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Michael Kühler
Veselin L. Mitrović *Editors*

Theories of the Self and Autonomy in Medical Ethics

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Theories of the Self and Autonomy in Medical Ethics

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Preface

This volume is the result of a longstanding cooperation between the editors and some of the contributors. Starting with a workshop on "Issues in Theoretical and Applied Ethics," organized by Gunnar Scott Reinbacher and Jörg Zeller in 2011 in Klitgaarden, Denmark, the central topic of our shared discussion since then had quickly been found, namely, the controversial relation between debates and arguments in theoretical ethics and metaethics, on the one hand, and applied ethics, esp. medical ethics, on the other hand. Since then an edited volume based on this first workshop followed (Zeller, Jörg/Riis, Ole Preben/Nykänen, Hannes (eds.): *Issues in Theoretical and Applied Ethics*, Aalborg: Aalborg University Press) as well as two further workshops: "Applied Ethics and Applying Ethics," organized by Michael Kühler and Jörg Zeller in 2013 in Münster, Germany, and "Theories of the Self and Respect for Autonomy in Palliative Care and End-of-Life Decisions," organized by Veselin Mitrović and Michael Kühler in 2016 in Belgrade, Serbia. The latter workshop has been the starting point for the current volume, which contains a number of revised contributions to this workshop but also a number of additional contributions by other colleagues, thus joining our ongoing discussion.

As with all such volumes, they are the result of many people's contributions and help. First of all, we would like to express our utmost gratitude to all contributors for putting in so much hard work to provide this volume with so many excellent and thought-provoking chapters. Furthermore, we would like to say a special "thank you" to Cecil Joselin Simon, Christopher Wilby, Floor Oosting, and Cynthia Kroonen at Springer for their tremendous support and truly admirable patience when it came to putting this volume together. Last but certainly not least, we are very grateful to Lucie White and Rachel Fedock for their invaluable help in proofreading and language editing. We cannot stress enough how much we appreciate their support.

Belgrade, Serbia — Veselin L. Mitrović
Enschede, The Netherlands — Michael Kühler
June 2020

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Veselin L. Mitrović is a senior research associate at the Institute of Social Sciences at the University of Belgrade. His research activities feature topics in Bioethics, Disaster Study, Sociology of Culture and Social Action in different strata (from marginal to elite). His recent publications include "Ethics and Floods: A Systematic Review." *Disaster Medicine and Public Health Preparedness.* 13/4, 2019, 817–828. "Parent's Religious and Secular Perspectives on IVF Planning in Serbia," *Journal for the Study of Religions and Ideologies* 15/43, Spring 2016, 48–81; "From Global Bioethics to Neuroethics," *TEME* XL/4, 2016, 1457–1475 (Serbian); "Resilience: detecting vulnerability in marginal groups," *Disaster Prevention and Management* 24/2, 2015, 185–200; "The Contingency of the 'Enhancement' Arguments: The Possible Transition From Ethical Debate to Social and Political Programs," *Journal for the Study of Religions and Ideologies* 13/37, Spring 2014, 93–124; "Ethos of the Elite and Future of Serbia," *Balkanske sinteze* 1/1, 2014, 167–189 (Serbian); "Nanotechnologies and Global Survival," *Sociologija* LIV/1, 2012, 37–54 (Serbian);

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Chapter 13
Understanding 'Euthanasia' Across Various Medical Practices

Veselin Mitrović

Abstract End-of-life decisions and assisted suicide are often equated with 'euthanasia.' In everyday parlance of social actors, the term euthanasia is understood rather broadly, even lumped together with other medical procedures. Still, the paper argues that 'intended merciful death,' whether we like the definition or not, ought not to be equated with other practices. Although all of these medical procedures result in the destruction of potential or actual life, the reasons behind such actions could be quite different from empathy or mercy, making the acceptance and advocacy of a problematic definition and understanding of euthanasia the subject of ethical and social debates and analyses. When considering the Universal Declaration on Bioethics and Human Rights, the debate stretches out to include also vulnerable groups in general, which in the contemporary context range from homeless persons and other marginalized groups to embryos created during IVF (in vitro fertilization). The paper presents two case studies, chosen from ten personal stories of former and current IVF procedure patients. In all ten narratives, interlocutors equate abortion with embryo reduction, and both of those with euthanasia. The paper analyzes their perspective to embryos that were not implanted, as well as similarities and differences in their views regarding the activities in the cases of implanted embryos (twin and triplet pregnancies).

13.1 Introduction

End of life decisions and assisted suicide are often equated with euthanasia. In everyday parlance of social actors, the term euthanasia is understood rather broadly, even lumped together with other medical procedures. Still, 'intentional merciful death', whether we like the definition or not, ought not to be equated with other practices. Although all these medical procedures result in the destruction of potential or actual life, the reasons behind such actions could be quite different from empathy

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or mercy, making consent, advocacy of a problematic definition and understanding euthanasia the subject of ethical and social debates and analyses.

Current debates about this topic are mostly focused on autonomy, generally understood from an individualist perspective.[1] Nevertheless, the approach in this paper demands we also consider scenarios other than only the individualist one.

13.2 Social and Ethical Background

The problem of euthanasia becomes more complicated considering contemporary history and the bitter experiences of various social and political programs, whether executed or on the level of debate and demands made by some social movements.[2] When we consider the Universal Declaration on Bioethics and Human Rights (from the 33rd session of the General Conference of UNESCO 2005), specifically the of human dignity and rights (Article 3),[3] principle of benefit and harm (Article 4)[4] and principle of autonomy (Article 5),[5] the debate becomes meaningful with regard to vulnerable groups and persons without the capacity to consent,[6] which in the novel contemporary context (from medicine to disasters) ranges from the homeless and other marginalized to embryos created during IVF (in vitro fertilization) (Mitrović et al. 2019, 6–9).

With this in mind, and taking a number of indicators (Table 13.1) into consideration, I here examine the role of information held by responsible persons, such as parents in an IVF process, in continuation or abandoning efforts to create life. In what way do they form ideas about their opinions, motives, and reasons? This examination

[1] Tom Beauchamp and James Childress, in *Principles of Biomedical Ethics*, begin their analyses of autonomy "in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action" (Beauchamp and Childress 2013, 104).

This issue is analyzed partially in the context of their three other principles, i.e. nonmaleficence, beneficence, and justice. For Beauchamp and Childress, individual autonomy is preserved wherever it is rooted in some social, cultural or religious belief. However, such social influences are understood as internal characteristics of autonomy. Thus, Beauchamp and Childress essentially still presuppose an individualistic conception of autonomy (Cf. Beauchamp and Childress 2013, 106).

[2] (Dowbiggin 2005).

[3] (a) Human dignity, human rights and fundamental freedoms are to be fully respected. (b) The interests and welfare of the individual should have priority over the sole interest of science or society.

[4] In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such on individuals should be minimized.

[5] The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

[6] In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

Table 13.1 Tabular representations of results

Participant	Euthanasia is the same as…	Self/autonomy in IVF (Participant view)	Reasons for abortion	Reasons for embryo reduction	Scope of euthanasia	Prevention of euthanasia	Eugenics and euthanasia
P3	Abortion, embryo reduction	Individualistic perspective	Malformation economic	Care	Narrow	Positive	Consistent
P8	Abortion, embryo reduction	Individualistic perspective	Malformation right moment/partner	Dear self	Wide	Negative	Consistent

also helps us to better understand how patients undergoing IVF themselves understand the procedures in which potential life is either created or destroyed. We must not forget that creation of embryos in vitro only carries the potential of life. Therefore, if one such embryo is offered the possibility to live (meaning that it will become a person), then we must take the same care in the course of deciding to destroy this potential life. In other words, the question becomes, why do parents undergoing IVF give certain embryos a greater chance to become life than others? This is the crucial question for understanding euthanasia through other medical practices, but also for avoiding justifying eugenic choices (Mitrović 2015).

Contemporary technology allows us early insight into some embryo defects, thus avoiding certain serious illnesses.[7] However, could the same technology be applied not merely to avoid defects, but to select for desirable ones, thus conducting a morally questionable selection among vulnerable embryo and potential human beings?

As we will see in this study, this approach to creation of offspring allows for the destruction of life for the sake of the most selfish of goals (dear self).

With these questions in mind, I present here a portion of a broader study conducted with IVF patients. More specifically, this paper presents the positions, conceptions, motives and experiences of embryo reductions and pregnancy termination (almost always equated with euthanasia in the case of certain fetus anomalies).[8]

Still, some of the participants in our study undertook these practices (which they themselves equated with euthanasia) for other reasons. Particularly interesting are the cases of twin or triplet pregnancies, which generated entirely diverse explanations for terminating embryo life created through IVF and implanted into the mother's body. Further, I examined other potentials that could influence such a decision or play a role in maintaining or changing this equating of different practices.

In this article, I will focus on the stories of Participants 3 (P3) and 8 (P8), chosen from ten personal stories of former and current IVF procedure patients. I analyze their perspective on eggs and embryos that were not implanted, as well as similarities and differences in their views regarding the activities in the cases of implanted embryos (triplet pregnancies). Patient P3 declared herself as religious, belonging to the Serbian Orthodox Church, even though she added that she did not go often to church. At the time of research, she was an unemployed high school graduate. Participant P8 was atheist, highly educated and employed full time. In the course of IVF, both were implanted with three early stage embryos. P3 gave birth to healthy twins, while P8 gave birth to a single healthy child. In addition to a basic goal, these stories reveal how verbalizing a narrative arrives at the authenticity, motives, and reasons that contributed to making a given decision. In other words, the interlocutor is never merely reporting on a series of data or information, but is always the narrator of a

[7]Mark S. Frankel. 2003. "Inheritable Genetic Modification and a New Brave World: Did Huxley have it wrong?" in The Hasting Center Report. 33 (2): 31.

[8]For detailed insight into the questions used for this research, see appendix, in Mitrović 2016.

multifaceted story (Holstein 1995). And since the narrative is generated in the very course of conversation with the researcher, the conversation can as such be the result of representation and analysis of empirical material (Hyden 2008, 50).

13.3 Self and Autonomy in Procreative Decision Making

In addition to the principle of nonmalefience and the principle of beneficence, respecting patient autonomy represents a significant role in making medical decisions, in particular when it comes to crucial life decisions (Beauchamp and Childress 2013, 104–149). Respecting Autonomy, that is, its understanding, as we shall see, has a decisive role in the decision and acts that would save, bring good, or destroy current or potential life. Such a scenario is especially important in the case of those vulnerable, without the power of choice or consent (Mehlman 2009). The question, from the perspective of those making the decisions, is how is one's own image and one's idea of autonomy formed, what is the partner's role in it, as well as of mutual trust within a family? Is autonomy something that can be lost or acquired in the course of one medical procedure, only to ultimately result in a negative result for some, instead of being of benefit to all involved—starting with the respect of autonomy in the number of embryos and the right to further information and procedure consent, to selfish embryo reduction.

The first challenge to formulating limits to autonomy, trust, and making joint decisions regarding creation (and later destruction) of life can be found in the portion of the conversation about the initiative and deciding on IVF. It is characteristic for men to think it entirely natural that the women take the lead as well as have the last word on the matter, while for their part, a common position was the slogan "your body—your decision." This approach to the issue of infertility, as a challenge to young married couples, at first seems like something that could significantly influence later decisions, meaning the joint demand for preserving all potential lives that could be preserved. It can also be understood as a matter of trust in the partner's decision, the way of formulation of the self in interaction with the partner. However, such a socially-conditioned approach to personal choice (Kühler and Jelinek 2013: xii–xvi) can also carry another, more latent significance and avoidance of responsibility in a joint decision (Beauchamp and Childress 107), and consequently have the opposite effect—mistrust. With this in mind, the rest of this text should be used to examine whether autonomy constituted thus carries the potential of endangering all potential lives, and whether it also plays any role in conceiving possible rationalization of an entirely different practice (Childress 1997), unconnected with the couple's reproductive familial challenges—euthanasia.

In all cases, participants or their partners answered the question of their partner's involvement in a similar way.[9] Aside from the answer to the question who was more responsible for the initiation of the IVF process, participant P3 also gives the influence of her surroundings:

> It was my initiative…. As opposed to the pressure from my family, that I should give up on this impossible mission, to withdraw from all this, that if I want children I should be making them with someone who has a chance, I even had my own mother telling me for four years, not to do this to myself, not to go through these hormone stimulation, not to put myself at risk for uterine or ovarian cancer, but that I should find another partner for fertilization. [laughs] However [laughs], erm, of course, I understood all this, I mean, she's a mother, caring for her child. I am after all her kid, unfortunately, she is less interested in my children. Simply, people become selfish. They want their kid to be healthy, but what that child wants and what makes it happy, that is already a luxury in Serbia.

Describing the role of the partner in the IVF decision, that is, whether that role was exclusively made based on the desire for children, or whether it was an issue of the survival of the relationship, she vacillates. There is a contradiction, that is, the verbalization of the problem. In other words, it is in the course of the conversation that she becomes aware of certain motives and reasons that influenced the decision:

> […] Hmm, no, not the relationship's survival, we both wanted children, even when we discovered that it is a matter of infertility, this really frightened us, and the road to IVF is really daunting. Because of the decisions, the paperwork of our health system, because it tests the relationship, because there is no guarantee that you will ever have children, although you invest a lot, and to be honest, I was quite near to leaving the relationship, precisely because of all the pressure, it's all on your back, you know. Simply, it changes everything, it changes your relationship with your partner. The partner who is sterile withdraws, erm, even if we had good relations before that…Everything changes, everything changes. It's shaken, and that's that…I really do not know how we made it. I am sorry that we didn't seek psychological help because that would have made it easier on both of us. Someone to talk to, but there was no such thing in Serbia. Now, there is a psych consult clinic on Svetogorska Street, I know all that, I even know some people who work there, they spoke to me about my own IVF, anyway, but in the clinics there is no psych help. Abroad, every clinic has it, you don't have to, but they strongly recommend it. I am sorry that for my first IVF, even this second one, which was conducted by the most "European" standards, because it was done in a different city abroad, I am sorry that I did not seek psychological help on time, but only after giving birth. Now I go to all the workshops, consults, to a therapist. Yes…it is very difficult for the relationship to survive (P3).

Telling us when she decided to undergo IVF, participant P8 says:

> […] When the doctors told me that we would never be able to have children naturally. So, after the information from the doctor. I was told that with these results, the two of you will never conceive naturally. Simply, my husband did not have good results (P8).

To my question whether in addition to this medical information, their decision was also motivated by preserving the relationship, she answers: "No, no. I am sure that it was not so important to us" (P8)!

[9] For example, a characteristic response of the partner was: "She lost patience, so it was her initiative, I had nothing against it, it was up to her. In May, we approached the clinic, the insemination was in July…" (P7).

Moving to the description of the partner's role in deciding on IVF, she told that: "He said, this is your matter, your body and you have to decide! I am for it, but your decision is crucial" (P8).

13.4 Three Versions of Abortion

Of the ten personal stories from patients taking the path of getting around sterility by way of ART (*Artificial Reproductive Technologies*), nine supported abortion, that is, considered it legitimate in similar, but also in different, circumstances. I found complete support for terminating pregnancy in cases when participants were faced with reliable information pertaining to irregular development of the fetus. In these cases, abortion was considered a kind of euthanasia, regardless of whether the participants were religious, agnostic or atheist.

In the course of their pregnancies, some of the patients were faced with information that the fetus is not developing normally (based on one of the tests); still, they did not reach for abortion right away, but consulted other experts who explained that the fetus development cannot be ascertained with absolute certainty through the obtained test results. The participants were asked, "if a routine test established that a potential fetus had certain anomalies, to what extent should the doctor go in informing the future parents about the quality of life of such a newborn?"

Participant P3:

> Well, so, I did the whole embryo reduction, after which I did the amniocentesis. Which means the genetic examination of the baby. I looked at whether I am at risk after the second penetration of the uterus, and I did the amniocentesis and one child has Down syndrome, then you do some five genetic tests, what happens with a twin pregnancy and after that test if one does have Down syndrome and it is already the fifth month, while the other does not – what happens then? The consilium just yelled at me and said that I best think of nice things and get out. In other words, they did not have an answer but were quite eager to offer the second amniocentesis. Which I accepted, but what happens if one child has Down syndrome, I cannot give up on it for the sake of the other, I give birth to two kids whatever they had. When it comes to twin pregnancy, I think it is not ok to do amniocentesis since the likelihood is small for both fetuses be damaged. Luckily, our results were great and this is a great risk for twin pregnancy (P3).

In order to obtain an even clearer answer, the participant was asked the following question: "What would you have done had one child turned out to have Down syndrome, would you save one and not the other?"

> There is an earlier and later amniocentesis, and I did the later. Had I found out that one had [Down syndrome], well I certainly would not kill it in the fifth or sixth month, I don't know, I would leave it. If the earlier were done, and that were the result, I would remove it. Simply, this is the answer why women are odd when pregnant. Really, you think too much or not at all. But I did the amniocentesis and all that, but to no avail (P3).

Even though participant P3 had no experience with abortion (she had embryo reduction), her position regarding that practice was that:

> My position is that I support it absolutely if people are not ready, either psychologically or existentially to bring up a child. But I am also against it, I mean, since there are forms of protection. Since I think it's a trauma for the person, thinking about abortion, that it is some kind of mere extraction. I think that this is a trauma, torturing both the woman and the man, that there is no reason for abortion, maybe in the case of rape or something, but not just for the heck of it, no (P3).

Six of eight patients (two conversations were held with men) had personal experience with abortion, pregnancy termination, or embryo reduction. In these cases, in addition to malformation, reasons given ranged from unplanned pregnancy (not the right moment or not the right partner) to financial unpreparedness for raising children.

Participant P8 was asked the same question of what would happen if routine control showed that the potential fetus has certain anomalies and the what extent, in the participant's opinion, should the doctor go in informing the future parents about the quality of life of such a newborn.

> […] Well, the doctor has every right to inform me. Without telling me what to do (P8).

I continued with the follow up question whether she would terminate the pregnancy if a test result indicated an increased risk of anomaly in the newborn? She answered in the affirmative.

As to her direct experience with abortion, and reasons for terminating pregnancy, given the efforts to treat sterility, the participant responded:

> I had an abortion, erm, some four years before IVF. It was a pregnancy termination. What is my position? Positive, since I can choose who will be the father of my child. That's what I think […] [laughter] (P8).

Another follow up question was whether she tied this decision exclusively to the autonomy of the mother, that is, the woman? She answered in the affirmative. In elaborating her reasons for terminating pregnancy, she answered briefly and symbolically:

> A dash outside of marriage [laughter], a dash outside of marriage [laughter] (P8).

The equating of abortion with euthanasia acquires significance when we compare the experiences of patients who despite such a view of abortion, conducted such destruction of life for other reasons. For now, this contingency in conceiving of abortion carries the potential of an ethical transition of justifying a means for achieving entirely disparate goals. In the following portion of the research, I will examine whether this potential can be achieved through a combination of experiences of different individuals in the same situation.

13.5 Embryo Reduction: Care, and Selfishness

There are clear differences between the statements given by P3 and P8 regarding embryo reduction, that is, the limits of decisions and motives for it. In the case of

participant P3, we can assume there was care for the remaining implanted embryos. The care for their health and survival had a crucial influence on the destruction of one of the three implanted embryos. Still, the answer also features an economic factor connected to the possibility of child-raising if they are born with defects. This background factor gives another reason for justification of embryo reduction in the case of triplets.

> […] Well, I did have embryo reduction. Three embryos were returned to me, even though I asked what if they are triplets, but the doctors said that they would turn out twins, it's only 5% likely that they would triplets. But I asked what if it turns out I am in those 5%? They said I would figure it out when it happened, now it is important to get pregnant. I understand their position. They asked if I wanted twins and I said yes. They gave me back three embryos and they turned into triplets. So I had a difficult decision to make. Do I remove one, as one doctor abroad who does IVF recommended, just like local doctors? Then I risk all three babies being born prematurely, that is, that I have them, erm…, or rather not have any or have them, but one with some defects, etc., due to the lack of oxygen and all that. A twin pregnancy is also quite risky. So I thought whether I should leave all three, that I do not have the money, I have no inheritance, I live in Serbia where child protection and health care is not a high priority. So, I thought how I would help these children if they have some difficulty, meaning developmental. Since they were three in my belly. Then I decided that since I am not financially strong enough, either considering my family or individually, to remove one anyway. It was a very difficult decision. But simply, I consoled myself and said ok, you underwent IVF and you know the potential risks as well as having two kids, and giving them the chance to be born healthy and strong, I had to remove one (P3).

Since she had not had direct experience with abortion, but had had experience with embryo reduction, I returned to the question of pregnancy termination in case routine control indicated increased risk of anomalies in the newborn. Further, I repeated the question of the doctor's influence on the decision. In other words, how much does the doctor, with their suggestion, influence the mother in her decision-making in these cases?

> […] Well, I felt they had influence regarding embryo reduction. I am thankful to our doctors, they told me, that is, one really good woman doctor told me, I saw triplets, they look fine, I don't know if yours will be like that, but I saw these and others who had something wrong with them. Think about what you are ready to do and what you…It's simply your decision whether to take the risk or not. Which is the same as what they said abroad. They told me that chances were 50% that you could give birth to all three babies dead if you leave them. If you undergo embryo reduction, you have 80% chance of having two healthy children. When someone gives you 80% chance and those other 50%, it really makes it easier. But not our doctors. They stay out of it. They just say that anything is possible, and it's up to you to decide. Abroad they gave advice.
>
> […] Abroad they told me that there is 80% chance to give birth to two healthy children. They know what the embryos are like, they even thought that I do not need to do the amniocentesis, since the embryologists knew in advance what they had done. I mean, experience is very important (P3).

In the case of participant P8, after the IVF treatment, one child was born, even though she had been implanted with three embryos. When I asked whether she had undergone embryo reduction and whether she saw this as termination of pregnancy or abortion (previously, termination of pregnancy of a fetus with an anomaly was equated with euthanasia). The answer was that:

> Yes, I did. Yes, I do see it as termination, and it was done in another local private clinic. One embryo disappeared on its own, while one was removed by me (P8).

When I asked why she made that decision and whether she was following medical advice, she said:

> No. I made the decision on my own because I know myself. After a few weeks, I was thinking about the twins, and I knew that I would not be able to do this, how am I supposed to support even one, no less two. I know I'll need help that I don't have. For me, the way things are, one child is what I can have (P8).

When I asked whether she considered early birthing due to the twins, she answered: "Yes, I did, and it turned out that had I not done that, I would not have had any children! But I could not have known that. I was going on knowing myself" (P8).

The two cases are also textbook examples of the discrepancy between ought and can. For P3, the principle of "ought implies can,"[10] means that all potentially salvageable lives ought to be preserved. But this principle was broken due to medical realities in which not all embryos could be preserved. On the other hand, for P8, this principle plays no role: potential life that might have otherwise developed was destroyed for selfish reasons.

Accordingly, we could speak about normative and social differences between regret or mourning and blameworthiness or guilt retrospectively (Kühler 2013, 207).

13.6 Scope of 'Euthanistic' Action

The scope of 'euthanistic' action is an imaginary scope of autonomous decisions that refer to the preservation or destruction of potential life created in the course of IVF. To obtain answers regarding this scope of action, I used a set of questions that refer to the *pro vivo* position about the remaining reproductive material after the IVF. Such questions helped us understand the decision about embryo reduction in these cases, since the initial relation of partner trust and the constructed self as well as the degree of autonomy in the initial decision would appear to be reflected onto all other decisions, but also onto a lack of moral support in cases of ambivalence regarding preservation of potential life.

In P3's statements, we see a *pro vivo* position towards the remaining cells, but the reasons are not for the preservation of this potential, but rather of economic nature.

Answering several connected questions about whether she would preserve all the embryos obtained via IVF, participant P3 said that the clinic staff actually preserved everything even though some of the material divided "slowly." Still, she got no guarantee from the embryologist that all five embryos are developing as they should.

> […] when I arrived, three were alive, they let them all divide and take photos of them constantly, they watch them divide and follow the fragmentation, etc. The other two simply

[10]For more about principle "ought implies can," see in Kühler 2017.

> stopped dividing, they died. I don't know how to say it, but these three were excellent, although I have an image of them and one really has quite a few fragmentations. So, we do not know whether this is one of these two twins today [laughs]. You know what I mean? Each embryo has to be frozen. If you ask me, no doctor or embryologist will tell you this will or won't be a baby. Even those "lame"[11] ones could well become babies (P3).

Answering what she did with the other, early embryos after IVF, participant P8 said:

> […] How many there were, I don't know, but three were good, and they were returned. No one told me, nor did the discharge papers say anything like that. I didn't insist, since that clinic does not freeze, so I didn't ask. I agree that they should have asked what we decided to do with our reproductive material, but at that moment, erm…how can I put this, if you decide to trust the doctor and everything is in his hands and the lab, then you simply do not ask. I had a different dilemma, which was that during hormonal hyper-stimulation, over thirty eggs were taken out. I wanted to know, where are all my eggs? I didn't freeze them, I didn't do anything with them, so where are they, what happened to them? If there is no possibility of returning them without being frozen, what's the third option? [laughs].

13.7 Prevention of Euthanasia

Opposing the potential of euthanistic action, I proposed the possibility of preventing what the participants took to be euthanasia, by destroying the fetuses and early-created embryos. This potential was measured by way of questions about potential donation of obtained embryos, eggs or semen for scientific research intended to prevent the very defects that lead to the euthanistic behavior in participants.

Participant P3 answers the question affirmatively:

> Research—always. Right away. Because it was thanks to research that I have these two children. That is, thanks to science, let's be honest. However, when it comes to donation, should they be thrown away or given to someone else to have a child…Well, I think I would give them away, I think that this is best (P3).

In the statement of P8, the question of donation of embryos for the purpose of research provokes an ambivalence caused by mistrust in scientific work, and it results in a negative answer.

> […] possibly for the sake of research. Although I have doubts. It would depend how much information I would have what's being done with the embryo, which I do not believe I would get here in Serbia. So, I would say no. Better to destroy it right away than have it developed and then have something done to it. I would most like to destroy my embryonic cells (P8)!

[11] The participant used the Serbian word *kljakavo*, an extremely derogatory version of lame or damaged. The patient is using the word ironically, because during the IVF procedure, at a private clinic in Serbia, one of the nurses used it to describe the embryos being implanted in her uterus, letting her know that the odds of a baby are slim.

13.8 Eugenics and Euthanasia

I thought it necessary to also examine the autonomy of participants regarding the possibility of creation of a perfectly healthy and, if possible, enhanced offspring (Harris 2010). The participants who developed their identities partly on the idea of reproductive difficulties, achieving parenthood, but also the possibility of justifying the destruction of potential life (which they considered euthanasia), were faced with the question of limit to which they would go in choosing characteristics and capacities of their future child. For example, avoiding chronic illnesses, choosing the sex, eye color, height, cognitive abilities, sexual orientation, etc.

A particularly dangerous potential in both cases comes from the subjective perspective and rationalizing euthanasia in the form of abortion of the fetus due to a defect, and the demand for a healthy and enhanced offspring, whether by way of reduction of the initially weak and asymmetrical embryos or by detection of illness.

To all this, from participant P3, I received the following answer:

> […] For illnesses, that can be done at the clinic where I got my IVF. On the embryo. Which is expensive. I would absolutely do it if I had the money, and if I had…erm…persons in my family who suffered from genetic disorders, etc. Absolutely yes, I would not give birth to such a child (P3).

Answering the follow up question, whether she would go further, and choose the sex, eye color, height, cognitive abilities, sexual orientation, etc., she said:

> […] The rest…you know, people often tell me, you have two sons, it will be tough with two daughters in law. To which I answer, what if there is a son in law! But I really, not only do I not prohibit it, but just as I would be happy to have two daughters in law, I would be happy to have, not one, but two sons in law. I would not do any of those… I would not choose those things. None of that (P3).

It is thus clear that participant P3 would not choose the potential sexual orientation of her offspring. Later on, in the conversation, she adds:

> […] Maybe in twenty years, maybe tall people, just as pretty people now, will have it easier. Erm…yeah…Anything would help them (P3).
>
> […] So, I would, if Serbia became a great place to live, erm, you know, I look at it from a global perspective. What if they live in a country where tall people are not prevalent? It would simply have to be global. That is, I would take that step based on world trends in twenty years. Do we know or not? Perhaps there will only be tall people or only short people, and in that case I would of course choose to have kids accordingly, I would think about that, yes (P3).

Participant P8 stated that she was not aware of the possibility of controlling obtained embryos, although part of her story referred to an event in the lab when she was able to follow the development of her early embryos.

> […] Yes, but what does that mean? Does he have to divide in the course 1, 2, 3 days or so? I have no idea whether that is a good thing, looking through a microscope. I have no idea how it's verified. I think that it is not even necessary to be explained how it's verified since he is the doctor and he knows the procedure… and the third day was the return of the embryos (P8).

Later in the conversation about potential avoidance of chronic illnesses, choice of other characteristics, abilities and capacities in her future offspring, she says:

[…] Avoiding illness, yes, certainly. Sex and the rest, no (P8).

Asked whether she would genetically predetermine or enhance other abilities of her future child, such as intelligence, she answers in the affirmative:

[…] That I would, why more stupid when it could be smarter (P8).

Asked whether she wished for a more empathic or more rational child, she said that she would not change anything in that case, and just like the other participant, she found that it is best that the child be empathetic and altruistic. The two cases held a common position that it is more ethical to turn to the study and manipulation of bodily, rather than embryonic cells. While P3 was more prepared to donate her genetic material in accordance with the altruistic drive, P8 was not ready to take that step.

13.9 Conclusion

Although both participants were entirely convinced that during the course of the IVF, they followed their own independent decision, during the conversation and verbalization of certain challenges, they arrived at the conclusion that their decisions were influenced by several different factors, such as the environment, their partner, doctors, etc. Often, the preservation of the relationship, as a latent social pressure, played a role in initiating this procedure and all its consequences. In addition, the neutrality of the partner regarding certain decisions gives an ostensible picture of autonomy. This form of decision-making could later be connected to the idea of acceptance of one's powerlessness to raise multiple children or relinquishing to fate the remaining eggs and early embryos. Further, there are the suggestions by the doctors, grounded in test results, that range from hyper-rational prognosis about the future health of the child, to awarding equal odds to the birth of healthy triplets as giving birth to triplets with defects, unless embryo reduction is conducted.

In the course of uttering and constructing the story in conversation with the researcher, both women often used hesitation markers such as "erm," or laughter in those places where, according to them, their choice does not respect the autonomy or integrity of their partner, or else is not socially acceptable.

Almost all patients considered abortion justified as a means of family planning, either in choosing the timing of the pregnancy or as termination in the case of fetal anomaly. All participants equated abortion and embryo reduction. Participant P8 had an abortion before the IVF process and embryo reduction during it. Participant P3 had embryo reduction during IVF. All the women in the survey encountered one or more of these experiences prior to or during the IVF process. They justified abortion and embryo reduction even as a type of euthanasia.

Participant P3 took the embryo reduction in a difficult way, even though it was recommended by doctors of a clinic abroad (where the IVF was conducted). Their explanation was that there was a high probability of defect or death of one or more of the embryos is she carries the triplets to term.

Several years on, she still feels the psychological effects. There is a heightened sensitivity and care for life and health of the twins, the result of the justification of this embryo reduction. In that sense, she remains of the belief that had she had the money, she would have preserved all the created early embryos, regardless of their initial irregularity in the first hours of cell division.

By contrast, participant P8 chose embryo reduction because she thought that she could not raise two children. This decision, in addition to a selfish motive, incorporates an irrationality tied to the risks of medical procedure entered and a decision to destroy a potential life created during this procedure.

The reasons for destruction or leaving to fate the unused genetic material are not only personal, but often socially determined, starting with economic to ethically questionable practices in the clinics. In the case of participant P3, the reason was exclusively economic in nature, while for participant P8, the reasons were relinquishing care and decision-making to the doctors.

In different circumstances, participant P3 would be prepared to donate her eggs or early embryos for research purposes. After verbalizing the problem, participant P8 hesitated and initial agreement ended up in a decision not to agree to a donation, broadening the scope of what was understood by her to be euthanasia.

Considering all the similarities and differences followed through these indicators, the conclusion I can offer is that the greatest danger lies in social and ethical justification of a practice that has nothing to do with infertility issues these couples face. Both participants were guided by the notion that there is not much difference between "advantageous" principles of Darwinian evolution and "Enhancement Evolution" as some scientists understand it (Harris 2010, 11) . Accordingly, they were ready to use biomedicine to enhance their offspring, to a certain degree and in accordance with the global social demands and trends. But we must not forget that "Darwinian evolution" is neither moral nor smart, but powerful and opportunistic. With that in mind, the contingency of eugenics and euthanasia gives rise to a dangerous and powerful social potential, which coupled with a loss of a traditional approach to parenting (Almond 2006) and general care for the weak, can produce unforeseeable consequences in modern society. Hope remains in the knowledge that these practices can be prevented by an active engagement in solving the problems faced. Interest and insistence regarding the genetic material left over in the course of IVF, as well as the solidary and empathic decisions (as in the case of P3), could help in medical research and treatment for infertility and hereditary illness.

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