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KAMRA TAD-DEPUTATI

KUMITAT PERMANENTI DWAR L-AFFARIJIET SOĊJALI

(Rapport Uffiċjali u Rivedut)

L-GĦAXAR PARLAMENT

Laqgħa Nru. 40

It-Tnejn, 6 ta' Ġunju, 2005

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Talba

MINUTI

Il-Minuti tal-Laqgħa Nru. 39 li saret fl-1 ta' Ġunju, 2005 ġew konfermati.

IL-BIOTEKNOLOĠIJA F'MALTA U D-DRITTIJIET TAL-BNIEDEM - KONTINWAZZJONI

Il-Kumitat irriżuma mit-23 ta' Mejju, 2005 id-diskussjoni fuq dan is-suġġett.

THE CHAIRMAN (Onor. Clyde Puli): Illum se nkomplu bid-diskussjoni dwar il-bioteknoloġija f'Malta u d-drittijiet tal-bniedem u għandna preżentazzjoni mill-Kummissjoni Nazzjonali għall-Promozzjoni ta' l-Ugwaljanza għall-Irġiel u n-Nisa (NCPE) u preżentazzjoni minn Dr Simon Attard Montalto. Għalhekk nsejjaħ lil Dr Janet Mifsud biex f'isem l-NCPE tagħmel il-preżentazzjoni li ħejjewlna.

DR. JANET MIFSUD (Commissioner – NCPE): Jiena Dr. Janet Mifsud, Kummissarju tal-Kummissjoni Nazzjonali għall-Ugwaljanza. Meigħi hawn Dr. Miriam Camilleri, membru fil-kummissjoni u Ms Sina Bugeja li hija l-*Executive Director* tal-kummissjoni. Il-membri l-oħra tal-kummissjoni li m'humiex preżenti huma Ms. Grace Attard, Is-Sur Wistin J. Zahra, Dr. Myriam Spiteri Debono, is-Sur Mario Mallia u Fr. Vanni Xuereb.

Nixtieq ngħid li d-dokument li ħejjejna huwa wieħed unanimu. Jiġifieri se nitkellem jien, u forsi jitkellmu sħabi, imma d-dokument ġie ppreparat mill-kummissjoni.

Nibda billi nispjega x'inhi l-pożizzjoni tal-kummissjoni in ġenerali fuq il-bioetika. Hemm avvanzi kbar kemm fil-qasam tar-riċerka fuq in-naħa tax-xjenza, kemm fit-teknoloġika medika kif ukoll fil-qasam is-saħħa. Dawn qed iqajmu ħafna mistoqsijiet etiċi mhux biss mal-professjonisti iżda wkoll mal-pubbliku in ġenerali. Kull persuna jinteressaha fejn tidħol is-saħħa u l-mediċina għaliex huwa hija importanti naraw kif is-saħħa tista` tinżamm b'mod etiku u f'ambjent etiku wkoll. Il-bioetika hija ambjent partikolarment diffiċli għaliex tikkonċerna ftit mill-iktar problemi li niltaqgħu magħhom kuljum u ċioe` x'inhi l-ħajja, x'inhi l-mewt, il-valur tal-ħajja, id-dritt tal-ħajja fuq il-mewt, x'inhu li wieħed joqtol, kif għandna nittrattaw persuni li huma vulnerabbli u f'ċirkostanzi fejn hemm it-tbatija x'responsabbiltajiet għandna fuqhom, id-drittijiet reproduttivi kif ukoll x'inhu assolut kontra dak li hu relattiv.

L-iktar prinċipju fundamentali fil-bioetika huwa li kulmin hu involut fit-trattament ta' xi mard l-ewwel dover tiegħu huwa lejn il-pazjent, sew jekk inhu individwu u sew jekk hi l-komunita` in ġenerali. Importanti li niftakru li fit-trattament mhux tobba biss hemm, imma hemm ukoll dawk li ngħidulhom *health care professionals* (HCPs), riċerkaturi u xjentisti li jkunu għamlu ħafna xogħol biex dan it-trattament jiġi għal *person's bedside*.

Dan kollu jrid jitqies bħala kuntest li l-mard għandu jiġi miżjud bħala kondizzjoni fejn persuna mhux biss qed issejjaħ it-trattament iżda wkoll għal pariri għax ħafna drabi jiġu pazjenti għall-pariri. Il-mard għandu ħafna oqsma, fosthom hemm dak bioloġiku, hemm ukoll mard strutturali, funzjonali, mentali jew *behavioural disorder*.

Importanti wkoll li nsemmu l-*hippocratic oath* li t-tobba jieħdu eżatt kif jiggradwaw bħala tobba li jgħid hekk:-

> "*I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice*".

Imma importanti wkoll li niftakru li kien hemm *physician* Ċiniż li qal li l-obbligi għandhom ikunu mhux biss min-naħa ta' dak li qed jikkura imma wkoll min-naħa tal-pazjenti. It-tobba għandhom ikunu umani u għandhom jagħmlu *effort* kbir biex jassistu lill-pazjenti, imma l-pazjenti għandhom ukoll

huma stess jagħżlu t-tobba li jiddeċiedu li jmorru għandhom għall-pariri.

It-teknoloġija qed tavvanza radikalment. Iżda importanti wkoll li naraw li l-bioetika mhijiex xi ħaġa indipendenti. Irridu nħarsu lejn id-diskussjonijiet etiċi u ċivili. Hawnhekk fil-fatt inħaffar dan il-kumitat talli qed jagħmel dan ix-xogħol siewi. Imma bħala kummissjoni inħosu li sfortunatament id-diskussjoni waqfet biss fuq is-suġġett tal-fertilita` u fuq ir-riproduzzjoni. Il-qasam tal-bioetika tolqot kull qasam mediku fejn tidħol il-mediċina u wieħed irid jitkellem fuq x'inhi r-riċerka, affarijiet bħal DNA *banking*, *clinical trials*, *euthenisia*, *informed consent* u *data protection* li sfortunament baqgħu barra mid-diskussjoni.

Li se nirrikkmandaw aħna bħala NCPE huwa li importanti li d-diskussjoni, anke meta tieqaf minn dan l-istadju, tibqa' ssir u tibqa' kontinwa għaliex ir-riċerka u x-xjenza dejjem tavvanza 'l quddiem.

L-edukazzjoni hija importanti ħafna wkoll għal dawk il-professjonisti li qed jaħdmu f'dan il-qasam u anke għall-istudenti kollha. Għandu jkun hemm konferenzi nazzjonali regolarment biex niddiskutu *updates* għax dak li qed nagħmlu llum fi ftit żmien ieħor jiġi *outdated*. Il-kumitat konsultattiv tal-bioetika għamel ħafna xogħol f'dawn l-aħħar ftit jiem imma forsi ma wasalx fejn kellu jasal. Importanti wkoll li dawn il-kumitati li qed jitwaqqfu b'liġi jħarsu wkoll lejn kumitati l-oħra li qed jitwaqqfu u li għandhom x'jaqsmu mal-qasam tal-bioetika, bħal dawk li hemm fid-dipartiment tas-saħħa, l-awtorita' tal-mediċini kif ukoll l-universita'.

THE CHAIRMAN: Qabel xejn tajjeb li niċċara xi ħaġa għax intom semmejtu xi affarijiet li għedtu li baqgħu barra mid-diskussjoni. Aħna xtaqna li din id-diskussjoni tikkonċentra iktar, għalkemm hija b'mod ġenerali dwar l-użu tal-bioteknoloġija, fuq il-prokreazzjoni assisti u t-teknoloġija ġenetika, anke minħabba li dan huwa suġġett li tista` tgħid ma jispiċċa qatt. Jiġifieri xtaqna li nikkonċentraw fuq xi ħaġa. Jiġifieri l-fatt li l-*euthanasia* mhux qiegħda fuq l-aġenda tagħna ma jfissirx li m'hijiex importanti, imma proprjament biex aħna nkunu nistgħu nikkonċentraw fuq xi ħaġa, u aktar milli nagħmlu sempliċement *hearings*, finalment noħorġu xi ħaġa pożittiva li jkunu rakkmandazzjonijiet mill-parlament, u l-gvern Malti jkun jista' jimxi dwar liġi jew inkella mod ieħor.

Intom bħala NCPE ovvjament titkellmu fuq diskriminazzjoni għalhekk xtaqt, per eżempju, nisma' x'taħsbu intom rigward it-teknoloġija ġenetika *vis-à-vis* il-persuni b'diżabilita'.

DR. JANET MIFSUD: Li nixtieq ngħid hu li r-*remit* tagħna bħala kummissjoni għalissa hu li tieqaf u tisma` r-relazzjonijiet bejn l-irġiel u n-nisa. Jiġifieri forom oħra ta' diskriminazzjoni aħna ma nidħlux fihom u ma naħsibx li għandi r- *remit* li nitkellmu fuq dawn l-affarijiet.

THE CHAIRMAN: Jiġifieri ma ddiskutejtuhomx intom, qgħadtu strettament mar-*remit* tagħkom biss.

DR. JANET MIFSUD: Hekk hu, bqajna biss mar-*remit* tagħna skond il-liġi għax allavoja aħna bħala membri, kif semmejt qabel, ġejjin minn ħafna oqsma differenti, ma naħsibx li għandna nidħlu f'affarijiet li m'huwiex fir-*remit* tagħna. Aħna naħsbu li hemm professjonisti, persuni li huma kwalifikati iktar minna biex jitkellmu fuq dan is-suġġett.

THE CHAIRMAN: Iddiskutejtu jekk tkunx diskriminazzjoni li l-prokreazzjoni assistita tingħata biss lil koppji miżżewġa jew inkella …… (Interruzzjonijiet)

DR. JANET MIFSUD: Aħna rrispondejna għad-domandi tal-kwetjonarju li bagħttulna u għaddejnielkom kopja tiegħu. Għall-ewwel mistoqsija li kienet tgħid jekk naqblux li għandu jkun hemm liġi li tirregola r-riproduzzjoni assistita, aħna għedna li naqblu,

pero` xtaqna li t-terminu “riproduzzjoni assistita” tkun definita biex id-diskussjoni tkun aktar fokata u ċara. Għall-mistoqsija jekk naqblux li għandu jkun hemm liġi li tirregola aspetti oħra tal-bioteknoloġija, per eżempju, testijiet ġeneriċi u riċerka ġenetika, għedna li naqblu. Jekk naqblux li l-liġi għandha tistabbilixxi l-parametri kollha li huma involuti, per eżempju, kemm-il embrijun tista’ tikkrea f’kull ċiklu għaedna li naqblu wkoll. Jekk naqblux li l-liġi għandha tkun waħda bażika u li l-parametri jiġu stabbiliti minn regolamentazzjonijiet li joħorġu perijodikament irrispondejna li naqblu.

THE CHAIRMAN: L-Onor. Gonzi.

ONOR. MICHAEL GONZI: Allura l-fatt li ma poġġejtux kummenti wara l-oħrajn, ifisser li taqblu magħhom.

DR. JANET MIFSUD: Aħna, bħala kummissjoni, ma nħossx li għandna *remit* xjentifiku biex nidħlu kemm huwa vijabbli jew le. Warajna se jitkellem espert f’dan il-qasam, u ma naħsibx li aħna bħala kummissjoni għandna *remit* xjentifiku għaliex kif semmejt qabel ir-riċerka għadha qed tiżviluppa…. (Interrruzzjonijiet)

THE CHAIRMAN: Ħalli nagħmluha ċara. Id-domanda m’hijiex biss xjentifika. Jiġifieri naħseb nagħmlu ħażin jekk inħarsu lejha min-naħa tax-xjenza. Id-domanda hija legali, xjentifika, filosofika u anke politika. Magħkom għaddejjin bħala parti mill-proċess ta’ konsultazzjoni. Imma minn Dr Simon Attard Montalto nippretendi verżjoni daqsxejn xjentifika.

DR. JANET MIFSUD: Ħalli nkompli ngħid kif irrispondejna għall-kwestjonarju. Għad-domanda jekk naqblux li l-liġi għandha tkun waħda bażika u li l-parametri jiġu stabbiliti minn awtorita` regolatorja, għedna li, iva, naqblu. Jekk naqblux li fir-regolamentazzjoni dwar l-użu tal-bioteknoloġija għandux jibqa` kollox kif inhu llum, irispondejna li ma nqablux. Għall-mistoqsija jekk naqblux li r-riproduzzjoni assistita għandha tkun permessa għall-koppji miżżewġa biss, i.e. biċ-ċivil u jew biċ-ċivil u l-knisja għedna li naqblu. U fil-kolonna “Kummenti oħra” għedna li għandha tiġi applikata proċeduri bħal ta’ l-adozzjoni.

THE CHAIRMAN: Imma x’jiġifieri. Nixtieqek li telabora fuq din. L-ewwelnett s’issa diġa’ wasalna hawnhekk li l-kwestjoni ta’ l-adozzjoni mhux eżattament bħar-riproduzzjoni assistita għaliex l-adozzjoni diġa’ għandek il-wild li qiegħed hemmhekk. Din il-kwestjoni se jiġi kreat xi ħadd, biex inpoġġiha b’dak il-mod. Nixtieqek tiċċara ftit fuq il-kwalifika. Id-domanda hawnhekk qiegħda jekk taqblux li r-riproduzzjoni assista għandha tkun permessa għal koppji miżewġa biss, jiġifieri biċ-ċivil jew biċ-ċivil bil-knisja, jiġifieri żwieġ li huwa magħruf finalment, jew inkella anke għall-koppji stabbli.

DR. JANET MIFSUD: Hekk kienet…. (Interruzzjonijiet)

THE CHAIRMAN: Intom taħsbu li għandha tibqa’ fiż-żwieġ.

DR. JANET MIFSUD: Għall-mistoqsija jekk naqblux li r-riproduzzjoni assistita għandha tkun permessa għall-koppji omosesswali għedna li ma naqblux. Jekk naqblux li r-riproduzzjoni assistita għandha tiġi regolata minn awtorita’ awtonoma minflok id-dipartiment tas-saħħa, u jekk ir-risposta tkun affermattiva spjega għaliex irrispondejna li naqblu għax naħsbu li jista’ jkun hemm konflitt ta’ interess bħala *provider* servizz simili, imma madankollu nifhmu li l-*health services act* l-ġdida diġa` taqsam bejn provvediment ta’ servizz u regolatur. Dan jisat` jsir mill-istess regolatur.

DR. MIRIAM CAMILLERI: Mhux eżatt. Jekk meta tgħaddi l-*health services act* il-ġdida se jkun hemm l-i*split* bejn il-*provider* u r-*regulator* ma narawx għal xiex m’għandux jkun ir-*regulator* jirregolaha. Imma jekk jibqa` kollox kif inhi llum irid ikun differenza. Jekk inti qed tipprovdi s-servizz

ma jistax ikun li tirregolah inti stess f'xi ħaġa sensittiva bħal din.

DR. JANET MIFSUD: Anzi aħjar ir-*regulator* ikun *independent* mill-*provider.*

THE CHAIRMAN: Intom assumejtu mill-ewwel li l-gvern se jagħti s-servizzi ….. (Interruzzjonijiet)

DR. JANET MIFSUD: Le.

DR. MIRIAM CAMILLERI: Imma dik hija irrelevanti.

THE CHAIRMAN: F'dan il-każ il-gvern sal-lum għadu mhux *service provider,* jew *very* ….…… (Interruzzjonijiet)

DR. MIRIAM CAMILLERI: Imma xorta huwa *service provider* tal-*health services.* Issa jekk fuq *assisted fertilisation* il-gvern xorta għandu jirregola bħalma suppost jirregola l-*private hospital,* jirregola f'dak is-sens.

DR. JANET MIFSUD: Dwar jekk naqblux jekk għandux ikun hemm limitu restrittiv dwar il-massimu ta' kemm jiġu kkreati zigoti f'kull ċiklu għedna li naqblu. Għall-mistoqsija jekk naqblux li l-embrijuni kollha kkreati għandhom jiġi impjantati kollha fil-mara fl-istess ħin għedna li naqblu, pero dan in-numru għandu jkun dak li skond in-normi tal-mediċina tal-lum jitqies bħala numru ta' embrijuni li huma *normally viable* fi tqala waħda. Imbagħad kien hemm il-mistoqsija jekk naqblux li għandhom jiġu kkreati embrijuni żejda biex jiġu ffriżati għal użu iktar tard li għaliha rrispondejna li ma naqblux. Għall-mistoqsija jekk naqblux li embrijuni li ġew iffriżati u li ma jkunux użati għandhom jitħallew imutu mewta naturali rrispondejna b'mistoqsija oħra u ċioe`, kif inhu possibbli għall-embrijuni li jmutu mewta naturali meta huma ffirżati.

THE CHAIRMAN: Kien hawn min għamlu dan l-argument. Mewta naturali kulma tagħmel huwa li titfi l-friża.

DR. JANET MIFSUD: Iva, imma *if you thaw them it is not a natural death. You don't die by being thawed off* ….(Interruzzjonijiet)

THE CHAIRMAN: Kien hawn min filosofikament ma qabilx.

DR. JANET MIFSUD: Għall-mistoqsija jekk naqblux ma' donazzjoni ta' gameti minn persuni barra l-koppja li qed tirrikorri għat-trattament irrispondejna li ma naqblux Għall-mistoqsija dwar *surrogate motherhood* għal nisa li għandhom problemi fiżiċi li ma jippermettiliex twasal tqal għat-tmiem weġibna li ma naqblux. Irrispondejna li naqblu li għandu jsir testjar ġenetiku fuq gameti sabiex jiġi evitat it-trasmissjoni ta' mard ġenetiku mill-ġenituri, imma ma naqblux jekk it-testjar isir biex jintagħżel is-sess tat-tarbija. Dik hija *qualified,* għax jista' jkun li jintagħżlu l-i*sperms* biex jiddeċiedu jekk hux se jkollhom *boy or girl.*

THE CHAIRMAN: U jekk is-sess tat-tarbija jkun jista' jsalva lil xi ħadd minn xi marda tibqgħu ssostnu l-punt tagħkom minkejja li l-*Oviedo Convention* hija kontra dan li qed tgħidu intom?

DR. JANET MIFSUD: Iva. Għall-mistoqsija jekk naqblux li għandu jsir testjar fuq embrijuni qabel l-impjantazzjoni sabiex jingħażlu dawk l-aktar ġenetikament f'saħħithom weġinba li ma naqblux, għall-mistoqsija jekk naqblux ma' testijiet ġenetiċi waqt it-tqala rrispondejna li naqblu sakemm dawn ma jkunux ta' ħsara għat-tarbija jew għall-omm, iżda żgur ma naqblux jekk dawn isiru sabiex jagħtu parir jew għal xi abort jew għal skopijiet ta' riċerka biss.

DR. MIRIAM CAMILLERI: Din il-*question* hija miftuħa ħafna. *We don't know what you mean by genetic testing.* Jiġifieri sakemm ikun *safe to the unborn child and safe to the mother,* jiġfieri mhux qed isir għal riċerka jew qed isir bi skop biex jgħin lit-tarbija jew lill-omm jew lit-tnejn f'daqqa…. (Interruzzjonijiet)

DR. JANET MIFSUD: Dwar il-kumitat konsultattiv tal-bioetika naqblu li għandu jsir statutorju. Jista' jkun li l-kumitat ukoll għandu jiġi trasformat f'awtorita` regolatorja u naqblu li Malta għandha tiffirma fil-konvenzjoni ta' Oviedo.

Fl-aħħarnett irrid ngħid li r-riproduzzjoni assistita ma tfissirx IVF biss. Id-diskussjoni għandha tifetaħ aktar għal suġġetti. Dan is-suġġett jinkludi wkoll *DNA testing* u *DNA banking* fost oħrajn. Għalhekk il-mistoqsijiet f'dan il-kwestjonarju huma limitati ħafna għal suġġett vast dan.

THE CHAIRMAN: Imma hemm xi forma ta' riproduzzjoni assistita li intom ma taqblux magħha, meta qed titolbu li għandu jkun hemm *definition* aktar iffokata?

DR. MIRIAM CAMILLERI: Jiddependi x'se tgħidu intom.

THE CHAIRMAN: Aħna ħallejniha *open* apposta biex jekk inti għandek xi riserva għal xi ħaġa tgħidilna inti. Jiġifieri stajt għedtli: Jekk qed tifhem biha *cloning* ukoll, ngħidlek le.

DR. JANET MIFSUD: Aħna t-tlieta li hawn hawnhekk inzertajna tabib, spiżjara u *nurse* u nafu li hemm ħafna modi ta' riproduzzjoni assistita, imma bħala kummissjoni aħna ma ddiskutejnihiex. Ma naħsibx li huwa remit tagħna bħala kummissjoni li nidħlu f'oqsma xjentifiċi bħal dawn.

THE CHAIRMAN: Hawn iktar domandi?

ONOR. FREDERICK AZZOPARDI: Meta għedtu li xtaqu li t-terminu "riproduzzjoni assistita" tkun definita aħjar, x'kien il-ħsieb tagħkom?

MS. SINA BUGEJA: Meta inti m'għandekx id-definizzjoni eżatta ta' x'qed jiġi diskuss, jien nista' ngħidlek iva fuq dak li qed nifhem jien, pero' għalik ifisser ħafna iktar għaliex limitata b'dak li naf li inti għandek ħsieb f'moħħok. Jiġifieri aħna qegħdin ngħidu li sakemm qegħdin niddefenixxu riproduzzjoni assistita *equals IVF*, u aħna nafu li d-definizzjoni hija ħafna iktar wiesgħa' minn hekk, sakemm qed inwaqqfuha fuq IVF, dawn huma r-risposti tagħna.

THE CHAIRMAN: M'aħniex qed nitkellmu fuq IVF biss, imma fuq kollox. L-IVF l-iktar wieħed li qajjem kontroversja.

MS. SINA BUGEJA: Iva, imma jekk għall-iva tagħna qed indaħħlu l-*cloning*, imbagħad tinbidel il-pożizzjoni kollha. Pero' kif diġa' qalet Dr. Janet Mifsud din ma ġietx diskussa bħala kummissjoni. L-*understanding* tagħna kien fuq dan il-limitu għaliex id-definizzjonijiet huma ħafna importanti, huma l-i*starting point* tad-diskussjoni kollha.

THE CHAIRMAN: Dan huwa l-isem ġenerali ta' kollox. (Interruzzjonijiet)

DR. MIRIAM CAMILLERI: Aħna nisperaw li l-liġi ma tkun biss *assisted reproduction* …. (Interruzzjonijiet)

THE CHAIRMAN: Semmejtlek il-każ tal-*cloning* għaliex huwa l-iktar wieħed ovvju. Jiġifieri għal *cloning* riproduttiv il-maġġoranza tgħid li assolutament le. Jiġifieri jekk inti kellek xi riserva stajt tgħidli: Isma', aħna naqblu ma' riproduzzjoni assistita, imma ma naqblux mat-tali ħaġa u mat-tali ħaġa.

DR. JANET MIFSUD: Imbagħad se nidħlu fl-ambjent ginekoloġiku. Jiġifieri trid *gynaecologist* biex jitkellem fuq *assisted reproduction*.

THE CHAIRMAN: Dak l-argument ma niddiskutihx hawnhekk għaliex jien assolutament m'iniex midħla f'dawn l-affarijiet, is-soċjoloġija l-linja tiegħi, jiġifieri nista' ma nitkellimx. Mhux il-każ, qed tifhem, f'dan is-sens. Ma ġara xejn. Jiġifieri jien qed nifhem li bażikament …. (Interruzzjonijiet)

DR. JANET MIFSUD: Peress li aħna *health professionals* nafu kemm hemm modi differenti, allura ħassejna li għandna nieqfu hemmhekk.

ONOR. FREDERICK AZZOPARDI: Intom għedtu li taqblu li l-embrijuni kollha kkreati għandhom jiġu impjantati fil-mara fl-istess ħin.

DR. JANET MIFSUD: Normalment il-ġisem tal-mara jista' jieħu mingħajr problemi *up to two* jew *three.*

DR. MIRIAM CAMILLERI: Aħna ħallejniha miftuħa u għedna li naqblu li dan in-numru għandu jkun dan li skond in-normi tal-mediċina sal-lum - sa mitt sena oħra forsi jkun *viable* li jkollok sitta f'daqqa u ma tkunx problema – jitqies bħala numru ta' embrijuni li huma *normally viable* fi tqala waħda. Imbagħad ħallejniha għall-*experts* li jiddeterminaw x'inhu *normally viable.* Fl-injoranza tagħna għedna forsi sa tlieta, imma mid-dehra qed jgħidu li sa tnejn.

THE CHAIRMAN: Hija diskutibbli għaliex f'San Raffaele, jekk m'iniex sejjer żball, sa erba' kienet mingħalija. (Interruzzjonijiet)

DR. MIRIAM CAMILLERI: Ifhimni, erba' twieldu, ħamsa twieldu u sitta twieldu wkoll.

DR. JANET MIFSUD: Tista' tkun *single pregnancy* U Jkollok problemi. Jiġifieri jiddependi ħafna mill-mara individwali, skond il-problemi fiżiċi tagħha, ta' l-utru, eċċ.

THE CHAIRMAN: Il-punt hu li m'għandux ikun aktar minn neċessarju.

THE CHAIRMAN: Hawn aktar domandi? Jidher li m'hawnx u għalhekk ngħaddi għall-preżentazzjoni li jmiss u nsejjaħ lil Dr Simon Attard Montalto.

DR. SIMON ATTARD MONTALTO (Chairman – Department of Paediatrics, St. Luke's Hospital): Jien se nitkellem fuq IVF u se nagħti l-pożizzjoni tiegħi pjuttost bħala individwu. Qed nitkellem bħala kap ta' dipartiment imma l-preżentazzjoni hi tiegħi.

THE CHAIRMAN: Mhux se torbot Lid-dipartiment magħha.

DR. SIMON ATTARD MONTALTO: Eżattament. Nista' ngħidilkom li bażikament kulħadd jaqbel fuq li se ngħid. Imma r-rapport ktibtu jien u l-preżentazzjoni hi tiegħi.

THE CHAIRMAN: Jiġifieri aktar milli bħala kap ta' dipartiment, se titkellem *as an expert in the field.*

DR. SIMON ATTARD MONTALTO: *In the next half hour what I'm going to try and do is just summarise what impact n vitro fertilisation has on the child. I think you've heard a lot from the obstetric side and from whatever but there is a major player in the equation, and that is the child and I think the child point of view is to be reviewed. It has been reviewed recently in the media, possible with a little bit of over height in terms of the response but we don't feel too bad that the child has been brought up. What I'm going to do is to present the child point of view from the medical aspect.*

Just a bit of background, yes, IVF does offer a viable option of conception, in any other words pregnancy for those couples who are infertile. So I don't think we would disagree with that. The success rate vary for IVF. In the USA it's about 30% at the moment, but people have quoted even up to 70% success rate. But the success rate depends very much on what you class a success rate, because if you mean that the woman becomes pregnant equal success that's fine.The problem is what is she pregnant with. Is she pregnant with one, with two or with five, and those have major impacts bearing on the on the child.

The highest success rate essentially implied there is multiple re-implantation. There is not one zygote or not one embryo but multiple embryos are re-implanted in the woman, and they depend on storage and freezing techniques which are not available locally. In other words, you fertilise a lot of embryos, re-implant a certain number will come to that again, and you can store the surplus and then use the surplus if the first lot haven't been successful, and then obviously it begs the question what to do with the surplus if they are surplus to requirements. And that's where foetus wastage comes in, at which point overseas usually they are discarded.

It's simple, I'm trying to keep it as simple as possible. If you implant one embryo and you have about 25% chance of getting the mother pregnant. If you implant three it goes up to 70%. So the more you put in the better the success rate as an IVF unit is going to be. But at the risk of multiple pregnancy. I think that the overall aim is this. We want to have good fertility treatment that ultimately delivers a healthy baby at term, i.e. 37 *weeks plus.* Jiġifieri *as close to nine months as possible without or with as little as possible negative side of complications,* kemm min-naħa ta' l-omm u kemm min-naħa tat-tarbija. *That's common sense.*

I think there are the key issues. I put them as questions and some of the answers are obvious. Is infertility a problem? The answer is yes, there is no debate without that. Does IVF address the problem? Again, the answer is yes, but it does so for only a small percentage of couples because of its availability, including costs, etc. I'm not going to go into details because I'm sure the obstetricians have given you a lot more details than I can.

Point 4 you are seeing on the slide is a point that needs to be raised. From where we sit we see couples who come to us who we do not think are unnecessarily fully or appropriately informed, and there is a problem with. I don't know if it's communication but I can appreciate the position. These are couples who are in a desperate situation. I see a lot of people who go through the adoption process, so I know what they are going through. They are probably even if they are told the potential problem with having triplets, quadruplets, etc. It may go over their head or they're not willing to hear what they're being told. So there are possible two problems. The first one is that they may not be given as realistic a picture as we would like. They are not told that if they have triplets these are the potential problems, and I come to this later. Secondly they may be told but they're really buying because ultimately they want a child, kważi *at all cost.*

The sixth point is the one I'm going to focus on. And that is what is the health impact to the child, always in the context of IVF. The ethical issues, again if the law of the land states that you cannot terminate a pregnancy, and also there are religious standards as you all know, then if you assume that a fertilised zygote is viable and can potentially become a self-sustaining individual, then anything that you do past the point of fertilisation can be construed as a termination of pregnancy. That's how I see it very simplictically. I'm sure people will debate that point of the basis that a two-cell embryo is not viable without all this support, but I mean equally you can say a 23-week gestation child is not viable with all the support that we have on the intensive care unit, etc., etc. So you can stretch the argument however you like to look at it.

Regarding embryos wastage, that basically means the surplus embryos what to do with them. Elsewhere abroad they are basically discarded. Now whether it is switching off the fridge or whatever, I think it's a mute point. The bottom line is that there are surplus to requirements and therefore they are not needed anymore.

Enhanced embryos selection comes to the point that maybe Dr Janet Mifsud was raising, with increasing and improving

genetic techniques and you can now when once you fertilise the embryos you can decide which is the best and you take the enhanced embryos, in another words the better ones and we implant those. The question of this, what do you do with the others, and they fall in the same bracket as the surplus, and therefore they are there for wastage.

Embryo reduction means that essentially you have implanted successfully a woman and all five re-implanted embryos have taken and we all know that quintuplets have an extremely high-risk of morbidity and mortally. So to reduce that risk, you then reduce the successful implants. So you convert the quintuplets uterus to a triplet uterus, for example.

I see these as all the same thing principally. You have a fertilised zygote which you are then manipulating in one way or the other to maintain a successful outcome in terms of pregnancy, but it is at the expense of you've made the embryo, if you like. There are issues, which I'm going to touch, relating to the infant morbity. I have already said that if you have triplets is it the same as having quintuplets, is it the same as having single. And hopefully I will show that is not the same at all, and it is a major parameter which needs to be taken into the equation.

This just refers to what does IVF impact on the pregnancy, in another words on the mother. There are increased complications. I do not want to stress on this because it is not my remit, but when you end up with a high order pregnancy, in other words triples, quadruplets, quintuplets, they are invariably related to premature delivery and they all can have problems. The caesarian section rate is obviously much higher. There are medical complications such as eclampsia, the blood pressure of the mother is raised during the pregnancy. Lots of studies have shown that very large families and families with twins, triplets have an increased risk of stress and depression particularly in the mother.

So there are problems which you could from a distance say that these aren't crucial problems. And I think if you address those problems to the prospective infertile couple they may well tell you: I don't have a problem with this. I don't mind if I have a caesarian section or I don' t mind if I have blood pressure, which is fair enough, and they're perfectly entitled to say that. But they need to be fully informed that that is a potential risk. I don't know if that always happened.

What about IVF and the infant. Initially I'm going to talk about what happens abroad. It is by far IVF or ART one of the major contributors to high order pregnancy. High order meaning more than twins. It's a major contributor to twins as well, but most high order pregnancies - and this doesn't just apply to UK, it also applies to Malta, and I'll come to this - are as a result of ART. So they are not a naturally occurring phenomenal. Homo sapiens in a hundred and fifty years of evolution has not designed the female uterus to cater for four, five, etc. And four, five, etc., have negative implications on the outcome of that pregnancy, and particularly of the infants concerned. If you like, in nature I won't say it's freak of nature but it's a fluke of nature to have multiple infants. So it is not something natural. So that is something we need to bear in mind. The risk of multiple infants ending up premature or born prematurely is at least twofold if you have multiple babies. It is simple mathematics.

Likewise the infants are in themselves at least twice as likely to be small for their gestational age. That means not only are they born early but they are born small, and in your report you have a whole page of complications associated with prematurity and small-for-gestational age. I'm not going to bore you with the details because you have them all there. So all that results what does it mean in practice? It means that if you have high order pregnancy you have a high risk pregnancy with a significantly increased morbidity for the mother as well, but not so much for the mother but particularly for the

infants, inclunding an increased mortality associated with that particular pregnancy.

This baby on this picture was born 1.1 kilos and again he needs a lot of support, he's on artificially ventilation. Outcome and the chances for somebody born at this gestation are not bad and we would expect in this day and age – now we're talking even about Malta – that if we have babies who have got up to thirty weeks gestation, thirty-two weeks gestations that the outcome would be good, and we would expect a normal healthy baby without neurological damage. But this, when we are talking for singletons, if you are talking for twins the outcome goes down and you have an increasing risk of neurological damage and other complications.

If you get even smaller, and this baby weighed 700 grams, then the chances of mortality are extremely high and the chances of morbidity are equally much higher. This baby is born, for example, at 25 or 26 weeks gestation. He has got three months of in neutral growth to make up. If there were four or five babies like this than there is a fair chance that the mother will deliver whatever you do, bedrest for several months or whatever, this likelihood that she will deliver early, and maybe as early as this and have babies that weigh only 600 grams or 700 grams. The outcome for these babies, in this day and age with modern technology - and we are not ta' wara l-muntanji hawn Malta, *we have got a decent neonatal intensive care unit with the state of the art supportable equipment - we cannot guarantee that all these babies will have a normal expected outcome. There is high risk of mortality and morbidity.*

Another thing which is an important point to mention is that this is a very labour intensive specialty. And if you have triplets born today, triplets born tomorrow, and quadruplets born the next week, we do not have enough intensive care support equipment as shown on this slide to cater for a sudden influx of ten babies. And we come to this problem because in a minute there is an issue of batching IVF mothers and so we suddenly get all these babies to come through in a wave and they literally, like a tsunami inundate the unit. And this is a serious point because we have a fine art service, staff, space and equipment, and we cannot stretch it beyond its ten size strength because it will eventually snap.

So what are the problems with prematurity. The major problem is in the lung. The lung is the last organ to develop in new born prematurely, than you are likely to have immature lungs, and they are so immature that they need to be artificially assisted, in other words on life support on a breathing machine. That carries major risk of lung damage and if they survive, they can survive with chronic lung disease.

The brain is the other major organ that is extremely sensitive and delicate and a small fragile very unstable baby is extremely likely to develop what is called an intraventricular haemorrhages. They bleed into their brain and that has a very high risk of mortality, and certainly for morbidity in terms of long-term neuro-disability. That means cerebral palsy, physical disabilities, mental disabilities and disabilities with development.

I will not touch on the others, they in your report. There is a long list that is associated with problems associated with babies being born before nature determined that should be. So the brain haemorrhages could be acute, the infection could be acute and the lung problems could be acute, but there is also a long-term and that's really the problem, because if there were acute problems and we manage get over them and everything then is alright, then it's not such a problem. But the issue is that the acute problem result in long-term and lasting problems, particularly cerebral palsy and developmental delay and a lot of these children can end up with epilepsy and seizure problems which could be life-long. They can have sensory deficits that includes blindness and deafness particularly, chronic lung diseases that I already

mentioned and small babies are going to be in intensive care for several months. They have a lot of procedures done to them, and the procedures themselves can incur disability. So if you put a drip into a baby whose hand is just 3 cm long, from the arm to the hand, there is a fair chance that maybe it will damage the circulation in that hand, and we had had babies who have lost limbs as a result to it. And that is not specific to Malta, that is specific to dealing with babies who might just be 600 grams or 700 grams. So it carries a high risk. Even though you might be supporting them, your own supported treatment can result in morbidity.

What about the research? I summarise it briefly because there are reams of paper to go through, but we do know that the health of a singleton baby is significantly better than that of twins, and that refers to even non-IVF twins. Twins across the board have an increased risk. The mother has an increased risk in pregnancy, the twins have an increased risk of health, and I'm taking health now in the broadest sense. But the risk is even more if you have triplets, even more if you have quadruplets, and it does go up exponentially if you have sixtuplets, etc., etc.

Likewise risk of neuro-disability and long-term irreversible neuro-disability increases with the order of pregnancy. Anything beyond three is classed as high order pregnancy. The higher the order the more likely you have disability. For Cerebral palsy - this is from a very large paper, they looked at about 3,000 patients in Australia if I'm not mistaken - the risk was 3.7 times greater, if you had multiple babies compared with those that were born by IVF. For developmental delay the risk was about four times, increased in babies born by IVF versus non-IVF babies.

Another group of workers looked at the use of health care resources in children who were born by IVF versus those who were not, and there was a 53% increase of health care resources in the IVF, essentially because they have an increase in medical problems, and needed to increase follow-ups, increase support, etc., etc.

What is the relationship between the number of embryos you implant and being born before your time, prematurely? This applies to both IVF and non-IVF. If you have only one foetus then there's about 5% of normal single foetuses which are born before their time. If you have twins it's almost half, and premature means you're born before 37 weeks.Obviously the smaller you are the more likely of disability. If you have triplets or more the risk of prematurely is almost invariable. It is very difficult to have triplets in a homo sapiens female who will carry those triplets all the way to term and deliver at term, and the average weight of new born baby is 3 kilos, as she would carry 9 kilos worth of babies which is physically virtually impossible.

What about the relation of the number of embryos and with disability? If you have only one embryo the risk of cerebral palsy, and these rates are per thousand children, is 1.6. Where as if you go all the way up to quadruplets the risk of having cerebral palsy is more than 45 per thousand children. So there is about 44 increased risk, the greater the number of embryos you have, whether they are natural or implanted, it doesn't make any difference. And likewise if you take all handicaps - and this was from a big paper in Japan - the risk is ten in thousand. If you have four the risk of having some form of handicap is ten times greater.

What about death and disability with birth weight. We have already said that birth weight is extremely important and the smaller you are the more likely to have problems, and we've already said that if you have multiple embryos then your weight is going to be smaller and you are going to be born earlier and even smaller again because you are premature. And if you a correlation between weight and the percent who die, again per thousand children, if you weigh less than 700 grams, 800 out of a 1,000 are

likely to die in 2005. So the little baby I showed you who weighed 600 kilos has got 800 out of a 1000 risk of not making it. And likewise as we go up in more than 2.5, there's only six per thousand. And the same sequence you can see if you look at the same sort of picture, but you look at it instead for mortality, you look at it for morbidity, and you look at disabilities. The disability goes up the smaller and the lighter the baby is.

What is unclear from the research? That is clear, there is no doubt about what I've just said now. What is not quite clear at the present time - and this has been written even in some of the local newspapers - is that IVF babies carry additional risk of, for example, cancer and other disability. There are some anecdotal reports that would suggest that there maybe a link, but they are based on very small number of patients. The risk with cancer, and there is only one particular cancer, this is a genetic form of eye cancer which is only seen in children which effects the eye, was in just five individual babies who were reported to have this tumour and they were not able to link a cause and effect, if you like IVF cause this problem. I couldn't find details of who the donors were or whatever because it was just a medical report. You would have to sift through it in a lot more details to see, but the authors themselves said: We are reporting this because we observed this but we are in no way saying that IFV causes this particular cancer, and/orl an increase in cancer in the offspring in general. So I think it has to be documented but looked at with caution.

And other papers have reported an increase in some particular syndromes and conditions. Again they are usually anecdotal reports and there is no hard statistical, if you like, robustness to the report. But there is an early, if you like, suspicion that, yes, maybe IVF can result in an increase of some, which otherwise extremely rare condition. But even if it is not going to be something that is extremely common, and we will be extremely surprised if we have hundred babies with IVF, five of them or ten of them will develop this eye tumour. That is exceedingly unlikely.

Regarding does IVF cause other congenital anomalies, there is not evidence from that at the present time. Does it result in an increase in chromosomal abnormalities, another major genetic imperfections in the child, again there is not evidence of that. I suspect in the look at this simplisticly the fertilisation will either work or it will not and if there is a major hiccup in terms of loss genetic material to the point of resulting in a major chromosome problem the likelihood of this foetus in vitro will not be viable and will basically not take anyway. That is my impression. It is difficult to prove them. If the zygote or the foetus fertilises then you probably have a viable foetus and it will spontaneously abort itself.

Regarding long-term impact psychological behaviour problems in children who were conceived by IVF, again there isn't sufficient data to be able to say, yes children who are conceived through IVF are more likely or less likely, to be behaviourly challenged or to have some other problem.

And just to conclude, what is the picture of IVF in Malta? What is happening here? As we see the practice essentially at the moment, it uses multiple implantation and there are many reasons for that. I suspect one of them is the lack of freezing facilities and so they have, if you like, one bite at the cherry and they want to try and get it right. They have a couple in front of them who is desperate for a child. They may have tried lots and lots of fertility treatments to-date and they've come for IVF and everybody would like that mum to be pregnant. So to improve her chances then we are implanting multiple embryos. And for logistic reasons they are being batched. This has a lot to do with logistics and facilities they have and also expense. So that means, in practice, that you will have a cohort which probably a relatively small cohort, five or ten, who are, if you like, those trying IVF in a relatively short window of time and they will

all be given several embryos re-implanted, and there is a reasonable chance that a percentage will become pregnant with twins, triplets, quadruplets and roughly pregnant at the same time, and so plus or minus there'll likely to deliver again almost all of them prematurely. But again roughly at the same time with a plus or minus of a few weeks, so it has a major tsunami effect, if you excuse the term, on the services we are providing in the unit. To that result invariable multiple, and therefore higher risk infants - I think we made that clear - and several sets which could be triplets and quadruplets born within a narrow period of time, with all that the strains not just on the mothers, the infants, buton the unit, the staff and the resources.

I have already alluded to this regarding counselling, and from where we sit the mums come up with their triplets in the hand. And I will say all the time, by any means, but very often they did not seem to be aware that this eventuality could come to pass, in other words that they will deliver that early and the babies would have potentially a very dismal outcome. So there is an issue that needs to be addressed, and it can be addressed. I mean this is not something that can't be sorted out. But it needs to be sorted out. So I think it should be stated.

Again our collaboration could be improved. It's not the remit, I suspect, of this committee. So I say if we here through grape vine that by the way the 28 week mother with triplets is going to give birth in an hour's time is not exactly an ideal state of plan. But that does happen. Sometimes we have very good collaboration. We know in advance, we counsel the mothers ourselves, and they are prepared, etc., etc. But I think that's the way it should be.

What are the risks actually? We talked a lot. What are the risks of having IVF in Malta in terms of the baby? Are we performing as good, as bad or the same as abroad? I think our evidence and our numbers still remain relatively small, but if you look at them I think we can say that we do not perform particular worse than abroad. In other words if you are born by IVF in Malta, looking from the child point of view, the risks are similar as if you were born in the UK. But you are going to be born early and you certainly are going to be small for your gestation, and therefore you have all the risks inherent with those two issues. So the risk itself is not greater than anywhere else, but there is a big risk of being born prematurely. And again because we are implanting multiple embryos.

If you look at the overall statistics for this special care baby unit, our neo-natal intensive care unit, the neo-natal unit admits by default high risk babies. We will not admit a normal crying baby who is having a bottle. So we will only admit higher risk babies and therefore they have an increased mortality. There are 8% of all the babies who come up to the unit will not survive. The vast majority of those are because they are premature, especially in the 28 week or less in particularly the 25th, 26th or 27th week gestation. Those babies have a very high chance of not making it.

If you look at the IVF infants, a lot of them will fall into that category and therefore they have an even higher risk. If you look at the overall, mortality is about 8%, the double for the IVF babies. Because they are multiples, three, four, five, they will come very early and fall automatically into the high risk categories before we start to do anything. And the disability for the survivors is also higher than the unit average and certainly higher than the national average.

So, having said all that, can we make some suggestions? There's no doubt that fertility is a major burden for an infertile couple, and we have a lot of sympathy with them and their position. Likewise IVF can offer them a viable option. So we would not be against facilitating IVF. We would not be in favour of an outright ban. However, I think there need to be a revision of what we're doing now and then an on-going regulatory process to

maintain a safe as possible service. We need to improve the counselling, That's something we could do in house, and its not difficult to do.

The issue of batching, ideally we should avoid it but I expect that it might be logistically very difficult to avoid it. I'm not sure if the obstetritions went through the details of what they do and what they don't do, but essentially they have to get a team over and so that they batch the IVF process in a space of two days or whatever. It may be something that we can't get round it because if you say we cannot batch it might kill the whole process

However, there are two last points that we can do something about. The law of the land would suggest that a termination of pregnancy is not on, and likewise the religious side. If we take the religion out of it and we just stick to the law and therefore you cannot terminate, therefore we have problems in terms of wastage, in terms of foetal reductions, in terms of choosing the better foetuses and then discarding the rest. So that is something that I think needs to be considered and spelled out. And it would be the remit of a regulatory body or a committee to do that, I suspect. And our strongest suggestion, I should say, would be this issue of multiple pregnancies because of all the problems it is creating, primarily for the infants and then for the mothers, the unit, the staff, etc. So we would propose, if there's an independent regulatory committee, that they would need to be informed, they need to know what is about.

Regarding wastage, if you had an option for freezing you could allow a limited number of fertilisations. And you would have to pre-counsel the couple to say that we will try and fertilise four, five or whatever, but we would have to re-implant them all at some stage and there is no option for wastage. Now, they may say that they don't want five children, but there have to be some agreement beforehand and decide on the maximum because you might try and fertilise five but only two of them will take. But all five might take and then you have a problem. So if you freeze them you have to re-implant them. So that's one way around. You cap the total number of zygotes that are actually fertilised, in the first place, and if you have options for freezing you can then re-implant them at subsequent attempts, if you like. But they would have to agree to re-implant them all. Categorically I could say that you do not accept any selection of foetuses and then foetal reductions. So if you have five that have taken, but default you would do not have that because the last point is that you will not re-implant five at any time, and we would limit the re-implantation per sitting to not more than two. A lot countries are now legislating for one. I guess that we have to look at this from our needs and the situation here, and it may well be reasonable to say that we go as far as two, but not beyond. That will not only emulates what other countries are doing, but it emulates what nature does. As I said before homo-sapiens is designed to deliver one baby or carry one baby, and occasionally a mother gets twins which is relatively common. Anything beyond that is a fluke of nature and is not something natural. So I don't see why we should be planning something that even nature itself doesn't feel, from an evolution point of view that this is a good idea.

So in conclusion, Mr Chairman, those would be our suggestions. Invariably they would result in prima facie reduction in the finite success rate of the IVF programme, if you look at it crudely in terms of the number of pregnancy sustained. But if you then add in to the equation what is the outcome of these babies, what is their morbidity and what is their mortality by limiting it to two, that should be considerably improved. So I would say the overall net result is a significant improvement in the programme and not the reverse.

THE CHAIRMAN: Nirringrazzjak, Dr. Attard Montalto, tal-preżentazzjoni tajba ħafna u estensiva – kelli numru ta' domandi

rrispondejtni għalihom *along the way* - pero' xtaqt niċċara xi affarijiet.

Inti donnok qed tagħmel il-kwestjoni aktar marbuta ma' kemm jiġu impjantati *embryos* iktar milli dwar l-IVF *as such*, għaliex l-argument prinċipali tiegħek kien dwar il-*prematurity*, hux hekk?

DR. SIMON ATTARD MONTALTO: Eżattament.

THE CHAIRMAN: Dan allura jfisser l-istess kemm għal twelid naturali u kemm għal twelid bl-IVF. Jiġifieri jekk inti għandek *prematurity* huwa irrelevanti jekk hux IVF jew le, il-problemi se jkunu hemm *anyhow*. U għalhekk allura inti mbagħad għedt li ma jkollokx problema li l-IVF jibqa' jsir. Jiġifieri mhux għaliex il-proċedura ta' l-IVF minnha, biex ngħidu hekk, iżżid ir-rata ta' mard. Per eżempju, kellna hawnhekk il-kumment li t-tfal li jitwieldu bl-IVF għandhom rata għolja ta' kanċer, imma inti għedt li mhux vera.

DR. SIMON ATTARD MONTALTO: Jekk hemm riskju, dan ir-riskju huwa żgħir ħafna.

THE CHAIRMAN: Dan kien kumment li smajnieh ftit ta' żmien ilu meta kien ikkwotata anke studju ta' l-SPUC mill-Kummissarju għat-tfal. Issa li qed tgħid inti hija xi ħaġa li sserħilna rasna, għaliex ovvjament tifhem li kien kumment allarmanti.

Issa meta tiżen dawn ir-riskji kollha li semmejt xorta waħda m'intix favur li tibbennja l-IVF, anzi favur li l-liġi tibqa' tipprovdi dan is-servizz. Sew qed nifhem, hux hekk?

DR. SIMON ATTARD MONTALTO: Iva, pero` dejjem bil-*proviso* li tiġi regolata biex ma jkunx hemm abbużi.

THE CHAIRMAN: Inti donnok qed tgħid li kważi kważi tasal biex tnaqqas in-numru ta' *embryos* impjantati. Aħna nafu li jiżdiedu l-*embryos* li jiġu impjantati - għallinqas hekk tgħallimna hawnhekk – l-ewwelnett għax *it is a very costly procedure*, it-tieni għax is-suċċess m'huwiex mija fil-mija u t-tielet għax l-IVF hija *harmful*, biex ngħid hekk, għall-mara għax jista' jkollha l-*hyperstimulation* u dan kollu. Allura ovvjament jiġu impjantati iktar *embryos* biex wieħed innaqqas dawk ir-riskji anke lejn il-mara. Inti ovvjament sew għamilt - u aħna hekk irridu nagħmlu wkoll - li l-kwestjoni rajtha mill-perspettiva aktar ta' l-ulied. Imma kważi kważi inti kont qed tgħid, jekk qed nifhmek sew, li tippreferi li jidħol il-*freezing* u għamilt *proviso* tajjeb fejn għedt li l-*embryos* kollha jridu jiġu impjantati allavolja se nagħmlu l-*freezing*.

DR. SIMON ATTARD MONTALTO: Irid ikun hemm *upper limit*.

THE CHAIRMAN: Ikun hemm *upper limit* ta' kemm se jiġu *fertilised*, imma jiġu kollha impjantati u sadanittant ikunu ffriżati biex inti tneħħi l-problema tal- *prematurity* li semmejt.

DR. SIMON ATTARD MONTALTO: Ovvjament hemm *issue* ta' *costing* li se jogħla ħafna.

THE CHAIRMAN: Jekk tagħmel il-*freezing*, hux hekk?

DR. SIMON ATTARD MONTALTO: Jekk tagħmel il-*freezing* u, per eżempju, ikollok ħames *embryos* fil-friża u tagħmel *implantation* ta' tnejn, imbagħad ta' tnejn oħra u imbagħad ta' wieħed. Jiġifieri tagħmel l-*IVF three times*..

THE CHAIRMAN: Jekk qed tgħid li se timpjanta tnejn kull darba sitta trid tagħmel.

DR. SIMON ATTARD MONTALTO: Sewwa. Għalhekk qabel għedt li importanti li l-koppji jkunu *counselled* minn qabel għaliex jista' jkun li huma sa erba` jkunu jridu, u daqshekk. Jiġifieri fil-każ il-*fertilisation* tasal….

THE CHAIRMAN: Imma inti qed tagħti massimu, hux hekk?

DR. SIMON ATTARD MONTALTO: Iridu jiddeċidu fuq il-massimu minn qabel għaliex jekk b'ċikka jieħdu kollha, hi għandha sitta fil-friża u tiffirma li *at some stage* se terġa' tagħmel l-IVF.

THE CHAIRMAN: Imma inti qed tagħti proposta u tweġiba għal biżgħat li kien hawn fuq il-*freezing.* Inti qed tgħid li tippreferi li jkun hemm *freezing* milli impjantazzjoni iktar għolja ta' *embryos* anke jekk tagħmel *proviso* li dawn jiġu impjantati kollha *along the way.*

DR. SIMON ATTARD MONTALTO: Għax ir-riskji għal kull *pregnancy* se tnaqqasha b'*two* jew *three times* jekk fl-*implantation* ikun hemm tnejn biss minflok erba jew ħamsa.

THE CHAIRMAN: Il-kwestjoni tas-*cerebral palsy* hija hija wkoll marbuta mal-kwestjoni ta' *prematurity*?

DR. SIMON ATTARD MONTALTO: Ħafna drabi s-*cerebral palsy* tiġi minħabba l-fatt li jkun hemm nuqqas ta' ossiġnu u l-pressjoni tkun baxxa. Ikollhom dik il-*haemorrhage* fil-moħħ, u kollha huma relatati ma' *babies* li twieldu ħafna qabel iż-żmien, immaturi ħafna jew ikunu żgħar ħafna.

THE CHAIRMAN: Issa filwaqt li kull persuna għandha l-integrita` u d-dinjita` tagħha, bejn wieħed u ieħor kemm qed tikkalkula li tara każi ta' *triplets*? Staqsejt din għax donnu li hemmhekk jibdew id-dubji tiegħek, hux hekk?

DR. SIMON ATTARD MONTALTO: L-aħħar sena kellna *three sets of triplets,* tnejn *quads* u *twins* lanqas għoddejthom.

ONOR. MICHAEL GONZI: Imma dawn kollha mill-IVF?

DR. SIMON ATTARD MONTALTO: *Set of triplets* kienet naturali. L-oħrajn kienu kollha IVF.

THE CHAIRMAN: Qed nistaqsik biex inpoġġu kollox fil-perspettiva għax naf li m'hawnx statistika.

DR. SIMON ATTARD MONTALTO: M'aħniex qed nitkellmu fuq *two sets* kull ġimgħa, xejn minn dan. Minħabba l-*batching* ma jiġux hekk infatti, jiġu f'salt. Imma *three sets of triplets* u żewġ settijiet ta' *quads* u ħafna *twins* f'sena m'humiex ftit.

THE CHAIRMAN: Fil-każ ta' *twins* ir-riskju ta' *cerebral palsy* jiżdied?

DR. SIMON ATTARD MONTALTO: Jekk tagħmel paragun bejn *twins* u *singletons* ir-riskji huma ikbar għal twins, anke għal dawk li m'humiex IVF.

THE CHAIRMAN: Rimarki? L-Onor. Gonzi.

ONOR. MICHAEL GONZI: Xi statistika ta' trabi li jitwieldu mill-IVF iżżommu intom fl-isptar, jew in ġenerali?

DR. SIMON ATTARD MONTALTO: Jien staqsejt lill-*health information unit* dalgħodu stess jekk għandhomx statistika. Huma jirreġistraw *quadruplets, triplets,* imma ma jkollhomx dettalji jekk humiex IVF jew le. Nista' ngħidlek li 90% jew iktar, jekk ikunu *triplets* jew iktar, huma ta' l-IVF.

THE CHAIRMAN: Id-domanda li staqsejt jien mhux dwar jekk jirreġistrawhomx, imma jistaqsuhom wara. Jiġifieri mara li tmur biex twelled jistaqsuha jekk għaddietx minn xi proċess. Jekk hi jogħġobha tweġibom iva jew le, jekk jogħġobha dejjem, allura mbagħad …..

DR. SIMON ATTARD MONTALTO: Mhux IVF bilfors, imma jista' jkun ART.

ONOR. MICHAEL GONZI: Fir-reġistru tal-*morbidity, malformations* u dawn l-affarijiet, kien hemm xi *changes* f'dan l-aħħar żmien li qed isir iktar ART minn żmien

qabel? Kien hemm xi statistika tal-*malformation* tat-trabi li jitwieldu fl-isptar.

DR. SIMON ATTARD MONTALTO: Bażikament ir-riskju li jkollhom probelmi ta' żvilupp b'*cerebral palsy* hafna iktar, imma r-riskju li jkollhom *anomalies* bażikament m'hemmx provi. L-idea tiegħi hi li bażikament jekk hemm *subtraction* ta' *genetic material,* eċċ., eċċ, bażikament dak il-*foetus* ma jkunx vijabbli. *I think it is an all or nothing.* Jiġifieri Ii jkollhom *anomalies, chromosomal problems there's no hard evidence* li tissapportja dik …..

ONOR. MICHAEL GONZI: Ġieli jiġu nies għandi li welldu t-tfal permezz ta' l-IVF u waħda mill-mistoqsijiet li jagħmluli hija jekk it-tfal tagħhom iktar 'il quddiem, jiġifieri ta' ħmistax, sittax jew għoxrin sena, hux se jibdew ibatu minn xi ħaġa. Hemm xi statistika li turi li dan mhux veru?

DR. SIMON ATTARD MONTALTO: Jekk hux se jkollhom problemi pjuttost mill-bidu nkunu nafu. *Babies* li jitwieled qabel iż-żmien li jkollhom ħafna problemi mill-bidunett u jispiċċaw b'*cerebral palsy, etc., etc.,* iċ-ċans hu li se jkomplu bil-problemi tagħhom. Imma xi ħadd li jitwieled bl-IVF, ir-riskji għalih jew għaliha li wara għaxar snin joħroġ f'epilesija jew xi ħaġa huma, safejn nafu aħna dejjem fl-2005, l-istess u ugwali bħal tfal li jitwieldu mingħajr IVF. *The overriding risk* hi li jitwieldu qabel.

ONOR. MICHAEL GONZI: Il-proċess ta' l-ART *as such* ma jżidx riskju lit-tarbija. Jiġifieri jekk se jkun hemm il-proċeduri teknoloġiċi biex l-isperma tingħaqad mal-bajda, dak il-proċess mhux qed iżid ir-riskju ta' ħsara lit-tarbija. Sewwa qed ngħid?

DR. SIMON ATTARD MONTALTO: Sewwa.

ONOR. MICHAEL GONZI: Ir-riskju qiegħed li jien bilfors irrid nimpjanta tnejn jew tlieta li jekk jinqadbu se jkollok *multiple pregnancies* u se jkollok ir-riskju ta' *multiple pregnancy* imma mhux tal-proċedura ta' l-IVF stess, sakemm ma toqgħodx tbagħbas fl-*embryo.*

DR. SIMON ATTARD MONTALTO: Jekk hemm riskju, hemm *inherent risk* li hi waħda żgħira. Almenu *it is under a long follow-up. It's been around since 1978.* Qed nitkellmu fuq *tens of thousands* ta' tfal li twieldu bl-IVF. Jiġifieri *it's not shown up.* Jiġifieri jekk hemm riskju, ir-riskju huwa żgħir. *And it's overwhelmed by the risk of prematurity.*

ONOR. MICHAEL GONZI: Il-*percentage* tal-*multiple pregnancies* ovvjament fl-ART se jkun iktar minn normal.

DR. SIMON ATTARD MONTALTO: Skond kemm trid timpjanta.

ONOR. MICHAEL GONZI: Skond kemm timpjanta. Imma normalment, ma nafx kemm jagħmluha hawn Malta, per eżempju, l-Italja jekk m'iniex sejjer żball jimpjantaw tlieta. Imma fl-istatistika, forsi se nerġa' nirrepeti wkoll, tas-*single pregnancies through IVF* ma kienx hemm żieda fil-*malformations,* jew fid-*diseases* tad-drabi li twieldu, huma l-istess normali daqs trabi oħrajn li jitwieldu mhux bl-IVF?

DR. SIMON ATTARD MONTALTO: Li għandna s'issa huma *anecdotal reports* biss. *Cancer* ta' l-għajn kien hemm ħames każijiet biss. Jiġifieri qed nitkellmu fuq ċifri żgħar ħafna li min-naħa ta' l-istatistika ma tista' tgħid assolutament xejn.

THE CHAIRMAN: L-Onor. Frederick Azzopardi.

ONOR. FREDERICK AZZOPARDI: Inti għedt li l-IVF *can offer viable options for infertile couples*. Issa naf li s-suġġett tiegħek huwa l-IVF, imma tista' tgħidilna jekk hemmx xi *options* oħra li huma *more successful* jew *less successful*?

DR. SIMON ATTARD MONTALTO: Hemm *options* oħrajn. Naħseb li *obstetritions* huma iktar kompetenti minni biex jirrispondu. Imma hemm tip ta' ART differenti, u hemm ukoll l-adozzjoni li m'hijiex xi ħaġa faċli.

ONOR. FREDERICK AZZOPARDI: Imma jiena m'iniex qed nirreferi għall-*adoptions.*

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DR. SIMON ATTARD MONTALTO: Hemm, per eżempju, *hyperstimulation,* mediċini, ormoni u affarijiet hekk. Ħafna minnhom ukoll jipproduċu ħafna *zygotes,* ħafna *embryos.* Per eżempju, f'nofs it-tmeninijiet meta kienu bdew ġewwa Liverpoll kienu kważi kollha jispiċċaw b'*sixtuplets, septuplets, octuplets.* L-ewwel koppja spiċċaw b'sitta *and they did very well.* U allura kulħadd, kif jgħidu l-Ingliżi, *jumped on the bandwagon.* Imma mbagħad sfortunatment meta beda jkun hemm *more sixtuplets, etc. they did very badly.* Imma dawk kienu *hyperstimulated* b'mediċini, bl-ormoni pjuttost milli bl-IVF.

ONOR. FREDIRCK AZZOPARDI: Imma kieku inti tmur għal dawn l-*options* jew tippreferi l-IVF?

DR. SIMON ATTARD MONTALTO: Jien kont immur għall-*option* li se tagħtik tarbija waħda fil-ġuf, jekk hija possibbli ovvjament. Mhux possibbli li tiddeċidi minn qabel u tkun assolutament ċert li se jkollok waħda biss. Tista' anke tagħmel *implantation* ta' *one embryo* u dan jisplittja u tispiċċa bi *twins,* kif jiġri fin-natura. Imma ċ-ċans huwa li tispiċċa bi *twins* u mhux *quadruplets.*

ONOR. FREDERICK AZZOPARDI: Għedt ukoll li jekk ikollok *fertilised embryos* iktar milli għandek bżonn *you will go for the best embryos.* Imma aħna qegħdin f'pożizzjoni li nagħżlu l-aħjar?

DR. SIMON ATTARD MONTALTO: Hi pożizzjoni diffiċli minħabba l-pożizzjoni legali tal-pajjiż fuq l-abort u ovvjament il-knisja ta' Malta. Naħseb li kieku konna barra minn Malta, f'pajjiż fejn l-abort kien legali inti tista' tagħmel kemm Alla ħalaq *fertilisations,* tagħmel *enhanced embryos selection,* jiġifieri tiddeċiedi liema huma l-aħjar, u xorta tagħmel l-*implantation of one or two.* Jiġifieri għal kull *pregnancy* se żżomm ir-riskju kemm jista' jkun baxx għaliex inti se tagħmel *implantation* ta' wieħed, l-iktar ta' tnejn, imma xorta għandek l-*option* għax fil-friża għandek għoxrin. Issa jekk l-ewwel *implantation* tkun suċċess u l-mara jkollha *baby,* tista` mbagħad tgħidlek li trid ieħor u terġa' tagħmel l-IVF u tispiċċa *with another viable baby.*

Imbagħad tista` tgħidlek daqshekk u inti użajt erba' per eżempju, għaliex għamilt tnejn u tnejn, u għandek għaxra oħra fil-*fridge.* F'dak il-pajjiż tista' bażikament tneħħihom. Il-problema li għandna hawn Malta hija li legalment, safejn jien, ma tistax tagħmel hekk. Għalhekk il-proposta hi waħda ta' kompromess, speċi qed tgħid: OK, nagħmluh imma jrid ikun hemm *capping,* irid ikun hemm *regulation* jekk, per eżempju, hux se naċċettaw jew le il-*wastage.*

ONOR. FREDERICK AZZOPARDI: Semmejt ukoll *lack of available data.* Fl-opinjoni tiegħek, inti taħseb li din in-nuqqas ta' *data* għandha żżommna mill-nilleġislaw? Billi l-proċess qed jinbidel kontinwament taħseb li għandna nistennew jew nimxu fuq li hemm illum?

DR. SIMON ATTARD MONTALTO: Għal liema *data* qed tirreferi?

ONOR. FREDERICK AZZOPARDI: *Data* anke fuq mard.

DR. SIMON ATTARD MONTALTO: Kif għedt qabel, hawn Malta m'għandniex ħafna data. Imma hemm ħafna *data* minn pajjiżi oħrajn. Dan il-proċess ta' l-IVF ilu għaddej għoxrin sena, jew ma nafx kemm, u wara għoxrin kont tistenna, kieku per eżempju veru kien hemm riskju ta' *cancer* li kien sostanzjali, li issa konna qed naraw tfal li twieldu bl-IVF li għandhom il-*leukemia,* li

hija l-aktar *cancer* komuni fit-tfal u li normalment toħroġ fit-tfal meta jkollhom tliet snin. Jiġifieri hawn tfal li għandhom ħafna iktar minn tliet snin li twieldu bl-IVF. Jiġifieri ċ-ċifri llum se jibqgħu żgħar, imma minn barra kont tistenna li konna naraw xi ħaġa wara dan iż-żmien kollu. Jiġifieri ma nistax ngħidlek b'ċertezza imma *statistically* nista` …. (Interruzzjonijiet)

ONOR. FREDERICK AZZOPARDI: Fl-opinjoni tiegħek, taħseb li għandna *data available* biżżejjed biex wieħed jieħu deċiżjoni?

DR. SIMON ATTARD MONTALTO: *It's as good as it's going to get.* U biex ikollok *a hundred thousand follow-up or whatever the figure is going to be* se terġa' tistenna ħames snin, għaxar snin. Il-problema *is here and now* u d-deċiżjonijiet irridu neħduhom issa. Jiġifieri naħseb li fuq li għandna xorta naħseb tistgħu timxu.

THE CHAIRMAN: Dak ovvjament biex inti tiżen jekk il-benefiċċji ta' l-IVF jissperawx il-ħsarat, imma ma tarahiex stramba li Malta ma tinżammx statistika f'dan ir-rigward?

DR. SIMON ATTARD MONTALTO: Naħseb li bażikament għandek raġun għaliex fuq xi ħaġa delikata u sensittiva bħal din suppost ikollna *follow-up.* Imma ħafna drabi lanqas tkun taf, tassumi li la għandha, per eżempju, *triplets* probabbli għamlet l-IVF. Qed tifhimni? Hemm nuqqas ta' kollaborazzjoni anke bejn l-ispeċjalisti, sa ċertu punt biss. Jien ma nippretendix li nisma`, kif jgħidu l-Ingliżi, *through the grapevine* li mara li għandha *triplets* jew *quadruplets* se twelled għada jew se jagħmlulha ċesarja għada. Bażikament nistenna li nkun naf biha. Biss biss jekk hemm mara bi *quadruplets* irrid nirranġa li jkun hemm erba' timijiet *standby twenty four hours* għax bażikament irid ikun hemm *team* għal kull tarbija, u t-*team* irid jinkludi li xi ħadd ta' esperjenza li jista' jintuba lit-tarbija u jpoġġija fuq *life-supporting unit.* Ma nistax nassumi li l-*junior houseman* li jkolli bil-lejl jagħmel dan ix-xogħol. Irid ikolli wieħed *senior* bil-lejl l-isptar u forsi jkun hemm wieħed mill-*middle grad* li jaf jintuba. Imma jfisser li għandi nuqqas ta' tnejn u jkolli bżonn il-konsulenti *stand-by* id-dar u mhux biss dak li jkun *on call*, imma jrid ikun hemm ieħor ukoll. Jiġifieri hemm ħafna irqaqat u affarijiet ta' loġistika.

THE CHAIRMAN: L-Onor. Galea.

ONOR. FRANCO GALEA: F'waħda mis-*slides* għandek li hija intitolata "IVF in Malta:1" titkellem dwar *batching due to logistical reasons*. Imbagħad hemm "*Results in: several sets born at the same time u significant strain on infants and resources"*. Imbagħad fis-*slide* intitolata *"Suggestions"* issemmi *"avoid batching"*. Qed nifhem li Malta għandna r-riżorsi tagħna limitati. Għal kemm *premature babies* nistgħu nikkejterjaw f'darba waħda fis-sistema li għandna fl-isptar preżenti?

DR. SIMON ATTARD MONTALTO: Jekk jitwieldu ta' ċerta eta` u daqs li jkollhom bżonn *support* min-naħa tal-pulmun, bażikament ikollhom bżonn makna tal-pulmun. Bażikament issa għandna xi disa' jew għaxra, imma dejjem trid tqis ….

ONOR.FRANCO GALEA: Pero' bħala *shifts* qed nikkalkolaw li kull tarbija trid erba' min-nies u ma nistax nimmanġina li erba' min-nies jistgħu jieħdu ħsieb għaxart itfal *at one go*, hux hekk?

DR. SIMON ATTARD MONTALTO: Teknikament il-*unit* suppost jesa *sixteen cots*, imma bażikament m'għandniex *option* fejn jekk huma mimlijin nibagħtuhom x'imkien ieħor.

ONOR. FRANCO GALEA: Jiġifieri *human resources* ġol-pajjiż, tobba, u professuri li huma speċjalizzati f'dawn l-oqsma għandna biżżejjed?

DR. SIMON ATTARD MONTALTO: Bħala *paediatritions* għandna xi 40 li nofshom huma mħarrġa biżżejjed li jistgħu jieħdu ħsieb dawn it-trabi li jkunu primaturi ħafna.

ONOR. FRANCO GALEA: L-argument tiegħi huwa dan. Jidher li min qed jagħmel dan fil-prattika m'għandux is-servizz hu *in house*. Voldieri jekk jien tabib u qed nipprattika l-IVF, jew l-isptar għandu l-IVF jidher li m'hemmx *supporting facilities* f'każ ta' emerġenza u f'każ li l-isptar ta' Malta jkun mimli? Qed nifhem sewwa?

DR. SIMON ATTARD MONTALTO: Assolutament. Mhux l-ewwel darba li jien għedt li r-riżors tagħna huma *finite.*

ONOR.FRANCO GALEA: Imma l-punt tiegħi huwa dan. Huwa tajjeb li bniedem jenfasizza li għandu jkun hemm *a sort of backup* f'dawn l-isptarijiet li jipprattikaw l-IVF?

DR. SIMON ATTARD MONTALTO: Inti qed tgħid għall-isptarijiet privati, hux hekk?

ONOR. FRANCO GALEA: Iva.

DR. SIMON ATTARD MONTALTO: Il-problema hi li d-*director general* tas-saħħa jsaqsini biex jien, bħala l-kap tad-dipartiment tal-pedjatrija, nagħti l-opinjoni tiegħi biex huma jagħtu liċenzja jew permess biex sptar privat jiftaħ *neo-natal intensive care unit,* ir-risposta tiegħi tkun *an emphatic no, absolutely no way*. Għaliex bażikament inti biex iżżomm il-livell ta' *skill* irid ikollu *throughput,* irid ikollok *turnover*. U dawn l-isptarijiet qatt m'hu se jkollhom *turnover. There's no way,* malli jkollhom problema immedjatament tiġi St Luke's. U dik mhux se tinbidel.

ONOR. FRANCO GALEA: Għalhekk qed nipprova nagħmillek dawn id-domandi.

DR. SIMON ATTARD MONTALTO: Għandek raġun.

ONOR. FRANCO GALEA: Allura meta nafu li aħna għandna post għal għaxra u nafu li r-riskju huwa tant…. (Interruzzjonijiet)

DR. SIMON ATTARD MONTALTO: Għaxra meta tinkludi dawk li jitwieldu primaturi b'mod normali.

ONOR. FRANCO GALEA: L-argument tiegħi huwa sempliċi. Jekk il-gvern se jilleġisla fuq dan, *would it make sense* li minħabba l-kwestjoni ta' *batching* u minħabba problema ta' riskju, il-leġislazzjoni ssir b'mod li għallinqas l-isptarijiet privati jaħdmu *hand in hand* ma' l-isptar statali biex anke nevitaw din il-problema ta' *batching*?

DR. SIMON ATTARD MONTALTO: Assolutament. Idealment *you stagger them*, qed tifhimni? Kważi jista' tagħmilhom *timetable* u tgħidilhom li fit-tali xahar tista` tagħmel tlieta jew erba' IVFs. Tifhimni? Il-problema hi waħda loġistika li ma nafx kemm *we can get round the batching.* Imma xorta jekk inti tillimita n-numru ta' *re-implantations,* iċ-*chances* huma li *we can absorb them.* Jekk ikollna tliet settijiet ta' *twins* li jiġu f'perijodu qasir ta' ġimgħatejn, iċ-*chances* li nkunu nistgħu nikkojpjaw u nikkejterjaw għalihom.

ONOR.FRANCO GALEA: Jidher li qed ikollna aktar żweġijiet bejn koppji li huma *over thirty.* Għalhekk jista' jkun li problema biex mara tinqabad tqila b'mod naturali tiżdied. Allura qed nifhem sew li *at an increasing rate* ta' l-IVF se naslu fi stat li ċ-ċentru ta' l-isptar se jkollu jikber?

DR. SIMON ATTARD MONTALTO: Dan huwa punt importanti ħafna. Fil-preżentazzjoni tiegħi sa ċertu punt qed nagħmel *an assumption* li r-rata ta' l-IVF mhux se tinbidel b'mod sostanzjali. Jekk bażikament tinbidel ħafna u ngħidu *limited IVF* sa tnejn, re-*implantation* ta' tnejn, imma minflok nagħmlu ħames koppji nagħmlu

ħamsin, dik se jkollha impatt qawwi fuq is-servizz, fuq ir-riżorsi u nispiċċaw l-istess. Anzi kważi agħar, għax bażikament jekk ikunu *singletons* u *twins*, iċ-*chances* huma li dawn se jgħixu, allura se jdumu ħafna iktar fuq il-*unit* u se jkollna iktar *backlogging* u *bottlenecking* fil-*unit.* Jiġifieri *it's an important point* għaliex aħna qed nassumu li r-rata ta' l-IVF fil-pajjiż mhux se tinbidel b'mod sostanzjali. Jekk se tinbidel ħafna se tagħmel impatt qawwi, speċjalment jekk *they improve the outcome of these babies.* Jiġifieri l-*survivability* tagħhom kif għedt qabel, *we will be holding the babies* għaliex m'hemmx *options* oħrajn.

ONOR. FRANCO GALEA: Issa se nagħmel domanda fuq in-*new born*, fuq it-tarbija *per se*. Għalkemm naf li l-IVF m'ilhiex issir ħafna, pero' saru xi testijiet biex jaraw jekk it-tfal li jitwieldu bl-IVF eventwalment jistax ikollhom huma stess il-problema ta' infertilita`?

DR. SIMON ATTARD MONTALTO: Bħala *follow-up* li rajt, bażikament ma sibtx xi studju ta' dak it-tip. Pero` din hija domanda u naraha. Imma llum m'għandix risposta.

ONOR. FRANCO GALEA: *Thank you.*

THE CHAIRMAN: Jidher li m'hawnx iktar domandi. Mill-ġdid nerġa` nirringrazzja lil Dr Simon Attard Montalto ta' l-informazzjoni utli li tana. Għal-lum nistgħu niefqu hawnhekk.

Fit-8.30 p.m. il-Kumitat aġġorna għal nhar l-Erbgħa, 8 ta' Ġunju, 2005 fis-6.30 p.m. b'din l-aġenda:-

> Il-Bioteknoloġija f'Malta u d-Drittijiet tal-Bniedem (Kontinwazzjoni) – Preżentazzjoni dwar il-Konvenzjoni ta' Oviedo mill-Onor. Michael Asciak MD, MP.