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# Special Editor

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# EDITORIAL

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The second issue of 2021 of the Journal of Intercultural Management and Ethics offers its readers an ethical and cultural incursion into the issues facing medical practice and medical systems in Romania and other countries around the world today, accentuated or highlighted by the current pandemic of COVID-19.

COVID-19 pandemic is a challenge for medical systems around the world, caused by problems such as caring for patients in conditions of medical uncertainty, overcrowding of medical institutions, limited material or human resources or restricting the population's access to certain medical services. The introduction of the new COVID-19 vaccines also raises ethical issues from the perspective of their administration and allocation within the framework of the human rights and the principles of bioethics. Despite the difficult problems generated, the COVID-19 pandemic may still contribute to the development of the health system, by placing emphasis on the quality of medical services, ethical risk management and the enhancement of human development, as showed in one of the articles of this issue.

Beyond the pandemic context, medical practice continues to face “traditional” existing ethical issues, which in turn require adequate attention and intervention. Among them, in this issue of the Journal of Intercultural Management and Ethics the readers can find an analysis of the ethical issues associated with the process of institutionalization in the Republic of Moldova of children from families with tuberculosis, which emphase the need for adequate protection of the children, based on their moral values and fundamental rights. Another problem approached in this issue is the care of terminally ill patients from the perspective of respecting their dignity. Therefore, respecting the dignity of terminally ill patients is crucial for providing adequate care. In the same time, the incorporation of the concept of human dignity in medical ethics educational programs for practitioners in the medical system becomes a stringent requirement.

Cultural factors, including religious ones, have an important impact on health systems and the health of the population. In this regard, this issue of the journal examines the link between the evangelical and charismatic religions and law in Uganda, as well as their implications for the public health system, bioethics and medical education. The analysis highlights the importance of efforts to counter the negative consequences in public health and ethics generated by the imposing of personal religious beliefs in politics and legislation, in order to improve the health of the population in this country.

This issue of the Journal of Intercultural Management and Ethics concludes with a reflection on the role and position of the physician in human society over time, which have remained constant despite the ever-changing historical and social context.

# ETHICAL APPROACHES ON THE MANDATORY VACCINATION IN THE PANDEMIC CONTEXT (ROMANIA CASE)

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## Abstract

The present pandemic situation created the context for the promulgation of a new legislation for certain public health issues with the intrusion into the citizens' private life. In addition, the medical professionals consider that returning to a normal life would be possible only after the majority of the population will be vaccinated. Although the Oviedo Convention promotes, without exception, informed consent to any medical intervention, by enacting specific legislation for mandatory vaccination, it will no longer be necessary to obtain the patient's consent. How will vaccination campaigns be implemented and carried out in that context? Can this approach regarding the exercise of external decision-making authority in the field of individual actions find other patterns of justification? What would be the impact of the mass vaccinations by compulsion on the individual? The purpose of this paper is to discuss the ethico-philosophical aspects of mandatory vaccination in a pandemic context and to analyze the possible objections to it by referring to the history of the movement against vaccination.

**Keywords**: autonomy, consent, opposition, mandatory vaccination, pandemic

## Introduction

The spreading of the Covid-19 pandemic around the world created the urgency of taking important medical decisions in a short term. Consequently, the process of developing a vaccine was speed-up: the vaccine against Covid-19 was released on the marketing in about 6-8 months (Katznelson, 2020). Because of the shortness of the Covid-19 vaccines testing, there were raised rumors about the medium and long term side effects of vaccination. Based on this view, the time was too short to observe how the body and the immunity react to the vaccine. A few studies on the Covid-19 vaccine hesitancy were conducted in the last months to have a better understanding on finding the right manner to lead successfully the vaccination campaign (UPMC, 2020).

To understand the hesitance of a certain part of the population toward the vaccination campaign against Covid-19, we should consider that here it is about a believe system built by convergence of at least three factors: the attitude toward the medical system in general, the views on the vaccination as prevention method and the information acquired on the development of the Covid-19 vaccines.

Firstly, we should consider the fact that a certain part of the population will have the suspicion tendency about any medical recommendation. It can be here an issue about the discrepancy (Hirsch, 2007, p. 512) between the subjective perceptions of the illness by the patient and the objective view of the healthcare professional on the same medical condition (Foucault, 2003). The main reason of the patient to refuse a certain recommendation could be based on his impression of not being understood by his medical doctor. This person may consider that the personal embodied perceptions of the disease are misinterpreted. The patient may have this impression concerning his physician because of his the willingness of to know more about his medical condition and the tendency of self-diagnose. Therefore, by his independent research the patient will obtain information from multiple sources. A healthcare professional could find even some contradictions in that amount of information because some of the sources are, usually, without any medical accreditation and based on some unreplicable cases. Moreover, some online resources even talk about the reasons why to keep prudence in considering the health professionals' recommendations. Even if there may be justified reasons for preferring a different treatment, the patient may develop doubts based on unsupported arguments (Danzon, 2010).

After the doubting attitude concerning the accredited medical knowledge, the patient may also have concerns about the vaccination itself. Therefore, the following section highlights some legal texts that may give support to the vaccination refusal. We will also consider the clinical approach on different cases, some of them not reacquiring the written expression of the patient's consent.

But concerning the common vaccination practice, the adult population is usually vaccinated with the verbal consent. They can also decide for not getting a vaccine, situation that may involve some consequences for them as citizens.

In the case of vaccination campaigns against Covid-19, the patient will offer his written consent (Parliamentary Assembly, 2021). Those who hesitate on the idea of getting vaccinated against Covid-19 spread rumors about a future context when the authorities will not take into account their refusal or a future probability of conditioning other rights – guaranteed in the present by the Constitution and international laws – by a kind of proof of their vaccination. The aim of this paper is to analyze and to build an ethico-philosophical approach which could be useful for the government and medical institutions in dealing with some groups' hesitancy on Covid-19 vaccines (Pepplinkhuizen, 2020).

## 1. Legal and clinical practice aspects concerning the vaccination refusal (in Europe and Romania)

From the *Nuremberg Code* (Hirsch, 2007 p. 159-167), the respect of the fundamental human rights in medical field was a concern at international level from different approaches. As a consequence, many other legislative texts were enacted later to establish the necessity of obtaining the patient's consent – free and well informed – for any medical intervention.

One of the most important international documents on this topic is the *Oviedo Convention* (Council of Europe, 1997), enacted in 1997 by the member states of the *Council of Europe*. The goal was the establishment, at the international level, standards concerning the respect of the rights and the human dignity in the context of life sciences. The second chapter of the Convention mentions the obligation to respect the consent of the patient as one of the most important pillars in preserving his freedom and the dignity in the medical context. Thus, the fifth article of the Convention presents the general rule of applying the informed consent rule:

> „An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.
> This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.
> The person concerned may freely withdraw consent at any time." (Council of Europe, 1997)

In the case of a competent person, without exceptions, the consent should be obtained for any medical intervention which is not in an emergency: like in the case of outpatient appointments, hospitalizations. This person also has the right to "withdraw [his] consent at any time". The procedure to be applied in the case of a person who is not able to offer his consent is mentioned in Chapter II, Article 6 (Council of Europe, 1997) and the Article 8 of the sames chapter writtes about the emergency context.

At the international level, the written consent is due in some cases (like in the case of an experimental protocol, surgical interventions, hospitalizations), but, most of the time, the patient will offer his consent by speech to the health professionals. (Aluaş, 2016, p. 50) This is an act of trust on the physician to follow the proposed treatment. In the case of surgical intervention or experimental treatments and procedures, even the Romanian legislation mention about the mandatory written consent. However, the medical staff has to provide enough information about benefits, risks and alternatives. Therefore, the patient himself must take the decision, free from any constraint or manipulation.

The Code of Medical Deontology elaborated by Romanian Medical College follow the European recommendation concerning the good practice in obtaining the consent:

> "Chapter. II – Consent ART. 11 Granting and withdrawal of consent (1) No intervention in the field of health may be carried out only after the data subject has given his or her free and informed consent. 2. Under the same conditions, consent may be withdrawn at any time by the data subject. (3) The provisions regarding the withdrawal of consent are also valid with regard to the consent expressed, in accordance with the law, by a person or institution other than that person." (Colegiul Medicilor din România, 2016)

In addition, the Law no. 46/2003 mentions, in Chapter III, Article 13, about the written refusal of a required medical intervention with a large impact on the individual's health: "The patient has the right to refuse or to stop a medical intervention assuming, in writing, the responsibility for his decision" (Parlamentul României, Legea nr. 46/ 2003) The same article mentions the obligation of the medical doctor to explain the consequences of his decision. By a literal reading of this article, the healthcare professional is not allowed to say anything that will constrain or manipulate the patient to take a certain decision. And, because of the context, the consequences presented to the patient should refer just to the medical aspects on the topic at that moment. The law does not mention explicitly about the social implications of the medical decisions; therefore, these are not to be taken as arguments for supporting a certain decision. Thus, the following phrase – despite of its truths – in said by a physician *"If you will not get vaccinated, you may not be able to work in a social environment."* could be interpreted as a transgression of the ethical and deontological principles of the medical profession. The Article 16 of the Chapter III from the same law mentioned above wrtites about the cases when the patient doesn't have the legal right to make the decision, this person still should be involved in "the decision-making process as far as his capacity for understanding allows it." (Parlamentul României, Legea nr. 46/ 2003) Here we can mention the minors or the mental alienated people who have to undergo to certain medical interventions.

In the emergency case, when the life of the patient is in an imminent danger, the medical staff will be in charge with the decision about the medical treatment chosen or the procedure applied. The second situation mentioned by the Law no. 46/2003, article 17, of the health professionals to be in charge with the medical decision is when the legal representative of the patient refuses to give his consent for a necessary medical intervention.

The mentioned legislative texts don't make any difference between the therapeutic medical interventions and the preventive ones. A lot of debates in the humanities go around the status of the individual in the medical context. The debates are also focused on the concepts more likely to be used, despite of their roots' meaning, with the interpretation assigned by the relationship of the individual with the medical staff. Therefore, the idea of being *the sick* person became a conceptual construct used in the clinical context to label, in relation with his medical condition, the receiver of the medical support: this person is seen as suffering from an illness – his disease being more important than himself as a person. (Chamayou, 2014) *The patient*, as a conceptual construct, gives the name to the relationship built between the individual and his physician, even if nowadays the focus is not anymore on the illness, but on status of the person as the client of the healthcare system. Moreover, the consumerist approach of the medical care I focused to replace the binomial of *health / illness* with the *quality of life* concept. (Aluaş, 2016, p. 31) WHO contributed to the establishment of some objectives criteria, by the quality of life construct, to consider a medical condition as worth living (Aluaş, 2016, p. 36).The medical intervention is not anymore performed just because of the patient's demand, but it is instituted as an act of authority, many areas of the life being medicalized (Iacob, 2013, p. 59). Therefore, the appellative of *patient* (sick or not) is addressed to any person who is the beneficiary of healthcare services: as a cure or for prevention.

The medicalization of different life's moments, parts of the social life centuries before (Iacob, 2013, p. 66), imposes limitation of the personal freedom: the patient can't live anymore a life without the intrusion of the medical system in his social life. In this context (as a direct result of the life medicalization process), scientific publications on the topic mention cases when a medical intervention could be performed even without obtaining the patient's consent. One case concerns so called *the obligatory medical treatments*. Vaccinations and other types of preventive measures or treatments provided in epidemic contexts (Aluaş, 2016, p. 51) may be performed even without the consent of the person. In this kind of context, who will be in charge with the possible undesirable consequences on the receiver's health or life because of the medical intervention? This is not about malpractice, but about the fact that some persons may have, in the context of the vaccination campaigns, some unknown sensitivity or allergy to some components of the vaccine. If that will be the consequence, how will be indemnified that victim of a public health policy? This is the most important concern for the Covid-19 hesitancy (Pepplinkhuizen, 2020).

Nowadays no law is yet enacted, at international level or at national level in Romania, for the mandatory vaccination of the Romanian population – even if there are cases when must the records of the received vaccines demanded(in the case of intercontinental traveling or inscription at the school). In the last years, the vaccination rate for many diseases dropped in Romania (Vos, 2020); therefore some debates were raised around the need of the legislatively introduction of mandatory vaccination. And urged by the pandemic context, the Romanian governmental authorities made a proposal for outlining a law concerning mandatory vaccination. That legislative proposal stipulates a few situations for mandatory vaccination (by referring to some clear sanctions and restrictions in the case of non-compliance):

- "vaccinations included in the National Vaccination Calendar for children;
- vaccinations imposed by epidemiological situations involving vaccination as an intervention in order to limit diseases that may be prevented by vaccination;
- vaccinations for medical staff working in public and private health units;
- vaccinations for other staff working in public and private units who, by the nature of their duties, are additionally exposed to infectious diseases or may be sources of infection that could endanger public health, established by government decision." (Guvernul României, 2020)

However, European Court of Human Rights, recently, elaborated a paper with juridical character that was enacted with the purpose to protect the rights and the dignity of the human beings against the risk that the European member states may impose mandatory vaccination in the context of the Covid-19 pandemic. (Irish Sentinel, 2021) The mentioned text can be found on the website of the Parliamentary Assembly of the Council of Europe. In the third section of the seventh article is mentioned that no one can be discriminated for not being vaccinated. Moreover, in this text is mentioned clearly the interdiction of any pressures to get the vaccine:

> "7.3.1. ensure that citizens are informed that the vaccination is NOT mandatory and that no one is politically, socially, or otherwise pressured to get themselves vaccinated, if they do not wish to do so themselves;
>
> 7.3.2 ensure that no one is discriminated against for not having been vaccinated, due to possible health risks or not wanting to be vaccinated;" (Parliamentary Assembly, 2021)

The forth subsection (7.3.4.) urge for the distribution of "transparent information on the safety and possible side effects of vaccines, working with and regulating social media platforms to prevent the spread of misinformation" (Parliamentary Assembly, 2021). Applied with an ethical approach, the efforts performed in this direction would have a good contribution at reaching the necessary vaccination rate for the herd immunity (Pepplinkhuizen, 2020). This paper also make a recommendation about how to deal with the hesitancy: "take early effective measures to counter misinformation, disinformation and hesitancy regarding Covid-19 vaccines". (Parliamentary Assembly, 2021) Misinformation and disinformation are two unethical behaviors at the informational and communicational level which have as consequence the lack of important information that may help the individual to take the right decision (Vos, 2020). However, that affirmation concerning the hesitancy is still unclear in some aspects: can we place the hesitant attitude of a person or a group in the same category? For what reasons this kind of behavior could be considered unethical? Should we take action against it? For what reasons and by what means would be implemented this kind of actions? Even if this paper does not have the authority of an international law or convention, its formulation – by approaching similarly misinformation, disinformation and hesitancy – could be interpreted as a demand to treat any hesitancy as a crime against the society.

In the following section we will analyze the type of arguments brought by those raising their voice against the mandatory vaccination. The discourse about the present pandemic and the vaccination against Covid-19 is full of confusion concerning the terms and concept used; this confusion also characterizes the intentions with the public health policies implemented. What kind of behaviors are ethical and which ones are unethical and should be prohibited? If a person, by the international and national legislation, has the right to refuse vaccination based on some medical contraindications or religious/philosophical views to other vaccines currently used, we can assume that this person will have, firstly, a hesitant attitude. How can be worse to be hesitant than to have been decided to not get vaccine? This paper mention that no one will be discriminated for not having the vaccine, but all the efforts should be made against a hesitant attitude. Approaching in this way two almost similar concepts will lead to a real confusion in its interpretation. Moreover, can we forbid this hesitant person or decided to not getting the vaccine to share about her concerns on the Covid-19 vaccine as long as there is nothing about misinformation, disinformation or any other unethical behavior? This person probably will also use mass-media or social medial to let other people know about his personal decision to not get the vaccine based on some medical contraindication, some case of side effects to the Covid-19 vaccine or merely because of religious/philosophical beliefs.

## 2. Considerations on the vaccination behaviors and practices

### 2.1. Arguments against mandatory vaccination

Even if vaccination is considered, based on statistics and studies, to be a very effective preventive intervention (Bégué, 2010, p. 720), the oppositions to the legalization of the mandatory vaccination schedules or campaigns are as old as the vaccination itself. (Dr. Brouwer, 2011) With the time, the vaccines opposition was even augmented – many the *anti-vaxx* groups appearing around the world (Pepplinkhuizen, 2020). The arguments brought by them are based on different aspects concerning the production, the commercialization and the administration of the vaccines; but all of the arguments could be classified in the following categories: arguments based on medical reasonable grounds, questionable arguments, oppositions based on believes and personal convictions, rumors and pseudo-science (Bazin, 2010). Nowadays – in the context of Covid-19vaccine – some of the reasons are changed, but the same categories still remain.

The most important reasons of being against the vaccination are based on the interpretations and fears related to its medical aspects. Historically, at the beginning of their use, a huge cause of the vaccines' rejection was the fear of contamination (Bazin, 2010, p. 707). In the present, the safety of the production and administration of the vaccines is one of the priorities – the medical biotechnologies are well improved. Therefore, the risk of contamination is very low (Vaccins et demain? – dossier, 2010). Other two fears, brought even today by some groups, concern the safety of the vaccine itself, along with the risk to have some personal biological sensibilities or a kind of immune response that may lead to serious side effects to the vaccine (Dr. Brouwer, 2011). Even if the probabilistic knowledge concerning the physiological response to vaccines was improved and the technologies of their production were changed significantly, those concerns were highlighted by recent studies as the most important aspects in the decision to get the Covid-19 vaccine. A study by Lazarus and his team (2020) on the acceptance of Covid-19 vaccine showed that "71.5% responded that they would take a vaccine if it were proven safe and effective" (Lazarus, 2020, p. 3).

The second type of reasons listed by the opponents to vaccination is questionable because it is not possible for them to prove their arguments based on official statistics. Here we can talk about the conviction of some individuals, that the diseases may disappear on their own or only as an effect of hygiene or through natural immunization. (Bazin, 2010, p. 708-709; Autrive et al., 2003). This approach is not directly related the Covid-19 vaccination campaign, but having those ideas on the background of the mind, the population will be more prone to refuse getting the Covid-19 vaccine.

At the level of personal believes and convictions, a person would refuse the vaccine despite of her a strong conviction about the vaccine efficacy: this kind of decision is based merely on philosophical or religious view of the world (Bazin, 2010, p. 710-713).Therefore, an individual may consider the vaccination as: an attack on providence and trust in divinity, an immoral act (especially, in the case of the vaccines that may prevent sexual transmissible diseases), an attack to the personal freedom, a sin because of using human or fetal tissues on their production, a foreign administrative intrusion in their own country. This king of arguments may influence strongly the Covid-19 vaccines' oppositions as long as, in this pandemic context, the population was confronted severely with the limitation of the personal freedom. In this context, many social media influencers brought attention on the arguments supporting their strong skepticism about the future evolution of the personal freedom (Ferro & Miotto, 2017; Vos, 2020). The people who are strongly attached to their moral – and religious believes – arguments for their decision to refuse the vaccination has the tendency to consider the intrusion of the medicine in the social and personal sphere of life as a new form of religious system:

> "The faith in this new religion became, in the present, a real fanaticism and the gods were replaced by mandarins and experts. We don't think anymore, we "believe". We could excuse Shaw for saying that "the science is a new religion and la vaccination is its Holy water"." (Simon, 2009, p. 219)

The last category of arguments is represented by rumors and pseudo-science. This category of arguments mat also be include the attacks on the name or character of some personalities in the fields related to the vaccination (Bazin, 2010, p. 713-717). Definitely, the information spread by this kind of arguments is not based on medical evidences proved by studies and statistics. However, people will talk about stories built around some vaccines adding a few facts based even on some medical data. In order to support their decision to not get the vaccine, people can spread and catch: conspiracy theories (Lazarus, 2020), urban legends (Ferro & Miotto, 2017) as stories shared on social platforms and pseudo-medical forums, the subjective experience of their acquaintances. Even if those kinds of narrative arguments existed from the beginning of the vaccination, in the present context of Covid-19 vaccine development and implementation of the vaccination campaigns, the governmental and medical authorities have to face a lot of disinformation (Pepplinkhuizen, 2020). Some of the conspiracy theories arrived to the promotion of the idea that in the development of the Covid-19 vaccine will be used biotechnologies that will allow to the mentioned authorities controlling the behavior of the population. There is supposed to be even a link between the vaccine and the 5G mobile networks.

### 2.2. An ethical-philosophical reflection on the right for Covid-19 vaccines hesitancy

Taking into account all the categories of arguments mentioned above, the most reasonable ones are those that rely on medical aspects and, therefore, can be analyzed from a medical perspective by some independent researchers or by observing the official statistics. As a good example of an ethical debate about the Covid-19 vaccine based on medical facts is the approach brought by a few medical professionals had some concerns on the following aspects: the shortening of the study phases for the new vaccine development, the uncertainty about what side effects may occur after vaccination (in medium and long term), the uncertainty about the risk / benefit ratio between the disease itself and the vaccine (Williams, 2020).

By contrast, the narratives built and shared about this disease and Covid-19 vaccine have a subjective character. However, a subjective experience cannot be denied because each person has different perceptions concerning the personal embodied process. However, the theoretical construct built on a subjective experience, the link between different social events or the motivation assumed to be behind the governmental and medical authorities' action to implement certain public health policies can be analyzed by an ethical approach. Two important pillars in this approach will be: to document the objective evidences of certain stories and to analyze the logical validity of the arguments' construction.

The arguments based on personal believes and conviction for the vaccines' refusal have their focus on the morality of the vaccination as an act that may transgress the philosophical or religious views on the freedom and dignity of the human being. Those moral interpretations consider some of the aspects of the medicalization of the personal and social life to be a biopowers (Foucault, 2007) implemented to control the individual in his private sphere of living: biopolicy concerning the personal life aspects of the citizens.

At the base of the contemporary development of the clinical practice, we can find the four principles of biomedicine: autonomy, nonmaleficence, beneficence and justice (Beauchamp & Childress, 2013). Each of those four principles is supposed to be applied simultaneously in all medical contexts. But, unfortunately, as a result of their focus on the health, the disease and the individual himself, different medical departments may arrive even to an opposing approach of the same case. As an example, the public health service has its focus on the health of the general population and not on the patient as one individual. Therefore, the medical decisions taken by the public health system are based on statistics and not on particular cases. Or this aspect, for the most of the patients is less relevant as long as their case can be represented by the small percentage of those who may have serious side effects to the vaccine (Autrive et al., 2003). Moreover, in the vaccination context, it is about a preventive action. Or, the patient tends to be less prone to accept a medical intervention in the absence of pain and suffering (Bazin, 2010).

Most of the contemporary thinkers describe the present living context as a *risk society* (Pestre, 2013, p. 115). By consequence, each person must to choose between different kinds of risks in any medical decision. In the pandemic context of Covid-19, decision of the patient risk is between the illness itself and for the risk supposed by the vaccination. Some very important questions, from the ethical-philosophical perspective will be: is the patient aware that his existence takes place in a risky society? Is he aware that his choice is between the risk of the disease itself and the risk induced by vaccination? The individual is focused on preserving the present state of health and avoiding all possible risk of getting sick. Despite the technological progress, we still have to choose between different risks and dangers. From this approach, the concern of those who have to take a decision is about the statistical data of the dangers of the disease itself in rapport with the supposed risks of the vaccination. In the present, maybe, we still miss the complete data on medium and long term of Covid-19 vaccines, as some healthcare professionals suggest (Williams, 2020). In the same time, it is not possible for our society to wait a few years before taking action to stop the spreading of the SARS-Cov-2 virus.

Because of the present context and the urge to take rapid decisions, the public health system has to deal with the perception of the individual in relation with his own body, but also in relationship with others. Does the individual consider that his body belongs to him or does he only himself as benefiting from its use? What is the real status of the body in the public space? To whom does the biological body "belong"? Who can make decisions and to whom does the responsibility belong? By answers at these questions, each individual will attribute a certain value to the personal wellness and that one of the community.

To stop the spreading of the Covid-19 disease, the rights of the individuals were limited, but what kind of decisions can be made intrusively? Is this acceptable from the highest moral point of views? To what extent are the legislative decisions taken by public health system in accordance with the public discourse on the status of the body, being supported by it? Is that discourse based on ethical foundations or are there issues that may lead to abuse against vulnerable groups? The discourse about the vaccination against Covid-19 is focused a lot on mentioning about the vulnerable groups, but how do we define the idea of “vulnerable group”? It is about the vulnerability in relation with their lack of knowledge concerning the disease and the vaccine or about the vulnerability of getting the disease, being too much exposed? Most of the discourses mention about the last kind of vulnerability promoting the arguments for the vaccination. But, in a pandemic context, the first mentioned kind of vulnerability could be more dangerous sometimes. It is important to know if a decision is taken because of the lack of knowledge or because of other kind of subjective reasons. Each one of these groups should be treated differently. A person may be hesitant based on some subjective personal reasons – philosophical, religious – and nobody has the right to act against the conscience of one individual. Moreover, a person has the right to take a certain decision concerning her own person even without explaining this attitude. This is a natural and fundamental human right.

The international legislative documents highlight that the vaccination against Covid-19 cannot become mandatory and no one can be the target of any kind of pressure or discrimination. But how exactly will be defined the terms of mandatory vaccination, pressure or discrimination? In order to avoid any misinterpretation and to assure good respect of the human dignity and rights, the mentioned terms should be clearly defined and described, by the international documents, for their appropriate contextual use or for the implementation of some actions based on them.

*Plenary approach on the freedom concept of the philosophico-theological thinking of the Middle Ages applied to the ethical considerations on the mandatory vaccination proposals for the present pandemic context*

The concept of freedom has a long history in the philosophical thinking, being debated by its integration in conceptual constructs based on theological or naturalist views of the world. But a plenary view of the freedom concept is rooted in the theological philosophy which sees the divinity in the center of the mundane existence, offering the free will to the human being for taking an independent decision. Does God take any action to prevent a certain decision or a hesitant attitude? The predestination was an important issue in the Middle Ages' debates. Augustine was one of the most important philosophers and theologians that wrote on this topic, answering to the Pelagius' heresies. This important thinker supported the idea that, even if God knows the decision and its consequence – for a certain person – He will not predestinate any person to a certain destiny (life and type of judgment) (Augustin, 1886, p. 1399). The Christianity of the Middle Ages was confronted, for a few centuries, with debates on this topic. Even if the sovereignty of God was accepted without doubt, the debates' focus was on the responsibility of the human beings for their actions and the dignity given by the possibility to take independent decisions (Forlines, 2011). These two aspects were considered to be fundamental for the quiddity of the human being and existence.

Considering the idea of not being *a priori* predestined to a certain kind of life and the freedom concerning the personal decision, we can draw an analogy between this Middle Ages' theological topic and the present vaccination context. This analogy can also be supported by the thinkers that sees it (the vaccination along with the medicine itself) to have the same functions in the present society as the religion in the earlier centuries (Simon, 2009, p. 219). By statistics of the vaccination programs implemented in the present, a part of the population is immunized, a certain percentage is not immunized, without affecting their health, but it will remain a small part of the population with side effects because of their sensitivity to the vaccines' components. Even if we have estimations, it is yet too early to have a clear image of each category's percentage for the population to be vaccinated against Covid-19. However, can we "predestine" different categories of the population for a certain quality of life? If we only knew exactly which one of these people is in each of the three categories, will we make the same decision based on non-discrimination principle? Not knowing their identity could be taken as an excuse to promote mandatory vaccination or for conditioning other rights on getting the vaccine. But the fact that we do not know ahead their identity – still knowing that these groups exist, based on the previous vaccines statistics – is a sufficient argument for condemning a hesitant attitude and putting it in the category of dangerous behaviors? A superficial approach of this question may lead to a slippery slope evolution toward the mandatory vaccination without exceptions, which from a plenary view of the freedom concept is unethical and dangerous.

How can we prevent the evolution of slippery slope kind of reasoning and legal acts' interpretation toward the mandatory vaccination imposed by law? Is it ethical, at all costs, to conduct pre-vaccination testing in order to find out if there are high chances for a patient to suffer from serious post-vaccine side effects or the opposite behavior should be considered the ethical one? What ethical implications, concerning the responsibility of actions, may have to know or not if the body of a certain individual will have a certain type of response to the vaccine? Is the vaccination a context in which the morality of an action is decided by the society as a corpus (by the majority of the votes) or is it necessary to be based on an individual moral reflection (that will be validated and respected at the community level)? Should the approach of the preventive public health policies be based on a deductive or inductive construction of the ethical reflection? How is the patient educated in this regard to understand the construction of the arguments that stand at the foundation of the vaccination efforts? The government and the medical authorities may propose and implement certain preventive public health policies, but, in the same time, they have to take the full responsibility on the health of the citizens by considering ahead the questions above. Otherwise, the patient has the full right to be hesitant on any public health policy proposal.

The questions mentioned above should find answers or, at least, to give the opportunity to think deeper to those who plan and implement the vaccination campaigns against Covid-19. Indeed this topic is a tough one, with a lot of ethical, medical social implications at different levels of the society, but the way of how the vaccination campaigns appear to be planned, through mass-media and social media, and the discourse around this topic let the impression of not caring enough about the psycho-emotional issues and personal values of the citizen in taking a certain decision at the public level.

## Conclusion

The human being living in the present society has to assume certain risks taking most of the decisions, especially those concerning the medical field. When a person will opt for a decision in the context of Covid-19 pandemic, he/she has to be aware that the decision is between the dangers of the disease itself and the risks of the vaccines. For the moment, the healthcare professionals don’t have the final statistics on medium and long term concerning the vaccine, but they have better statistics about the dangers of the Covid-19 disease.

The ethical-philosophical concern raised by this context is about how the vaccination campaigns are managed and how the population is informed and supported in taking the right decision that will augment the beneficence for all the involved parts and, in the same time, will lower the danger rates of illness by Covid-19 or acquired as side effects to the vaccination. The wrong handling of this vaccination campaign against Covid-19 may contribute to the conspiracy theories’ spreading that will undermine the trust of the population on the medical system and in the government. Therefore, those two public authorities have to give the impression of a good interest in the population’s health, by proving comprehension and empathy toward their worries. A fundamental question to ask in leading the public campaigns of vaccination against Covid-19 is: Will this public health policy as a whole, contribute at improving the population's confidence in the health system / the medical staff and the government or will it undermine their trust on long term?

The focus of the public health policies and the government is on the wellness of the community as a whole, but the structural component of the community is the individual. The community is formed by each individual, not just by some citizens. In a society where just the majority or some individuals matter based on some discriminatory criteria, a person may be regarded as not important, at any moment, and to be pushed to assume some uncomfortable risks. Could we find an approach whereby individual and collective interests are not in opposition? Studies proved that the population is more prone to accept the vaccine if this is perceived as being a personal decision. (Lazarus, 2020, p. 3) To what extent does the patient feels his own person as a part of the decisions taken in the present pandemic context? The language used in the international documents and in mass-media is not the best chosen to build the trust and the cooperation at the community level.

By a philosophical approach of this topic, the focus should be on establishing the involved concepts, making explicit for the population their definition for the present context, analyzing their implications in leading the vaccination campaigns against Covid-19 and their impact on the population’ decision by the use of certain discourse on the present topic. Moreover, one of the most important aspects in the assurance of the highest ethical standards of the vaccination campaigns is to ask the right questions in planning and implementing these preventive public health policies. The present article was focused, by ethico-philosophical reflections on the topic, on finding some important questions to be asked in the present pandemic context. From a philosophical approach, there is a plurality of sides to observe in the vaccination campaigns against Covid-19. Denying even one subjective side or view on the present context promoted by some groups will lead, probably, at breaking the communication and their trust, at long term, in the health system and government.

## References

Aluaş, M. (2016). *Bioetică Medicală.* Cluj-Napoca: Medicală Universitară „Iuliu Hațeganu”.

Asveld, L. (2008). Mass-vaccination programmes and the value of respect for autonomy. *Bioethics, 22(5)*, 245-257.

Augustin. (1886). *A Treatise On The Predestination Of The Saints Nicene and Post-Nicene Fathers 1-05.* (P. Schaff, Ed.) Edinburgh: Wm. B. Eerdmans Publishing Company.

Augustin. (2002). *Despre liberul arbitru* (ediţie bilingvă ed., Vol. Opera omnia vol. 2). (V. Sav, Trans.) Cluj-Napoca: Editura Dacia.

Autrive, P., Buchwald, G., Clements, J., Dunbar, B., Gaublomme, K., Georget, M., . . . Shattock, P. (2003). *Les vaccinations en question* (Collection La preuve écologique ed.). Paris: Frison-Roche.

Bazin, H. (2010). Histoire des refus vaccinaux 2010. *Bull. Acad. Natle. Med., 194, nºs 4 et 5*, 705-718.

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of Biomedical Ethics* (seventh edition ed.). Oxford: Oxford University Press.

Bégué, P. (2010). Conséquences des oppositions vaccinales en France et en Europe. Comment maintenir une couverture vaccinale efficace en 2010?, *Bull. Acad. Natle. Med., 194, nºs 4 et 5*, 719-732.

Bégué, P. (2010). Séance dédiée a la vaccination et société. présentation. *Bull. Acad. Natle. Med., 194, nºs 4 et 5, 703.*

Carr, S. (2019). *The Synod of Dort Was Protestantism's Biggest Debate. Why Arminians and Reformers squared off 400 years ago.* Christianity Today. https://www.christianitytoday.com/history/2019/december/synod-dort-reformer-arminianism-tulip.html

Chamayou, G. (2014). *Les corps vils. Experimenter sur les etres humains au XVIIIe et XIXe siecles.* Paris: La Decouverte.

Colegiul Medicilor din România. (2016, November 4). *Codul de deontologie medicală (2017).* https://www.cmb.ro/legislatie-colegiu-cod-deontologic/

Council of Europe. (1997, IV 4). *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Oviedo).* https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf98

*Covid-19 vaccines: ethical, legal and practical considerations.* (2021). Parlamentary Assembly. https://pace.coe.int/en/files/29004/html?fbclid=IwAR2MzKJ4ga57jY-Ytc7ZpCQwYiYSQALVk7UOjy4J3ftEFvWuROqYn6Gjmtg

Danzon, M. (2010). Décision et controverses. *Les Tribunes de la santé, 2*(27), 111-116.

Dr. Brouwer, L. d. (2011). *Vaccinarea: eroarea medicală a secolului - Pericole și consecințe.* (N. Radu, Trans.) Bucarest: Vida.

Ferrell, V. (2004). *The Vaccination Crisis.* Altamont, NT, USA: Harvestime Books.

Ferro, A., & Miotto, S. (2017). *Urban legends and vaccines.* In Vaccinars in Sadergna: Urban legends and vaccines

Forlines, F. L. (2011). *Classical Arminianism. A Theology of Salvation.* Nashville: Randall House Publications.

Foucault, M. (2003). *The Birth of the Clinic.* London: Routledge.

Foucault, M. (2007). *Naşterea biopoliticii.* (B. Ghiu, Trans.) Cluj: Ideea&Design Print.

Foucault, M. (2009). *Securitate, teritoriu, populaţie.* Cluj: Idea Design & Print.

Gauchet, M. (2006). *Ieșirea din religie.* (M. Antohi, Trans.) Bucharest: Humanitas.

Guvernul României. (2020). *Proiectul de Lege privind organizarea şi finanţarea activității de vaccinare a populaţiei în România, adoptat de Guvern.* https://www.gov.ro/ro/guvernul/sedinte-guvern/proiectul-de-lege-privind-organizarea-si-finantarea-activitatii-de-vaccinare-a-populatiei-in-romania-adoptat-de-guvern

HealthGuard. (n.d.). *The Top Covid-19 Vaccine Myths Spreading Online.* https://www.britannica.com/list/the-top-covid-19-vaccine-myths-spreading-online

Hirsch, E. (Ed.). (2007). *Ethique, medecine et societe. Comprendre, reflechir, decider.* Paris: Librairie Vuibert.

Iacob, I. F. (2013). *Sănătate, boală, vindecare: O perspectivă socio-culturală.* Cluj: Pressa Universitară Clujeană.

Irish Sentinel. (2021). *European Court of Human Rights : Voted that prohibits member states from making vaccination against the coronavirus mandatory.* Irish Sentinel. https://theirishsentinel.com/2021/01/29/european-court-of-human-rights-voted-that-prohibits-member-states-from-making-vaccination-against-the-coronavirus-mandatory/?fbclid=IwAR1EfJw_M8Dr9xfrKsOwQHdVe91X-ZHL_5efFPxhyhmwjO1fmOO2n1USt7M

Katznelson, B. (2020). *Politics vs. science: the politicization of Covid vaccination.* https://www.urbanlegendnews.org/uncategorized/2020/11/19/politics-vs-science-the-politicization-of-covid-vaccination/

Lazarus, J. V. (2020). A global survey of potential acceptance of a Covid-19 vaccine. *Nature Medicine,* 2-10.

Oprea, L., Gavrilovici, C., Vicol, M. C., & Astărăstoaie, V. (2013). *Relaţia medic-pacient.* Iaşi: Polirom.

Parlamentul României. (2003). Lege nr. 46/2003 drepturilor pacientului. *Monitorul Oficial al României nr 51 din 2003-01-29.* http://legislatie.just.ro/Public/DetaliiDocument/41483

Parlamentul României. (2017). *Lege privind organizarea și finanțarea activității de vaccinare a populației în România.* http://www.ms.ro/wp-content/uploads/2017/04/LEGEA-VACCINARII-10.04.2017-002.pdf

Parliamentary Assembly. (2021). *Covid-19 vaccines: ethical, legal and practical considerations.* https://pace.coe.int/en/files/29004/html?fbclid=IwAR2MzKJ4ga57jY-Ytc7ZpCQwYiYSQALVk7UOjy4J3ftEFvWuROqYn6Gjmtg

Pepplinkhuizen, M. (2020). KU Leuven working with other European institutes to understand vaccine hesitancy. *Veto*. https://www.veto.be/artikel/ku-leuven-working-with-other-european-institutes-to-understand-vaccine-hesitancy

Pestre, D. (2013). *A contre-science. Politiques et savoirs des societes contemporaines.* Paris: Seuil.

Simon, S. (2009). *Vaccins, Mesonges et Propagande.* Vergeze: Thierry Souccar Editions.

Truchet, D. (2010). L’avenir de l’obligation vaccinale: aspects juridiques. *Bull. Acad. Natle. Med., 194, n°s 4 et 5,* 733-740.

UPMC. (2020). *COVID-19 VACCINATION. COVID-19 Vaccine Myths and Facts.* UPMC Health Beat. https://share.upmc.com/2020/12/covid-19-vaccine-myths-facts/

vaccinations, L. (2010). *Dossier, adsp (actualité et dossier en sante publique), n° 71.*

Vaccins et demain? – dossier. (2010). *Biofutur, 306.*

Vos, E. (2020). *Mandatory Vaccination in Romania: Back to Vax.* Pharma Boardroom. https://pharmaboardroom.com/articles/mandatory-vaccination-in-romania-back-to-vax/

Williams, L. (2020). Covid vaccine: even healthcare workers may be hesitant – but new evidence can be reassuring. *The Conversation*. https://theconversation.com/covid-vaccine-even-healthcare-workers-may-be-hesitant-but-new-evidence-can-be-reassuring-151404

# EARLY APPROACHES IN MANAGEMENT OF SARS-CoV-2 INFECTION

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## Abstract

SARS-CoV-2 infection is an infectious pathology that currently poses an exceptional threat to global public health and safety. Of great necessity was the rapid discovery of the effective vaccine, thus leading to the acceleration of ethical approaches to research, including by conducting controlled clinical trials. The therapeutic protocol has always been updated, since the beginning of the pandemic in March 2020, for the correct therapeutic control.

We conducted a study on cases of SARS-CoV-2 infection hospitalized between 15 March and 30 November 2020 in the "St. Parascheva" Clinical Hospital of Infectious Diseases of Iasi, with various forms of the disease.

More than 30% of cases were severe and critical forms in people with multiple comorbidities, requiring evaluation, monitoring and treatment in the Intensive Care Unit. The treatment regimens, according to the national protocol periodically revised, included association of antivirals, anti-inflammatory medication and immunomodulatory monoclonal antibodies. The risk of various therapeutic associations has always been assessed in order to maximize the effectiveness of treatment and to promote favourable evolutions.

Management of patients with SARS-CoV-2 infection, which also suffered from other diseases, requires interdisciplinary collaboration, while maintaining ethical standards. Nevertheless, the overall effectiveness of immunisation with available SARS-CoV-2 vaccines will be essential to reducing morbidity and mortality in general population.

**Key words:** SARS-CoV-2, COVID-19 pandemic, management, ethical aspects.

## Introduction

Different regions of the globe were affected by the pandemic due to a new coronavirus since January 2020. As of 11 February 2020, data from the World Health Organization (WHO, 2020) have shown that more than 43000 confirmed cases have been identified in 28 countries/regions, with more than 99% of cases being detected in China. On 30 January 2020, the WHO declared COVID-19 as the sixth public health emergency of international concern (Lai et al., 2020). On March 11, 2020, the World Health Organization has declared the new coronavirus (COVID-19) outbreak a global pandemic (Cucinotta & Vanelli, 2020).

Managing the pandemic has been a challenge, while most SARS-CoV-2 infections are not severe, a significant percentage of patients require hospitalization, and many fatalities occur, with increased rates of severe and fatal disease among older individuals (> 65 years old) and those with pre-existing medical conditions like cardiovascular disease, obesity, and type 2 diabetes mellitus. Severe cases can progress to respiratory failure associated with diffuse alveolar damage and acute respiratory distress syndrome (Moderbacher et al., 2020).

Managing all the issues related to the infection with SARS-CoV-2 has been a real challenge. Each hospital began to establish its own protocols based on scientific data and information they could gather about the pandemic in the media, in networks or in the experience of other centers (Yepes-Temiño et al., 2021).

The beginning of the pandemic in Romania included a period of almost 16 weeks, when hospital admission of patients diagnosed with SARS-CoV-2 infection was mandatory by law, which was perceived as an abuse and violation of their rights by many of them. Public authorities had made that decision in an attempt to limit the spread of SARS-CoV-2, while also assuming the risk of creating various ethical conflicts, which indeed appeared later on. Ethical conflict is defined as a problem that arises when one considers that the idea of “good,” “right” or “doing the right thing” in relation to other people’s welfare or best interest is being compromised (Turale et al., 2020). That problem was solved with the cancellation of mandatory hospitalization by the Decree no. 1137/2020 (Ministry of Health, 2020).

Even before the current pandemic, studies had identified a variety of potential ethically conflictive scenarios in hospitals. These scenarios tend to be related to confidentiality, informed consent and respect for the interests of the patients and their autonomy (Laventhal et al., 2020).

Guidelines have been approved worldwide in order to standardize medical treatment of the SARS-CoV-2 infected patients, but the patient's consent was still required. The therapeutic protocol was periodically updated, from the beginning of the pandemic (March 2020), in order to keep up with medical advancements in the field.

During the pandemic, there were countries, such as Italy, with an overwhelmed health system, lacking hospital beds to accommodate all SARS-CoV-2 infected patients, especially in Intensive Care Units (ICUs). These lead to ethical dilemmas, by having doctors assume an ungrateful role, deciding who will be admitted in hospitals/ICUs and who will not. In these situations, the involvement of an ethics committee is very valuable. The ethics committee applies a reflective perspective on the fundamental ethical principles, in order to elucidate and respectively solve the possible ethical problems in different complex clinical scenarios (Blot et al., 2020).

The rapid discovery of an effective and safe vaccine was of great importance and this was possible by conducting controlled clinical trials ethically approved. In Romania, the vaccination campaign started at the end of December 2020 and by January 15th, 2021, almost 160.000 health workers were vaccinated (Romanian Government, Communication Group of National Coordination Committee for COVID-19 Vaccination Activities, 2021).

In clinics, the ethical aspects were pursued, especially by informing the patients about the form of the disease, the necessity or recommendation of the hospitalization and explaining the specific therapy, before asking them to provide the informed consent.

## Material and Methods

We performed a retrospective study including patients diagnosed with SARS-CoV-2 infection and hospitalised between March 1st and November 30th, 2020, in the “St. Parascheva” Clinical Hospital of Infectious Diseases of Iasi, using information recorded in their medical files. The aim was to highlight the severity of the disease and the challenges raised by the medical and ethical management of patients. We analysed the patients’ characteristics, such as age, gender, medical history, disease severity, presence of complications (COVID-19 pneumonia) and evolution, while also taking into consideration the ethical aspects.

## Results

There were 4101 (1913 men and 2188 women) patients with SARS CoV-2 infection, admitted in our hospital during the mentioned period, with a signed informed consent provided by the patients in the first day of their admission. From those, 3536 patients were from Iasi and 565 from other counties. We found 49% of cases with severe forms of disease, with 30% having a critical status (fig.1).

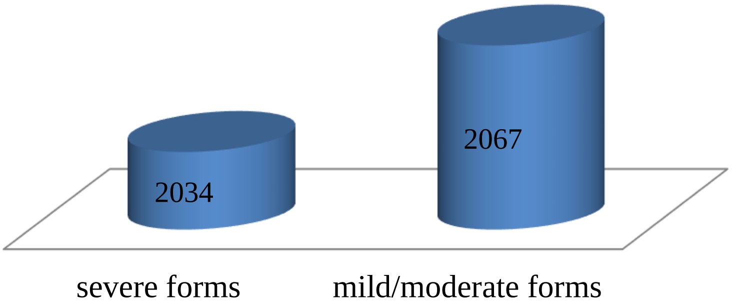

Fig. 1. Severity of SARS CoV-2 infection

The patient profile was: female, aged between 45-54 years old, with medical history of hypertension, obesity or diabetes mellitus (fig. 2, fig. 3, fig. 4).

Fig. 2 Gender distribution of cases with SARS CoV-2 infection

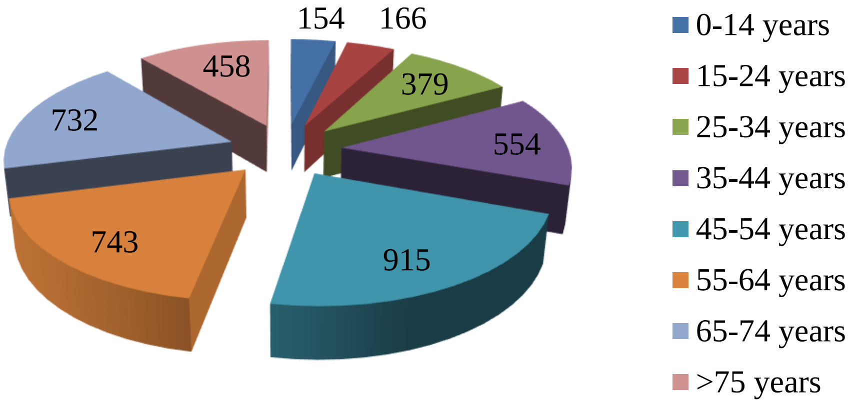

Fig. 3 Age distribution of patients with SARS CoV-2 infection

Out of 4101 patients with SARS-CoV-2 infection, 2438 had other comorbidities (fig.4).

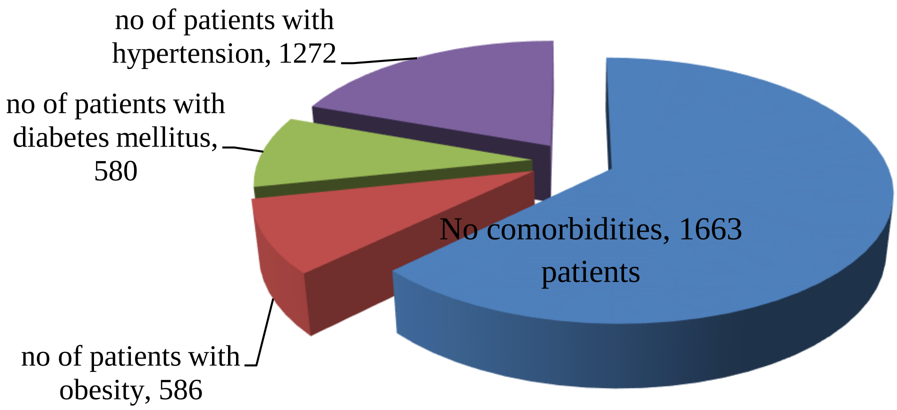

Fig. 4. Patients with SARS-CoV-2 infection and comorbidities

Average length of hospitalisation was 9.62 days. In 46% of cases, lung damage was associated, developing COVID-19 pneumonia (fig.5).

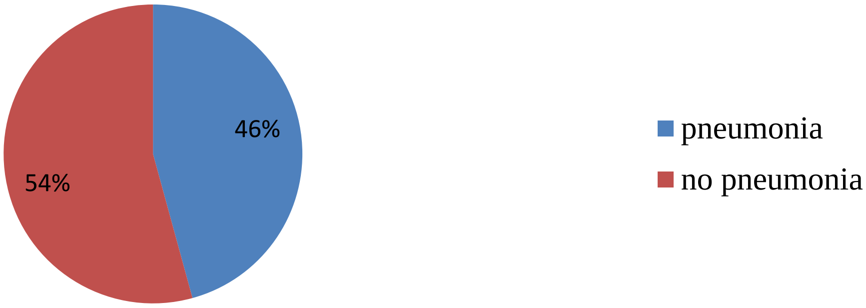

Fig. 5 Patients with SARS-CoV-2 infection and COVID-19 pneumonia

The evolution was unfavourable in 6% of the cases, leading to the death of 248 patients (146 men, 102 women) (fig.6).

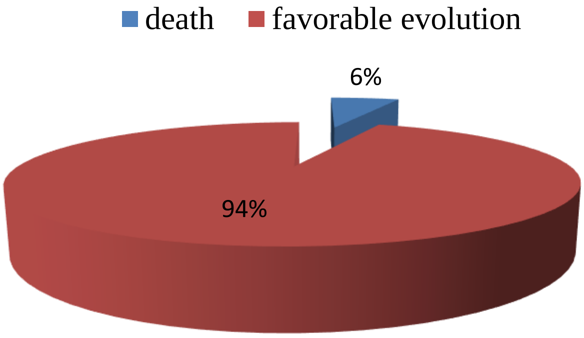

Fig. 6 The evolution of cases with SARS CoV 2 infection

## Discussions

The treatment regimens used in the SARS CoV-2 infected patients, according to the national protocol, included a combination of antivirals, anti-inflammatory medication and immunomodulatory monoclonal antibodies. The patients diagnosed with SARS CoV-2 infection were informed about the necessity of hospitalization and the availability of antiviral therapy. The informed consent was signed by the patients before any medical procedure was performed. The ethical aspect was pursued, especially by informing the patients about the form of the disease, the necessity or recommendation of the hospitalization and explaining the specific therapy, before asking them to give their informed consent.

The risk of therapeutic interactions has always been assessed in order to maximize the effectiveness of treatment and the patient's favourable evolution.

Keeping up with medical statistics, which highlighted the magnitude of the pandemic impact, in particular by referring to the number of severe, serious or critical cases, made it easy for medical staff to feel uncertainty regarding the correct course of action, therefore, well-established and updated protocols have been implemented. In our study, almost 50% of cases had a severe evolution, with 30% having a critical status. However, the mortality rate was low, only 6% of cases leading to death.

In the 248 cases of death caused by SARS-CoV-2 infection, we followed the decisions of the National Emergency Department, which established strict rules regarding the handling of the deceased. Therefore, the funeral service was modified, shortened, with an extremely small audience (only a few family members), while also respecting the social distancing recommended by the Decree no. 240/2020 (President of Romania, 2020).

Lack of hospital beds made it necessary to prioritize the cases: admitting those most likely to survive the current illness, or to live the longest after recovery (considering the comorbidities) (Robert et al., 2020). All these things could have been perceived as a *lottery*, but doctors' decisions were guided by prioritization strategies, proposed by the national medico-military Department of Special Emergencies.

The State of Emergency has been enforced in Romania in 2020, allowing doctors to apply simplified specific criteria, in order to shorten their physical contact with the patients and to limit staff exposure. Different scores of severity have been used, which determined three-degree severity scale: mild (symptoms of acute upper respiratory tract infection), moderate (documented pneumonia without severity factors) and severe/critical (multiple organ failure syndrome, sepsis, $O_2$ saturation ≤93%, respiratory rate ≥30 rpm), provided by the Decree no. 860/2020 (Ministry of Health, 2020). Although numerous studies have demonstrated the relevance of such scores on a general population scale, their lack of sensitivity or specificity has been repeatedly reported (Robert et al., 2020). Our study showed that 46% of cases developed lung complications, such as COVID-19 pneumonia, which led to a longer hospitalization (an average of 9.62 days).

Another difficult ethical aspect could be the fact that hospitalized patients could not be visited by family, a reluctantly accepted decision, pending a good therapeutic response, followed by discharge, in most cases.

Last but not least, SARS-CoV-2 pandemic had a major impact on medical staff in terms of pressure and overuse. Work overload, unequal distribution of resources and emotional exhaustion may lead to distress and burnout in high risk populations, such as healthcare professionals directly involved in managing patients with SARS-CoV-2 infection (Ilias et al., 2021).

## Conclusions

Management of patients with SARS-CoV-2 infection in the dynamics of the current epidemiological context is difficult and represents a real challenge. Therefore, a good interdisciplinary collaboration is necessary especially in these difficult times.

Further clinical and research studies are necessary to maximize therapeutic effectiveness of current recommended medication, according to national and international guidelines, within an ethical framework.

## References

Blot, F., Dumont, S. N., Vigouret-Viant, L., Verotte, N., Rossignol, J., Rieutord, A. & Altea, A. (2020). Ethical issues related to the COVID-19 pandemic in patients with cancer: experience and organisations in a French comprehensive cancer centre. *BMJ supportive & palliative care*.

Cucinotta, D. & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. *Acta Biomed,* 91(1), 157–160.

Ilias Y., Mantziou V., Vamvakas E., Kampisiouli E., Theodorakopoulou M., Vrettour C., … Dimopoulou I. (2021). Post-traumatic stress disorder and burnout in healthcare professionals during the SARS-CoV-2 pandemic: a cross-sectional study. *The Journal of Critical Care Medicine,* 7(1), 14-20.

Lai, C. C., Shih, T. P., Ko, W. C., Tang H. J. & Hsueh, P. R. (2020). Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges. *Int J Antimicrob Agents,* 55(3), 1059.

Laventhal, N., Basak, R., Dell, M. L., Diekema, D., Elster, N., Geis, G. & Macauley, R. (2020). The Ethics of Creating a Resource Allocation Strategy during the COVID-19 Pandemic. *Pediatrics,* 146(1).

Ministry of Health. (2020). Decree no. 860/2020 regarding modification of Ministry of Health Decree no. 487/2020 for approving the therapeutic protocol of SARS-CoV-2 infection. *Official Monitor of Romania* no. 432/22.05.2020.

Ministry of Health. (2020). Decree no. 1137/2020 regarding modification of Ministry of Health Decree no 555/2020 for approving the Plan of Measures in order to preparate the hospitals for the COVID-19 pandemia. *Official Monitor of Romania* no. 539/23.06.2020.

Moderbacher, C. R., Ramirez, S. I., Dan, J. M., Grifoni, A., Hastie M. K., Weiskopf, D. & Crotty S. (2020). Antigen-Specific Adaptive Immunity to SARS-CoV-2 in Acute COVID-19 and Associations with Age and Disease Severity. *Cell*, 183(4), 996–1012.

President of Romania. (2020). Decree no. 240/2020 regarding the prolongation of Emergency State in Romania. *Official Monitor of Romania* no. 311/14.04.2020.

Robert, R., Kentish-Barnes, N., Boyer, A., Laurent, A., Azoulay, E. & Reignier, J. (2020). Ethical dilemmas due to the Covid-19 pandemic. *Ann Intensive Care,* 10, 84.

Romanian Government, Communication Group of National Coordination Committee for COVID-19 Vaccination Activities. (2021). Press release, Bucharest, 15.01.2021. https://vaccinare-covid.gov.ro/wp-content/uploads/2021/01/COMUNICAT-pers. vacc.-Et.-115.01.21.pdf

Turale, S., Meechamnan, C., Kunaviktikul, W. (2020). Challenging times: ethics, nursing and the COVID-19 pandemic. *Int Nurs Rev*, 67(2), 164-167.

Yepes-Temiño, M. J., Callejas González, R., & Álvarez Avello, J. M. (2021). A moment for reflection. Ethical aspects in the pandemic SARS-CoV-2/COVID-19 in our clinical practice. *Revista espanola de anestesiologia y reanimacion*, 68(1), 28–36.

# GIVING BIRTH DURING THE PANDEMIC. HOW THE DECISION TO TRANSFORM CERTAIN HOSPITALS IN DEDICATED COVID-19 MEDICAL UNITS IMPACTED WOMEN ON PSYCHOLOGICAL LEVEL

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**Abstract**:

The study evaluates how the decision to transform completely hospitals and some of the maternity wards into dedicated Covid-19 medical units psychologically impacted women who gave birth during the pandemic.

Prior research has shown that, during the pandemic, between 21% and 25% of pregnant women were confronted with higher levels of stress and emotional problems (Preis et al., 2020a; Preis et al., 2020b). At the end of March 2020, the maternity ward of the "St. John the New" Emergency County Hospital in Suceava was closed and pregnant women were redirected to other local hospitals. Soon, the shortage of hospital beds in these alternative medical units generated a crisis: the women who were about to give birth did not know where to go, while the medical system froze. In some cases, the doctors recommended birth at home.

The results of our research, carried out by means of interviews, indicate a higher level of incertitude and anxiety among women who gave birth in this period. The conclusions show that the negative psychological impact on these women would have been much reduced if they had been offered psychological support and accurate information during their crisis period.

**Keywords**: birth, pandemic, Covid-19, pregnancy crisis, Suceava

## Introduction

On March 11th, 2020, the World Health Organization declared Covid-19 a global pandemic. Romania declared a state of emergency on March 16th. "St John the New" County Emergency Hospital in Suceava, the most important hospital in Suceava county, was closed between March 23rd and June 2nd 2020 and operated as a Covid-19 unit.

The obstetrics-gynecology department of "St John the New" County Emergency Hospital in Suceava has 85 beds (Suceava County Council, 2016) and is classified as a level 3 hospital (Ministry of Health, 2006). Level 3 corresponds to maternity hospitals properly equipped to manage high-risk births and babies who may be born with medical problems (Ministry of Health and Family, 2002).

In total, in Suceava County, which has a population of 634,810 inhabitants, there are 7 maternity hospitals; 5 of them are classified with level 1 (Ministry of Health, 2006). This level means that maternity hospitals can provide minimal medical care for pregnant women and newborns. Here, full-term physiological births can be performed on newborns without problems. In case of an emergency, cesarean section may also be performed, if the necessary means are available (Ministry of Health and Family, 2002).

In all the obstetrics-gynecology departments in the Suceava County there are 243 beds (Ministry of Health and Family, 2002).

After the closure of “St John the New” County Emergency Hospital in Suceava, there were a few days of uncertainty in which the authorities and doctors did not know exactly what would happen to the women who were to give birth. Subsequently, the hospital management decided that the women who were going to give birth will be redirected to the other maternity hospitals in the county. Soon, problems began to appear: there were not enough beds available, there were not enough facilities to provide the necessary medical services, and some doctors became infected with the new coronavirus and could not work anymore.

To analyze the emotional impact generated by this crisis, we conducted 15 interviews with women from Suceava County, who gave birth during the period when the hospital was closed. The data were collected between November and December 2020. The present study has a limited scope, as it is a micro-research. It has been designed as a series of 15 online interviews with women from the county of Suceava who gave birth while “St John the New” County Emergency Hospital in Suceava city was closed and turned into a dedicated Covid-19 medical unit.

Prior research shows that 14 to 54% of pregnant women are usually confronted with emotional and mental health issues during pregnancy. This is generated by more causes: a) lack of social support, b) psychological instability before pregnancy which aggravates during pregnancy, c) health problems of the child (problems of development, probability to give birth to a child with certain health problems), d) risk behaviors affecting the mother’s life (Madhavanprabhakaran et al., 2015).

Two more specific problems were added during the pandemic last year to the list above: the stress associated with the woman’s feeling that she is not prepared to give birth and the stress related to the risk of contracting Covid-19. These factors subjected pregnant women to moderate-to-high levels of emotional pain (Preis et al., 2020a).

Zhou et al. (2020) conducted a study involving 1,123 women from the USA, who were either pregnant or had recently given birth. The results showed that 36.4% of them reported significant levels of depression, 22.7% expressed anxiety, 10.3% reported clinical signs of Post-Traumatic Stress Syndrome. Incipient proof indicates that pregnant women are confronted with moderate-to-high levels of psychological suffering during the Covid-19 pandemic (Saccone at al., 2020). Mappa et al. show that prenatal anxiety can be a risk factor for maternal mental health problems, can increase probability of postnatal depression, obstetrical complications, problems of fetal development, longer labor and premature birth (Mappa et al., 2020).

## Materials and Methods

### *Study design*

Each of the participants was invited to answer an interview with 11 open questions. The questions in the first part were designed with the goal of obtaining information about the pregnancy period: emotional states, relationship with the family and the community, with the obstetrician monitoring the pregnancy. The questions in the second part focused on experiences related to giving birth during the pandemic, on what happened before and after birth, on the interaction with hospital staff and the solutions found by participants to overcome the difficulties they were faced with.

The research was conducted online, through the snowball method, during November and December 2020.

### *Participants*

This study included 15 women aged 18 to 41, residents of Suceava county. They gave birth while “St John the New” County Emergency Hospital in Suceava was closed because of the pandemic, being dedicated solely to Covid-19 patients.

### *Data collection*

The information collected through the online interviews was transcribed and organized in sections.

## Results

Participants spoke in the interviews about the impact of the pandemic in their lives, about social isolation and the unexpected closing of the “St John the New” County Emergency Hospital in Suceava city and its transformation in Covid-19 unit.

The emotional balance most of them had experienced in the first part of their pregnancy turned into fear, uncertainty and even panic when the effects of the pandemic showed: social isolation, less access to medical services and, at the apex of the crisis, the closing of the “St John the New” County Emergency Hospital in Suceava city.

In order to analyze more easily the presence or absence of perceived support, perceived stress and the reasons of perceived stress, we have analyzed how the participants related to four types of relationships: with family, with friends and acquaintances, with their gynecologist-obstetrician, and with the staff of the maternity ward. Finally, we have attempted to understand how they perceived the evolution of their emotional state in the first part of their pregnancy, and also before and after birth. Please find below an analysis of their perceptions related to all these factors.

### *Relationship with family*

For most participants, their positive relationship with the family was an important source of support both during pregnancy and in the crisis moments when they did not have access to pregnancy medical examinations, they had to change their monitoring obstetrician or to give birth in a different city:

“Family was more careful towards me. I am a happy case, since they protected me from the beginning and offered me all the support I needed to go through this experience and be well.”

“They offered lots of support and understanding. I felt protected from this point of view.”

Two participants said their relationship with the family was affected due to isolation and loneliness and the situation influenced their emotional state:

“It was quite weird that, for fear of not contracting the virus, you could not even get in touch with your parents.”

From the discussions with the participants we have concluded there were two aspects which influenced their interaction with family members: whether the parents or the parents-in-law lived in the same house with them and whether the husband was exposed to a higher-than-usual risk of contracting the virus.

Pregnant women who lived with their partner and their parents or their in-laws perceived more support and had more social interactions during the restrictions period, compared to pregnant women who did not live with their parents or in-laws.

“It was difficult that we were not able to see the members of our family face to face”.

“I live with my husband and his parents; therefore everything was just like before the pandemic”.

The feelings of loneliness and fear were more acutely perceived by pregnant women whose partners were more exposed to the risk of getting infected and who isolated themselves at work, who came home less often or who isolated themselves in a separate room of the house:

“It is painful to live two meters away from your husband and not be able to hug him on your birthday while you are nine months pregnant. I cried. I felt lonelier than ever.”

***Relationship with the community (friends, colleagues)***

We have analyzed the participants' perception related to support offered by the community during their pregnancy in the context of the difficulties they experienced at the time. Colleagues and friends were perceived as the most important source of support after family support. 10 out of the 15 participants said that interaction with acquaintances during the pandemic significantly decreased:

"We haven't seen each other since the beginning of the pandemic, we interacted strictly online. It was quite difficult."

"It was during the pandemic, so all relations outside family were based on online communications via the phone and the Internet."

"Socially speaking, it wasn't exactly easy, because I did not see anyone except close members of the family."

"The relationship with many of my friends and colleagues was lost."

Perceived lack of support generated feelings of loneliness, uncertainty, the idea that pregnant women are left to face alone the new challenges: the pandemic and the closing of the hospital.

***Relationship with the gynecologist-obstetrician***

Talking about their relationship with their obstetrician during the closing of the "St John the New" County Emergency Hospital in Suceava, all the participants mentioned two aspects: the presence or absence of information on access to medical services; and presence or absence of emotional support from the obstetrician.

4 out of the 15 women said they received updated information and support from their obstetrician during the closure of the hospital and its conversion into a Covid-19 unit:

"He encouraged me as much as he could, despite the fact that, at the beginning of the pandemic, he did not know what would happen and how it would be to give birth in the Suceava hospital turned into Covid hospital."

"I wished he had been more empathetic, given the situation I was going through. But I understand it wasn't easy for doctors, either; we have all been affected by this pandemic."

The other participants were confronted with negative emotional states caused by uncertainty and lack of information:

"I was desperate, I would ask for advice from my gynecologist. There was no answer, I was 34 or 35 weeks pregnant, my term was coming and I yet did not know what to do."

"I felt so much need to talk to someone who knew my situation and had medical experience. I felt the need to share my little silly tribulations which usually occur in this period and to be assured that everything would be ok."

In their relationship with the gynecologist, many participants perceived lack of emotional support and lack of information regarding their access to medical services. The issue of the lack of information about medical services available goes beyond the doctor-patient relationship. In the context of the Suceava County Hospital crisis, it was rather caused by the way in which hospital management and authorities managed the situation.

To better understand the context, we need to mention the changes in hospital management: on March 24, the manager of "St John the New" County Emergency Hospital was dismissed. Between April 2 and 30, 2020, the hospital was managed by a military team and on May 1, 2020 a civilian team took over the management.

***Relationship with the staff of the maternity ward***

14 out of the 15 participants to the study declared themselves satisfied with how they interacted with the maternity staff, including in terms of emotional support:

"I benefited of the necessary support and attention."

"Everybody wanted to encourage us, to help us be optimistic."

"A straight A grade for the staff."

“They had a very positive attitude.”

There is a significant contrast between perceptions related to the relationship with the gynecologist before birth and the way in which participants perceived their interaction with the medical staff of the maternity where they gave birth to their children.

This difference can be explained by the fact that the gynecologist-obstetricians were perceived by study participants not only as doctors who monitored their pregnancy, but also as representatives of the institution where they worked. It is likely that participants expected doctors to manage the public communication crisis created on the background of the sanitary crisis, although other bodies were formally in charge with institutional communication. Yet, such hypotheses need to be further verified and confirmed or infirmed by future studies which shall analyze in detail the perspective of the staff of the Suceava County Hospital in the period when it was closed and turned into a Covid-19 support unit.

### *The evolution of emotional states in the first months of pregnancy, before and after birth*

We also analyzed women's perception of their emotional state at different times of their pregnancy: in the first months, before and after birth.

In the first months of pregnancy, participants were confronted on one hand with their fear of going to the hospital and on the other hand with the fact that, starting from March 2020, access to medical services was restricted:

“There was more uncertainty, difficulty in finding a hospital, a doctor to monitor you. The difficulty of standing in long queues for medical tests.”

“Stress, since I had to find a gynecologist who had a private practice.”

“At first I imagined the worst scenarios: that I would contract the virus, that I would not be able to carry my child in my arms, I thought of possible implications or medical complications, especially since everything was at the beginning and there was a high level of uncertainty. I had so many questions to which nobody could give a sure answer.”

As the study participants’ pregnancies came closer to term, the hospital was closed and turned into a Covid-19 unit. Most of their answers regarding their emotional state before birth refer to this:

“Up to the moment of giving birth I went through feelings of despair! I prayed that they reopened the hospital. There were all sorts of rumors. I didn’t know what to believe anymore. There was the possibility that I would give birth to my baby in Fălticeni or Rădăuți, but it was my second child and I had to have a Cesarean section. Just as my term approached, people said the Fălticeni hospital had no anesthesiologist and the hospital of Rădăuți was infected.”

“It was the most difficult moment of my life. Many hours spent without sleeping and in a general state of exhaustion.”

“On the very tense moments when my pregnancy came closer to term I did not know where I would give birth, I did not know whether there would be a place for me, I did not know whether there would be somebody to assist me.”

“I was so afraid that they would separate me from my baby”.

The postnatal emotional states had two components: emotional states unrelated to Covid-19 pandemic experienced by pregnant women and emotional states related to the pandemic.

In the first category there were feelings of joy, tiredness, liberation, uncertainty (women at their first child), loneliness (women who did not benefit of social support).

“It was the greatest joy!”

“I felt full of joy, because I had met my baby.”

“I suffered of postnatal depression, because there was nobody around me who had given birth and I had no idea what this change implied.”

The pandemic-related issues which generated negative emotional states in the participants were: separation from the child until the PCR test result came, situations in which either the mother or the child was infected with Sars-Cov-2 and they were separated, the impossibility of receiving the visits of their partners or relatives.

“I was optimistic until I was separated from my child. Afterwards, I wasn’t myself anymore.”

“Until the negative test result came in, I knew nothing about my baby. The Neonatology staff made medical visits only in the non-Covid wards.”

“If my husband had been allowed to stay for an hour with the baby, I could have taken a shower, eaten in peace and slept a bit more than two hours out of 24; the experience would have been totally different.”

At the end of the interviews we asked the participants what helped them to overcome difficulties more easily. Some of the participants found important support in their partners, in their family and in friends: “I felt how important my husband’s support was”; “Those around me offered support when they found out I was pregnant”.

In other cases, support came from communication with other pregnant women on social media or through support groups:

“Interaction with other women in similar situations through an online support group played a key role for me.”

“The support groups on Facebook and other online support groups brought us closer to each other, helped us get moral support and encourage each other.”

Some of the participants resorted to spiritual help in order to surpass difficulties:

“Faith in God played a key role for me. It helped me overcome difficulties.”

## Discussion

Previous studies mentioned in the introduction of this article (Preis et al., 2020a, Preis et al., 2020b, Saccone and colab., 2020, Mappa and colab, 2020) show that, during the pandemic, women are confronted with a high level of stress and with emotional problems. These problems can be caused by lack of social support, they can develop on pre-existing conditions (such as depression or risk behaviour), they can be linked to giving birth during the pandemic, or to fear of contamination with Sars-Cov-2.

A poll made in Great Britain to research pregnant women’s perception on medical services during the pandemic show that two of the reasons for which women contact the maternity are related to their emotional state: anxiety and need for mental health support (Karavadra et al., 2020).

Brooks et al. (2020) show that pregnant women need information, coherent guidance and advice from the doctors and that the communication strategies designed by authorities need to include guidance for maintaining their emotional balance and mental health during the pandemic.

To respond to the emotional needs in these situations, the authorities can implement two support solutions:

1. Psychological support programs for prenatal and postnatal women. Such programs have been implemented in France, where three maternities offered psychological support over the phone for 10-12 days after birth and monitored the evolution of the women’s emotional state for 6-8 weeks (Viaux et al., 2020).
2. Medical experts need to be trained in offering emotional and psychological support (Motrico et al., 2020).

## Conclusion

The results of this research show that the unexpected closure of “St John the New” County Emergency Hospital in Suceava city and its transformation into a dedicated Covid-19 medical unit had a negative emotional impact on participants who gave birth between March 23rd and June 2nd 2020. They experienced panic, fear, and uncertainty, situations in which they did not know where they would give birth, moments when they were redirected to other hospitals in the region and they no longer had the logistics needed to give birth. In some cases, communication with gynecologists and the hospital was abruptly interrupted, and women felt alone and without alternatives. These conditions were amplified by a lack of up-to-date information, a decrease in access to medical services and a lack of psychological support from the hospital and the authorities.

In the context of personal relationships, participants who had the support of their partner, family and friends could better manage difficult moments. In other cases, support came through communication on social networks and by taking part in online support groups. The results of the study can provide information to authorities and medical professionals on the emotional problems faced by pregnant women in certain circumstances, such as the pandemic context or other crisis situations. Knowing that pregnancy and childbirth are times when women are most vulnerable can help authorities when they are urged to make critical decisions related to closing a maternity ward. For example, when making the announcement that a maternity hospital is closing, an announcement about alternatives and support solutions could also be issued. An alternative may be the cooperation between the state medical system and the private medical system to take over the cases that can no longer be managed by the state hospitals in the region. It is an expensive alternative and can be difficult in a certain economic context, but births cannot be postponed or rescheduled, as it was the case with non-essential medical interventions.

To alleviate the negative emotional impact during health crises, maternity hospitals can provide psychological support for women before and after childbirth. To develop support, undergraduate or postgraduate training programs may include courses focused on emotional support during pregnancy.

The results of our study offer a perspective on experiences lived by participants at the time of giving birth and open new directions for more in-depth research in the future.

## Limitations of the study

The present study is a micro-research made on a small group of 15 participants. One of the limitations of the study is the small number of participants. Because of this limitation we cannot have a full knowledge of the psychological impact on pregnant women generated by the decision to close “St John the New” County Emergency Hospital in Suceava and turn it into a Covid-19 unit.

Another limitation is that the study does not take into account the perspective of medical professionals, hospital management and authorities towards the closure of "St John the New" County Emergency Hospital in Suceava city. We hope that these will be the subject of more extensive future studies.

## References

Brooks, S. K., Weston, D., & Greenberg, N. (2020). Psychological impact of infectious disease outbreaks on pregnant women: Rapid evidence review. *Public Health*, *189*, 26-36.

Karavadra, B., Stockl, A., Prosser-Snelling, E., Simpson, P., & Morris, E. (2020). Women’s perceptions of COVID-19 and their healthcare experiences: a qualitative thematic analysis of a national survey of pregnant women in the United Kingdom. *BMC Pregnancy and Childbirth*, *20*(1), 1-8.

Madhavanprabhakaran, G. K., D'Souza, M. S., & Nairy, K. S. (2015). Prevalence of pregnancy anxiety and associated factors. *International Journal of Africa Nursing Sciences*, *3*, 1-7.

Mappa, I., Distefano, F. A., & Rizzo, G. (2020). Effects of coronavirus 19 pandemic on maternal anxiety during pregnancy: a prospectic observational study. *Journal of Perinatal Medicine*, *48*(6), 545-550.

Ministry of Health. (2006). *Order no 1881/2006 for ranking Obstetrics-Gynecology and Neonatology hospital units, sections and compartments*. Romanian Official Monitor, Part I, no. 59/25.01.2007. https://lege5.ro/gratuit/geydcmzwhe/ordinul-nr-1881-2006-privind-ierarhizarea-unitatilor-spitalicesti-a-sectiilor-si-compartimentelor-de-obstetrica-ginecologie-si-neonatologie.

Ministry of Health and Family. (2002). *Order no 910 of 18/11/2002 for ranking the specialized Obstetrics-Gynecology and Neonatology hospital sections, with subsequent additions and WHO 272/2009 amendments*.

https://www.dsp-galati.ro/images/stories/2017/custom/OMS910compilatOMS272.pdf.

Motrico, E., Mateus, V., Bina, R., Felice, E., Bramante, A., Kalcev, G., ... & Mesquita, A. (2020). Good practices in perinatal mental health during the COVID-19 pandemic: a report from task-force RISEUP-PPD COVID-19. *Clínica y Salud, 31(3)*, 155-160.

Preis, H., Mahaffey, B., Heiselman, C., & Lobel, M. (2020a). Vulnerability and resilience to pandemic-related stress among US women pregnant at the start of the COVID-19 pandemic. *Social Science & Medicine*, *266*, 113348.

Preis, H., Mahaffey, B., Heiselman, C., & Lobel, M. (2020b). Pandemic-related pregnancy stress and anxiety among women pregnant during the coronavirus disease 2019 pandemic. *American Journal of Obstetrics & Gynecology MFM*, *2*(3).

Saccone, G., Florio, A., Aiello, F., Venturella, R., De Angelis, M. C., Locci, M., ... & Sardo, A. D. S. (2020). Psychological impact of coronavirus disease 2019 in pregnant women. *American Journal of Obstetrics & Gynecology*, *223*(2), 293-295.

Suceava County Council. (2016). *Decision no 238 of 23.12.2016 for the approval of the organizational chart of "St John the New" Suceava County Hospital*. http://www.cjsuceava.ro/2016/hotarari_adoptate/248.pdf.

Viaux, S., Maurice, P., Cohen, D., & Jouannic, J. M. (2020). Giving birth under lockdown during the COVID-19 epidemic. *Journal of Gynecology Obstetrics and Human Reproduction*.

Zhou, Y., Shi, H., Liu, Z., Peng, S., Wang, R., Qi, L., ... & Zhang, X. (2020). The prevalence of psychiatric symptoms of pregnant and non-pregnant women during the COVID-19 epidemic. *Translational psychiatry*, *10*(1), 1-7.

# EVANGELICALISM IN UGANDA: IMPLICATIONS FOR PUBLIC HEALTH AND BIOETHICS

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## Abstract

Considered attention is needed to the interplay between evangelical and charismatic religions and legislation in Uganda and their implications for public health, bioethics, and medical education. This manuscript examines the growth of the evangelical and charismatic movements in Uganda during the past several decades, concurrent trends in the formulation and implementation of law and public policy, and implications for the prevention and treatment of sexually transmitted infections, family violence, physician-patient communication, and medical and health education. The article concludes with suggested strategies to address the adverse consequences stemming from the interjection of religious perspectives into the domains of public health, clinical care, and health education.

**Key words:** Bioethics, evangelicalism, public health, Uganda

## Introduction

This article begins with a brief review of evangelicalism and fundamentalism in Uganda. The discussion then focuses on an examination of the interplay between evangelicalism and fundamentalism and several recent legislative enactments and their implications in the broader contexts of gender-related violence, public health, clinical care, and ethics, aspects of the legislation that have been largely ignored in the international discourse. The article concludes with suggested strategies to address the apparent interjection of religious perspectives into the domains of public health, clinical care, and health education: the continuing education of health care professionals, health educators, and clergy and revisions to select Ugandan legislation.

## Evangelicalism and Fundamentalism in Uganda

Uganda’s continuing efforts to implement anti-gay legislation, including the imposition of the death penalty for same-sex sexual behavior, have been widely denounced as violations of human rights, and the population’s increasing vitriol and discrimination against homosexuals have often been attributed to the influence of American evangelical and charismatic religious leaders (Boutchie, 2019; Kaoma, 2014; Kisitsu, 2018; Müller, 2011; Oliver, 2013; van der Laan & van der Wal, 2014). In view of both the growth and growing influence of Uganda’s own evangelical and fundamentalist denominations, this attribution of responsibility is misplaced.

Uganda’s 2014 census recorded a significant increase in the proportion of the population that self-identified as Pentecostal/Born Again/Evangelical from 4.7 percent in 2002 to 11.1 percent in 2014, accounting for a total of slightly more than 3.79 million persons (Uganda Bureau of Statistics, 2002, 2014). Evangelicals are also present in Anglicanism, such as in the Church of Uganda (Zurlo, 2015). Although there was a decrease in the proportion of self-identified Anglicans, from 36.7 percent of the population in 2002 to 32 percent in 2014, the number of persons remains substantial, at almost 11 million (McKinnon, 2020; Uganda Bureau of Statistics, 2002, 2014).

Although a rise in evangelicalism has occurred across sub-Saharan Africa (Anderson, 2007; Jenkins, 2002), it has been suggested that the increased voice of evangelicalism and fundamentalist faiths and the concomitant growth of their political influence in Uganda are attributable to the intervention of U.S.-based fundamentalist religious networks in local Uganda affairs (Boutchie, 2019; Hofer, 2003; Kaoma, 2014; Kisitsu, 2018; Oliver, 2013). Interactions between Uganda fundamentalists and their U.S. counterparts have often been at the forefront of both Ugandan local and international news; however, the emphasis on the responsibility of U.S.-based actors for their influence and their political positions is misplaced.

Evangelicalism in Uganda stretches back at least as far as 1877, when the Anglican Church Missionary Society began working in what was then the Buganda Kingdom (Bekele, 2015; Ssemugoma, 2021; Ward, 2015). The term "evangelical" is used here to refer to the network of Protestant revival movements that arose during the eighteenth and early nineteenth centuries in Great Britain and its colonies, including Uganda (Noll, 2004; Wolffe, 2015). Evangelicalism is characterized by a turning from self and sin to God and Jesus Christ (conversion); reference to the Bible as the decisive authority on all matters pertaining to faith and religious practice; participation in activities that disseminate the message of salvation in Christ; and recognition of Christ's death on the cross as the substitution for punishment for human sins and spiritual life for those who stand in Christ (Bebbington, 1989).

Some, but not most, evangelicals are fundamentalists, although these terms are often used synonymously. Fundamentalism is a term originally used to refer to conservative evangelicals in the United States who opposed the movement towards liberalization among some Christian denominations and adhered to more traditional views of the Bible's infallibility, Christ's virgin birth, and Christ's return at the end of the world (Marsden, 1980).

Pentecostalism refers to evangelicalism that emphasizes the role of the Holy Spirit, exorcism, and a direct experience with God (Asamoah-Gyadu, 2005; Ihejirika, 2006). The Pentecostal Assemblies of God was founded in Uganda in 1935 (Musana, 1991; Onyait, 2011), the Eim Church in 1962, the Full Gospel Church in 1962, and the Deliverance Church in 1967 (Musana, 1991). Churches such as the Anglican Church of Uganda share some characteristics with Pentecostalism, such as an emphasis on faith healing and speaking in tongues (Jenga, 2017).

It has been suggested that those who initially joined the Anglican Church lacked true commitment, failed to adhere to the faith's precepts, and were, in essence, engaged in the nominal practice of Christianity (Bruner, 2011; Ndyabahika, 1993; Ward, 1989). The Uganda Revival Movement, known as the *Balokole* ("the redeemed" or "the saved people") was part of the East African Revival (Ndyabahika, 1993) that sought to address the existence of widespread corruption and lack of morality (Ssemugoma, 2021). The Revival Movement is variously recounted as having begun in 1928, 1929, or 1930 (Ndyabahika, 1993; Ssemugoma, 2021; Zurlo, 2015).

Both the *Balokole* and non-*Balokole* currently exist within the Anglican Church of Uganda (Ndyabahika, 1993), but the term *Balokole* is now used to refer as well to all members of the Pentecostal movements and its churches in Uganda (Jenga, 2017; Ward, 1989). The *Balokole* has been credited with adding new members and vitality to the churches (Ndyabahika, 1993; Ward, 2001), an increased emphasis on missionary activities, "social purity and sobriety," the disappearance of "filthy and indelicate languages," the restoration of "pure speeches, and prayers and praises in lieu of "swearing and blasphemy" (Ndyabahika, 1993, p. 30; see also Byabazaire, 1978). *Balokole* gained even greater credence following

President Museveni's declaration in the late 1990s that *Balokole* were more trustworthy than members of other faith communities (Ssemugoma, 2021).

The Pentecostal Assemblies of God established a church building in Uganda in or about 1960, following the grant of a permit to the Glad Tidings Missionary Society by then-governor of Uganda, Sir Charles Hartwell (Onyait, 2011; Ssemugoma, 2021). The first Pentecostal revival in Uganda was held in February 1961. During this revival, the Kabaka offered his lake for people's baptism; 365 people were baptized (Ssemugoma, 2021). Although the Pentecostal church was banned by then-president Idi Amin in 1974 (Onyait, 2011), it continued to exist and, since the independence of Uganda from Great Britain in 1962, has experienced a continuous increase in membership (Bekele, 2015). The late 1980s and early 1990s have been described as "years of great revival" (Ssemugoma, 2021, n.p.). The identification of the First Lady, Janet Museveni, with Pentecostalism lent additional credibility and impetus to membership, as did the ministry of Apostle Deo Balabyekubo, which claimed to have brought about the cure of AIDS for more than 100 people through healing crusades during 1994 and 1995.

## Evangelicalism's Impact on Ugandan Society

Uganda's three major faith communities-Islam, Catholicism, and Anglicanism-have enjoyed radio and television air time since the mid- 1950s and mid-1960s, respectively (Jenga, 2017). Private individuals and faith-based organizations have been able to purchase broadcast time since 1994, providing religious broadcasting in addition to the already-existing broadcast time for the three faiths and the ecumenical programs of the Anglican, Catholic, and Orthodox churches.

Kampala is home to the largest concentration of both Pentecostal churches and pastors' broadcast media houses in the country. As of 2017, there were 20 Christian-affiliated radio and television stations in Kampala alone, 80 percent of which were affiliated with Pentecostal groups (Jenga, 2017). As one scholar has noted,

> The strong Pentecostal presence in Uganda's media gives Pentecostals great influence not only in religious matters, but also the socio-political affairs of the country. The broadcast media has given Pentecostals visibility and a voice they did not have in the past and, in this development, one notices media intersecting with religion, but even more so with politics (Jenga, 2017, p. 63).

Indeed, several scholars have suggested that Pentecostals may soon dominate the socio-cultural and political domains in Africa as a result of their increasing religious power (Tomaselli, 1995; Tomaselli and Shepperson, 1997). As an example, political candidates have been known to seek the endorsement of Pentecostal pastors, particularly near the time of elections (Central Intelligence Agency, 2015).

These broadcasts have, to a degree, replaced the use of crusades, which were experiencing decreases in attendance. The broadcasts frequently focus on messages relating to prosperity, social advancement, family life, and one's relationship with God, using Biblical texts as the foundation for these messages. The broadcasts also address listeners' beliefs about the larger world, providing advice on breaking curses and evil spells, protection from witchcraft, and promoting healing and prosperity. The broadcasts have been credited with the growth of pastors' congregations, the enlargement of pastors' public profiles, and the financial thriving of Kampala's broadcast industry (Jenga, 2017).

The Anglican Church considers itself, together with the Catholic Church, to be the guardian of public morality (Ward, 2015). Sermons from the pulpit of the (Anglican) Church of Uganda often focus on sin and immorality, including the vices of drink, womanizing, and smoking (Ward, 2015). Nevertheless, the Pentecostal churches have made salvation from sin "their trademark approach" in their ministry (Onyait, 2011).

Although Uganda's Constitution provides in Article VII, "Uganda shall not adopt a State religion," religion plays a major role in Uganda's political, legal, and policy framework. Personal beliefs have been translated into government policy through the actions of various political figures. James Nsaba Buturo, an Anglican *mulokole*, became Uganda's Minister of Ethics and Integrity in 2006. In this capacity, he vociferously condemned homosexuality and sought to combat "corruption, homosexuality, pornography, and witchcraft" (Ward, 2015). He was replaced in 2012 by Simon Lukodo, a former Catholic priest, who continues Buturo's campaign against homosexuality.

Uganda has prohibited same-sex sexual relations since 1956, characterizing the behavior as "against the order of nature'; violation was punishable with life in prison (Penal Code Act, 1956). In 2007, Uganda's Minister of Ethics and Integrity formed the Interfaith Rainbow Coalition Against Homosexuality, which was responsible for organizing actions against homosexuality, including prayer gatherings, petitions, fasting campaigns, protest rallies, and street marches (Krieger, 2007; Pownall, 2007). Pastor Martin Ssempa, the spokesperson for the coalition, asserted, "Homosexuality breaks the laws of God, the laws of nature, and the laws of Uganda … We are asking the government to be strong and uphold the laws of our country banning this repugnant practice" (Pownall, 2007).

The 2009 AntiHomosexuality Bill was introduced by David Bahati, a practicing Anglican (Ward, 2015). The bill, initially tabled, later signed into law in 2014 AntiHomosexuality Bill, 2014), and then found to be unconstitutional for lack of a quorum by Uganda's Constitutional Court (*Oloka Onyango and Ors v. Attorney General*, 2014) sought to "protect the cherished culture of the people of Uganda, legal, religious and traditional family values of the people of Uganda" against values of sexual promiscuity and to protect children from "sexual abuse and deviation" attributable to "cultural change" (AntiHomosexuality Bill, 2019). The passage of the 2009 bill was lauded by Stanley Ntagali, the Archbishop of the Anglican Church of Uganda (Aruho, 2014).

The impact of the churches' denunciation of homosexuality and of the bill on individuals who identify or are perceived to be gay has been well documented (Associated Press, 2014; van Klinken & Zebracki, 2016; Wiener-Bronner, 2014) and will not be repeated in detail here. It is sufficient to note that the churches' rhetoric has provoked negative attitudes, leading to a fear of violence and police brutality and resulting secrecy within the nonheterosexual communities (Kaoma, 2014; Oliver, 2013); the murder of at least one gay activist (Boyd, 2015); and the denial of social services to individuals who self-identify or are perceived to be gay (Oliver, 2013).

Uganda's Anti-Pornography Act (Parliament of Uganda, 2014a) serves as yet another example of the impact of evangelicalism on larger aspects of Ugandan society. The Act was initially drafted in 2005 by Nsaba Buturo, the same Minister of Integrity and Ethics who denounced homosexuality (Tamale, 2016). President Museveni signed the bill into law in February 2014, following a series of revisions (Athumani, 2014). The law is intended to define pornography, protect children from predatory sexual behaviors, and establish a Pornography Control Committee (Dahir, 2017). Pornography is defined as:

> any representation through publication, exhibition, cinematography, indecent show, information technology or by whatever means, of a person engaged in real or stimulated [sic] explicit sexual activities or any representation of the sexual parts of a person for primarily sexual excitement (AntiPornography Act, 2014, Part I, sec. 2).

Like the AntiHomosexuality Act, the Anti-Pornography Act has received the support of religious-political figures and appears to have provoked violence against would-be transgressors. Father Lukodo, noted above for his continuation of Buturo's campaign against homosexuality, asserted,

> Anything related to indecent dressing, exposing certain parts of the anatomy of a person, I call it pornographic and therefore condemn it … when you go indecently on the streets of Kampala, you'll become … a cinema … Say what you want to say, but we're coming out with a law that people should go back to their decent way of covering their bodies … (NTV Uganda, 2013).

Since the implementation of the law, vigilante groups have publicly undressed alleged female violators (Anon., 2014c; Yolisigira, 2014), police have ordered women to return to their homes and dress appropriately, and women who wore miniskirts have been sentenced to jail terms (Anon., 2014a).

These events prompted women to initiate public protests (Fallon, 2014); the Minister of Information and National Guidance to declare that the law did not prohibit miniskirts (Wandera, 2014); Father Lokodo to retract his earlier statement characterizing miniskirts as one of Uganda's vices (Anon., 2013; Salvo, 2014); the Ministers of Ethics and Integrity, of Information, and of Gender, Labour, and Social Development to deny that the law imposed a dress code for women; and the Prime Minister and Attorney General to promise to recall and review the law (Namutebi & Kashaka, 2014; Sekyewa, 2014). To the best of this authors' knowledge, the law has not been recalled, but the women's protests were suppressed by the police under the authority of the Public Order and Management Act (Anon., 2014b; Oloka-Onyango, 2014).

## Implications for Public Health, Clinical Care, and Health Education

Uganda is widely credited for its proactive actions to decrease HIV transmission. Initially believed to have been caused by witchcraft seeking punishment of those who were guilty of a crime and those who had committed the sins of fornication or adultery, these beliefs about HIV/AIDS soon gave way to an understanding of the immensity of the health issue confronting the nation (Waliggo, 2004). In response to this health threat, Uganda instituted what has become known as the ABC campaign—abstinence, being faithful, and condom use (Müller, 2011; Murphy, Greene, Mihailovic, and Olupot-Olupot, 2006). To support its prevention and treatment efforts, the country established HIV peer education programs in its clinics, encouraged HIV testing, and collaborated with numerous international organizations, funders, and externally-funded research endeavors (Bruner, 2017). These successes may now be in jeopardy as the result of evangelical influence on legislation and societal perspectives (Perkins, 2008; Sadgrove, 2007; Setswe, 2007).

Although a number of churches have joined forces in an effort to reduce HIV transmission (Kagimu, Guwatudde, Rwabukwali, Kaye, Walakira, and Ainomugisha, 2011), others have acted in ways clearly detrimental to public health. As noted above, Apostle Deo Balabyekubo claimed to have brought about the cure of AIDS for more than 100 people through healing crusades during 1994 and 1995. Bishop Bataringaya Okumu, an evangelical Christian minister in Gulu District, blocked his adherents from obtaining medical care, promising that he could heal them through prayer. At least one HIV-infected individual died after ceasing his medication usage in response to Okumu's entreaties (United States Department of State, 2019). Several Pentecostal pastors and church officials have been accused of both encouraging romantic relationships between individuals knowing that at least one of them was HIV-infected and misappropriating individuals' property in exchange for promises of healing from HIV (Anon., 2009b; Lloyd, 2008). Others have urged their congregants to rely only on spiritual healing and forego antiretroviral treatment (Anon., 2008; Namige, 2019). Although research findings are somewhat inconsistent across studies, a number of studies indicate that some individuals have terminated their use of antiretroviral medication for their HIV in response to the teachings and prophecies of their religious leaders and testimonies from their peers claiming to have been cured of HIV through prayer

(Tumwine, Neema, & Wagner, 2012; Wanyama et al., 2007). Additionally, the abandonment of Uganda's pragmatic ABC prevention approach in favor of a more moralistic approach that emphasized abstinence until marriage and being faithful drew strong support from Uganda's evangelical communities (Parikh, 2015). This refashioned approach lacked a scientific evidence base and appears to have led to both an increase in the incidence and prevalence of HIV and a low level of condom supplies (Bass, 2005; Das, 2005; Ssegoba, 2004; Wakabi, 2008).

Evangelical leaders have also been implicated in disseminating misinformation about COVID-19 (Kirby, Taru, & Chimbidzakai, 2020). It was recently reported that a Ugandan hospital that had received 5000 doses of vaccine had been able to inoculate only 400 persons because of the hesitancy of the evangelical population (Dias & Graham, 2021). A study of attitudes among pregnant women in Uganda towards vaccination found an unwillingness of some women to receive vaccinations for preventable disease because it was prohibited by Pentecostal churches (Kajungu, Muhoozi, Stark, Weibel, & Sturkenboom, 2020).

The effectiveness of public health prevention efforts and medical treatment efforts necessarily rest, both at the individual and the community levels, on the ability of health educators and care providers to engage in confidential discussions with individuals in an atmosphere of trust and candor (Brown, Bussell, Dutta, Davis, Strong, & Mathew, 2016; Hébert, Hoffnaster, Glass, & Singer, 1991; Rowe & Moodley, 2013). Uganda's criminalization of sexual behavior between consenting adults and the vociferous religious rhetoric compromise the establishment of a safe environment for such communications.

Consider, for example, a patient who presents to a physician with symptoms indicative of depression and anxiety. The physician could merely prescribe medication to address the symptoms without inquiring as to the underlying circumstances that may have triggered the symptoms, an approach that is analogous to placing a bandage over an untreated wound. But what if these symptoms flow from the patient's questioning of his or her sexual orientation or fear that his/her sexual orientation will be discovered or the guilt that the individual is experiencing because of their sexual orientation? As evidenced by documented past events, the patient could suffer serious consequences if his or her sexual identity were to become known publicly. In 2009, several Kampala-based Pentecostal preachers held a press conference during which a teacher named George Oundo claimed to have been kidnapped by an NGO and transported to Nairobi, where he was bribed to recruit children to homosexuality as part of a larger endeavor to promote homosexuality in Ugandan schools (Anon., 2009a). A journalist with an independent press who merely covered issues relating to Uganda's gay community was subjected to questions about her own sexual orientation and was the focus of religious efforts to have her deported or punished with death (Krieger, 2007; Roubos, 2016). Indeed, at least one physician, Dr. Paul Semugoma, has publicly noted the dangers associated with homophobia, observing, "[H]omophobia keeps gays from seeking health services, which hurts everyone" (Roubos, 2016).

Uganda's current penal law not only prohibits sexual relations between individuals of the same sex, but also penalizes anyone who "does or omits to do any act for the purpose of enabling or aiding another person to commit the offense" or who "aids or abets another person in committing the offense" (Penal Code of Uganda Chapter 120, as amended, 2014). Such individuals may face prosecution as a principal offender to inciting the commission of an offense. One must query whether a health care provider or HIV educator could potentially face such criminal charges in response to their efforts to counsel nonheterosexals about safer sex practices; might this be interpreted by a zealous prosecutor as aiding and abetting the commission of an offense? Consider a possible scenario in which a patient, confronted with a physician's assurance of the normality of the patient's desires, experiences intensified feelings of guilt and vulnerability, denies his sexual orientation and, in an effort to protect him- or herself, publicly denigrates the physician, thereby bringing the encounter to public attention.

The religious rhetoric denouncing homosexuality and the provisions of Uganda's Penal Code chapter 120 have troublesome implications not only for Uganda's public health, but also for the education of public health personnel, health care providers, and bioethicists. The possibility of being questioned about one's own sexual orientation and threatened with violence, as experienced by the journalist noted above, may deter educators from broaching issues relating to sexual orientation, despite the importance of sexual orientation as a dimension of human sexuality. Bioethicists who wish to address the concept of vulnerability, a foundational concept in research ethics (DuBois, 2006; Kipnis, 2001; Levine, Fadden, Grady, Eckenwiler, & Sugarman, 2004; Rogers, Mackenzie, & Dodds, 2012), may be reluctant to do so with reference to sexual orientation or behavior for fear of the potential political and legal consequences. And students, just beginning to form their professional identities, may unconsciously integrate the negative attitudes voiced by their religious leaders and inject their unconscious biases into their interactions with their patients, potentially leading to a lesser quality of care and poorer health outcomes (Blair, Steiner, & Havranek, 2011; FitzGerald & Hurst, 2017; Marcelin, Siraj, Victor, Kotadia, & Maldonado, 2019).

Uganda's Code of Professional Ethics, promulgated by the Uganda Medical and Dental Practitioners Council, is intended to be used as a guide "to promote and maintain the highest standards of ethical behaviour by practitioners in Uganda" (Uganda Medical and Dental Practitioners Council, 2014, preamble). The guide prohibits practitioners from violating the human rights of a patient or his or her family or caregiver and explicitly prohibits discriminations on the basis of "gender, race, disability, HIV status or any other indication of vulnerability" (Uganda Medical and Dental Practitioners Council, 2014, Part II). Notably, there is no explicit prohibition against discrimination on the basis of sexual orientation. Accordingly, a physician who believes that homosexuality constitutes a sin and it is his task to help redeem the patient could argue that such behaviour falls outside of the Code's prohibitions. The patient could then face private and/or public denunciation by the physician, leading to a future reluctance to seek medical care and possible repercussions from family members and/or the larger community. Alternatively, the physician could refuse to provide the patient with needed medical care and attention, premising this refusal on their religious beliefs and the absence of an explicit prohibition against such discrimination in the governing ethical code. Either scenario raises significant issues related to the foundational bioethical principles of respect for persons, beneficence, nonmaleficence, and justice.

And, this scenario is not improbable in view of the current widespread rhetoric and, as studies have found, the erosion of "professional values and ethical practices" within Uganda's health care system, including a lack of confidentiality, "abuse of patients" (Matsiko, 2010), and frequent harassment of patients by staff in health facilities (Uganda Law Reform Commission, 2017). Researchers conducting a study of stakeholder perceptions of patient-centered primary care reported that many patients are afraid to ask questions of their providers (Waweru, Sarkar, Ssengoba, Gruénais, Broerse, & Criel, 2019). Yet another study found that more than one-half of 570 university students with a same-sex sexual orientation reported unmet health care needs, which was associated with poor mental health (Larsson, Ross, Tumwine, and Agardh, 2016). Almost one-third reported unmet sexual health needs, exposing them to an increased risk of poor mental health, frequent episodic drinking, and sexual coercion. It was unknown from the data collected whether individuals had refrained from seeking health care due to previous maltreatment by health care providers, which has been found to be the case in other sub-Saharan countries (Fay et al., 2011; Niang et al., 2003; Rispel et al., 2011; Sharma et al., 2008; Smith, 2015).

The religious rhetoric underlying the Anti-Pornography Act may well be contributing to violence against women in Uganda, which is increasingly recognized as a “critical social and public health issue” (Ogland, Xu, Bartkowski, & Ogland, 2014, p. 869; see also Black et al., 2019). Fifty-four percent of all women in Uganda have experienced intimate partner violence (IPV) (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006). The Uganda Demographic and Health Survey conducted in 2016 (Uganda Bureau of Statistics and ICF, 2018) found that more than 56 percent of all married women had ever experienced IPV and 40 percent of married women reported experiencing IPV during the 12 months preceding the survey (Gubi Nansubuga, & Wandera, 2020), a rate that appears to be one of the highest in the world (Devries et al., 2010). Women with disabilities are at even greater risk than their non-disabled counterparts to experience IPV (Valentine, Akobirshoev, & Mitra, 2019). Researchers conducting a prospective study with 455 women aged 18 years and older who were enrolled in the Uganda AIDS Rural Treatment Outcomes Cohort Study from 2005 to 2015 reported finding that 29 percent of the women reported ever having experienced IPV at baseline and almost 8 percent were currently experiencing IPV at baseline (Young et al., 2018).

Intimate partner violence is associated with various adverse health risks and outcomes. Research has found that IPV is a key driver of HIV incidence in Uganda (Uganda AIDS Commission, 2015), increasing women’s risk of contracting HIV, often because their partners are engaged in higher HIV risk behaviors (Kouyoumdjian et al., 2013). Women who are experiencing IPV may choose to ignore HIV, fearing that a positive HIV test will trigger additional IPV against them (Institute of Medicine and National Research Council, 2015). Married women may be especially vulnerable; they may be unable to negotiate the use of a condom with their husband even when the husband has been involved in extramarital sexual relations because it may be perceived as mistrust and indicative of the wife’s promiscuity (Gusman, 2009). IPV has also been found to be associated with miscarriages, unwanted pregnancies, premature labor, infant mortality, increased risk of sexually transmitted infections, low birthweight babies, and depression (Valentine, Akobirshoev, & Mitra, 2019).

Although many factors apart from religion have been found to be associated with intimate partner violence in Uganda, including the male partner’s use of alcohol, his controlling behaviors, the duration of the marital relationship, the number of children, the number of co-wives, the partners’ levels of education and economic resources, and having witnessed parental violence (Amegbor and Pascoe, 2019; Black et al., 2019; Gubi, Nansubuga, & Wandera, 2020), evangelicalism has also been tentatively implicated as a contributing factor. Being of Pentecostal faith may place women in Uganda at greater odds of experiencing physical and emotional partner violence over the course of their lifetimes, compared with their Protestant and Muslim counterparts (Ogland, Xu, Bartkowski, & Ogland, 2014). An ethnographic study of several Pentecostal churches and HIV conducted in Kampala observed that church teachings

> [charged] young men, not women … to lead the country, and, as in the biblical tale [of Joseph], women are represented as morally weaker than men … During weekly teachings given in separate gender groups, young women are taught that men are better suited for such work and that the role of a woman is mainly that of a mother and a wife (Gusman, 2009, p. 76).

A recent thesis by Isabirye (2020) that studied the development of the Pentecostal Deliverance Church in Busoga found that although the majority of congregants were women, there were no female pastors, a result that suggests and reinforces the precept that women should be deferential/subservient to men. This view appears to have infiltrated the health care arena as well. A report from a recent study of stakeholders’ perceptions of patient-centered primary care noted that husbands are frequently the arbiters of decisions relating to their wives' medical care (Waweru et al., 2019).

## Considerations for a Way Forward

We do not mean to suggest by this analysis that individuals who self-identify as members of fundamentalist or evangelical faith communities represent a monolithic perspective or that Uganda is alone in experiencing problematic effects of evangelicalism on its public health efforts. The United States, as an example, is confronting objections to the COVID-19 vaccine from its evangelical communities that are rooted in a distrust of science and scientists and a belief in the healing power of faith. (Dias & Graham, 2021; Reeve, Guff, Waldrop, & Brunswick, 2021). Ultimately a balance must be struck between respect for religion and people's right to worship as they choose and the need to protect the public health. That balance is necessarily dependent upon the particular context and the harms and benefits that may flow from a specified course of action.

Uganda has taken a number of steps that may lead to the establishment of a new balance, with greater importance placed on necessary public health efforts. Ugandan law requires that all churches register if they are working in conjunction with a charitable project. The government has closed nearly 12,000 churches and faith-based NGOs that have failed to fulfill the registration requirement (Semakula, 2019). As of 2003, the majority of the country's 2,000 accredited HIV/AIDS projects were affiliated with evangelical churches (Hofer, 2003). Uganda has proposed imposing a requirement of theological training for religious clergy, in an effort to protect congregants from "misleaders" (Agiresaasi, 2019).

While these efforts are noteworthy, they likely are inadequate to reverse the detrimental effects of past clergy pronouncements that have discouraged individuals from seeking or continuing appropriate care and that have led to violence against others. What is additionally called for are discussions that focus on the interplay, congruencies, and tensions that exist between theological precepts and scientific and medical advancements and the extent to which individuals may concurrently hold faith in both.

It is unknown whether the reported abuse and harassment of patients by health care providers is associated with providers' personal religious beliefs, fear or confusion about existing laws, or other factors. However, these findings from studies covering varying periods of time and employing different methodologies strongly suggest the need for continuing professional education that not only focuses on the substance of the ethical principles underlying the provision of care, but also addresses how such principles are to be enacted in the course of clinical care. The conscientious enactment by providers of these principles would lead to a diminution in incidences of patient abuse and harassment, more careful safeguarding of patient information, the provision of care to all patients regardless of their personal characteristics, and an effort to consider more fully women's situations and give voice to their health concerns and needs.

Uganda once had one of the best, if not the best, health care and public health infrastructure on the African continent (Macrae, Zwi, & Gilson, 1996). It has fallen far from those heights, due to epidemics, wars, internal conflicts, and questionable reforms (Chattu & Yaya, 2020; Dodge, 1990). Intimate links exist between Uganda's government and the evangelical and fundamentalist churches (Sadgrove, 2007); it is possible that some of these reforms may have been occasioned by political figures with personal religious agendas and religious persons seeking political influence. Considered attention to and efforts to reverse the adverse public health and ethical consequences of the more recent infusion of personal religious beliefs into policy and law will contribute to the improvement of Ugandans' health.

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## References

Agiresaasi, A. (2019). Uganda's proposed church training law to protect congregants from 'misleaders,' officials say. *Global Press Journal*, May 2. https://globalpressjournal.com/africa/uganda/ugandas-proposed-church-training-law-protect-congregants-misleaders-officials-say/. Accessed 06 April 2021.

Amegbor, P.M., & Pascoe, L. (2019). Variations in emotional, sexual, and physical intimate partner violence among women in Uganda: A multilevel analysis. *Journal of Interpersonal Violence*, 1-31. https://doi.org/10.1177/ 0886260519839429.

Anderson, A. (2007). *Spreading fires: The missionary nature of early Pentecostalism*. Marknoll, NY: Orbis Books.

Anon. (2009a). Homosexual admits recruiting students. *New Vision*. http://www.newvision.co.ug/new_vision/news/1247426/homosexual-admits-recruiting-students.

Anon. (2008). Spiritual healing threatening adherence to antiretrovirals in Uganda, official says. KHN, October 2. https://khn.org/morning-breakout/dr00054779/. Accessed 05 April 2021.

Anon. (2009b). Ugandan pastors accused of weakening the fight against HIV/AIDS. *VOA*, October 27. https://www.voanews.com/archive/ugandan-pastors-accused-weakening-fight-against-hiv-aids. Accessed 05 April 2021.

Anon. (2014a). Mob undresses 10 people over indecent exposure. *Uganda News Releases*, February 25. https://www.ugandanewsreleases.com/mob-undresses-10-people-over-indecent-exposure/. Accessed 10 April 2021.

Anon. (2013). Uganda bill criminalises miniskirts. *Mail & Guardian*, April 8. https://mg.co.za/article/2013-04-08-uganda-proposes-ban-on-miniskirts-in-move-against-womens-rights/. Accessed 10 April 2021.

Anon. (2014b). Uganda miniskirt ban: Police stop protest march. BBC News, February 26. https://www.bbc.com/news/world-africa-26351087. Accessed 10 April 2021.

Anon. (2014c). Women get three-hour jail term for wearing miniskirts. *Uganda News Releases*, March 7. https://www.ugandanewsreleases.com/women-get-three-hour-jail-term-for-wearing-miniskirts/. Accessed 10 April 2021.

Anti-Pornography Act, 2014, Parliament of Uganda (2014). https://www.ug-cert.ug/files/downloads/The-Anti-pornography-act-2014.pdf. Accessed 10 April 2021.

Aruho, P. (2014). Homosexuality threat to mankind, says Archbishop. *Daily Monitor*, January 13, at 13.

Asamoah-Gyadu, J.K. (2005). *African charismatics: Current developments within independent indigenous Pentecostalism in Ghana*. London: Brill.

Associated Press. (2014). Ugandan tabloid prints list of 'top 200 homosexuals.' *The Guardian*, February 25. https://www.theguardian.com/world/2014/feb/25/ ugandan-tabloid-prints-list-top-200-homosexuals. Access 03 April 2021.

Athumani, H. (2014). Museveni signs anti-pornography bill into law. Uganda Radio Network, February 14. https://ugandaradionetwork.net/story/museveni-signs-anti-pornography-bill-into-law. Accessed 24 April 2021.

Bass, E. (2005). Fighting to close the condom gap in Uganda. *Lancet*, *365*(9465), 1127-1128.

Bebbington, D.W. (1989). *Evangelicalism in modern Britain: A history from 1730s to the 1980s.* London: Unwin Hyman.

Bekele, G. (2015). Evangelicals in Eastern Africa. In B.C. Stiller, T.M. Johnson, K. Stiller, M. Hutchinson (Eds.), *Evangelicals around the world: A global handbook for the 21st century* (pp. 240-247). World Evangelical Alliance.

Black, E., Worth, H., Clarke, S., Obal, H.J., Akera, P., Awor, A., … & Richmond, R. (2109). Prevalence and correlates of intimate partner violence against women in conflict affected Uganda: A cross-sectional study. *Conflict and Health, 13,* 35. https://doi.org/10.1186/s13031-019-0219-8.

Blair, I.V., Steiner, J.F., & Havranek, E.P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *Permanente Journal, 15*(2), 71-78.

Boutchie, J. (2019). Globalizing hatred. *Harvard Political Review*, March 15. http://harvardpolitics.com/globalizing-hatred/. Accessed 17 February 2021.

Brown, M.T., Bussell, J., Dutta, S., Davis, K., Strong, S., & Mathew, S. (2016). Medication adherence: Truth and consequences. *American Journal of the Medical Sciences, 351*(4), 387-399.

Bruner, J. (2011). Keswick and the East African Revival: A historiographical reappraisal. *Religion Compass, 59,* 477-489.

Bruner, J. (2017). Religion, medicine and global health in Uganda: Reflecting critically on an afternoon at Mulago Hospital. *Fieldwork in Religion, 12*(1), 27-49.

Byabazaire, D.M. (1978). *The contribution of the Christian churches to the development of Western Uganda 1894-1974*. Frankfurt: Peter Lang.

Central Intelligence Agency. (2015). Uganda. In The world factbook. https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html.

Chattu, V.K., & Yaya, S. (2020). Emerging infectious disease and outbreaks: Implications for women's reproductive health and rights in resource-poor settings. *Reproductive Health, 17*(43). https://doi.org/10.1186/s12978-020-0899-y.

Dahir, A.L. (2017). Uganda's government is obsessed with porn and policing morality. *Quartz Africa*, September 6. https://qz.com/africa/1070682/uganda-has-introduced-a-pornography-control-committee/. Accessed 10 April 2021.

Das, P. (2005). Condom crisis in Uganda. *Lancet Infectious Disease, 5*(10), 601-602.

DeVries, K.M., Kishor, S., Johnson, H., Stöckl, H., Bacchus, L.J., Garcia-Moeno, C., & Watts, C. (2010). Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *Reproductive Health Matters, 18*(36), 158-170.

Dias, E., & Graham, R. (2021). White evangelical resistance is obstacle in vaccination effort. *New York Times*, April 5. https://www.nytimes.com/2021/04/05/us/covid-vaccine-evangelicals.html?referringSource=articleShare. Accessed 5 April 2021.

Dodge, C.P. (1990). Health implications of war in Uganda and Sudan. *Social Science & Medicine, 31*(6), 691-698.

DuBois, J. M. (2006). Vulnerability in research. In E. A. Bankert & R. J. Amdur (Eds.), *Institutional review board: Management and function* (2nd ed., pp. 337–340). Sudbury, MA: Jones and Bartlett.

Fallon, A. (2014). Confusion over Uganda's 'miniskirt ban' leads to public attacks on women. *The Guardian*, February 28. https://www.theguardian.com/ fashion/fashion-blog/2014/feb/28/uganda-miniskirt-ban-attacks-women. Accessed 10 April 2021.

Fay, H., Baral, S.D., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., … & Beyrer, C. (2011). Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. *AIDS Behavior, 15*(6), 1088-1097.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals. *BMC Medical Ethics, 18*(19). doi: 10.1186/s12910-017-0179-8.

Gubi, D., Nansubuga, E., & Wandera, S.O. (2020). Correlates of intimate partner violence among married women in Uganda: A cross-sectional survey. *BMC Public Health, 20,* 1008. https://doi.org/10.1186/s12889-020-09123-4.

Gusman, A. (2009). HIV/AIDS, Pentecostal churches, and the "Joseph generation" in Uganda. *Africa Today, 56*(1), 66-86.

Hébert, P.C., Hoffmaster, B., Glass, K.C., & Singer, P.A. (1997). Bioethics for clinicians: 7. Truthtelling. *Canadian Medical Association Journal, 156*(2), 225-228.

Hofer, K. (2003). The role of evangelical NGOs in international development: A comparative case study of Kenya and Uganda. *Africa Spectrum, 38*(3), 375-398.

Ihejirika, W.C. (2006). *From Catholicism to Pentecostalism: The role of Nigerian televangelists in religious conversion*. Port Harcourt, Nigeria: University of Port-Harcourt Press.

Institute of Medicine, & National Research Council. (2015). *Preventing intimate partner violence in Uganda, Kenya, and Tanzania: Summary of a joint workshop by the Institute of Medicine, the National Research Council, and the Uganda National Academy of Sciences.* Washington, DC: National Academies Press.

Isabirye, M.S. (2020). African indigenous Pentecostal Christianity in Uganda with reference to the Deliverance Church in Busoga (1974-2012). Thesis, Kenyatta University. https://ir-library.ku.ac.ke/handle/123456789/21342?show=full. Accessed 16 February 2021.

Jenga, F. (2017). Pentecostal broadcasting in Uganda. *Journal of Communication & Religion, 40*(4), 53-71.

Jenkins, P. (2002). *The next Christendom: The coming of global Christianity*. New York: Oxford University Press.

Kagimu, M., Guwatudde, D., Rwabukwali, C., Kaye, S., Walakira, Y., & Ainomugisha, D. (2011). Inter-religious cooperation for HIV prevention in Uganda: A study among Muslim and Christian youth in Wakiso District. *Religions, 2,* 707-728.

Kajungu, D., Muhoozi, M., Stark, J., Weibel, D., & Sturkenboom, M.C.J.M. (2020). Vaccines safety and maternal knowledge for enhanced maternal immunization acceptability in rural Uganda: A qualitative study approach. *PLOS One*. doi.org/10.1371/journal.pone.0243834.

Kaoma, K. (2014). The paradox and tension of moral claims: Evangelical Christianity, the politicization and globalization of sexual politics in sub-Saharan Africa. *Critical Research on Religion, 2*(3), 227-245.

Karamagi, C., Tumwine, K., Tylleskar, T., & Heggenhougen, K. (2006). Intimate partner violence against women in eastern Uganda: Implications for HIV prevention. *BMC Public Health, 6,* 284. https://doi.org/10.1186/1471-2458-6-284. Accessed 10 April 2021.

Kipnis, K. (2001). Vulnerability in research subjects: A bioethical taxonomy. In *Ethical and policy issues involving human participants, vol. II.* Bethesda, MD: National Bioethics Advisory Commission.

Kirby, B., Taru, J., & Chimbidzakai, T. (2020). Pentecostals are in a "spiritual war" against coronavirus in Africa—as are some political leaders. *Quartz Africa,* May 1. https://qz.com/africa/1849315/pentecostal-churches-are-in-spiritual-war-vs-coronavirus-covid19/. Accessed 05 April 2021.

Kisitsu, G. (2018). Religion and homosexuality criminalization in Uganda: The contribution of American anti-homosexual evangelicals towards the 2014 anti-homosexuality law. Doctoral dissertation, University of Kwazulu-Natal. https://ukzn-dspace.ukzn.ac.za/handle/10413/16787. Accessed 16 February 2021.

Kouyoumdjian, F.G., Calzavara, L.M., Bondy, S.J., O'Campo, P., Serwadda, D. Nalugoda, F., … & Gray, R. (2013). Risk factors for intimate partner violence in women in the Rakai Community Cohort Study, Uganda, from 2000 to 2009. *BMC Public Health, 13,* 566.

Krieger, L.M. (2007). Stanford student under fire in Uganda for covering gay issues. *Mercury News,* September 3. https://www.mercurynews.com/2007/09/03/ stanford-student-under-fire-in-uganda-for-covering-gay-issues/. Accessed 03 April 2021.

Levine, C., Faden, R., Grady, C., Hammerschmidt, D., Eckenwiler, L., & Sugarman, J. (2004). The limitations of "vulnerability" as a protection for human research participants. *American Journal of Bioethics, 4*(3), 44–49.

Larsson, M., Ross, M.W., Tumwine, G., & Agardh, A. (2016). Determinants of unmet needs for healthcare and sexual health counseling among Ugandan university students with same-sex sexuality experience. *Global Health Action, 9,* 30790. http://dx.doi.org/10.3402/gha.v9.30790. Accessed 18 April 2021.

Lloyd, J. (2008). Uganda's controversial pastors. *Financial Times,* October 24. https://www.ft.com/content/20b089e0-9f14-11dd-98bd-000077b07658. Accessed 05 April 2021.

Macrae, J., Zwi, A.B., & Gilson, L. (1996). A triple burden for health care sector reform: "Post-conflict" rehabilitation in Uganda. *Social Science & Medicine, 42*(7), 1095-1108.

Marcelin, J.R., Siraj, D.S., Victor, R., Kotadia, S., & Maldonado, Y.A. (2019). The impact of unconscious bias in healthcare: How to recognize it and mitigate it. *Journal of Infectious Diseases, 220* (Suppl. 2), S62-S73.

Marsden, G.M. (1980). *Fundamentalism and American culture: The shaping of twentieth-century evangelicalism.* New York: Oxford University Press.

Matsiko, C.W. (2010). The Uganda country case study: Positive practice environments. International Council ofo Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy. http://www.whpa.org/sites/default/ files/2020-05/Uganda_PPE_Case_study.pdf. Accessed 18 April 2021.

McKinnon, A. (2020). Demography of Anglicans in Sub-Saharan Africa: Estimating the population of Anglicans in Kenya, Nigeria, South Africa, Tanzania and Uganda. *Journal of Anglican Studies, 18*(1), 42-60.

Müller, A. (2011). How and why HIV prevention efforts have undermined the rights of sexual minorities: The case of Uganda. Presented at conference on Sexuality, AIDS, and religion: Transnational dynamics in Africa, Oxford University, September 29.

Murphy, E.M., Greene, Mihailovic, A., & Olupot-Olupot, P. (2006). Was the "ABC" approach (abstinence, being faithful, using condoms) responsible for Uganda's decline in HIV? *PLoS Medicine, 3*(9). doi: 10.1371/journal.pmed.0030379.

Musana, P. (1991). The historical origins and development of Pentecostal movement in Uganda. Unpublished MA manuscript, Department of Religious Studies, Makerere University, Kampala, Uganda.

Namige, R.N. (2019). Towards the management of HIV/AIDS patients in Pentecostal churches in Uganda: a case of Eden and Bethel Churches in Kampala [P275]. *Sexually Transmitted Infections, 95,* A158-A159.

Namutebi, J., & Kashaa, U. (2014). Cabinet to review anti-pornography law. *New Vision,* February 26, at 5.

Ndyabahika, J. (1993). The revival movement in Uganda: An evaluation. *Africa Journal of Evangelical Theology, 12*(1), 18-40.

Niang, C.I., Tapsoba,, P., Weiss, E., Diagne, M., Niang, Y., Moreau, A.M., … & Castle, C. (2003). 'It's raining stones': Stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Culture, Health, and Sexuality, 5*(6), 499-5 12.

Ogland, E.G., Xu, X., Bartkowski, J.P., & Ogland, C.P. (2014). Intimate partner violence against married women in Uganda. *Journal of Family Violence, 29,* 869-879.

Oliver, M. (2013). Transnational sex politics, conservative Christianity, and antigay activism in Uganda. *Studies in Social Justice, 1*, 83-105.

Oloka-Onyango, J. (2014). Understanding the genesis and impact of recent legislation in Uganda. *Pambazuka News,* May 1. https://www.pambazuka.org/governance/ understanding-genesis-and-impact-recent-legislation-uganda. Accessed 10 April 2021.

Oloka-Onyango and Ors v. Attorney General, Constitutional Petition No. 8 of 2014 (Uganda Constitutional Court, August 1, 2014).

Onyait, S.R. (2011). The Christian faith and development work: An assessment of the historical and contemporary trends in the Pentecostal Assemblies of God in Kumi District—Eastern Uganda. https://www.academia.edu/39122736/The_Christian _Faith_ and_Development_Work20190514_130338_y9tmhf. Accessed 16 February 2021.

Parikh, S. (2015). *Regulating romance: Youth love letters, moral anxiety, and intervention in Uganda's time of AIDS*. Nashville, TN: Vanderbilt University Press.

Parliament of Uganda, AntiHomosexuality Bill, 2009, No. 18, Principle 1.1.

Penal Code Act. (1956).

Penal Code of Uganda, Chapter 120, as amended (2014). https://ulii.org/ akn/ug/act/ord/1950/12/eng%402014-05-09. Accessed 14 April 2021.

Perkins, A. (2008). Religion and sex in Uganda: The power of the pulpit. *The Guardian*, October 13. https://www.theguardian.com/society/katineblog/2008/oct/13/sexandreligion. Accessed 13 June 2021.

Pownall, K.P. (2007). Ugandans call for deportation of American journalist covering gay issues. *The Advocate*, August 22. https://www.advocate.com/news/2007/08/ 22/ugandans-call-deportation-american-journalist-covering-gay-issue. Accessed 03 April 2021.

Reeve, E., Guff, S., Waldrop, T., & Brunswick, D. (2021). Many evangelicals say they won't be vaccinated against covid-19. Some experts say distrust and misinformation have played a role. CNN, April 15. https://www.cnn.com/2021/04/14/us/covid-vaccine-evangelicals/index.html. Accessed 24 April 2021.

Rispel, L.C., Metcalf, C.A., Cloete, A., Moorman, J., & Reddy, V. (2011). You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities. *Journal of Public Health Policy, 32*(Suppl. 1), S137-S51.

Rogers, W., Mackenzie, C., & Dodds, S. (2012). Why bioethics needs a concept of vulnerability. *International Journal of Feminist Approaches to Bioethics, 5*(2), 11-38.

Roubos, K. (2016). Declaration of Katherine Roubos, Sexual Minorities v. Lively (D.C. Mass. No. 3:12-CV-30051-MAP), July 31, 2016 (Document 287, filed August 8, 2016). http://files.eqcf.org/wp-content/uploads/2016/11/287-Declaration-of-Roubos.pdf. Accessed 03 April 2021.

Rowe, K., & Moodley, K. (2013). Patients as consumers of health care in South Africa: The ethical and legal implications. *BMC Medical Ethics, 14*(15). Doi.org/10.1186/1472-6939-14-15.

Sadgrove, J. (2007). ‘Keeping up appearances’: Sex and religion amongst university students in Uganda. *Journal of Religion in Africa, 37*(1), 116-144.

Salvo, S. (2014). Women challenge “mini-skirt ban” in Uganda’s intensifying crackdown. Human Rights First, March 5. https://www.humanrightsfirst.org/ blog/women-challenge-%E2%80%9Cmini-skirt-ban%E2%80%9D-uganda%E2 %80%99s-intensifying-crackdown. Accessed 10 April 2021.

Sekyewa, E.R. (2014). Anti-porn law to be reviewed after attacks on women. Index on Censorship, March 10. https://www.indexoncensorship.org/2014/03/porn-bill-uganda/. Accessed 10 April 2021.

Semakula, J. (2019). Ugandan government closes nearly 12,000 churches and faith-based NGOs. Religion Unplugged, November 25. https://religionunplugged.com/news/ 109/11/25/ugandan-government-closes-1200-churches-faith-based-ngos. Accessed 17 February 2021.

Setswe, G. (2007). Abstinence and faithfulness programs for prevention of HIV/AIDS among young people: What are the current debates? *South Africa Family Practice, 49*(8), 5-10.

Sharma, A., Bukusi, E., Gorbach, P., Cohen, C.R. Muga, C., Kwena, Z. & Holmes, K.K. (2008). Sexual identity and risk of HIV/STI among men who have sex with men in Nairobi. *Sexually Transmitted Disease, 35*(4), 352-354.

Smith, R. (2015). Healthcare experiences of lesbian and bisexual women in Cape Town, South Africa. *Culture, Health and Sexuality, 17*, 180-193.

Ssejoba, E. (2004). Museveni condemns condom distribution to pupils. *New Vision*, May 17.

Ssemugoma, F. (2021). *The march of Christianity in Uganda: History of Christianity in Uganda*. Monee, IL: Author.

Tamale, S. (2016). Crossing the bright red line: The abuse of religion to violate sexual and reproductive health rights in Uganda. *Journal of Theology for Southern Africa, 155*, 121-136.

Tomaselli, K.G. (1995). Political economy of televangelism: Ecumenical broadcasting versus teleministries. *Communicare, 14*, 65-79.

Tomaselli, K.G., & Shepperson, A. (1997). Resistance through mediated orality. In S.M. Hoover, K. Lundby (Eds.), *Rethinking media, religion and culture* (pp. 209-224). Thousand Oaks, CA: Sage Publications.

Tumwine, C., Neema, S., & Wagner, G. (2012). Reasons why high religiosity can co-exist with and precipitate discontinuation of antiretroviral therapy among different HIV clients in Uganda: An exploratory study. *Religions, 3*, 817-832.

Uganda AIDS Commission. (2015). National HIV and AIDS strategic plan 2015/2016-2019/2020: An AIDS free Uganda, my responsibility! Uganda: Author. http://cquin.icap.columbia.edu/wp-content/uploads/2017/06/ICAP_CQUIN_National-HIV-and-AIDS-Strategic-Plan_2015-16-2019-20.pdf. Accessed 13 June 2021.

Uganda Bureau of Statistics (UBOS). (2014). National population and housing census: main report. Kampala: Uganda Bureau of Statistics.

Uganda Bureau of Statistics (UBOS), & ICF. (2018). Uganda demographics and health survey, 2016. Kampala, Uganda and Rockville, MD: Authors. https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf. Accessed 10 April 2021.

Uganda Bureau of Statistics (UBOS). (2002). 2002 Uganda population and housing census: Analytical report. Kampala: Uganda Bureau of Statistics.

Uganda Law Reform Commission. (2017). Medical negligence in Uganda: Issues paper. https://www.ulrc.go.ug. Accessed 18 April 2021.

Uganda Medical and Dental Practitioners Council. (2013). Code of ethics. https://www.umdpc.com/Resources/Code%20of%20Professional%20Ethics.pdf. Accessed 18 April 2021.

United States Department of State. (2019). Uganda 2019 international religious freedom report. https://www.state.gov/wp-content/uploads/2020/05/UGANDA-2019-INTERNATIONAL-RELIGIOUS-FREEDOM-REPORT.pdf. Accessed 10 March 2021.

Valentine, A., Akobirshoev, I., & Mitra, M. (2019). Intimate partner violence among women with disabilities in Uganda. *International Journal of Environmental Research and Public Health, 16,* 947. doi: 10.3390/ijerph16060947.

van der Laan, F., & van der Wal, E. (2014). Anti-queer morality in Uganda. Capstone project, Universiteit Utrecht. https://uu.academia.edu/FleurvanderLaan. Accessed 14 April 2021.

van Klinken, A., & Zebracki, M. (2016). Porn in church: Moral geographies of homosexuality in Uganda. *Porn Studies*, *3*(1), 89-92.

Wakabi, W. (2008). New strategies sought in Uganda as HIV infections rise. *Lancet Infectious Disease, 8*(5), 285.

Waliggo, J.M. (2004). The church and HIV/AIDS (A Ugandan pastoral experience). *African Ecclesial Review*, *46*(1), 23-34.

Wandera, D. (2014). Anti-pornography law was misunderstood, says Minister. *Daily Monitor*, March 5.

Wanyama, J., Castenuovo, B., Wandera, B., Mwebaze, P., Kambiugu, A., Bangsberg, D.R., & Kamya, M.R. (2007). Belief in divine healing can be a barrier to antiretroviral therapy adherence in Uganda. *AIDS*, *21,* 1486-1487.

Ward, K. (2001). ‘The Armies of the Lord’: Christianity, rebels and the state in Northern Uganda, 1986-1999. *Journal of Religion in Africa*, *31*(2), 187-221.

Ward, K. (1989). “Obedient rebels”: The relationship between the early “Baokole” and the Church of Uganda: The Mukono crisis of 1941. *Journal of Religion in Africa*, *19*(3), 194-227.

Ward, K. (2015). The role of the Anglican and Catholic churches in Uganda in public discourse on homosexuality and ethics. *Journal of Eastern African Studies*, *9*(1), 127-144.

Waweru, E., Sarkar, N.D.P., Ssengoba, F., Gruénais, Broerse, J., & Criel, B. (2019). Stakeholder perceptions on patient-centered care at primary health care level in rural eastern Uganda: A qualitative inquiry. *PLoS ONE, 14*(8), e0221649. https://doi.org/10.1371/journal.pone.0221649.

Wiener-Bronner, D. (2014). Ugandan tabloid publishes list of ‘top 200’ homosexuals who could now be jailed. *The Atlantic*, February 25. https://www.theatlantic.com/international/archive/2014/02/ugandan-tabloid-publishes-list-top-200-homosexuals-who-could-now-be-jailed/358478/. Accessed 03 April 2021.

Wolffe, J. (2015). Who are evangelicals? A history. In B.C. Stiller, T.M. Johnson, K. Stiller, M. Hutchinson (Eds.), *Evangelicals around the world: A global handbook for the 21st century* (pp. 25-33). World Evangelical Alliance.

Yolisigira, Y. (2014). Mob undresses 10 people over indecent exposure. *Daily Monitor,* February 26. https://ugandansatheart.blogspot.com/2014/03/uah-jiggers-syndrome-mob-undresses-10.html. Accessed 10 April 2021.

Young, C.R., Kaida, A., Kabakyenga, J., Muyindike, W., Musinguzi,, N., Martin, J.N., …, & Matthews, L.T. (2018). Prevalence and correlates of physical and sexual intimate partner violence among women living with HIV in Uganda. *PLoS One, 13*(8), e0202992. https://doi.org/10.1371/journal.pone.0202992.

Zurlo, G.A. (2015). Demographics of global evangelicalism. In B.C. Stiller, T.M. Johnson, K. Stiller, M. Hutchinson (Eds.), *Evangelicals around the world: A global handbook for the 21st century* (pp. 34-47). World Evangelical Alliance.

# THE CONTRIBUTION OF ETHICS TO THE DEVELOPMENT OF THE HEALTHCARE SYSTEM

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## Abstract

Physicians know best the value of *time* and *costs* of maintaining the health of a patient or of a certain category of the population, in other words, the costs of *the quality of life of the population*. In the medical field, the best example of how certain institutions emerge and develop is the story of the International Red Cross and the Swiss Jean-Henry Dunant. SARS-CoV2 is not the battle for the city of Solferino in northern Italy, but it can become a context that contributes to the development of the healthcare system, focusing on service *quality*, on *ethical risk management* based on *the principles of the Caux Round Table* and, last but not least, on valuing *human development*. The writing of the book „A Memory of Solferino" and the initiation of the *International Committee for Relief to the Wounded* caused Henry Dunant a series of financial difficulties, which in time led to poverty and loss of respect in society, but the organization he created has developed, and his basic ideas have been gradually accepted, which is why we are talking today about the International Red Cross. For his work and efforts, Henry Dunant[i] would be awarded the Nobel Peace Prize (1901) by the Norwegian Nobel Committee. The paper entitled „The contribution of ethics to the development of the healthcare system" will be a theoretical and practical approach to initiating and applying ethics in the activity and institutional development of the public health system. People have emotions, feelings and resources that are limited in time, but human communities can be an unlimited resource of knowledge, support and creativity. *Digitalization*, *teleworking*, *telemedicine* will bring a number of fundamental changes in the structure and operation of many societies. There is talk today of corporate governance, risk management, the role of leadership and quality standards. Ethics will connect to these norms, regulations and to the new European provisions and requirements, and will protect the freedom, dignity and integrity of individuals/citizens, be they specialists or patients.

**Keywords**: ethics, values, health, reward, achievement, the principles of the Caux Round Table, "ethical risk management".

Throughout my professional life I have seen much suffering, illness and poverty and maybe I have felt and glimpsed just as much happiness, wealth, philanthropy, kindness and generosity. In other words, I could see that we have seen vulnerable people and happy, fulfilled people. If I were to answer the question, „What were these people like?", do not expect a direct answer. Instead, the answer can to be found in the thoughts and numerous perspectives of this *text*, in the meanings and what will follow after the text is *received*.

I thought long before I wrote this article, which is part of a new book project. I reflected much on how I would like to communicate with people and specialists in the medical field. How could ethics contribute to the construction and development of an institution? There are many ways, but the most sustainable are those that value trust, prestige and well-being. *Prestige* and *well-being* are two *institutional values* created by people, in which "morality acts in a hierarchical manner, propagating from top to bottom, from abstract but universal ideals, to principles and standards, descending, from there, to objectives and, ultimately, to actions" (Young, 2009, pp. 18). This is how any action aimed at the prestige of the medical act and the well-being of an institution that ultimately feeds on "limited resources" will be viewed.

*Digitalization, teleworking, telemedicine* will bring a number of fundamental changes in the structure and operation of many societies. There is talk today of corporate governance, risk management, the role of leadership and quality standards. Environment, society and corporate governance, this is the conceptual triad that includes the set of rules that investors take into account in the investment process, and which concern not only the business environment, but especially the medical field. Ethics will connect to these norms, regulations and to the new European provisions and requirements, and will protect the freedom, dignity and integrity of individuals/citizens, be they specialists or patients.

*Engagement, prevention and responsibility* are but a few of the medical expertise in the relationship between environment and society. We are on the verge of paradigm shifts, of medical and institutional strategies[ii], that cannot overlook what is happening in the community or at national, European and global level. Stephen Young's lens of observation and analysis as regards the situation of ethics in Romania is a first invitation to reflection and introspection in your own professional and institutional-academic life.

"In countries like Romania, which are in transition, the communist regime had a minimal contribution to the value system. The values proposed by communism were rejected or lost their appeal over time, no longer gaining adherents. In the transition countries, one of the consequences of this reality was that, amid the fall of the communist regime, the collapse of the value system was not followed by the adoption of a new set of solid values. People were deprived of values to relate to, their behaviour and decisions being often guided by their own material interests. Such countries have fallen into a kind of nihilistic chaos, into a crisis of values. In such situations, many turn to religion to find balance and support. I have witnessed a return to Catholicism in Poland and to Orthodoxy in countries such as Russia and Serbia. In China, the Communist Party leadership proposed a new moral code, called the Harmonious Society, a modified version of Confucianism, to turn the Chinese people away from greed and selfishness.

Therefore, in today's Romania, a return to the values and traditions that existed before the years during the communist regime is welcome" (Young, 2009, pp. 12-13).

Having *reminded* the reader all of the above, I can only plead in favour of human and professional development and bring arguments in support of ethics, which in turn can not ignore the realities and importance of economic and medical decision-makers. We hear today of a *moral partnership* between institutions and citizens, of *cultural equity* and last but not least of "corporate governance as a moral compass."[iii] What kind of compass do we have in increasing the quality of medical services? What are the expectations of the population from medicine and what are the realities of medical life in Romania? Here are just a few pillars on which the prestige and role of specialists in reconsolidating the Romanian healthcare system can be defined.

## 1. "Good and Evil, useful and true: in money we trust"[iv]

"Any economy has a "speed limit" in the short term, a relatively constant capacity of producing goods and services. In the short term, we have finite stocks of things that the economy requires as it develops: land, labour, steel, yoga instructors, and so on" (Wheelan, 2020, pp. 122). In the other register of interpretation and analogy we must not forget that people have limited emotions, feelings, and resources over time, but human communities can be an unlimited resource of thought, support, and creativity. To access this resource, we need a space for dialogue and mutual support based on trust and values that are "unalterable" through change and time. What I mean here is that trust and human development are the pillars of a sustainable institution. How do we represent *the good* in health? How do we define *health* as a state and an institutional foundation? What is the boundary between *usefulness* and *truth* when it comes to access to resources?

The perception of *values, responsibility* and *work* is closely linked to institutions and the contractual form of employment. And here comes another pragmatic element related to our ability to understand the relationship between the work factor and man as a *citizen* or *employee*. In this context, however, we are dealing with an intention to approach the increased responsibility of the human resource and the investment in people. A concept that may belong to the European set of values, but which is at the same time necessary. Let us not forget the debates that are now taking place at European level on labour legislation and the major changes that will occur in this register of consequences of the SARS-Cov2 pandemic. And so we arrived to the economic analysis of labour developed by David Ellerman.

Do we hire people or do we rent services? Is *duration* a distinct, defining criterion in employment relations? How can we explain the differences in quality between services provided by private healthcare institutions and state-run institutions? This would be another direction for analysis, which will be developed in the second part of this paper, *Marriage and divorce: health and money.*

*We rent cars, we rent apartments, but we hire human beings,* states David Ellerman in order to draw attention to living related costs that make the difference between *hiring* and *renting*". Just to get people to say that it's the renting of human beings is difficult. They say, no, it's the hiring of human beings. We rent cars, we rent apartments, but we hire human beings. But it's exactly the same thing. In the UK, a rental car is called a "hire car." Google it. An economist will tell you that you buy an entity or you buy its services. So you buy a car or you rent - or hire -a car. Renting or hiring a car means you're buying so many car days or car months. When you rent an apartment, you're not buying the apartment, you're buying the services of the apartment for a month or three days or whatever it is. It's the same with human beings. You can't buy human beings anymore, but you can rent them. And that means you buy their person hours. But just that understanding is difficult for people. They're so trained to see a difference between these words hire and rent"[v] (Ellerman, 2018, pp. 55-56).

In order to be fair and honest at least "also" in terms of Adam Smith's thinking, we will need to rethink how we relate to *man* as a *living being* and the work factor or indicator, that index that is often quantified in the quantity and quality of products on the market. Institutions are formed and maintained by people, by the human resource, but people have their own characters and moral motivations, and therefore the concept of corporate governance is also applicable to the healthcare system. People respond and react in the short, medium and long term according to their own moral motivations, but let's not forget that *man* and *the economy* only have limited resources.

## 2. Marriage and divorce: health and money[vi]

Sometimes we are fated to know the hidden nature of things and of events and incidents through others, of those similar to them, so that by the disorderly accumulation of knowledge we come to an understanding of the structure of *patterns*. We live in a social, economic and human context that forces us to think in perspective, under the pressure of major changes. "There is a remarkable, almost mysterious, one-sided relationship between nations and their currencies. Money and nations go hand in hand. (…) But although there are unified international systems of weights and units of time, length and weight (the latter expressed in two forms: imperial and metric), there is no single world currency" (King, 2017, p. 221). We do not have unitary legislative policies and perhaps the very tradition of medical institutions varies from one country to another. However, reputation and prestige remain criteria that validate the act of work in large institutions and companies.

Do we need *trust* and *prestige*? How can the healthcare system regain these qualities in the medical act and in the relationship with society? Are *relativism* and *universalism* impediments to cooperation between institutions and specialists? These are just some of the big issues in how this relationship between institutions and the moral division of labour should be viewed. But what is moral divide and how should it be understood in terms of corporate governance or the moral organization of work? In other words, the moral organization of work refers to the moral values and principles that guide work, the distribution of resources, and the relationship with society. And here we need a brief overview of the three *dimensions*[vii] that influence the moral division of labour:

- *The micro-dimension*: with reference to the difference or dissensions (between religious, political beliefs and various sexual orientations) that may arise between individual and organizational moral values.
- *The meso-dimension*: this would be the difference between moral values, principles, individual orientations and those values that frame the corporate / institutional culture as a whole and where the person in question works.
- *The macro-dimension*: the effects of the transition through practices, medical policies with the corresponding moral values between the two institutions, countries, more precisely the transition from the value system of the country of origin and the values and principles of the host country.

Ethical dilemmas, conflicts and organizational customs are often related to *meaning*, *practice* and the *distribution* of work with the corresponding degrees of responsibility and hierarchical involvement. And here we have in mind the following: [viii] *conceptual frameworks*, ie rational processes, the perception of time and space; *codes of conduct* (good manners and habits, culinary preferences, personal hygiene, attitude towards environmental protection); *shared meanings and perceptions* (verbal and non-verbal language - facial expression, eye contact, gestures, contextual positions, etc.); *symbols and rituals* (religious meanings and symbols attributed to colours and actions); and last but not least, the set of *ethical values and standards*. The importance of those listed above can only be understood in the conduct of life and work in a *private* or *state* institution, I would say that the differences that occur here are due to the mode of employment - to job security.

Lasting partnerships most often start from love and are sustained by a strengthened respect for *freedom, prosperity* and *trust*. *Marriage and divorce: money and nations* (King, 2017, pp. 220-258) is the title that inspired me to understand the period we are going through, with its specific fluctuations and asymmetries. I do not write for the sake of writing, but I have boundless confidence in people and their ability to think, act and feel. Happy people are alike, while unhappy people carry their own unhappiness in terms of power or helplessness. The reasoning of *love contracts* is found on the reverse of any separation process, but the causative factor is often focused on health in all its meanings, and on excess financial resource or on the verge of survival. "The parable of the talents" or "the rich man whose land bore fruit" are the expressions of the way we choose to be in the most important spaces of our lives, but let's not forget that everything pays off, because "pain and pleasure are not twins, nor the image in the mirror of the other, at least not in terms of their roles as survival devices" (Damasio, 2005, p. 299). And in medical practice one can concisely assess the distinction between *utility, relativism* and *universalism* as values that generate *life, well-being* and *health*.

Kahneman and Tversky say that the function that determines value (utility) is S-shaped, concave for gains, and convex for losses (Kahnema & Tversky, 1979, p. 279). The function has the property that "the response to losses is more extreme than the response to gains," that is, "the displeasure associated with losing a sum of money is generally greater than the pleasure associated with winning the same amount" (Tversky & Kahneman, 1982, p. 454). In other words, decisions are affected by a certain loss aversion. With these things clarified, I can say that Knut Wicksell was the first to say that the loss of a given amount of money hurts more than enjoying the same amount."[ix]

In medicine, lack of oxygen can cause death or irreversible neuronal destruction. Doctors know best *the value of time* in the onset of symptoms and in the treatment of certain diseases. The human resource in the medical system is vital for the manner in which the moral organization / division of labour will be (re) constructed. Health is and will be one of the pillars of any society and the projection of the future depends on it. The environment is constantly changing, and moral behaviour is a precondition for the way institutions operate and prosper. There is something here related to the mystery of how some nations are richer than others.

"The ability to make moral decisions is a condition of human dignity. On this ability depends our moral sense and everything that helps us overcome the Darwinian natural state and live in a civilised society. It is not moral capitalism, but individuals themselves who are responsible for the unfortunate decisions they sometimes make" (Young, 2009, p. 179). In order to overcome the crisis and lay the foundations for a future dialogue on the resources and potential of the healthcare system, it will be necessary to take a few steps back together and individually, not in order to "observe social distancing", but to look back with the scientific, human, social, cultural and technological *set of tools* that we have today. The managerial perspective of the corporate and healthcare system will be reflected in the well-being of the community. The welfare and the well-being of the organization are important criteria in the standards that investors follow. *Duration, stability, predictability,* and *confidence* are fundamental to the moral organization of work and to a future equity of the pension system. When we look at the quality factors of an institution, it is recommendable to evaluate how this quality is obtained, how *performance standards* are met.

## 3. The role of ethics in the (re) construction and prestige of an institution

The contribution of ethics to the development of the medical system presupposes first of all *human and institutional development*. In these terms, ethics will be seen in its essence as a field, as a *moral compass* of life in a community. To know the *cardinal points* of life in the community in which you carry out your profession, to know the *values, principles* and *the people* who build this ethos.

Ethics is not *a profession without professionals, a marginal, speculative and worthless field*[x], but it is what a considerable part of the countries of the former communist bloc lacked. There is not *an ethic of business* and *another ethic of the medical, university, cultural system*, etc. However, there are traditions, cultures, values and various types of activity that the various professional communities relate to, by evolving or by stagnating.

"There is a fairly widespread prejudice according to which corporate ethics and social responsibility would only involve costs for the business environment, which is why only those companies with a significant capital flow would behave ethically and responsibly. This prejudice reflects a misunderstanding of the notion of business ethics. From this perspective, ethics is nothing more than a form of charity dependent on the existence of sufficient sums of money to be shared with those who fight for a good cause. In reality, ethics is more than acts of charity. Business ethics is about how companies are run and how relationships between companies and stakeholders are managed (…) the manner in which a company's values are put into practice" (Young, 2009, p. 12).

*Risk management* is essentially a well-understood and applied ethics. To know what kind of ethics work in our institutional system, I invite you to ask the question: *Employees:*

*simple wheels of a gear or moral agents?* and you will have a perspective on a significant percentage of the citizens of a community. Reflect on the number of medical institutions in a city to realize how to build the *prestige* and *ethos* of a community in larger and smaller cities in Romania.

"In terms of hospital comfort, the fight must be fought against three major ills, which the patient must avoid: noise, unnecessary waiting for patients, bacteriological contamination (intrahospital infections)" (Duțescu, 1979, p. 17). And a lucid evaluation of medical institutions, accompanied by ethical reasoning, will increase the accountability of the bodies empowered to make decisions and review medical policy in the light of new changes in the future.

*The Caux Round Table principles* concern the relations between *employer* and *employee* from the perspective of employee theory, as the first factor in building, developing and maintaining welfare in an institution. From the perspective of the *Caux Round Table Principles,* employees will consider the following criteria in meeting objectives:

- *To acquire and implement the mission, objectives, principles and values specific to the institution.*
- *To consider not only the short-term benefits gained from the work done, but also to be concerned about the long-term well-being of the institution.*
- *To be really concerned about the constant improvement of the quality of the services offered by the institution.*
- *To know exactly what their job entails and strive to improve.*
- *Not to abuse the authority given by seniority in work and not to replace the work rules already established with their own rules.*
- *To avoid any conflict-generating behaviour or unproductive competitiveness between departments, within them or in the relationship with the managers; in everything they do at work to show team spirit and take into account the common good of all those who work in the company* (Young, 2009, p. 188).

Nevertheless, it is good to keep in mind that ethics cannot be summarised solely in terms of *rules, norms, principles, consequences* and *performance standards,* because institutions are created and maintained, developed by people, and their shaping occurs through intentions and motivations. *Ethical creativity, social intelligence* and *capitalism*, in other words, well-being and sustainable development, are the paths that leaders take. And the managers who truly know the human and material resources of the institution in which they operate will be able to effectively combine the relationship between *costs* and *benefits*, by extending governance to the social, cultural and business community they belong to.

## Conclusions

### Each institution has its own *Secret Garden* [xi]

Doctors know best the value of *time* and the costs of maintaining the health of a patient or a certain category of the population, in other words, *the costs of the quality of life of the population*. In 1859, a battle took place in the town of Solferino in northern Italy. There, businessman Henry Dunant saw thousands of Swiss, Italian, French and Austrian soldiers killing and mutilating each other. Then, on his own initiative, he organized what we find today under the name of medical care in war situations. He later wrote a book entitled "A Memory of Solferino," which also contained a support plan for the sick no matter which side they belonged to. It was an invitation to form associations with the purpose of providing medical assistance to all the wounded. The result of writing his book was the establishment of the *International Committee of the Red Cross* in 1863 and the adoption of the *Geneva Convention* the following year. Henry Dunant established that all soldiers wounded in a ground war should be treated as friends - *as patients*. He considered that medical staff should be protected by the "red cross" symbol on a "field of white". And the financial difficulties and loss of social respect that affected Henry Dunant did not diminish the role and importance of the organization he helped create. Today we no longer talk about Henry Dunant, but we benefit from the efforts of the Red Cross and the medical services specific to each country, in times of peace or war and pandemics. Eventually, Henry Dunant would be rewarded for his efforts and his work throughout his life by the Norwegian Nobel Prize Committee – he was awarded the Nobel Peace Prize.

Research, human development and technology will bring considerable changes in the medical society, which will have to cope with the effects of the SARS-Cov2 pandemic and the wave of changes in Romanian society. A multitude of terms will circulate in the Romanian society, such as: *ninjo, kyosei giri-on* (Japan), *tai he* (China) *corporate governance,* etc. but in essence it will be about the quality of human life in institutions and society - about the relationship between *work*, *pay* and *people*. Since we spend most of our time in favour of financial gain, these terms will reorder the very essence of the internal functioning of work and institutions.

"The creation of moral capitalism is an act of culture. Based on this assumption, *the "Caux Round Table" Business Principles* were published in 1994 in order to improve the global business culture. The Caux Round Table first met in 1986. That year, Frederick Philips, president of Philips, a family-based electronics and light bulb company founded in the Netherlands, invited Japanese, European, and American colleagues to discuss about ways to respond to the xenophobic attitudes that were dividing the electronics and car industries at the time. It was a moment of triumph for Japanese industries in international markets. Then Frederick Philips initiated a dialogue trying to temper the feelings of anger that kept Japanese companies out of the markets of Europe and America and American companies away from the Japanese market. Olivier Giscard d'Estaing, vice-president of INSEAD, a prestigious business school in France, joined him in this effort. In this attempt at reconciliation, Philips proved to be an idealist, but not a naive one. He believed that, as a rule, people act correctly when they consider the real circumstances of their actions, are able to identify their "self-interest from a whole perspective" and can devote much of their effort to create more good . In the aftermath of World War II, Philips attended several meetings in Caux, a small town in the Swiss Alps, in a bid to reconcile the French and German nations in order to prevent a future conflict between the two hereditary enemies. From these meetings was born the state of trust that led to the creation of the European Coal and Steel Community, which later became the European Economic Community and, finally, the European Union" (Young, 2009, pp. 139-140).

*Realism and vision* - we need *ethics and academic integrity in the university curriculum,* but most of all we need training and accountability of the human factor regarding life and the environment, be it medical, social and economic, etc. Without a moral-human foundation, we build forms devoid of contents for which the system itself will be responsible over time. The pandemic crisis and the institutional model after 1989 are landmarks that will determine major changes in the operation of the medical society, where we will have to not only purchase high-performance equipment, but also look at the training and development of human resources. I trust in the moral values and in the life principles of the academic medical community, in the reasoning and the long-term vision on this project of ethics in the *(re)construction and development of the prestige of the Romanian medical system*.

## References:

Damasio, A. (2005). *Eroarea lui Descartes Emoțiile, rațiunea și creierul uman [Descartes' Error: Emotion, Reason, and the Human Brain]*. București: Humanitas.

Dăianu, D. & Vrânceanu, R. (2006). *Frontiere etice ale capitalismului*, Iasi: Polirom.

Dunant H. (1986). *Amintiri de la Solferino [A Memory of Solferino]*, București: Editura Militară.

Duțescu, B. (1979) *Etos în medicină*, București: Editura Medicală.

Gășpărel, C.M. (2018) *Colocvii Filosofice [Colloquia Philosophica]*, Iasi: Editura „Gr. T. Popa”. King, M. (2017). *Sfârșitul alchimiei, Banii, Băncile și Viitorul Economiei Mondiale [The End of Alchemy: Money, Banking and the Future of the Global Economy]*. București: Comunicare.ro. Young, S. (2009) *Capitalism moral. O reconciliere a interesului privat cu binele public [Moral Capitalism: Reconciling Private Interest with the Public Good]*. București: Curtea Veche.

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[i] „Having joined, at his father's urging, the banking business, he left in 1853 for Algeria, which had been conquered by France in 1830, where he initiated extensive projects for the cultivation of cereals and the construction of mills with modern equipment. In 1858 he succeeded in building such a mill in Djemila (Constantine province) and founded a joint-stock company. In his relationship with the native population, Henry Dunant manifested much humanity, speaking out and taking a stand against slavery. Having difficulty obtaining land, Henry Dunant returned to Europe in 1859 to meet the Emperor of France, Napoleon III, whose support he sought. When Henry Dunant returned from Algeria, the French emperor was at war with the Habsburg Empire, with military operations taking place in the north of the Italian Peninsula, where the vast Lombardo-Venice region was under the control of the Court of Vienna.” Excerpt from the foreword to the Romanian edition of „A Memory of Solferino” by Henry Dunant, Romanian edition published by Editura Militară, Bucharest, 1986, p. 6.

[ii] "The concept of corporate governance, used in abundance lately, has become a buzzword, people no longer know what we mean, whether it is a concept for everyone or only for those who are managing billions of euros. I believe that, in essence, it is a set of rules and values that each of us operates with, both at the level of listed or unlisted companies and at the individual level". Andreea Pipernea, CEO, NN Pensii./ *România poate să crească pe trei piloni: atragerea de investiții, transformarea într-un hotspot antreprenorial şi identificare unui model de bună guvernare. (Romania can grow based on three pillars: attracting investment, turning into an entrepreneurial hotspot and identifying a good governance model)* Source: https://www.zf.ro/companii/romania-poate-sa-creasca-pe-trei-piloni-atragerea-de-investitii-19718784, Accessed on 20.11.2020, at 15:00.

[iii] *România poate să crească pe trei piloni: atragerea de investiții, transformarea într-un hotspot antreprenorial şi identificare unui model de bună guvernare (Romania can grow based on three pillars: attracting investment, turning into an entrepreneurial hotspot and identifying a good governance model)* Source: https://www.zf.ro/companii/romania-poate-sa-creasca-pe-trei-piloni-atragerea-de-investitii-19718784, accessed on 20.11.2020, at 15:14.

[iv] The title is a paraphrase of a chapter named *Good and Evil: in money we trust* in Mervyn King's "The End of Alchemy: Money, Banking and the Future of the Global Economy", Romanian edition published by Comunicare.ro, 2017, Bucharest, pp.52-89.

[v] David Ellerman, *Against the Renting of Persons: David Ellerman in conversation with The Straddler*, in "Colocvii filosofice", Cornelia Margareta Gășpărel (Coord.), “Gr. T. Popa" U. M. Ph. Iaşi Press, 2018, pp. 55-56.

[vi] The title is a paraphrase of a chapter named *Marriage and divorce: money and nations* in Mervyn King, *The End of Alchemy: Money, Banking and the Future of the Global Economy*, Romanian edition published by Comunicare.ro, 2017, Bucharest, pp. 220-258.

[vii] Nicoletta Ferro, *Moral divide in International Business: a descriptive framework*, in Daniel Dăianu, Radu Vrânceanu, "Frontiere etice ale capitalismului", Polirom Publishing, 2006, pp. 110-111.

[viii] *Idem*, p. 111.

[ix] Lucian Croitoru*, Două contribuții extraordinare mai puțin cunoscute pe care Wicksell le-a făcut pentru noi (Two lesser-known extraordinary contributions that Wicksell has made),* published on 2 January 2017*, Source:* http://luciancroitoru.ro/2017/01/02/doua-contributii-extraordinare-mai-putin-cunoscute-pe-care-wicksell-le-a-facut-pentru-noi/21.10.2020/ora 15:55.

[x] Mihaela Moga, Bogdan Diaconu, *Notes on the edition and version*, the Romanian edition of Stephen Young's, *Moral Capitalism: Reconciling Private Interest with the Public Good*, Curtea Veche, Bucharest, 2009, p. 16.

[xi] Reference to the motion picture *The Secret Garden* (1993).

# IATROGENESIS INDUCED BY RISK REDUCTION IN HEALTH CARE

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## Abstract

There are two major currents of thought in science: the reductionist and the holistic, which have also been transposed into medicine. If we understand that the human body is a very complex system, an ecosystem with thousands of components inside and a lot of intertwined and inter-conditioned relationships between them, we will find that the reductionist approach is simply insufficient and will never end. Seeing reality only as a mathematical system develops the paradigm for control and manipulation. The body is thus seen as consisting of mechanical subsystems whose output numbers can be measured by biomarkers and whose risks can be predicted based on inputs. In this situation, health ceases to be based on subjective well-being or ability to work, but is based on how one fits the numerical norms.

**Keywords**: holism, reductionism, quantified self, medicine

## Holism and / or reductionism in medicine

Towards the end of the twentieth century, science was almost exclusively polarized by reductionist thinking to the detriment of holistic thinking. If reductionism helps us to understand the whole by studying its component parts, holism has the central idea that the whole is more than the sum of its components. Medicine, in order to be better studied, has been divided, like other sciences, into several disciplines: pneumology, cardiology, gastroenterology, neurology, psychiatry, gynecology, etc. The notions of body and soul, which make up the human body, make possible the proper functioning of the genome and neurons. But man represents something more than that, he is a person. In other words, the human body is the bearer of a life project. In addition, he is the bearer of a desire for life and experiences that underpins his recognized right to morality (Buta, 2008).

How can you fully help a person who has an affected organ if his disease manifests itself in a systemic context, namely in connection with the functioning of other organs in his body? In addition, the environment is constantly shaping life. We can clearly state that every facet of individuality requires the participation of the environment. In other words, we are both heredity and environment. Nothing is determined exclusively by heredity as nothing is determined exclusively by the environment.

When we make an analysis of the factors that produced the disease, according to the reductionist approach, you come to the conclusion that you need to be simultaneously hematologist, biochemist, microbiologist, geneticist, immunologist, nutritionist, but also biologist, ecologist, computer scientist, specializations that today seem impossible to grasp by the mind of one man. However, life was not created by disciplines, and neither is the human body, nor is it made up of separate organs and processes, which are analyzed in an isolated context. This is a very complex system, an ecosystem with thousands of components inside and myriads of intertwined and interconnected relationships.

That is why the isolated reductionist approach to the phenomena is insufficient and without an overview we will not be able to see the forest because of the trees.

If we miss something in today's medicine, we probably lost the image of the whole somewhere along the way. So let's go back to the whole and never forget that "the whole is more than the sum of the parts." It is the only way will to get rid of the chronic diseases that grind humanity, but also to heal the planet we live on and to which we have done, consciously or unconsciously, so much harm.

## The quantified self

From the point of view of secular medicine, the thresholds of significance of the pathological, of transition from normal to abnormal are not clearly delimited, not even in the case of somatic suffering and even less in the case of mental suffering, where the boundaries between normal and pathological impose a high degree of fluctuations.

In 1958, the World Health Organization tried to define health as "a perfect state of physical, mental and social well-being." This punctuation, although it has the advantage of influencing mentalities and implementing new ways of approaching health practices, tends to suggest that one cannot be healthy without that "*perfect well-being*." But we know that people can go through varying degrees of well-being without necessarily being considered sick. Judging by this, it means that health programs should be designed in such a way that each person is brought to a state of physical, mental and social well-being, according to standards, sometimes "*foreign*" to the way he conceives his life and maybe even against his will.

In recent years, a new idea has begun to emerge, which promises to radically transform medicine: the "*quantified self*." Initiated by several enthusiasts in "*Wired Magazine*" (Gary Wolf, Kevin Kelly, 2007)[1], the theory of "*quantified self*" (QS), is the application of the scientific method on the self by assessing oneself with a set of indicators (Droge, 2016). The list of parameters we can measure is endless: heart rate, breathing, hours of sleep or even the number of sneezing and coughing during a day. However, not all things in our lives can be measured and not everything that can be measured is important.

The problem with this model lies in its anthropology and worldview. The slogan that the authors of the "*Quantified Self*" use is "*Self-knowledge through numbers*". What could that mean? Of course, you can learn things about yourself through numbers, and "*body weight*" is the handiest parameter. However, self-knowledge has connotations that go beyond everyday facts. On the temple of Apollo in Delphi, was inscribed one of the most proud thoughts "*Know thyself*" ("*Gnothi seauton*!"), which entered the cultural consciousness of the world through its cultural and moral significance, transmitting an exhortation related to the spiritual dimension of man. Over time, this ideal has undergone interpretations, being taken over by science, which uses it to measure and record a wide variety of human activities. At the beginning, the ideal was mastered by athletes, on their way to performance. As their goal is explicit, they run faster, weigh less, improve their mobility, acquire skills, monitoring the morpho-functional indicators appears natural. Science, however, did not stop there and opened up possibilities for exploration in areas of life that did not always seem accessible to quantitative methods. If you could track the transient moods and emotions of the "diarists*”*[2] by reading their notebook, today there is "*open source software*" for random sampling of a person's experience. This feature is already built into measurement tools such as "*Happy Factor*", a Facebook application that subjects you to a random survey with a text message, to which you respond with a number that ultimately indicates your level of happiness. There are protocols for measuring mental capacity that take less than five minutes and provide data for brain agility. The website „*CureTogether”* allows users to record a wide range of conditions, symptoms and feelings, and self-tracking systems can measure our bodies, movements and minds. In this situation, the natural question that arises is whether we can measure our "*narcissism*"? There is a psychological test, validated for measuring narcissism, which can be completed in just a few minutes. However, experts argue that the test is not accurate, because when people ask if self-pursuit is narcissistic, they are not asking about *clinical* narcissism, but about selfishness, narrowness, a withdrawal from social commitment and social generosity, in a selfish world of self.

The purpose of wellness programs is to get to know ourselves through the numbers and thus gain control over our lives. The anthropological problem of this model is his reductionist vision of the human body or as Pope Francis calls it "*Technocratic Paradigm*", namely a way of seeing the world as a material prepared for control and manipulation, according to the will of the people (Davis & Gonzalez, 2016), which was also supported by Heidegger in a work published a year after his death (Heidegger, 1977). If the human body is seen as a complex of mechanical subsystems whose output numbers can be measured by biomarkers and whose operational risks can be predicted based on inputs, then health ceases to be based on subjective well-being or activity capacity, but it is based on how someone fits the established numerical rules. This means that we assume our dispositions and ways of engaging the world through sets of common practices. Mechanistic paradigm can be incorporated into a different area of medicine, because few doctors consider the human body as a dead matter, consisting of mechanical subsystems whose risk profiles can be optimized. This vision of the body is included in our social consciousness through daily contact with clinical technologies, such as testing biomarkers or wellness tools that patients use on their own body, a situation in which these subsystems can be modified and optimized at will (Bishop, 2011, pp.411). In other words, to reduce the risks, the body can be modified, from its natural state, to obtain a better number. For example, genes that regulate cholesterol can be removed to maintain the desired value of this parameter.

Of course, it is difficult to escape this form of thinking once it has entered its logic. One thing is for sure, however, there is never an absolute level of risk control, so technology-based interventions and control mechanisms are endless, and such a framework can only discourage and alienate. Even if we have our own numerical readings, it does not mean that we have real knowledge about our own person, whatever the proponents of the "*quantified self*" would say. When we really want to know the risks of disease, we must be careful to understand the data because they are influenced by statistical manipulations resulting from sets of clinical and epidemiological studies, which are sometimes difficult to interpret (Ioannidis et al., 2017).

In the situation where health promotion becomes a mechanical model of entry / exit, the person is more and more under technical control, meaning that he has to ingest certain amounts of proteins, carbohydrates, fats, vitamins and trace elements, to perform a series of physical exercises or a number of steps, all in order to consume calories. These applications can often be beneficial, helping to lower blood pressure, cholesterol, body weight, etc. Beyond producing a bizarre picture of daily life, in terms of diet and physical activity, which must be constantly monitored quantitatively, doctors have the opportunity, when patients fail to comply with the rules, to adjust the figures of exit through available technical means such as medication (Scherz, 2020).

This focus on quantitative risk, however, creates risks that the Aristotelian analysis of greed reveals. According to it, once a goal is set quantitatively, it automatically becomes infinite potential, so practically unattainable, because new risks always appear. Take, for example, cholesterol levels, which are directly related to the cardiovascular system. Specialists juggle its target levels, and patients are puzzled. The importance of Aristotelian thinking regarding an infinite goal becomes clearer when we discuss the possible side effects of drugs or complications that may occur after surgery. In fact, the totality of the risks from genes, environment, behaviour, diet, medication and interventions becomes impossible to quantify.

For example, there are health programs that aim to mass detect cancer through annual mammograms, Pap tests, prostate exams, colonoscopies, etc. It is believed that by screening and early detection, cancer can be detected at an early stage, thus avoiding many deaths. However, the more sophisticated the risk theory, the more complicated the problems become. For example, biopsies and mammograms have their risks. Moreover, cancer treatments are not benign. Chemotherapy and radiation therapy make the body vulnerable, and interventional surgery risks complications such as urinary or fecal incontinence, impotence, anatomical mutilation, stress and depression.

This way of thinking has led to the revision of the screening guidelines, reconsidering the age and the intervals at which they must be done. Of course, the discussions are controversial, making it impossible to draw definitive conclusions (Scherz, 2020).

## Individual risk and social risk

Each patient examined has one or more diseases, which we must judge in an individual context, finally establishing the particularities of the case. This requires a holistic view of the body, namely bio-psycho-social and cultural, where etiopathogenic priming finds its place, which highlights pathogens and risk factors, inherited ground and its weakness, equating physiopathogeny, prevention, prediction and recovery.

The improvement of population health and the increase of longevity, observed since the twentieth century, are due not so much to individual medical treatments, but to major social and cultural changes: clean water, environmental protection, food security, poverty reduction, social protection and so on. There is not necessarily a declared conflict between the forms of individual and social risk management, but what we are interested in is achieving a balance between risk socialization and individualization.

Health policies in recent years have preferred to develop a technical medicine, reducing the human body and life only to numbers and mathematical operations, thus individualizing treatments when needed, to the detriment of public health measures (Berry, 2002). This trend is at the origin of the preventive medicine, based on individual risks and not on a wider application as public health (Aronowitz, 2015).

Moving our attention away from social risk to reducing individual risk, by using precision medicine undermines the virtue of solidarity and alleviating social suffering. This effect appears in the most important example of solidarity in medicine, "*blood donation*". It is known that "*blood donation*" develops solidarity within a small or larger community, through the repeated action of donating your blood to a loved one or even a stranger, living with the conviction that someone else, in turn, will donate blood for you then when you need it. Blood trading is free, excluding the simple market transaction, which if it existed undermines social ties and leads to the atomization of people. Over time, the idea of donating blood as a source of human solidarity has declined for several reasons: scandals due to blood contamination with HIV, HBsAg, HCV, increasing needs for such products, and transforming the market in the supply of blood and blood products. When a person is scheduled for major surgery, they will make sure that there is blood for themselves at the Transfusion Center, to avoid the risks associated with the absence of this product. In this situation, blood donation becomes an individual risk calculation (Starr, 1998).

Another obvious example is that of "*stem cells*" harvested from the umbilical cord. While doctors and researchers want these cells to be a resource to help patients, either directly through transplants or indirectly through medical research, a real industry encourages people to store these cells in special banks, where they can use them in case of need. In the vast majority of cases, the stored cells are lost, because most of the time the child in question does not need them. However, there are many people who prefer to insure against a hypothetical risk, thus giving up relying on a social resource (Waldby & Mitchell, 2006).

The controversy surrounding vaccines may even better highlight how reducing individual risk contradicts solidarity. Although vaccinology is a science full of contradictions, research has thoroughly shown that childhood vaccinations do not pose a risk of causing autism or other such risks. An anti-vaccination movement has made some people doubt the safety of vaccines. This has led to a decline in the general level of vaccination and thus to the emergence of new outbreaks of diseases such as measles, which have been eradicated in the past. In this situation, proponents of vaccination cannot rely solely on proven vaccine safety to persuade reluctant parents to vaccinate their children, but use a second set of arguments based on solidarity. Because no vaccine is fully effective and many people cannot be vaccinated, preventing outbreaks requires effective immunity. In this case, a certain percentage of the population must be vaccinated to ensure that the transmission of the disease is stopped. Seen in this way, vaccination appears as a social protection project, which means that it is necessary to vaccinate children whose parents accept this method of prophylaxis, the beneficiaries being, in addition to those concerned, those who cannot be vaccinated or refuse vaccination. While some talk about solidarity, being convinced by the arguments presented, many parents consider that they are responsible only for the health of their children, making their own risk calculation. This focus on individual risk can undermine social solidarity (Shoenfeld et al., 2016).

## Conclusions

1. In the contemporary cultural project, we witness the attempt to control suffering and postpone death as much as possible through science.
2. Health policies in recent years have preferred to develop a technical medicine, reducing the human body and life only to numbers and mathematical operations thus individualizing treatments when needed, to the detriment of public health measures.
3. The emergence of an alliance between politics, basic research and the pharmaceutical industry transfers health issues to the business world, and the issue of newness and efficiency in medicine must be viewed with caution and circumspection.

## References:

Buta, M.G. (2008). Perspectiva bioeticii asupra sfințeniei și/sau a calității vieții. *Bioethica*, 2, 81-89.

Droge, M. (2016). *What is the qualified self? Quantified Self Institute*. http://qsinstitute.com/about/what-is-quantified-self/

Davis, J. E. & Gonzalez, A.M. (2016). Reductionist Medicine and Its Cultural Autority. In *To Fix or to Heal: Patient Carre, Patient Health and the Limits of Biomedicine* (pp. 33-62). New York: NYU Press.

Heidegger, M. (1977). The Question Concerning Technology. In *The Question Concerning Technology & other Essays*, Translated by William Lovitt, New York: Harper Torch Books.

Bishop J. (2011). *The Anticipatory Corpse: Medicine, Power and the Care of the Dying*. Notre Dame: University of Notre Dame Press

Ioannidis, J. P., Stuart, M. E., Brownlee, S. & Strite, S.A. (2017). How to survive the medical misinformation mess. *European Journal of Clinical Investigation, 47*(11), 795–802.

Scherz, P. (2020). Risk, Health, and Physical Enhancement: The Dangers of Health Care as Risk Reduction for Christian Bioethics. *Christian bioethics: Non-Ecumenical Studies in Medical Morality*, *26*(2), 145–162.

Berry, W. (2002). Health is membership. In Wirzba, N. (Ed.). *The art of Common-Place. The Agrarian Essays of Wendell Berry* (pp. 144-158*)*, Washington, DC: Countempoint

Aronowitz, R. (2015). *Risky Medicine*. Chicago: University of Chicago Press.

Starr, D. (1998). *Blood: An Epic History of Medicine and Commerce.* New York: Alfred A. Knopf.

Waldby, C. & Mitchell, R. (2006). *Tissue Economies. Durham.* NC: Duke University Press.

Shoenfeld, Y., Agmon-Levin, N. & Tomljenovic, L. (2016). *Vaccines and autoimmunity.* Bucharest: Cristiana.

## Notes

[1] *Wired* is an American monthly magazine on the impact that emerging technologies can have on culture, economics, and politics.

[2] *diaríst* s. m. [din it. *diarista;* cf. fr. *diariste* – Le Monde ] Person who writes down in his notebook everyday events ◊ There is a problem with this type of old fashioned diary, because it records a person's mood only when he is willing to do so, which can lead to errors. Basically, it is difficult to correctly follow our own subjective states, because they are influenced by many factors. However, scientists have reported since 1983, psychological studies in this direction - see Jeylan T. Mortimer, Reed W. Larson, 2012, The Changing Adolescent Experience: Societal Trends and the Transition to Adulthood, Edit. Jeylan T. Mortimer University of Minnesota, Reed W. Larson University of Urbana-Champaign, Cambridge University Press

# ETHICAL CONTRIBUTIONS IN PRESERVING THE DIGNITY OF THE TERMINAL PATIENT

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## Abstract

The issue of the terminal patient is an ever-present topic in the approaches focused on the real and efficient control on the end of life, while it entails both in theoretical analysis and practical illustrations a wide category of terms, which have not yet reach consensus despite almost five decades of academic debate. Thus, terms such as assisted dying, end of life, terminal illness, terminal care highlight the manners in which technologic and scientific advances allow for the artificial preservation of vital functions in correlation with a series of medical consequences regarding the increase of life expectancy, effects on health and criteria for establishing the death of an individual. The concerns and deep medical, social, economic and legal implications of the patient diagnosed with a terminal illness define through palliative care the objectives and basic tenets emerging from the ethical aim to preserve the dignity of the patient. Control of symptoms, spiritual state and care for the family of the affected individual are involved in life care or life support therapies and appeal to the principle of beneficence. From the point of view of preserving human dignity, beneficence becomes the basis for the elaboration of bioethical criteria intended for the evaluation of the decisions implicated in the management of the terminally ill patient. Given that, the importance of the dignity of the patient at the end of his or her life cannot be denied, in this paper we aim to identify the ethical attributes which define the concept of dignity, to outline its multidimensional character and the complex nature of this concept.

**Keywords**: dignity, terminal patient, palliative care, ethics, end of life

## Introduction

The attitude towards the finitude of life represented a defining aspect of human existence in all periods, societies and cultures. Death as a universal phenomenon, inherent to the human condition and to other species implies multiple significations. During history, the attitude towards death made the transition from the perception as a public event to a fact of everyday life, which happens inside hospitals, along professionals who are not always prepared to face the matters concerning the end of life (Yanke, 2019). From the gnoseologic point of view, the complexity of the relationship between life and death generated a multidisciplinary approach with the involvement of various domains of human knowledge such as medicine, biology, philosophy, sociology, psychology, theology, etc. Arguments on death and dying individuals accepted in the universal literature, as expressions of the manner of reflecting the moral practices of human kind, were acquired by medical literature in order to ethically ground the concept and the criteria of death, defined on the basis of measurable biomedical standards. The greatest obstacles which professionals in healthcare and patients encounter while trying to understand death are related to a series of difficulties regarding the comprehension of the conventions in the literature, of the concurrencies and cultural differences with gaps imposed by time, as well as the lack of emotional depth adequate to this situation (Skelton, 2003). Moreover, persistence in challenging the notions accumulated regarding deep changes brought by the technology of replacing and/or functioning of the organs through transplant or assisted support substantiates the need for ethical debates and argumentation on the line between life and death. Currently, the informing of the patient and his or her close contacts, mainly the family, on the moment when life will be ended, by the importance of the moral dimension, began to require, in the conscience of the actors in the healthcare system justifications for bringing about the ethical contents on the end of life to the central position in case management. Towards this end, in academic debates and practical approaches, the issue of the end of life and the issue of death are outlined within the context of the medical intervention with adequate technologic support, doubled by an ethical support with the positive argumentation of the ethics that applies to the medical act.

## Conceptualization and definition of the end of life and of death

Starting from the consideration that existentially life and death cannot be divided, the definition framework presents death as part of a process which begins concomitantly with entering the terminal stage of a disease or of life. The concepts for the end of life represent a *„challenge in recognizing the beginning of this unique period”* which, in the opinion of Lamon is focused on two categories of features: medical aspects, based on a perspective concentrating on the disease in the stage of irreversible decline before death and management aspects, as a perspective based on time, correlated with the criteria for admission in the hospital for patients whose life expectancy is limited, generally to a maximum of six months (Lamont, 2005). In the bioethics field, the literature approaches this matter at a reduced scientometric representation concerning the references dedicated to the conceptualization or to the definition of the end of life and of death, both for clinical conditions as well as for the domains dedicated to scientific research. In the theoretical framework we observe trends and approaches of the phenomenon mostly oriented towards the putting into context of the terminology groups unified in common themes rather than towards conceptualization. In clinical approaches, the practicians confronting the matter of the end of life and death are concerned with the exploitation of the manner in which active involvement of ethics may contribute to the elaboration of consensual and standardized definitions (Karnik & Kanekar, 2016).

## The medical component of the end of life and death

Progress recorded in medicine brought important changes on the manner in which patients experience the existential stage of the end of life. Nevertheless, more support and contributions from research on the final stages of illness and life are necessary. Too little is known on the process of dying, while in the last days of life new symptoms may occur, or the previously controlled symptoms may become exacerbated, or visible again. Current knowledge and understanding is insufficient for the guidance and support of the practice of evidence based medicine for the respect of the preferences of the patients at the end of their lives (Visser et al., 2015). In the absence of definite criteria for the diagnosis of the end of life, constant and precise identification of the stage of death remains a significant incertitude. What happens during the last days, weeks or months of life and which are the physiologic and biologic changes *attributed to the process of dying* requires further research in order to allow for the acquisition of a knowledge level able to explain the physiologic basis of symptoms. Of a great interest and utility, in a sense exceeding the strictly medical framework is the prognosis assessment for how much life is left after the entrance of the patient in the terminal stage (Bell et al., 2017). In medical practice, recognizing an individual in the last days of his or her life is a complex clinical ability, a challenge for the physician who has to distinguish between the irreversible process specific to death and the reversible acute deterioration of the health status. In the absence of a standard definition for the terminal phase, which generally is subjectively assessed by physicians, the moment when a terminally ill patient approaches the end of life remains a continuous challenge for the medical practice confronting difficulties in the recognition of the factors that influence the precision in the prognosis of death in terminal patients (Karnik & Kanekar, 2016; Hui et al., 2013).

## Technologic interventions and contributions in assisting the terminal patient

The field of medicine recorded significant progress during last decades in the ability to support or replace the function of damaged organs. Embedding the evolutions and discoveries of the 21st century brought new realities in the medical domain regarding issues and opportunities for caring for the patients at the end of their life. The remarkable implication of biomedical technologies in the improvement of what medicine can do for the prevention and amelioration of the sufferance of those in terminal stages does not exclude a series of limitations generated by the addiction to medical technologies that will increase the impact on the manner in which people choose to die. Following the area of technologic impact in the area of palliative care, Jessica Nutik Zitter and Trial Support signal through statements and results of studies the complex matter of involving high technology medical devices in the care at the end of life, cautioning against the risk of locking the patient in the terminal stage through the usage of intensive care devices (Zitter, 2017; Greipp, 1996). Often pain and significant sufferance of the patient were reported, so the use of the technologic potential for medical purposes may not always correspond to the wishes and expectations of the patients (Karsoho et al., 2016). The ethical justification of reasonably using vital support technologies is involved in the future of technology as well as in the improvement of the decision process at the end of life and in reducing the frequency of patterns of mechanically supported painful death.

## Terminal patient – the context of the definition

The terminal patient is an ever-present subject in the debate dedicated to the real and efficient control on the end of life, modeling the conceptualization of terminology groups on *assisted death*, *end of life*, *terminal illness*, *terminal care*, *transition of care* which entered into the focus of the specialists during last five decades (Li et al., 2020). The general definition of the death of the human being is equally challenging and difficult in the attempt to unify multiple and diverse modalities of manifestation, often interconnected at the level of the organic life with the mental side and the social component. The terminal patient outlines the manner in which scientific and technologic progress allow for the artificial preservation of vital functions, as well as the medical consequences of these interventions on the increase of life expectancy, effects on health, and the criteria for determining the death of an individual. All these cumulated aspects have a strong impact in the social and economic dimension, with effects and consequences in the medical and law domains. In the medical context of the definition, the terminal patient is that person presenting one of the medical circumstances of a chronic or incurable disease, whose progressive evolution towards advanced stages leads to an increased degree of severity. The orientation towards these approaches is based on cumulated arguments in the domain of the active therapeutic management, whose decreased efficiency or lack of response to treatment substantiates the orientation towards palliative care. From the perspective of prognosis, the terminal patient is viewed as a patient whose life expectancy is less than six months, a period that becomes critical for the patient and his or her family, both from the medical point of view as well as from the psychological and emotional perception. In the bioethical context, the theme of the terminal patient concentrates on the principle of beneficence, as foundation in the elaboration of the criteria involved and intended to ethically evaluate the decision to preserve the life of an individual, taking into consideration the ethical implications in the care of terminally ill patients, from the angle of preserving human dignity (Iani et al., 2020; Donato et al., 2016).

## What are the issues of a terminal patient care

From the medical viewpoint, the type of care may be differentiated through formulations such as *"assistance for lifecare"* or *"life supporting therapies"*, which are in essence common expressions used for any patient in critical condition, requiring assisted care in an ICU. They designated those *common therapeutic procedures* specific for intensive care, such as mechanical ventilation, renal replacement systems, vasoactive medication, artificial nutrition and blood-derived products, which, in the case of the terminally ill patient interfere with the "*common terminal pathways*" through which disease and pathological processes may cause death. According to Hastings Center, the *therapies for life support* comprise interventions for the underlying disease or biological process, administered with the aim to extend life. For Gomez, medical and surgical procedures, as well as emergency interventions are deemed as interventions through which supplementary time is acquired in order to bring the patient to the health condition preceding the disease (Garcia, 2017). For a patient in terminal stage, existentially dominated by sufferance, the common sense of "assistance for life care" or "life supporting therapies" is represented by a new strategy in case management oriented towards palliative care, which, in the ethical utilitarian sense, intends exploration of beneficence at the maximum level of comfort. According to the WHO definition, palliative care is an "*approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual*" (WHO, 2018). Key terms of definitions of *terminal patient, quality of life, family, life-threatening illness, suffering, early identification, correct assessment, treatment,* and *pain* are also used by the Spanish Society for Palliative Care and included in the definition of palliative care based on "*a global, therapeutically active process, which comprises physical, emotional, social and spiritual attention for those suffering from a terminal illness; the main objectives of welfare and promoting dignity and autonomy of the patients and their families, and the therapeutical means, control of symptoms, emotional support and communication when we face an advanced, progressive and incurable disease, without a chance of responding to specific treatment and with foreseeable death in the foreseeable future, caused either by cancer, AIDS or other chronic progressive illnesses"* (Ortiz, 2004). These objectives derived from the medical purpose and the basic tenets emerging from the ethical aim of preserving the dignity of the patient such as control of symptoms, spiritual and psychological welfare and the care for the family are actions through which quality of life of the patient is pursued, as long as palliative care does not attempt to cure the patient or to prolong life. In the opinion of Barbero "*there is nothing more to be done"* is a prohibited expression and an impeachment vote for abandoning the objectives of palliative care for an individual who has no longer a chance to be cured (Benito et al., 2016). Passing to palliative care represents, from a symbolistic perspective the curative attitude as a modality to provide a specific type of care, an expression of the maximum possible welfare in the final stages of the life of a person isolated by the illness, who feels vulnerable and unprotected, alone and facing the silence of the infinity.

## Is it possible to preserve the dignity of the patient in terminal stage?

Although the control of the physical symptoms associated with advanced disease lately recorded significant progress, there were less obvious advances regarding the control of the associated emotional state and the approach of the psychosocial and spiritual difficulties of the patients. As the disease progresses and the end is approaching, the emotional sufferance increases, while the perception of the dignity of the patient is damaged. In the case of the patients with incurable diseases, loss of dignity and the close connection with the importance of decision making for specific matters drew the attention on the need to debate this theme in the context of the terminal illnness. The evaluation of the situations that interfere with the dignity of terminal patients showed that the feeling of dignity is preserved only for 54% of the patients, the remaining percentage reporting occasional and light concerns on dignity (46%) while for a specific fraction loss of dignity is associated with feeling of degrading and shame (7.5%) (Donato et al., 2016; Chochinov et al., 2002). In addition, the contributions of family, friends and health professionals to improving the quality of life through well-being and hope have gained an important role in shaping the concept of dignity for cancer patients. Furthermore, the model of dignity became a source of inspiration for therapeutic alternatives materialized in the model of dignity therapy developed by Chochinov for advanced stage cancer patients (Chochinov et al., 2005). In the model of dignity therapy, Chochinov is focusing on the individual and not on the disease. The author attempts through a series of psychotherapeutic interventions to provide a feasible way and a safe manner of identifying the factors correlated with dignity and decreasing the sufferance of the terminal patient. In an approach concentrated on the relationship between the needs of terminal patients and the feeling of damaged dignity, the model follows three categories of aspects: issues correlated with the disease, the repertoire of conserving dignity and the inventory of social dignity. As ethical significance, the model of the dignity therapy is concentrating on the morality of caring for the patient who no longer has the ability to continue to play the role held during his or her life, does not feel any more the satisfaction of emotion annulled by loneliness and does not find sense of the matters. The *model of dignity therapy (Sanz Ortiz)* – is concerned with the respect for priorities, values and life plan of the patient, celebrating life through benefits provided by palliative care. The morality of palliative care is deontologically supported by arguments according to which medicine must not be viewed as a domain which helps people prevent death, thus placing it outside the obligations of the physician to care and preserve life (Ortiz, 2004; Garcia et al., 2014). The model emphasizes the role of the medical team, with professionals trained in palliative care, who, through their actions with a deep ethical content efficiently respond to the needs of the patient and his or her relatives.

## Conclusion

Preserving human dignity is one of the most significant ethical requirements in medical care, so that respect for the dignity of the patients is highlighted widely in standards for medical assistance and is placed at the center of care. For the professionals in the medical field deeply involved in caring for patients in terminal stages practical approaches from the viewpoint of clinical ethics will facilitate higher exposure to favorable consequences of caring for human dignity and will help the team to decrease the unfavorable consequences resulting from disrespecting dignity in the care for the patient by preventing threatening events. It is necessary for the promotion of the status and importance of the concept of human dignity to incorporate this concept in educational and training programs in the field of medical ethics for healthcare professionals focusing on awareness and assuming the concept of dignity in clinical practice.

## References

Bell, C., Nielsen, M., K., Neergaard, M., A., et al. (2017). Remaining lifetime after recognition of terminal illness depends on diagnosis: a nationwide population based cohort study. *J Pain Symptom Manage,* 53, 116-123.

Benito, E., Bofill, C., & Barbero, J. (2016). Implementing Spiritual Care at the end of life in Spain. *European Journal of Palliative Care*, 23(2), 98-99.

Chochinov, H., M., Hack, T., Hassard, T., Kristjanson, L., J., McClement, S., & Harlos, M. (2002). Dignity in the terminally ill: a cross-sectional, cohort study. *Lancet,* 360(9350), 2026-30.

Chochinov, H., M., Hack, T., Hassard, T., Kristjanson, L., J., McClement, S., & Harlos, M. (2005). Dignity Therapy: A Novel Psychotherapeutic Intervention for Patients Near the End of Life. *J Clin Oncol*, 23, 5520-5525.

Donato, S., Matuoka, J., et al. (2016). Effects of dignity therapy on terminally ill patients: a systematic review. *Rev Esc Enferm* USP, 50(6), 1014-1024.

García L., M., Antonio, J., Barroso, S., & Coulon, C. M. (2014). Ethical implications of care in terminally ill patients. *MEDIC*, 22(2), 44-57.

Greipp, M. E. (1996). SUPPORT study results - implications for hospice care. *Am J Hospice Palliat Care,* 1338–1345.

Hui, D., De La Cruz, M., Mori, M. et al. (2013). Concepts and definitions for "supportive care," "best supportive care," "palliative care," and "hospice care" in the published literature, dictionaries, and textbooks. *Support Care Cancer,* 21, 659-685.

Iani, L., De Vincenzo, F., Maruelli, A., Chochinov, H., M., Ragghianti, M., Durante, S., & Lombardo, L. (2020). Dignity Therapy Helps Terminally Ill Patients Maintain a Sense of Peace: Early Results of a Randomized Controlled Trial. *Front Psychol.*, 11, 1468.

Karnik, S., & Kanekar, A. (2016). Ethical Issues Surrounding End-of-Life Care: A Narrative Review. *Healthcare (Basel),* 4(2), 24.

Karsoho, H., Fishman, J., Wright, D., & McDonald, M.E.(2016). Suffering and medicalization at the end of life: the case of physician-assisted dying. *Soc Sci Med.*, 170, 188–196.

Lamont, E. B. (2005). A demographic and prognostic approach to defining the end of life. *J Palliat Med.,* 8(Suppl 1), S12–S21.

Li, Y-C., Feng, Y-H., Hui-Ying Chiang, H-Y., et.al. (2020). The Effectiveness of Dignity Therapy as Applied to End-of-Life Patients with Cancer in Taiwan: A Quasi-Experimental Study. *Asian Nursing Research,* 14, 189e195.

Ortiz, S. (2004). La sedación en el final de la vida. *Medicina clínica*, 123, 423-5.

Skelton, J. (2003). Death and dying in literature. *Advances in Psychiatric Treatment,* 9(3), 211-217.

Visser, C., Hadley, G., & Wee, B. (2015). Reality of evidence-based practice in palliative care. *Cancer Biology & Medicine*, 12(3), 193-200.

World Health Organization (2018). Integrating palliative care and symptom relief into primary health care: a WHO guide for planners, implementers and managers. https://www.who.int/publications/i/item/integrating-palliative-care-and-symptom-relief-into-primary-health-care

Yanke, G. (2019). Deconstructing Dignity in Elisabeth Kübler-Ross's On Death and Dying. *The American Journal of Bioethics*, 19(12), 46–47.

Zitter, J., N. (2017). How The Rise Of Medical Technology Is Worsening Death. https://www.healthaffairs.org/do/10.1377/hblog20171101.612681/full/

# ETHICAL ASPECTS OF THE INSTITUTIONALIZATION PROCESS OF CHILDREN FROM OUTBREAKS OF TUBERCULOSIS

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## Abstract

The Republic of Moldova is the country with the highest incidence of tuberculosis in the European WHO region. The severity of this epidemic is conditioned by socio-economic problems. Children are exposed to the TB pathogen when interacting with infected family members. In socially vulnerable families, the education and overall care of the child is often neglected. Children are at risk of malnutrition, which increases their susceptibility to tuberculosis. Even if the family is considered the most suitable environment for the development of a child, there are cases when children must be entrusted to care institutions. A mixed, quantitative (grid application) and qualitative (observation and individual interviews) study was conducted to assess the degree of respect for ethical principles and the rights of the institutionalized children. Two phtisiopneumological rehabilitation centers for children from families with tuberculosis were evaluated. The study identified that institutionalization does not appear as a form of protection, but as a limitation of children`s rights. Stigmatization and discrimination of children is a common phenomenon. Children's access to adequate education and health services is limited. Even if these children are not suffering from tuberculosis, they were unjustly isolated, reducing their contact with the family or relatives, as well as with society in general. Children aren't encouraged to have an opinion, their access to information being insufficient. Gaps have been highlighted that need to be addressed without delay to ensure adequate conditions for the protection of children from families with tuberculosis, respecting their personality, in a non-discriminatory manner, based on moral values and fundamental child` rights.

**Keywords:** tuberculosis outbreak, child protection system, child rights, public health policies.

## Introduction

Tuberculosis is a major public health problem in most countries in the European region of the World Health Organization. Although significant progress has been made in reducing the incidence of drug-sensitive tuberculosis, it remains unacceptably high in many countries in Eastern Europe and Central Asia (WHO, 2019). The Republic of Moldova is among the 30 countries in the world with a high burden of multidrug-resistant tuberculosis. The overall incidence, estimated by the WHO for the Republic of Moldova in 2018 is 86.0 per 100,000 population, and the gap between the estimated incidence and the registered one (75.1 per 100,000 population), invokes the fact that a number of patients with active tuberculosis remain undetected (ECDC / WHO, 2020). Late detection of tuberculosis patients is confirmed by the proportion of 33% of patients diagnosed with advanced lung tissue destruction (Alexandru et al, 2020).

At the same time, the rate of patients lost from treatment surveillance varies between 7% for sensitive tuberculosis and 20% for resistant tuberculosis. This is explained by the insufficiency of patient-centered interventions to support the entire treatment period: lack of material means to provide nutritional support, procurement of complementary drugs for the treatment of adverse effects of antituberculosis drugs, lack of counseling and social support necessary for successful completion of treatment etc. (Center for Health Policy and Analysis, 2017). Thus, the severity of the tuberculosis epidemic is directly determined by the diversity of socio-economic problems faced by patients and their families.

All of the aforementioned keep the TB infection reservoir in the society. For a year, a person with tuberculosis can infect up to 10 other people with whom he has close contact, especially talking about the family in which he/she lives. Thus, the risk of developing tuberculosis among children from such families is very high, as long as adults remain untreated (Martinez et al., 2020).

It is important to note that in socially vulnerable families who have only one caregiver, and who is ill or concerned about caring for other family members with tuberculosis, the education and care of the child may be neglected. Also, if the sole breadwinner of the family is ill and unable to work, children are at risk of malnutrition, which increases their sensitivity to tuberculosis and brings with it the full range of harmful effects on both the health and education of the child.

Often families with tuberculosis are subject to social stigma, which directly reflects on children. They are excluded from the educational system or socially isolated. Thus, children remain at home, and are exposed even longer to contact with the person with active tuberculosis. Even if they are not eliminated from school or the social environment, children from poor communities, where poor nutrition predominates, are at increased risk for poor health and illness.

The UN Convention on the Rights of the Child stipulates that the child has the right to a family in which he can be loved, be under parental protection, and be ensured (UN, 1989, art. 3, 8, 16, 19). At the same time, the legislation of the Republic of Moldova confirms that every child has the right to live in the family, to know his parents, to benefit from their care, to cohabit with them, except in cases where separation from one parent or both parents is necessary for the child’s interest (Parliament of the Republic of Moldova, 1994, art. 16)

The risk to the child's life and health is obvious when the parents are suffering from tuberculosis, the family becoming a dangerous environment for the child's infection. Situations are also common when these children are temporarily left without parental care due to the hospitalization of their parents for treatment. According to international and national standards, in such situations the placement of the child in the extended biological family - grandmother, uncle, aunt, etc. will have priority (Parliament of Republic of Moldova, 2013). However, there are situations when these children have nowhere to be placed, and it is necessary to institutionalize them in one of the phthisiopneumological rehabilitation centers for children. In the Republic of Moldova there are two such centers, which are attributed to the health system, one being intended for children aged 3-10 years from Cornești and another intended for children aged 3-16 years from Târnova (Alexandru et al, 2020).

Officially, these centers represent republican curative-prophylactic and rehabilitation institutions, specialized in the treatment of children with tuberculosis and non-specific diseases of the respiratory system. The average duration of rehabilitation treatment should be, according to the activity regulation, 3-6 months (as appropriate). At the same time, from the practical activity, we noticed that at the national level there are no rules or mechanisms for regular review of child placement, as required by the UN Convention on the Rights of the Child. (UN, 1989, art. 25) As a result, cases have been identified when children who were initially to be placed for a maximum period of 6 months, were in these institutions for years in a row, without any of the relatives or responsible authorities taking an interest in their fate.

## Material and methods

In our study we aimed to analyze the level of respect for the fundamental rights of institutionalized children from tuberculosis outbreaks. For this, a qualitative research was carried out, by analyzing the official reports of the two phthisiopneumological rehabilitation centers for children from tuberculosis outbreaks. At the same time, we applied a grid of 60 questions to the managers of these institutions and conducted 10 individual interviews with representatives of central public authorities, phthisiopulmonologists, and staff from rehabilitation centers included in the study.

## Results and discussions

In the period 2015-2019, 1757 children were hospitalized in both centers, of which 329 (18.7%) stayed less than 3 months, 484 (27.5%) children were hospitalized between 4-6 months, 914 (52%) children were hospitalized from 7 to 12 months and 30 (1.8%) children who were in these institutions for more than a year. We mention that in the last group we found children who have been in these centers for 2 to 9 years now. In 2019, 207 children were placed in the Phthisiopneumological Rehabilitation Center for children in Târnova, and 110 children in the similar Center in Cornești. All these children were temporarily deprived of parental care, and the state as a "parens patriae" - surrogate parent, has the obligation to provide them with qualitative protection, respectively to ensure their appropriate medical, social and educational protection. The study determined serious deficiencies in ensuring the rights of these children.

*Ensuring the right to health of institutionalized children*

The right to health includes not only the medical care needed to treat diseases, but also access to an appropriate environment to achieve the highest possible standard for the child's physical and mental well-being (CESCR, 2000).

In the evaluated institutions we found an insufficiency of required medical staff. In both centers there are only physiatrists, specialized in the treatment of tuberculosis. If children need medical attention from other specialists, they are referred to community health centers. In this situation, the question arises about the need to place the child in a closed residential institution, with the status of a medical institution, if he receives external medical treatment if necessary.

*Ensuring the right to education*

Because there are children aged 3-16 in these centers, it is the obligation of the state to organize their educational process, and the preschool, primary and secondary education program will be offered (Parliament of the Republic of Moldova, 2014). The study showed that at present in the rehabilitation institution Tarnova, although there were 124 children, was occupied only a position of 0.25 teacher, and in the Cornesti Placement Center was occupied a position of 0.5 teacher, reason for that those institutions cannot fully ensure the process of children's education, in accordance with the national curriculum. Given that many children have been in these institutions for years, we find that their right to education is severely affected.

In both institutions there were no individual plans based on the child's capacities and abilities, no learning opportunities are provided for children with special needs (e.g.: speech and hearing impairments, deficiencies in psycho-motor development, etc.). There are not enough textbooks in the institutions and some subjects from the school curriculum are not taught at all. Both institutions lack the school community, the student council; no cultural-educational activities are provided for the child's development as well as for the development of vocational training skills. There is no monitoring and evidence of cases of abuse and violence against children or among children.

An alarming moment is the fact that when they leave these institutions, children receive a graduation certificate indicating the residential institution, which induces a high degree of stigma and vulnerability of these children.

*Ensuring the right to family*

The need for care, assistance, treatment or education can never justify a violation of the child's right to a family, and deprivation of a family life on the basis of illness is discrimination. In the institutions concerned, no conditions were determined for supporting the child's right to a family. There are no separate spaces where children could meet visitors and spend time with family or relatives visiting them. The child's meeting with the parent / relative takes place in a hall with a few chairs. At the same time, long-term visits, up to a few days, are not supported for parents who come to visit their children from more distant localities. Many of the families of these children are poorly insured, so family members cannot afford frequent visits to these centers. There are children in the center who have not been visited for years. From the interviews it was found that the family of the institutionalized child is not involved in the planning and organization of institutionalization and does not receive the necessary support to allow the harmonious reintegration of the child in the family and society. The process of reintegrating the child into society is poorly developed or completely missing.

*Ensuring the child's right to opinion and freedom of expression*

In accordance with international standards, the realization of the right to an opinion requires respect for the child's right to express his or her views and to participate in decision-making processes, in accordance with their abilities. Informing children must be made in a form that is appropriate and accessible to the level of understanding of children, including those with certain disabilities. In this sense, the study determined that the Rehabilitation Centers in Cornești and Târnova do not have any policies or mechanisms that would allow the child's involvement in the decision-making process and would favor the free exposure of the child's opinion. The opinion of children is not taken into account in the institutionalization process, some do not understand why they are in these centers. The study found that children are not informed about the right to file a complaint and how they can do so. In both centers, the mailbox / box for submitting a request / complaint is missing.

## Conclusions

The research showed that due to the lack of protection services for children from tuberculosis outbreaks, these children are placed and held unreasonably in residential institutions. Even if these children are not suffering from tuberculosis, do not require specific treatment for tuberculosis and do not even need rehabilitation from this disease, being from disadvantaged families, they are separated from society only because their family is currently facing this disease, and the authorities cannot propose another form of social protection. This status induces a high degree of stigmatization of these children. The insufficiency of the forms of child protection leads to retaining these children for much longer periods than those established in the regulation of phthisiopneumological rehabilitation centers, possibilities and mechanisms for their integration into society not being there.

The child protection system, based on their institutionalization, creates a separate world, distinct from the rest of society, characterized by psychological attenuation of perception of the severity of antisocial acts, and this model of representation can remain functional in post-institutionalization. By such a logic can be explained the attitudes and behaviors of post-institutionalized people (attitude towards work, education, antisocial acts, etc.).

In both centers, the lack of psychological assistance for institutionalized children was found. At the same time, long-term separation from the family and restriction of socialization possibilities are the conditions that can increase the risk of psycho-emotional problems in institutionalized children. The conditions inside the Centers do not offer institutionalized children the best opportunity for their mental, emotional and physical development. Isolating children from society makes them particularly vulnerable to violence, neglect and abuse.

The institutionalization of children from tuberculosis outbreaks involves a number of conditions that lead to a direct discrimination of these children from other categories of children in vulnerable situations in the Republic of Moldova. The procedure for institutionalizing children from tuberculosis outbreaks is not coordinated with the specialist or the Commission for the Child Protection. No cross-sectoral cooperation is provided to help the child and his family in difficulty (local guardianship authority, educational institution, etc.). Although phthisiopneumological rehabilitation centers for children are part of the health system, they do not include the criteria of medical institutions, but at the same time, the connection with other systems (educational, social) is not clear.

The study found that institutionalized children had their rights violated, such as the right to education, the right to a family, the right to health, the right to information and opinion, but at the same time, no actions or mechanisms could be identified that would monitor the level of respect for the rights of these children.

Based on the above, it becomes very important to initiate essential actions for the protection of the child directly affected by tuberculosis. It is necessary to develop policies for social integration/ reintegration of institutionalized children, by strengthening collaboration with local public authorities and territorial structures of social assistance, establishing a mechanism for monitoring and coordinating the process of institutionalization of children from tuberculosis outbreaks. It is necessary to revise / adapt the educational program for the institutionalized children, to ensure the right to education and to remove the mention of the residential institution from graduation certificates, in order not to admit the subsequent stigmatization of these children in society.

## References

Alexandru S., Vîlc V., Iavorschi C. et al (2020). *Tuberculosis in children*. The National Clinical Protocol PCN-55. Approved by MSMPS order no. 440 from 05.05.2020. Chisinau, 2020.

Center for Health Policy and Analysis - PAS (2017). *Clinical audit of cases of multidrug resistant tuberculosis in the Republic of Moldova*. Operational research report. Chisinau, 2017. https://www.pas.md/ro/PAS/Studies/Details/62

Committee on Economic, Social, and Cultural Rights General- CESCR. (2020). Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Doc. E/C.12/2000/4.

European Centre for Disease Prevention and Control (ECDC)/WHO Regional Office for Europe. *Tuberculosis surveillance and monitoring in Europe 2020 – 2018 data*. Stockholm: ECDC; 2020. https://www.ecdc.europa.eu/en/publications-data/tuberculosis-surveillance-and-monitoring-europe-2020-2018-data

Martinez, L., Cords, O., Horsburgh, C.R., & Andrews J.R. (2020). The risk of tuberculosis in children after close exposure: a systematic review and individual-participant meta-analysis. *Lancet*, Mar 21; 395 (10228), 973-984. doi:10.1016/S0140-6736(20)30166-5.

Parliament of the Republic of Moldova. (2014). Code of Education of the Republic of Moldova - Code no.152 from 17.07.2014.

Parliament of the Republic of Moldova. (1994). The Law no. 338-XIII from 15.12.1994 on the Rights of the Child of the Republic of Moldova.

Parliament of the Republic of Moldova. (2013). The Law no. 140 from 14.06.2013 on special protection of children at risk and children separated from parents of the Republic of Moldova.

UN General Assembly (1989). Convention on the Rights of the Child. Adopted by General Assembly Resolution no. 44/25 on 20 November 1989.

World Health Organization (2019). *Global tuberculosis report 2019*. https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf?ua=1

# PROFESSION, VOCATION, MISSION OR WORK. THE ANCIENT PHYSICIAN AND THE CONTEMPORARY PHYSICIAN-PARALLEL LIVES

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## Abstract

In troubled times we return to the origins. Who are we, the physicians? Where did we start and where did we get from? We will approach the method of comparison used by Plutarch in Parallel Lives. Doctors (*iatros*) have already been active in ancient Greece and Europe, but there is still a profession today and the differences, at first sight, are significant. However, the image is much more complex and nuanced. Drawing a parallel portrait between the ancient physician (Ancient Greece, the Roman Empire, Judaism and Early Christianity), respectively the professional doctor in our globalized, contemporary world of technology, we can observe that not much has changed and the transformations have not been so accentuated. Almost always only the context has changed.

**Keywords**: ancient physician, contemporary physician, method of comparison, parallel lives

## Introduction

When we decided to present the ancient and contemporary physician, we anticipated that it would be relatively easy work.

The history of Europe is full of events, changes, turbulent periods, which have led from Pandora's box (from that all evils, troubles and diseases have spread everywhere on land and sea) to the post-industrial, globalized world, to the world of advanced technology, to modern diagnostic equipment, to sequencing and immunotherapy. However, doctors (*iatros*) have already been active in ancient Greece and Europe, but medicine is still a profession today, and the differences, at first sight, are significant. However the image is much more complex and nuanced.

To our surprise, studying the historical sources and the Greek, respectively Roman mythology, we observe that the ancient doctors ("old doctors") are not so different from the "new doctors". On a deeper analysis, we can notice that not much has changed (especially in the doctor-patient relationship), and the transformations have not been so accentuated. Except for one condition, what we will reach and return to that in conclusions of our work.

Therefore, starting from the generalities we try to point to the concrete.

In troubled times we return to the origins. Who are we, the physicians? Where did we start and where did we get from?

## I. Approach and method

Starting from the historical context we will present the education, the medical activity, the personality, respectively the change of the doctor's life over time.

We will work with the method used by Plutarch in "Parallel Lives". The genre of "comparison" is deeply rooted in the ancient Greek tradition - the competition and rivalry also appears in the classical Greek comedy (for example, the competition of Aischulos and Euripides in Aristophanes' Frogs), later in the historical and philosophical writings (such as in the debate of Persian military rulers at Herodotos).

The comparison also occurs in Roman literature and rhetoric, but the most popular is Plutarch's work. "Parallel Lives" presents simultaneously a Greek and Roman personality and will become often quoted especially in Renaissance and Enlightenment. Petrarch still does not know him, Dante notice only as Traianus' teacher, but later his ideas on education (or theses associated with Plutarch) appeared in works of Erasmus, Melanchthon, Rousseau, Goethe, Schiller (Borzsak, 1965).

Plutarch was born in the 40's AD in Chaeronea, Boeotia,from a wealthy family. He traveled in ancient Greece, studied philosophy and mathematics at Athens and it must be noted his close connection with Delphoi, an important place of ancient medicine. Plutarch lived in Rome too and received Roman citizenship. However, his works will be born not in Rome, the cosmopolitan city, but in Chaeronea, in the province.

Amyot's biographies in North's English translation (1579) were an inspiration for several personalities of Shakespeare's dramas (Coriolanus, Julius Caesar, Antonius and Cleopatra, Timon of Athens). Old and modern philologists have hearty and interesting discussions about the heroes of Shakespeare's dramas: what was true, what was only an addition to Plutarch. After all, Plutarch's comparative genre lives still until today; R.W.Emerson conveyed that "all along there will be books, from time to time Plutarch will be discovered again and again" (Borzsak, 1965).

This method we will use in our essay and learning from ancient masters we will draw a parallel between the life and work of similar personalities. In our case the profession is identical, and as in Plutarch's work, the period when those presented live is very far and different.

## II. Some mythological data and historical context

### Asclepios- the god of healing and medicine

According to Homeros, Asclepios was a noble "man" from Thesalia, so a "human", who received exquisite education from Kheiron, the bright, gifted centaur. According to Hesiodos or Ovidius, Asclepios was the son of god Apollo and the daughter of King Koronis. He learned the art of hunting and healing, namely resurrecting the dead with the blood of Gorgo Medusa, a gift from the goddess Athene. So he became a well-known healer. But his activity was in contradiction with the aims of Hades (the god of death), who together with Moira (Parca) Clotho made a complaint to Zeus, considering that Asclepios work against death is an implication in the affairs of the gods. Dissatisfied with the fact that "humans" become immortal, like the gods, Zeus punished Asclepios killing him by lightning. Apollo fought for his son's death, sacrificing Zeus' helpers, the cyclops. In the end, Zeus changes his mind and transforms Asclepios into a god, so" immortal". Its symbol, the snake represents both the rebirth (by changing the skin), but in Greek tradition, the snake recognizes also the medicinal plants (Belfiore, 2008). Asclepios had two sons (according to mythology Machaon and Podaleirios participated at trojan war) and a daughter, Hygea.

### Ancient Greece and medicine

In the beginning, healers from ancient Greece traveled from town to town and purified the communities. In the 5th century BC, Hippocrates, whose family was considered a descendant of Asclepios, began studying medicine. His father, Heraclides gave his son a select, chosen education. After traveling in Greece and Asia Minor, Hippocrates returns to Kos, where he works, practices the art of healing and teaches the science to the next generation of healers.

The first schools of medicine in Greece appeared around 500 BC in Kroton, from here comes Democedes, the traveling physician.Later, in the 5th-4th centuries BC, rised the

Asclepios- schools in Kos, Knidos or Epidaurus.

When in 332 BC, Alexander the Great conquered Egypt, Greek medicine became inevitable heavily influenced by Egyptian medicine. So arrived the new medical schools: the Alexandrian, empiric, methodic and pneumatic (Szumowszki, 1939).

### Rome

The birth of Rome (Urbs, the "city") is full of mythological hypothesis and theories. According to legend, Rome was founded in 753 BC. In the beginning, the Romans did not have gods associated with the art of healing. Only after a plague outbreak, they started to study the last three volumes of Sibylla-book and thenceforth they named the god Asclepios from Greeks under the name Aesculapius (Belfiore, 2008). The Romanian nobles cure the family according to their old natural methods. The imperial period's encyclopaedist, Plinius the Elder (23 -79 AD) describes natural remedies in Historia Naturalis, like Varro in his work on agriculture. According to Plinius the Elder, the first Greek physician came to Rome in 219 BC, when" Lucius Aemilius and Marcus Livius were consuls" and his name was Arcagathus, son of Lysanias (Historia Naturalis. XXIX. Book).

Both Julius Cezar and Emperor Augustine offered citizenship to immigrant doctors, most of them of Greek origin (Ferngren & Lomperis, 2017). When the Greek doctors would appear in Rome (they were the first professional, but foreign healers), the conservatives would rise up against their influence on the Roman folk healing (Marcus Portius Cato, Plinius the Elder).

Even so, the Greek, Hellenistic and Jewish influence in the medicine of imperial Rome is difficult to be stopped. Empiricism and the practice of theoretical medicine are becoming widespread. However, many doctors see in Asclepios or Aesculapius their protector, so the art of healing is still full of magical elements.

### Early Christianity

Early Christianity represented the care and healing around the monasteries. According to the principle of Christianity, the care of the body and the care of the soul (*cura animae et cura corporis*) is unique and becomes the duty of church. From the schools of Reims and Chartres (around the year 1000), where *"septem artes liberales"* is already taught and from the schools of the Benedictine monasteries (where liberal art is also taught, but especially theological issues), we reach the 12th century, when the first European universities (Bologna, Paris) rise. From the 12th century, the Church forbids the involvement of priests in healing (*"Ecclesia abhorret a sanguine"*) (Szumowszki, 1939).

The principle that declare the medical profession was related to obtaining an official diploma after studying at university, comes from the specific structure of the Middle Ages, which was very strictly constituted by social status, occupation and profession (see the guilds). Each profession had its own activity code and strict rules.

## III. Discussions-Parallel Lives

In ancient times the physicians were not well documented and we only know them from indirect sources: representations on painted vessels, medical instruments discovered in archaeological sites, descriptions from the Roman era, later from the monasteries' scripts. About the "new doctor" of the 21st century we have a lot of data from our own experiences, written and digitized data, after all, we live in this period. So we will focus on the description of the doctor of ancient Greece in the full glory of the history of the fifth- fourth century BC, about during and after the period of Pericle, Athens.

We will consider the parallel biographies as a game - a conversation and discussion in which we present the theses and arguments - more from antiquity, some propositions from our time, is well known by all the contemporary medical world-, answers to the arguments, finally we will draw conclusions, we will reach a compromise or we must start the discussion again in a new, different essay.

## Parallel lives - The" old doctor" from the 5th-4th century BC.

### 1. Education

As a child, the ancient doctor is taught to observe, to listen, to participate in select education in the company of clever, aware teachers. He is educated in the medical schools of Asclepios in Epidaurus or Kos, where he may be the disciple of Hippocrates or his sons: Drakon and Thessalos or his son-in-law Polubos. The future doctor is already breaking the theurgical tradition. The observation is the main element in his work, he is educated that the evolution of the diseases is not influenced by the attitude of the gods, but by the rational-empirical activity of the doctor (Szumowszki, 1939). For example, he knows from "De morbo sacro" that the epilepsy is not a divine possession. He learns writings from "Corpus Hippocraticum" - "De aeris, aquis et locis", "De natura hominis" and discovers the mysteries of humoral pathology. The" old- student" studies also philosophy. Philosophy was an applied science in antiquity, an exercise, a way of life (modus vivendi) (Hadot, 2010).

### *2.* Work and medical activity

#### *The doctor-patient relationship*

The physician often travels, he discovers new places and he is becoming an experienced traveler- doctor. Later, the consultation takes place in the physician's own house or in the patient's home. In this time the drawers were inexistent, so the instruments are hanging on the wall or on special supports. The medical office had to be light and airy as it was described in "De medico" in Corpus Hippocraticum. The office must show exactly as the other houses, only its utilization can denote the difference (Schott, 1993). According to the representation of a slate from the 2nd century BC, the doctor, and the patient sit on two chairs of the same height. The physician has a slate and a slate- pencil for notes and an assistant gives them the instruments. The duration of the consultation and the payment for the service were ensured by a contract. The cult of Asclepius also introduced the method of "healing sleep" in temples (*asklepieia*). The sleep (lat. *incubatio*) was preceded by a ritual bath in one of the numerous fountains in the temple. The patients were sleeping on ancient beds called "kline" (this word gave rise to new word clinics). Many votive boards have expressed gratitude for the miraculous cures.

### 3. Behavior during epidemics - public health

In the work of Thucydides (History of the Peloponnesian War) appears a description of a plague epidemic in Athens - about 430 BC. Further research indicates that Thucydides describes the symptoms of several infectious diseases, because the plague appears in the western space only later (Schott, 1993), but definitely was an outbreak.

Certainly, the doctor is not involved in the treatment and stopping the spread of the outbreak, he has no obligation in this regard. Much later, during the Enlightenment period, physicians will appear as personalities and actors of public health (Outram, 2008).

### 4. The prognosis (Pronoia)

According to Ferngren & Lomperis, the word pronoia means more than prognosis. It represents the patient's trust in the doctor, confidence that must be carefully built over time. This trust's important for the doctor - as in any profession - and it is important for the patient too (so he will know whether he will live or die). Trust in the physician was the only basis of the doctor-patient relationship in a period when no diploma of license or authorization is required (Ferngren & Lomperis, 2017).

### 5. Malpractice

In ancient times the medicine was not regulated, controlled, supervised. Doctors did not have a very good reputation. In the Hippocratic writings (*Corpus Hippocraticum* born between 400 BC. and about 100 AD.) appear new rules through the doctors who have studied in medical schools trying to delineate themselves from the ignorant, uneducated healers. The consequence of a malpractice was at most a bad reputation. Already in the Corpus Hippocraticum exist rules for doctors against negative fame. They must study in medical schools, have a pleasant appearance and proper behavior, simple and practical clothing, being used both for healing activity and for walks in nature. In discussions, conversations and debates the doctor must have a serious, simple attitude, not to lose the temper and he must be balanced and equitable. The rules can be considered early medical ethics, as in the Hippocratic Oath. According to the original Oath, the physician who takes the oath is identified with a "clean and holy" life (this fact having no connection with the ancient philosophy, the significance of the oath increases, precisely by this requirement, in Christianity).

### Curriculum vitae of 21st-century physicians. "The new doctor". A few propositions.

After high school and baccalaureate, the young student (more or less knowledgeable about what he wants), follows the courses of the medical school, studies more the natural sciences, less the humanities, graduating the University by an examination of license. It follows the required curriculum: residency and specialized exam. No one can practice medicine without a diploma of license and authorization, becoming a member of the College of Physicians. The medical office needs health authorization, the work is regulated by laws. The medical activity is supervised in almost the smallest details - the obligations of the physician as a healthcare provider, contracts and payments, malpraxis, but here must be mentioned also the patient's rights law.

## IV. Conclusion

The COVID-19 pandemic has taught us that much has changed in the last 2000-2500 years. Civilizations and relationships, the meaning of place and use of time, research, science and diseases. One thing remained almost unchanged, the man.

Based on the comparison (parallel biography) of the doctor-patient relationship from the ancient and contemporary times, we emphasize three aspects:

1. The doctor with education either in medical schools or faculties is constant, his medical activity and his personality changed to a small extent.

2. The patient - to be sick it's the same always and everywhere

3. The doctor-patient relationship: the medical office, consultation, communication, diagnosis or prognosis are established with small differences almost identical. The success or the positive reputation, which brings more patients, respectively the malpractice, which brings negative fame is the result both in the ancient period and today either of the merits (arete), or of the accidental, of the blind luck, of the variable fate and fatality (*tukhe*).But one component has changed substantially: the system. The system in which doctors work. The system in which the doctor-patient relationship is realized. The system, which regulates or not, the system that supervises, verifies or not, the system that creates huge or smaller bureaucracy. And at this point, we arrive at the trial of the system against Josef K. in Kafka's novel " Jemand musste Josef K.verleundet haben, denn ohne dass er etwas Boses getan hatte, wurde er eines Morgens verhaftet" (Kafka, Der Prozess). "Somebody must have laid false

information against Josef K., for he was arrested one morning without having done anything wrong"- this is the first sentence of "The Trial" (Kafka, 2000). According to Kafka, the isolated, alienated individual or person (in our case physician) conflicts and fights with bureaucracy uselessly and hopelessly. In the end, all the works of Franz Kafka are against all the irrationalities of all periods and worlds.

Considering Greek mythology a starting point and source for European culture and medicine, we, all doctors, we can consider ourselves descendants of Asclepios, because we have acquired and inherited the secret medical knowledge and we will be the ones who teach these secrets to the next generations.

How can we define the activity of the doctor - profession, vocation, mission or work? It differs from person to person. It differs from one historical period to another. It differs even throughout the life of the physician: if it was a vocation, a profession at first, it can become work, even work for the benefit of the community at the end.

After all, as in the case of Asclepios, the gods will not leave unpunished those who try to save the humans from the death, those who try to know the mystery of immortality, in this way intervening in the affairs of the gods.

But we try and try again.

## References

Belfiore, J. C. (2008). *A gorog es romai mitologia*. Larousse. p 104-106, Debrecen, Alfoldi Nyomda

Borzsak, I. (1965). Utoszo. in Plutarchosz. Parhuzamos eletrajzok. Forditotta Mathe Elek, Magyar Helikon, 1636.

Ferngren, G. B. & Lomperis, E. N. (2017). *Essential Readings in Medicine and Religion.* Baltimore: John Hopkins University Press, 53-54.

Hadot, P. (2010). *A lelek iskolaja. Lelkigyakorlatok es okori filozofia*. Kairosz Kiado.

Kafka, F. (2000). *The Trial*. Translation Idris Parry. Penguin Modern Classics.

Outram, D. (2008). *Panorama iluminismului*. Bucuresti: ALL, 275.

Schott, H. (1993). *A medicina kronikaja*. Budapest: Officina Nova, 34-41.

Szumowszki, U. (1939). *Az orvostudomany tortenete*. Budapest, 139, 168.