Health and religion: a bioethics approach

Jorge Alberto Álvarez Díaz

Update

Abstract

Religion is an element of culture that is present in the process of health-illness-care. This presence is not only at a personal level, but at a collective level through public health policies. These policies should be thought for the whole population, regardless of whether they believe or do not believe in a particular religion. However, Christianity is a proselytizing religion, in whose history can be seen imposing its vision on other visions (Middle Ages is the best example). In the contemporary world, religion continues to seek to impose its criteria, also in the field of health. The proposal of this work is that there are ethical issues that underlie the collective and that make this type of impositions is not correct in contemporary societies, multicultural and morally pluralist.
Keywords: Religion and medicine. Bioethics. Health sciences.

Resumo

Saúde e religião: uma abordagem bioética

Religião é elemento cultural presente no processo saúde-doença-cuidado não apenas em nível pessoal, mas coletivo, por meio de políticas de saúde pública. Essas políticas devem ser pensadas para toda a população, independentemente da crença pessoal em determinada religião. No entanto, o cristianismo é religião proselitista, em cuja história pode-se observar a imposição de sua visão sobre outras (a Idade Média é o melhor exemplo). No mundo contemporâneo, a religião continua a procurar impor seus critérios, também no campo da saúde. Este artigo propõe que existem questões éticas subjacentes ao coletivo e que esse tipo de imposição não é correto em sociedades contemporâneas, multiculturais e moralmente pluralistas.
Palavras-chave: Religião e medicina. Bioética. Ciências da saúde.

Resumen

Salud y religión: un enfoque bioético

La religión es un elemento de la cultura que está presente en el proceso de salud-enfermedad-atención. Esta presencia no solamente es a nivel personal, sino a nivel colectivo a través de políticas públicas de salud. Estas políticas deben pensarse para toda la población, independientemente de si creen o no creen en una determinada religión. Sin embargo, el cristianismo es una religión proselitista, en cuya historia puede verse la imposición de su visión sobre otras visiones (la Edad Media es el mejor ejemplo). En el mundo contemporáneo, la religión continúa buscando imponer sus criterios, también en el campo de la salud. La propuesta de este trabajo es que hay cuestiones éticas que subyacen en los colectivos y que hacen que este tipo de imposiciones no sea correcto en las sociedades contemporáneas, multiculturales y moralmente pluralistas.
Palabras clave: Religión y medicina. Bioética. Ciencias de la salud.

Doctor bioetica_reproductiva@hotmail.com – Universidad Autónoma Metropolitana, Ciudad de México, México.

Correspondência
Edificio A, 2º Piso. Área de Postgrados en Ciencias Biológicas y de la Salud. Calzada del Hueso, 1.100, Colonia Villa Quietud, Delegación Coyoacán CP 04960. Ciudad de México, México.

Declara não haver conflito de interesse.

Update

Health and religion: The personal level

It is difficult to define what is religion [1]. In the broader sense of the term "religion" is defined by the Diccionario de la Real Academia Española (DRAE - Dictionary of the Royal Spanish Academy) as a *Set of beliefs or dogmas about the deity, feelings of veneration and fear towards it, moral standards for individual and social behaviour and ritual practices, especially prayer and sacrifice to worship the deity* [2]. This definition arises in the western world, where two Mediterranean traditions merge: the Greco-Roman and Judeo-Christian. The Christian tradition (mainly Catholic) has had more influence in Latin American countries than other great monotheistic religions, so there will be a special emphasis on it. It leaves aside the historical relationship in which bioethics largely arises as a discipline for philosophical and Christian reflection (Catholic and non-Catholic), in addition to questions about legal aspects. It is true that thought groups have been formed that have contributed to the development of bioethics, but this will not be the approach taken later on. In addition, although there are many other religions in Latin America, they have few followers, and the influence they can have on public health policies is less relevant.

Religions carry moral standards as seen in the definition of the DRAE. A way of understanding ethics is as a moral philosophy, as a philosophical reflection on morality. Thus, ethics leads in different ways to religion, and every religion carries an ethic; but religion and ethics are not synonymous.

The origin or source of the moral norm must be analysed in order to carry out a moral philosophy. If the origin of the norm is a divinity, then it is a *theonomous ethic*. The origin of the norm can be something different from the divinity and different from the human being, in which case we have a heteronomous ethic. Finally, if the origin of the norm is not in a divinity or it is in something different from the deity and the human being, then the source of the norm is the human being itself; These ethics are called *autonomous*.

For Diego Gracia, theonomous ethics can be understood in three possible ways [3]. The first way would be the God-centred theonomy; under this modality, the rules are directly dictated by the deity, so there is nothing to discuss, and one can only obey. The second of the meanings would be a heteronomous or theological theonomy; in this case there is a text revealed by the deity, which admits different interpretations by legitimate representatives (priests, for example, for catholic christianity). The third and last of the ways corresponds to an autonomous or philosophical theonomy; as it is a theonomy, it is based on the belief in the divinity, which gives the quality of rationality as a grace; free will is provided from this condition and then a decision is made autonomously.

This clarification is very important. Religion has given a special emphasis on sexual morality among other moral issues. A morally controversial issue throughout history, with clear repercussions on health, has been that of the voluntary interruption of pregnancy (VIP)v [4]. For this reason we take it as an example around which we can reflect about the different ways of understanding and practicing a theonomous ethics.

If the personal position of a believer is to adopt an ethics based on a God-centred theonomy, it is transparent that the Bible is not entirely clear on the subject. For example, in Exodus 21: 22-25 it says: *If men strive, and hurt a woman with child, so that her fruit depart from her, and yet no mischief follow: he shall be surely punished, according as the woman's husband will lay upon him; and he shall pay as the judges determine. And if any mischief follow, then thou shalt give life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burning for burning, wound for wound, stripe for stripe* [5]. Therefore, it can be understood that abortion is not comparable to the death of an adult and that sanctioning an abortion can not have the same criteria or the same magnitude of sanctions against the killing of an adult human being. However, in Job 3: 9-23 it is read that *Let the stars of the twilight thereof be dark; let it look for light, but have none; neither let it see the dawning of the day: Because it shut not up the doors of my mother's womb, nor hid sorrow from mine eyes. Why died I not from the womb? why did I not give up the ghost when I came out of the belly? Why did the knees prevent me? Or why the breasts that I should suck? For now should I have lain still and been quiet, I should have slept: then had I been at rest, with kings and counsellors of the earth, which built desolate places for themselves; or with princes that had gold, who filled their houses with silver: Or as an hidden untimely birth I had not been; as infants which never saw light. There the wicked cease from troubling; and there the weary be at rest. There the prisoners rest together; they hear not the voice of the oppressor. The small and great are there; and the servant is free from his master. Wherefore is light given to him that is in misery, and life unto the bitter in soul; which long for death, but it cometh not; and dig for it more than for hid treasures; which rejoice*

exceedingly, and are glad, when they can find the grave? Why is light given to a man whose way is hid, and whom God hath hedged in? [6]. In this other quote it would seem that a voluntary interruption of pregnancy (VIP) could be something desirable. Thus, a "pure" God-centred theonomy is complicated. The text may not be clear.

On the other hand, if the believer assumes an ethic based on a heteronomous theonomy, he or she will resort to interpretations of those who consider themselves specialists. Thus, in the case of Catholic Christianity, the Catechism of the Catholic Church in its section 2270 says the following*: Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person - among which is the inviolable right of every innocent being to life"* [7]. *On the other hand, the Declaration on Procured Abortion says that: "From the time that the ovum is fertilised, a life is begun which is neither that of the father nor of the mother, it is rather the life of a new human being with his own growth. It would never be made human if it were not human already. To this perpetual evidence - perfectly independent of the discussions on the moment of animation - modern genetic science brings valuable confirmation. It has demonstrated that, from the first instant, there is established the program of what this living being will be: a man, this individual man with his characteristic aspects already well determined. Right from fertilisation is begun the adventure of a human life, and each of its capacities requires time- a rather lengthy time- to find its place and to be in a position to act* [8]. (This text is cited in the Instruction Donum Vitae of 22 February 1987). The "official" position of the Catholic Christianity is based on these documents, which in turn are allegedly based on a revealed truth; what they add is an interpretation that allows us to understand and apply the message of divinity. Under this official position, it is never possible to interrupt a pregnancy. There is no possibility of establishing exceptions.

However, not every believer assumes a God-Centred theonomy ethical posture or a heteronomous theonomy. More and more believers assume positions of autonomous theonomies. It is the position that can be seen in the advocacy group Catholics for Choice. They start by accepting the existence of the deity, assuming that their reason is a divine grace, and appealing to the reason so that each woman in conscience decides whether she considers it ethical or not to interrupt her pregnancy. Whoever believes in divinity also has reasoning, not just priests. When sociologists have studied the religiosity of human beings, they have introduced some concepts such as the *popular expression of religion* [9]. This term refers to how people feel, live, or express an "official" religiosity, but from their personal interpretation and their own practice. They refer to this theonomous ethic as autonomous, but from a social rather than philosophical meaning.

Up to this point it is clear that there is no single generalisable position when speaking of a person who identifies himself as belonging to Catholicism. The repercussions on sexual and reproductive health (to follow the example of the VIP) would be the most varied. From a theonomous ethic there would be doubts about which decision to make about interrupting a pregnancy or not; this could have some repercussion on the mental health considering the doubt on how to act.

From a heteronomous theonomous ethic it would be clear that a pregnancy should never be interrupted and under no circumstances; there is abundant literature around the world that indicates that this brings serious damage to the health of women, having forced pregnancies, leading them to undergo the risk of an abortion in unsafe conditions [10], raising unwanted offspring [11], etc. It is false that the VIP damages the mental health of women, since scientific evidence shows that denying the VIP to a woman who requests it increases her psychological distress [12], whereas if theVIP service is provided then women do not diminish their self-esteem or satisfaction with life [13]; after the VIP, the risk of mental illness (such as schizophrenia) is not increased [14].

From an autonomous theonomous ethic it is clear that the criterion is personal, in conscience, so that each woman would determine whether to interrupt her pregnancy or not. This brings benefits to women's mental health (providing the VIP service to women who request it leads them to maintain a positive view regarding their future and the realisation of their goals [15]), as well as public health benefits (decriminalising the VIP involves the conversion of a clandestine and unsafe practice, into a safe procedure under medical conditions [16]). Clearly, the possibility of deciding about one's own body does not lead anyone to force the woman to interrupt a pregnancy. Because the undesirable thing is not the interruption of pregnancy itself, but a woman being pregnant when she does not want to be pregnant (there is no ethical justification to force a woman to carry a pregnancy), then this position would entail pregnancy

prevention strategies. It is known, for example, that the best combination to prevent pregnancies is access to sex education and contraceptive methods (especially among adolescents) [17]. It is also known that there is a mathematical relationship between the number of children desired by women and their partners, the percentage of them that usually uses a method of contraception, and the voluntary interruption of pregnancy (VIP). For women who want an average of two children, 75% should regularly use a contraceptive method to avoid around 12 VIPs during their fertile life. In the case of women who want 6 children (increasingly rare), it is possible to prevent 4 VIPs if a quarter of them regularly use a contraceptive. Regardless of the number of children desired (2, 4 or 6), 1.6 VIPs per woman are prevented by increasing the population coverage of contraceptive methods by 10% [18]. The mortality caused by voluntary interruption of pregnancy (VIP) in a legal context is 14 times lower than that of a full-term pregnancy [19]. The rate of mortality due to VIP in a legal context is directly related to the weeks of gestation: the earlier the procedure is performed, the more certainty of a positive outcome. Within the first 12 weeks of gestation, mortality is less than 0.5 per 100,000 procedures [20].

These considerations point out that the personal level of religion can be very different among believers, and therefore, it can have very different implications for personal health. This can not be lost sight of, since the personal level does not disappear in the collectivity; It is true that collective is not synonymous with the sum of individuals, but it is no less true that without individuals there is no possible collective.

Health and religion: The collective level

Cruz Velandia says that according to the Levcovitz's Brazilian group, the characteristic of political intervention and social transformation has been the one that has gained most strength above all in the process of building collective health (criticisms of the traditional biomedical model; reflection on health practices and institutions, etc.). In addition, Cruz Velandia, based on Almeida Filho y Coelho, considers that after introducing humanities in the biomedical field, the constitution of the theoretical discourse of collective health restructures its axes, highlighting the symbolic, philosophical, ethical, political and socioeconomic dimensions [21]. If a great emphasis on collective health is represented by political intervention and social transformation and one of the axes is ethics, we should continue to highlight the ethical issues in collective health, in this case in relation to religion.

To approach the collective, one could take the perspective of Taylor's multiculturalism [22], or that of moral pluralism, whether in the versions of Rawls [23], Habermas [24] or Cortina. For reasons of space, we will mention only Cortina's proposal.

For Adela Cortina the central problem is how to proceed before the reality of moral pluralism. Thus, the problem would not be so much at the level of religions and secularisation, but in the multiple moral views of the world, which may be religious or not. For Cortina, the great challenge in the 21st century is to build a global ethic that can face the challenges of technology, science and economics. Global ethics would have to be constructed from a multicultural universe and taking into account moral pluralism.

In very general terms, morality refers to a set of customs that a certain society at a given historical moment considers good or bad. An ethic results from the philosophical reflection of morality; it is not a purely specialised act, since human beings submit to discussion the moral assumptions of the society in which they live, and although they end up accepting many of these moral assumptions, it is not the same to accept them in a reasoned and reasonable way than in an uncritical way. It is true that the specialists in the subject, the philosophers, elaborate ethical theories, but they are about great systems that can not be separated from an activity that all human beings carry out.

In this way, there would be as many ethics as there are human beings; that is why Aranguren spoke about *ethica utens*, as the one used personally by each human being, and *ethica docens*, as the one that appears in the ethical treatises. It is an attempt to make a classification of different ethical systems.

Cortina was a disciple of Aranguren, and considers that the ethics that coexist in a society are of two types: ethics of maxima and ethics of minima [25]. The ethics of maxima are proposals that are related to happiness. Aristotle says in the *Nicomachean Ethics* that the *telos* of human beings is *eudaimonia*, which is usually translated as "happiness"; in fact, *eudaimonia* in Greek, *beatitude* in Latin, or *felicidad* (happiness) in contemporary Spanish do not have the same meaning. There are many ways of understanding the realisation of the good in order to achieve happiness. These different forms can be religious, or they can be nonreligious or secular proposals. In order for several ethics of maxima to coexist, an ethic of minima is

required, which would correspond to shared justice. It is essential to differentiate proposals of happy life from demanding claims to justice. Happiness is invited; justice is demanded.

Justice raises claims not because it does not like or does not suit something in particular at the personal or group levels: the claims that justice raises are supposed to be extended to all humanity. When someone labels an act as "fair" or "unfair", it does not mean that they do not like it, or that it does not suit them, it means that this should not be the case for anyone. Ethics of minima (or minimum ethics) corresponds to the essential requirements that a certain society believes it must have to be considered human; being below them would place that society as inhuman.

If a person thinks that happiness is achieved, he or she must periodically attend a series of practices (religious, such as a certain rite, or secular, such as sports or recreational activities) and be very happy, but they should not impose on others to do the same in order to achieve happiness; At the most the person can invite other people. On the other hand, if it is known that unsafe abortion is still one of the major causes of maternal death, which occurs globally in 14.5% of all maternal deaths, that almost all of these deaths occur in countries with laws which restrict access to legal abortion, that the criminalisation of voluntary interruption of pregnancy (VIP) increases maternal morbidity and mortality [26]; and that in countries such as Mexico there is experience that mortality is greater in federal entities with restrictive laws than in Mexico City, the capital that allows legal abortion [27]; One should think that a demand for justice is that every woman has legal access to interrupt her pregnancy, since no woman should die from the complications of an unsafe abortion. Nor should only women who live in Mexico City, or in Mexico, or in Latin America, have access to legal abortion. It should be a demand for justice around the world. To fall below this and allow a woman to die from preventable causes is to fall under minimums of humanity.

The public sphere would correspond to the place where public reason is expressed, which corresponds to the nucleus of pluralistic societies. Cortina considers that the public reason of a pluralistic society is the one that has to present norms or proposals (ethical and political) that are acceptable for all types of citizens (believers, having in mind that there are different types of beliefs or religions, as well as non-believers, considering that there may be agnostics, atheists, etc.). Cortina is a disciple of theorists of the Frankfurt school critical theory (she is the introducer into Spanish of the work of Karl-Otto Apel), and considers that a pluralist society has a set of ethics of maxima that share a minimum of justice, so that ethics of maxima, whether religious or secular, are part of the very structure of a pluralistic society. Basically, as is clear, it is not about sacrificing the good for the just or the just for the good, so that the relations between an ethic of minima and the different ethics of maxima in a pluralist society can be made compatible.

The starting point of discourse ethics is communicative action; this ethic is the one that starts from the second generation of the Frankfurt School, with Apel, Habermas and others, and continues with particular courses by Cortina in the Spanish language, some already mentioned so far. In the discourse ethics there is a logical link between those who participate in a communication. Apel considers that *all beings capable of linguistic communication should be recognised as persons, since that in all their actions and expressions they are virtual interlocutors, and the unlimited justification of the thought can not renounce any interlocutor and none of their virtual contributions to the discussion* [28]. And he adds, *In my opinion, it is not, therefore, the logically correct use of individual understanding, but the requirement of reciprocal recognition of people as subjects of logical argumentation, which justifies the discourse on the ethics of logic* [29].

Cortina continues this proposal and affirms that the philosophical foundation is essential. The author then proposes an *Ethica cordis* [30], an ethics of cordial reason [31], which she describes as a warm version of discourse ethics, and with it a procedural ethic. The framework of an ethic of minima, in principle, must be procedural, since if it is substantial or contained, it would correspond to an ethic of maxima. If the discourse ethics takes the transcendental logical level, the intersubjectivity of those who participate in a dialogue is a transcendental logical link; it speaks of a logical link and intersubjectivity is established among those who participate in a dialogue; nevertheless, for Cortina the pure transcendental logical link is insufficient to account for human communication. The communicative action makes us recognise that human beings are not isolated individuals, but that they are what they are through reciprocal recognition. The key to an ethics of minima is not individualism, but born from reciprocal recognition, philosophical tradition taken up by Hegel, which arrives at the Frankfurt School in

Update

different ways, Apel as one of them, and in Spanish continues with Adela Cortina.

With the above, individualism can not be the key to a ethic of minima, but the key is a group of individuals who recognise each other; they are linke, they are in relationship, they are united by that *ligatio*, which leads them to an *ob ligatio*; when someone is linked, he or she is linked to others. In addition to the logical link, Cortina considers in her proposal that there are elements which enrich the communicative link. For mutual recognition, at least three points are necessary. The first, that people are able to estimate values (autonomy, equality, solidarity, etc., without which the communication link does not work). The second, to work an *ethos*, a character, to recognise values and to opt for interests (the discourse ethics ends up saying that a norm will be so just if those affected by it recognise that it is because it defends interests which can be made universal; this point is usually forgotten or misunderstood, since these interests are those that benefit the least advantaged; the well-placed seek privilege; In order to be willing to recognise universal interests, it is necessary to develop a character willing to recognise fairness). The third point is that emotions and feelings should be considered; if they do not recognise themselves, obviously linked to reason, then it is not recognised what is just. Thus, the communicative link is not only formal but also cordial, a compassionate recognition, a mutual recognition of those who recognise themselves as sympathising in suffering and sympathising in joy. Sympathise in suffering is difficult; sympathise in joy is even more difficult. Cortina's proposal is already producing some repercussions to take into account in the field of health [32].

A bioethical approach to the relationship between health and religion: an example of Catholicism in Mexico

Diego Gracia, considered by many *as the most important bioethicist in the Ibero-American world* [33], is influenced by the idea of an ethic of minima and different ethical of maxima. Therefore, he considers as basic characteristics of bioethics to be a civil, pluralistic, autonomous, rational ethics and beyond conventionalism. When talking about civil ethics, he says *that people have the right to have their freedom of conscience respected, social institutions are obliged to establish the moral minimums required of all but they can not be set according to the mandates of religious morals, but rather based on secular, civil or rational criteria* [34]. Bioethics is either secular or it is not bioethics. Any idea of imposition can not be considered ethical.

On the other hand, Álvarez Díaz proposes, based on his Spanish teachers Diego Gracia and Adela Cortina, in addition to retaking the proposals of the Argentine José Alberto Mainetti, that bioethics has three levels: micro bioethics, mid bioethics and macro bioethics [35].

The micro bioethics level includes making decisions about one's own body, that is, what has also been called clinical bioethics. Following with the voluntary interruption of pregnancy (VIP), includes the subjects of respect for the autonomy of the patients, evaluation of their capacity and competence, process of the informed consent, etc.

The level of mid bioethics is located in the taking of institutional and structural decisions. An example would be ethics in public health policies. In this topic, Emanuel says *that medical ethics must stop being oriented to clinical cases and be oriented institutionally. We, the bioethicists, must stop approaching the problems from a philosophical perspective and adopt the perspective of political science* [36]. Public policies around the VIP need to follow scientific evidence to offer the best care to women.

The level of macro bioethics is related to globalisation and its processes. It covers issues of environmental bioethics, problems of global justice (with new areas such as health tourism, medical tourism, which in the case of the VIP has been called "abortion tourism"), etc.

Whereas Gracia proposes that bioethics should be elaborated with secular criteria (not secularist, that eliminates all forms of religiosity, but not confessional, that emanate from a certain religion), and that Álvarez Díaz proposes the articulation of three levels, we should say that micro bioethics, mid bioethics and macro bioethics must develop in a secular form. This is clear from the reflection of a morally pluralistic society. However, the reality is that religious bioethics, such as Catholic bioethics, rather than bioethics, represent the attempt to impose their ethics of maxima as an ethic of minima. In this sense, the case of Mexico is paradigmatic, and not necessarily similar to expression of Catholicism in other Latin American countries.

David Brading is an English historian who has proposed that at the beginning of the independent life of Mexico, before the cultural pluralism that was reinforced by the caste system in the Viceroyalty of

New Spain, the link that arose in the population after the Independence was more the Catholic religious than the idea of nationality[37]. His analysis highlights the figure of the Virgin of Guadalupe as central to the development of Catholicism in Mexico[38]. The Virgin has a Basilica that has a *Cabildo*. The *Cabildo de Guadalupe is in charge of maintaining the rites, liturgical and sacramental ministry of the Sanctuary, with the help from a group of chaplains. Every day they perform the laud prayers and the Solemn Eucharist*[39]. One of its members is Jorge Antonio Palencia Ramírez de Arellano[40], who studied medicine at the *Universidad Nacional Autónoma de México* (UNAM -National Autonomous University of Mexico), and later began working at the *Comisión Episcopal de la Salud* (Episcopal Commission of Health) (1979-1997). In his words, *They were eighteen very beautiful years because the pastoral health care was founded at the international level, with a vision of attention to the sick and the defense of life, of the unborn, of the terminally ill*[41]. (our emphasis)

One of the first products of this work was the publication of the Directorio de Pastoral de Salud (Directory of Pastoral Health Care), later assumed in the Vatican as the official book of this pastoral. This directory contains the bases for the formation of pastoral health care agents (biblical, Christology, ecclesiological, etc., patient care). In Palencia's words, *it also contains the presentation of health-salvation in the midst of suffering, that is, the Christian meaning of suffering. Then it brings the tools of pastoral health care: pastoral counselling, Catholic bioethics, among others*[40]. It admits what from academic and political perspectives is not always so clear: that there is a Catholic bioethics.

Subsequently, Palencia says that *in agreement, on 9 December 1998, the Asociación de Médicos Católicos (Catholic Doctors Association), the Asociación del Voluntariado Católico (Catholic Volunteer Association) and the Asociación de Enfermeras Católicas (Catholic Nurses Association)*[40] added that the *Asociación de Médicos Católicos* began to create faculties and bioethics schools, in the Anáhuac, La Salle and Pan-American universities. Evidently, he does not say that the Anáhuac University network is directed by Legionaries of Christ, that La Salle University is directed by the Brothers of La Salle, nor that the Pan-American University is directed by Opus Dei. Palencia states that it is *the birth to the defense of human life from the medical point of view*[40]. It should be clarified that it is not the medical point of view, but the confessional, Catholic religious point of view.

In addition, Palencia says that then began the dialogue with the Mexican government in what is called in Catholicism as "the struggle for life." It states that *there is a strong presence of Catholic doctors, who to date have been placed in work on congressional committees and with the Federal Government*[40]. It is clear that political actors emanate from Catholic Christianity; It is also clear that Mexico is a secular state, so that they do not always confess directly their aspirations to impose an ethics of maxima as the minimum required in justice for the entire population.

Palencia adds that after the foundation of bioethics committees in religious and private hospitals *begins a campaign for the foundation of these committees that integrate the presence of priests. At the national level, the diocesan commissions and the medical colleges were already functioning and they began to do their own work under the same guidelines*[42]. It refers to the *Comités de Ética Clínica o Comités de Ética Asistencial* (Clinical Ethics Committees or Health Ethics Committees); in Mexico, a country where there is a legal requirement since late 2011 to have such committees, the law calls them Comités Hospitalarios de Bioética (Hospital Bioethics Committees). Nowhere in the current regulations is it said that they must have priests. However, the attempt to impose the Catholic ethics of maxima in health care to the entire population has led them to see those committees *as a space for evangelisation*[43].

Palencia relates that *We are the only ones who have stopped the situation of the Instituto de Medicina Genómica (Institute of Genomic Medicine). We have taken the fight against frozen embryo procedures, in vitro fertilisation, and against all the parts who deny that the embryo is a person*[41]. (our emphasis) The parts that deny that the embryo is a person are the ones who have been promoting that the laws should not be restrictive in terms of legal abortion so that women would not die for something that can be prevented by providing safe medical care for an voluntary interruption of pregnancy. The parts, which should be the demand in justice, continue to fight against the ethics of maxima, such as Catholicism, to ensure that safe conditions of interruption of a pregnancy are offered to all women in Mexico. Still not achieved. Evidently, the micro bioethics, the mid bioethics and the macro bioethics, to be able to be really bioethics and to consider each one of the people, must be secular. In morally pluralistic societies, such as the Mexican and Latin American, it is not admissible that the Catholic ethics of maxima Catholic imposes itself as an ethic of minima on the entire population.

Update

Referências

1. Sharpe EJ. Understanding religion. London: Duckworth; 1983.
2. Real Academia Española. Diccionario de la lengua española [Internet]. [s.d.] [acesso 15 maio 2018]. Religión. Disponível: https://bit.ly/2llF6OH
3. Gracia D. Religión y ética. In: Gracia D. Como arqueros al blanco: estudios de bioética. Madrid: Triacastela; 2004. p. 129-96.
4. Álvarez-Díaz JA. El concepto de interrupción voluntaria del embarazo (IVE) en bioética. Rev Fac Med Unam [Internet]. 2008 [acesso 11 fev 2019];51(6):249-51. Disponível: https://bit.ly/2Dx9htj
5. Biblia de Jerusalén. Bilbao: Desclée de Brouwer; 2013. p. 105.
6. Biblia de Jerusalén. Op. cit. p. 822.
7. Catecismo de la Iglesia Católica. Ciudad de México: Libreria Editrice Vaticana; 1997. p. 696.
8. Seper F, Hamer J. Congregación para la doctrina de la fe: declaración sobre el aborto [Internet]. 1974 [acesso 15 maio 2018]. Disponível: https://bit.ly/2aHi2SW
9. Rostas S, Droogers A, editores. The popular use of popular religion in Latin America. Amsterdam: Cedla; 1993.
10. Langer A. El embarazo no deseado: impacto sobre la salud y la sociedad en América Latina y el Caribe. Rev Panam Salud Pública [Internet]. 2002 [acesso 11 fev 2019];11(3):192-205. Disponível: https://bit.ly/2TJk0HL
11. Bitler M, Zavodny M. Did abortion legalization reduce the number of unwanted children? Evidence from adoptions. Perspect Sex Reprod Health [Internet]. 2003 [acesso 11 fev 2019];34(1):25-33. DOI: 10.1363/3402502
12. Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. Jama Psychiatry [Internet]. 2017 [acesso 11 fev 2019];74(2):169-78. DOI: 10.1001/jamapsychiatry.2016.3478
13. Biggs MA, Upadhyay UD, Steinberg JR, Foster DG. Does abortion reduce self-esteem and life satisfaction? Qual Life Res [Internet]. 2014 [acesso 11 fev 2019];23(9):2505-13. DOI: 10.1007/s11136-014-0687-7
14. Simoila L, Isometsä E, Gissler M, Suvisaari J, Sailas E, Halmesmäki E *et al*. Schizophrenia and induced abortions: a national register-based follow-up study among Finnish women born between 1965-1980 with schizophrenia or schizoaffective disorder. Schizophr Res [Internet]. 2018 [acesso 11 fev 2019];192:142-7. DOI: 10.1016/j.schres.2017.05.039
15. Upadhyay UD, Biggs MA, Foster DG. The effect of abortion on having and achieving aspirational one-year plans. BMC Womens Health [Internet]. 2015 [acesso 11 fev 2019];15:102. DOI: 10.1186/s12905-015-0259-1
16. Cates W Jr, Grimes DA, Schulz KF. The public health impact of legal abortion: 30 years later. Perspect Sex Reprod Health [Internet]. 2003 [acesso 11 fev 2019];35(1):25-8. DOI: 10.1363/3502503
17. Oringanje C, Meremikwu MM, Eko H, Esu E, Meremikwu A, Ehiri JE. Interventions for preventing unintended pregnancies among adolescents. Cochrane Database Syst Rev [Internet]. 2016 [acesso 11 fev 2019];2:CD005215. DOI: 10.1002/14651858.CD005215.pub3
18. Bongaarts J, Westoff CF. The potential role of contraception in reducing abortion. Stud Fam Plann [Internet]. 2000 [acesso 11 fev 2019];31(3):193-202. Disponível: https://bit.ly/2DtXI64
19. Grimes DA. Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to 1999. Am J Obstet Gynecol [Internet]. 2006 [acesso 11 fev 2019];194(1):92-4. DOI: 10.1016/j.ajog.2005.06.070
20. Bartlett L, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol [Internet]. 2004 [acesso 11 fev 2019];103(4):729-37. DOI: 10.1097/01.AOG.0000116260.81570.60
21. Cruz Velandia I. La salud colectiva y la inclusión social de las personas con discapacidad. Invest Educ Enferm [Internet]. 2005 [acesso 11 fev 2019];23(1):92-101. Disponível: https://bit.ly/2E5KCxc
22. Taylor C. El multiculturalismo y "la política del reconocimiento". Ciudad de México: Fondo de Cultura Económica; 2009.
23. Rawls J. El derecho de gentes y una revisión de la idea de razón pública. Barcelona: Paidós; 2001.
24. Habermas J. Entre naturalismo y religión. Barcelona: Paidós; 2006.
25. Cortina A. Ética mínima: introducción a la filosofía práctica. Madrid: Tecnos; 1986.
26. Faúndes A, Shah IH. Evidence supporting broader access to safe legal abortion. Int J Gynaecol Obstet [Internet]. 2015 [acesso 11 fev 2019];131(Suppl 1):S56-9. DOI: 10.1016/j.ijgo.2015.03.018
27. Darney BG, Saavedra-Avendano B, Lozano R. Maintaining rigor in research: flaws in a recent study and a reanalysis of the relationship between state abortion laws and maternal mortality in Mexico. Contraception [Internet]. 2017 [acesso 11 fev 2019];95(1):105-11. DOI: 10.1016/j.contraception.2016.08.004
28. Apel KO. La transformación de la filosofía II: el a priori de la comunidad de comunicación. Madrid: Taurus; 1985. p. 380.
29. Apel KO. Op. cit.
30. Cortina A. Ethica cordis. Isegoría [Internet]. 2007 [acesso 11 fev 2019];37(2):113-26. DOI: 10.3989/isegoria.2007.i37.112
31. Cortina A. Ética de la razón cordial: educar en la ciudadanía en el siglo XXI. Oviedo: Nobel; 2007.

32. Costa-Alcaraz AM. Ética del reconocimiento recíproco en el ámbito de la salud. Dilemata [Internet]. 2012 [acesso 11 fev 2019];4(8):99-122. Disponível: https://bit.ly/2SseyN8
33. Mendoza-Fernández A. Palabras de presentación: ceremonia de homenaje del CMP al Padre Dr. Gustavo Gutiérrez-Merino Días y Dr. Diego Gracia Guillén. Acta Méd Peru [Internet]. 2003 [acesso 11 fev 2019];20(2):61-3. Disponível: https://bit.ly/2DtYwb6
34. Gracia D. Ética y vida 1: fundamentación y enseñanza de la bioética. Santa Fe de Bogotá: El Búho; 1998. p. 18-20.
35. Álvarez Díaz JA. Aspectos éticos de la nanotecnología en la atención de la salud [Internet]. Ciudad de México: Universidad Autónoma Metropolitana; 2016 [acesso 15 maio 2018]. Disponível: https://bit.ly/2GFufJp
36. Emanuel EJ. Medical ethics in the era of managed care: the need for institutional structures instead of principles for individual cases. J Clin Ethics [Internet]. 1995 [acesso 11 fev 2019];6(4):335-8. Disponível: https://bit.ly/2GnBciZ
37. Brading DA. Los orígenes del nacionalismo mexicano. Ciudad de México: Secretaría de Educación Pública; 1973.
38. Brading DA. Patriotismo y nacionalismo en la historia de México. In: Flitter DW, Dadson TJ, Obder de Babueta P. Actas del XII Congreso de la Asociación Internacional de Hispanistas. Madrid: Asociación Internacional de Hispanistas; 1995. p. 1-18.
39. El Cabildo de Guadalupe. In: La Insigne y Nacional Basílica de Santa María de Guadalupe [Internet]. [s.d.] [acesso 15 maio 2018]. Disponível: https://bit.ly/2N2ULOb
40. Vallecillo Gómez M. Retratos y semblanzas. Boletín Guadalupano [Internet]. 2006 [acesso 15 maio 2018];5(69):20-2. Disponível: https://bit.ly/2N0JUEq
41. Vallecillo Gómez M. Op. cit. p. 21.
42. Vallecillo Gómez M. Op. cit. p. 21-2.
43. Ornelas Duarte A. Comités hospitalarios de bioética en México: un espacio para la evangelización [Internet]. 2013 [acesso 25 ago 2015]. Disponível: https://bit.ly/2RYj40u

Jorge Alberto Álvarez Díaz

0000-0001-9935-8632

Recebido: 14.1.2018

Revisado: 27.7.2018

Aprovado: 10.9.2018

Update