# Update on Life Issues - June 2020

## Abortion

**Abortion statistics – 2019**

Brace yourself, these are the worst statistics ever, ever since the 1967 Abortion Act legalised the procedure. Published on 11 June, the 2019 abortion figures for England and Wales record a total of 209,519, which is the sum for 207,384 residents plus 2,125 non-residents. The rate of abortion during 2019 was the highest ever at 18 per 1,000 resident women aged 15-44. Although most (82%) were performed under 10 weeks of gestation, 2% were at 20 weeks and over. The number after 24 weeks (the normal legal limit) was 279. And 126 abortions involved 'selective reduction' as a result of overzealous IVF treatments. The detailed data can be viewed here.

Then consider these weighty facts and figures. Almost all (99%) of these abortions were NHS-funded with 74% sub-contracted to the independent sector clinics, such as Bpas and Marie Stopes. Medically-induced (as opposed to surgical) abortions accounted for 73% of the total.

Numbers carried out under the different grounds were similar to previous years. For example, 202,975 (98%) were performed under ground C, the comprehensive 'social clause' compared with 196,083 (97.7%) in 2018. Of these 99.9% were again reportedly due to a risk to the mother's mental health. A further 3,183 (2%) were conducted under ground E (the 'handicap clause') including 656 for Down's syndrome.

A total of 40% of women undergoing abortions in 2019 had had one or more previous abortions (88 women had already had 8 or more) and 55% were already mothers having had one or more previous pregnancies that resulted in a livebirth or a stillbirth.

It is instructive to compile an archetypal woman who aborted her unborn child during 2019. She is 22 years old, white, unmarried, living in London with a partner. She has never had an abortion before. Now she is 6 weeks pregnant. She attends an independent clinic for a medically-induced abortion, under ground C, funded by the NHS.

What should we think about all this? These figures typically get worse and worse each year, but these are the gravest ever. 4,000 each week, 800 every MTWThF, on your doorstep. Does it matter? Isn't it just the way things are? Should we care? Doesn't abortion solve a problem? After all, is it really a real child? Who wanted it anyway? We shame ourselves by such thoughts. They are sub-standard Christian notions. Each little number represents a now lifeless child and a childless mother. What should be the proper Christian response? Pray, educate, engage, care, support. Have you?

**Abortion in Northern Ireland**

This sad and convoluted saga has rumbled on. After a vote in July 2019, new regulations for the provision of abortion services were drawn up by Westminster that came into force in Northern Ireland on 31 March 2020. The matter was meant to be debated by 17 May, but the coronavirus crisis intervened. The new enactment date was moved to 14 May. Many in Ulster were incensed – abortion is a devolved matter and therefore should be decided not by Westminster but by the newly-restored Stormont Assembly.

Wednesday 25 March was a sad day for Northern Ireland. It was the day that the Northern Ireland Office (NIO) published the new legal framework for abortion services across the Province. It means that abortion will be legal up to 12 weeks for any reason and up to 24 weeks in cases of risk to the mental or physical health of women. It will mean essentially 'abortion on request' up until 24 weeks. In addition, abortion on the grounds of serious disability, including 'non-fatal disabilities', will be permitted up to birth, namely, 40 weeks. The door of entitlement has been flung wide open because sex-selective abortions, abortions for Down's syndrome, abortions for cleft lip will all be sanctioned.

Moreover, these new regulations were approved contrary to the democratic rights of the people – 79% of respondents in a recent NIO consultation voted against the proposals. On 2 June, the Assembly voted, 46 *vs*. 40, to reject 'the imposition of abortion legislation' formulated at Westminster. The vote will have no effect on the new laws but it sent a strong message to Westminster that the regulations are not supported by Stormont.

Following that win at Stormont, momentum to undo some of the extreme abortion measures by Westminster continued to build. On 4 June, Sir Jeffrey Donaldson MP was granted an urgent question in the House of Commons with other MPs putting pressure on the Government to hand back control of abortion law to the Assembly. He argued that, 'Since the Northern Ireland Assembly is sitting again, and has clearly expressed a view opposing the Westminster Government's abortion regulations, they should be scrapped and the power to decide on this devolved matter returned to Stormont.' However, the Secretary of State for Northern Ireland, Robin Walker MP, insisted that the Government had a legal duty to proceed with these abortion regulations.

Mr Walker also told the Commons that, 'The Regulations are due to be debated in this House at the Delegated Legislation Committee on Monday 8 June, and in the Lords after that.' Voting was expected when MPs and Peers would have the opportunity to vote down the regulations. Ahead of those votes, Northern Irish Peer Baroness Nuala O'Loan and Northern Irish MP Carla Lockhart launched an open letter to Peers and MPs in England, Wales and Scotland to ask them to vote against the regulations.

On 8 June, a Delegated Legislation Committee sat to debate the Abortion (Northern Ireland) (No.2) Regulations 2020. Despite excellent pro-life speeches by Carla Lockhart, Ian Paisley and others, the final vote was 15 *vs.* 2 in favour of imposing this Statutory Instrument. On Monday 15 June, there was a 90-minute debate in the House of Lords. Sadly, 355 Peers voted for the Regulations and 77 voted against. Two members, Baroness O'Loan and Lord Shinkwin, proposed motions to decline the Regulations. The former was rejected by 388 *vs.* 112 votes and the latter was 'not moved'. Then on Wednesday 17 June, the Regulations proceeded to the House of Commons where 253 MPs voted in favour of them and 136 voted against.

The upshot – now the law in Northern Ireland allows for abortion, unconditionally, on demand up to 24 weeks. Safeguards, such as a requirement for two doctors to certify an abortion, have been abandoned. Abortions up to 12 weeks can be signed off by only one doctor, nurse or midwife. Sex-selective abortions are permissible. Unborn children with disabilities can now be aborted up to birth. In short, MPs from England, Wales and Scotland have imposed abortion laws on Northern Ireland that are more extreme than anywhere else in Great Britain. The lovely pro-life Province is no more. The decriminalisation of abortion across Northern Ireland is the sad and tragic end to this saga.

**Abortion (Cleft Lip, Cleft Palate and Clubfoot) Bill (2019-21)**

The 1967 Abortion Act generally allows abortions for any reason up to 24 weeks of pregnancy. After that point, abortions are permitted if the mother's health is at serious risk, or if the unborn child could be born 'seriously handicapped'. However, 'seriously' can be widely interpreted and can allow late-term abortions for unborn children with medical conditions, which can be easily corrected by surgery.

On 3 June, Fiona Bruce MP presented the above Private Members' Bill to the House of Commons. Officially it is described as a 'Bill to amend the Abortion Act 1967 to exclude cleft lip, cleft palate and clubfoot as qualifying physical abnormalities for the purposes of medical termination of pregnancy under section 1(1)(d).'

In other words, it seeks to clarify the 1967 Act so that these medical conditions cannot be used as grounds for abortion, as they currently are. As it was the First Reading of the Bill there was no debate. The Second Reading, where debate normally takes place, is scheduled for Friday 10 July 2020.

This issue of abortion for such minor and correctable conditions is of personal significance to Fiona Bruce as

her son was born with a club foot. Decades after his club foot was corrected by two surgical operations and a year of physiotherapy, her son is now studying for a doctorate at Oxford.

## IVF and ARTs

**Surrogacy in Ukraine**

Surrogacy is always a bad idea. The coronavirus pandemic has made it even worse. Consider the Ukraine, the hothouse for international commercial surrogacy. It is legal there. Also it is relatively cheap, medically advanced, and with plenty of willing, poor young women. Unlike most Asian countries Ukraine still welcomes overseas couples. Indeed, it recognises the commissioning parents as the biological parents. In addition, it does not limit payments to the surrogates.

An estimated 500 couples a year come to Ukraine to collect their babies from its 50 or so surrogate clinics. Enter the coronavirus. Such surrogate traffic ground to a halt. The babies and parents were trapped apart. From early June some foreign commissioning parents have been allowed in. But when will all parents meet their babies? What about commissioning parents losing interest? Who will pay for the babies' extra accommodation costs? Meanwhile, who will care for and cuddle these babies? A calamity? Yes, it is.

**A baby girl for transgender parents**

Be honest, you would never have predicted this predicament. In May, a British couple, who are both transgender, announced the birth of their first child. Hannah and Jake Graf's daughter was born in April via a surrogate.

Interviewed on ITV's *Good Morning Britain*, Hannah Graf, who came out as a trans-woman in 2013, said, 'I never thought I would be in this position to be in a relationship, or be married, or have kids. The fact that I have found Jake, we got married and having our little baby is amazing.'
After getting 'married' in 2018, Hannah and Jake found a surrogate through the National Fertility Society. The baby is genetically linked to Jake, who paused his testosterone therapy for six months during his transition in 2008, so that his ova could be harvested and frozen at a fertility clinic. Donor sperm then was used.

The couple want to share their story to let other transgender people know that having a family is possible. Hannah said, 'We have had such an outpouring of love coming towards us. From the LGBT community, from people who aren't able to have babies and are thinking about the surrogacy option, and people who are in a very low place because of coronavirus and just want a bit of joy in their world.' Well, who would have thought? Look where 40 years of changing public mores and assisted reproductive technologies have landed us.

**A baby boy for a male same-sex couple**

Ross and Chris Muller from Edinburgh, the first male same-sex couple to receive IVF on the NHS, have announced they are expecting a baby son via a surrogate this summer.

The Scottish Government had banned using NHS funding for fertility treatment via surrogacy – that meant that homosexual men were excluded. That ban was lifted in 2018. The NHS initially said it would not consider treating a male same-sex couple. But after intervention by their MP, the Edinburgh Royal Infirmary agreed to treat the Mullers.

The couple found their own surrogate in England. Eight embryos were created from donated ova and Ross's sperm. One was transferred to the surrogate last November, resulting in the pregnancy.

Chris hopes that sharing their experience will encourage other LGBTQ families to investigate their fertility treatment options. He said, 'A lot has changed since what we went through – the forms don't say 'mother and father', they say 'parent A and B' – it's little things like that. I think it will be a lot easier for people to go down this path if they want to.'

**Man is still a mother**

Freddy McConnell, born a woman, was, in 2017, issued with a Gender Recognition Certificate, which gave legal recognition to his male gender. Later that year, he underwent fertility treatment, became pregnant, and gave birth to a son in January 2018. But because he had given birth he had to be registered as his child's 'mother'. In 2019, the High Court ruled that McConnell was a 'male mother' – a person of the male gender who has given birth.

That 2019 case, before Sir Andrew McFarlane, President of the Family Division, established an important opinion. It stated, 'The principal conclusion at the centre of this extensive judgment can be shortly stated. It is that there is a material difference between a person's gender and their status as a parent. Being a 'mother', whilst hitherto always associated with being female, is the status afforded to a person who undergoes the physical and biological process of carrying a pregnancy and giving birth. It is now medically and legally possible for an individual, whose gender is recognised in law as male, to become pregnant and give birth to their child. Whilst that person's gender is 'male', their parental status, which derives from their biological role in giving birth, is that of 'mother'.'

In May 2020, the Court of Appeal upheld that 2019 decision. In other words, McConnell again failed to be registered as the child's 'father' on the birth certificate. This trans-man, who gave birth, is still to be regarded as the child's 'mother'. Had McConnell's appeal been successful, his child would have been the first to be born in the UK without a legal mother.

McConnell has responded to the judgment, 'This isn't about a man having a baby. This is about all trans-people retaining their autonomy and their right to start a family in whatever way they wish, and having their identity recognised in that, or at least respected.' It is understood that he will seek permission to apply to the Supreme Court.

**Surrogacy US-style**

Barrie Drewett-Barlow is a British expat. He and his then-partner, Tony, were the first same-sex couple in Europe to have their names on the birth certificates of their children. Now they live in a US$7-million mansion in Florida and run an international surrogacy agency.

Barrie and Tony have had a long partnership. They also have an unusual family life with their four sons and a daughter created with the help of a variety of ova donors and surrogates. In 2014, Barrie and Tony got 'married'. By October 2019, they had separated. And Barrie had partnered with Scott Hutchinson, who was half his age, and who used to date Barrie's 20-year-old daughter, Saffron.

This coming October, Barrie and Scott are expecting triplet daughters via a surrogate mother, selected because of her 'gorgeous looks' and high IQ. They all plan to live under the same roof. Tony has agreed to be godfather to the triplets. As Barrie has said, 'Tony is Dad, I'm Daddy and while at the moment Scott is stepdad, soon he's going to be Daddy Two.' Even that is not all – Barrie has also donated sperm to a lesbian couple in the UK and both of the women are pregnant and due to give birth in September.

As already stated above, 'Well, who would have thought? Look where 40 years of changing public mores and assisted reproductive technologies have landed us.'

## Euthanasia and Assisted Suicide

**MSP and euthanasia**

A 34-year-old man, known only as MSP, was to be kept in intensive care at Barnsley Hospital in an induced coma and denied clinically-assisted nutrition and hydration (CANH) until he dehydrated to death. Mr Justice Hayden at The Court of Protection in London made this decision on 1 June in the case of Barnsley Hospital NHS Foundation Trust vs. MSP [2020] EWCOP 26.

MSP had a history of serious depression, self-harming, mental illness and chronic bowel difficulties. In October 2019, he had a temporary stoma inserted as doctors tried to overcome the bowel problem. He 'utterly loathed life with a stoma'. MSP repeatedly expressed great horror at that prospect and his parents believed, given his 'advance directive', drawn up on 4 February 2020, and their many earlier and subsequent conversations, that he would commit suicide if released from hospital. However, for reasons not entirely clear, the 'directive' was produced only post-surgery by MSP's parents and, because it was unwitnessed, it proved to be 'legally invalid'. Later in February 2020, he suffered a significant prolapse which he found distressing. On 14 May, MSP insisted that this temporary stoma be removed. A few days later, MSP was rushed to hospital with abdominal pain and sepsis. But after an attempt at corrective surgery, Mr M, the on-duty consultant gastroenterological surgeon, decided, because MSP's condition was life threatening, that the stoma would have to be permanent. MSP consented, having apparently changed his mind, perhaps when faced with the possibility of an imminent death. At that time MSP obviously had mental capacity. On 27 May the stoma was formed. The operation left MSP in intensive care, ventilated and heavily sedated.

Surprised by MSP's apparent change of heart, the Barnsley Hospital made an urgent out-of-hours application to Mr Justice Hayden to decide if life-saving treatment should continue in MSP's 'best interests'. On 1 June, Mr Justice Hayden made the order to withdraw life support. Barnsley Hospital NHS Foundation Trust said that following the Court's decision, 'The Trust will now proceed, in discussion with the patient's parents, to withdraw treatment. The patient will be provided with palliative care to ensure that, as far as practicable, he retains the greatest dignity and suffers the least discomfort until such time as his life comes to an end.' Lawyers for the Hospital reported on 10 June that MSP had died.

This case raises serious questions. First, MSP was not terminally ill. Second, on 27 May, he changed his mind by consenting to the permanent stoma operation. Therefore his last wish was to live. Third, he had a good 60% to 70% chance of surviving. Fourth, though stomas can require emotional adjustment they are commonplace life-savers – some 200,000 people in the UK live with them. Fifth, although MSP did have capacity enabling him to consent, he later lacked capacity because he was sedated. Sixth, if allowed out of the coma, he would probably have been able to breathe and eat and drink. Seventh, this was not medical treatment, this was not even 'palliative sedation', it was 'terminal sedation', a slow form of euthanasia commonly practised in the Netherlands by medical practitioners uneasy about administering a lethal injection. Eighth, major medical crises regularly lead to suicidal thoughts, but given time, a majority of patients recover a buoyancy and are glad to live again.

Yet, despite all these arguments, Mr Justice Hayden, apparently disregarding MSP's change of mind, and believing that MSP's true intention was still his February 'advance directive', even though it was not legally valid, ruled that MSP should be allowed to die rather than live with a stoma bag. He found that MSP had, 'made a practical, utilitarian calculation that life in these circumstances is not what he wants.' But was the withdrawal of food and water really in MSP's 'best interests'? The Judge insisted that, 'No amount of support, love or understanding could change MSP's mind.' Was this true? Was it ever tried? Had MSP simply been denied, by the Hospital and the Court, any opportunity to recover? This was not doing the right thing. This was wrong. Where is this type of medico-legal thinking and practice heading? Are we not again somewhere down that road of killing patients deliberately? The tragedy of MSP is a model case of non-voluntary euthanasia, where the patient is killed without an explicit request because he is incompetent, meaning he is senile, newborn or, of course, comatose. This is beyond troublesome.

**Germany approves assisted suicide**

Assisted suicide is a fundamental right. What? What! On 26 February, Germany's Federal Constitutional Court handed down a long-awaited judgement endorsing the legality of assisted suicide. It ruled that a 2015 law banning suicide with professional assistance – 'business-like facilitation' Dignitas-style – was unconstitutional, as it deprived terminally-ill patients of 'the right to a self-determined death'. The move is deeply controversial given Germany's record of human rights' abuses under the Nazi regime.

The existing law, Paragraph 217 of Germany's Criminal Code, was passed in 2015 to stop people from offering the kind of assisted suicide service that is legal in neighbouring Switzerland. The Government now says it needs to study the ruling before redrafting the legislation. The Court has conceded that some restrictions are still possible – as long as 'sufficient space remains for the individual to exercise their right to a self-determined death and to pursue and carry out the decision to end their life on their own terms.' As one observer summarised it, in Germany now 'everyone has the right to [assisted] suicide, regardless of age and illness.' So, its highest Court has not only decriminalised assisted suicide; it has described suicide as a fundamental human right. And because most German doctors oppose it, there is obviously a legitimate need for commercial suicide-assistance services.

This is even more radical than legislation in Belgium and the Netherlands, where patients are supposed to be terminally ill. In Germany any reason will be sufficient – fear of illness or old age, romantic disappointments, professional failure, or just the feeling that life is no longer interesting.

The Court's press release stated that suicide '... must, in principle, be respected by state and society as an act of autonomous self-determination.' This notion, the Court said is consistent with the European Convention on Human Rights and decisions by the European Court of Human Rights. The German Court continued, 'The right to a self-determined death is not limited to situations defined by external causes like serious or incurable illnesses, nor does it only apply in certain stages of life or illness.' And, 'This right is guaranteed in all stages of a person's existence. The self-determined act of ending one's life is a direct, albeit final, expression of the pursuit of personal autonomy inherent in human dignity.' In other words, autonomy is more important than life itself.

This is a serious paradigm shift in West European bioethical thinking and practice. While there is no consensus across Europe on this issue, the Bundesverfassungsgericht's decision will be a powerful influence on the judiciaries in other countries. It is an astonishing capitulation to extreme libertarianism.

Protestant and Roman Catholic churches in Germany have united against the ruling and issued a joint statement. It said, 'We fear that allowing organised services for suicide could subtly place old or ill people under pressure. The more natural and accessible options for assisted suicide become, the greater the danger that people in an extremely desperate situation will feel internally or externally pressurised … to put an end to their own lives.' Das ist so wahr!

## Genetic Engineering

**Improved CRISPR-Cas9 genome-editing system**

Conventional CRISPR systems include an enzyme called Cas9, which recognizes and cuts a target stretch of DNA – it is the 'molecular scissors'. To edit DNA sequences, the Cas9 enzyme must first detect a short genetic sequence, called a protospacer-adjacent motif (PAM), embedded in the target DNA. The most commonly-used Cas9 variant does not work properly unless it detects a PAM that has a chemical makeup known as NGG.

Now Benjamin Kleinstiver and his colleagues at Harvard Medical School in Boston, Massachusetts, report that they have engineered Cas9 enzymes (named SpG and SpRY) that can recognize a wide variety of PAMs, not just the NGG sequence. The authors used their new enzymes to edit the genomes of human cells in a laboratory, targeting many previously inaccessible regions of the genome. This updated, improved system

could aid the correction of mutations associated with conditions, such as heart disease, type 2 diabetes, osteoporosis and chronic pain.

The work is reported as, ‘Unconstrained genome targeting with near-PAMless engineered CRISPR-Cas9 variants’ by R T Walton *et al*., in *Science* (2020, **368**: 290-296).

**CRISPR-edited cells safe in humans**

The first human phase 1 clinical trial of cells modified with CRISPR gene-editing technology appears to be generally safe and lasting.

A team led by You Lu at the West China Hospital in Chengdu took immune system T cells from people with aggressive lung cancer and applied CRISPR to them to disable a gene called *PD-1*. Usually, this gene’s product, PD-1 protein, sends signals that keep immune cells from mounting an attack against the body’s own tissues, but active *PD-1* can open the door to the spread of cancer. In other words, knocking out *PD-1* on T cells should confer antitumour activity against the lung cancer.

The team injected each of the study’s participants with edited versions of their own T cells. Participants experienced only mild to moderate side effects, and potentially dangerous off-target mutations caused by gene editing – the researcher’s main fear – were limited.

This preliminary trial was significant, but also inevitably limited. The modified cells remained in the blood for about 4 weeks, showing that the strategy could possibly have a prolonged effect. And the trial involved only 12 people with cancer, and it did not lengthen the participants’ lives.

The work is reported as, ‘Safety and feasibility of CRISPR-edited T cells in patients with refractory non-small-cell lung cancer’ by You Lu *et al*., in *Nature Medicine* (2020, **26**: 732-740).

## Miscellaneous

**Coronavirus and bioethics**

Anyone and everyone seemingly has something to say about coronavirus. Whatever. But let no-one underestimate the global devastation caused by this wretched little virus – this invisible enemy with the strain name of severe acute respiratory syndrome coronavirus 2 (or SARS-CoV-2), which causes the coronavirus disease 2019 (or COVID-19). And the costs of this pandemic are mounting. Currently they include unexpected deaths, loss of jobs, family separations, doubting scientists, dishonest politicians, conspiracy theorists, business collapses, government U-turns, failed targets, disrupted education, food shortages, pulpit proclamations and so much more. It’s enough to make the head ache and the heart faint. The future costs will be even larger and largely unknown. A long-lasting global recession is talked of, and, without an effective vaccine, COVID-19 may be with us, wreaking havoc, for many years to come.

Moreover, apart from the dire daily death data, the talk has mostly been about scientific and medical issues – the r values, social distancing, testing, tracking, tracing, vaccines, drug treatments, and so on. But what about bioethical issues and coronavirus? Not much of that from the media and the policymakers. Even so, there is a connection, albeit, largely overlooked. Take four such topics.

First – truthfulness and transparency. These are the proper marks of decent government. Anyone who has watched the daily TV updates from 10 Downing Street will know the failures on both of these counts. Misinformation, fake numbers and an uneasy, affected bonhomie have been their characteristics. How many people have been tracked and traced? What about ibuprofen as treatment? What about 1-metre social distancing? Has the Joint Biosecurity Centre been established? How many tests have been completed? Have care home residents been neglected? Just watch those scientists and politicians squirm. Come on men (and women), tell the truth.

Second – resources. When medical resources are overstretched, as they undoubtedly have been, how is patient care to be allocated? In crude terms, who gets access to that last ventilator? The previously-healthy 45-year-old man, or the 90-year-old lady with Parkinson's from the local care home? Not all patients are equal. Or should the worst off have priority? Who decides? On what grounds? Are we really 'all in this together'? When push comes to shove are we, disappointingly, all pragmatists? Can money buy not just face masks, but also a jump up the queue? Is there a proper pecking order – me, family, church, neighbour, stranger?

Third – assisted suicide and euthanasia. What affect will the pandemic have on the debate around these issues? If COVID-19 brings on unexpected deaths and tidies up the numbers of long-term sick, surely that is a decent and positive outcome? After all, what's wrong with survival of the fittest? Are we not really all utilitarians at heart? And should there be a 'duty to die'?

Fourth – vaccines. They are heralded as the way out of this crisis, the ultimate 'exit strategy'. Yet some past vaccines have been created using cells from (either recent or historic) aborted human embryos and foetuses. Will ethical COVID-19 vaccines be produced and widely available? We should be told. And if only unethically-derived vaccine is available, are we morally obliged to use it, not only for our own safety but, importantly, for that of others? Or is that just a convenient consequentialist argument? And are vaccine trials acceptable, giving placebos alongside unfamiliar medicines of unknown efficacy? When biology conflicts with social justice, what are we to do?

These are four issues and questions, and there are several more, mostly unasked and unanswered. See, awkward bioethics creeps in everywhere. After 2,000 years under the combined sway of the wholesome Judaeo-Christian doctrines and the Hippocratic Oath, medical ethics and practice, and us, have drifted way off course. For human life to thrive, it is more than a matter of technology and money, deep bioethical thinking and practice are also required to ensure that everyone is valued and protected. What about the disadvantaged and the vulnerable? What has happened to freedom, fairness and public health? Is bluster, obscurity and self-interest really the way to handle a pandemic? Oh, for some global, truthful, bioethical leadership.

### Anosmia and ageusia

The COVID-19 pandemic has taught us these two new words, unless, of course, you are already some sort of New Testament Greek scholar. While a new and continuous cough and a high temperature have long been recognised as possible symptoms of COVID-19, a loss of smell (anosmia) or taste (ageusia) were added to the list much later by the UK Government.

Lots of respiratory viruses can cause problems with smell receptors. And in, for example, South Korea, where testing for COVID-19 has been extensive, 30% of patients testing positive have presented with anosmia as their major symptom in otherwise mild cases. However, the onset of the hay fever season may well confuse such diagnoses. Maybe using perfumed soap should be the order of the day for those frequent hand-washing sessions. Warning – do not try eating it to test for ageusia.

## Stem-cell Technologies

### Stem cells and Parkinson's

The idea of repairing the brain by replacing the neurons that die in Parkinson's disease has been a long-standing dream for stem-cell researchers. Over several decades many cell types have been suggested as candidates. These include cells from the midbrain of aborted human foetuses and human embryonic stem cells, neither of which are bioethically acceptable to many. Therefore there is particular interest in any treatment using adult or induced pluripotent stem cells (iPSCs). Here is one such.

A team of investigators from the McLean and the Massachusetts General Hospitals has reported remarkable results in a recent issue of the *New England Journal of Medicine*. The article entitled,


affinity
gospel churches in partnership

‘Personalized iPSC-Derived Dopamine Progenitor Cells for Parkinson’s Disease’ is by J S Schweitzer *et al*., *NEJM*, (2020, **382**: 1926-1932).

The researchers reprogrammed a 69-year-old Parkinson’s patient’s skin cells to induced pluripotent stem cells (iPSCs), then differentiated them into dopaminergic progenitor cells and transferred them (six months apart) into the left and right hemispheres of the brain of the patient. The idea is that the cells will implant and release the neurotransmitter dopamine, which is lacking in Parkinson’s patients.

The patient reported an improvement in his quality of life. Routine activities, such as tying his shoes, walking with an improved stride, and speaking with a clearer voice, have become possible again. Kwang-Soo Kim, the team leader, said, ‘Because the cells come from the patient, they are readily available and can be reprogrammed in such a way that they are not rejected on implantation. This represents a milestone in ‘personalised medicine’ for Parkinson’s.’

Maybe. But they are results from only a single patient. And there are other peripheral problems. For a start, the patient, Dr George Lopez, helped fund the research. Would this have distorted his and the team’s judgements? Is the patient above the science? Should a wealthy patient jump the queue? A proper clinical trial is called for.

**Good news for fatties and baldies**

Stem cells derived from fat can lead to hair regrowth for people with a common type of baldness, namely, androgenetic alopecia (AGA). South Korean researchers showed that the use of extracts of fat tissue – termed adipose-derived stem-cell constituent extract (ADSC-CE) – increased both hair thickness and density in patients. A double whammy for the obese and receding.

Dr Sang Lee from Pusan National University Yangsan Hospital and his colleagues conducted a randomised, placebo-controlled trial in middle-aged men and women to explore the effects and safety of ADSC-CE in AGA.

First, the team disrupted the membrane of stem cells found in fat tissues using a low-frequency ultrasound wave and enriched the secreted stem cells with protein. They recruited 38 patients – 29 men and nine women – with AGA for the clinical trial. One half of the patients applied the ADSC-CE lotion, twice daily, to their scalp with their fingers, and the other applied a placebo solution. After 16 weeks, the group that used the ADSC-CE lotion showed a significant increase in hair density of 28.1% in comparison to 7.1% in the control group, and also hair thickness with 14.2% greater in comparison to 6.3% in the control group. No side effects were recorded.

The research has been published as, ‘A randomized, double-blind, vehicle-controlled clinical study of hair regeneration using adipose-derived stem cell constituent extract in androgenetic alopecia’ by Young Jin Tak *et al*., in *Stem Cells Translational Medicine* (18 May 2020).

## USA and Elsewhere

**The race to the White House**

It will certainly be on Tuesday 3 November. And the winner will definitely be the 46th incumbent of the White House. And now we know it will either be the 74-year-old, Presbyterian, businessman, Donald Trump, or the 77-year-old Roman Catholic, lifetime politician, Joseph Biden unless, of course…. What a choice – the Republican Twitter bully *vs*. the gaffe-ridden Democrat. And bioethically they are oceans apart. On bioethical issues there is no contest. Trump has steered his administration in a positively pro-life direction, like no other previous president. By contrast, Biden is a pro-choice extremist, wanting *Roe vs. Wade* as federal law, abortion up to birth and the restoration of federal funding for Planned Parenthood. Then there is the no-small matter of choosing running mates, potential vice-Presidents. Will Trump again pick the thoroughly pro-life Mike Pence? Will Biden pick the thoroughly pro-abortion Elizabeth Warren, or Kamala Harris, or even Michelle Obama?

Not long ago, this 2020 election looked as if the defining issue would be the value and protection of human life, especially unborn human life. Now it looks as if tackling the coronavirus pandemic and the planned return to normal life and the recovery of the economy will be centre stage. Or will racism trump all other issues?

**Overturning *Roe vs. Wade***

The repeal of the 1973 *Roe vs. Wade* case is still the major aim of pro-life supporters in the USA. Apart from Justice Clarence Thomas, it is not generally known where the other eight members of the Supreme Court of the United Sates (SCOTUS) stand on overturning *Roe*. Hints are emerging. For example, their support for overturning legal precedent, known as *stare decisis*, and Justice Kavanaugh's recent decision citing the overturning of abortion precedent as one instance where the SCOTUS can go, and has gone, back on *Roe*, is an encouraging sign showing that the conservative Justices on the SCOTUS are open to reversing precedent and abortion precedent in particular.

There are nine members of the SCOTUS. Most observers believe there are from 3 to 5 votes in favour of repealing *Roe*, with Justice Thomas firmly in support. Justices Kavanaugh, Gorsuch and Alito are also likely to support reversal while Chief Justice Roberts is a 'maybe'. Some pro-life legal scholars think it would be helpful to replace one of the four pro-abortion liberal Justices with another conservative to make it even more likely that there are enough votes to overturn *Roe*. The only way to accomplish this is to secure a second term for President Donald Trump to have another four years enabling him to appoint more pro-life Justices and so move the Court away from its current abortion-on-demand ethos.

**Louisiana law challenge**

Could this be it? It has been a long time coming, but on Wednesday 4 March, the Supreme Court of the United States (SCOTUS) heard oral arguments in the most high-profile abortion rights case in decades. Some have heralded it as 'The beginning of the end for *Roe*.'

In a case known as *June Medical Services vs. Russo*, the nine SCOTUS Justices heard arguments on whether Louisiana can impose restrictions on abortion doctors. The 2014 Louisiana law at the centre of the case requires abortion providers to have 'active admitting privileges' at local hospitals in order to treat patients with emergency complications should an abortion go seriously wrong. The fundamental question was this, does the imposition of these safety requirements violate a woman's access to abortion?

This current case is considered by the prosecution to be about legal precedent. Just four years ago, the SCOTUS ruled that a Texas case, known as *Whole Woman's Health vs. Hellerstedt*, was unconstitutional because 'admitting privileges' were seldom granted and rarely used and created obstacles for women to access abortion, a constitutional right established by *Roe vs. Wade*. The Louisiana law at issue here is the Louisiana Unsafe Abortion Protection Act (Act 620). It is similar to that Texas case. If upheld, the law would leave Louisiana with just one clinic and one doctor, who already has admitting privileges, to perform the 10,000 or so abortions that Louisianan women procure each year.

This is the first abortion-related case to be heard by both Justices Neil Gorsuch and Brett Kavanaugh, two recently-appointed Justices, who are considered conservative and thus give the SCOTUS a conservative majority. Some abortion rights advocates believe the Court's majority may grant the opportunity from this case to overturn *Roe vs. Wade*. The Louisiana judgement will be announced at a date yet to be decided, though it is expected to be before the end of the 2019-20 term.

*John Ling*

*(A fuller version of John's regular update of bioethical news and views can be found at www.johnling.co.uk)*

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