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Advocate Aurora Health

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Sex-Selective Abortion: Social, Cultural, and Religious Considerations

An immigrant couple, recently arrived from India, requests an ultrasound procedure for their expected third child (they have two daughters). They tell the physician that they are concerned about the health of the fetus. The ultrasound detects no problems.

"And is it a boy or a girl?" the parents ask.

An alert physician might wonder how best to respond to the couple's question. Requests for prenatal sex determination as a potential prelude to sex-selective abortion have surfaced among Indian immigrants in the United States and Canada.¹ Abortion for the purpose of sex selection is widely practiced in India. Sources report that the sex ratio in India is approximately 93 females for every 100 males, whereas in most societies the ratio is about even. (In the Indian state of Haryana the ratio is 83 females for every 100 males.) Ultrasonography is commonly used in India to determine the sex of fetuses that are subsequently aborted. Social and cultural factors there conspire to favor male offspring, thus placing female fetuses at risk for selective abortion. "The root of the problem is ancient and economic. Male children are favored since they carry the family name and frequently get the family inheritance. Girls are viewed as liabilities, who will cost their parents a dowry when they marry and

move into their husband's homes [sic]..."² The Indian government has attempted to stem the tide of sex-selective abortions. A 1994 law banning the use of prenatal tests for sex determination has been only marginally effective in the face of traditional attitudes.

While no U.S. law prohibits prenatal sex-determination procedures, discussions about ethical aspects of preconception sex selection for nonmedical reasons provide an apt analogy. The ethics committee of the American Society for Reproductive Medicine advises that, if preconception sex selection methods such as X- and Y-sperm cell separation are established as safe and effective, physicians may perform these procedures "for gender variety in a family" when couples "are fully informed of the risks of failure" and "affirm that they will fully accept children of the opposite sex if the preconception gender selection fails."³ This second condition precludes aborting fetuses solely because of their sex.

The AMA's Council on Ethical and Judicial Affairs has taken a different tack. Its policy statements on artificial insemination advise physicians against participating in sex selection of sperm "for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes."⁴ A related statement on genetic counseling

holds, "It would not be ethical to engage in selection on the basis of non-disease related characteristics or traits." Physicians who are morally distressed by the possibility that parents may request abortions on the basis of genetic information may "choose to limit their services to preconception diagnosis and advice or not [to] provide any genetic services," including ultrasonography.⁵ (The physician in our opening scenario might opt for this approach.)

These considerations would suggest that healthcare professionals are obligated to disclose only the medically relevant information that results from prenatal tests and procedures. If, however, they disclose to some patients "nonmedical" information—such as the sex of a fetus when no related medical concern is present—and withhold similar information from other patients, they run the risk of acting in an arbitrary and unjustifiably discriminatory way. It is better to establish a consistent stance concerning such disclosure, and stick to it.

At the same time, healthcare professionals should not overdraw the association between sex selection and persons of Indian descent. Sex selection and sex-selective abortion are not unique to India and immigrants from India. The latter practice may be even more prevalent in China and Korea than in

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India. Worldwide, according to one source, 42 percent of female fetuses are aborted, compared with 25 percent of male fetuses.⁶ Further, although Hinduism is the majority religion of India, Hindu teaching does not support sex-selective abortion but condemns it. The cumulative weight of Hindu tradition rejects abortion for *any* reason other than jeopardy to the mother: "[F]rom earliest times, ... abortion (viz., deliberately caused miscarriage as opposed to involuntary miscarriage) at any stage of pregnancy has been morally condemned as violating the personal integrity of the unborn, save when it was a question of preserving the mother's life. No other consideration, social or otherwise, seems to have been allowed to override this viewpoint."⁷

Avoiding unwarranted generalizations about peoples, their culture, and their religious traditions is important because such generalizations can become stereotypes that are applied unjustly to persons from that cultural or religious group. Not every couple of Indian descent will ask about the sex of their child-to-be; not every couple who ask will be considering abortion. (Conversely, some couples from non-Indian backgrounds will seek the same information precisely because they have sex selection and possible abortion in

mind.) Moreover, unexamined cultural generalizations can lead us to overlook the differences *within* cultures and religious traditions—especially when, as in India, authoritative voices within the culture and its traditions are seeking to reverse a widespread, long-established practice.

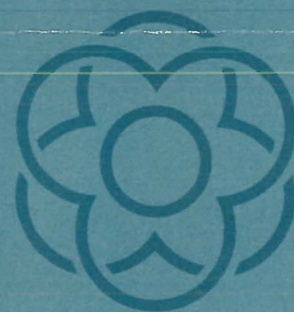
1. B. D. Miller, "Population Ethics: Religious Traditions: Hindu Perspectives," in W. T. Reich, ed., *Encyclopedia of Bioethics*, rev. ed., vol. 4 (New York: Simon & Schuster Macmillan, 1995), p. 2001.
2. "Cover Story: Sex Selection in India," *Religion and Ethics Newsweekly*, June 1, 2001, <http://www.pbs.org/wnet/religionandethics/week440/cover.html>.
3. "Preconception Gender Selection for Nonmedical Reasons," *Fertility and Sterility* 75,5 (May 2001), 863.
4. Current Opinions of the Council on Ethical and Judicial Affairs, E-2.04 Artificial Insemination by Known Donor, E-2.05 Artificial Insemination by Anonymous Donor.
5. Current Opinions of the Council on Ethical and Judicial Affairs, E-2.12 Genetic Counseling.
6. V. G. J. Rajan, "Will India's Ban on Prenatal Sex Determination Slow Abortion of Girls?" *Hinduism Today* 18,4 (April 1996), <http://www.hinduismtoday.com/1996/4/#gen241>.
7. J. J. Lipner, "The Classical Hindu View on Abortion and the Moral Status of the Unborn," in H. G. Coward, J. J. Lipner, and K. K. Young, *Hindu Ethics: Purity, Abortion, and Euthanasia* (Albany: State University of New York Press, 1989), p. 60.

Selected Resources:

- S. C. Crawford, *Dilemmas of Life and Death: Hindu Ethics in North American Context* (Albany: State University of New York Press, 1995).
- P. N. Desai, *Health and Medicine in the Hindu Tradition: Continuity and Cohesion* (New York: Crossroad, 1989).
- R. Mutharayappa, M. K. Choe, F. Arnold, and T. K. Roy, *Son Preference and Its Effect on Fertility in India* (Honolulu: East-West Center, 1997).
- A. Sharma, *The Hindu Tradition: Religious Beliefs and Healthcare Decisions* (Chicago: Park Ridge Center for the Study of Health, Faith, and Ethics [forthcoming]).

e-Ethics provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required. The discussions in *e-Ethics* should not be construed as legal advice and do not necessarily represent official positions of Advocate Health Care.

For information about *e-Ethics* or the Park Ridge Center, contact David McCurdy at (312) 266-2222 ext. 225 or dbm@parkridgecenter.org.



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e-Ethics

When Cure Isn't the Goal, Palliation Is

Mrs. Swanson was in the recovery room following surgery for an intestinal obstruction. Disoriented from her anesthesia and in great pain from her operation, she called over and over for pain relief. The recovery room nurse told Mrs. Swanson that the doctor would be by in a while and assess her pain at that time.

■ Diagnosed with AIDS three years ago, Tom recently developed respiratory failure and wound up in the ICU. An endotracheal tube was inserted for breathing support, and after treatment proved ineffective, Tom could not be weaned from the respirator. He had previously expressed his wish not to be sustained on artificial life support, and he now asked the physicians to withdraw the respirator and allow him to die. Tom developed severe anxiety, but his physician refused to administer sedation during the process of withdrawing the respirator, saying, "I will not euthanize this patient."

✦ ✦ ✦

What do these scenarios have in common? Each reveals some of the ethical problems associated with treating patients when curing them is no longer the goal. In some instances, this point will come when the patient is terminal, in others when the patient has had a medical procedure but is still in pain.

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The art and science of alleviating the suffering of the sick is called palliation, and it's a central goal and duty of medicine. The ways in which healthcare practitioners understand and provide palliation varies quite a bit, as nurses and doctors balance competing moral concerns while caring for patients.

In Mrs. Swanson's case, as in many post-operative situations, the nurse was reluctant to administer sufficient post-operative pain medication. Nurses may be afraid of violating established procedures, and physicians may fear producing addiction in the patient, although short-term medicinal use of these drugs rarely produces true addiction. Establishing an adequate plan for pain management during a pre-operative conversation between Mrs. Swanson and her doctor might have prevented her distress.

The AIDS patient's physician balked because he feared that strong sedatives would hasten or even cause the patient's death. Yet if the doctor intends Tom to expe-

rience maximal symptom relief but does not intend to actively bring about Tom's death, the doctor is morally justified in administering the medication. Most ethicists agree that the risk of hastening death is morally acceptable if withholding the medication would cause the patient to suffer.

Improved coordination of care and an emphasis on palliation rather than curing requires healthcare providers to shift their focus from fighting and curing disease to alleviating suffering and maximizing life's quality for the person in pain. Indeed, a healthcare practitioner employing good palliation pays attention to patients' emotional, spiritual, and social needs, an attention that affects the ethical decision-making process. The moral landscape changes when the nurse and doctor realize that they are not trying to cure, but simply trying to minimize pain. Aspects of a quality palliative care program include effectively communicating with patients and their families to determine appropriate goals of treatment in light of the patient's changing condition; sufficient control of pain and other symptoms; and a collaborative, multidisciplinary approach to meeting the patient's and family's physical, emotional, psychosocial, and spiritual life.



After a long absence, spirituality is returning to health care. Recent studies have suggested that religious participation reduces the incidence of illness, that church attendance accelerates recovery, that intercessory prayer (when one person prays for someone else's recovery) speeds healing, and that prayer and meditation can measurably reduce emotional and physical distress. As a result, health-care researchers and caregivers are turning to religion and spirituality as potential new allies in their efforts to heal.

Such an interest might be expected in systems like Advocate, with its strong heritage of religious affiliation. However, even faith-based organizations have often viewed religion and spirituality as a means of comfort and emotional support rather than a means of healing. Today, not only faith-based organizations but also non-religious healthcare providers are examining the potential benefits of incorporating spirituality into their treatment programs.

In daily clinical practice, health-care practitioners are coming to see the patient's spirituality as essential to treating that patient as a whole person. In the doctor's office and at the hospital bedside, an increasing number of physicians are engaging in prayer with their patients, and medical and nursing schools have begun integrating religion and spirituality into their curricula.

Like all innovations, however, these developments have potential complications. For one thing, the current turn to spirituality often raises the question of just what "spirituality" means. In addition, when a

patient and a practitioner from different traditions interact, they may encounter difficulties communicating because they speak different spiritual languages.

Such complications suggest a variety of practical and ethical questions: Is there potential for abuse of authority by a physician who wants to initiate prayer or spiritual discussion? How does the would-be spiritual practitioner demonstrate or develop respect for the diversity of beliefs and practices? If providers begin to take patients' spirituality into account, should such "treatment" be accompanied by an informed consent process? Should spiritual conversations be charted, and if so, should they be subject to a higher standard of confidentiality than other psychosocial information?

Advocate is addressing these questions in several specific ways. First, a task force to address the possibilities and challenges that spirituality presents to Advocate as a faith-based organization has recently begun working. Second, this year's Advocate ethics conference took up the theme, "Spirituality in Clinical Care: Ethical Principles Meet Personal Faith."

From the perspective of modern medicine, the idea that spirituality should be taken seriously sounds new and is intriguing at least in part because of its novelty. From a historic perspective, though, the assumption that spirituality plays a role in health is a long-established one with what many would call an honorable past. It may be that we have come full circle and that a positive role for spirituality in health care is an idea whose time

Calendar of Events May - June

all events take place
at the Park Ridge Center except
where noted

May 6

Spiritual Issues in Health Care

Cost: \$125

May 14

Complementary & Alternative Medicine: The Ethics of Integration and Integrity

Cost: \$50

May 21

Retrieving Spiritual Traditions: Train-the-Trainer Workshop

Cost: \$150

June 22-27

Talking Ourselves to Death: Narratives and Caregiving at the End of Life

The Center for Literature, Medicine, and the Health Care Professions. Contact Carol Donley, (330) 569-5449 or e-mail: Donleycc@hiram.edu. at Hiram College, Hiram, OH.

June 24-25

Care at Home and in the Community: Ethical Insights and Practices

Cost: \$250

To register or obtain more information about Park Ridge Center events, call Bernice Chantos at (312) 266-2222 ext. 255, or fax (312) 266-6086, or e-mail bmc@prchfe.org

To list an event in this calendar, contact Mary Ann Clemens at ext.240 or mac@prchfe.org