrhage in 1995 when she was 77 years of age (Tsurumi, 1998, pp.30-1). She was admitted into a rehabilitation hospital after twelve days from the onset. She practiced ambulatory training with parallel bar and was advised by a physical therapist. Sometime later, she was at the high risk of falling because of left equinovarus deformity grater, and she could not use her left hand in the activities of daily living. With all these factors, she was notified by physical therapists that she will not be able to become ambulatory independent (Tsurumi, 1998, pp.57-9).

After six months from the onset, she was moved to facility in a nursing home (Tsurumi, 1998, p.59). She got accustomed to locomotion using a wheel chair. At this time, she met two physiatrists, and she was received medical attention by the physiatrists (Tsurumi, 1998, pp.70-2). She demanded to the physiatrists that she just have to publish my writings. They got a scent of her mind that she believes no help at all if she ask her demand to anyone (Tsurumi, 1998, pp.123-4). The physiatrists advanced for her to peal an apple training using her right hand only, on the ground of her remark that she had eaten an apple every day till onset. She believed that it is impossible. However, she was able to peal an apple through the use of right hand only and the device as a chopping block with the nail (Tsurumi, 1998, pp.124-5).

After this opportunity, she developed the trust for the physiatrists because their advices lead her for the better. She has actively written essays and worked continuously after having rehabilitation medicine for two years.

4-2. Tomio Tada

Tomio Tada was an immunologist who had a right hemiplegia with a brain infarction in 2001 when he was 67 years old (Tada, 2007, pp.11-3). He had severe dysphasia and dysarthria simultaneously (Tada, 2007, pp.21-3). He stated rehabilitation medicine after two weeks from the onset. Though he expected recovery of physical dysfunction at an early stage, did not find it for two months.

After two months from the onset, he felt frantic gradually. He was admitted to the hospital selected by himself. However, he felt disappointed there about physician's inadequate disclosure and therapy which had lack of evidence (Tada, 2007, pp.51-8).

After five months from onset, he moved to the rehabilitation hospital (Tada, 2007, p.71). He was impressed by patient's approach who challenged therapy in the physical therapy room desperately. He was able to ambulate short distances by physical therapist's advice that is very theoretical and adequate concern about the ways of trunk and lower extremity movement (Tada, 2007, pp.79-81). He thought that he has another side to him concerning being able to ambulate himself, and expressed to himself "a giant awakening" (Tada, 2007, p.83).

He commented that the physical therapist as excellent because the therapist has great expertise in rehabilitation

medicine, muscle anatomy and kinesiology (Tada, 2007, pp.80-1).

4-3. Kanta Ikenoue

Kanta Ikenoue was a manager who had quadriplegia with traumatic brain injury in 1999 when he was 49 years old (Ikenoue 2009, p.2). His quadriplegia was severe and he was in a bedridden state (Ikenoue 2009, p.12).

He stated therapy two weeks after onset (Ikenoue 2009, p.15). He was able to sit in a wheel chair with receiving three nurses assistance (Ikenoue 2009, pp.17-8). He had moved to four rehabilitation hospitals within ten months after onset.

During that time, he suffered from real situation which did not make dysfunction recover and severe pain by therapy, which created a sense of mistrust by physician and therapist's unclear disclosure. He questioned the profession's level of conscious responsibility for patients and the difference of technical skills among physical and occupational therapists (Ikenoue 2009,pp.22-7). Nevertheless, he was able to live with hope after his attending physician logically explained matters concerning therapy for living in his home.

Eventually, he experienced the benefits of therapy and acquired personal computer skills with the aid of devices recommended by his occupational therapist (Ikenoue 2009, pp.144-6). The rehabilitation staff discussed about the quality of life for patients with seriousness, and he discussed with rehabilitation staff concerning the different of patient's future vision between staff and him (Ikenoue 2009, pp.148-9).

Through the things, he was able to cognize his current state and future vision, he opened up a window of the mind for the staff (Ikenoue 2009, p.162). He became to have good days because he felt that staffs are always thinking of the patient's future with patients (Ikenoue 2009, p.149).

4-4. Yasuaki Hayama

Yasuaki Hayama was a lecturer of accounting who had a left hemiplegia with intracerebral hemorrhage in 2006 when he was 42 years old (Hayama 2012, p.102). Though he was unable to ambulate, he could locomote by wheel chair two months after the onset. Meanwhile, he could not grasp anything by his right hand. Moreover, he could not communicate with his family by dysarthria.

About two months after onset, he experienced being able to cook pasta as per his occupational therapist's advice (Hayama 2012, p.107). Through this experience, he has come to understand that he will be able to do something with his left hand only even if his right hand does not make a recovery. He had motivation which he wanted to challenge various occupations more strongly. He developed a feeling of respect for occupational therapists who thought a great deal of patient's listening, set the environment that he wants to cook pasta, and pave the way to get back on his feet without conversation (Hayama 2012, p.107).

After three months from the onset, he was discharged from the hospital. He could ambulate with a cane. He went to the facility for the elderly to practice muscle strength training and group exercise. However, he developed a feeling of impatience that his body did not make a recovery. Just then he went to a trip with his friend. Through this trip, he has felt certain that occupation has been very important because dysfunction passed from his remembrance.

A year from the onset, he became the manager of a facility for the disabled elderly, and he has informed the challenged elderly people and the therapists about the good points of occupational therapy since then (Hayama 2012, pp.8-10, 102).

5. Discussion

It doesn't mean that license of the professionals who are able to build a trusting relationship for the patients are not specific from the writings written by the four patients. Maybe, the patients who build and promote trusting relationship for professionals are persons who understand the stand of the patients and follow the same fate as patients.

Table 1. Comparisons of the license of the professionals concerning rehabilitation medicine whether the four patients build trusting relationship or not based on their writings

	Did not trust	**Built trust**
Tsurumi	Physical therapist	Physiatrists
Tada	Physiatrist, Occupational therapist. Speech-Language-Hearing Therapist	Physiatrist, Physical therapist
Ikenoue	Physiatrist, Physical therapist Occupational therapist	Physiatrist, Physical therapist, Speech-Language-Hearing Therapist
Hayama	None	Occupational therapist

It is important to consider what the real qualifications of professionals are in rehabilitation medicine from the point of view of the patients. Though time is different, four patients felt impatience because they did not make a recovery from their dysfunction. Besides, they have frustration because of inadequate disclosure concerning level of dysfunction recovery. Most of patients request that the professionals inform patients of professional's explanation and act clearly. However, if professionals inform patients with a focus on level of dysfunction recovery, the major focus tends to be functional prognosis. That, of course, patient's degree of dysfunction recovery is different among the patients. Besides, it is not likely to lead directly to an ability on the basis of level of dysfunction recovery. Thus, professional's explanation for the patients becomes that we can understand in time finally. If it is so, professionals cannot obtain patients trust.

Concerning these discussions, the author practiced focus group interviews for rehabilitation professionals, patients and their families three years ago. As a result of interviews, patients and their families hope to keep good relationships based on the trust with rehabilitation professionals. The author considers that this idea is confirmed from the result.

For patients, the "real qualifications" of a professional in the practice of rehabilitation medicine is reliability and value. Professions who obtained the trust of these four patient's set realistic and applicative goals for use of not only dysfunction but also devising their environment, for example, experiencing personal computer, wearing kimono, cooking pasta, and so on. Patients require a professional who is able to explain the therapy plan clearly and bring with them the experience that encourages patients to make use of their potential ability for activities of daily living. Moreover, he or she is a person of virtue who considers the patient's present and future life. These qualifications are not distinct among the various types of license.

Note

The Physiatrist has been called the physician who has the specialty of rehabilitation medicine. Rehabilitation medicine is a specialized clinical medicine which follows patients who have motor dysfunction mainly. On the other hand, medical rehabilitation stands that not only stop worsening patient's disease, but also notice to reach the purpose of medicine to live independently and return to work. Therefore, the subject of medical rehabilitation is important for patients of all clinical medicine.

References

Ikenoue K (2009) *rihabiri no kekka to sekinin (The result and accountability for patients in rehabilitation medicine)*, Miwa-shoten.

Tsurumi K (1998) *Kaisei wo ikiru (I live in refreshing),* Fujiwara-shoten.

Hosoda M (2006) *Nousottyu wo ikiru imi* (*The means of spend one's life as patients who have cerebral vascular disease with dysfunction*), Seikaisya.

Tada T (2007) *kamokunaru kyojin (The Silent Giant).* syueisya.

Hayama H(2012) *dakara sagyouryouhou ga daisukidesu (So, I like occupational therapy very much)*, Miwa-shoten.

Yamano K(2012) Consideration of issues concerning "Physician's Prescriptions" in the Practice of Occupational Therapy in Japan. *EJAIB* 22 (2), pp.82-5.

Right without Choice and the Future of Bioethics Discourse in Post-Colonial Society

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Abstract

The future bioethics paradigm of post-colonial under-developed societies like Pakistan oscillates between *right-based-health-care* and *aetiological medicalization of life-world*. The contemporary discourse of bioethics presumes a delicate distinction between right-based-health-care and institutionally determined medicalization of life-world.

The former considers the health care as a fundamental right of an individual, whereas the later emerges from the institutionalization of scientific methodological studies i.e. a never ending process of excavating the causes of diseases and reasons of their spread, which is the result of the compartmentalization of knowledge to actualize modern dream of transcendental standard of ideal human life.

In this paper both paradigms of bioethics will be evaluated critically with reference to healthcare. It will be argued that both these bioethics paradigms provide a passive resistance to the moral foundations of traditional societies. They also have a potential to disintegrate communal particularities of such communities. The paper will be divided into two sections. In the first section it will be argued that right-based health care paradigm presumes an antagonistic relation with local moral foundations which are rested upon the priority of ***Good over right***. In the second section we will argue that medicalization of life-world either determined by state apparatus or by market driven mechanism will eventually facilitate the process of modern discursive practices.

In the conclusion we will try to establish that both paradigms are complementary to each other and the institutionalization of right-based-health care is directly proportional to the positivistic scienticization of traditional life-world.

Section 1: Post-colonial bio-ethical discourse and the trajectory of irony

The Contemporary bio-ethical issues prevailing in post colonial societies like Pakistan cannot be understood without contextualizing these issues in the gradual process of progress and development. This technologically driven transformation of the life world from pre-scientific traditional life to modern scientific ways of living is being under way, institutionalized and idealized. The process of modernization is not only defining the traditional, pre-industrial culture as irrational and claimed to rested upon arbitrary backward authoritative mechanisms but most importantly it also questions the legitimacy of the values and their corresponding belief structures i.e. religious-cum-traditional value system as an obstacle in the realization of scientific enlightenment. The gradual revaluation and cultural transformation is presumed to be the unconditional imperative of the age "the only remaining alternative is that of intelligent, voluntary acceptance of the industrial ways of life and values that go with it".[57]

[57] Ayers C.E., *"The Theory of economic progress": A study of the fundamentals of economic development and cultural change,* New York, Schocken Books. 1962 P. xxiv- xxv

The data has been referred in the paper is taken from the sources of ***planning and development division, government of Pakistan***. [58]

Country	Life Expectancy 2011	Mortality Rate under 5 per 1000 2010	Infant Mortality Rate per 1000 2011	Population Growth Rate (%) 2011
Pakistan	**65.99**	**86.5**	**63.26**	**2.03**
India	66.80	62.7	47.57	1.34
China	74.68	18.4	16.06	0.49
Indonesia	71.33	35.3	27.95	1.07
Bangladesh	69.75	47.8	50.73	1.57
Sri Lanka	75.73	16.5	9.70	0.93
Malaysia	73.79	6.3	15.02	1.58
Nepal	66.16	49.5	44.54	1.60
Thailand	73.60	13.0	16.39	0.57
Philippines	71.66	29.4	19.34	1.90

Source: World Development Report 2011

(Rs. Billion)

Fiscal Years	Public Sector Expenditure (Federal and Provincial)			Percentage Change	Health Expenditure as % of GDP
	Total Health Expenditures	Development Expenditure	Current Expenditure		
2000-01	24.28	5.94	18.34	9.9	0.72
2001-02	25.41	6.69	18.72	4.7	0.59
2002-03	28.81	6.61	22.21	13.4	0.58
2003-04	32.81	8.50	24.31	13.8	0.57
2004-05	38.00	11.00	27.00	15.8	0.57
2005-06	40.00	16.00	24.00	5.3	0.51
2006-07	50.00	20.00	30.00	25.0	0.57
2007-08	60.00	27.22	32.67	20.0	0.57
2008-09	74.00	33.00	41.10	23.0	0.56
2009-10	79.00	38.00	41.00	7.0	0.54
2010-11	42.00	19.00	23.00	(-)47	0.23
2011-12	55.12	26.25	28.87	31.24	0.27

Source: Planning & Development Division

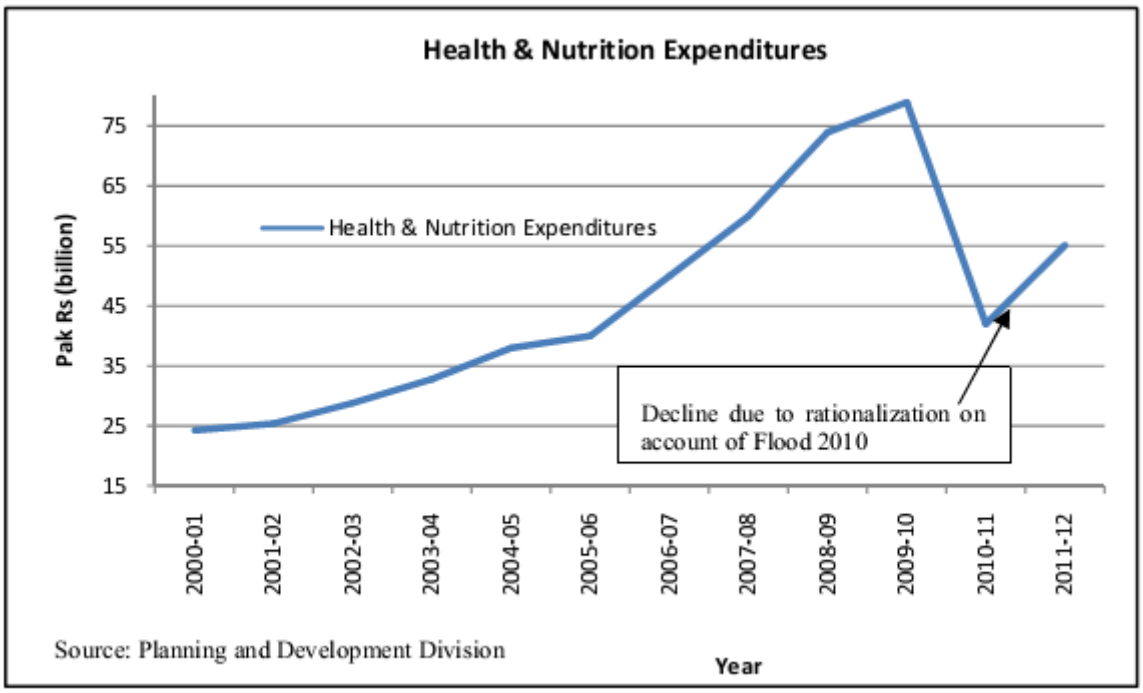
The data reveals that although the state is not successful enough to provide health care facilities compatible with the universally acknowledged standards of health care available in the advanced industrial societies. However it is also obvious that the justification of the non-contestable idealization of the model of health care is not other than medicalization of life form as a fundamental moral imperative for both state and society. The data is also helpful to understand the gravity of the ***belated consciousness*** i.e. consciousness of being left behind[59] felt by the people regarding the unavailability as well as inaccessibility to the available health care apparatus in the country.

Sub Sectors	Targets (Number)	Estimated achievements (Numbers)	Achievement (%)
A. Rural Health Programme			
New BHUs	50	30	60
New RHCs	10	7	70
Strengthening/ Improvement of BHUs	50	35	70
Strengthening/ Improvement of RHCs	20	15	75
B. Hospital Beds	5000	4000	80
C. Health Manpower			
Doctors	5000	4300	86
Dentists	500	450	90
Nurses	4000	3000	75
Paramedics	5000	4500	90
TBAs	550	500	91
Training of LHWs	10000	9500	95
D. Preventive Programme			
Immunization (Million Nos)	7.5	7	93
Oral Rehydration Salt (ORS) (Million Packet)	22	20	91

Source: Planning & Development Division

[58] See Ejaz S. Wasti, Pakistan Economic Survey 2011-2012, chapter 11 copy right ministry of finance Govt. of Pakistan. P.152-154.www.finance.gov.pk.

[59] See Suri W.A. " What is living and what is dead in Iqbal: The incommensurable hermeneutical circle prevail in Iqbal thought, in in Revisioning Iqbal: As poet and Muslim Political Thinker. (ed) *Gita Dharampal-Frick, Ali Usman, Katia Rosteller, Heidelberg,* Published by Oxford University Press Pakistan Lahore 2011



Healthcare Facilities

Health Manpower	2009-10	2010-11	2011-12
Registered Doctors	139,555	144,901	149,201
Registered Dentists	9,822	10,508	10,958
Registered Nurses	69,313	73,244	76,244
Population per Doctor	1183	1,222	1,206
Population per Dentist	16914	16,854	16,426
Population per Bed	1592	1,701	1,665

Source: Planning & Development Division

The commitment with modern ways of life is not just of political or an institutional nature rather it has specific ontologically determined teleological foundations. In post colonial societies the prevailing life form of advanced post-industrial societies is presumed to be the "natural culmination of the potential already existing in Neolithic man"[60]. This presumed metaphysical assumption has conceptually transformed the process of modernization from a historical process to a natural evolutionary phenomenon. The pursuit of progress and development has substantively been interpreted within the theoretical parameters of modern enlightenment thought and its corresponding institutions. There is no doubt that in post colonial societies "modern man is defined by progress"[61]

The claim that people in the western world are "living in the golden age of scientific enlightenment and artistic achievement"[62] has very well received by the post colonial societies. It is an acknowledged fact that at national and state level there is no doubt that science should be consider as state subject. The cost of this epistemological as well as methodological prioritization will be beard because the inevitability of profound cultural change is empirically evident but every body assumes that "the rewards are considerable."[63]

The scientific methodological prioritization has not been confined to specific task oriented projects and endeavors pursued by state apparatus or local industrial complex. Rather it has been interpreted as an objective epistemological criterion to judge the credibility of traditional religious and of course historical foundations of post colonial epistemological tradition.

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[60] Estava Gustavo, "Development" in Wolfgang Saches (ed.), *The Development Dictionary: A Guide to Knowledge as Power,* Johannesburg University Press. 1995 p.9

[61] Ibid.,p.16

[62] Ayers C.E., "The Theory of Economic Progress": A Study of the Fundamentals of Economic Development and Cultural Change. Op.cit. p.xxv

[63] Ibid., p. xxv

Vaccine/doze.		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011(R)
B.C.G.		5,070,031	4,777,166	5,114,865	4,862,494	5,203,061	5,364,136	5,790,371	5,884,435	6,133,378	5,924,868	5,924,868
POLIO	0	1,734,707	1,842,279	2,132,474	2,352,552	2,625,604	2,846,229	3,098,116	3,428,749	3,650,026	3,773,055	3,773,055
	I	4,583,673	4,543,243	4,819,735	4,512,848	4,858,592	5,250,568	5,645,107	5,556,128	5,884,871	5,852,612	5,852,612
	II	4,079,328	4,014,687	4,281,717	4,098,187	4,387,392	4,869,878	5,178,706	5,034,410	5,402,701	5,526,671	5,526,671
	III	4,023,674	3,780,170	4,035,457	3,916,351	4,159,987	4,738,953	5,070,490	4,819,065	5,277,352	5,422,439	5,422,439
	IV	-	-	-	-	-	-	-	-	-	-	-
	BR	226,529	138,207	105,640	77,721	49,428	33,007	46,615	60,917	35,842	81,322	81,323
COMBO												
	I	-	-	-	-	-	-	3,999,759	5,071,729			
	II	-	-	-	-	-	-	3,720,089	4,612,518			
	III	-	-	-	-	-	-	3,656,495	4,356,169			
D.P.T												
	I	4,688,768	4,558,086	4,768,665	4,427,751	4,581,347	5,275,075	1,710,723	-	-	-	-
	II	4,175,545	4,038,630	4,227,754	4,025,465	4,126,599	4,886,576	1,523,243	-	-	-	-
	III	4,112,538	3,795,573	3,982,974	3,839,571	3,918,794	4,756,441	1,479,364	-	-	-	-
	BR	46,518	22,626	5,959	2,418	105	284	55	-	-	-	-
H.B.V												
	I	-	1,772,217	4,482,628	4,212,720	4,458,183	5,053,306	1,617,799	-	-	-	-
	II	-	1,290,550	3,892,582	3,879,701	4,065,343	4,692,279	1,441,447	-	-	-	-
	III	-	965,850	3,576,321	3,616,543	3,840,703	4,571,006	1,401,189	-	-	-	-
Pentavalent												
	I	-	-	-	-	-	-	-	-	5,924,991	5,862,892	5,862,892
	II	-	-	-	-	-	-	-	-	5,461,294	5,555,135	5,555,135
	III	-	-	-	-	-	-	-	-	5,338,521	5,407,251	5,407,251
T.T												
	I	4,179,310	4,678,265	3,590,786	3,391,488	4,539,131	4,069,365	3,877,897	4,307,085	4,919,757	5,050,174	5,050,174
	II	3,286,376	3,539,711	2,969,663	2,649,564	2,857,932	3,133,454	3,048,345	3,384,967	3,791,733	4,065,119	4,065,119
	III	868,820	1,278,078	1,423,277	765,268	793,128	894,639	810,023	865,694	937,769	897,008	897,008
	IV	310,995	310,448	337,968	292,941	519,086	286,368	239,055	279,024	284,879	268,213	268,213
	V	163,747	159,402	163,699	131,888	157,382	176,530	141,288	152,080	168,861	164,970	164,970
MEASLES		4,546,632	4,105,614	4,163,032	4,124,958	4,387,211	5,050,347	5,386,101	5,277,766	5,297,362	5,299,641	5,299,641
	II	-	-	-	-	-	-	-	-	1,806,309	2,799,723	2,799,723

- not available — Source: Ministry of Health

B.C.G. Bacilus+Calamus+Guerin
D.P.T Diphteira+Perussia+Tetanus
T.T Tetanus Toxoid
Note: The DPT from the year 2007 onward has discontinued and is replaced by Combo - a combination of DPT and HBV
R: Repeated

This gradual but remarkable shift in the epistemological paradigm of post colonial societies has questioned rather delegitimized their historically derived identity consciousness and its corresponding values and normative stances. On the one hand, this prioritization opens up a new domain of reformation of traditional and religious epistemological claims in compatibility with modern scientific discourse on the other hand it opens up a gradual process of "making modern self identity"[64]. If we try to understand the phenomena of progress in the context of post-colonial cultural specific particularities, it reveals a historically determined relation between progress and modern self identity. "To modern man and to those who want to share his identity, rejecting faith in progress is unbearable".[65].

The grand narrative of modern discourse compels post colonial intelligentsia to consider scientifically driven technological progress and development as non contestable imperative. It is because of this reason it is claimed that "the third world had to develop first before even think about real progress"[66]. Therefore progress particularly scientific progress is not just a state policy rather a moral imperative which compels the post colonial intelligentsia to reinterpret whole human history from the spectacles of "purely western genealogy of history"[67].

It is quite ironic to critically evaluate the theoretical foundations of the process of medicalization in a society where the availability of physician per 1000 people is around 0.74.The total spending on health care sector has never raised to 2.5% of the over all GDP of the country in its entire history. It will be better to provide a statistical representation of the available health care apparatus in the country. This statistical representation provides an opportunity to the reader

[64] Taylor C. *Sources of Self: The making of modern self identity,* Cambridge, Cambridge university press,1989, p.25.
[65] Jose Maria Sbert, " Progress" in Wolfgang Saches (ed.), The development dictionary: A guide to knowledge as power, op.cit. p.195
[66] Ibid.
[67] Estava Gustavo, "Development" in Wolfgang Saches (ed.), The development dictionary: A guide to knowledge as power, op.cit.p.9

to understand the how difficult is to critically evaluate the theoretical limitations of the medicalization process in a post-colonial socio-cultural context where people are comparing the available health care apparatus to the universally acknowledged standards of health care which are derived from the process of medicalization in it self.

Year	Registered Doctors ***	Registered Dentists ***	Registered Nurses ***	Registered Mid-wives	Registered Lady Health Visitors	Population per		Expenditure(Mln. Rs)^*	
						Doctor	Dentist	Development	Non-Development
1963	1,049	17	..	..	..	46,615	..	34.55	80.00
1964	1,325	81	..	..	..	37,970	..	75.22	78.00
1965	1,591	151	..	..	..	32,533	..	46.47	84.00
1966	2,008	195	..	..	..	26,524	..	35.31	86.00
1967	2,588	233	..	..	..	21,170	..	70.80	92.00
1968	2,668	273	..	..	..	21,128	..	59.79	99.00
1969	3,322	332	..	..	..	17,459	..	67.99	128.00
1970	3,913	384	..	..	..	15,256	155,468	61.70	151.00
1971	4,287	446	..	..	..	14,343	137,870	57.62	141.10
1972	4,802	511	..	..	..	13,190	123,953	95.55	171.90
1973	5,138	549	..	..	..	12,824	120,018	175.67	210.10
1974	5,582	610	946	522	51	12,164	111,311	363.00	278.00
1975	6,018	650	1,985	1,201	118	11,628	107,661	629.10	360.64
1976	6,478	706	2,526	1,637	197	11,133	102,153	540.00	439.20
1977	7,232	733	3,204	2,577	246	10,278	101,405	512.00	558.60
1978	9,142	781	3,892	3,106	341	9,526	98,079	569.00	641.60
1979	10,167	846	4,552	3,594	453	8,695	93,309	717.00	661.89
1980	11,860	928	5,336	4,200	547	7,549	87,672	942.00	794.82
1981	14,996	1,018	6,110	4,846	718	6,101	83,369	1037.00	993.10
1982	18,256	1,121	6,832	5,482	928	5,087	77,948	1183.00	1207.00
1983	21,942	1,222	7,348	6,031	1,144	4,308	73,560	1526.00	1564.00
1984	26,700	1,349	8,280	7,078	1,374	3,605	68,490	1587.00	1785.12
1985	31,107	1,416	10,529	8,133	1,574	3,160	67,041	1881.50	2393.81
1986	35,102	1,558	12,014	10,315	2,144	2,865	62,580	2615.00	3270.00
1987	39,639	1,636	13,002	11,505	2,384	2,594	61,180	3114.41	4064.00
1988	43,921	1,772	14,015	12,866	2,697	2,396	57,963	2802.00	4519.00
1989	48,342	1,918	15,861	13,779	2,917	2,228	54,927	2681.00	4537.00
1990	52,935	2,068	16,948	15,009	3,106	2,082	52,017	2741.00	4997.00
1991	56,616	2,184	18,150	16,299	3,463	1,993	50,519	2402.00	6129.65
1992	61,081	2,269	19,389	17,678	3,796	1,892	49,850	2152.31	7452.31
1993	64,038	2,394	20,245	18,641	3,920	1,848	48,508	2875.00	7680.00
1994	67,224	2,584	21,419	19,759	4,107	1,803	46,114	3589.73	8501.00
1995	71,718	2,747	22,299	20,910	4,185	1,455	44,478	5741.07	10613.75
1996	75,239	2,933	24,776	21,662	4,407	1,689	42,675	6485.40	11857.43
1997	79,474	3,154	28,661	21,840	4,589	1,636	40,652	6076.60	13586.91
1998	83,696	3,434	32,938	22,103	4,959	1,590	38,185	5491.81	15315.86
1999	88,117	3,857	35,979	22,401	5,299	1,578	35,557	5887.00	16190.00
2000	92,838	4,165	37,528	22,525	5,443	1,529	33,629	5944.00	18337.00
2001	97,260	4,612	40,019	22,711	5,669	1,516	31,579	6688.00	18717.00
2002	102,644	5,058	44,520	23,084	6,397	1,466	29,405	6609.00	22205.0
2003	108,164	5,531	46,331	23,318	6,599	1,404	27,414	8500.00	24305.00
2004	113,309	6,128	48,446	23,559	6,741	1,359	25,107	11000.00	27000.00
2005	118,113	6,734	51,270	23,897	7,073	1,310	25,297	16000.00	24000.00
2006	123,146	7,438	57,646	24,692	8,405	1,254	20,839	20000.00	30000.00
2007	128,042	8,215	62,651	25,261	9,302	1,245	19,417	27228.00	32670.00
2008	133,925	9,012	65,387	25,534	10,002	1,212	18,010	32700.00	41100.00
2009	139,488	9,822	69,313	26,225	10,731	1,184	16,814	37860.00	41000.00
2010	144,901	10,508	73,244	27,153	11,510	1,222	16,854	18706.00	23382.00
2011	149,201	10,958	76,244	27,153(R)	11,510(R)	1,206	16,426	26248.00	28873.00

R : Repeated

Source : Ministry of Health, Planning & Development Division

.. : Not available

^* : Expenditure figures are for respective financial years 2011 = 2011-12

*** : Registered with Pakistan Medical and Dental Council and Pakistan Nursing Council.

Note: Data regarding registered number of Doctors/Dentists is vulnerable to few changes as it is affected by change of province or if there is any change in registration status from time to time

Date for medical personal for the year 2011 is estimated by adding the output actually achieved during the year to the medical manpower in 2010.

There is no doubt that these statistics show that people of Pakistan are surviving without appropriate health care apparatus and the most valuable moral contribution one can make is to provide best available techno-scientific facilities in health care sector to the people of this country.

Therefore it seems quite unrealistic to raise moral questions against the institutionalization of scientific methodological studies to address actual as well as potential problems faced by the people concerning health care sector even run by the public sector or managed by the private sector. Because in the contemporary social order of such post colonial life form establishing health care unit i.e. Hospital is in it self presumed to be “non contestable” good which guarantees the emancipation from pain, suffering, actual or potential abnormalities, and in extreme cases from painful death. The hospital i.e. techno-scientifically driven institutional apparatus is

presumed to be the most efficient mechanism available to ensure healing, compassionate care, counter physical or psychological threats or sharing burden of sickness, life time abnormalities, terminal illnesses and dreadful experience of dying love ones.

In pre-modern, under-developed post-colonial societies all these miseries, sufferings and traumatic experiences etc. either caused by diseases, abnormalities (both physical and psychological) or casualties etc. are generally faced and countered although inappropriately by the families of the affected one, due to the unavailability of modern techno-scientifically driven health care institutions. Therefore it is an acknowledged fact that making these institutional apparatus available to combat this evil of disease, pain and abnormalities is the ultimate, non contestable moral imperative. All kinds of resources including public welfare funds, religious charities, corporate social benefit funds, philanthropic activities made by celebrities, sports men and retired professional are used to accelerate this process of medicalization and to gain cultural capital.

The only moral cum political problem identified, discussed and critically evaluated is the issue of the accessibility of the general public to the health care institutional order which is derived embryonically from the scientific industrial complex. It is quite fashionable for both the educated underprivileged middle class intelligentsia and foreign qualified bourgeois social activist to condemn state apparatus for not providing appropriate resources to make facilities of modern health care available.

The most popular moral argument used in contemporary literature of bioethics discourse in our part of the world regarding health care issues is to ensure the ***right to medical care*** to every citizen of the country.

The fundamental principles of bioethics particularly the principle of autonomy and principle of justice are explicitly being interpreted in the context of the priority the right over good. Therefore the availability of health care facility is not just a fundamental moral imperative rather it is also presumed to be a fundamental political objective to develop free democratic order. The autonomy and self-determination of an individual which is guaranteed by the constitution of the country will be meaningless if the psychosomatic freedom of the individual is not realizable due to the unavailable or inappropriate health care apparatus. This right of the individual is also protected under the covenant of Universal Declaration of Human Rights article 25:1. Therefore the state is not only answerable to the people of the country rather it is also answerable to the international community, under the conditions of United Nations and its corresponding transnational bureaucratic order.

The individual right of self determination is presumed to be the fundamental condition of self respect therefore the lack of proper health care facility or inaccessibility to the health care units will be interpreted as a violation of individual psychosomatic freedom, hence undermines the possibility of self respect and consequently social well being of individual this may lead to class antagonism and social unrest.

It is very important note that protection of health care as fundamental right has also been supplement in article 12 of the International Covenant on Economic, Social and Cultural Rights thus the right to health is not just presumed to be a natural or moral right of an individual rather it has been presented as one of the fundamental obligation of a given system of justice corresponding to the international system of justice.

In the western world it was presumed to be inconceivable to consider gradual process of medicalization as some thing problematic till the 1960s.[68] Medicalization process was generally interpreted as mechanization to counter the morbidity. It was presumed to be reasonable to invest on this process of medicalization because it will not only reduce the possible morbidity but it will eventually decrease the cost of health care. Thus the excessive process of medicalization and its corresponding discourse has created a hermeneutical circle which establishes an inverse relational between the growing competence of health care and the tolerance of diseases or abnormalities.

The formalization of the health care apparatus has redefined the status of physician. The de-professionalized method to interpreted diseases, handle patient, manufacturing and use of medicine has been considered as a sign of ignorant, regressive, obscurantist, unhealthy and sick minded criminal offence.

Unlike the traditional conception of medicine which was rested upon a foundationalists or essentialist conception of human being and presumes an instrumental role of medicine to enhance the imbedded immunity potential individual has to combat diseases. This traditional conception of medicine has been repudiated by the gradual process of medicalization. It was not just the issue of reducing morbidity rather the issue to improve health level and new standards of health and body efficiency have been idealized through effective medical interventions. It was believed that "health levels will improve with the amount spent on medical service, that more medical interventions would be better and that doctors know best what there service should be".[69] The conception of human "isness" has been transformed due to the gradual victories against epidemic diseases. The transition from being to becoming has gradually been substantiated and trust on the non-contestable telos i.e progress has been established. "Everywhere the belief on unlimited progress was still unshaken and progress in medicine meant the persist effort to improve human health, abolish pain, eradicate sickness and extend the life span by using ever new engineering intervention"[70]. The trust on the transition from actual to possible human being is the unintended corollary of the institutional penetration of medicalization process and its capacity to

[68] Illich Ivan " The medicalization of life", *Journal of Medical Ethics*, 1975 p.74

[69] Strickland, Stephen P. , US health care: What's wrong and what' right,NY universe Books,1972 p. 127, quoted in " The medicalization of life" by Ivan Illich, *Journal of Medical Ethics*, 1975 p. 74

[70] Illich Ivan "The medicalization of life", *Journal of Medical Ethics*, 1975 p. 74

make medical intervention. Thus transcendence from actual to potential human existence is the ultimate objective of this process. For instance, genetic, engineering, cloning, abortion, genetic mutation, gender transformation stem cell methodologies etc. are all not presumed to be the fears any more rather the expectations of what the process of medicalization is intended to realize.

Section 2: What is wrong with Medicalization

The overall process of progress and development has made technological revolution possible but at the same time there are voices emerged against the unintended consequences of this ruthless thirst to dominate reality by virtue of scientifically driven mechanism of progress. "Science the greatest creation of the rational mind has turned out to be a specter of doom, posing the greatest threat to our natural environment and our human existence. If there has been any progress since western man rebelled against God and deified himself in 'the age of Enlightenment' it has been in the sphere of human suffering, greed and oppression".[71]

It is very interesting to note that the phenomena of medicalization which is in it self one of the manifestation of the scientific enlightenment progress has been reinforced by the general critique on environmental deterioration. It was claimed that environmental degradation, poisonous pesticides, gas-chambers, weapons of mass destruction etc. are not the only threats caused by the scientific progress, rather health damages (both actual and potential) caused by this over all process of progress and development demands more comprehensive mechanism of health care.

There is no doubt that medicalization is in itself an ongoing process of excavating the causes of diseases and reasons of their spread. But at the same time it not easy to identify the status of physician in the whole process of medicalization what actually their role is? The protectors, repairers or the architects of future humans?.

The popular literature in our part of the world acknowledges the central role of the physician in this whole process of medicalization. However it has been argued that what actual role physician should perform substantively.

"Do they maintain health?"

"Do they repair health?"

"Do they protect health?"

Despite this fact that what actually the core concern of the process of medicalization i.e. maintenance, repair or protection from the possible future threats to human health either caused by external factors or by internal genetic, congenital or hereditary factors. The role of physician is presumed to be inevitable to counter the actual and possible threats to human health.

The health policy framework either designed by the politicians or technocrats they always consult the specialists of the concerned discipline of knowledge. But thanks to the modern epistemological discourse the compartmentalization of knowledge has created obstacles to develop a uniform policy framework to address the core concern of human health because of their imbedded antagonistic relation with each other. Its never-ending ***Iatrogenesis*** process has made human health as intrinsically an unstable state of existence. Iatrogenesis is actually a three dimensional process.

a) Defining diseases

b) Search for their cures

c) Redefining the diseases which are the result of medical treatment i.e side effect

It means that the iatrogenesis process is not only cynically vicious circle but it is also a growing and extending area of control. It is making things medical which were not supposed to be the part of the realm of medical. In critical sense medicalization is a process of over medicalization.[72] The process of medicalization and its relation with the problem of social control has been identified in social scientific discourse of 1970s. Since then significant work has been done in this regard which reveals the multi-dimensional capacity of social control that has been exhibited by the gradual process of medicalization. For instance the works of "Conrad (1975) on hyperactivity in children, Scull (1975) on mental illness Pfohl (1977) on child abuse and Schneider (1978) on alcoholisms as a disease" have problematized the issue of medicalization regarding it potential of social control. Unlike the above mentioned case studies regarding the medicalization of social deviance as well as the normative predication of the process of medicalization have also been problematized, the "studies analyzed changes from non medical to medical definition and treatments… e.g. Foucault 1965, Gusfield 1967, Wertz and Wertz 1989, Illich 1976 " all have identified and critically evaluated this overwhelming mechanism of discipline, control and its over all impact on the meaning and the sense of one's existence. Zola's definition of medicalization incorporate both aspects of medicalization i.e. pathological and socio-cultural, "medicalization is a process where by and more of everyday life has come under medical domain, influence and supervision".

Conrad has elucidated three different levels of medicalization to understand the scope of this process.

a) The conceptual level

b) The institutional level

c) The interactional level

The conceptual level deals with the creation of terminologies and linguistically derived jargon to understand order and explicate the problems to which health care professionals are or will be confronting with. The institutional level is the formalization of the terminologies, vocabulary and models, medical professionals i.e. specialist have conceptualized or theorized to address the given problem, within the parameters of the organization's prescribed manual.

In this sense physician works within the formal structure of a given health care apparatus. Thus "physician may function as gatekeepers for benefits that

[71] Manzoor S. Pervez, "A Fetish on trial", in *Progress*, vol.-5, no. 1 London Jan.1988. p.1

[72] Conrad Peter, Medicalization and social control, in *Annual Review of Sociology*, vol.18 1992 p.210

are only legitimate in organization that adopt a medical definition and approach to a problem".[73]

The interactional level has relatively far more important sociological, cultural and axiological implications then the rest of the two levels. The patients/physician interaction demands comprehensive re-evaluation as well as the revaluation of the matrix in which the patient has been situated. The disease carrier i.e. patient and the disease interpreter i.e. physician have substantively different vocabularies, hermeneutical perspectives, and risk/stakes associated with their mutual relation etc. all these factors directly or indirectly affect their mutual interactive space and its corresponding outcomes.

The identification of the problem either as pathological or psychological or other form of social deviance by the concerned health care authorities is not just redefine individual as a patient rather redefines the whole matrix in which the patient has been situated. The strength and socio-cultural legitimacy of this authoritative status derived from the institutional recognition of the conceptual formation previously made by the specific discipline of knowledge and its corresponding practices in a given health care unit. Therefore this medical form of treatment is not just specific to the body of the patient concerned rather it has far reaching sociological, cultural and axiological implications for both patient and his family.

It is important to note that this re-evaluation and revaluation capacity of the medicalization process is relative to the level of modernization and its corresponding institutional order. According to Cornwell (1984) "subcultures, groups, or individual may very in their readiness to apply, accept, or reject medicalized definitions". [74] The dominant role of the physician regarding the legitimate execution of bio-power is directly proportional and functional to the intensification of the process of medicalization. However, this soft expression of bio-power regarding the redefinition of human being or becoming human i.e. actual or potential existence of concerned individual is relative to the scope and the institutional penetration of the process of medicalization.

It is very interesting to note that the under the burden of so-called positivism "medicalization researches are much more interested in the etiology of definitions than the etiology of the behavior or conditions".[75] The cause of this redefinition process might be positivistic but its effects are never morally neutral. This actually leads to comprehensive shift in the spectacles of socio-cultural understanding which is the result of gradual replacement of religious or social model of human understanding to medical model. The work of Whalen and Henkes 1977 in this regard is important.[76]

This replacement of model although has not been substantiated in post-colonial, pre-modern societies like Pakistan but the theoretical idealization of medicalization reveals that it will eventually the intended or unintended consequence of the overall process of progress and development. The most interesting aspect of medicalization process is that it addresses both aspect of individual existence i.e. natural life processes which include "sexuality childbirth, child development menstrual discomfort (PSM), menopause, aging and death, etc."[77] where as the socially deviant behaviors for instance, "alcoholism, homosexuality, eating problems from over eating (obesity) to under eating (anorexia), child abuse, compulsive gambling, infertility and transsexualism"[78] etc.

This all encompassing scope of medicalization process has extended the capacity of social control and as well replacing the competing mechanism of control i.e. religious or traditional models from that of medical. The domination and also the socialization of the medical model regarding the production of truth have been established by the health care unit (i.e. Hospital). The Hospital according to Foucault is "a place of investigation for a hidden truth and of testing for a truth to be produced".[79] The hospital is a micro-unit to establish the discipline of bio-power under the conditions of truth produced by the discourse of bio-medical sciences. The whole idea of Hospitalization presumes that *"the sick person left at liberty in his 'milieu' in his family, in his circle of friends, with his regimen, his habits, his prejudices, his illusions could not help but be affected by a complex, mixed and tangled disease, a kind of unnatural illness that was both the blend of several diseases and the impediment preventing the true disease from being produced in the authenticity of its nature"*.[80] According to Foucault, the history of ideas reveals a delicate relation between the manifestation and the production of truth. The understanding about the manifested disease, social deviance, meaning of crime, abnormality etc. is possible *"within the limits of a manifestation of truth inside the norm of knowledge"*.[81]

The production of truth is primarily based upon its testifiablity. However, the production of truth always derived its substantive justification from the manifestation of truth i.e. the norm of knowledge. In this sense the manifestation of truth and the production of truth are not only two different complementary processes but also can not be separated from each other. Secondly, it also reveals that constant production of truth in any specific discipline of knowledge, let's say medicine establishes its justificatory capacity from the manifestation of truth. Consequently it also determines the status and also antagonistic relation of such disciplines with other competing spheres of knowledge or mechanisms of control.

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[73] Ibid., p.211

[74] Ibid.

[75] See Conrad, Medicalization, Etiology and Hyperactivity: Reply to Whalen and Henker. *Soc. Prob.* 24:596-98. quoted in Ibid.p.212

[76] See Whalen ,C.K., and Henker, B., The Pitfalls of Politicization: Response to Conrad's "The Discovery of Hyperkinesis: Note on The Medicalization of Deviant Behavior", *Soc.Probl.* 24:583-95

[77] Conrad P., "Medicalization and Social Control" op.cit. p.213

[78] Ibid.

[79] Foucault M., "Psychiatric Power" in M. Foucault *Ethics: Subjectivity and Truth* (ed.) Paul Rabinow vol.1 NY, The New Press, 1994 p.39

[80] Ibid.

[81] Ibid.

There is no doubt that enlightenment epistemological discourse has generated a most sophisticated mechanism of specialization which is the result of the compartmentalization of knowledge. This never-ending process of the compartmentalization of knowledge has initiated multiple dialectic of the production of truth. It implies that different structures of knowledge derived from enlightenment discourse presume an antagonistic and competitive relation with each other. Foucault believes that the crises emerges due to the clash of different disciplines of knowledge which seeks their justification from the same norm of knowledge, *"the crises in these discipline does not simply call into question their limits or uncertainties in the sphere of knowledge it calls knowledge into question, the form of knowledge, the 'subject-object norm'; it questions the relation between our society's economic and political structure and knowledge (not in its true an untrue contents) but in its 'power-knowledge function".*[82]

It is very important to note that the clash of different knowledge structures is not beanie rather aggressively malignant and in extreme cases intellectually oppressive. The structures of knowledge are intrinsically competitive, for instance the enlightenment epistemological discourse has dominated its rival discourse i.e. religious discourse regarding the determination of legitimate public sphere. The structure of medicine along with the myth of naturalism and positivism associated with it and its complementary disciplines have contributed a lot in this regard. Under the illusionary burden of positivistically derived objectivity the organic relation between morality and epistemology was disentangled and the comprehensive replacement of religion not just as a legitimate epistemological paradigm but also a moral foundation has also been done, according to Zola medicine has "nudged aside"[83] the religion as medium of discipline. Turner has also acknowledged that religion has replaced[84] medicine as a legitimate mechanism of social control.

Foucault on the other hand has explicated the internal competitive relations between different knowledge structures derived from same epistemological norm. His analysis regarding the determination of the meaning is very important to understand the axiological and normative implications of medicalization process in post colonial socio-cultural context. According to his analysis genealogical understanding of abnormality reveals a direct relation between the extension of the area of control of medicine and the extension of the definitional scope of abnormality.

The definition of abnormal presumed these fundamental elements

1. The human Monster.[85]
2. The individual to be corrected.[86]
3. The Onanist[87]

The Human Monster is derived from the traditional mythological discourse the theoretical matrix of this idea is intrinsically legal but not just specific to social connotation of law rather in the context of "natural law as well".[88] According to Foucault, the intellectual traces of these kinds of abnormalities manifested in different courses of ancient, classical and medieval intellectual discourse. Foucault has discussed the human monster as an allegorical expression of abnormality to explicate the antagonistic relation between two different structures of knowledge regarding the imposition of their authority claims about the status of normality and the legal cost one has to pay from the deviation of established pattern of normal behavior. Foucault has referred the trial of hermaphrodite in which jurists and physicians clashed from the Rouen affair".[89] Foucault has provided a detail historical account of the epistemological clashes between Christian jurists and medicine. The exposition of different cases, for instance, Anne Grandjean 1752, F.E. Cangiamila 1758, Henrieette Cornier 1825, Antoine Leger 1824, Louis Auguste Papavine 1825.[90]

Human to be corrected is another way to look and interpret abnormality according to Foucault. *How man should be* presumes that those individuals who have deviated from the mechanism and standard of modern disciplinary power are abnormal but they can be normalized by effective use of the disciplinary techniques emerged from the modern myth of transcendental reasoning.

This shift in the attitude regarding the determination of the status of abnormal is the reflection of increasing methodological reliance on medicine and its capacity to correct human being in compatibility with the life world emerged from the modern discursive practices. The institutionalization of modern standard of disciplinary power in school, work place, families', army and other socio-cultural and state apparatus provides functional standards of normality. In this sense the idea of normativity has explicitly been redefined from the enlightenment epistemological discourse. It reveals that normality has not just pathological foundations but individual's capacity to harmonize with any given order of discipline is also needed to address clinically. This systematic realization has extended the scope of abnormality from pathological to socio-cultural.

Thus abnormality as simply the deviation of the standard behavior Institutionalized by the modern disciplinary practices, is one of "the new procedures for

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[82] Ibid., p.17

[83] See Zola, I.k. "Medicine as Institution of Social Control." Social. Rev. 1972 ,20: 487-504

[84] Turner, B.S. The Body and Society, Oxford, Basil and Blackwell. 1984. p.280

[85] Foucault M. " Abnormals" in M. Foucault Ethics: Subjectivity And Truth (ed.) Paul Rabinow vol.1 NY, The New press,1994 p.51

[86] Ibid., p.52

[87] Ibid., p. 53

[88] Ibid., p.51

[89] Ibid.,51-52. In his foot not Foucault has provided the detail of the case as " *This concern the case of Marie Le Marcis. Born in 1581 and baptized as agirl, she eventually adopted men's dress and took the name of Marin, and undertook to marry a widow, Jeanne Le Febvre. Arrested, she was given death sentenced on May 4,1601, for the 'crime of sodomy.' The report by doctor Jacques Duvel saved her form being burned at stake .She was sentenced remain a girl."*Ibid.,p.56

[90] See footnotes numbers 2,3,4. In which Foucault has mentioned these cases. Ibid., p.56

training the body, behavior and aptitudes open up the problem of who escape that normativity which no longer the sovereignty of the law."[91] Considering the long term implications of such kind of deviation compels the power structure to increase the cost of such deviation to discourage the actual and the potential offenders of rising modern disciplinary order. At the first instance disqualification of the deviated person from the sphere of ***legal subject*** is the punishment of the violation of modern discipline**.** The immediate institutional impact or consequence of this disqualification is the suspension of all the rights guaranteed by the constitution. The individual has to fulfill the manual behavior pattern prescribed by the ever extending process of medicalization, otherwise all the constitutional rights of the given to individual will be taken away. The cost of being identified as abnormal in modern mechanism of disciplinary practices is unquestionably phenomenal. All these judicially imposed imperatives are rested upon the non-contestable authority of medicine. It is also interesting to note that the bio-power determines both the process i.e. the exclusion from the paradigm of normality by imposing a tag of abnormality on an individual who has failed to adjust in modern disciplinary order. On the other hand, it has also developed a mechanism of correction to make the re-inclusion of those unfortunates who have been left behind.[92] "This juridical and negative frame will be partly filled partly replaced by a set of techniques and method by which the authorities will under take to train those who resist training and correct the incorrigibles."[93]

The third element of abnormality is defined in term of the misuse of one's own body for sexual pleasure. The discourse of sexuality is according to Foucault is intrinsically a modern phenomena. Under the condition of overwhelming growth of industrialization the significance of the productive use body has dominated the mechanism of control *"a process of repression linked to the new requirement of industrialization, the producing body as against the pleasure body"*.[94] The discourse of the body and its use or misuse has developed a mechanism of discipline and control, it has opened a new realm of extensive medicalization of life. The scope of which extended from body to its legitimate and illegitimate, normal /abnormal function of desire, its suppression, repression, its linguisticality and its corresponding identity paradigms, *"sexuality limitless etiological power at the level of bodies and diseases is one of the most constant theme not only in the text of that new medical ethics but also in the most serious works of pathology"*[95]

The most important aspect which sustains this overwhelming medicalization of the life world irrespective of the fact that the damages caused by this iatrogenesis process is far more greater than the decline in morbidity it caused. The internal paradigmatic incoherence of this aloes specific axiological process is derived from its comic apology. The rich men (who can afford all the burden of facilities made available by scientific industrial complex through the medicalization apparatus, consider themselves as unlucky and consider that the cause of their miseries is the will of the God.

The poor on the other hand consider themselves as deprived from their legitimate right of health care due to the inequitable distribution of resources. Thus it is presumed that although increased morbidity has made available by the medicalization process. However due to the inherent and structurally determined class discrimination or the violation of fundamental right of health care has made unavailability of decent living conditions impossible.

Concluding remarks

The traditional bioethical approaches, i.e. Good-based ethical theories, which are rested upon essentialist foundations and absolutist conceptions of human being are not consistent with a contemporary dynamic of ever changing dialectical process of iatrogenesis. The ontologically essentialist conception of human nature has been institutionally compromised by the process of medicalization.

If we look at the contemporary approaches of medical sciences toward the understanding of human beings it is obvious that they are not focusing on the "is ness" of human being rather than that of becoming of human. The whole discourse of cloning, genetic mutation, stem, cell methodologies, innumerable possibilities of vaccinations, transplantation etc. are predominantly futuristic and teleologically harmonized with a grand mechanism to engineer a ***super human being i.e. Ubermench***. The emergence of techno-sciences has opened a new realm of technological development particularly in the field of biotechnology, robotics, nanotechnology, pharmacology, artificial intelligence etc. to become more human as compared to our previous generations. This attempt of transition from human being to human becoming is not just theorized by the enlightenment intellectual discourse rather it has substantively been practiced and institutionalized by the scientific industrial complex.

It appears that this process will lead to never ending rather never achieving transcendental standard of ideal man i.e. Ubermench.

In our part of the world the nature of bioethics discourse is predominantly traditional. The traditional applicatory ethics undermines the complexity of the process of medicalization because it is just the application of traditional normative ethical principles like, utilitarianism, virtue theory, religions authoritarianism, cultural relativism or right based moral principles. The result of this application of moral/ethical principles without questioning the legitimacy of the system in itself makes the applicatory ethics as intrinsically procedural. It means that without questioning the legitimacy of the dominant medical scientific discourse and its corresponding institutional procedural mechanism, bioethics is just the accommodation of whatever possibility techno-scientific

[91] Foucault M "Abnormal" op.cit. p.52
[92] This model of exclusion and inclusion can also be used to understand the prevailing antagonism between fundamentalism and modernism, traditionalism and feminism, Islam and West, etc.
[93] Foucault M. "Abnormal" op.cit. p.52
[94] Ibid.
[95] Ibid., p.54

model has explored. It is important to understand that the contemporary techno-scientific mechanism is not in the search of understanding or discovering facts about human body it is actually in process of creating reality and trying to impose human will on the reality to stretch the possibility of possibilities. Therefore the techno-scientifically driven process of medicalization is interpreting human as not being rather becoming.

It is because of this reason it is reasonable to claim that the fundamental problem of contemporary bioethics is intrinsically existential and without addressing the ontological foundations of contemporary process of medicalization bio-ethical discourse will be just the management of the findings, discoveries, inventions, distortions and instillation of techno-scientific model of medicalization. The maximum potential this bioethics discourse has, to make power structure realize that health care is a fundamental right and it is the responsibility of the state, civil society and of course market forces to provide common people an opportunity to realize this fundamental right, i.e. free or subsidized access-to-health-care.

It is important to note that due to this overriding process of aetiological medicalization the scope as well as the cost of health care has remarkablely increased. For instance due to excessive scientific development many issues which were not presumed to be the part of the realm of medicalization, and are now very much being consider as a part of it, like vaccination, transplantation etc. are now claimed to be a right of the individual which is to be available by the state, international health care associations or charity organizations. As the time passes the list of rights will be extended dramatically, for instance the right of, abortion, cloning, genetic mutation, gender transformation stern cell treatment etc. The guarantee of right, or the availability of right either by market forces or state apparatus legitimizes that the ongoing mechanism of medicalization and quest to become supermen, constant struggle of stretching the possibility of possibilities is in itself logically coherent and morally consistent? Which is obviously required an ontological leap other wise it will be an ironic end.

The Current State of Surrogacy in Thailand and the Ethical Assessment of Dr. Somboon Kunathikom – A Study of Thai Reproductive Medicine (Surrogacy) Ethics, by Means of a Three-Layer Structural Analysis

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Abstract

The practice of surrogacy in Thailand, with its base in the capital city of Bangkok and the nationwide number of surrogacy cases exceeding one hundred, goes back to 1991. Dr. Somboon Kunathikom of Bangkok Hospital has practiced non-commercial surrogacy under silent authorization from the Thai government which strongly promotes medical tourism as a national project.

Based on the result of an ethical investigation based on a three-layer structural analysis, this paper consists of an introduction to the current state of surrogacy in Thailand (layer 1), an inquiry into Dr. Somboon Kunathikom's ethical assessment (layer 2), and Theravada Buddhism's view of reproductive technology in support of commercial surrogacy perfomed at Superior ART in Bangkok (Centre for Assisted Reproductive Technology and Preimplantation Genetic Diagnosis) and so on (layer 3).

1. The current state of surrogacy in Thailand (layer 1):

According to Dr. Somboon Kunathikom, he has been involved in more than 10 of 100+ cases of surrogacy that have been performed in Thailand.

2. Dr. Somboon **Kunathikom's ethical assessment** (layer 2):

According to Dr. Somboon Kunathikom, in Thailand where IVF-ET is implemented up to 4000 times per year with an elevated pregnancy rate of 30%, the establishment of regulatory legislation is needed in order to prevent any trouble accompanying surrogacy. Patients born without a uterus, patients whose uterus has been surgically removed, and heart disease patients who wish to give birth to a child are considered as subjects for salvation. However, in anticipation of the consequences of commercial surrogacy, Dr. Somboon Kunathikom also pleads for a possibility to restrict future developments.

3. Theravada Buddhism's view of reproductive technology in support of both the surrogate mother's position and commercial surrogacy performed at Superior ART in Bangkok (Center for Assisted Reproductive Technology and Preimplantation Genetic Diagnosis) and so on (layer 3):

The Thai parliament has been deliberating on regulatory legislation for surrogacy since 2010. Due to their deliberation, both hospitals and private practitioners do not engage publicly in surrogacy. As such, couples requesting surrogacy either search for a surrogate mother by themselves or through an intermediary, or recruit a surrogate mother on the internet, with many of the women volunteering to become surrogate mothers placing self-introductions on the internet on their own initiative.

In Thai society, where large differences exist in the income between people living in the metropolis of Bangkok and those from rural villages, for women of poor families the high earning surrogate motherhood appears as an alluring road towards large income gains. But, this is not the only reason why women from poor families are entering the reproductive technology market. To the surrogate mother reserve corps of Thailand, surrogacy would also appear to be a fulfilling job that grants them a taste of the blissful sensation of pregnancy. Many of these women, as followers of Theravada Buddhism, have

a strong sense of desire to be useful to their fellow women suffering from an incapacity to bear children. There are also those that possess a strong altruistic motivation to help people in a state of suspended atonement for their sins for the purpose of thamboon (accumulating virtue). And there are also exceptional cases of women who offer surrogate motherhood without asking for any compensation. The Thai populace, of whom 94% believe in thamboon and reincarnation, concepts that form the core of Theravada Buddhism (Hinayana Buddhism) and that have deeply permeated daily life, maintains a relatively tolerant attitude towards commercial surrogacy to which women from poor families offer of their own accord.

Keywords: Surrogacy, Medical Tourism, Art, Somboomn Kunathikom, Ethics

Preface

In Thailand, the country where medical services and tourism melded to create medical tourism, the acquisition of medical tourists, as with India, Singapore and Malaysia, has been established as the biggest project for the combined public and private sectors. The Thai government's promotion of medical tourism as a national policy extols the three sales points below that are based on a global hospital management policy to directly accept foreign medical tourists in Thailand's general hospitals equipped with state-of-the-art medical facilities.

1. Accessibility to medical treatment – a solution to the long lists of patients waiting to receive medical examinations in countries with free public health insurance like England and Canada
2. Cheap, high-level medical services – offering state-of-the-art medical services by foreign trained physicians at lower rates than in the US or Europe, etc.
3. 5-star rated supplemental hotel[96] facilities (luxurious lobbies with doormen, etc.) and various other services[97] and guidance brimming with hospital staff hospitality –from hospital formalities to visa information and tourist activities, and, of course, airport transportation

The concept of large hospital management focused on foreign medical tourists is aimed at improving customer satisfaction, and 16 hospitals[98] in Thailand have been certified evaluation as international hospitals[99] by the Joint Committee International (JCI) as of late December, 2011. The Bumrungrad International Hospital[100] in Bangkok, for example, has witnessed a sudden increase in the number of wealthy patients from the Middle East (UAE, Qatar, Oman) since the 9.11.2001 terror attacks in the USA. As a result of the sudden increase in the strictness of US immigration screening procedures, the oil money from Arab countries is now, instead of flowing into the US where strong anti-Islamic sentiments have taken root, being redirected into the energetic Theravada Buddhist (Hinayana Buddhist) country of Thailand. At present, the level of medical tourism cost-performance in Thailand is ranked very high in the world.

Many of the private general hospitals that open their doors directly to foreign medical tourists are offering high-level Assisted Reproductive Technology (ART) as well as noncommercial surrogacy. According to FY2009 statistics from the Thailand Medical Tourism Cluster of the Thai Department of Tourism made public on their homepage[101], medical tourism in Thailand has shown "an

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[96] Facilities attached to the hospital: restaurants serving national foods from all countries, McDonalds, shopping facilities (Seven Eleven), cafés, etc.

[97] Services offered at other facilities attached to private general hospitals catering to foreign medical tourists are: medical treatment resorts with luxurious private rooms and care, a place for Islamic worship (Bamrunrad International Hospital), lodging accommodations for patients and their company. Inside the hospitals large numbers of non-medical staff are posted, offering meticulous customer service. The business model of private general hospitals in Thailand is focused on the expedient offering of medical services at low labor expenses funded by the medical costs covered by the foreign residence insurance of foreign medical tourists.

[98] Private large hospitals that have received a certified evaluation by the JCI of Thailand are as follows:
1. Bumrungrad International Hospital (established in 1980, performance of PGD and non-commercial surrogacy, Japanese speaking medical staff and Japanese interpreter in residence, Japanese customer service department in place) (JCI certification in 2002)
The following hospitals (2-9) belong to the Bangkok Hospital Medical Center (BMC) Group that is managed by the Dusit Group
2. Bangkok Hospital (BH) (performance of noncommercial surrogacy, Japanese speaking medical staff and Japanese interpreter in residence, foreign institute for Japanese)
3. Bangkok International Hospital (BIH) (the first hospital in Thailand to accept foreign patients)
4. Bangkok Heart Hospital (BHH) (Thailand's only private hospital specializing in cardiology)
5. Wattanosoth Cancer Hospital (WCH) (Thailand's only private hospital specializing in cancer)
6. Samitivej Sukumvit Hospital (performance of PGD, JCI certification in 2007, Japanese speaking medical staff and Japanese interpreter in residence)
7. Samitivej Srinakarin Hospital (JCI certification in 2007)
8. Samitivej Srinakarin Children's Hospital
9. Samitivej Sriracha Hospital
10. Bangkok Nursing Home Hospital (BNH) (performance of noncommercial surrogacy, Japanese interpreter in residence)
11. Praram 9 Hospital (Japanese speaking medical staff and Japanese interpreter in residence)

[99] In Japan, since 2010, Kameda Medical Center (Kameda Hospital – Kameda Clinic) in Kamogawa city, Chiba prefecture, and NTT Japan Kanto Hospital in Shinagawa-ku, Tokyo (March 2011), have JCI certification. http://www.jointcommitteeinternational.org

[100] The Bumrunrad Hospital was, in 2002, the first Asian hospital to receive JCI international hospital certification. 540 beds, 1200 physicians and dentists, 900 nurses, 600 co-meds, 200 non-medical staff, more than 1 million patients per year, and among 400,000 foreign medical tourists Japanese patients number 3000 (Nomura Research Center: *Report concerning Business Creation Support Service Innovation in FY 2009*)
Percentages for foreign medical tourists visiting Thailand per residential region (2008) are, UAE 44%, Qatar 9%, Oman 6% (Development Bank of Japan Inc.: New Currents in the Health Care Industry ⑧ The Internationalization of Advancing Medicine, *Topics of this month*, No. 147-1, 2010)

[101] http://japan.thailandmedicaltourismcluster.org/治療旅行について/治療旅行/治療旅行とは.aspx Incidentally, medical tourism

average annual growth of 16.5% (over the years 2001-2009)" and a sudden increase exceeding GDP, with the combined hospital/tourism income profits generated by medical touris[102] amounting to 285.9 billion yen (108,197 million baht; exchange rate 1 baht=2.58 yen) and an annual number of 1,390,000 foreign patients (the number of patients increased from 630,000 in 2002 to 970,000 in 2003, exceeded 1 million after 2004, and reached 1.4 million in 2006).

Bangkok is the base for surrogacy in Thailand, with the origins of its practice dating back to 1991, and the nationwide number of surrogacy cases exceeding 100 to date. The number of nationally registered IVF (in vitro fertilization) clinics that have been authorized by the Royal Thai College of Obstetrics and Gynecology, the organization that has regulated physician conduct in the field of assisted reproductive medicine, since 2007 is 35 (30 principle teams and 5 affiliated teams), with more than 100 IVF physicians.[103] During FY 2008, reproductive medical therapy was performed approximately 4000 times in Thailand, with a pregnancy success rate of 30%.[104]

With Thai governmental silent authorization strongly promoting medical tourism as a national project, one physician involved with non-commercial surrogacy, Dr. Somboon Kunathikom of Bangkok Hospital, has been performing advanced reproductive medical activities.

The goal of this paper is to investigate Thai advanced reproductive medicine (surrogacy) ethics by way of a three-layer structural analysis, as part of a larger research project, *An Investigation of Asian Bioethics based on a Three-Layer Structural Analysis* (research leader: Prof. Takao Takahashi, Faculty of Arts, Kumamoto University); a project funded by the Scientific Research Fund for Fundamental Research (B). In this paper, I introduce the current state of surrogacy in Thailand (layer 1), as well as search for Dr. Somboon Kunathicom's ethical assessment (layer 2) and Theravada Buddhism's view of reproductive medicine that supports commercial surrogacy practiced at Superior ART in Bangkok (Center for Assisted Reproductive Technology and Preimplantation Genetic Diagnosis) and so on (layer 3). In conclusion, after touching upon the Thai government's position on ethical problems associated with commercial surrogacy, some future topics of research will be introduced.

1. The current state of surrogacy in Thailand (layer 1)

(a) Medical tourism stimulation measures by the Thai government and surrogacy regulation

The Thai government wholeheartedly promotes medical tourism as state policy. The catalyst for this change in policy occurred in 1997 with Asian financial crisis, in which Thailand was at the hypocenter. In 2002, the cabinet of the 31st Thai prime-minister Thaksin Shimawatra (9 February 2001 – 19 September 2006), taking the free-fall of the baht to its advantage, began with an announcement of its plan for a medical hub (medical services transcending national border), issued in rapid succession the "Thai medical hub" measures aimed at the reconstruction of the economy. The cabinet published a 5 year medical tourism plan in 2003, formulated a policy with the goal of transforming Thailand into a medical hub country in 2004, and increased financial investments into the medical infrastructure. Following the Thaksin administration, the Thai government regarded the free-fallen baht as a strong weapon against Thai weak economics and embarked upon economic reconstruction based on stimulation measures for high quality low cost medical tourism. In order to attract large numbers of tourists and wealthy medical tourists from abroad, the Thai government raised aerial portal services maintenance as its main policy, opening the airport with the world's largest airport terminal building at Suvarnabhumi in 2006, and waiving medical visa fees. In 2010, the Thai International Airline TG launched a Low Cost Carrier (LCC) subsidiary.

Today, the Thai government[105] considers medical tourism as an effective means for the acquisition of foreign currencies and for increasing domestic demand, providing state-of-the-art medical treatment ranging from cosmetic and plastic surgery to reproductive medical treatment (including sex reassignment surgery; SRS, i.e. sex change surgery, surrogacy and IVF-ET) to foreign countries. Historically, the initiative for Thailand's

has also been established as a new growth strategy (decision made at Cabinet meeting December 2009) in Japan. Estimated number of medical tourists 430.000, market size approximately 550 billion Yen, tentatively calculated economic affect of approximately 280 billion Yen (*ibid.*)

[102] "by 2012 it is predicted to be worth $100 bn annually." "the foreign medical services sector is already expected to make 100 bn baht($3.3bn) by 2015."(Thai embrace of medical tourism divides professionals [*guardian*.co.uk 26 April 2011])

[103] Comments of Dr. Somboon Kunathikom. Reference to the statistical documents for Assisted Reproductive Technology in Thailand from 2001 through 2007.

[104] Comments of Somboon Kunathikom M.D., president of the Royal Thai College of Obstetrics and Gynecology, in attendance at the forum "All about Surrogacy Problems" (4 June 2010), organized by the Scientific Media Center of the Thailand National Science and Technology Development Agency , NSTDA (independent research institute supervised by Thailand Royal Cabinet Ministry of Science and Technology). Incidentally, during FY 2008, the number of times IVF has been performed in various South-East Asian countries, as compared to 4000 cycles in Thailand, is as follows: 1500 cycles in Indonesia, 2500 cycles in Singapore, 3000 cycles in Malaysia, and 6000 cycles in Vietnam.

[105] Thai economist Ammar Siamwala tells it like this. The Thai government's policy for the promotion of medical tourism is, as opposed to making Thailand economically affluent, "the worst policy that the government could ever think of" destroying medical treatment for the poor. Through this policy, the differences in distribution of physicians in rural villages and physicians in the metropolis of Bangkok has seen an increase of 8 times, and the salary for doctors is about 8-10 times more in a private clinic than in a state hospital." Because of this, the affluent class of Thailand and foreign tourists are the ones able to be treated or to be hospitalized at Bangkok's private general hospitals. Receiving treatment at a private general hospital has come to present a difficult situation, not only to many Thai people from poor families, but also to people from middle class families. (Thai embrace of medical tourism divides professionals [*guardian*.co.uk 26 April 2011])

advanced reproductive medicine dates back to the birth of Pavornvitch Srisahaburi, who was born as a test-tube baby in Chulalongkorn hospital. It was Dr. Pramuan Viruntamasen, a physician attached to this hospital, who in August of 1987 succeeded in the IVF-ET procedure that gave birth to Pavornvitch Srisahaburi. It was at the same hospital, in 1991, that the first successful case of surrogacy was performed. However, as a result of extensive coverage by the media of the surrogacy of a Thai actress for her husband's brother and his wife in 1994, the Medical Council of Thailand and the Royal Thai College of Obstetricians and Gynecologists promulgated *the Standard for the Provision of Assisted Reproductive Medical Technology* (22 October 1997 medical council advisory notice no. 1/2540). By limiting the provision of assisted reproductive technology to physicians authorized by the Royal Thai College of Obstetricians and Gynecologists, the two bodies have only administered self-regulation on the physician side. Afterward, in 2000, a case that was taken to court by personnel of a national university petitioning for medical and education expenses for children born out of surrogacy was lost. The Thai Committee on Judicial Affairs that deliberated on the petition decided, in referring to section 1546 of *the Thai Civil and Commercial Code*, that the mother of a child born out of surrogacy will be the biological mother, i.e. the surrogate mother, and that, therefore, the couple requesting surrogacy can become neither the legal mother nor the legal father. At the opportunity presented by this precedent, the Medical Council of Thailand promulgated in 2001 *the Standard for the Provision of Assisted Reproductive Technology* (22 August 2002 medical council advisory notice no. 21/2544). Within this notice, the following provisions have been specified as the guiding principles concerning surrogacy.

1. In the event that a couple wishes to make a surrogacy request to a woman other than the wife, the person undergoing the medical treatment will only be recognized as responding in accordance with the service in the event that a fertilized ovum originating from a gamete of the concerned couple is utilized. (medical council advisory notice no. 21/2544 paragraph 4/2 (2))
2. Remuneration of the gamete donor by commercial transaction is not allowed. (same as above, (3) (A))
3. Remuneration of the surrogate person by employment is not allowed. (same as above, (3) (B))
4. The surrogate person must be a blood relative of one of the concerned couple. (same as above, (3) (C))

In 2008, an Australian couple (husband Australian, wife Japanese) signed a surrogacy contract with two Thai women, receiving 3 children from the women in 2009. However, the Thai government, in referring to *the Thai Civil and Commercial Code* that stipulates that the woman giving birth to a child is the legal mother, did not issue passports for the surrogate children. There upon, the couple that had requested surrogacy appealed against the judicial decision by delivering the results of a DNA test. Following the amendment of *the Citizenship Act* in January 2010 by the Australian government, the couple that had requested surrogacy were able to take the three children back home with them to Australia. Based on this incident, for reasons for guaranteeing the rights and welfare of surrogate children, the Ministry of Social Development and Human Security drafted *the Protecting Children Born Through Assisted Reproductive Technology Medical Act*, which was deliberated on by the Council of State. The act was passed by the Committee of Judicial Affairs in May of 2010, with the following surrogacy regulatory provisions stipulated by the act (surrogacy articles no. 21-22).

1. (The use of egg cells from the surrogate mother shall be prohibited): In the case of surrogacy, at least whether the sperm cell or the egg cell from the couple shall be used.
2. (Commercial forms of surrogacy shall be prohibited): Juvenile-family court will have jurisdiction over cases of children born through ART and a committee for the protection of ART children shall be established.
3. (The surrogate mother shall be married and a woman with experience in childbirth): The surrogate mother shall be a married woman with experience in childbirth and, for the use of sperm cells for surrogacy, permission from the husband is required.
4. (The couple requesting surrogacy shall be legally married, no blood relationship shall exist between the surrogate mother and the requesting couple, and the requesting couple shall have legal rights as parents of the surrogate child): The Medical Council of Thailand will have jurisdiction in protective regulations concerning surrogacy and surrogate mothers.
5. (In the case the person requesting surrogacy dies before the birth of a surrogate child, a legal court shall decide on the caretaker of the child, regulations concerning the disposal of fertilized egg cells and embryos, and the prohibition of postmortem reproduction): The use of the gamete of the deceased without prior written consent will be prohibited.
6. (Disciplinary action against physicians violating regulations): Penalties for physicians performing ART in violation of regulations.
7. (Provisional measures prior to legal enforcement): To certify the surrogate child as the legal child of the requesting couple.

With regard to the aforementioned stipulations, two of the points require further elaboration. The first point is that by which the requesting couple is recognized as the legal parents of the surrogate child. According to this stipulation, not only is the surrogate child granted succession rights, but also a refund of medical and other costs for the legal parents of surrogate children that have come to be acknowledged as being legitimate becomes possible. While the protection of the rights of the surrogate children and the requesting couples has been enhanced, health support and the protection of rights for the surrogate mother have not been mentioned, and one is left completely in the dark concerning the rights of the fertilized egg cell donor and the child's right to know its origins. The second of the above points in need of elaboration is the prohibition of commercial surrogacy. Within this stipulation, surrogacy mediation and advertising are also prohibited and violators of this law will be punished. However, due to the obscurity of the provisions prohibiting surrogacy, implementation of the

law will likely offer room for flexibility. For example, it is stipulated that a surrogate mother cannot be paid more than her actual expenses for treatment and health maintenance. However, in spite of someone's wish to make commercial surrogacy subject to legal punishment, as health maintenance expenses are not specified, it can be expected that the real world of commercial surrogacy contracts will also cause them to be adaptively accepted as altruistic surrogacy contracts.

It is important to note that the above law has not yet been established. Hereafter, enactment and effectuation of the law will have to wait for deliberations of the Legislation and Regulation Committee and the House of Representatives. The Catholic Church in Thailand, stressing the importance of the bond between mother and her naturally born child more than anything else, exhibits a determined resistance against the establishment of regulatory surrogacy legislation that has as its premise the recognition of surrogacy which entails human intervention in reproduction. And since the Islamic and Buddhist communities are drawing up their battle lines in unison, establishment of the law is not yet a foregone conclusion.

(b) The current state of surrogacy in Thailand as experienced by Dr. Somboon Kunathikom

Dr. Somboon Kunathikom is a physician at Bangkok Hospital and at present occupies a prominent position in the Medical Council of Thailand. He has also in the past been a visiting scholar at the Medical Department of Osaka University and, therefore, as a Japanese speaking obstetrician and gynecologist is a reassuring presence to the tens of thousands of Japanese living in Bangkok. Statistics for FY2008 show that, of the 150.000 foreigners who received treatment at Bangkok Hospital (equivalent to 20% of the total number of patients), the largest group was Japanese. Most of these patients were residents of Thailand with their families, with medical tourists traveling from Japan to Thailand limited to patients with special medical circumstances. The reason for this is that, thanks to the universal health insurance system that is maintained in Japan and its reimbursement system for expensive medical treatment, Japanese nationals can receive high quality medical treatment at a fixed liability share without having to travel abroad for medical procedures.

According to Dr. Somboon Kunathikom, of the more than 100 cases of surrogacy that have been performed in Thailand to date, he was involved in more than 10 of them, with 3 foreign patients among those people. Whether there were Japanese among those his cases was not noted, but it can be assumed that among the surrogacy cases performed by Dr. Somboon Kunathikom requested by foreigners were a Chinese, a Burmese and a Cambodian. Incidentally, even though the Medical Council of Thailand has published a council announcement prohibiting Preimplantation Genetic Diagnosis (PGD), PGD is implemented in choosing the sex of unborn babies in Thailand on a daily basis. Many Chinese utilize PGD in Thailand for the purpose of choosing the sex of unborn babies. Because they will have had a strong desire for an heir, moreover, under the influence of the one child policy of their homeland, they will want a boy to be born.

1. The ethical assessment of Dr. Somboon Kunathikom concerning the practice of commercial surrogacy in Thailand (layer 2)

In June of 2011, the Bangkok Post[106] published an article entitled *Should commercial surrogacy be legitimized?* Listed below are the pros and the cons of this debate on commercial surrogacy, which call for an upsurge in the discussion pertaining to these issues.

The majority of Thai women who wish to undergo surrogacy are from poor families. In developed countries, due to insufficient information concerning surrogacy in Thailand as silently sanctioned by the Thai government, critical intellectuals are raising condemning voices, stating things like, the use of surrogate tourism by childless rich couples from developed countries comes down to "exploitation of body and mind of poor Thai females", and, the procedure is "a commercialization of humans, i.e. human trafficking".

In the case of the former argument, defenders of surrogacy retaliate against such criticizers of commercial surrogacy as follows.

1. If you insist on calling it "exploitation of body and mind of poor Thai females", then you should think about providing protective measures ensuring the maintenance of high incomes generated by legal surrogacy.
2. If you wish to make an issue of economic exploitation, you should think about security against the actual working hours and risks of surrogate mothers.
3. According to surrogacy investigations conducted in the US during the 1980's, surrogate mothers were not just women from poor families. The hypothesis that only women from poor Thai families form the surrogate mother reserve corps cannot be upheld. Furthermore, the motivation of women offering themselves for surrogacy is not just financial, some are eager to experience pregnancy, while others see it as an altruistic deed.

The latter argument, stating that it is immoral to deal with humans as if they were commercial products that can be bought and sold with money, is countered by the defenders of surrogacy as follows.

1. The surrogacy contract that is entered into by the couple requesting surrogacy and the surrogate mother is not a sales contract for a surrogate child.
2. The remuneration that is paid by the couple requesting surrogacy to the surrogate mother is compensation for the actual working hours and risks of the surrogate mother, not the price of a surrogate child.

On 4 June 2010, Dr. Somboon Kunathikom, while attending a forum on *All about Surrogacy Issues* held under the auspices of the Thailand National Science and Technology Development Agency's (NSTDA) (an independent research institute under the supervision of the Thailand Royal Ministry of Science and Technology) scientific media center, expressed, by and large, the following opinion on the surrogacy regulatory law-*The*

[106] Should commercial surrogacy be legalised? [*Bangkok Post* 6 May 2011]

Protecting Children Born Through Assisted Reproductive Technology Medical Act, that is now under deliberation.

Today, with the implementation of Assisted Reproductive Technology reaching the number of 4000 times per year and the pregnancy rate elevated to 30%, it has become necessary to establish surrogacy regulatory legislation in order to prevent trouble occurring hand in hand with surrogacy. Those in line for salvation by surrogacy are patients born without a uterus, patients whose uterus has been surgically removed, heart disease patients with a wish for a child and so on. At present, the surrogacy regulatory law that is under deliberation by the government prohibits commercial surrogacy that offers a monetary goal. Consequently, in the event that one would engage in commercial surrogacy, under the new law they would be punished by a prison sentence and a fine. On the expectation that career women, not wanting to discontinue their work in lieu of pregnancy or giving birth, or that young women, seeking to avoid deforming their figures as a result of pregnancy and childbirth, might request surrogacy, Dr. Somboon Kunathikom furthermore points out the need to impose limitations.

The following details his opinion on regulations for commercial surrogacy and the surrogacy regulatory law.

Definite progress has been made for the welfare of surrogate children by the surrogacy regulatory law currently under deliberation. Nevertheless, among physicians there is both approval and disapproval with several points in debate among physicians. For example, the issue of sperm cell/egg cell donation, and what would be an appropriate amount of money as liability for the parents. When this law is enacted and enforced, a council will be convened to discuss the details, but as long as the law has not become official, we are the ones, in accordance with the medical association's assisted reproduction technology regulations, making decisions to a large extent. In the event a hospital, a clinic, or a facility affiliated to assisted reproductive technology is established, a certificate from the Royal Thai College of Obstetricians and Gynecologists is required. Although the inspection of medical instruments and equipment is conducted by us, and the medical association has many rules and regulations, these rules are not laws, and we have even been told that we lack a medical ethical standpoint. Regardless of this viewpoint, I believe that physicians will always act with an ethical sense of awareness.[107]

3. The position of the surrogate mother and Theravada Buddhism's view of reproductive medicine in support of commercial surrogacy practiced at Superior ART in Bangkok (Centre for Assisted Reproductive Technology and Preimplantation Genetic Diagnosis) **and so on** (layer 3)

How would Thai women volunteering for surrogate motherhood view both native and foreign couples requesting surrogacy, who are secretively using surrogate tourism as a part of the medical tourism that is strongly promoted by the Thai government? And how about commercial surrogacy? Are Thai surrogate mothers victims of exploitation with their bodies dominated by their husbands or by strangers? Or, is surrogacy clinical labor freely decided upon by these poor Thai women? A field inspection of surrogacy in Thailand is required.

In Thailand, since 2010, the surrogacy regulatory legislation-*the Protecting Children Born Through Assisted Reproductive Technology Medical Act* - has been under deliberation in parliament. Accordingly, hospital and private physicians are, not only in hospitals, refraining from the practice of surrogacy. In these circumstances, couples wishing to make a request for surrogacy are either looking for surrogate mothers by themselves or by using intermediaries, or recruiting them on the internet. In fact, even if couples requesting surrogacy were not endeavoring to recruit them on the internet, many women volunteering to become surrogate mothers post their own self-introductions online through their own initiative.

As far as one can see from reading these online bulletin boards, many of the surrogate mother candidates who use them are businesswomen in the reproductive medicine industry. Among them are also people who search for couples requesting surrogacy by means of intermediaries and on the internet. In Thai society there is a huge income differential between people living the metropolis of Bangkok and people living in rural villages, so to women from poor families, surrogacy generating high income appears like an alluring road towards cash income. Nevertheless, this is not the only reason why women from poor families are entering the market of reproductive medicine. To the surrogate mother reserve corps of Thailand, surrogacy appears like a fulfilling job that allows them to experience the elation that comes with pregnancy. More than anything else, many of women adhering these Theravada Buddhism have a strong wish to be of assistance to their fellow women who suffer from an inability to become pregnant. Of course, there are also those among these surrogate mother reserve corps harboring such a strong altruistic motivation to help others, who refer to a sincere desire to help people or to atone for past sins for the purpose of thamboon[108] (accumulation of virtue), but there are also those who, exceptionally, offer surrogate motherhood free of charge.

Moreover, fortunately for the Thai women of less fortunate families, the Thai people of whom 94% are believers of Theravada Buddhism maintain an understanding attitude towards assisted reproductive technology. With Theravada Buddhism, one would expect that only the group of monks, renouncing the world and performing severe ascetic practices (sangha), could be saved, but in fact, for commoners (non-sangha) who have also not renounced the world, the road to

[107] 4 June 2010, forum "All about Surrogacy Problems" organized by the Scientific Media Center of NSTDA.

[108] Today, the concept of thamboon is used in the meaning of almsgiving, but the essential meaning is the performance of virtue, i.e. the accumulation of virtue, which stands for the three good acts (almsgiving, strict adherence to the Buddha's admonitions and rules, meditation) and the ten good gifts (ten kinds of articles donated to monks and apprentices).

salvation is open, and thamboon is its vehicle. In Thailand, where daily life is permeated by a belief in reincarnation, it is believed that if commoners, who are living in a world of suffering, accumulate good deeds through the offering of alms and donations to temples and monks, they will be reborn happy in the next life, and surrogacy is perceived as altruistic behavior that brings relief to infertile patients, or, in other words, thamboon.

In Theravada Buddhism, life in the present world is perceived as the result of thamboon accumulated during a previous life. Happiness or unhappiness in the present life is caused by the difference, high or low, in accumulated virtue during that life. Since good deeds result in good results and bad deeds in bad results, if people neglect thamboon in the present world, one can even be reborn as an animal. In Thailand, where the belief system of reincarnation, in which human beings are thought to be reborn again and again within the six lower worlds (hell, hungry ghosts, animals, Asura, human beings, heaven) by their own karma, is common sense to their religion, people hoping for a peaceful life in the next world will inevitably want to be saving thamboon for the long term. The best thamboon can be gained by becoming a monk (hierarchy within a group of monks is based on the number of years spent since renouncing the world) and conducting ascetic practices day and night. If a son renounces the world before the age of 20, this is thamboon for his mother. If this son officially becomes a monk after his coming of age, this is thamboon for his father. However, not just anyone can become a monk in the human world. Here, for commoners living in a world of suffering who have not renounced the world, the second-best thamboon is to be diligent every day. Quick thamboon can be gained by acts of charity towards temples and monks. The proprietary class make donations for temple construction and buy their thamboon insurance in order to ensure a prosperous life in the next world. Conversely, the middle and lower classes give alms to mendicant monks devoted to the Buddha's teaching that "monks must be beggars". It is never the sangha (monks) that rejoice in receiving alms in the form of thamboon sets (bags including rice or ready-prepared food and a beverage) bought at the supermarket; it's the non-sangha commoners that feel pleasure in the giving. This is because, to the common people who have not renounced the world, the accumulation of daily virtues on behalf of temples and monks is a prior investment that promises a better birth into the next world. In Thailand, where the belief system of thamboon and reincarnation is deeply ingrained into the daily lives of people, there is tolerance towards commercial surrogacy to which women from poor families are offering themselves.

4. The position of the Thai government on ethical issues concomitant with commercial surrogacy, and future topics of research

a) The position of the Thai government on ethical issues concomitant with commercial surrogacy

Which position did the Thai government take in the affair concerning the Taiwanese surrogacy placement company "Babe 101"[109] that shocked Thai society?

On 23 February 2011, Thai police searched 2 residences located in a Bangkok suburb. Alongside of the arrest of the staff of the Taiwanese-managed surrogacy placement company "Babe 101" (4 Taiwanese, 1 Chinese, 3 from Myanmar), 15 foreign women (19 to 26 year old Vietnamese, including 7 pregnant women, of whom 11 were volunteer surrogate mothers, and 4 victims of the surrogacy business), employed as surrogate mothers for couples whose surrogacy placement had been arranged by this company, were rescued. The company held its headquarters in Taiwan and recruited commercial surrogacy customers on its website. The honorarium paid by couples to the company was 35.000 dollars, with surrogate mothers receiving a remuneration of 5.000 dollars. Surrogate mothers were women of Thai, Cambodian and Vietnamese nationality; surrogacy contracts were not made with women from Taiwan where surrogacy is legally prohibited.

By the opening of an investigation against 4 Thai physicians (2 directors and 2 physicians in charge) who were involved in the "Babe 101" incident and 2 hospital,[110] hospitals that had been performing surrogacy had removed, for the sake of appearance, articles related to commercial surrogacy from their homepages, and the tendency became to limit surrogate motherhood to relatives with whom remuneration would not become an issue. From the beginning, aforementioned guideline (no. 1/2540) of the Medical Council of Thailand has prohibited commercial surrogacy, and with respect to altruistic surrogacy, has sanctioned the provision of assisted reproductive technology services to patients only by assisted reproductive technology specialists authorized by the Royal Thai College of Obstetricians and Gynecologists. Since 2010, the Thai government has continued its deliberation of the surrogacy regulatory legislation-*the Protecting Children Born Through Assisted Reproductive Technology Medical Act,* that will establish the legal position of surrogate children. When this law is enacted, people directly involved in commercial surrogacy will be liable to maximum imprisonment of 10 years and a fine of 200.000 baht. Intermediaries and people involved in notifications will be liable to maximum imprisonment of 5 years and a fine of 100.000 baht.

(a) Future topics of research

Although the present paper, a pilot study of reproductive medicine (surrogacy) ethics in Thailand, and based on an original three-layer structural analysis method, has yielded some specific results, the research was restricted to *the current state of commercial*

[109] Surrogate moms to give birth in Thailand [*Thanh Nien* 3 November 2011]

[110] When surrogacy was performed in these hospitals, one hospital had acted, without an approval in advance by the Royal Thai College of Obstetricians and Gynecologists, in violation of *the Hospital Service Standard Act*, article 32 paragraph 2, of *the Standard for the Provision of Assisted Reproductive Medical Technology* (medical council advisory notice no. 1/2540, dated 22 October 1997)

surrogacy in Thailand and, physician in charge, Dr. Somboon Kunathikom's ethical assessment. The nationwide number of IVF clinics in Thailand that are involved in surrogacy is unclear, so future research will be needed to make a continued, gradual and steady investigation of the leading Thai commercial surrogacy clinics and to make continued inquiry into the ethical assessments of the physicians in charge.