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BIOETHICS AND RELIGION: SOME IMPLICATIONS FOR REPRODUCTIVE MEDICINE

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Abstract: This paper addresses the topic of bioethics in reproductive medicine from the perspective of the religious implications for the field. The assumption underlying the approach is that religion remains a factor that influences the field of bioethics even in a secularized postmodern society. The first part of the paper analyses the main bioethical issues which mark obstetrics and gynecology, uttering that the four basic principles of bioethics (beneficence, non-maleficence, autonomy and justice) are available both in obstetrics and gynecology and must be applied in association with the practitioner's virtues. The second part of the paper focuses on the main directions that guide the debate on the presence of religion in the field of bioethics, with a special interest in their relevance for reproductive medicine. Despite the difficulties implied by the task of advocating for the place of religion at the secular table of deliberation in medical ethics, the relevance of religion for bioethics cannot be ignored.

Key Words: religion, bioethics, secularization, reproductive medicine, conflict of interests, ethical dilemmas.

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1. Introduction

Bioethics represents a very important point of progress for the moral philosophical knowledge. The formation and development of bioethics are linked with the process of transformation of traditional ethics, in general, and of medical ethics, in particular. The growing interest in human rights and the creation of new medical technologies have given rise to many problems that need moral or juridical regulation (ACOG, 2004, 3-18, 67-71, 119-124; Chervenak and McCullogh, 1997, 91-94).

The place of religion in the field of bioethics represents a very complex and debated topic. In a recent article, Nigel Biggar questions "secular medicine" understood as a field of pure reason that transcends the metaphysical and moral disagreements stating that medical ethics is characterized by "spiritual and moral mixture and ambiguity" (Biggar, 2015). Affirming the importance of religion for secular medicine, he identifies some of the contributions of Christianity to bioethics, such as good manners, respect for human dignity, respect for other beliefs, respect for the truth and the use of reasonable means of persuasion (Biggar, 2015). Biggar's argument generated sharp reactions holding that these contributions are in fact the elements of "moral philosophy" and not of religion (Earp, 2015) and that the traits inherent in religion (i.e. flawed empirical basis, lack of rationality and non-universality) disqualify it from the ethical discourse (Smith, 2015).

The present paper addresses the issue of bioethics in reproductive medicine from the perspective of the religious implications for the field. It starts from the premise that bioethics demands a balance between what Beauchamp describes as the "specified moralities" which include "the many moral norms, aspirations, ideals, attitudes, and sensitivities that spring from cultural traditions, religious traditions, professional practice, institutional codes of ethics, and the like" and "the general moral standards" which are shared by all moral persons and are "conspicuously abstract, universal, and content thin" (Beauchamp, 2003, 270).

The dynamics of the relations among these "specified moralities" has a major impact on the sphere of bioethics and religion represents an essential element in this equation because it remains a factor that influences the individuals' sexual behavior and their attitudes towards sexuality in today's secularized postmodern society. The complexity of the issue of the religious influence on reproductive medicine and its multifaceted character is well known and extensively studied both form general and specific perspectives, coming from individual religious contexts. The relevant dimensions of this challenging relation are better emphasized by the analysis of the religious implications for reproductive ethics. The following part of the paper presents, on the one hand, the main issues and discussions that substantiate the area of bioethics in

obstetrics and gynecology, and, on the other hand, the main lines that guide the debate on the presence of religion in the field of bioethics, with special interest in their relevance for reproductive medicine.

2. The principles of bioethics in obstetrics and gynecology

In obstetrics, which is concerned with two patients, ethical decisions are complex and more difficult. Temperance and sobriety are virtues in all physicians. In the course of practice, difficult cases demanding the use of memory and judgment frequently occur. Ethical dilemmas and conflicts among the main bioethical principles are paradigmatic examples. Fortunately they are not frequent and they arise only when there are moral considerations implied in solving a conflicting medical situation. Nevertheless, their resolution is not easy since it demands to determine which moral value overrides the other. The physician faced with an ethical conflict in patient care should follow the golden rule: "Do unto your patients as you would want done to you under the same circumstances", if the patient consents (Chervenak et al., 1992, 84-87).

W. D. Ross' theory of the *prima facie* principle was adapted to medical ethics by Beauchamp and Childress in their "*Principles of Biomedical Ethics*" (Beauchamp and Childress, 2001, 14-15; Childress, 2007, 15-45). W. D. Ross considers that our moral beliefs are based on duties belonging to the fundamental nature of the universe and include the duties of fidelity, reparation, gratitude. Justice, self-improvement, and non-maleficence - these duties are always under obligation unless they get into conflict with one other.

Medical ethics recognizes the four basic principles that must be defended during medical actions: beneficences, non-maleficence, autonomy and justice. These principles must act as "universally valid norms that warrant us in making intercultural and cross-cultural judgments about moral depravity, morally misguided beliefs, savage cruelty, and other moral failures" (Beauchamp, 2003, 269).

Autonomy means self-governance or self-ruling. The patients have the right to hold views, to make choices, to take actions based on personal values, to have beliefs and interests. In bioethics, autonomy means freedom, self-control and informed decision making (Frunză et al., 2010; Sandu, 2013). In accordance with the principle of autonomy, the informed pregnant woman can choose to interrupt or not to interrupt her abnormal pregnancy; alternatively, she can choose the type of delivery. Both of them are possible only when the patient's interest dovetails with other social or legal interests. Chervenak and McCullough identify three types of patient interests: social role interests, subjective interests, and deliberative interests (Chervenak and McCullogh, 1997, 91-4). All of them must be accepted by the physician and have to be legally permitted.

Beneficence and non-maleficence is the obligation to act in a manner that benefits the patient and does not harm her or him. This principle is best expressed in the statement "primum non nocere". These principles are operative together when taking decisions because every medical or surgical treatment has both benefits and risks, which must be balanced knowledgeably. Beneficence may be in conflict with the respect of autonomy. For example, a pregnant woman with a probable fatally malformed fetus (Chervenak et al., 2003, 473-483) may desire to deliver by cesarean section because she believes that this procedure will increase the chance of the newborn survival. Our legal background makes such desires theoretically possible. The physician's judgment is that the risk of the surgical delivery to the woman does not justify the relative benefit to a "nonviable" infant. In such a situation, the obstetrician has to consider the patient's psychological, physical, and spiritual well-being, but in our practice the section is indicated only by medical judgment.

The welfare of the patient (*beneficence* and *non-maleficence*), the respect for the rights of the patients (*autonomy*) and health care without discrimination on the basis of race, color, religion, national origin or any other basis (*justice*) are fundamental. To deal with patients and colleagues honestly (*veracity*) is an obligation of the practicing physicians especially in obstetrics and gynecology. Potential conflicts of interests are inherent in the practice of medicine and physicians are expected to recognize and resolve them in the interest of the patient; in addition, the physician serves as the patient's advocate (ACOG, 2007, 1479-1487; ACOG, 2004, 3-18, 67-71, 119-124; and ACOG, 2003, 1424-1427).

It is important for each practitioner to develop a decision-making scheme that can be applied in ethical expertise when ethical dilemmas are faced (Frunză, 2011; Grad and Frunză, 2016). In obstetrics and gynecology these situations appear frequently, they may vary from one circumstance to another, and they are particularized by the needs of women.

Several logical steps must be taken in approaching an ethical problem (Pikerton and Finnerty, 1996, 289-295). The first one is to answer the question "whose decision is it?". Generally the patient is presumed to have the authority and capacity to choose among some medically acceptable alternatives, to refuse treatment or surgical procedures or even to influence the procedure in the case of some complex and difficult issues, such as the anonymity of donors and recipients in organ donation (Mamode et al., 2013, 540) if the patient is supposed to be incapable of making a decision or has been found legally incompetent, which is when a surrogate decision maker must be identified. In the obstetric setting, a pregnant woman is generally considered the appropriate decision-maker for the fetus that she is carrying. However, decision-making intersects with outside influences in the case of unplanned pregnancies that create conflictual situations in the personal, social or family life of the patient. The gynecologist must be sure that the patient's choice is voluntary, that

it is not coerced by internal or external constraints. In rare cases of alcohol or drug-abusing pregnant women, who lost the sense of fetal priority, the obstetrician must became the defender of the fetus and the decision-maker in fetal interests, but in this cases she or he need the support of an ethical committee (Chervenak and McCullogh, 1997, 91-94). This step can be neglected only in cases of incapable persons, in vital emergencies; thus, the common laws recognize that emergency is an exception from the requirement of consent (Bernat and Peterson, 2006, 86-92; Mironiuc et al., 2008, 75-86). A patient's informed consent is generally required before diagnostic and treatment interventions, except in cases of emergencies, threats to public health, or danger to self or others. The physician's fiduciary duty to protect and promote the patient's interest may become more complex in emergencies (Clara et al., 2004, 125-128; Mironiuc et al. 2008, 75-86). Obstetricians should face all clinical decisions with some ethical reasoning. This attitude is not time-consuming, it may frequently help to unmask potential conflicts of interests and to approach real ethical dilemmas with honesty, sensitivity and reasoning. In general, even if a pregnant woman has strong interests that must be protected, an act determined by purely vicious motives toward her fetus may occur and it is far more plausible that any decision to terminate the pregnancy arises out of genuine moral conflict. The second step is the collection of data and the establishing of facts. When the available information about the diagnosis, treatment, and prognosis has been obtained, the patient will be informed and allowed to take her own decision. The physician must be sure that the patient understands the medical information and must be informed about her (or her husband's) cultural or religious beliefs (Mironiuc et al. 2008, 75-86). Consent has three components: disclosure, capacity and voluntariness (Chervenak and McCullogh, 1990, 3013-3017). Informed consent is theoretically a major way in which the patient's autonomy is promoted in the clinical setting; it is more than a signed document, it is an on-going, evolving feature of the physician-patient relationship. Informed consent might be defined as "the willing and unforced acceptance of a medical intervention by a patient, after adequate disclosure by the physician of the nature of intervention, its risks and benefits, as well as of alternatives with their risks and benefits" (Jonsen et al., 1998, 51).

Obstetrics brings along many challenges, some of them being sources of ethical dilemmas. The pregnant woman is binomial, with a frail partnership between the mother and her product of conception with possible conflicting interests (Chervenak and McCullogh, 1990, 3013-3017). The feminist opinion of Mary Anne Warren is that "there is room for only one person with full and equal rights inside a single human skin" (Warren, 1989, 46-65) but the concept of "fetus as a patient" is a contrary medical profile (Di Renzo, 2008). The clash of interests takes place in some fields: mother vs. fetus, fetus vs. mother, fetus vs. society, fetus vs. fetus,

newborn vs. society and conflicts between professionals who take care of the mother and the infant (Di Renzo, 2008). The *maternal-fetal conflict* may begin with the implantation, the mechanism which occurs both in spontaneous or assisted fertilization. There is no mechanism of maternal control able to oppose this fetal access, except for the intrauterine device. In the course of pregnancy, some maternal habits have potential fetal risks. Moreover, during pregnancy, because of a maternal pathology, the administration of any drugs can be harmful to the fetus (Di Renzo, 2008). Thus, during pregnancy it is necessary to use drugs known not to have embryo-fetal toxicity. When a pregnant woman suffers from a malignant illness, the maternal interest is for an immediate treatment. However, the optimal treatment, be it chemotherapy, radiotherapy or surgery, may impose great risk on the fetus (Manciuc, 2010, 74-77). The *conflicts between the interest of the fetus and of the mother* (Pikerton, Finnerty, 1996, 289-295; Di Renzo, 2008) appear very frequently when the mother must be treated for the benefit of the fetus and the pregnancy. The situation gets more complex in twin pregnancies, where it might be necessary to make a therapeutic treatment for the sick fetus potentially harmful for the other fetus or for the mother (twin to twin transfusion syndrome). Another example of *conflict of fetus versus fetus* is the selective reduction of a multiple pregnancy implying an aleatory termination of pregnancy (Chervenak et al., 1992, 84-87).

Regrettable situations of maternal death may occur in obstetrics and this generates a *special* type of *conflict* (Buta et al., 2010, 29-35; Di Renzo, 2008). In the third trimester of pregnancy, it would seem legitimate that the fetus be born regardless of any acquisition of consensus (medical, ethical, religious and legal), but in the event of a "not vital" fetus, the decision is doubtful (Chervenak et al., 1992, 84-87). *Conflicts* between the *mother and newborn* rarely happen. An example of such an event is an anencephalic fetus (Chervenak et al., 2003, 473-483). Prenatal diagnosis of anencephaly confronts the parents with the decision of termination of pregnancy, of letting the fetus follow his or her destiny or of consenting to organ transplantation from the anencephalic fetus. The *conflict between the fetus or the newborn versus society* has positive aspects (the umbilical cord is a source of stem cells, an anencephaly fetus is a good organs donator), but also negative aspects (the care of a newborn with genetic pathologies, with handicap and mental delay or with HCV or HIV infection is very expensive for the society) (Di Renzo, 2008). Some dilemmas may appear when a sick pregnant woman needs a multispecialty approach to the management of pregnancy or needs an aggressive or attending attitude. All these represent *professional conflicts versus mother* (Di Renzo, 2008). The treatment of a sick pregnant woman demands the co-operation of different professionals (obstetricians, medical internists, neonatologists, pharmacologists, a. s. o) in favor of both the mother and

the fetus, and this co-operation is not easy to obtain.

The *maternal-fetal conflict* includes a broad range of possible interventions, non-interventions, and coercive influences ranging from forbidding alcohol, drugs or nicotine consumption (Di Renzo, 2008). The obstetrician must constraint the pregnant woman to respect bed rest and hospitalization in fetal interest or, in some cases, to accept an unwanted medical intervention (for example a caesarean section) (Doukas and Elkins, 1993, 721-728). "Acting on a refusal of treatment positively would amount to acting on unreliable clinical judgment, justifying the physician's resisting the patient's exercise of a positive right when fulfilling that right contradicts the most highly reliable clinical judgment, it dooms the beneficence-based interests of the fetus, and it virtually dooms the beneficences of the pregnant woman" (Di Renzo, 2008). When acting in agreement with the concept "fetus as a patient", we accept the fetus as a potential moral person, possessing moral and legal status (Buta et al., 2010, 29-35). The problem of the *fetal- maternal* conflict reflects the multiplicity of moral values and cannot be solved by appealing to any unitary principle (Di Renzo, 2008).

In order to be efficient in the investigation of actual cases, the abstract principles of bioethics need to be specified, meaning that the indeterminateness of general norms is reduced in order to give them "increased action guiding capacity, while retaining the moral commitments in the original norm" (Beauchamp, 2003, 269). The inherent normative conflict demands, in the complex cases, flexibility and willingness to match and adjust the "moral judgments in order to render them coherent with the full range of our moral commitments" (Beauchamp, 2003, 269).

3. Religion, bioethics and reproductive medicine

Beside the major part played by the religious arguments in the debate concerning the fetal-maternal conflict, with the differences specific for particular religions, there are other important frameworks starting from which the relation between religion and bioethics can be addressed. For example, religion and spirituality well-being play an important role in coping with disabilities (Stancu et al., 2016, 87). As concerns reproductive medicine, religion and spirituality represent a decisive factor in, for example, the decision making and coping processes that are in line with the genetic counseling, and thus, "counselors should feel empowered to incorporate spiritual exploration into their patient conversations" (Katelynn et al., 2016, 923).

The complexity of the ethical issues that confront the practitioners in obstetrics and gynecology, issues that cannot be solved by resorting to an "unicitary principle", and also the recent scientific developments in the area of reproductive medicine highlight the idea that, among the plurality

of the perspectives necessary for addressing these challenges and for outlining a comprehensive picture of the field, religion represents a dimension which cannot be avoided. On the one hand, this required presence regards the clarification of the perceived attitudes toward these issues for different religious communities (Schenker, 2000, 77). At the same time, it is essential to regard this relation from the point of view of the physician. In this respect, it is important for the professionals in reproductive medicine to learn about the different religious attitudes vis-à-vis the reproductive health problems, to acknowledge their importance and to take into account these insights on the area of bioethics.

Though contested by many voices, religion represents a factor that acts in an unarguable manner upon the area of bioethics. This is even more evident in the realm of reproductive medicine, where, as mentioned in the first part of this paper, the moral dilemmas that challenge the physician are built around issues and concepts that are relevant for a religious approach. The core of the debate on the relation between bioethics and religion is represented by the "balance between protection for the distinctive religious witness of faith-based health care institutions and protection for the rights of individuals to seek reproductive services according to their own needs and particular moral values" (Ryan, 2006, 392). The balance between the respect for the religious beliefs and the best medical decision is a process that periodically demands adjustment and reevaluation, a process that implies a "never ending search for coherence and for solutions to new problems that may challenge our prevailing moral convictions" (Beauchamp, 2003, 270).

Even in a postmodern secular society, the "profound needs of human beings remain in their substratum deeply connected with the sphere of the sacred and of the desire to live in a universe of the values invested with a certain form of transcendent power" (Frunză, 2016, 17). Howard Brody and Arlene MacDonald underscore that the investigation of the relation between religion and bioethics within the framework of contemporary society has to take into account the answer to the two questions concerning religion in the postmodern world: firstly, what religion means and how we should think about it? And secondly, what is its role in democratic societies? (Brody and Macdonald, 2013, 133). Starting from the "weak" meaning of the term religion, understood mainly as a cultural form, influenced by various factors, the authors investigate the growing interest of medicine towards religion. They consider that the postmodern concept of religion and the special dynamics of the relation between the religious and the secular, understood not as "binaries or polarities, but fluid and porous cohabitants" (Brody and Macdonald, 2013, 138) represents a major challenge to bioethics. In order to underline this assumption, the authors try to demonstrate that the appreciation of religion in the public sphere is possible if we resort to Rawls's concept of "social reciprocity", which offers "a dual benefit of learning about

comprehensive doctrines foreign to our own. (...) If we view religion as embodied experience and as a form of social life rather than a set of fixed beliefs, we have even more grounds to insist that dialogue within the public square would be seriously impoverished if religious considerations were excluded" (Brody and Macdonald, 2013, 143).

Beside the benefits of dialogue, another key used for exploring the relation between religion and bioethics is the idea that religion can be understood as a social determinant in public health. The social determinants of health are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies and politics" (Idler, 2014, 8). Although the influence of religion on public health is not always benign, it is ubiquitous in most societies. The juxtaposition between religion and public health is justified because "religion, as public health, has an essentially social character and cannot be understood apart from the group of people who form themselves into groups for the purpose of practicing their faith" (Idler, 2014, 3). The author identifies several functions of religion that transform it in an "invisible social determinant", such as: social capital, social support, religion offering "health protective social ties in the lives of their members" (Idler, 2014, 5). Since it regulates behavior, Idler underlines at this point the complexity and the extremes which characterize the role of religion in public health as a control factor. The assumption underlying the analysis proposed by Idler is that the impact of religion on public health is not properly acknowledged by the specialized literature. Thus, she states that religion not being on the list of the social determinants of health represents a "blind spot" for any research on the social determinants of health, since religion is a "primary important determinant, both positive and negative, of popular health alongside economic inequalities" (Idler, 2014, 14).

Idler's affirmation of the significance of religion as a determinant of popular health is even more relevant if we focus on the area of reproductive medicine, since all traditional religions offer a different belief system and guidelines for the believers concerning sexual and reproductive health matters, and all religions are "concerned with affairs that are regarded as extraordinary and as having unique importance in life, being an intrinsic aspect of the culture of all societies", religious groups exerting an important influence on authorities in issues of reproduction in pluralistic societies (Schenker, 2000, 77-86).

Religion is a factor that acts upon the sexual and reproductive behavior and upon health-care utilization (Arousell and Carlbom, 2016, 78), with some important impact on the public policy concerning the reproductive health care. In this respect, a key role is played by the "ecclesiastical authority and its impact both on the personal decision and on the individual attitude towards the secular law that regulates the

reproductive health care" (Solinger, 2013, 34). An interesting example, with an important historical value, is the debate on the religious objection concerning the use of anesthetic in labor and the main argument that the author resorts to: "The very fact that we have the power by human measures to relieve the maternal sufferings, is in itself a sufficient criterion that God would rather that these sufferings be relieved and removed" (Simpson, 1847, 19).

The main implications of religion for the individual reproductive behavior point up both the obligation of governments to adopt legislations which reflect the socio-religious views of the majority of population, and the necessity of the balance of these views with the reproductive autonomy of citizens (Crozier, 2015, 396; Frunză, 2015, 65-74). This influence is relevant at the level of the believer's attitude towards sexuality. There are numerous studies which demonstrate the impact of religious affiliation on the sexual health knowledge, sexual attitudes and sexual behaviors, and demonstrate at the same time the necessity of taking into account the religious factor when "tailoring health education and promotion interventions to meet the specific needs of young people from a variety of different religions" (Coleman and Testa, 2008, 55-72).

Moreover, the religious factor acts also on the level of civil authorities in the field of reproduction health care, influencing the policies in the area. In Romania, for example, as A. Iordache states, the religious and conservative ethics strongly marks some of the legislative initiatives concerning the reproductive health. Analyzing the evolution of the initiatives regarding the control of reproduction in the Romanian context, Iordache draws attention to the fact that the recent discourse is under the influence of the ethnic nationalism and the "conservative ethos of the religious influence and the free market" (Iordache, 2014, 23).

4. Conclusions

Contemporary society is a secular society but the human need for the sacred is a constant that cannot be disregarded even when issues such as health policies are in discussion. Despite the fact that secularization represents one of the most important cultural and ideological product of modernity (Hosu and Frunză, 2013; Gal and Kligman, 2003; Fukuyama, 2004), religion, in more or less institutionalized forms, remains a major factor which acts both on individuals' attitudes concerning reproduction and on health policies, permanently challenging practitioners. Bioethics, as part of the morals of a society, is subjected to the influences of the characteristics and specificity of a community. The ethnic and religious particularities add some specific common laws to the general principles and they must be known and taken into account in the medical practice, in a manner that, as Beauchamp states, balances the general moral standards and the particularities characteristic for specific religions.

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