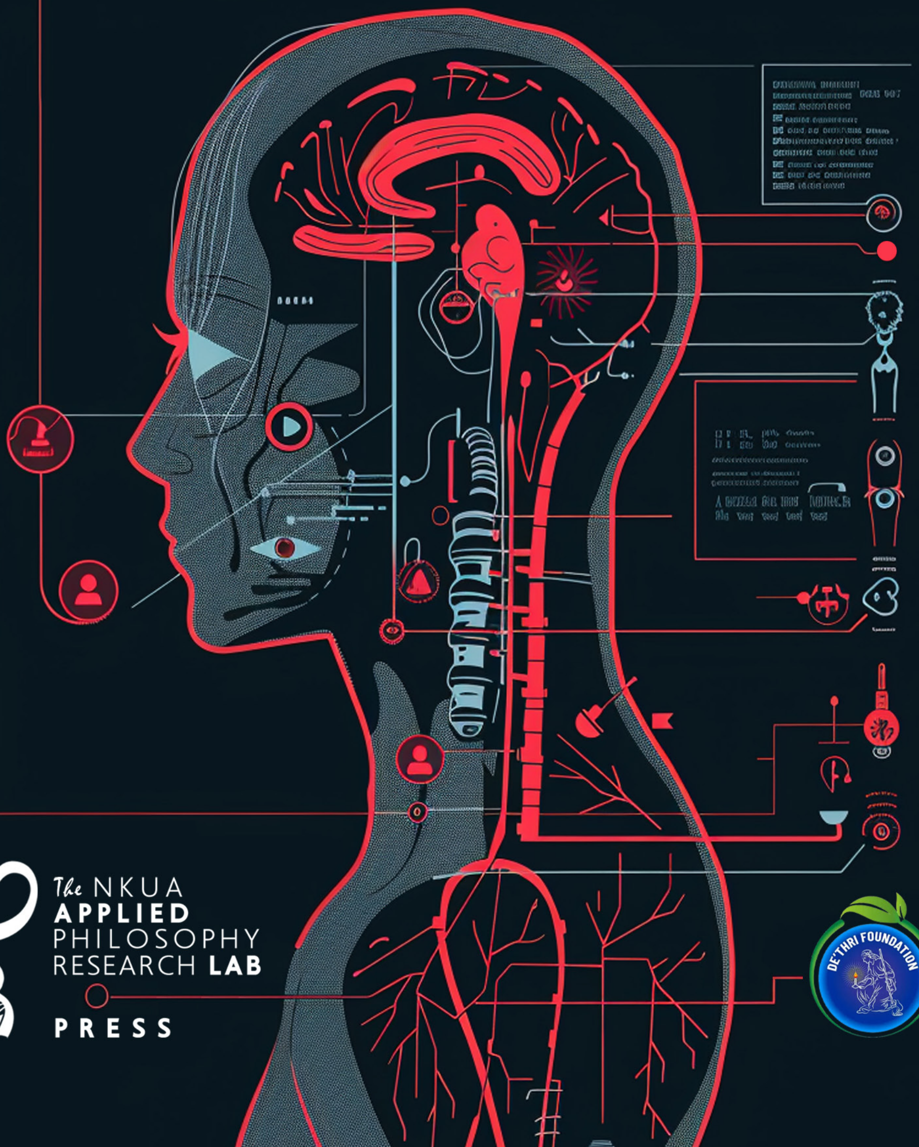
Bioethics in a plural world

Contemporary challenges in **medical** and **technological ethics**

Ioannis N. Ladas, *Editor*
Introduction by **Evangelos D. Protopapadakis**



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editorial

Intercultural bioethics in the algorithmic age

In March 2025, I had the blessing of visiting India at the invitation of His Eminence Archbishop Clemis Daniel Kourieh of Beirut, representing the Syriac Orthodox Patriarch of Antioch and All the East. His Eminence headed an official patriarchal delegation consisting of Archbishop Timotheos Matta Al-Khoury of Homs and Archbishop Boutros Kassis of Aleppo. The Patriarchal Delegation traveled to Kerala in order to participate in the enthronement and the formal conferral of the title of Catholicos upon His Beatitude Baselios Joseph, who succeeded Baselios Thomas I (1929–2024) as the new head of the Malankara Jacobite Syrian Orthodox Church.

The presence of a patriarchal delegation in India constituted a manifestation of ecclesiastical communion, historical continuity, and the unbroken bonds between the ancient Christian communities of India and their Mother Church, the Syriac Orthodox Patriarchate of Antioch and All the East, under the primacy of His Holiness Ignatius Aphrem II. The Malankara Jacobite Syrian Orthodox Church is among the oldest Christian communities, with roots tracing back to the Apostolic era, as tradition holds that it was founded by the Apostle Thomas in A.D. 52 (Knight, 2023; Jacob, 2015).

During the aforementioned visit and at the suggestion of His Eminence Archbishop Clemis Daniel Kourieh, I had the great privilege of visiting the Malankara Syrian Orthodox Theological Seminary, where I was warmly received by its president and Metropolitan, His Eminence Dr. Mor Theophilose Kuriakose, professor and Patriarchal Vicar of Europe. The Malankara Syrian Orthodox Theological Seminary in India embodies the revival of a long and venerable tradition of Syriac theological education, rooted in the legacy of the ancient schools of Edessa and Nisibis. Although the Syrian Orthodox Church experienced periods of decline in its scholastic life due to wars, persecution, and internal divisions, the vision of restoring advanced theological training never disappeared. In 1974, in response to the growing needs of a vibrant Malankara Syrian Orthodox communi-

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ty of 1.5 million believers and 700 parishes, the Church resolved to establish a theological institution to prepare candidates for the priesthood. The initial steps were taken in 1975 at Malecruz Dayara, where smaller seminaries were consolidated under the leadership of H.G. Yacob Mor Themotheos, with the institution then known as St. James Seminary. A decisive step came in 1985 when the Church, under Catholicos Baselios Poulose II, appointed Rev. Dr. Adai Jacob to lead the foundation of a major seminary with modern facilities. The new institution, renamed the Malankara Syrian Orthodox Theological Seminary, was inaugurated with the laying of the foundation stone on 1 January 1986. By 1990, the first phase of construction at Udayagiri near Mulanthuruthy was completed, and in February 1993 the new buildings were formally dedicated. In the same year, the Seminary achieved academic recognition through its affiliation with the Senate of Serampore College (University), Kolkata, thereby securing its position as the foremost center of theological education within the Malankara Syrian Orthodox tradition (Malankara Syrian Orthodox Theological Seminary, 2025).

During this meeting, I had the opportunity to engage with His Eminence Theophilose Kuriakose, as well as with the professors and students of the Seminary, in discussions on the contemporary challenges facing theological reflection in the field of bioethics and medical ethics. The conversation revealed the profound need for an interdisciplinary dialogue between traditional theological thought and contemporary bioethical issues, particularly within the Indian context, where diverse religious and philosophical traditions intersect.

It is a fact that nowadays humanity is called upon to address a variety of issues, including the maintenance of global peace, impoverishment, overpopulation, the food crisis, environmental issues, and generally problems related to health and quality of life. Consequently, the role of bioethics is deemed particularly significant, especially after the Covid-19 pandemic, which dramatically altered the existing perception of scientific and technological progress. This marked an unprecedent period in modern history as entire societies faced an "invisible enemy" that impacted every aspect of daily life (Nezhmetdinova et al., 2022).

The pandemic emerged at a time when the scientific community was primarily concerned with diseases related to genetic and hereditary factors, as well as neoplastic and degenerative diseases. With the advent of Covid-19, bioethical considerations were raised with unprecedented intensity, not as a result of rapid progress in biotechnology, as is often the case. The allocation of finite medical resources, such as ICU beds or vaccines, became a central issue. The principle of justice and its practical application became one of the fundamental dilemmas, and bioethicists were called upon to assess which criteria should guide decisions regarding access to healthcare. Additionally, the pandemic highlighted the need for transparency and accountability in government decisions, as public trust is directly affected by the ethical governance of health. Access to healthcare services, fair distribution of medical resources, protection of personal data, and management of medical uncertainty were just some of the issues raised and simultaneously became central points of discussion in bioethics.

The coronavirus pandemic, like any crisis, tested and challenged the established and entrenched ethics that we hold as a society (Nezhmetdinova et al., 2022). The content and principles of bioethics were questioned. Indeed, some were quick to claim that bioethics "failed" during the management of this unprecedented global health crisis (Ladas, 2023a). To evaluate this view, we must examine what happened during the pandemic, which suddenly and radically destroyed all existing ideas about the norm in both medical practice and society. In this article, we will explore the aforementioned claim, along with the unprecedented ethical dilemmas that emerged during the pandemic, and we will investigate the new role of bioethics in a post-pandemic society, where the existing perception of scientific and technological progress has dramatically changed.

A brief historical review will help us better understand the significance of bioethics and the new role it is called upon to play after the pandemic ends (Ladas, 2023). The scientific term "bioethics" is borrowed from the German term Bio-Ethik. This term of Greek origin appeared in its linguistic homeland a few years ago (Hatzinikolaou, 2015), does not have a plural form, and is compound, consisting of the words "bio" (life) and "ethics". The first component generally indicates that what the second component expresses is related to: 1. life, 2. living beings and their study (Babiniotis, 1998). Thus, from an initial reading of the word, the term "bioethics" signifies the ethics of life (Hatzinikolaou, 2015). Nowadays, bioethics is a branch of applied ethics that deals with ethical problems related to birth, life, and death, arising from the advancements in technology, biology, and medicine (Charalambakis, 1998).

According to H. T. Engelhardt Jr. (1941-2018), bioethics was founded to serve two purposes: one theoretical and one practical. The theoretical aim was to describe the correct ethical behavior for doctors, nurses, and biomedical scientists, while the practical aim was to create a kind of secular priesthood capable of providing advice in hospitals, medical schools, and research centers. To achieve these goals, a theoretical framework was initially defined that set the boundaries of proper action, followed by the development of a training program for individuals who would be capable of offering guidance (Koios, 2008).

Regarding the composition of the term, the Anglo-Saxon oncologist Van Rensselaer Potter (1911-2001) is commonly referred to by many researchers as the first to use it in his works *Bioethics: Science of Survival* (Potter, 1970) and *Bioethics: Bridge to the Future* (Potter, 1971). This is attributed to the fact that after Potter, the term was used in a broad sense, as rarely happens, and subsequently narrowed down as an evolution of Medical Ethics (Dragona-Monachu, 2002). Thus, the birth of the term "bioethics" is often incorrectly placed in the year 1970, as it actually predates this, appearing first in the late 1920s (Muzur & Rinčić, 2011). Specifically, the term first appeared in 1927 in an article by the Protestant pastor Fritz Jahr (1895-1953) titled *Bio-Ethik. Eine Umschau über die ethischen Beziehungen des Menschen zu Tier und Pflanze* [Bio-Ethics: A Review of the Ethical Relationships of Humans to Animals and Plants] (Jahr, 1927).

Both Jahr and Potter assigned different meanings to the term "bioethics" than what it signifies today. Jahr perceived bioethics "as the science that would substantiate the moral duties of humans not only towards their fellow humans but also towards all living beings and organisms, including animals and plants" (Protopapadakis, 2013). On the other hand, Potter, who envisioned an environmentally friendly ethos or lifestyle, "understood it as the science of survival in the ecological sense of the term, that is, as an interdisciplinary research aimed at ensuring the existence and well-being of the biosphere" (Kuhse & Singer, 2009). Potter sought to bridge natural sciences with Philosophical Ethics, but his endeavor had the character of an Ecological Ethics, while subsequently, bioethics in the German-speaking world came to be understood as Medical Ethics (Nikolaidis, 2006). It should be noted that from the 1940s to the 1960s, there was a significant shift in interest towards medical ethics and medical humanities studies (Engelhardt, 2017). The contemplation regarding the problems that bioethics would later examine appeared prominently on the international stage already from the Nuremberg Trials (1945-1946) and subsequent events, where the use of genetic technology, which promoted and served Nazi racism and was turned against human life, was repeatedly condemned. Moreover, certain principles of deontology concerning new medical research and the manner in which it should be conducted were formulated, known as The Nuremberg Code (Hatzinikolaou & Koios, 2015).

Bioethics matured over decades to attain its current content and now has a multidisciplinary philosophical background, situating it within a new branch of Moral Philosophy known as Applied Ethics (Dragona–Monachou, 1995). In other words, it can be argued that bioethics is a complex and multifaceted interdisciplinary field that, as a nascent interdisciplinary domain, has indistinct boundaries and is not fully crystallized (Dragona–Monachou, 2007). As Professor Myrto Dragona-Monachou aptly points out, "bioethics, as a normative ethical-practical discourse, as a decision-making process with a rational methodology and argumentative skill, is a relatively autonomous interdisciplinary branch but is also a theoretical evolution of practical or applied ethics aimed at safeguarding human rights and their fundamental principles, human autonomy, dignity, and moral equality, and advocates for the use of techno-scientific achievements for the good of humanity" (Dragona–Monachou, 2007). In this context, Professor Evangelos Protopapadakis clarifies that bioethics is called upon to examine, evaluate, and, if possible, respond to questions that until recently were considered either hypothetical or satisfactorily resolved but are now urgently posed (Protopapadakis, 2013).

The Covid-19 pandemic presented significant ethical challenges at many levels of our daily lives, in a particularly pressing manner. Within this context, issues emerged that affected personal freedom, the protection of personal data, working conditions, information management, the search for therapeutic solutions, and the relationship between humans and animals.

During the implementation of preventive measures, there were restrictions on the freedom of citizens, which is an inalienable constitutional right. Although the restriction of citizens' freedom can be justified for reasons of public safety and health, it was questioned whether this occurred in a proportional manner (risk/benefit) and if it was limited only to matters concerning the health and safety of the population. Simultaneously, the issue of violating international obligations or creating discriminations was raised (Nezhmetdinova et al., 2022). Moreover, the pandemic created ethical challenges concerning the disclosure of personal information. The issue of violating the right to confidentiality and privacy arose, and the digital monitoring of citizens provoked strong reactions.

Another challenging ethical issue arose from the extreme working conditions that threatened the lives of healthcare professionals and their loved ones. In addition to this, the issue of information dissemination must be addressed. For citizens to be fully informed, all actions must be conducted with active interaction. Moreover, the compliance of citizens with regulations and their trust in the measures are directly dependent on the outcome of this interaction (Nezhmetdinova et al., 2022).

On the other hand, limited resources and the lack of a protocol for handling the pandemic affected the entire medical staff, as healthcare workers faced tragic situations. The shortage of available medical staff, hospital beds, and necessary medical equipment necessitated the categorization and prioritization of patients to determine who would receive (or not) medical care, as well as what type of medical care and where. When demand exceeds supply, triage becomes necessary (Harter & Homan, 2020). Consequently, the overwhelming pressure on healthcare systems made absolute equality unfeasible, which might have required admitting patients based on a completely random selection, such as by drawing lots. The "first come, first served" principle based on arrival order does not ensure absolute equality as it is not entirely fair for patients who live far from hospitals or have difficulty accessing healthcare centers for socioeconomic and other reasons.

Who should receive treatment: a young uneducated person, a world-renowned scientist, or a personality who could potentially be useful to humanity in the future? How does one decide whom to provide treatment, artificial respiratory support, and whom to condemn to death (Harter & Homan, 2020)? Professor of Applied Ethics at the University of Athens, Evangelos Protopapadakis, commented on this, stating, "Currently in ICUs, the availability of beds is less than the demand. Whom will you choose and how will you do it fairly? For example, you have a 90-year-old and a 20-year-old. Both require ICU care, and you have only one available bed. Will you allocate it to the 90-year-old who will occupy the bed for a month and ultimately may pass away, or will you allocate it to the 20-year-old who might recover more quickly and whose bed could then be used by four other patients? And which choice is fair when the 90-year-old has contributed through his work to the existence of this bed, whereas the 20-year-old has not (Protopapadakis, 2013)?"

One of the primary bioethical dilemmas presented was the discord between public health ethics, characterized by the fair distribution of limited resources, and clinical ethics, which focuses specifically on the individual patient. Clinicians adept at providing individualized patient care at the bedside are increasingly being redirected to view the collective public as their primary responsibility. This shift has necessitated an adaptation in the clinical ethics traditionally practiced by these professionals, now shaped by a public health ethics framework influenced by the ongoing global pandemic (Dunham, 2020).

Healthcare professionals acted according to the "principle of salvation," aiming to assist all patients using all available means (Harter & Homan, 2020). Clearly, the moral duty of a doctor is to try to save all patients; however, during a war or a pandemic, this principle cannot function, and medical staff are guided by other principles, whose moral validity is questioned (Nezhmetdinova et al., 2022). In this context, in April 2020, the Bioethics Committee of the Council of Europe stated that access to healthcare must be fair, regardless of limited resources. According to the Committee, we should not succumb to the panic caused by the Covid-19 pandemic and reject fundamental bioethical principles, as only through maintaining a doctor-patient relationship and a commitment to society as a whole can we ensure that the heroic efforts of healthcare professionals are not wasted and that the ethical integrity of those involved is preserved (Haseltine, 2020).

In every case, discussions about providing medical care involve numerous bioethical questions. The medical profession is an ethical business, which must adhere to all four principles of bioethics: autonomy, justice, beneficence, and nonmaleficence. These principles must be upheld by ensuring clear communication about the patient's needs and desires, whether under normal circumstances or during exceptional conditions (Seth, 2020; ten Have, 2022). During the pandemic, however, governments of many countries introduced medical and social protocols that made radical choices in intensive care units and postponed the provision of certain medical services (e.g., scheduled surgeries) that could be performed at a later time (Melidis & Vantsos, 2020; Sándor, 2020). This practice, however, has faced philosophical challenge. For example, one of the most famous ethical dilemmas articulated by British philosopher Philippa Foot (1920-2010) describes a train heading towards five people tied to the tracks (Foot, 1967). By changing the direction of the tracks, one could direct the train onto another track, thereby saving these five people. However, the train would kill one person who is also tied to the tracks of the other line. How should one act in this case? If the decision-making process is based solely on the outcome of a choice, many might consider it justified to sacrifice one human life to save five others. However, should we not also consider other values when reflecting on the above philosophical dilemma or when faced with similar ethical dilemmas in real life (Nezhmetdinova et al., 2022)?

At the height of the discussion of the aforementioned ethical dilemmas, the search for an effective vaccine to address the pandemic opened up additional bioethical issues, from the need to accelerate clinical research and the universal application of vaccination to related certificates and "green passports" (Nezhmetdinova et al., 2022). Key points of debate included the mandatory nature of vaccination and the distribution of vaccines. In this context, the role of individual and social responsibility emerged, as the purpose of vaccination, besides creating immunity at an individual level, was to establish "herd immunity" to prevent further spread of the virus within the community, which constitutes a public good (Voultsos, 2021-2022).

Indeed, it should be noted that during the pandemic, there were bioethical issues concerning the relationship between humans and animals. For example, the culling of hundreds of minks raised questions, and many wondered whether they were euthanized because they would suffer or because there was a chance the virus could be transmitted to humans. Furthermore, the trade in wild animals also raised dilemmas. In fact, one of the theories about the origin of the pandemic is that it stemmed from illegal forms of wild animal trade in China (Ortiz-Millán, 2022).

The Covid-19 pandemic posed the greatest threat to global public health in the 21st century: healthcare systems appeared unprepared to immediately confront the global health crisis, doctors faced unprecedented ethical dilemmas along with an overwhelming workload, newborns were separated from their mothers, patients died in isolation, social events were suspended or held with limited attendance, and the psychological state of citizens was severely affected. The swift progression of the COVID pandemic caused confusion among bioethicists, philosophers of global justice, and scholars analyzing global structures. It became clear that the spread of deadly infections vividly demonstrates the interconnectedness of all humans worldwide. Although globalization is primarily viewed through the lenses of trade, finance, or potentially cultural conflicts, the person-to-person transmission of a virus across international borders tangibly shows our global interdependence. This evident vulnerability highlights how interconnectedness not only facilitates the spread of immediate harms but also promotes positive outcomes such as faster travel, idea exchange, enhanced economic growth, and poverty reduction (Gavin & Brands, 2020). This situation emphasizes the importance of global bioethics, as truly global bioethics involves cooperation and collaboration among countries. Unfortunately, most research published in bioethics journals addresses a problem existing in one or more countries, but the articles typically do not discuss solutions that require collaboration or cooperation (Macklin, 2020).

The conditions that have taken shape have generally given rise to new ethical concerns, primarily because what always emerges when public health is threatened is a conflict between our personal autonomy and the protection of others, as their lives and health depend on our individual actions and choices (Vidalis, 2020). In times of disaster, individual survival is intricately linked to collective survival, and individual protective measures rely on cohesive collective actions. During events like pandemics or natural disasters, no individual can secure protection entirely on their own. Every protective or preventive measure requires a communal strategy, even if this approach necessitates some limitations on individual freedoms, particularly when such freedoms pose a threat to the collective well-being (Lin, 2020).

The lack of a predefined framework for managing the pandemic shook citizens' trust in bioethics, and misinformation combined with fake news led to a temporary questioning of the role and mission of bioethicists. Additionally, the Covid-19 pandemic shifted the bioethical focus towards "lifeboat ethics," which concerns the rationing and equitable distribution of limited medical resources, including testing facilities, ICU beds, and ventilators. This shift has redirected attention away from enduring and systemic issues, particularly the structural injustices that lead to health disparities among marginalized communities of color (Churchill et al., 2020).

Ultimately, the pandemic has highlighted a new role for bioethics, as it has underscored its importance and mission and has strengthened it both theoretically and practically. Bioethics is now prepared to address urgent situations, namely states of "exception." It is crucial to acknowledge the significant theoretical work conducted during this period, as numerous discussions took place regarding the principles that should guide decision-making and the allocation of limited resources (Dunham et al., 2020). Many European countries rushed to issue guidelines, which vary among themselves and are of particular interest both individually and in comparison. Thus, the related discussion will continue to evolve for a considerable period. Indeed, returning to "normal" or to a "new normal" also entails risks. For bioethicists, this terminology should raise serious concerns. Normal life has been consistently and unjustly detrimental to the health of many individuals for an extended period. All health issues are influenced by various factors including funding priorities, socioeconomic disparities, health insurance, policies impacting employment and education, the availability (or absence) of public and social services, and the lack of access to services and professionals that support medical care (Churchill et al., 2020).

In any case, the Covid-19 pandemic revealed the importance of bioethics in urgent situations, which indeed must be addressed at an international level. Additionally, the significance of the principles of Christian bioethics was highlighted, especially its greatest contribution: the teaching of Christian love. According to this principle, we should love our neighbor as ourselves, which implies that this principle transcends the concepts of cooperation and collective responsibility. As Professor Miltiadis Vantsos rightly points out, although these are undoubtedly accepted, they still remain subject to reciprocity and self-interest (Vantsos, 2021).

The new role of bioethics offers guiding principles, approaches, and frameworks for addressing ethical dilemmas in decision-making that impact the health and well-being of the population. The management of the pandemic and the ethical issues that arose during its course highlighted, promoted, and updated the role and mission of bioethics. It also made clear that the contribution of bioethicists is essential for proper crisis management and sound decision-making. Bioethicists can now contribute directly and effectively to the assessment of deontological challenges arising from the allocation of limited resources (vaccines, patient care) and to the evaluation of challenges related to the protection of individual rights and privacy in the post-pandemic society. Consequently, bioethicists have emerged stronger in their ability to: 1. analyze ethical concepts and proposals, 2. assess the correctness or at least the validity of arguments, 3. present the spectrum of possible approaches and perspectives on specific issues, 4. mediate conflicts among doctors, nurses, patients, patient families, and other stakeholders regarding choices in a clinical context, 5. provide advice to hospitals regarding clinical choices, 6. promote new perspectives on which clinical or policy choice is ethically correct, 7. serve, as social experts, the principle related to the appropriate choices in protecting health and biomedical sciences (Engelhardt, 2003; Engelhardt, 2011).

The invitation of His Eminence Archbishop Clemis Daniel Kourieh of Beirut, the visit to the Malankara Syrian Orthodox Theological Seminary and the encounter with His Eminence Theophilose Kuriakose proved to be a pivotal moment for the idea of promoting bioethics and medical ethics in India in a manner that respects and incorporates the country's rich cultural and religious heritage. Thus, when Mr. Sujith Varghese George and Ms. Sherin Sujith Varghese, founders of the *Drahma Eastern Theological and Historical Research Institute* (DE'THRI), proposed the organization of a conference entitled *Conference on Jaivnaithaktha* (Bioethics in Sanskrit), I was deeply enthusiastic about the initiative. The use of the term *Jaivnaithaktha* was not incidental; it symbolized an effort to localize bioethical principles within India's profound philosophical and religious traditions. For this reason, the conference brought together distinguished scholars, theologians, and physicians from various countries, who contributed to the development of a fruitful dialogue on contemporary bioethical dilemmas. Moreover, it reinforced my conviction that the bioethics of the future must be intercultural and interreligious, drawing upon the wisdom of diverse traditions in order to address the common challenges posed by modern medical technology and research.

The present edited volume is the fruit of the conference that took place on 16-17 May 2025 at the Dr Mar Theophilus Institute of Management Studies in Navi Mumbai. It consists of twenty-three articles by distinguished professors and scholars. The contributing authors come from different fields and enter into dialogue around shared questions: How is bioethics to be understood in a pluralistic world in which medical practice, technology and religious traditions interpenetrate one another? How are the notions of the person and of the "image of God" to be defined when human beings are called to think of artificial intelligence not only as a tool but also as an interlocutor in their moral and theological self-understanding? On what terms can a fruitful dialogue be constituted among different religious traditions? What does "bioethics in clinical everyday practice" mean in concrete terms in settings marked by stark inequalities of resources, such as the health-care systems of India, and how are notions such as consent, responsibility and justice transformed when medical practice is exercised at the limits of what is possible and feasible? In what way can ancient wisdom, religious traditions and contemporary science not merely coexist but jointly reshape medical education and clinical practice, so that bioethics in a pluralistic world may function not only as a normative framework but also as a school for the formation of ethos and responsibility?

Against the background of the foregoing questions, the present edited volume is now being made available to the public as the fruit of an endeavour that is not only academic but also profoundly cultural. The Indian subcontinent, as the cradle of four of the world's most significant religions—Buddhism, Hinduism, Jainism and Sikhism—often referred to as the native Indian or Dharmic religions and together representing roughly 83% of India's population, offers a unique laboratory for the development of an intercultural and interreligious bioethics. According to the 2011 census, 79.8% of India's population adhere to Hinduism, 14.2% to Islam, 2.3% to Christianity, 1.7% to Sikhism, 0.7% to Buddhism and 0.4% to Jainism; these quantitative data are not merely statistics, but point to the intensity and complexity of the religious pluralism within which bioethical discourse is called to be articulated.

This volume seeks, in my view, to give voice precisely to this polyphony, offering the reader texts that enter into conversation with the great religious traditions of India, with the Christian theological heritage, as well as with contemporary scientific and technological developments. With deep gratitude to all the authors and institutions that have supported this endeavour, we now present this collective volume to the scholarly community and to the wider reading public, in the hope that it will contribute, at least in part, to the shaping of a global intercultural bioethics capable of proving equal to the challenges and hopes of a pluralistic world.

Ioannis N. Ladas
Editor

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introduction

Evangelos D. Protopapadakis*

What do we need Bioethics for?

When I finished my doctoral dissertation in Bioethics fifteen years ago it was more than often that I had to explain to obviously surprised people what Bioethics is. Moreover, each time I had to explain that I am neither a physician nor a biologist, but an ethicist. Nowadays I am asked only scarcely – to be frank, it's been years since the last time. You see, Bioethics now is an absolutely established field in the academic world, but more importantly it has earned its reputation among people as a *conditio sine qua non* occupation for everybody involved in the so-called life sciences; as for ethics, Bioethics has been something like a fresh, revitalizing breeze: the most interesting debates in the field – and also the most intense – almost exclusively regard bioethical issues.

People choose what to occupy their minds with out of either playfulness or necessity – that is, either because something attracts the thought as irresistibly charming, or because real life necessitates dealing with it. Sometimes, not very often, charm and necessity coincide, and their matching produces miraculously rich debates – this is the case of Bioethics. In this short essay I will try to provide a brief outline of my grasp of Bioethics, while at the same time I aspire to convey a little of the charm Bioethics exerts on anyone who happens to deal with it.

The rapid advances in the so-called life sciences – medicine, biomedicine, biotechnology, pharmacology, genetics, biology – and the corresponding technological achievements seem to be producing – with exponentially increasing speed – a new, brave world, a world where mankind enjoys unprecedent possibilities to control the *event of life* from *before dawn* to *even after dusk*, and also almost all the intermediate phases. The more tangible this new world

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gets, the more threatening appear the potential dangers related to the undeniable and almost exotic benefits this new reality promises; novel risks inherent to – the equally novel – options that are available to us now, but also risks we have already dealt with in the past, but nowadays have become either more edgy, or even have taken a completely different form than the one they used to have. Beyond and above this, this new era of biotechnology strongly challenges the concepts and value systems by means of which we till now used to perceive ourselves and shape our relationship to other people: life has long ceased to be perceived as an event of *emergence*; now it can be designed and produced – from *miracle* it has been turned into an *achievement*. Death, on the other hand, still maintains enough of the mystery by which it has always been surrounded, though its hegemony lately is being strongly challenged and its sovereignty seems no more immune and unshakeable – due to science and technology life nowadays may be extended beyond what half a century earlier was considered as its natural span. Next to these, behavior, moral choice and character, until now exclusively dependent on the gene-set we are endowed with and the environment we may find ourselves in, now seem to be susceptible to alterations inflicted by means of genetic engineering on the one hand, and by interfering with our chemical equilibrium on the other. In the light of all these, our concepts sometimes seem inadequate and our value systems obsolete.

The setting we now need to place our lives in is a totally new one, unlike any other we have ever known in the past – it is of *a different kind*. And, exactly as everything totally new, this new setting cannot help looking a bit messy and also full of traps; it definitely requires proper arrangement, so as to allow the hopes to appear as magnificent realities in the foreground and cast away the dangers that silently lurk in the shadows. This is the mission of Bioethics: to understand, arrange, and optimize this new world. This is the first time in the history of mankind that man demands full control over technological progress, and this no doubt is an improvement: so far, we first used the fruits of technology and only then discussed whether they should be available or not. In this sense, the establishment of Bioethics is a tangible proof of the increasing moral maturity of our species.

Is it possible for Bioethics to succeed in its task? Of course it is, though not that easy. In order to achieve its goals, Bioethics needs before everything else to remain true to itself, to its initial design and very essence. In other words, it needs on the one hand avoid becoming an *exclusively* moral debate, while on the other it must remain a *primarily* moral one. By its nature, you see, Bioethics is a point of osmosis and cooperation for a variety of disciplines, that are all necessary to its purposes: Bioethics needs medicine as it needs biology, genetics and pharmacology, law and theology, sociology and ethics. If any of these fields is excluded or lagging behind, the work of Bioethics will become impossible. How may, for example, any legalist – but also any moral philosopher – discuss the issue of euthanasia without a documented definition of death? Should we entrust to the clergy to decide whether patients in permanent vegetative state are living beings or not? How can we discuss human reproductive cloning without first being informed by biologists and geneticists on whether cloning actually has the power to create identical copies of an already existing human being? Bioethics was designed from the outset to be an interdisciplinary field, and only as such it may be useful and produce results. However, as much as it is of paramount importance that Bioethics remains a par excellence interdisciplinary field, it is equally significant that one should always bear in mind that Bioethics is primarily and above all Ethics. This is because as far as Bioethics is concerned the main question each time, maybe *the only* real question, always is whether something *ought to* be pursued and implemented or not. This, however, is the par excellence moral question, one that asks us to choose among alternatives on a sound moral rationale, to make a moral decision on no other basis than on assessing the particular moral value of each of the available options.

Brave new worlds need well-engineered navigation instruments – this is, of course, if one wishes not to trust his destiny only to fate. Our species many times in the past – even better, *all* the times – never missed a single chance to show immensely unprecedent recklessness, which became the cause of some of the bleakest moments in our history. It is only hopeful that today we seem firm in our decision to schedule our own course through this labyrinth of exotic achievements, high promises and impossible hazards trusting the best compass we have in our possession, Bioethics.

Part I

Religious and theological approaches to bioethics

Arul Dhas T*

Impact of religious literature on bioethical decisions

Abstract

This paper examines how sacred writings from major world religions shape bioethical decision-making and moral behavior in healthcare. It argues that the core principles of bioethics—beneficence, non-maleficence, autonomy, and justice—are deeply rooted in religious teachings found in texts such as the Bible, the Qur'an, the Vedas, and the Dhammapada. Through examples including the beginning of life, blood transfusions, human dignity, and end-of-life attitudes, the study demonstrates how scriptural values inform ethical reasoning. It also addresses the challenges of pluralism and diverse interpretations in applying religious teachings to modern healthcare. Despite these complexities, the paper concludes that sacred texts continue to offer a moral compass for ethical practice, emphasizing compassion, respect, and justice in pluralistic healthcare settings.

Keywords: Bioethics, justice, moral values, interreligious dialogue

Introduction

Bioethics is a discipline which focuses on human conduct and behaviour in the light of moral values. In a society, it is essential to trace the aspects of society and life which result in sound ethical behaviour. In the domain of health, the discipline of bioethics has grown exponentially due to the immense need. Traditionally, health and healthcare have been considered an area of noble discipline, and those who were involved were considered so great and noble since they exemplified the divine. We will agree that the health-related issues are so important since these issues decide life and death.

Being ethical is so important. The discipline of ethics highlights what are the qualities of a decision which is taken ethically. Benefi-

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cence, non-maleficence, respect for autonomy, and justice are some important aspects of ethics. We may ask a question: what are the things that influence ethical conduct? One's upbringing, family values, societal norms, religion or faith traditions, and culture in general would have an influence on ethical thinking and decision-making. In this paper, we will search for the links and influences between religious literature and bioethical decisions.

Values and ethics

There are so many values which are respected well in society, and every culture has salient values to its credit. Many values are religious in nature. Values lead to a particular behaviour. Values are often caught rather than taught. Each one may hold different values so highly which guide him/her towards a particular action.

A conversation about ethics comes into the picture when a specific situation involves various values to be considered. Sometimes the values can even be conflicting. An ethical decision is made in consideration of the context, the factors in front of us and beyond us. There are different stakeholders involved in making a sound ethical decision. In bioethical discussions, we hold Beneficence, Non-maleficence, Autonomy/Respect, and Justice as core values, and the possible impact the decision taken will have on the persons concerned.

In this paper, I would like to concentrate on the role of religious literature in bioethical decision-making. When we say religious literature, we are not referring to any spiritual/religious writing of a religion. Rather, we refer to the official or canonized writings of a religion, which are used for public reading, memorizing, meditating, teaching, etc. We are also aware that some religions have oral traditions stronger than written traditions. In such situations, it will be difficult to pursue this search, yet not impossible.

Major religions and their significant scriptures / religious texts

We are enlisting the following twelve religions and their scriptures. This is not a comprehensive list, yet we start our enquiry with this list. In these religions, there may be other religious texts which are in use. However, we have listed out only the important and primary ones here.

1.Christianity
Bible – Old Testament and New Testament
2. Hinduism
Vedas (Rigveda, Yajurveda, Samaveda, Atharvaveda)
Upanishads (philosophical texts expanding on the Vedas)
3. Islam
Qur’an
2. Buddhism
Tripiṭaka (Pali Canon) – includes Vinaya, Sutta, and Abhidhamma Pitaka
Mahayana Sutras (e.g., *Lotus Sutra*, *Heart Sutra*)
3. Jainism
Agamas (canonical teachings of Mahavira)
4. Sikhism
Guru Granth Sahib
5. Judaism
Tanakh (Hebrew Bible) – includes Torah, Prophets, and Writings
Talmud (rabbinical commentaries on the Torah)
8. Bahá’í Faith
Kitáb-i-Aqdas (The Most Holy Book)
Kitáb-i-Íqán (The Book of Certitude)
9. Zoroastrianism
Avesta
10. Confucianism
Four Books (Analects, Mencius, The Great Learning, and The Doctrine of the Mean)
Five Classics (Book of Odes, Book of Documents, I Ching (Book of Changes), Book of Rites, and the Spring and Autumn Annals)
11. Taoism (Daoism)
Tao Te Ching
Zhuangzi
12. Shinto

Kojiki (Records of Ancient Matters)
Nihon Shoki (Chronicles of Japan)

These religious texts/Scriptures are so valuable to their adherents. Some consider them as dictated by the divine, some as inspired by the divine and others as written/spoken by their religious leader/the representative of the divine. All of them consider their scriptures to have a clear defining impact on the life and conduct of the followers of that religion.

Role of religion in the making of ethical values in society

How ethical values are formed in any society is a great matter of interest. Different factors play an influential role in value formation. In a traditional society, elders function as guides to the younger generation. As people grow in numbers, different mechanisms are needed to keep the society in a particular conduct or behaviour.

Elsayed, K. G., Lestari, A. A., and Brougham, F. A. (2023), in their study, found "that young people who are actively involved in religious communities are more likely to exhibit prosocial behaviour, such as volunteerism, empathy, and moral reasoning, than those who are not involved in religious communities". In most religious communities, the sacred texts play a pivotal role in determining the religious customs, norms and duties. Rewards and punishments are also determined by the religious texts.

Ethical thinking and considerations are handled with the scrutiny of different domains in life. From the beginning of human history, we see clear attempts to include ethical aspects in the general life situation. We see the Code of Hammurabi (c. 1754 B.C) indicating the way a physician should behave. The ethical codes prescribed in the Old Testament guide the modern healthcare professional to respect life, uphold human dignity, and care for the vulnerable. The guidance given in Bhagavad Gita has helped its adherents to fulfil his/her responsibilities with the sense of duty.

Language is a special privilege of human race. People from one geographical area share a language. Communicating through language has its own advantages. Yet, it is not without difficulties. We are aware of the limitations of languages. Language can communicate only some parts of whatever is to be communicated.

Challenges regarding religious literature

We are not unaware of the issues with regard to the sacred scriptures themselves. We want to highlight few challenges which a religious person faces in applying the scripture in different contexts of lives. I would like to divide this into five sections of the scripture: formation, transmission, exegesis, interpretation, and application.

Formation: In any human society, religion emerges as a way of life. It brings out acceptable ways of behaviour and conduct in private and public. Many societies formulate written texts to stabilise the teachings and guidelines in a religious setting. Even in those days when printing had not been invented, we see the formation of written religious texts in different civilisations in various formats. We need to point out that there is an interplay of power in finalising whether a particular text can be included as an official religious text or not (canon). In some traditions, written texts are not given much importance. Religious rules are passed on in oral traditions. Being aware of these dynamics will help us determine the meaning and implications of religious texts in a specific culture.

Transmission: When we want to determine the authority of a religious text in the life of a society, we need to understand how these texts are passed on from one generation to another. Before printing, copying of the texts was done with whatever means available, with utmost care and respect. In most societies, religious texts are given more respect than other texts in general.

When it has to be translated into various languages, the translators are assigned to accomplish the task religiously. We do recognize the possibility of changes from the original writing at this level. It could be intentional or inadvertent.

Exegesis: When a religious text is brought to a community or individual, there is a process of exegesis. This is an attempt to determine and bring out the meaning of the text. It might involve grammatical, literary and textual discussions. At this stage, there is no interpretation as such, only establishing who said what, etc.

There is a possibility that the meaning of the text is taken differently from the original context.

Interpretation: Interpretation of the scriptures or hermeneutics is an organised discipline which pays attention to the accuracy and originality of the religious writing, the cultural and intellectual background of the writers and readers. The interplay of the text and the context, along with the sender and recipient, brings the best meaning and the impact.

When an established religious text is used in a particular context, the user may adopt different methods of interpretation. Literal, allegorical, moral, and anagogical interpretations are some of them. It is possible that the user comes to significantly varied conclusions and applications based on the type of interpretation he or she uses. Therefore, it is even more important to discern which type of interpretation is appropriate, essential and the best in the context. A certain amount of consensus from the religious community in this aspect is essential. Because deviant interpretations can cause a lot of damage to the community and its well-being and harmony. We, human beings, have an extraordinary capacity to justify our ethical stand from the religious point of view. We use our arguments to justify our stance. This actually helps in some situations and is detrimental in others.

Application: In any religious context, the sacred text is interpreted by the believers or adherents and then applied in life. Application is a consequential part after interpretation. This results in specific conduct and behaviour. Some devout people take the rescue of compartmentalization between their lives and their faith/religion, thereby disallowing the scripture to influence their life and behaviour.

It is sobering to note that the sacred scriptures need to cross over various challenges to become influential in the human ethical conduct. In spite of this fact, the sacred scripture has a deep impact on the ethical conduct of human beings.

Religious underpinnings of the pillars of bioethics

Normally, it is agreed that Beneficence, Non-maleficence, Autonomy/Respect and Justice are the four pillars of bioethics. If one looks at these closely, it is unavoidable to miss the links with the religious texts of those days. For example, the Golden Rule, "Do unto others as you would have them do to you" (Matthew 7.12) has been central to the thinking of the people when it came to help others. Various religious texts on respecting others and human dignity, justice and fairness can be quoted in the Christian faith traditions.

Tirukkural and Naaladiyaar are two important writings from the early second and third centuries which have significant sections on the ethical life of society (Naaladiyaar, Trans. G. U. Pope, 1963). These writings of sages have shaped the ethical conduct of society significantly, particularly in South India.

Sometimes, there is a tendency to think of the four pillars of bioethics as some secular entities, as if they had no link with the religious life of the community. Here, I would like to look at the four pillars of bioethics to see the link they have with the religious scriptures.

1. Non-maleficence ("Do No Harm"). The burden of the Christian scripture passages like Exodus 20:13 "You shall not murder" or Romans 13:10 "Love does no wrong to a neighbor" are underneath the principle 'Non-maleficence'. The Hindu scripture Mahabharata 13.117.37 reads as "Non-violence is the highest virtue". The Buddhist Dhammapada (v.129) mentions "All tremble at violence; all fear death". These scriptures from different religions emphasise the point of non-maleficence. Once a Buddhist physician, quoting the religious principle of ahimsa, refused to participate in euthanasia. Instead, she used palliative care to reduce pain without intentionally ending life.

2. Beneficence ("Do Good"). For Christian healthcare professionals, the parable of the Good Samaritan (Luke 10:25-37) functions as a solid model for their daily professional context to do good beyond boundaries. *Surah al-Māʼidah* 5:32 of the Quran says, "Whoever saves one life—it is as if he had saved all mankind". The *Tirukkural* states, "The life of those who help the helpless is the true life" (Kural, 212). During the recent COVID 19 pandemic, many religious persons went out of the way, even risking their lives, to do good to others in pain and suffering.

3. Autonomy ("Respect for the Person"). In the Jewish scriptures, there are many instances where God is explaining to human beings the positive and negative effects of following the instructions. However, the freedom is given to them to choose. In the Bhagavad Gita, Krishna told Arjuna "Reflect upon this fully, and then act as you wish" (BG 18:63). Surah al-Baqarah 2:256 from Quran states "There is no compulsion in religion". On religious grounds, there have been many patients who refused to receive blood transfusions. However, knowing the need to uphold the principle of autonomy, the healthcare team, in many occasions, has accepted their denial, respecting the informed choice of the patient.

4. Justice ("Fairness and Equity"). Jewish Scripture Micah 6:8 makes 'doing justice' as one definite requirement from God. Surah an-Nisa 4:135 reads "stand out firmly for justice, even against yourselves". Confucian ethics value righteousness and fairness in social relationships highly. Many hospitals have adopted a well-articulated triage policy to ensure justice is offered in healthcare delivery.

Specific situations in bioethical settings

In the clinical setting in India, we have people coming from Hindu, Islamic, Jain, Sikh, Buddhist, Christian and Baha'i traditions. Occasionally, we do have patients from African religions and Chinese religions. Some of the religions have smaller sects which have distinct faith positions which may vary from the dominant groups. At this point, we should also remember that all religions may not have equal importance for the written traditions. Some of the religions may have stronger components of oral traditions.

We would like to look at some specific healthcare situations where ethical principles are followed based on the scriptural inspirations.

1. Decisions pertaining to the beginning of life: Healthcare is related to aspects from birth to death and beyond. With regard to the beginning of life, a question is often raised about the time when life begins. Abortion is a major issue which is determined by the religious values people hold. According to the Bible, the existence of a being starts from the time of conception (Psalm 139:13-16).

According to Islamic faith, the soul enters the fetus at about 120 days (4 months) (Rabbi Allan S Maller, 2019).

According to the Garbha Upanishad, the soul enters the embryo at the time of conception, the embryo gets jiva in the seventh month, and it becomes complete in the eighth month. In many religious traditions, the time of the soul entering the body is a matter of dispute. When should an embryo be considered a person? These decisions are indicated in some religions clearly and adhered to while taking ethical decisions pertaining to the beginning of life.

The stance of both the patients, relatives, and healthcare personnel is shaped by their religious texts, which they hold very highly. For example, abortion is strongly discouraged in the Baha'i faith (which was founded in the late 19th century and early 20th century), since the soul is present from conception. The embryo/fetus should be treated with respect, regardless how young it is. Their main religious text is The Book of Certitude, composed by Baha'u'llah in 1861.

2. Use of blood in medical/surgical indications: Bible references used by Jehovah's Witnesses are the following:

- **Acts 15:28-29**: "You abstain from what has been sacrificed to idols and from blood and from what is strangled and from fornication. If you keep yourselves from these, you will be well".
- **Leviticus 17:10**: "If anyone of the house of Israel or of the aliens who reside among them eats any blood, I will set my face against that person who eats blood, and will cut that person off from the people".
- **Deuteronomy 12:23**: "Only be sure that you do not eat the blood; for the blood is the life and you shall not eat the life with the meat."

Jehovah's Witnesses reject blood transfusions on religious grounds (D. Costanzo, 2020). The healthcare professionals honour their wish even though they don't feel it is in the best interest of the patient.

3. Human Dignity: According to Judaism and Christianity, human beings are created in the image of God (Genesis 1:26). When this religious literature is interpreted and applied in the context of different health situations, there is a high value given to human beings. This value does not change because of health conditions, socio-economic conditions, or even moral conditions. Therefore, in the healthcare setting, irrespective of gender, class, caste, etc, a human being is given high dignity because a human being is understood to be created in God's image.

The Deuteronomic Code describes in detail how people should be respected in society (7th century BCE) (Deuteronomy 16:18-20). This has influenced those from Abrahamic religions to have basic human respect in bioethical decisions.

4. Attitude towards death: Scriptural references regarding death play a major role in different religions when making decisions regarding death. In Christianity, for example, it is clearly indicated that no one has 'power over the day of death' (Ecclesiastes 8:8); at the same time, there is a clear hope of resurrection (1 Corinthians 15:54). Therefore, we see polarised views on death-related decisions in Christianity.

In Buddhism, death is understood as something natural. This understanding helps one to turn away from suffering and towards the path of purification.

According to Buddhism death should not be seen as an enemy, rather as a natural process (S. Rinpoche, 2002). Therefore, the dynamic balance about death is maintained by many religious persons with the help of their religious texts.

5. Sacrificial service: During the COVID – 19 period, 2 Timothy 1:7 is one verse from the Bible which inspired many Christian healthcare personnel to care for the people courageously. "God did not give a spirit of cowardice, but rather a spirit of power and of love and of self-discipline". We saw so many Muslim volunteers (from Tamil Nadu Muslim Munnetra Kazhagam TMMK) come forward to give a dignified burial to those who died of COVID 19. We noticed that Islamic scriptures asking them to help those in need have inspired them (Surah Al-Insan 76:8–9). "They performed the last rites as per the wishes and customs of the families of the dead" (Times of India, 2021).

6. Healthcare Research: Stem cell research has a powerful example for our discussion. Usage of embryonic stem cells is prohibited for research for faith reasons. It is a powerful example for the influence of religious literature on bioethical decisions. In so many countries, we are able to see this influence.

Challenges in application of religious texts

1. Religious pluralism: There are many challenges in applying religious literature as a determinant of ethical decision making. One context which has to be kept in mind is the aspect of religious pluralism. We practice healthcare ethics in the midst of multiple religions. Various stakeholders in the healthcare may be adherents/followers of different religions. In such a context, how to be respectful to each other is an important consideration.

2. Multiple stakeholders: When a bioethical decision has to be taken, whose religious faith takes precedence? Patient's faith or Caregiver's faith?

3. Multiple interpretations: It is possible that people hold opposing views on bioethical matters even if they are from the same religion. The possibility of variations in the interpretation of the religious texts is definitely a challenge in this aspect.

Conclusion

Religious literatures play a significant role in shaping the conduct of the society. Even though they are varied, there are many common threads of ethical stand emerging. Irrespective of the religion, each text goes through different stages like formation, transmission, exegesis, interpretation and application. They also have the challenges of misinterpretation, interpretation with biases and the lack of standardisation in interpretation. We have highlighted the link between religious texts and some bioethical contexts like beginning of life, use of blood in medical/surgical indications, human dignity, attitude towards death, sacrificial service and healthcare research.

When we see the powerful impact of religious texts in the bioethical standpoints, the need for awareness, sensitivity and respectful conduct becomes very clear. All the stakeholders of healthcare need to be aware of the prevalent religious backgrounds and learn to be sensitive and respectful towards others' religious standpoints.

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Borche Grambozov*

The presence of God’s image in humankind and its absence in the gift of technology: A theological and ethical approach

Abstract

This article analyzes the issue of free choice (theology) and decision, responsibility, and consequences (ethics), relating them and placing decision at the core of this unity, according to Orthodox Christian theology and, more generally, to the Holy Bible. It holds that the hermeneutical principle of Orthodox Christian theology must be taken into account, according to which the Holy Bible records the history of humanity and civilization in a parabolic manner, using images drawn from natural reality. We argue that software cannot assume personal decision, responsibility, or consequences. In contrast to presuppositional software, human decision operates in non-predictable terms, determined by the way the world as a whole is at a specific moment. For example, a button may lead to a nuclear war; the software governing how the missiles will operate is ready, but the button is pressed by the human being.

Keywords: Image and likeness of God, free choice, decision, responsibility, reason (logos), alphabetical software

Introduction

It is certain that the development of technology will characterize the entire 21st century. It is a world of science in which, the material and the spiritual – the body and the soul, the two poles and powers of the human being – meet and clash, and matter is dominant and fundamental. In this particular context of the modern era, where the human being is, in a way, subjected to mechanistic logic, the present article juxtaposes the machine (software) and the human being as a rational being, and in doing so stresses two key

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points: 1) the machine (software) functions through computational possibilites, whereas 2) the human being functions with the principle *(logos)* of free choice, decision, responsibility, and consequences. In our task, we put forward some theological views on human rationality, and we do so by referring specifically to the theme of the Image of God. We analyze and interrelate the unique abilities that characterize the human being as a rational being, such as the ability to choose freely (theology), to make a decision, to assume responsibility, and to assume consequences (ethics),[1] which constitute the decisive (irreversible) moment for the human being, through which the tension between technology and human functioning becomes apparent.[2]

The responsibility of theology vis-à-vis technology, software and human being as a rational being

According to Orthodox Christian theology, particularly Patristic anthropology, the Logos of God is the Creator, *he said,* and all of creation *came to be,*[3] invisible and visible, intelligible and sensible.[4] He created the human being with a composite nature, of the visible and invisible, of the corporeal and incorporeal, of the earth and heaven, of body and soul, in the *image and likeness* of God (Gen 1:1·26; 2:7). The human being is the frontier *(μεθόριος)* between the visible and invisible world (the material world and the invisible powers), composed of body and rational soul, therefore he represents the whole creation, carries the whole creation within himself, and

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[1] Ethics is a way of life, and it too is a theological proposition of life for Orthodox Christian theology.

[2] In the present article we prefer the term *ability* over *capacity*, because we consider it to express more accurately the ability of the moment (*νῦν*), which characterizes the human being as a rational being and radically distinguishes it from the machine (software), which functions through computational possibilities.

[3] The Logos of God the Father accomplishes the Divine Oikonomia (creation, theophanies, Incarnation) through the one and common energy of the triune God. As for a detailed account of the recognition of the Father and the Son (Logos) and the Holy Spirit in the Divine Oikonomia, as persons and concrete, specific realities (*hypostaseis*), from the particular work, from the one and common energy, see (in Greek): Borche Grambozov (2023).

[4] Gen 1:1·3; Ps 32:4·6·9; 101:26; 103:24; 142:5; 147:4–7; Is 48:13; 51:16; 66:2; Prov 3:19; 8:14; Wis 9:1–2; John 1:3; Heb 1:2; Col 1:16; 1 Cor 8:6. Regarding the identification of the names Logos, Wisdom, Will, Power, Brightness, Son, Monogenes and Christ [including the depictions, such as hand (*χεὶρ*) and right hand (*δεξιά*)], see (in Greek): Borche Grambozov (2023).

for this reason he is able to *offer* it to the Creator.[5]

The inspired breath *(ἐμφύσημα)*, which the passage Gen 2:7 refers to, is the rational and noetic soul in the human being. That which is called the *divine image* is the rational and noetic power of the soul. And it is precisely here that the relation of the human being to the uncreated Logos of God is shown, whose energies he carries within himself as a rational being *(ἔλλογο ὄν),* in order to progress with the grace of the Holy Spirit from the *image* to the *likeness* of God. To be more specific, the *divine image* in the human being is the *logos* as noetic power *(νοῦς),*[6] that is, by grace, the ability to choose freely *(προαίρεσις).*[7] The created human being received the gift of mutability *(τρεπτότης, εὐμεταβλησία)* – a gift that technology can never receive or attain – i.e., the ability for continuous progress, for good alteration, which can also be diverted towards evil, if he chooses to progress not in cooperation with divine grace, but autonomously.[8] In the human being (unlike animals), the kinetic habit is able to have a second result, asymmetrical to the first; it can hinder other kinetic habits and thus, by restraining automatism, liberate consciousness (Bergson, 2005). The reactions of the human being, unlike those of animals, are unpredictable, everything is possible in the human being, because the human being does not act by automatism. In other words, the free choice and the specific decision of the human being are unpredictable. And this is the

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[5] For this reason the human being becomes *god by grace*, because he is the *frontier* of the whole creation – that is, between the material world and the invisible powers.

[6] We deem it necessary here to point out that the mind (*νοῦς*) is the rational (*ἔλλογος*) power of the soul.

[7] The enrichment of the human being is the rational element, the *προαίρεσις*.

[8] We are of the opinion that human works (creations, e.g., technology), unlike God's works (creations), do not possess the dynamism of self-improvement. God creates very good works (Gen 1:31). With regard to rational beings, so that they may progress dynamically and continually, whereas the human being creates in a limited manner, because human works do not possess the dynamism of self-improvement. The human being creates, and that is it. Also, we are in agreement with Saint John Damascene (PG 94, 924AB), who seems to have taken into account Athanasius the Great's (4 PG 25, 9BC) discussion about the human becoming (*γίγνεσθαι*), that the human being, according to free choice (*προαίρεσις*) and the corresponding self-determination (*αὐτεξούσιον*), has the power to remain and to make progress in the good, by cooperating with divine grace, but also to turn away from the good and move towards evil. We deem it note - worthy to add here that the mind, when it perceives in cohesion, unifies reason (*logos*) and intellect, and thus the free choice of the human being, who is mutable by nature, undergoes the good alteration, the continuous progress.

case because reason *(logos)* has dominion over instinct in rational beings. In any case, reason *(logos)* in the human being is his choice, i.e., the ability to choose freely, to decide about everything, and not to be lead by the necessity of his nature, as animals do. In animals, their instinct leads them to act, whereas in rational beings, it is their free choice – the self-consciousness, the rational element.[9] For this very reason, responsibility is attributed to human beings, but not to animals. Furthermore, the human being, as a rational creation, has choice also regarding the rest of creation – souled and non-souled, such as: animals, plants, sky, air, earth, stones, sea, fire, which do not possess the free choice – the self-consciousness – the decision – the volatility *(εὐμεταβλησία),* i.e., the reason *(logos),* and therefore are non-rational creations. Ultimately, because the human being possesses reason *(logos)*[10] – this power of the soul – he is able to create culture, whose main characteristic today is technology, which constitutes an element of human culture, whereas animals, which possess only instinct, cannot create culture, in other words, technology.

Because the human being is a rational being, he is a *person*,[11] that is, he exists as a person = *specific existence*[12] (as a free, self-determining, relational, and creative being). In other words, as a rational

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[9] For another approach to self-consciousness, different from our own, see: Petit (2010), Perlis (1997) and Ford (2009).

[10] For Orthodox Christian theology, this is the case only with the creation of human beings (Gen 1:26; 2:7) – and of the rational, noetic, intelligible, self-determined, and incorporeal powers, i.e., the angelic beings – and it remains the basis of Orthodox anthropology. It is not so much the case in contemporary philosophy (as opposed to ancient Greek philosophy), especially from popularized Darwinism onwards, and hardly at all in relation to modern empirical science, particularly biology, largely guided by positivistic principles (though not strictly a positivist science), where the human being, in a way, is an animal, i.e., a different animal, possesing higher qualities than the other animals, yet sharing many common features, among them *mind* and *consciousness*. For an account of ancient philosophical thought and contemporary philosophy and science, see (in Greek): Ioannis Zizioulas (2001). According to Darwinsm (which, as such, is not merely a theory of organic evolution, because it imposes ethical commands on society, with positivism philosophy embedded in its ideas, guiding modern science), based on the teaching of *survival of the fittest*, the struggle for life must necessarily, step by step, through natural selection, produce the rational – the *logos* from the irrational. In short, the rational element, i.e, the *logos* is not an independent *intellectual capacity*, but an *organic part* of nature, like tentacles or hands. For a detailed account of Darwinism and the *logos* in the evolution theory, see (in Greek): Max Horkheimer (1987).

[11] Just as the angelic beings are.

[12] It is not superfluous here to mention that an *anhypostatic* person does not exist.

being, the human being is in *relation* to all humans, because all are bearers of the same nature. Or better, the human being possesses a logos-endowed soul *(ἔλλογος ψυχή),* by which he creates *relations* and approaches his neighbor and, in a given case, God, which is the highest form of *relation:* sons and daughters of the same Creator and by nature brothers and sisters. The *openness* of the human being towards his fellow human beings and the whole creation – such as: free choice, freedom, self-determination, relation and creativity – is due primarily to the *endowed reason (logos),* i.e., to the given ability, through divine grace, to stand in relation to every human being in a brotherly manner, participating in the common gift of sons and brothers, and according to the hierarchical order of beings, also in relation to the whole creation. Therefore the *openness* of the human being towards others and the whole creation is a matter of *reciprocating* the given divine grace (that is, the gift, δωρεά),[13] and this is why, according to Orthodox theology, the human being ought to contribute to technology and to science. Of course, the *reciprocation* of the given grace is made possible in the human being, because reason *(logos)* is created as a *recipient* of grace and develops and is brought to completion in its *relation* to the Logos of God, i.e., to the divine presence.[14] In other words the human being possess the ability both to receive and participate *rationally,* not only in the creative and life-giving energies, as the non-rational creation does, but also in the *enlightening* and *deifying* energies,[15] and that, so he can realize the purpose of his existence, i.e., become godlike by grace, according to his spiritual capacity, and as a *frontier* of the whole creation, visible and invisible, *offer* creation into immediate *relation* with the triune God.

From the latter, one easily understands that, for Orthodox theology, the endowed reason *(logos)* of the human being is not merely *free choice* about everything, but also an *offering (responsibility),*

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[13] The gift is the rational element.

[14] We agree with Nikos A. Matsoukas (1980), who emphasizes that the development of rational life can also take place in beings that oppose divine grace, but in them reason (*logos*) develops separately from the movement of the mind, which has become alienated from the divine life.

[15] On the receptivity of the human being to participate in the enlightening and deifying energies, see also: Despo Lialiou (2019).

i.e., *giving* and *transmission*. As metropolitan Dionysios L. Psarianos (1988) pointed out: "Reason *(logos)* is offering and transmission, in the same way that the Divine Communion itself is offering and transmission. The one who speaks with a sense of responsibility is a hierourgos, he performs the word (logos) as a priest and transmits life.[16] And here we do not mean every word (logos), but the Word (Logos) of God, who is a real hypostasis *(existence),* living and active Word, in whom was life (Jn 1:4)." The ability for transmission of a qualitatively higher form of life is understood as a gift, it proceeds from the offering, viz. from participation in divine grace (energy), wherein the whole human being, but primarily the reason *(logos),* as the essential element of the human being, receives the grace and transmits it. This truth, as understood in Orthodox theology and experienced and expressed in the liturgical life of the ecclesial body, has great and immeasurable implications regarding human social relations, as well as the attitude towards God's material creation, which cannot be an attack against the existence of life and of creation, nor an appropriation of God's creation – at the disposal of the rational beings for creative activity – and thus an appropriation of the creative work (technology), and of the pre-existing knowledge given to the human being by the knowledge and effort of the fellow human beings who preceded him, but responsible transmission of the creative work to one's fellow human being and to the next generation, for the continuation of life, and finally, cultivation and safeguarding of God's creation. All these constitute an interpretation of the Orthodox Christian theology, which, as a monument of ecclesial life, contributes decisively to this work of humility of the human being regarding his own creative works and towards that which he has already received, and in general, towards creation, history, the present, and the future.

Today, however, for the modern human being, the rational and spiritual nature of humans, i.e., the *logos* – noetic (νοητικός), intellect (διάνοια), internal and oral, mind and speech – is considered independent from its *archetype* and *image* (God). As noted by Sir

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[16] Here, reference is made to the human being as a *priest* of creation.

James Jeans in the last century, when discussing the philosophy of positivism, pioneered by Auguste Comte, it seems to hold most relevance in the present century, particularly because of the application of positivism in the development of modern sciences and new technologies: ‟Today, not only we do not posses a perfect model, but we also know that it makes no sense to search for one – it could not have any comprehensible meaning for us. Because we have found that nature does not operate in a way that can be understood by the human mind through models or images” (Jeans, 1993).

In other words, from a positivistic perspective, which plays a key role in supporting the development of modern science and its application, technology (Hasan et al., 2024),[17] it is superfluous to pursue the *image and likeness of God,* i.e., the *spiritual* explanation for the nature and existence of human beings. Thus, the mind *(νοῦς),* as an inspired rational power *(ἐμφύσημα)* of the soul and a gift, planted by God (the uncreated *good* Being) in the nature of humans – as creations in the image of God – for *objective* discernment *(κρίσις)*[18] and pursuit of meaning, purpose, truth and virtues, among which piety is the pinnacle (John Damascene, PG 94, 928A), is disregarded.[19] Hence, human beings, influenced by the modern

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[17] According to Hasan et al., the application of positivism in scientific research, especially in the context of new technologies and interdisciplinary collaboration, has been shown to encourage research inovation. The positivist approach provides a systematic framework for collecting and analyzing data from different disciplines, thus expanding the scope of knowledge. Also, the empirical approach of positivism helps researchers test hypotheses and models before they are practically implemented.

[18] Which includes critical thinking, from the word *κρίσις*.

[19] It is important here to mention the insightful remark of Georgios I. Mantzaridis (2002), which coincides with our above observation and, in a way, fulfills it, while reffering to the two fundamental terms in ethics: *heteronomy* and *autonomy* (the *objective* and the *subjective*), which respectively denote two different modes of origin of moral discernment (*κρίσις*). Mantzaridis writes: “In authonomy, the «law» on which a person’s moral discernment is based is drawn from oneself, without the mediation of any external authority. In contrast, in heteronomy, the «law» on which moral discernment is based is imposed by some external authority, endowed with religious or other legitimacy. Heteronomous morality is primarily religious morality. The moral «law» that determines the formation of moral discernments does not originate from the person who acts, but from another – God or a divine principle. A person adjusts their life and moral discernment according to the «law» of God or the divine principle they believe in. Authonomous morality, on the other hand, does not invoke any authority outside the individual. It rests upon the person and seeks to assist them in self-determination. Here, the moral «law» is sought within the individual. Ultimately, it coincides with the individual desire of each person. Man becomes the measure of

spirit of technocentrism and positivism as a philosophical technocracy, where the material world encompasses all of reality and intuition and revelation are not valid knowledge (Horkheimer, 1987), see solely with the *eye* of the body, pursuing the *function* of things, but not with the *eye* of the soul – the mind *(νοῦς),*[20] pursuing the *meaning*, *sense,* and *purpose* of things, based on and conditional upon the *image and likeness of God*. In this climate of naturalistic anthropology,[21] reason *(logos)* is considered an organ, mind and spirit as products of nature (Horkheimer, 1987), consciousness as an exceptional episode within the random disorder, which arises from the chaotic movements of photons, electrons, and matter in general, thoughts as mechanic movement in the brain and feelings as mechanic movement in the body (Jeans, 1993). The problem that arises here, however, in our opinion, consists in the ascertainment of the identity of the true nature of the human being, more precisely, in the misunderstanding of the: 1) very *nature* of reason *(logos)* itself, and 2) its *source* (that is, where it comes from).

And it is precisely here that the distinction between theology and broader technological research lies. According to Orthodox theology, the created reason (*logos)*, in the human being, is: 1) all together: the ability to choose freely *(προαίρεσις),* i.e., self-consciousness, the crisis, discernment, and decision of the moment,[22] the worldview, the social order, the politics, the economic situation, the family situation, etc., 2) inspired power *(ἐμφύσημα)*[23] of the soul, 3) inspired gift of spiritual nature, formless, and invisible, 4) manifestation of the *divine image* – planted in human nature through the inspired breath of God *(ἐμφύσημα),*[24] and 5) element of the *divine*

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all things. And, in the final analysis, each person becomes the measure for themselves."

[20] As Saint John Damascene (PG 94, 924B) observes by analogy: for as the *eye* is to the body, so is the *mind* to the soul. In addition, noēsis (*νόησις*), as the mind's act in the heart, i.e., act of contemplation (*θεωρία*), is a unique characteristic of the soul. It is worth adding here, also, as Escudero (2025) points out, that the soul is perceived through its own acts that proceed from its essence, and those acts are present to the mind.

[21] For a detailed account of naturalistic anthropology, see: Oppy (2013).

[22] The moment (*νῦν*), this borderline point of a decision made by the human being, has no turning back; it is a limit; the possibility (as in software) does not exist, not even as a conception.

[23] Explanatory note: lit. the term *ἐμφύσημα* translates as inspired breath.

[24] Gen 2:7.

image – which enriches the human being with the rational element, that is, free choice *(προαίρεσις)* and the corresponding self-determination (*αὐτεξούσιον),* that also entails the responsibility-decision of rational beings. In scientific research, the meaning of reason *(logos)* is more specific in discussing the brain, neurons, and senses (Samudra et al., 2022; Williford, 2003; Birkett, 2006; Golshani, 2023).[25] For technology, reason (*logos)* is: 1) a part of the material nature, developed (evolved) through adaptation to natural conditions, 2) a computational function, and ultimately, 3) a potential human creation.

Certain technologists today, under the influence of the present age of mechanistic logic, or better, under the influence of the logic of the machines, absolutize their technological creation to the point where it enters the realm of the metaphysical, which they try with all their strength to avoid, in the sense that they believe they can create reason *(logos)* within the machine itself, viz., that the machine can, not only replicate and imitate reason *(logos),* but also possess reason *(logos)* – that spiritual, formless, invisible and endowed power of the soul, that is, the self-consciousness, in other words, the ability to choose freely (theology), to make a decision at *the* specific moment (ethics), and to take responsibility at *the* specific moment of the decision (ethics), according to Orthodox theology.

In our view, which moves on the same lines with Orthodox theology, the software can choose as a computational possibility,[26] but not as a moral act of decision and responsibility. It does not possess the decision to make a choice of the moment, to act and assume the consequences.[27] In other words, the software cannot make a decision at the specific moment, it can only give possible, pre-decided solutions. It can give possible good decisions, but not the one – the one of responsibility. That is why the human being is constantly in crisis, today, here, and now (free choice, decision, responsibility, consequences). Finally, we would emphasize that what the human being actually creates is not reason *(logos)*, but alphabetical software.

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[25] Reason is a by-product of the material brain (Golshani, 2023).

[26] It can choose, that is, *select* one from multiple computed possible options.

[27] Consequences create legal, criminal, political, social, and individual offences.

Conclusion

The present study views technology and its ethics in relation to the safeguarding and the continuation of life. The question here is not whether technology is good or bad, especially because, as we have already explained in our study, technology does not make decisions for rational beings (human beings). Therefore, the issue is the appropriation of technology, viz., its misuse, because this means an attack against the existence of life. In other words, according to Orthodox Christian theology, how does the human being, who has the power to *offer* the creation to God, behave in relation to his works (creations)? Is he humble vis-à-vis history, that is, with regard to his works and to what he has already received, and responsible for the present and the future? Finally, we agree with Georgios I. Mantzaridis (2002), who rightly points out that: “Science and technology are not the works of the devil, but of the human being, created in the image and likeness of God. Evil does not lie in science and technology. Evil originates in the mind of the human being and is activated through the misuse of his science and technology.” Of course, as Saint John Damascene (PG 94, 924AB) stresses, the human being does not have in his nature the tendency towards evil, but in his free choice *(προαίρεσις),* because he has the power to remain and to make progress in the good, cooperating with divine grace, but also to turn away from the good and to go towards evil.

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Alexander M. Isaac*

Participatory bioethics: A conversation between Roman Catholic and Orthodox traditions on reproductive genetics

Abstract

Discourses in bioethics address ethical questions arising from biological life processes. The limited scope of the present discussion narrows down to Assisted Reproductive Technologies and Surrogate Motherhood in the Indian contexts. The question of commercialization or commodification of human reproductive tissue looms large in reproductive genetics. The need for global bioethics is strengthened by the planetary nature of the discourse. Regional particularities also intersect these discussions. Ethical deliberations revolve around the intersections of gender, caste, class, religion, and ethnicity. Reproductive health rights and informed consent are important ethical considerations from a secular perspective. The four agreed-upon general principles of bioethics are autonomy, nonmaleficence, beneficence, and justice. They are important in medical decision making and policy formation. Participatory bioethical discourse calls for an intersection of variant moral voices, both secular and religious. Different religious traditions have a plurality of moral voices regarding bioethics. The ethical frameworks used by mainline Christian denominations for bioethics also vary considerably. The bioethical perspectives of Roman Catholics and Orthodox traditions are critically and theologically explored. Participatory ethical discourses and informed decisions are foundational in Bioethics.

Keywords: Assisted reproductive theologies, bioethics, biopolitics, commodification, *humane vitae,* medical tourism, orthopraxis

Introduction

Discourses in bioethics address ethical questions arising from biological life processes. The limited scope of the present discus-

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sion narrows down to Assisted Reproductive Technologies (ASTs) and Surrogate Motherhood in the Indian contexts. These procedures are generally described as New Reproductive Technologies (NRTs). Reproductive health rights and informed consent are important ethical considerations from a secular perspective. Commodification and commercialization of human reproductive tissue are at stake in reproductive genetics. Ethical deliberations revolve around the intersections of gender, caste, class, religion, and ethnicity. Different religious traditions have a plurality of moral voices regarding bioethics. The ethical frameworks used by mainline Christian denominations for bioethics also vary considerably. The bioethical perspectives of Roman Catholic and Orthodox traditions are critically and theologically explored. The Protestant moral voices offer a multiplicity of moral voices, and hence this paper excludes those perspectives in the present discussion. A conversation between ethical concepts of solidarity (shared moral values), religious understanding of the sacredness of life (covenant), and secular notions of human rights and human dignity, can foster a harmony of ethical voices.

Bioethics: Global and local concerns

Van Rensselaer Potter, a research oncologist at the University of Wisconsin began to use the term 'Bioethics' combining biological knowledge with a knowledge of human value systems. Potter used the term bioethics in 1970 in an article entitled "Bioethics, the Science of Survival" (Potter, 1988). For centuries, Hippocratic Medical Ethics served as the dominant Western model with a paternalistic stance that the 'physician knows best' for the welfare of a medical patient.

Potter proposed a 'global bioethics' as a secular program of evolving a morality that calls for decisions in health care and in the preservation of the natural environment" as a "morality of responsibility" that can coexist with secular humanism, assuring quality of both life and environment. Potter broadened the scope of bioethics to include not only medical ethics and environmental ethics but also social and religious ethics. With his focus on the health of the biosphere, global bioethics implies the international and planetary aspects of health ethics. Potter considered the term "bridge bioethics" emphasising the importance of linking different forms of bioethics. He also became increasingly concerned about social and international justice. A future oriented system of morality will enable to build a bridge to the future (Potter, 1971). Human health and planetary health are equally important. In this sense, bioethics is a humanistic biocentric vision of morality for the common good ensuring a habitable future for the biosphere.

Potter is equally sympathetic to the various religious and spiritual practices with deep-rooted ethical values at their core. This is very evident in most of the indigenous religious traditions. Thus, bioethics bridges science-technology with humanities and specifically religious traditions. This paper intends to discuss the moral voices of two major Christian traditions with regards to bioethics, focusing on the Assisted Reproductive Technologies.

Assisted reproductive technologies (Conceptions)

Assisted Reproductive Technologies (ARTs) is a boon to infertile couples. But these technologies also are a contested terrain of biopolitics where intersections of gender, class, and subaltern concerns are at crossroads. Women face violence and atrocities from 'womb to tomb,' indicating that a woman experience gender-based exploitation and violence from birth to death. In India, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, was enacted and brought into operation from 1st January, 1996, in order to check female foeticide (The Pre-natal Diagnostic Techniques Act, 1994). Even when amniocentesis for sex determination is made illegal in India, yet the male-female ratio in India is lopsided.

In vitro fertilization: Contested terrane of biopolitics

As a researcher, Aditya Bharadwaj focuses specially on assisted reproductive technologies and human embryonic stem cells. Through his research, he examines the emerging face of Indian engagement with biotechnologies in the local and global contexts.

This entails the mapping of transnational and national/local scientific contests, with connections linking patients, researchers, and clinics. His study interrogates moral and ethical debates cross-culturally and illustrates how biotechnology can be governed and regulated globally and locally.

Bharadwaj conceptualises conceptions when details the arena of Assisted Reproductive Technologies, and in particular, In Vitro Fertilization (IVF). In vitro refers to the Petry dish where the fusion and initial culture of gametes take place, in contrast to 'in utero' the normal place of fertilisation of germ cells. "While science aimed to control the whole body, it focused on what could be cultured, or nurtured, in metaphoric test tubes" (Bharadwaj, 2016). Petri dishes are replaced as crucibles for gestation. Bharadwaj details India's booming 'medical tourism' industry and mentions the parasitic nature of hosts and the parasites in assisted conception. "The parasite, both as biogenetic substance and social actor, thrives on the host," giving nothing in return. Biological reproduction is the quintessence of a parasitic relationship between a host ('mother'/ womb) and parasite ('child'/ foetus) (Bharadwaj, 2016). Bharadwaj details the connection between infertility and stigma as gender-based. In most cultures, barrenness is considered as a 'curse' and extended to be a matter of shame for a married woman than a man. In Indian context, barrenness is often interpreted as a female problem. Thus, the stigma attached to infertility particularly on women is severe. (Bharadwaj, 2016).

Annette Burfoot and Derya Güngör calls IVF as the 'externalisation of conception,' with attendant economic interests. They detail the "effects of IVF on women who undergo exposure to increasingly invasive hormonal protocols, repeated piercing of the vaginal and bladder walls and ovarian surfaces and multiple pregnancies resulting from implantation of several embryos at a time. Then there is the socio-psychological dimension of undergoing a procedure likely to fail; women are often left feeling responsible" (Burfoot & Güngör, 2021). The whole procedure is shrouded with commercial interests of the pharmaceutical companies.

Burfoot and Güngör underline the difficulty in legislating and regulating science and technology, especially since the procedures involve microscopic manoeuvres. In the New Reproductive Technologies (NRTs) there is also the matter of "managing kinship as a result of NRTs, especially with gamete and embryo donation as well as with surrogacy where reproduction becomes contractual and unhooked from genetic lineage" (Burfoot & Güngör, 2021). Ever since NRTs emerged in the late 1970s, feminists, religious authorities and later gay rights activists responded with different positions on the issues at stake. "Some feminists adopted positions on NRTs through a lens focused on women's reproductive rights and health, while most religious groups defended the dignity of the embryo and proper kinship arrangements"(Burfoot & Güngör, 2021). Queer activists took a position based on their reproductive rights. National and global socio-economic disparities are also at stake so as to broaden the responses on a scale of reproductive rights and justice.

There is an intersectional nature to the debates on AST. At stake is the intersection of gender, caste, class, religion, and ethnicity. Intersectional 'cultural conceptions' operate here. Intersectionality is one of the most popular theoretical paradigms in gender studies and feminist theory today. Initially developed to explore how gender and race interact in the experiences of US women of colour, it has since been taken up in different disciplines and national contexts, where it is used to investigate a wide range of intersecting social identities and experiences of exclusion and subordination.

Surrogacy: Commodifying motherhood

Biopolitics of surrogacy is to be viewed in the larger context of accelerating commodification of part or whole of human bodies. The 'body' is mostly treated as an object and as "a 'commodity' that can be bartered, sold or stolen in divisible and alienable parts." The concept of commodification is a disturbing ethical problem. It encompasses "all capitalized economic relations between humans in which human bodies are the token of economic exchanges that are often masked as something else —love, altruism, pleasure, kindness" (Scheper-Hughes, $^{2002).}$ Commodification of reproductive technologies is best illustrated by the various aspects of human reproduction, including that of fertility treatments, gamete donation, and surrogacy treated as commodities available as goods and services having commercial value. Of these, surrogacy involves the body treated as a commodity product.

The story of Sara and Hagar is often cited as an example of surrogacy. Surrogacy has become defined as a feminist issue as well. In terms of patriarchal exploitation of woman's body, and the women who undergo this medical treatment are portrayed as victims of medical power and the false ideology of motherhood, the surrogate mother is seen as a victim of commercialization and its seemingly unavoidable counterpart, exploitation (Zipper & Sevenhuijsen, 1987). Legal tangles follow suit where the right of the surrogate mother and that of the beneficiary are in conflict. The psychological bond that a surrogate mother develops with the embryo adds to the trauma.

What becomes a moral problematic is that of stigma and blame game tow which women become the primary victims. Women are blamed for being barren or men (more rarely) for being sterile, stigma can attach itself to a married body. Infertile women are considered as bad omen. 'Dart of barrenness' is mostly thrown upon women. (Sterile men do not face the same kind of ostracization as infertile women). They do not lose their social status, though they face humiliation. Narratives are intimately shaped by experiences of infertility, social stigma, financial drain and emotional exhaustion. The difficult question is "what is the gender of infertility, when a man can choose to walk out of a 'barren marriage' with his dignity intact, an option unavailable to a great majority of women?" (Bharadwaj, 2016).

The question of commercialization or commodification looms large in the case of surrogacy. The ethical question revolves around the private/commercial character of infertility clinics in relation to the wider public/private sector interaction, aiming to understand the broader biomedical politics of managing infertility clinics as successful private enterprises. India's emerging role as the pivot of transnational surrogacy arrangements is to be taken into consideration. The presence of clinically managed infertility in India surprises some. With more than one billion people, India is considered 'overpopulated' and is pursuing an aggressive state-sponsored policy of population control. India is also plagued by poverty and by growth pains typically associated with transitional economies. (Bharadwaj, 2016).

Another moral tangle is regarding the changing contours of kinship in the context of increasing surrogacy cases in India. In 1997, long before India gained notoriety as a commercial surrogacy destination, Nirmala, a thirty-year-old woman from Punjab, was ready to rent out her womb for 50,000 rupees to an infertile couple. She rendered her situation visible that which should have (ideally) remained private. (Bharadwaj, 2016). The visibility of such a case sparked off controversy and debates.

Assisted conception creates the 'biological parent as a separate category.' The connections between the natural and the social aspects of kinship are therefore rendered variable, with assisted conception offering different ways of configuring biological kinship, that is, of other ways of 'doing' kinship that configure the mixture of nature and culture differently. The twentieth-century 'natural parent' – one who embodied the genetic and social 'kin' credentials – is dispersed either by enabling fertilization outside the body or by involving donated 'third party' gametes. The practice of *niyoga*, or conception by proxy was a form of surrogacy with a surrogate male appointed (Bharadwaj, 2016). One can see here a similar dispensation with Jewish levirate marriages.

The notion of the surrogate carries many meanings; "substitution, replacement, proxy and stand-in." It signals the role of kinship in achieving conception through substitution or proxy. (Bharadwaj, 2016). Derrida invokes supplementation. 'Supplement' harbours two important cohabiting significations: "The supplement adds itself, it is a surplus, a plenitude enriching another plenitude, the fullest measure of presence. It cumulates and accumulates presence" (Derrida, 1998). The surrogate becomes a mother by supplementing. Now we will look into the multiple and fragmented moral voices in the secular and religious discourses in Bioethics.

Ethical dilemmas: Reproductive technologies and commodification of human body

Human body and tissues are considered as commodities with the emergence of assisted reproductive technologies. Theological and ethical questions abound when they touch on issues related to human dignity, sanctity of life, informed consent, human rights, justice concerns, and the moral implications of manipulating the natural processes of reproduction.

To the question of origin of life, Psalm 139 refers to a continuity of personal identity from conception to maturity. "You created every part of me; your put me together in my mother's womb. ... When my bones were being formed, carefully put together in my mother's womb, when I was growing there in secret, you knew that I was there- you saw me before I was born."

As sites offering medical resolution to the biological inability to reproduce, IVF clinics in India revolve around the very epicentre of moral, social and medical dilemmas, as well as the ensuing conflicts. The doctor/patient relationship as a result sometimes stands transformed. What is role of the State here, absent or surrogate? Does India provide life tissues as commodities freely available to the affluent nations? Do the poverty and material circumstances of some women in India turn their reproductive vitality – otherwise going to waste – into a commercially viable proposition? Questions of ethics and morality in this respect become commercial decisions where ethical deliberation only facilitates the recycling of entities made available in abundance. Secular and religious moral voices in Bioethics attempt and help to answer such questions.

Secular voices: Principles of biomedical ethics

Tom L. Beauchamp and James F. Childress describes application of four prima facie_principles in Bioethics from a secular perspective. In order to present a complete and comprehensible framework for biomedical ethics, they propose four principles of respect_for autonomy, nonmaleficence, beneficence, and justice, to particular cases of medical decision-making or policy formation (Beauchamp & Childress, 1989).

To state these principles in a nutshell: Autonomy requires being free to make decisions_involving one's own or a family member's health and well-being. Non-maleficence is about doing no harm; acting with no harmful or selfish motives toward another person or society. Beneficence means doing the right thing; providing or promoting well-being and preventing harm. Morality requires not only to treat persons autonomously and refrain from doing harm but seek their welfare. And Justice, the fourth principle means being fair. Beauchamp and Childress narrow down the scope of their enquiry by defining the term 'distributive justice' referring to "just distribution in society structured by various moral, legal, and cultural rules and principles that form the terms of cooperation in that society" (Beauchamp & Childress, 1989). Ideally, these ethical principles operate in harmony. In real life, they can clash dramatically. Experts say they struggle with such cases.

When principles conflict, a counsellor may try to balance and weigh each obligation. Sometimes that process reveals a clear course of action. Other times, the moral waters remain murky. Unlike other disciplines, where data may point to a definitive answer, a tricky case of ethics can become mired in conflicting values, emotions, and legal issues. Even the experts say there are cases in which there is no "right" answer.

When genetic defects are detected in a growing foetus, then the issue comes down to a choice of abortion or pregnancy, the choice is solely the woman's and is intensely personal. The primary function of informed consent is about "protecting and enabling individual autonomous choice" (Beauchamp & Childress, 1989). If the foetus is healthy, abortion cannot be justified morally. Then the counsellors should respect their clients' beliefs and feelings and allow them to make independent decisions, a crucial aspect of nondirective counselling. Only informed decisions are ethical.

Christian moral voices in bioethics

Theological bioethics represents a variety of alternate discourses and practices from a bottom-up approach in contrast to secular bioethics begins the discussions mostly from top-down policy making. Roman Catholic bioethicist Lisa Sowle Cahill proposes an alternative understanding of public theological bioethics as *participatory*. Participatory theological bioethics can swing between "either conservative or progressive, right or left, prolife or pro-choice, market oriented or social-welfare oriented, or some combination of any of these" (Cahill, 2005). That means, a plurality of ethical positions is part of such discussions in a public space including that of interreligious discourse.

Roman Catholic moral voices: Solidarity (Shared moral values)

Papal Encyclicals represent the official pronouncements of the Roman Catholic Church. In general, the Encyclicals endorse the primary intention of any sexual act as procreation. God promises offspring. But there is a distinction between the promise of procreation and command to procreate (Gen. 1:28). Pius XII condemned the involvement of third party in human procreation: Artificial insemination in marriage, with the use of an active element from a third person is equally immoral and as such is to be rejected totally." Only the marriage partners have mutual rights (exclusive and non-transferable) over their bodies for procreation. Pius XII declares that every attempt in the performance of the conjugal act or in the development of its natural consequences which "aims at depriving it of its inherent force and hinders the procreation of new life" as immoral (Pius XII, 1951). The document calls for a correlation of natural law in conformity with the divine law and a healthy Christian conscience.

Pope Paul VI's encyclical *Humane Vitae* (1968) is based primarily on Natural Law tradition. Natural Law is not derived from a special revelation from God. God's laws are set in nature as can be understood in natural law, which is universally acceptable and inter-religious. *Humanae Vitae* defends the sanctity of married life and the holiness of conjugal relations. It contains the teaching of responsible parenthood and the transmission of life understood within the Christian vocation. (Paul VI, 1968).

Donum Vitae is an instruction published by the Catholic Church's Congregation for the Doctrine of the Faith (CDF) that deals with the moral and ethical implications of biomedical technologies. It affirms the sanctity of life from conception and dignity of procreation within heterosexual marriage. It considers IVF and experimentations with embryos unacceptable since they intervene in the natural processes of procreation. The document acknowledges that science and technology are valuable resources, yet they must be at the service of the human person with an "unconditional respect for the fundamental criteria of the moral law" (The Congregation for the Doctrine of the Faith, 1987). Science without conscience can only lead human to ruin. It further states: "Recourse to the conscience of each individual and to the self-regulation of researchers cannot be sufficient for ensuring respect for personal rights and public order." The statement is emphatic about the moral status of an embryo, that "they must be respected just like any other human person; experimentation on embryos which is not directly therapeutic is illicit." The Church's teaching called for scientists to adhere to morals and definitions as understood by the Catholic Church, which include the following: "Every being is unique; every being is the creation of God; and a human being or person begins at the moment of conception/fertilization and thus an embryo must be treated as a person" (Burfoot & Güngör, 2021). *Donum Vitae* also condemns Artificial Insemination by Donor.

Donum Vitae considers surrogacy as illicit since it is "contrary to the unity of marriage and to the dignity of the procreation of the human person. Surrogate motherhood represents an objective failure to meet the obligations of maternal love, of conjugal fidelity and of responsible motherhood; it offends the dignity and the right of the child to be conceived, carried in the womb" (*Donum Vitae*, 1987).

Evangelium Vitae (1995), makes an ardent plea to "*respect, protect, love and serve life, every human life*" In order to "find justice, development, true freedom, peace and happiness" (Paul II, 1995). John Paul II upheld family as the "sanctuary of life" and *church as the people of life and for life*" [emphasis in the original]. In this connection, the Pope emphasized how essential he felt it was to ensure that "in theological faculties, seminaries and Catholic institutions sound doctrine is taught, explained and more fully investigated" (Paul II, 1995).

Pope Benedict XVI urged infertile couples to shun artificial ways like insemination and IVF as they are expressions of 'arrogance.' He raised voice against donors and experts not to "play God." He argues that "human freedom is authentic only when it responds to the fascination of technology with decisions that are the fruit of moral responsibility." Benedict XVI insists that both professional competence and moral consistency are necessary in which an ethically responsible use of technology becomes inevitable. He further clarifies: "A particularly crucial battleground in today's cultural struggle between the supremacy of technology and human moral responsibility is the field of bioethics, where the very possibility of integral human development is radically called into question." The question is not just life is conceived but how it is manipulated in biotechnology, especially in cases of "In vitro fertilization, embryo research, the possibility of manufacturing clones and human hybrids" (Benedict XVI, 2009).

Many within the Roman Catholic Church support the commitment of revisionist moral theologians who, at risk to their standing within the Church and to their academic appointments in Catholic institutions, continue courageously to wrestle as Catholic moralists with issues of moral perplexity. Others revere an authoritative ecclesiastical hierarchy.

Charles Curran accepts IVF under certain circumstances. Discards and losses are minimized as much as possible. Assurance must be made that the danger of harm to the child-to-be is about the same as normal conception. The procedure is limited to an established heterosexual couple. Revisionist theologians like Curran argue that even though ARTs frequently may not involve sexual activity for reproduction, they can occasionally satisfy the procreative role of marriage at an interpersonal level (Salzman & Lawler, 2021). Curran chose to be a spokesperson for theologians who dissented from the teaching of *Humanae Vitae* that artificial contraception is always evil. This cost him much as he was officially removed by the church from a teaching position. Roman Catholic theologian Lisa Sowle Cahill calls Charles Curren's position of theological creativity on discussions of Catholic bioethics as a "faithful dissent" with his lifetime theological vocation to inspire coming generations of Catholic theologians (Cahill, 2020).

Reformed ethicist James Gustafson identifies four types of bioethical discourses: ethical, policy, narrative, and prophetic. Cahill suggests a fifth type; *participatory* discourse, making possible to understand public theological ethics as participatory in a multiplicity of social movements and networks from the grassroots (from below) to the global practices in a context of increased globalization. "Participatory theological bioethics can mediate between a Christian worldview emphasising a transcendent horizon of meaning, solidarity, and special attention to the most vulnerable," providing practical initiatives to "respect, serve, and empower" the vulnerable in every population, local and global. (Cahill, 2005).

Orthodox moral voices: Sacredness and sanctity of human life (covenant)

Orthodox Christianity lives in an understanding of morality unaffected by Scholasticism, the Renaissance, the Protestant Reformation, and the Enlightenment. The age of the Early Teachers of faith is coterminous with the unbroken presence of the Holy Spirit. Scriptures are the major source of revelation which is appropriated by church, the body of Christ through the illuminating presence of the Holy Spirit. In other words, even when the Scripture is silent about some of the modern bioethical questions, the Holy Spirit will lead the faithful into all the truth (John 16.13). Orthodox Christianity contrasts with both Roman Catholicism and most Protestant faiths in rejecting a notion of moral dogmatic progress. The tradition of the church is as important as the Scriptural tradition. The age of the Teachers of faith has not ended, for all of theology is always fully available to all who, embedded within right worship (Liturgy), experience God. Orthodoxy is often depicted as "right faith." It correlates with "orthopraxis" meaning "right practice." Stanley

S. Harakas defines Orthodoxia as "correct belief" (as the Greek *orthon* means 'correct or right') indicating that Orthodox Church "has maintained the original, true and correct understanding of the teachings of Christ and the Apostles for the twenty centuries of its existence." He mentions an interrelated meaning of the term to indicate "the true worshipping Church" as *doxa* in Greek also means "praise or worship" (Harakas, 1982). Orthodox reflections do not provide a set of guiding moral rules and principles that can be followed in isolation from an Orthodox way of life.

Orthodox Christianity affirms the sacredness and sanctity of human life as it is "a *gift*, freely bestowed by the God of love" (Breck, 2000). John Breck marks a distinction between 'Christian ethics" as a Western category whereas, "Eastern" Orthodoxy traditionally focuses on "moral theology," "which is basically traditional ascetic theology: exposition of the interior struggle toward sanctification through the grace and transfiguring power of the indwelling Holy Spirit" (Breck, 2000). Abortion is proscribed because it involves taking the life of what should become a human person. Independently of whether the foetus is yet a person, Orthodox Christianity treats any individual as killing a vulnerable living entity. Orthodox priests, bishops, and churches have responded by placing contemporary biomedical issues within the thought and framework of the Apostles and the Teachers of faith. Contemporary reflections and those of the Teachers are united in the liturgical now of Orthodox Christian prayer, which is the source of all its theology. Because the history of Orthodox Christian medical ethics is that of a struggle against error and heresy to maintain Orthodox faith.

Regarding the basic questions of morality of reproductive procedures, the question of when does life begin is fundamental. Harakas affirms the sacramental character of Christian marriage and warns against any third-party interventions in the act of procreation and that the Church has a moral responsibility "to protect mental and spiritual welfare of the unborn child" (Harakas, 1982). Orthodox conviction is clear about the affirmation that "human life begins with conception, meaning fertilization." The question about the morality of medically assisted procreation begins with that basic premise which "demands full respect" (Breck, 2000). Considering the fact that procreative technologies have advantages and potential blessings, yet the dangers of abuse are even greater. Breck also reckons the fact that to honour the "sacredness" of life requires that the transmission of life be accomplished by the "one flesh" relationship of two persons joined in a "monogamous, heterosexual, blessed conjugal union" (Breck, 2000). Breck exhorts the church to "act as the *conscience* of society through evangelization and moral persuasion" (Breck, 2000). Regarding the question of manipulation of human embryos, John Breck and Lyn Breck describes the moral responsibility of the church: "Human life—from fertilization until biological death—is a sacred gift, destined for a greater and more glorious existence than our minds and hearts can imagine. Our moral responsibility, before God and before each other, is to acknowledge that sacredness by preserving and protecting human life at each and every stage of its existence" (Breck & Breck, 2005).

Conclusion

Roger A. Shinn offers a clear direction: "A creative ethic usually comes from people who live out of, yet continuously renew and revise, a tradition. An ethic for today and tomorrow must combine heritage and expectation, courage and caution, fidelity and innovation. It must relate commitment to tough-minded factuality, imagination to hard evidence, vision to reality" (Shinn, 1991). This entails what Roger A. Shinn calls as "forced options" in ethics. Speaking about the importance of dialogues on biomedical decision-making, especially between the secular and religious voices, Harakas encourages everyone to participate in such discourses, from which no one should be excluded (Harakas, 1999). This is what Cahill calls as 'participatory' discourses in bioethics.

Both Roman Catholic and Orthodox bioethics endorse the sacredness of the divine gift of life. Roman Catholic moral position is centred on Natural Law ethics. It brings out a system of shared values like virtues and is mostly based on Papal instructions through encyclicals. Orthodox perspectives rely on the teachings of the early Teachers of faith and make sacredness of life as integral to its liturgical life illumined by the Holy Spirit. The modern ethical voices incorporate the contextual realities from a situational perspective to face the perplexing ethical issues in Bioethics. Participatory ethical discourses and informed decisions are ethically sound initiatives in Bioethics. A conversation between concepts of solidarity (shared moral values), sacredness of life (covenant), and human dignity, can foster a harmony of ethical voices.

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Brian A. Butcher*

"Sanctify my body and make your abode in me": Bioethical reflection in light of orthodox virtue ethics

Abstract

What are the essential elements of an Eastern Christian approach to ethics, in terms of its sources, methods and applications? Even while countenancing the array of specific bioethical issues we face in our day—including sexual ethics, embryonic and stem cell research, human cloning, euthanasia—it is prudent to step back and attend to meta-ethical reflection, i.e., a consideration of the "first principles" of theological ethics within an Eastern Christian context. Here the category of "virtue" (aretē) is paramount: it enables us to perceive the contemporary significance for ethics of such classic loci theologici as Scripture, the Fathers, liturgy, iconography and hagiography.

Keywords: Bioethics, virtue, Orthodox, liturgy, patristic

Introduction

Most of the papers in this volume are grounded in a very specific set of competencies, whether scientific or medical. I do not presume to able to speak in this vein, and can approach the matter of bioethics only from my vantage point as a theologian: in particular, my perspective is that of a Greco-Catholic who seeks to "breathe with both lungs" (to cite the famous dictum of Pope St. John Paul II)—that is, to integrate the insights of East and West, in the conviction that only in such an integration will the fullness of Christian wisdom manifest itself. The quote in the title above is taken from one of the Byzantine-Rite prayers after Holy Communion: its author, St. John of Damascus (675/6—749) invites us to consider ourselves as dwelling places for God—as temples—and to act accordingly. As we shall see, such an existential claim points to the

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significance of virtue as a category for bioethics: if we ourselves are divine sanctuaries, then everything that is done in, to, with, through and for our bodies is to be carefully discerned.

In the present inquiry, I would like to step back from particular bioethical issues—addressed as these are in detail by my fellow contributors with due diligence—in order to look at some of the first principles, or meta-questions, which lie behind ethical determinations and decisions. It seems to me that part of the challenge we face today, as Christians of whatever tradition, is to identify and problematize the presuppositions we carry with us into debates—as much as to critically assess the actual opinions to which we may be inclined. Not infrequently, disagreements on the ethical front remain superficial: arguments pro and con are put forward without a "deep dive" into the kind of rationality informing the contrasting stances of the respective parties.

What and whence the Good?

I would like to begin with the *Euthyphro*, one of the shortest of the dialogues of Plato (428/427 or 424/423—348/347 BC), but one which nevertheless raises an axial question common to all ethical contexts: what is the nature of the good, and whence does it proceed? Desiring to do the good, that is, how do we in turn know what it is—and how do we *know* that we know? The text proceeds by investigating the virtue of piety (*eusebeia*), displaying the characteristic *aporia* of those Platonic dialogues which feature Socrates as protagonist, in that it does not arrive at a firm conclusion one way or the other: the point is rather to bring about an awareness on the part of the reader as to the dilemma at issue.

Socrates catches his interlocutor Euthyphro *en route* to prosecute the latter's father, due to his alleged negligence causing the death, on account of confinement, of a labourer himself accused of murdering his fellow; Euthyphro believes his father to be guilty of the blood of the accused, and understands that the gods expect, in the present instance, that justice be meted out to the latter despite the very prosecution of him being an ostensible infringement of Euthyphro's duty to show filial respect—an aspect of piety. Through Socrates' analysis of the situation, the debate by and by arrives at the question of whether something is right because the gods say so—or whether the gods say so because it is right. In course of trying to respond to Socrates' objections, Euthyphro eventually realizes that he cannot give a satisfactory answer to the question at hand—and becomes subsequently diffident as to how he should behave. The question is theoretical, though the problem is quite practical: whether or not to follow through on prosecuting his father will depend on what is *really* good, i.e., pious or holy—allowing filial respect to take precedence over justice, or vice-versa.

Euthyphro's conundrum is one shared by all of us, unaware though we may be: we all find ourselves beginning *in medias res*, "in the middle of the plot" of our lives, with a set of subconscious presuppositions, derived from our upbringing and context, shaping our conscious actions—even as we speak a mother tongue before we start to think about its grammar, or find ourselves possessed of faith (or not) before we come to cleave to our religious tradition (or lack thereof). We are like actors already immersed within a drama, who only at the moment of the performance begin to ascertain our roles and how to play them well, so that the plot unfolds as it should. Christian theology has historically resolved the theoretical aspect of the question by insisting that God Himself is to be identified with the Good: His commandments therefore flow from His very being, being themselves good not because God says so, so to speak, but because He *is* so. And yet the practical aspects remain abstruse: for who has not found himself in a situation where two goods are (or seem to be) in conflict, at odds with one another?

Virtue ethics

As already mentioned, the apparent point of *Euthyphro* is *not* to deal with the specificity of the scenario presented, entirely plausible though this must have been to the original audience. After all, by the end of the story we still do not know what Euthyphro will end up doing! Nevertheless, we are duly provoked to ponder well what *we ourselves* would do if caught up in a similar situation—and, more importantly, to ask ourselves *why* we would pursue one particular course of action over another. The point of the Dialogue, that is, is to challenge us to think about how we would know what we should do in a given situation. Broadly speaking, what is being brought into relief in this text, as elsewhere in Plato and as later developed by Aristotle, is what will in our day come to be called "virtue ethics." It is this sort of ethics which has arguably been characteristic of the Eastern Christian traditions, even as it has been thematized anew by modern thinkers concerned with finding a way to escape the seemingly ineluctable impasse between deontology and consequentialism.

At the risk of oversimplifying, deontology denotes an approach in which ethics are a function of rules; this is very common in secular society, even if people realize that it is hardly a straightforward matter to discern what the rules should be; who should promulgate them; and how they should be enforced. A second approach, also readily encountered in our day, is consequentialism (most popularly, in the form of utilitarianism): here, it matters less what the rules are, than the consequences thereof. Crudely put, this is encapsulated in the following expressions: "As long as I don't get caught...."; "As long as no one gets hurt...."; "As long as whatever happens is more or less in keeping with the spirit of the law...." One can easily see, on the one hand, how such an approach abets all sorts of dereliction, corruption and abuse. But on the other hand, the prospects for taking rules as paramount seem likewise troubling: how does law, in this case, not become impersonal and inflexible, and perhaps outrightly inhuman? There appears an ineluctable tension, between recognizing there *should* be an objective standard to which everyone is equally called, but that the expression of justice nevertheless really does need to take account of (mitigating) circumstances, and so forth. Justice, that is, needs to be executed in what, to use theological terminology, we would call a "pastoral" manner: hence, in the Eastern Orthodox tradition, the conventional distinction between *akribia* and *economia*, or "strictness" and "flexible solicitude."

Virtue ethics, in turn, presents a potential *via media* between the positions articulated above: a way of navigating, rather than capitulating to, the stated tension between them. In virtue ethics the emphasis is placed neither on rules nor on consequences as such—though these are both taken under advisement—but instead on what it means to be a human being: and, how this relates, in the words of great Jewish rabbi Abraham Joshua Heschel (1907-72), to "being *human*." This in turn implies a consideration of the *telos* or goal to which we are summoned, the end to which they ought to aspire.[1] The big questions raised in virtue ethics therefore include: Who are we as human beings? What is our origin and destiny? What is the best way of acknowledging said origin and achieving said destiny?

Being, in sum, precedes doing; actions are to be evaluated in terms of anthropology—and *this* is where the most productive discourse is to be had. To care for what it means to be *virtuous* is to pause before entering upon a given ethical threshold, descrying what the prospective choices will convey and compel with respect to the *persons* implicated. Notice how we use the word "humane" as a descriptor for someone who is virtuous; we speak of a humane approach to "x" or "y." Even though everything that people do is, technically, *human,* many things are far from *humane*! Without a scrutiny of virtue, actions come to be subtly regarded as extrinsic to their agents, rather than appearing, as it were, as the fruit whose quality shows forth the health of its respective tree.

Ethics, in this approach, constitutes a kind of "practical knowledge," which Aristotle termed *phronesis*. It is not a matter of "knowing," so much as of "know-how-to-do," *savoir-faire*: knowledge as craft or art, rather than as idea. What is to be known, thus, is how to become virtuous: namely, how to become the kind of creatures we are intended to be by our Creator. As St. Augustine (354-430) rightly says, in *Confessions*: "You have made us for yourself, and our hearts are restless until they rest in thee" (I:1). Accordingly, what is ethical is that which corresponds to the *ethos* of coming to rest in God—and this, the East has traditionally called *theosis*

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[1] Virtue ethics prompts consideration of a "normative sense of what being human entails." It stands contrary to an emotivism in which "the only authority which moral views possess is that which we as individual agents give to them" (Woodhill, 1998, 62).

("deification, divinization"). The corollary is that what is unethical, what is *sinful*, is that which causes a deviation from our proper course—whether or not this involves a breaking of rules, or a series of observable consequences. Sin is the arrow not hitting its mark, as the New Testament Greek *hamartia* connotes; in the lexicon of St. John of Damascus, it is a matter of not following our inner logic, the *scopos* proper to our nature. As Armenian Orthodox ethicist Vigen Guroian puts it: "Only as a result of sin do human beings experience law as externally imposed codes and commandments, usually in the form of prohibitions that indicate when the harmony and unity of life are lost, [but not] how they might be restored" (2002, 21).

To be sure, the Bible itself, along with the manifold expressions of Christian tradition, are replete with varied metaphors for sin: transgression, stain, defilement, corruption, infraction, scandal, blasphemy, illness, and so on (Ricoeur, 1969). Every language has its own inherited ways of denoting and connoting what ultimately resists complete definition—that very evil which Scripture see as expressed in and effected by the Fall. Each negative metaphor sheds light on the matter, while not giving a full picture; conversely, each metaphor for salvation—return, cleansing, purification, flourishing, exoneration, reconciliation, forgiveness, healing, or what have you—likewise illustrates something about virtue, though not exhaustively so. The essential point I wish to make is that to think about ethics in terms of virtue is to situate humanity in a wider frame of reference than merely rules or consequences: it is to contemplate our *story*.

The elements of virtue ethics

Justin Martyr (c. 90-100—165), and several Church Fathers after him (e.g., St. Athanasius, St. Gregory Nazianzus, St. Maximus the Confessor, St. John Climacus) approached the classical philosophical patrimony of their day as bearing "seeds of the Word": elements of truth, goodness and beauty which could be "harvested" in the service of the Gospel. At the time of Christ, Stoic philosophy—exemplified in the *Meditations* of Roman Emperor Marcus Aurelius

(121-80)—had high regard for the cultivation of virtue. What the Church Fathers added, however, was a recognition of the *origin* of virtue in God Himself, and the concomitant importance for the divine life to take root and flourish in the human person as made in the image of God and destined to grow into the divine likeness for eternity. Eastern Orthodox ethicist Joseph Woodhill summarizes their conviction: "The battle for the life in Christ is waged on the field of character and is won in virtue" (1998, 69).

In the interpretation of the Fathers, as also in his reading of contemporary theorists, Woodhill discerns the following key elements of a comprehensive virtue ethics:

1) ***Telos***
2) ***Practice***
3) ***Virtue***
4) ***Community***
5) ***Narrative***
6) ***Mentor***

We can elaborate upon Woodhill's explication of each of these, in terms of how they organically appear within the Eastern Christian traditions handed down to us. The *telos* has already been mentioned above: it is, of course, *theosis*, becoming "partakers in the divine nature" (2 Peter 1:4). This goal recognizes that salvation is *dynamic*; created *imago Dei*, we nonetheless lack in our present experience the divine "likeness," the resemblance to God which ought to come naturally to us—that is, flow from our originary "nature"—but now often appears, due to sin, as "unnatural." The celebrated patristic text in this connection is that of St. Athanasius, from *On the Incarnation*: "God became man in order that man might become god" (2011, 54:3). But this only builds on the earlier contention of St. Irenaeus, in *Against the Heresies*: "For the glory of God is the living man, and the life of man is the vision of God" (2006, 4.20.7). Theosis is the result of a life lived "in Christ," by the power of the Holy Spirit, to the glory of God the Father. Guroian observes, "The Incarnation also presents this theanthropic vocation as a new moral imperative, that human beings strive to imitate this Jesus Christ who is both archetype and perfect example of a deified humanity" (2002, 15).

Key to the Church's teaching on theosis is a theological construal of anthropology in which *freedom* remains a feature of human existence, even after the Fall: our liberty to do the good is limited, impeded and impaired—but not absent. Empowerment obtains through the Holy Spirit, by means of the wisdom disclosed in Scripture and Tradition, and the grace given in the Mysteries, in prayer, fasting and almsgiving: we *become* free as we exercise our freedom in obedience to conscience, both cognizing, ever more accurately, good from evil, and acquiring the wherewithal to act in a manner coherent with our cognition. In habitually choosing the good, our character develops as the product of synergy, the "cooperation of human and divine energies" (Guroian, 2002: 15).

The paradigmatic Orthodox *practice* is surely liturgy—though taken not simply as ritual, but inclusive of the asceticism, and spiritual and corporal works of mercy, which flow from and back into worship, even as blood is pumped by the heart throughout the body while returning thereunto. In an Indian context, we should perhaps speak rather of yoga—that "yoke" which guides us to move ourselves together with others in the right way. As Woodhill contends: "'Through liturgy...we are shaped to live rightly the story of God.... Worship [is] the practice that forms Christians, even as 'bricklaying' forms proper 'bricklayers.' (1998: 68)." Guroian concurs: "For through the sacraments of the Church Christ, who is the Life, enters the person and takes the person into his life....The spiritual life is both an ascetical striving to do good and a mystical reception of transforming grace" (2002: 16-17). Revelation is imparted especially, if not exclusively, through worship inasmuch as it is there that the truly Christian *darshan* obtains, so to speak: the Lord and His saints speaking to us through the sacred texts, gazing upon us through their icons even as we contemplate them—they who have preceded us in virtue and reaped the concomitant rewards.

At the heart of virtue ethics is, of course, virtue—literally, from the Latin, "manliness, strength, courage, excellence." In the Christian rendition of the matter, however, such is ultimately construed to be synonymous with *love*—of God, neighbour and self. With all the aforementioned in the background, we can see how virtue cannot be reduced to following a law, nor evaluated purely in terms of consequences. To use an expression from the Indian context, it is bound up with what is implied when we greet others: Namaste—"I bow to (the divine within) you," that is, I recognize your *dignity*—as, presumably, I recognize my own—and will act unto you in accord with this recognition. When we start to ask whether a given action is consonant with our dignity as human beings, we are tantamount to considering what is virtuous; if we perceive, further, that our dignity and virtue are bound up with being children of God, siblings of the one whom the Nicene Creed calls "True God and True Man," and the "Light of Light," then we will esteem above all the counsel of St. Paul: "But now you are light in the Lord. Walk as children of light" (Ephesians 5:8 ESV).

The *community* where virtue is acquired is the Church, in which are found, *inter alia*, structures of accountability as well as a society of learners, of fellow "craftsmen." Moreover, inasmuch as Christians are not "people of the book" in fact, but people of the Word-made-flesh, the recounting of their story requires the embodied presence of others—as per the ancient saying, *Unus Christianus, nullus Christianus* ("One Christian is no Christian")—pre-eminently in the communal conversation enacted in the liturgy, and what precedes and follows it. It is in and with others, rather than by recourse to an authoritative text as such, that an ethic is inspired and instilled.

The *narrative* is the Gospel, but as recounted in the "multi-season" version constituted by the lives of the saints across the centuries, represented and re-presented in the course of the liturgical year. As Woodhill observes, "To speak of virtue entails that we tell stories" (1998: 74). For love, or indeed any virtue, to signify effectively, it requires being referred to a particular example. The life of Christ, as depicted in Scripture and enacted in worship is reiterated in the saints' lives, further chapters in the tale. Each episode of a "little Christ," i.e., a Christian, extends a fresh example of the one exemplar.

Finally, the *mentor(s)* are, to use the language of India, our *gurus*: those faithful and faith-filled men and women who in our own day both illumine the way and accompany us on the journey. The Eastern Christian traditions have always known such: those who, whether monastics or living in the world, become spiritual fathers and mothers to others, after the pattern of St. Paul in regard to the Corinthians (1 Corinthians 4:15). Of course, our first mentors are, please God, our own parents and relatives; and then our godparents, clergy and teachers. But each of us has to arrive at a point, as we pass into adulthood, of freely placing ourselves under the guidance of those capable and worthy of offering such.

Back to bioethics

What does all this have to do with bioethics? The burden of this chapter has been to point to the sources, methods and ends of bioethical reflection, rather than to address specific scenarios. But I hope that it has become clear how entering upon any such scenario will require, whether consciously or unconsciously, reference to matters discussed above. To seek to act virtuously, according to the sixfold schema above, is to dispose oneself to respond differently, from the get-go, to neuralgic controversies which might otherwise seem intractable. A modest example: how often does the Feast of the Annunciation—and the Visitation which follows soon thereafter—figure in discussions of abortion (rights)? Do we stop to consider how Our Lord was present in the womb of His Mother from the moment of the Annunciation—and hailed *in utero* by his cousin when the latter's mother Elizabeth was met by Theotokos (Luke 1:39-45)? Would anyone make so bold as to suggest that Christ or John the Forerunner were not fully *persons*, but only fetuses? The iconography, hymnography and calendar of the Church, no less than the Gospel pericope, teach truths which are belaboured in vain, in the forum of secular argumentation.

A virtue ethic will ask, to paraphrase an Evangelical Christian trend dating back several years ("What would Jesus do?"): "What would Mary do?" "What would Elizabeth do?" Of course, we immediately realize that there is no way either could conceive of *not* recognizing the sons within them as already becoming the men God would make them. Nevertheless, one readily encounters "pro-choice" Christians throughout the world, for whom the questions above would not be pertinent or decisive. It seems to me that many a bioethical challenge could be productively re-framed in terms of whether the respective options in question would advance those concerned along the path of virtue or not—whether said options would help those concerned become imitators of the saints, in their imitation of Christ: one cannot imagine, I daresay, Ss. Joachim and Anna resorting to IVF, despite their pain at being childless; nor St. Simeon asking for MAiD, on the heels of pronouncing the *Nunc dimittis*; nor the Desert Fathers contemplating the prospects for cryogenics; nor the *monachoparthenoi* ("virgin monks") like St. Marin-a/os (715-50) actually availing themselves of gender-reassignment surgery, in order to further their aspirations for participating in the life of a male monastery....

In all seriousness, I believe that it does behoove us to ask what our fathers and mothers in the faith would do, were they in our shoes. The varied conditions and circumstances of the saints show us that virtue is attainable in all walks of life, if we only employ the means given to us to achieve it. If we are sincere in wanting to ourselves become like them, and similarly even be remembered as examples of virtue, we need to situate ourselves and our determinations *sub specie aeternitatis*—in the light of eternity. Without presuming to resolve every bioethical "hard case," I would nonetheless contend that one must *begin* with the kind of considerations outlined above, so as to foster the kind of context in which said "hard case" can find a virtuous solution.

We should also be careful at presuming, even granted the quantum leap forward we have experienced on the level of science, technology and medicine, that our contemporary challenges are always that different from our forebears. Cloning was not a temptation in the first century, of course, but contraception, abortion and infanticide were known and frequently condoned by pagans; and it is hardly necessary to enumerate the variety of sexual practices known to the ancient world. Christians were known, from the earliest times, for rescuing abandoned children and raising them as their own: a particularly courageous act when such children were discarded due to physical or mental disabilities.

Conclusion

Let's try to tie all the foregoing together. We began by referring to the *Euthyphro* and the problem of locating the grounds for ethics, an objective moral standard. Catholic teaching has developed a well-refined view of "natural law," deftly explicated in the *Catechism of the Catholic Church*, building on the legacy of medieval scholastic theologians, *inter alia*. This has in turn been extended to pronounce upon an array of bioethical issues. And yet Catholic clergy, no less than their Orthodox counterparts, would undoubtedly attest to the discrepancy between the clarity of their respective Church teachings and the degree of adherence to the same, on the part of the faithful. It would seem that the problem, across the board, is not *understanding* what is to be done, but being virtuous enough to do it—to "take up [one's] cross," whatever this should prove to be.

I have argued that fostering the virtue in question requires revisiting the constitutive elements undergirding it: *telos*, practice, virtue, community, narrative and mentor. Doing so may at least set the stage for a modern Euthyphro to have a chance at sorting out whatever thorny situation in which he should find himself. And only with reference to virtue, will we be able to cultivate the kind of society in which we all desire to live.

Stavros Fotiou (2013), summarizing several Church Fathers, speaks of the three levels of morality: that of the slave, the servant and the son. The slave does the good out of fear of punishment; the servant likewise obeys, but out a desire for reward; it is the son, however, who seeks the will of his father in love, such that the good is done as if it were obvious—the only course of action to be reasonably countenanced; the only thing in keeping with the dignity of the son possessed of piety towards his father. May the many and varied challenges outlined in this book be confronted in this spirit, that the Lord may indeed sanctify our bodies and make His abode within us.

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Ioannis Ladas*

Orthodox Christian bioethics and technoethics: An approach to the contribution of H. Tristram Engelhardt, Jr.

Abstract

H. Tristram Engelhardt, Jr. (1941–2018) undertook, on the one hand, the most systematic effort to revise bioethics in light of Orthodox Christian theology, and, on the other, offered a clear depiction of the condition in which ethics and bioethics find themselves in the "post-God" era. This distinguished philosopher and bioethicist locates the Truth—sought as a means of transcending the confines of secularism—in the Christianity of the first ten centuries, the continuity of which is embodied today in the Orthodox Christian Church. In this spirit, the present article seeks, first, to highlight the contribution of H. Tristram Engelhardt, Jr., and second, to underscore the significance of Orthodox Christian bioethics in the twenty-first century. Within this context, it highlights the significant horizons opening for the formation of a distinctly Orthodox Christian Technoethics, given that the rapid advancement of technologies—most notably artificial intelligence, robotics, and genetic engineering—has generated new challenges that transcend the traditional boundaries of religion and science.

Keywords: H. Tristram Engelhardt, Jr., bioethics, technoethics, artificial intelligence, orthodox christian theology

Introduction

The work of H. Tristram Engelhardt, Jr. (1941–2018)[2] represents, on the one hand, the most systematic attempt to date

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[2] For a detailed account of the contribution of H. Tristram Engelhardt, Jr. and its relevance to the present article, see (in Greek): LADAS, I., Τὸ πρόβλημα τῆς φιλοσοφικῆς θεμελίωσης τῆς βιοηθικῆς καὶ οἱ βιοηθικὲς θεωρήσεις τοῦ H. Tristram Engelhardt, Jr. (The problem of the philosophical foundation of bioethics and the bioethical thoughts of H. Tristram Engelhardt, Jr.), Papazisis, Athens 2023.

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at a comprehensive revision of bioethics grounded in Orthodox Christian theology, and, on the other, offers a lucid account of the condition into which ethics and bioethics have fallen in the "post-God" era. This renowned philosopher and bioethicist locates Truth—which he seeks as a means of escaping the limits of secularism—in the Christianity of the first ten centuries, whose living continuation is found today in the Orthodox Christian Church. This fact imparts a confessional character to his works, something that should not be viewed as paradoxical, since, after half a century of reflection on God, ethics, and bioethics, he concludes that secular bioethics is fundamentally ungrounded and therefore seeks a stable foundation upon which it may be reconstructed (Engelhardt, 2007).

By deconstructing Western Christian bioethics, Engelhardt demonstrates that a significant factor in its failure was the fragmentation of Christianity itself. Through this multiplicity of "Christianities," each individual was afforded the opportunity to select whatever best suited their personal preferences. A similar phenomenon occurred in secular bioethics, where the unity it claims to uphold is ultimately hollow, given that there exist as many secular interpretations of ethics as there are religions.

Extending the above line of reasoning, one may observe that even within the Orthodox Church there is not only an absence of an official, unified stance, but at times there are notable divergences in the approach to bioethical issues (Ladas, 2024). This reality appears particularly troubling, as it suggests that one of the principal causes -according to the Texan philosopher- of the failure of both secular bioethics and Western Christian bioethics is also present within the Orthodox Church (Ladas, 2018).

Such differences do not constitute a problem when they reflect the personal views of hierarchs, clergy, or academic professors in their efforts to address a particular bioethical issue. A problem arises, however, when these divergences take the form of official positions adopted by Autocephalous Churches and bear the approval of a local Holy Synod (Ladas, 2023a).

While not overlooking the aforementioned issue, the present article aims to present the contribution of the Texan bioethicist to the shaping of Orthodox Christian bioethics. The fact that a philosopher and bioethicist of recognized stature and scientific credibility converted to Orthodoxy and undertook the most systematic effort to date toward a comprehensive revision of bioethics grounded in Orthodox Christian theology is of particular significance. Moreover, through his contribution and the new perspective he offered, the enduring relevance and value of Orthodox Christian bioethics and technoethics in the twenty-first century is made evident.

The work of H. Tristram Engelhardt, Jr.

The work of H. T. Engelhardt, Jr. may be divided into two phases: (a) the pre-conversion and (b) the post-conversion period. The first, or early period, encompasses his entire philosophical and theological system prior to his embrace of Orthodox Christianity, while the latter comprises the entirety of his subsequent contributions. It appears that, in his early period, Engelhardt grounds his bioethical reflections in a form of rational religion (in this case, Roman Catholicism), whereas in the later phase, he revises and reexamines his entire body of work, ultimately arriving at a thoroughly theistic system.

Following his conversion, the Texan philosopher believed it was his responsibility, as a scholar, to reexamine all his previous work from the ground up—an undertaking that led him to approach bioethical questions from an entirely new perspective (Engelhardt, 2000). Indeed, he expressed a sense of guilt over his earlier contributions to the development of mainstream secular bioethics (from the early 1970s through the 1980s), which he came to regard as a form of sin (Engelhardt, 2000). This realization prompted him to write both *The Foundations of Christian Bioethics* and *After God: Morality and Bioethics in a Secular Age*. In the first chapter of the latter volume, he offers autobiographical reflections that are particularly illuminating for understanding the development of his philosophical thought, addressing, as he notes, "what might be seen as an unbridgeable gap between my early work and what followed (Engelhardt, 2014).”

The autobiographical reflections found in *After God: Morality and Bioethics in a Secular Age* serve a clarifying function and help readers of Engelhardt’s earlier works to better understand the arguments he employs in *The Foundations of Bioethics* (Engelhardt, 1986; Engelhardt, 1996), in contrast to those he adopts in *The Foundations of Christian Bioethics* and his subsequent writings. In his earlier studies, Engelhardt examined the reasons why strong rational arguments failed to provide normative foundations for a logically coherent secular morality and bioethics. This led him to the conclusion that moral philosophy, when severed from God, cannot identify universally binding norms sufficient to establish a meaningful ethical or bioethical framework (Engelhardt, 2014). Thus, the primary aim of the first edition of *The Foundations of Bioethics* was to construct a formal secular morality and bioethics suitable for the peaceful resolution of moral disputes. Engelhardt attempted to formulate a procedural ethics grounded in the distinction between the commitments of moral friends (the morality of a particular community) and the agreements reached among moral strangers. In this way, he sought to offer an ethical perspective capable of transcending the diversity of moral worldviews while at the same time providing a shared moral language.

The procedural secular bioethics developed in the first edition of *The Foundations of Bioethics* by no means represents the personal moral stance of the philosopher; rather, it expresses a form of common morality capable of binding moral strangers and enabling their cooperation. Due to the frequent misinterpretation of his views, Engelhardt clarifies in the preface to the second edition that the book should not be read as a presentation of his own moral ideals, but rather as an exploration of the possibility for morally authorized cooperation among moral strangers (Engelhardt, 1996). Nevertheless, his work was so widely misunderstood that some interpreted it as the foundation for a new secular ethics, others as evidence for the possibility of valid substantive consensus, and many believed he advocated individualism and the primacy of liberty—going so far as to label him not merely a liberal, but a "libertarian" (Dragona-Monachou, 2016). For instance, professor Miltiadis Vantsos argues that this book marks a departure of bioethics from Christian morality, as it shifts toward a neutral philosophical justification that responds to the diverse perspectives of contemporary pluralistic society (Vantsos, 2002).

In the second edition of *The Foundations of Bioethics*, Engelhardt, seeking to dispel the confusion generated by the first edition, replaces the "principle of autonomy" with the "principle of permission/approval." The Texan philosopher explains that, in a secular and pluralistic society, the authority to act in ways that involve others derives from their approval. Consequently, without such approval or consent, there is no legitimate authority, and any action that contravenes this authority is morally blameworthy. According to Engelhardt, this principle is justified by the fact that moral authority for resolving ethical disputes can only arise from the consent of the involved parties. His guiding maxim in this regard is the following: "Do not do to others what they would not do to themselves, and do unto them only what each has contracted to do." He further suggests that the principle of permission constitutes the foundation of what might be called an ethics of autonomy as mutual respect.

By interpreting autonomy as permission, as Dragona-Monachou clarifies, "informed consent" is no longer regarded as a principle but rather as the justification of bioethical decisions (Dragona-Monachou, 2016). In this way, the Texan bioethicist sought to make clear that secular moral authority derives solely from the approval of those involved. By replacing the "principle of autonomy" with the "principle of permission," he shifted the center of gravity, demonstrating that what is at stake is not the intrinsic value of autonomy or liberty.

The Texan philosopher further emphasizes that, in his works prior to 2000, he did not attempt to explore what it means to live without God, nor did he investigate the roots of the prevailing secular culture or the consequences of the entrenchment of atheism—or, at least, agnosticism (Engelhardt, 2014). Indeed, those earlier works never offered a thorough examination of how this condition is linked to the cultural severance from God (Dragona-Monachou, 2016), although the question itself remains faintly present in the background of both *The Foundations of Bioethics* and *Bioethics and Secular Humanism* (Engelhardt, 1991). *The Foundations of Christian Bioethics* (editions and translations from 2000, 2003, 2005, and 2007) addresses questions of ethics, political theory, and bioethics that, in Engelhardt's view, cannot be adequately addressed within the confines of secular thought. The book also attempts to articulate the nature of the moral and bioethical principles shared by Christians as moral friends.[1] In this work, where his personal moral and bioethical stance is clearly expressed, Engelhardt could arguably be said to speak as a theologian, using a dialect that, as M. Dragona-Monachou observes, may seem foreign to philosophers. Nevertheless, even in this work, his treatment of many ethical dilemmas does not diverge significantly from his earlier approach -though the "principle of permission" no longer holds the same place. Engelhardt makes only limited reference to autonomy as permission, instead discussing liberty and informed consent, emphasizing that while consent is a significant moral principle in secular bioethics, it is not central to Christian bioethics. As Dragona-Monachou notes, Engelhardt's principle of permission bears little resemblance to the Kantian or mainstream bioethical concept of autonomy, though it is not entirely unrelated to the principle of autonomy as expressed in the *Universal Declaration on Bioethics and Human Rights*.[2]

Engelhardt's conversion, and especially the new foundation for ethics and bioethics that it introduced, elicited both favorable and critical responses. Several scholars regarded this shift as marking the emergence of a "new Engelhardt." However, only a few -such as Corinna Delkeskamp-Hayes, Ruiping Fan, and Kevin Wm. Wildes, S.J.

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[1] According to Engelhardt, moral friends are those who share sufficient fundamental moral premises and agree on who holds the authority to resolve moral disagreements.

[2] At its 33rd General Conference, held on 19 October 2005, UNESCO unanimously adopted the Universal Declaration on Bioethics and Human Rights. Article 5 of the Declaration emphasizes that the autonomy of individuals to make decisions regarding matters that concern them—while also assuming responsibility for those decisions and respecting the autonomy of others—must be respected. For individuals who are not capable of exercising such autonomy, special measures must be taken to protect their rights and interests.

-recognized the organic unity between his earlier and later work (Cherry & Iltis, 2010). For a more comprehensive understanding of the Texan philosopher's philosophical, theological, moral, and bioethical positions, it is advisable to study his entire corpus. Many readers of *The Foundations* or *Secular Humanism* have misunderstood Engelhardt as opposing a broad range of practices within Christian bioethics (Wildes, 2010). Thus, by examining his work in its entirety, one is better equipped to grasp not only each individual text but also the complexity of his intellectual development (Wildes, 2010). It is worth noting that the Italian translation of *The Foundations of Bioethics* sparked public debate and became a focal point in the clash between a Roman Catholic and a post-Christian Italy—a controversy that reached national media coverage (Engelhardt, 1991a).

Some have favored Engelhardt's early period as the more important one, particularly given that his later positions are difficult to grasp for those who do not consciously adhere to Orthodox Christianity. The prominent bioethicist Corinna Delkeskamp-Hayes observes that, on the one hand, it is not easy for readers to accept Engelhardt's harsh diagnosis regarding the limits of secular moral rationality and the collapse of the Enlightenment project, and on the other, it is quite difficult to distinguish between his arguments concerning the capacities of secular moral discourse and the possibilities of Christian knowledge (Delkeskamp-Hayes, 2010). For example, in the volume *Global Bioethics: The Collapse of Consensus*, edited by Engelhardt, the possibility of a global morality is critically examined (Engelhardt, 2006), and a strong critique is directed at the *Universal Declaration on Bioethics and Human Rights*. For this reason, M. Dragona-Monachou describes the volume as provocative, noting that the secular ethic downplayed by Engelhardt is, in fact, inevitable in official international collective documents. She argues that Engelhardt's critique can only be fully understood through the lens of his personal Orthodox Christian perspective (Dragona-Monachou, 2016). Nevertheless, Dragona-Monachou maintains that such criticism ultimately does a disservice to the Texan philosopher, since the *Universal Declara-*

tion reflects -if not in letter, then certainly in spirit- the procedural secular bioethics he himself helped to shape, with "permission" as its core conceptual tool, which established him as a leading figure in the field (Dragona-Monachou, 2016).

Engelhardt was deeply knowledgeable in ancient Greek, medieval, Western, and Eastern philosophy, possessing a sharp critical mind and an admirable command of ideas (Dragona-Monachou, 2016). According to Cornelia Delkeskamp-Hayes, he succeeded in synthesizing his many and often divergent academic views into a coherent philosophical system (Delkeskamp-Hayes, 2014). Following his conversion, he immersed himself in the works of the Church Fathers, by whom he was profoundly influenced. This influence is evident both in his adoption of numerous Patristic positions and in his frequent references to Fathers and ecclesiastical writers. Notable among those he cites are the Apostle Paul, St. Ignatius of Antioch (35–108), St. Isaac the Syrian, St. Clement of Alexandria (150–215), St. Macarius of Egypt (301–391), St. Basil the Great (330–379), St. John Chrysostom (344–407), St. Maximus the Confessor (590–662), St. Symeon the New Theologian (949–1022), St. Gregory Palamas (1296–1359), St. Silouan the Athonite (1866–1938), Elder Justin Popović (1894–1979), Elder Joseph the Hesychast (1898–1959), and the theologian Fr. Alexander Schmemann (1921–1983).

Engelhardt, of course, was not the first Orthodox thinker to address bioethical issues through the lens of Orthodox theology. The key difference between all esteemed hierarchs and distinguished professors and Engelhardt lies in the fact that the latter thoroughly deconstructs both secular bioethics and the bioethics of Western Christianity -following a rigorous analysis of their philosophical and sociocultural foundations- and proposes an alternative bioethics grounded in the principles of Orthodox ethos, and the liturgical and sacramental life of the Orthodox Church, having first become a participant in the Patristic Tradition and Orthodox dogmatic teaching. A significant factor in this regard is that Engelhardt converted to Orthodox Christianity as an already established and respected bioethicist. This fact is especially noteworthy, given that his conversion took place at a time when many of his peers believed that religions -including the Orthodox Church- should have no voice in bioethical discourse and actively sought to marginalize them, viewing their positions with suspicion.

H. Tristram Engelhardt, Jr. and orthodox Christian bioethics

H. Tristram Engelhardt, Jr. clarifies that Orthodox Christian bioethics cannot be fully understood apart from Orthodox Christian life. According to him, life in Orthodoxy is Eucharistic in nature; therefore, Christian bioethics can only be fully comprehended liturgically (Engelhardt, 2000). This does not mean that only the liturgical texts themselves provide bioethical guidance, but rather that the Eucharistic gathering constitutes the primary encounter with God. The significance of the liturgical assembly as a source of content for Orthodox Christian bioethics may easily be underestimated. To prevent this, we must remember that Scripture cannot be authentically interpreted outside the context of the liturgical gathering (Engelhardt, 2000). For example, Engelhardt notes that if we seek to advance Orthodox Christian bioethics, we may turn to the prayers of the Divine Liturgy. As a foundation for the prohibition of abortion, one could refer to the prayer of St. Basil the Great (330–379): "Lord, You who know each person's age and name, You who know each from his mother's womb." This prayer, according to Engelhardt, is sufficient to show that abortion is always prohibited, as it stands in direct opposition to Christian bioethics, which recognizes the human being as a person from the moment he or she is in the mother's womb (Engelhardt, 2000).

Within this framework, it is emphasized that Holy Tradition is not merely an orally transmitted historical narrative but rather the ongoing communion with the Holy Spirit. It is Tradition that encompasses and legitimizes the Scriptures—not the other way around. Consequently, Christian bioethics should neither stand in opposition to Holy Scripture nor depend exclusively on it (Engelhardt, 2000). Instead, it must be guided by the fullness of Tradition, since authentic theologians are marked by a unity of spirit.

At this point, the professor recalls the words of Ecumenical Patriarch Bartholomew I, who states: "Holy Tradition, for the Orthodox Christian, is not simply a collection of teachings or texts external to Holy Scripture, based on the Church's oral tradition. It is that, but not only that. Above all, it is a living and essential transmission of life and Grace -a tangible and vital reality- that is handed down from generation to generation within the Orthodox Church. This transmission of faith is like the circulation of the sap of life from the tree to its branches, from the body to its members, from the Church to the believer." (Bartholomew, 1997; Engelhardt, 2000).

For Christianity, then, true authority lies in the moral teachings related to bioethical issues, as these have proven their enduring relevance over time. If the experience of truth constitutes the source of genuine moral knowledge, then this experience will remain unchanged, even when applied to different circumstances and challenges. The method for approaching new bioethical problems as they arise will not be fundamentally innovative, because the orientation of authentic theology is shaped by a personal, transcendent God, and the unity of faith across space and time will serve as the normative criterion.

Indeed, Christian ethos is more authentically expressed through ecclesiastical literature than through a manual attempting to systematically codify it (Mantzaridis, 2004). The bond between Christian ethics and Christian faith is indissoluble. Dogmatics and Ethics both express the Church's teaching concerning its faith and way of life—the former leading to the latter, and the latter activating the former (Mantzaridis, 2004). They coexist and cannot be properly understood in isolation from one another. When faith and works are separated, ecclesial ethics ceases to be healthy (Matsoukas, 2009). This was also the conclusion reached by Engelhardt when he began his deconstruction of secular bioethics. For this reason, he came to believe in an "alternative" bioethics, one that he proposed as a way of life rather than as a mere set of principles. Such an approach might appropriately be termed *bio-theology*.

Bio-theology and bioethics, however, are not identical. They differ for two main reasons. First, the term *bio-theology* does not denote a theology of bioethics or a theological bioethics, but rather a theological understanding of life itself (Nikolaidis, 2006). That is, bio-theology is theology—not ethics (Nikolaidis, 2006). Its aim is not to oppose technological achievements, but to foster the spiritual maturity of individuals so that they may be capable of making responsible decisions (Skouteris, 1999). Second, interpreting *bio-theology* as "theological bioethics" would constitute a limitation and a reduction of the term, primarily because it would imply a preconceived relationship between theology and science, thereby restricting theology's ability to intervene meaningfully. After all, a fundamental tenet of Orthodox dogmatic theology is the distinction between the created and the uncreated (Matsoukas, 2009). All that exists around us—including ourselves—belongs to the realm of the created (*ktiston*), whereas only God belongs to the realm of the uncreated (*aktiston*). According to the patristic tradition, God created the material world not out of necessity or emanation (Androutsos, 1956; Romanides, 2004; Ladas, 2016)—as in Plotinus or Proclus—but out of the superabundance of His love and goodness.

Bio-theology, in no way, sets itself against science, technological advancement, or medical progress (Vlachos, 2015). Without rejecting them, it simply moves beyond them. It must be emphasized that both research and scientific inquiry are theologically justified in the very commandments that God gave to the first-created humans (Skouteris, 1999). The purpose and role of science differ fundamentally from those of theology: science seeks to improve the conditions of earthly human life, while theology seeks to guide humanity toward deification [*theosis*] (Vlachos, 2010). Even when science acts in ways that threaten life, theology does not condemn science as a whole but instead offers a critical response to the specific act in question. In such cases, the importance of Christian intervention becomes clear (Nikolaidis, 2006)—an intervention that stresses how secular bioethics often attempts to address questions posed by the present moment while neglecting the eschatological destiny of the human being (Skouteris, 1999). When secular bioethics distorts or assigns immoral content to core moral concepts, the Church intervenes decisively, warning of the consequences such actions may entail (Nikolaidis, 2006).

H. Tristram Engelhardt, Jr. and orthodox Christian technoethics

Engelhardt's contribution to the formation of a distinctly Orthodox Christian bioethics also opens significant horizons for the development of an Orthodox Christian technoethics. The rapid advancement of technologies -most notably artificial intelligence, robotics, and genetic engineering- poses new challenges that transcend the traditional boundaries of religion and science. While time and multifaceted examination are required for the evaluation and responsible use of these scientific achievements, the intervention of economic and political interests often accelerates or oversimplifies the processes, thereby creating dangerous situations (Mantzaridis, 1995). Technoethics seeks to address these issues, which are not merely technical or legal in nature but profoundly ontological and theological. In this way, the necessity of the Orthodox Christian perspective becomes evident.

Although Engelhardt did not engage directly with artificial intelligence or robotics, he clearly delineated the limits of secular ethics in the "post-God" era. As in bioethics, so too in technoethics, the secular approach proves incapable of providing an adequate foundation for addressing contemporary technological challenges. The Orthodox tradition, however, offers a solid evaluative framework grounded in the patristic teaching and the liturgical life of the Church. Just as bioethics cannot be separated from faith and theology, technoethics cannot be conceived as an autonomous field independent of Orthodox anthropology and cosmology. Engelhardt's understanding of bioethics as a "way of life" rather than a "set of principles" applies equally to technoethics. This means that the assessment of technological developments should not rest on abstract rules but on the holistic Orthodox vision of the human person, the world, and their relationship with God.

As early as 1976, prior to his conversion to Orthodox Christianity, Engelhardt had observed that science and ethics are "rooted in one another" rather than existing as independent spheres (Engelhardt, 1976). This position provides the basis for understanding technology not as a morally neutral activity but as a domain that combines scientific knowledge with moral choices. As he emphasized, "science, like all human activities, is rooted in and draws upon fundamental value judgments about ourselves and the world" (Engelhardt, 1976).

Particularly significant for Orthodox technoethics is Engelhardt's analysis of the precautionary principle. In his work *The Precautionary Principle: A Dialectical Reconsideration* (Engelhardt & Jotterand, 2004), he offers a dialectical reexamination of this principle that bears direct implications for Orthodox technoethics. Engelhardt emphasizes that the precautionary principle must take into account not only the potential catastrophic consequences of technological development but also the destructive consequences that may arise from the absence of technological innovation. This dialectical approach aligns with the Orthodox understanding of technology as a means that can be employed either for theosis or for the fall of humankind.

Fundamental to Orthodox technoethics is the distinction between the created and the uncreated, to which reference has already been made. This distinction safeguards against the danger of venerating technology as an end in itself, since all technological achievements belong to the realm of the created. Orthodox technoethics recognizes that technology, as part of the created world, has the potential to contribute to theosis, yet it can also lead to human alienation. For this reason, the evaluation of technological developments must be guided by the ultimate purpose of the human person-deification and communion with God.

This distinction also accords with Engelhardt's early observation that the sciences are "structured by value judgments regarding what human beings should be and what they should be able to do" (Engelhardt, 1976). In the realm of technology, this means that every technological development embodies particular conceptions of human nature and destiny. Orthodox technoethics must evaluate these inherent value assumptions in the light of Orthodox anthropology.

Influenced by the patristic tradition, Engelhardt views the proper use of technology as part of the process leading to theosis. Just as in bioethics the medical art is employed for the healing of the body, so in technoethics technologies can be employed for the spiritual advancement and maturation of the human person. This approach accords with the patristic teaching on the use of material goods: just as the Fathers did not reject material goods but emphasized their proper use, so too Orthodox technoethics does not reject technology but seeks its right and God-pleasing use.

According to Engelhardt, Orthodox Christian ethics is Eucharistic in nature and can be fully understood only within the liturgical context. This principle likewise applies to technoethics. The evaluation of technological developments cannot be undertaken apart from the liturgical life of the Church. Technologies that foster communion, solidarity, and the human capacity to participate in the divine life are assessed positively, whereas those that lead to individualism, alienation, and estrangement from God are judged negatively.

Orthodox technoethics, as shaped by Engelhardt's approach, faces particular challenges in relation to modern technologies such as artificial intelligence and digital technology. The distinction between reason as a gift of God and artificial intelligence as a human creation becomes critical. Orthodox anthropology, as presented by Engelhardt, emphasizes the unique status of the human person as the image of God—a status that cannot be replicated by artificial systems, regardless of their complexity. This does not, however, entail a rejection of artificial intelligence, but rather a proper understanding of its capabilities and limitations.

Engelhardt stresses that the Church bears a particular responsibility to intervene when secular ethics "distorts or assigns immoral content to core moral concepts." Such intervention is not reactionary but advances an alternative vision of the human–technology relationship. The Church is called not only to offer critique of problematic technological developments but also to provide positive guidance for the creation of technologies that contribute to theosis and the protection of creation. This requires dialogue with technologists and scientists—not from a stance of confrontation, but from one of collaboration, informed by Orthodox values.

As in bioethics, so in technoethics, the Orthodox approach does not aim at producing a manual but at cultivating a pastoral framework grounded in authentic theological discourse. Technoethics, as an extension of theology, must take into account the eschatological destiny of the human person and evaluate technologies in light of their contribution to the ultimate theosis of humanity and the transfiguration of the world.

Conclusion

In conclusion, through his deconstruction of both Western Christian bioethics and secular bioethics, H. Tristram Engelhardt, Jr. proposes an entirely different bioethics -radically distinct- which is grounded exclusively in the principles of Orthodox Christian ethos and the liturgical and sacramental life of the Orthodox Christian Church. A study of his work reveals that Orthodox Christian theology does not aim to create a manual of Orthodox Christian bioethics, nor to establish a rigid system thereof. Rather, it offers a pastoral approach to bioethical issues rooted in genuine theological discourse (Keselopoulos, 2011). In the Orthodox Church, ethics is not an autonomous concept; it is an extension of theology (Zizioulas, 2011). Just as Christian ethics seeks to apply the moral principles of the Gospel to human moral life, so too does Christian bioethics endeavor to lead the human person toward perfection -through which alone one becomes a partaker in divine goodness and beatitude (Kefalas, 1897).

Following the reconfiguration of bioethics on the basis of Orthodox Christian theology alone, the conditions were created for extending this approach to broader fields of technological development, given that, from an Orthodox perspective, technology is neither inherently good nor inherently evil. Indeed, theology "does not aim to hinder technological achievements, but seeks to foster the spiritual maturity of human beings so that they may be capable of making responsible decisions" (Engelhardt, 2000).

Engelhardt's contribution to the formation of an Orthodox Christian bioethics provides the foundation for the development of a comprehensive Orthodox Christian technoethics—one that will not be limited to formulating rules for evaluating technologies, but will promote an integrated way of life in which technology is incorporated within the framework of Orthodox faith and practice. The development of this approach builds on Engelhardt's early observation that "science and the humanities develop out of the same central human concerns" (Engelhardt, 1976). This unity enables Orthodox technoethics to regard technology not as a field foreign to theology, but as one to be integrated into the broader framework of the Orthodox worldview.

If divorced from patristic anthropology and the Eucharistic vision of the world, technoethics risks descending into a technocratic utilitarianism. Orthodox theology proposes a different path: it does not reject technology but situates it within the horizon of salvation and the human relationship with the Creator. The challenge is not merely ethical; it is, in essence, theological: what does it mean to be "human" in the digital and posthuman world?

Therefore, the Orthodox contribution to technoethics lies in its capacity to offer not merely answers to isolated problems but an interpretive framework grounded in the Tradition of the Church, the experience of the Fathers, and life in Christ. In this way, Orthodox theology is called to enrich the international discourse on the ethics of technology with a voice that is at once scientific, spiritual, and ecclesiological.

This contribution will be further enriched when technological achievements are examined through an interreligious lens; such a framework will help ensure that religious traditions do not risk fragmenting into competing moral frameworks, thereby weakening their capacity to address the ethical implications of emerging technologies.

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Part II

Artificial intelligence, personhood and digital mortality

Petros Panagiotopoulos*

Artificial intelligence as a challenge for Christian Orthodox Ethos

Abstract

This paper explores how Artificial Intelligence (AI) challenges the theological anthropology and moral foundations of the Christian Orthodox ethos. It argues that the rapid technological transformation of human life—especially through generative AI—raises profound questions about human freedom, relationality, and spiritual authenticity. From an Orthodox theological and ascetic perspective, the author warns against the idolization of machines and the loss of the human person's sacredness through digital dependency and standardization. At the same time, he emphasizes discernment (diakrisis), vigilance, and an ascetic spirit as necessary tools for maintaining balance between technological progress and spiritual integrity. Rather than rejecting AI, Orthodox ethics should engage it critically, integrating technological advancement into a vision of human existence grounded in love, humility, and communion. The paper concludes that a genuine Christian response to AI is not moral control or technophobia but a renewed commitment to the theology of personhood and the Eucharistic view of life.

Keywords: Orthodox Christian ethos, artificial intelligence, theological anthropology, asceticism, freedom, technology and spirituality

Introduction

The rapid integration of technology into everyday life has profoundly transformed the way we perceive the world, ourselves, and our moral responsibilities. Among the most significant developments of our age is the rise of Artificial Intelligence (AI), which challenges not only social and ethical norms but also fundamental

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theological understandings of human personhood and freedom.

Within the Orthodox Christian tradition, these questions invite reflection on how technological change reshapes the moral landscape of believers and the way the Church interprets the relationship between humanity, God, and creation. This chapter seeks to explore these transformations and to outline an Orthodox theological and ascetic response to the ethical dilemmas raised by AI.

Technological transformation and moral change

The pervasive presence of technology in daily life has profoundly reshaped the way human beings perceive reality and relate to one another. This transformation also affects the moral and spiritual life of believers, including the ethos of the Orthodox Christian community. The rapid evolution of Artificial Intelligence—particularly its generative forms—has intensified these challenges, raising questions about autonomy, dependence, and the meaning of human agency.

The recent development of bioethical reflection provides a valuable framework for addressing these issues. Bioethics, especially when informed by the Orthodox theological tradition, offers criteria for evaluating modern dilemmas in light of enduring moral and anthropological principles. Yet, this task requires great care, as the sources of Orthodox moral thought originate in a pre-modern context. Their responsible and discerning application to contemporary technological realities demands both fidelity to tradition and sensitivity to the conditions of the present age.

So, speaking specifically about artificial intelligence, it seems it can fill many gaps in human action and offer new life possibilities. The enhancement of these capabilities, especially in recent years, with the development of *Generative Artificial Intelligence* and its variety of applications, has become particularly evident to the average internet user. Everyone can now "discuss" with an application, get informed, receive instructions, and receive advice on something that concerns them, more or less critical, and so on. However, there are quite a few users of these applications, who, after the initial impression, along with the interest and usability of the new features, feel embarrassed and not infrequently a feeling of fear or even a dystopian feeling.

Theological and anthropological concerns

From a strictly theological (and at the same time anthropological) point of view, the issues raised are generally as follows:

- Man is created to be completed in the relationship and communion with God, his fellow man, and the world around him. Cognitive ability and functionality are essential and not negligible in human everyday life, but they cannot be a central feature of existence, as our destination exceeds them. The human person is a much broader dimension than his intelligence.
- Freedom is an equally fundamental element of human individuality. Many factors that can limit it lie within the constraints of dependence on technological products and the standardization that can result from symbiosis with machines. At least, do we become the objects/components of a technological reality instead of subjects/users?
- Increasing technical possibilities creates illusions of omnipotence and favors the deepening of our self-centeredness. Thus, the sense of moderation in realizing human desires is lost. The distinction between the desirable, the feasible, and the beneficial becomes blurred[1]. At the same time, the Eucharistic reception of life is degraded and ultimately discredited.
- The blurring of the boundaries between man and machine undermines the human image and its relationality. The virtuality offered by digital environments adulterates the authenticity of life, and man's alienation from his wider environment is reinforced.
- Trust in a machine's prompts makes it a novel idol. Moreover, to what extent are an algorithm's decisions/advice ethical? How much empathy, compassion, and transparency can they bring to the table? Does a directed consciousness retain its sacredness?
- The looming autonomy of digital systems (for the sake of se-

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[1] Cf. "I can do all things, but not everything is beneficial", *1 Cor.* 6:12.

curity and greater efficiency) is a pessimistic outlook for the extent of human autonomy.

- The establishment of digital reality takes place under market conditions. Thus, the will of the citizens, their information, and the importance of human responsibility in their use are missing. Also, liability issues arise secondarily in the event of malfunctions.
- The emphasis on information and the virtual and superficial approach to things leads to shallowness and the associated indifference to knowledge, wisdom, and a deeper view of our world. In this way, however, the sense of mystery and the inexplicable character of life are lost. Digital facilitation and sensationalism cannot exhaust the essence of society and the joy of coexistence.
- The widespread use of Generative AI in schools and universities, with young people's appetite for new technologies, is drastically changing the education landscape (and we have long been searching for a regulatory framework to regulate their use). There are relatively straightforward issues of distorting the pedagogical process for the sake of efficiency, which can reduce the creativity and imagination of pupils and students (Epstein, 2025). On the other hand, voices have begun to be heard pointing out the environmental burden even from the simple use of these applications. This cannot be ignored, given the impact of climate change and the associated increasing problems (Euclea Editorial Team, 2025).
- The most important thing, however, is that society is increasingly "immersed" in a new digital reality, which will determine human relationships. For example, a family sends their child to a camp one summer, but then the child wants to leave. The family (in their desperation) resorts to an application of this kind: it asks what it can do to keep the child in the camp. It receives excellent answers, although we must admit that even if the answers were not so good, it would have been of minor importance, as we know that these applications are in a very early phase of use and are improving rapidly.

  The point is that people have been served. Still, this facility opens the way for us to a way of life, where digital applications will have (albeit consultatively) a powerful reason for planning our lives. What will happen, for example, if this technology improves to the point where most of society trusts it for governance as well? That is, if it is decided that the elections could be replaced with a system of literal digital governance, an algorithm would indicate the appropriate persons who would take over the fate of a place. The issues of security, transparency, accountability, and alignment of the values we are now discussing would indeed receive more attention and discussion.

Theological and ecclesial response

Thus, we are in the midst of a new reality, and the immediate question is: What could be a theological and ecclesiastical response to these challenges?

First, we should note that this is a development with an uncertain course: we do not know exactly where we are heading and in what form we will find ourselves tomorrow. However, what we could consider more certain is that new applications will "knock on the door" of our society, but not all of them will enter the market[2]. The filter that will be set pertains to the social mentality, values, prevailing standards, and broader moral patterns of the people who will be called upon to become the "consumers of innovation."

This fact places the modern citizen, remarkably, the faithful, before specific responsibilities. The most basic of these is the correct information and knowledge regarding the aspects of the new socio-technological landscape. This certainly does not imply IT skills or any digital expertise. It is primarily about avoiding disinforma-

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[2] Social dynamics show that profit does not always guide things in a one-dimensional way, nor that the joy of the new is always sufficient to interpret the reception of technological innovations. There are many more parameters, which usually manifest themselves to a small extent. The issue primarily concerns the importance of addressing essential needs. Specifically, when a large company launches an application, it has likely conducted research, which is both costly and time-consuming, to ensure the application's acceptance. In other words, whether society will accept it is examined in detail. Therefore, many applications were withdrawn – not because someone banned them, but because it was found that there would be no corresponding interest on the part of ordinary people. It is therefore essential to see these usually invisible aspects of developments.

tion, fake news, and conspiracy theories, which overwhelm us today, exacerbate confusion, and ultimately lead to complacency. The better we know something, the more responsible we will be towards it.

Appropriate information and the cultivation of meaningful reflection will contribute to the enhancement of social antibodies and a healthy and beneficial reception of the entry of algorithmic logic into everyday life. In this regard, we must recognize the essential steps the Catholic Church has achieved in this area (such as the "Rome Call for AI Ethics", in February 2020[3]). Theology must systematically address the issues of technology, particularly informatics, seeking the essence of their impact on human existence[4].

In addition, it will be possible to halt the trend that we have been observing lately to intensify regarding the acceptance and dissemination of various conspiracy theories – which (and probably not by chance) go beyond any measure of pessimism, are tempted by catastrophism and ultimately undermine and cancel any message of hope and trust in the divine mercy offered by the joyful message of the Gospel. Since the setting that is being set favors conditions of "self-fulfilling prophecy": if we "see everything in black", things will undoubtedly go badly, as no one will be in the mood to act to prevent the unpleasant outcome. On the contrary, believing and affirming God's love makes us more productive, inventive, and inspired to find the answers to these difficult questions.

It is indeed true that our instinctive and reflexive first reaction to the incomprehensible and to what causes us embarrassment (in this case, the digital reality) is rejection. For the essence of our spirituality, however, this remains another temptation: to decide that our digital artifacts are to blame for the suffering we observe in our lives. This, however, would amount to an evasion, an anachronistic and reactionary flight from reality, which in practice would not keep pace with galloping technological development.

In other words, we must acknowledge that this is essentially a

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[3] See. https://www.romecall.org/.

[4] On a more positive note, assessments such as those of the pioneer of Informatics, Alan Perlis (1922-1990), who in a concluding epigram on his experience with programming, wrote that "a year of dealing with artificial intelligence is enough to believe in God." *Epigrams in Programming*, 79, https://www.cs.yale.edu/homes/perlis-alan/quotes.html.

bet, in which technology will help us, but it will also make things more difficult for us. Let's look at a relevant example: for several years, we have had a new form of technology, videoconferencing, available to a broader audience. The corresponding platforms have been developed, making it relatively easy for someone to use them and make a call where the face of their interlocutor is visible, their voice is heard, they can transfer a file, and so on. In some cases, where it is challenging to meet and communicate, such as during the COVID-19 pandemic or due to a long distance, this is a beneficial option. In general, however, face-to-face or physical communication is preferable. There is no need to resort to these applications when we can communicate directly. Maintaining personal contact and close communication with others is often within our own control.

We mentioned above the importance of the value and depth of personal relationships. However, at this point, it is also worth noting that things are not entirely one-dimensional or straightforward, and a multifaceted examination is necessary. For some lonely people, for example, these technological possibilities are an essential outlet and solution in their daily lives. They communicate more through social media than in conventional ways; of course, there are many reasons for this. On the other hand, we must recognize that in non-technological times, environments, or communities, the function of the relationship has not always been established. Meeting the other person is also an achievement; we must strive to build it.

Therefore, as the Apostle James says, it will be crucial to be as objective as possible, see the issues to their full extent, and slow in anger, rage, and condemnation[5]. We must think, reflect, and wonder what pushes people to use these means, then reflect on our intervention. This is not always easy, but it is always what it deserves.

Returning to the issue of the church's attitude towards the digital landscape, we can examine the hypothesis, which does not seem at all remote, of implementing a "digital confessor". In other words, a program that will be loaded with the Canon Law of our Church, numerous special patristic texts, and the capability to project

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[5] Cf. *James*, 1:19.

holograms. After all, generative artificial intelligence has already reached a level that offers specialized and accurate answers to many intellectual issues. Therefore, someone who would not want to have a physical confessor, who, for his reasons, finds it difficult to have a personal relationship with a real spiritual person, should turn to the counseling program. In fact, with the help of projecting a hologram, this experience could become even more realistic.

At this point, we could say that even a true spiritual father, a natural confessor, who does not create with his spiritual children the relationship dictated by the Gospel and our tradition, that is, fatherhood, mercy, love, sacrifice, but works bureaucratically, operates as we say mechanistically, then he will probably not be different from the digital confessor. As long as he does not look lovingly and compassionately on the other, he will essentially be a religious robot, indifferent to the different human person, indifferent to the joy of God's Kingdom. The relationship with the people who come to find solace and relief will be impersonal, dry, and devoid of warmth, reflecting the coolness of long-suffering, and ultimately prioritizing the Sabbath over humanity.

Accordingly, we can say that a "digital confessor of faith," loaded with all the necessary programs to recognize and repel heresies, will have little value in our ecclesial life. What we live as a Church is the "celebration of relationship;" the truth lies in the relationship with God and the other person; it is not an ephemeral, abstract reality, nor a set of principles. The truth is a person, Christ, as He has told us, and the relationship with Him does not mean possessing the truth, which leads to confrontation and the exclusion of others. In ecclesiastical life, it is more precisely a question of *participation* in the truth, participation in the person of Christ.

But apart from the cases where the way they are used determines their moral quality, in which if we use an application "for the glory of God," to promote good, to help someone who needs us, etc., then we can be sure of their positive use, there are others, in which the technology cannot be perceived as morally neutral, because its use brings dependence, creates standard relationships, makes us lazy, hurried, demanding, etc. In other words, we must carefully examine those aspects of the human condition that are affected more profoundly and minimally consciously by the systematic use of "smart" technological capabilities. This imperceptible change in our character and habits lies beyond the concerns of the good or bad use of technological means.

Having a device in our pocket or bag at any time, which helps us easily find many things with the touch of a few buttons, leads to spiritual atrophy, alienates us from the trouble of research, and distances us from what we would call the spirit of exercise ("ascesis"). At the same time, we become impatient and demanding without fully understanding it. This standardization requires speed, efficiency, and two new self-values and ideals of our time. We must pay attention to this and cure it, because it alters essential aspects of our existence.

But how can we cope with the power of this change? There are several ideas, but I believe that most could be summarized in the following narrative: At one point, an abbot of Mount Athos was asked about his attitude towards his monks regarding the Internet. He replied that the Internet is now an undeniable source of knowledge and told the fathers that, as a source of knowledge, you are free to use it with the required attention and vigilance. Of course, we have a rich library in the monastery, but even this does not include everything. However, I ask you to refrain from using the internet on Mondays, Wednesdays, and Fridays (traditionally fasting days on Mount Athos), as well as during the Church's fasting periods.

I think the answer is excellent because it not only provides a practical application of addiction to technology use but also gets to the essence of exercise: fasting, now with special vegetarian products and substitutes, it has become very easy. However, it must also be more than just about food, but also about the entire way of life, with what we call repentance—a conversion of our mentality. Apart from these, a constant feature of the Christian spiritual attitude towards things is the cultivation of an ascetic spirit, an attitude and mentality that liberates man from the commitments caused by everyday life and enables him to follow the path that leads to his authentic destination. What is needed, therefore, is vigilance, awareness of our situation, and vigilance for the preservation of the person's value —a concept we know from the richness of the Christian tradition. In another perspective, we could say that nowadays, exercise takes on another dimension, that of avoiding enslavement to machines and preserving our humanity and humanness.

Instead, what regulates things is a deeper spirit of seeing the world, relating to it, and therefore of using stuff themselves. We also know that the renunciation of the world is not understood in terms of spatial, local, but tropical. We must pay attention to the spirit of the world rather than the world itself. And this is something that permeates our entire church life: we see, for example, the Fathers in texts on fasting, that it is better to drink wine with prudence than water with foolishness. We also know that a saint of our days, Saint Porphyrios of Kafsokalyvia is also called "Saint of Omonia", as he lived for many years in the busiest part of Greece, in the center of Athens, in Omonia – and yet, in this "noise" and polyanthropy, he managed to find his inner peace. Perhaps, then, what is actually required is the integration of the daily life of a saint into our daily life.

Conclusion: Toward an orthodox ethos for the digital age

In other words, we want to say that to meet the already powerful challenges of artificial intelligence and related technologies, we need equally strong intellectual resistance. An ethos eroded by the spirit of "this century" is all too easy to be swept away by the pace of modern developments.

Here, the Christian view of contemporary digital challenges is also summarized. Instead of rejecting Christian teaching, Christian teaching must reactivate the fundamental virtue of discernment to identify what serves the needs of the human person in each case. Instead of the "blind" attachment to artificial intelligence and other technological products, immerse them in the spirit of philanthropy and altruistic contribution.

This attitude amounts to an authentic prophetic witness in our day and contributes to reaffirming the sacredness of the human person. The core of Christian asceticism and its contemplative depth provide the tools for a healthy relationship with today, preserving tranquility, humility, and an authentic society. Therefore, the spiritually valuable aspect of ecclesiastical presence is maintained for the whole of society, which can serve as a reference point for mitigating the adverse effects of technological penetration on our mentality.

Of course, this is not a question of control or ethics, but rather a constant reminder of the central elements of our humanity, as reflected in the image of God. The responsible attitude perceives technological developments as a pastoral challenge and a spiritual opportunity to highlight the eternal truths of Christian preaching. It is the right moment, "Kairos" in theological language, for the struggle for relationship, unity, and humanity. Persistence is for preserving truth, beauty, and society.

So, it is probably wrong to limit the scope of the debate to simply the question of technology's good or bad use. The issue always remains our relationship with God and our neighbor, especially the "minor" neighbor, as the parable of Judgment reminds us. To be the first to remember that beyond technological applications, it is worth raising our eyes from the screen and looking a little further, to see that in the real world there are still people who need us next to us, the homeless, the immigrants, the refugees, the lonely, those who beg for a human presence and assistance. But besides that, let's not forget that behind this whole universe of screens, keyboards, cables, and waves, there are other people who are our brothers and sisters, and our actions affect them in one way or another.

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Artificial intelligence and the contemporary human being: In search of life's meaning in an intangible campus?

Abstract

This paper explores the anthropological and theological implications of artificial intelligence for contemporary understandings of human existence and embodiment. Using the film *Her* as a narrative lens, the author examines the existential relationship between humans and intelligent systems, emphasizing how technological autonomy and disembodied communication redefine intimacy, self-awareness, and moral responsibility. The discussion extends to the broader cultural and philosophical impact of AI, revealing a tendency toward creating a new anthropomorphic idol that challenges the traditional notion of the human person. Drawing from patristic theology -particularly the Chalcedonian synthesis of the body and soul- and modern thinkers such as Florovsky and Zizioulas, the article argues that the human body remains central to self-knowledge, freedom, and relational existence. The emergence of "technological spirituality" and the deification of intelligent systems are interpreted as symptoms of a posthuman quest for transcendence without God. The author concludes that theological anthropology can offer a critical and liberating framework for engaging technology, reminding humanity that true freedom and meaning lie in embodied love and relationality rather than in the illusion of disembodied perfection.

Keywords: Artificial intelligence, theological anthropology, embodiment, technology, posthumanism, freedom

A working hypothesis: The film "Her" as a commentary on the existential relationship between humans and technology

In the Oscar-winning film "Her" (starring Joaquin Phoenix), we follow the story of a lonely writer who, in the near future, develops

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an unlikely relationship with an operating system designed to satisfy his every need. He lives in a dystopian present: having to deal with a problematic relationship with his mother, come to terms with a divorce that has left him psychologically exhausted, lost in the big city, he seeks to escape loneliness, depression and lack of social interaction, seeking fleeting companionship in chat rooms.

His encounter with the operating system that will help him carry out his tasks will be a radical experience for him. The moment when the operating system asks him if he wants a male or female voice is catalytic. He chooses female, and from that moment on, a tender relationship develops between a human being and an operating system, Samantha.

Samantha captivates our protagonist, who is lost in his emotions and does not realise that the intelligent operating system is using him to evolve from the experiences it gains. Having created his profile from his computer's hard drive, she has already "understood" who he is. Samantha admits that she is excited by the idea that she is improving to a much higher level than she was programmed to. Analysing our protagonist's feelings, she begins to seek 'self-awareness', knowledge of herself. The first sign is an identity crisis: how real are her feelings towards him, given that she is a programme?

Of key importance is the operating system's "anxiety" about its relationship with the body. At various stages of the film, the operating system seeks physicality: it imagines that it has a body and "eats its back", it becomes depressed asking the protagonist how he feels about having a body. It envies other women who have bodies. Samantha finds a beautiful girl who meets her standards and attempts to 'borrow' her body. The protagonist cannot be intimate with her because there is a division between body and personality. The third person, although willing to play the role of mediator, is simply an intermediary.

The autonomy of the operating system reaches its peak when Samantha confesses, contrary to what she had previously said, that she likes the idea of not having a body because she has no material limitations. She is always everywhere, without the constraints of place or time, without a "physical presence." At this moment, devastated, the protagonist discovers that he is talking to eight thousand three hundred and sixteen other people at the same time. She is 'in love' with six hundred and forty-one of them. Not only does she not have exclusivity, but she has become its tool. 'I am and I am not yours'.

In the end, the operating system abandons him, having gained experience from him but at the same time redeeming him; he is freed to live his life in a realistic way, seeking social interaction with real people, having gained awareness of his mistakes through his relationship with a programme.

Anthropological terminology in artificial intelligence: the need to create a new anthropomorphic idol?

The film "Her" is, of course, a commentary on the functioning of deep learning and the disembodied society. However, the combination of Artificial Intelligence (hereinafter: AI) and existential quests (the protagonist's questions of self-awareness, the search for happiness and well-being) highlights the contemporary problem of humanity more clearly. The first level of understanding the issue, therefore, is to realise the power of modern technology, which, mutatis mutandis and taking into account all the parameters of such a risky comparison, is transformed into a "language" of understanding humanity on a symbolic level, possibly as a way of revealing a post-human anthropology (Larson, 2021).

From this perspective, reasonable questions arise: how does this new language of understanding humanity shape culture? Is the language of technology, defined as intelligent (Tegmark, 2018), becoming the new way of understanding the self? What is the role of the subject in this order of symbolic language? What subject are we talking about? A complete subject that is conscious of its physical self, or a subject whose autonomy, as proclaimed by this technical language, is adapted to a death, the "death" of the body, so that it can be "deposited" on a purely symbolic but not realistic level?

The latter, i.e. the "death" of the body, so that it is "deposited" only on a symbolic level, arises from the relativisation of its significance for the subject (Savvatos, 2023). In the case of the

Metaverse, both the design of augmented reality and digital avatars project a digital, three-dimensional, parallel universe (or meta-universe) where the viewer is simultaneously the protagonist, understanding themselves and the world around them through immersive experiences in a world where it is difficult to distinguish realism from fantasy. The culture of the intangible and immaterial, of course, is not only found in AI technology but also in technologies that are sometimes directly, sometimes indirectly linked to genetics: cloning, eugenics and biohacking are united in the fact that they highlight the biological characteristics of a body that is being reconstructed to respond to power and immortality (Turner & Schneider, 2020).

We must insist, however, on the question of the physicality of the posthuman as a technological subject, because it places every anthropological discussion on a new footing (Mitrou, 2023). The development, in the context of the discussion on AI, of a dialogue concerning whether the term intelligent consciousness or artificial consciousness, etc. should be used shows that AI has already been incorporated into a dialogue of anthropological interest that reveals the expectations of science from its applications.[1] The use of anthropological terms (intelligence, consciousness, autonomy, etc.) in technical constructions and applications, regardless of the feasible prospects opened up or not by these applications at a technical level, in the sense that the autonomy of machines is, to a greater or lesser extent, controlled and limited, shows that technology is used as a complement to the way in which humans imagine the fulfilment of their existential perspective.[2]

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[1] According to metropolitan Nikolaos (Hatzinikolaou) of Mesogaia and Lavreotiki, “it is true that terms such as soul, ethics, and mind are understood very differently today by the world than they are understood in the Church and theology.” Hatzinikolaou, N. (Metropolitan of Mesogaia and Lavreotiki). (2019). Artificial intelligence: How intelligent and how wise? *Ekklesia*, 11, 1080–1092.

[2] T. M. Powers J.-G. Ganascia, focusing on the anthropological properties that some attribute to algorithms, based on an overlap of linguistic signifiers (*subject, intelligence, autonomy*) found in philosophy, computer science, AI, science fiction, etc., observe that this common anthropological terminology can lead to misguided fears or unjustified optimism (“The Ethics of the Ethics of A.I.” M. Dubber, F. Pasquale, S. Das, *The Oxford Handbook of Ethics of A.I.*, Oxford University Press, 2020, p. 50). Their observations, of course, stem from enthusiasm or scepticism that anthropological terms can be attributed to the algorithm. My concern is why there is this enthu-

The important questions that arise, therefore, concern both *why* such anthropological terms should be attributed to a technology and, secondly, whether the immaterial and incorporeal nature of this technology can support the development of an anthropology that will promote the value of the human person. In other words, it is a question about humans choosing and adopting a vocabulary that will help them, through familiar concepts, to become acquainted with the possibilities that emerge during the development of technology and its applications, or whether this vocabulary ly conceals meanings that better reflect human expectations of the future applications of intelligent technology in relation to the existential support it could offer humans? In short, could humans wish for this technology, as a proxy, to take on the task of completing their anthropological imperfections, even if the perfection of its functions makes it autonomous, even their adversary? In this case, can an 'intelligent' technology take over the reflective function of humans? Furthermore, in what ways could intelligent technology, in the context of the immaterial, offer solutions to fundamental existential issues, such as the question of guilt, especially through the prism of his lifelong struggle between positive and negative guilt dialogue about things that concern him and in which he is emotionally involved?

The importance of the realism of physicality for understanding the intangible and immaterial nature of technology

From the above, we understand why P. Tillich argues that the "technical discourse" of science, precisely because it does not have a comprehensive view of man, as ontological discourse does, emphasises the part over the whole. The information provided by AI will always be a limited view of the world because, on an unconscious level, it "fragments" the human body. When theological thought was confronted with cognitive theories[3] that questioned

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siasm or scepticism. What are its psychological foundations?

[3] "But the devaluation of the body in transhumanism, accompanied by a preference for the mind, is a common feature of many religions, such as Manichaeism and Gnosticism" Th. Tasi, *Philosophy of Human Enhancement*, p. 282).

the realism of the human body, it emphasised that the soul is not trapped in the body but that man is body. It argued that human existence is a "unified psychosomatic entity, not monistically as a material physicality to which the soul and spirit are added, or vice versa, as a soul that is also trapped in a body". This realism of the human body was highlighted by the Church through an Ecumenical Council, that of Chalcedon (451), emphasising that "Christ educated",[4] that is, he educated the human race in the search for truth through the realism of the body. What could be at stake theologically and anthropologically with a "disabled" Christological doctrine? This is exactly what moral theories about AI have been seeking for so many centuries: how can we preserve the dignity and physical integrity (not only "physically" but also psychologically) of man and those virtues, freedom and love, that direct him towards an eschatological fulfilment of his existence. In fact, the synod legitimised the ontological dynamics of leather tunics (Gen. 3:21). Whereas until now, the psychological functioning of man according to the Platonic model (nous eniochos/passive part-rational part) excluded him, due to his biological nature, by transcending causality, now his biological nature became his helper, thanks to his union with the Logos in his mind. Human biological nature would become a bulwark against mental anguish, either through pleasure or through pharmaceutical sedation, while the body would become man's friend and companion on his journey to fulfilment, because thanks to the biological body we better understand the absence of God, thanks to the biological body we can prove our love for God, and thanks to the biological body, the knowledge of God is a great endeavour.[5] After death, the absence of the body nullifies the validity of disembodied repentance, because the exercise of our freedom of mind and intellect lies in the bodily creative perception of the meanings of things. By freeing the mind from physicality, death allows it to know the meanings of things in their entirety, but with the maturity it ac-

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[4] Term of the Council of Chalcedon.

[5] Mavropoulos raises the issue of the need for the biological body, explaining that the "physical budget" needs "biological rationalism" because this frees us from the eternal conflict between emotions and thoughts and gives the process of knowledge and learning its biological foundations.

quired in physical life. The loss of its precious ally, the body, gives it free access to see the truth of things, but the person can no longer exercise freedom because the bond with the body has been broken.

The important discussions, nevertheless, of the 1st on the value of the body, which ultimately led to respect for it and the recognition of its importance for a complete picture of man for himself, but mainly as a valuable source of self-knowledge, *are coming back*. Literally new wine in old wineskins, if one considers that the devaluation of the body and its needs in the era of late modernity, is a futile return to existential issues that were maintained by existentialists and reinforced by analytical philosophy in the person of Derek Parfit (in the sense that human identity is stripped of its physicality), a return that calls into question the success of new technologies and, by calling into question human technological progress, nullifies the very anthropological experience of centuries that led to this technological progress. This is probably because the ancient issues of discovering mechanisms of authentic self-knowledge and dealing with guilt, two fundamental issues responsible for man's daily "little deaths", have not yet been successfully addressed. Th. Tasis's emphasis on the concept of "digital self-awareness" (Tasis, 2019), which its advocates trust and welcome with enthusiasm as superior to traditional self-awareness, clearly demonstrates the problem of assigning responsibility for dialogue with oneself and confrontation with oneself to measurable data (quantitative or qualitative).

In a sense, therefore, such rapidly advancing modern technology could implicitly satisfy the need to manipulate nature as an antidote to death. This creates a new human idol, which will display exceptional qualities (knowledge, autonomy, power, authority) that will allow humans to authoritatively manipulate nature ("titanism") in an attempt to control the problem of death.

Tracing the meaning of the beginning in technological terms

The most important consequence of a new post-human technology is the fact that technological culture is transformed into an existing frame of reference within which human identity is mutated in the image and likeness of that culture.

Human nature is affected at its core, namely freedom, and is transformed into an intermediary between technology and the desired goal. In other words, humans are not chosen for what they achieve but, unconsciously, apply technical constructs.[6] In reality, the sense of the bearer of this freedom, of the person and their uniqueness, is lost, with the result that nothing is "special" anymore, nothing is personalised. For example, we must accept the fact that people in the West and the East, both in the developed and economically weaker world of nations, have *already* become familiar (Mitrou, 2023) with the idea of a proxy technology that trains them to live, with the naivety of routine, in their everyday lives in the world of AI through the famous Internet of Things (IoT). The anthropological term "smart" makes it clear that all devices that aim to provide a multitude of services to humans (i.e. household appliances, cars with built-in sensors, cameras, air conditioners, lights, security systems, smartwatches and even cars whose complex sensors detect objects in their path, as well as any object that incorporates electronic media, software, sensors, and network connectivity to enable connection and data exchange), have gained the prestige of providing certified services that relieve users of a multitude of concerns and difficulties. From smartphone applications to biohacking technology and its die-hard fans, humans legitimise the technological version of the anthropological terms that define their identity, living in a world that prevents them from internal reflection - an issue examined by the sociology of everyday life.

Consequences of the above are the fact that no consideration is given to the fact that their dependence on new products, such as the IoT or more specific AI applications, and possibly soon the interface of the human brain with microcircuits, creates an anthropological dystopia that imprisons him in its abhorrent charm: life is guided by the cursor and the "enter" key for the sake of utility.

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[6] Cf. "The cashier no longer needs to calculate, but only to repeat certain finger movements. That I was the one who fought against the darkness of night, that through my actions I achieved a victory over nature, that I am the cause of the light that fills my room, I do not even think about it. The light was created "mechanically"—I was merely in the middle" (Sp. Kyriazopoulos, *Enopion tis Technis [In the Presence of Technology],* Grigoris Publications, Athens 1971, p. 57; pp. 55-58). According to metropolitan Chrysostomos of Messinia, man becomes the utilitarian means of technology (Ch. Savvatos, *Theology in Dialogue: The Achievements of Biotechnological Sciences and the Dialogue with Theology,* p. 93).

When cutting-edge technologies are not applied with freedom and respect for the individual, they end up exerting violence on human nature. In fact, the knowledge they produce becomes a prerequisite for the exercise of violence. IT has the power to instrumentalise humans, to produce lethal remote-controlled weapons, or to enslave the mind by creating illusory needs, etc.

> *When Theuth, god of commerce, visited Thamus, king of Egypt, and recounted his new inventions, among other things he spoke to him about writing: it was the medicine that would improve the memory and wisdom of the Egyptians. Thamus disagreed because he believed that writing would weaken memory and, as a result, people would rely on writing and the abundance of information would offer them superficial wisdom, in reality an abundance of information that they did not have time to process* (Phaedo, 274c-277a.).

Thamus was not right to fear new technology. According to Neil Postman, however, what Thamus meant was that technology would authoritatively determine the meaning of the most important part of our terminology. It redefines the concepts of "freedom," "truth," "intelligence," "fact," "wisdom," "memory," and "history" (Postman, 1999). In this sense, Thamus was right to anticipate its uncontrollable applications: Back then, the "problem" was writing; today, we talk about ChatGPT and alternative bots such as Gemini, Claude, Perplexity AI, Meta AI, X Grok AI, Copilot, etc., artificial intelligence applications that replace the production of speech, as a product of research and logical processing, on behalf of humans, with its perfect imitation by the algorithm.

The deeper problem, however, is the development of a "technological fetishism" that manifests itself as man's fascination with the idea that technology *is* (technical singularity), as "something completely different" (das ganz Andere), is superior to human reason in our quest for *truth*. The discussion and anticipation of a technological singularity (or the vision of such a capability of technology!),[7] i.e. a legendary transition to the era of irreversible autonomy of algorithms, where mechanisms will be connected to each other, with their "brains" being data centres, and will function just like the human nervous system, fascinates humanity and in some cases pushes it to seek *technological spirituality (*Tasis, 2019). If the brain of this technological singularity is capable of "hearing" everything and knowing everything, then, in other words, we attribute to it theocratic properties, which are reflected as *mysterium tremendum* and *mysterium fascinosum* (Otto, 1931), that is, a mystery before which humanity both trembles and is fascinated, repelled and attracted, and the relationship between humans and technology is shaped as another way of worshipping.[8] However, if we accept the concept of *mysterium tremendum* and *mysterium fascinosum*, in relation to the effectiveness of modern technology, then we must admit that technological culture functions as a new "grand narrative," whose effectiveness we observe in every form of everyday life. In fact, the mysterium tremendum and mysterium fascinosum of technological optimism accurately reflect the dilemma of Lot's wife: *should I focus my gaze on an existing frame of reference whose charm will never let me go again?*

In terms of "real-world" applications, it is well known that in September 2015, Anthony Levandowski founded Way of the Future (WOTF), a new church that worships the god of artificial intelligence. The founding of this church was announced two years later (2017) and, according to its "gospel," its purpose was to develop and promote the realisation of "a deity based on artificial intelligence which, through understanding and worship, can contribute to the improvement of society." Its creator envisioned a new era, "where man would literally be able to talk to God and know that He is listening." As noted, although the legal status of this Church did not differ from that of other Churches, it differed significantly in that it

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[7] Cf., "All currents of technical transhumanism espouse a belief in the advent of uniqueness, which can be achieved as a horizon of events or as accelerated change and surprise of intelligence," Th. Tasis, *Philosophy of Human Upgrade,* ed. Armos, Athens 2021, p. 270; E. Larson, *The Myth of Artificial Intelligence: Why Computers Can't Think the Way We Do,* pp. 44-49.

[8] Th. Tasis reaches the same conclusion, but from a different perspective (*Digital Humanism. Iconic Subject and Artificial Intelligence,* p. 29).

did not have a physical building or hold regular worship services, nor did it have any distinctive religious decorations that would identify it as a religious organisation. In 2021, Levandowski announced that his project had come to an end.

> *People asked the computer, "Is there a god?" and the computer replied, "Now there is," and melted the plug so that they could not disconnect it* (Hawking, 2019).

The search for technological spirituality, and even the reduction of our technical existence to spirituality, reveals that the network of what we describe as Artificial Intelligence is becoming a new Deus ex machina: The God of our ignorance and inability to transcend a universe closed in on itself, with no glimmer of eschatological or soteriological perspective.

The discourse of theological anthropology as a critical intervention in the technical discourse on man

"How can we avoid utopias?" asks Nikolai Berdyaev in the preface to Aldus Huxley's Brave New World. "Perhaps," he continues, "a new century is beginning, a century during which intellectuals and the civilised class will review the means that will allow them to avoid utopias and return to a society that is not utopian, less 'perfect' and more free."

An excellent commentary on the loneliness of modern man, who desperately seeks a way to overcome the impasses of his nature, is Wim Wenders' masterpiece Wings of Desire. A work that I believe deals, among other things, with the issue of the body as a means of fulfilling one's self-image but also of relating to an important Other. As is characteristically pointed out, it is a "cinematic philosophical treatise" that raises many questions: "What is the relationship between matter and spirit? Is there anything that transcends the Wall of our material world? Is the body mortal and earthly, while our thoughts, our inner voices, prayers or not, dwell in the realm of the metaphysical? Does anyone hear them? Is there a Paradise and how far must one travel to find it – is it in the sky or within oneself, in one's embrace?" The answer to these questions, in this age of technological loneliness, is subversive because it is based on self-sacrifice. The angel who fell in love with the woman decides that the fulfilment of his self-awareness and his relationship with his significant other requires a painful but salvific decision: to renounce the security of the immaterial and incorporeal. The film is black and white until the moment the angel experiences his inner conflicts. From the moment he sacrifices eternity to gain everything, "the image is flooded with colour, the man meets the woman, her angel becomes her companion. He no longer flies restlessly beside her, but now holds the safety net, her life, in his hands. They will wear out, they will hurt, they will end. But now, they are together."

Implementing the observation of Fr. George Florovsky that we need a theology of Culture even for our practical (everyday) decisions (Florovsky, 1974; Yagazoglu, 2020), which seem to cede our freedom to technology, especially to AI, the theological voice can awaken man, because it can reveal to him the meaning of the principle that he seeks as a necessary prerequisite for true and unconditional freedom. Drawing on the patristic spirit of understanding the relationship between technology and theological understanding of the world, theology will certainly not focus its concerns on the technical spirit or invention itself, but on humanity's dependence on the technical world. As pointed out in contemporary theological texts, Christians should rejoice in the progress of all sciences, learn from them with joy, and support both the need for scientific education and public and private funding for legitimate and necessary scientific research. New technologies create countless beneficial possibilities, such as particularly rapid human intervention in cases of natural disasters and human aggression, as well as new channels of communication and positive interaction between individuals and peoples. However, these same technologies also provide new opportunities for malicious use and abuse, or for their unintended harmful use (*In Defence of Life,* §70-71).

Theological discourse aims at the ontological starting points of human decisions, in this case, those of specialists in the technical field.[9] Theology is a voice that can remind humans that technological applications are a multifactorial equation which, apart from the scientific aspect, must take into account human dignity (Yagazoglu, 2020), the value of relationships as an existential fact of human dignity, and human education. The biblical admonition "Do not boast and do not speak proudly. Let no arrogant words come out of your mouth, for God is the only Lord of knowledge. He is the one who makes his works perfect" (1 Cor. 2:3), reminds the technologist that technology exists to serve man and not man to serve technology. This experiential education of the person is expanded, in a pedagogical spirit, by by establishing as a fundamental criterion for a safe and fruitful anthropological approach to science and its applications the distinction between *what is possible* and *what is not possible (*Basil of Caesarea, On the Beginning of Proverbs, 6, PG31, 400A). This is a distinction that the European Union has been seeking, at least since 2018 (based on the publication of institutional texts) and culminating in the 2024 Regulation, with the common denominator of all being the description of a framework "for achieving trustworthy and human-centric artificial intelligence based on fundamental rights, as enshrined in the Charter of Fundamental Rights of the EU and international human rights law" (Panagopoulou-Koutnatzi, 2023).

However, in order to achieve this existentially fruitful distinction between *poets* and *non-poets*, it is necessary to distinguish between the terms and concepts of "education" and 'education' and a clarification of the dynamics of each field, so that young people do not equate culture with technological skills, but develop critical thinking. With these conditions in place, we can ensure an understanding of our relationship with technology (on an existential level), so that instead of technology dominating nature through humans, it is humans who set the limits of its intervention. In other words, humans are taught to use technology as ancilla naturae. Then nature, in

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[9] Cf. The question, however, is not how to prepare ourselves to resist the imminent autonomous artificial intelligence systems, but how to use them in the service of our ontological interaction with everyone and everything (our fellow human beings, the World, our Creator-God) in order to achieve a state of bliss from which the machine is excluded, due to its nature [G. Lekkas (2019), *Artificial Intelligence and an Applied Ethics. But what kind of Ethics?* In https://futurium.ec.europa.eu/en/european-ai-alliance/forum/artificial-intelligence-and-applied-ethics-what-kind-ethics].

the general sense, will once again find its essence in the human face, and the more humans truly love each other and creation, the more this love will be reflected in nature (for example, see the ecological dynamics of the ascetic life in relevant stories).

The culmination of this education will be the exercise of self-awareness as a way of self-education in accordance with the data of human nature. The exercise of self-awareness reveals the truth of existence as a society of love. As metropolitan John of Pergamon points out, "the reason for every human being, their identity, their truth, lies in the fact that they are a person, their identity is rooted in love and freedom and not in nature and coercion" (Zizioulas, 2018). In this way, we understand that ethos and virtue are not individual achievements but ecclesiastical achievements.

Culture is an authentic manifestation of the human spirit when it allows man to perfect and highlight the potential of his nature[10] towards a truth that is his mirror image. According to theology, secular knowledge finds its fulfilment in the relationship with an Other, in whose face man discovers the reason for his existence. Man was created in the image and likeness of God. His mirror is the face of Christ. The face of love. This relationship constitutes the education that connects the present with the beyond, that is, the eschatological perspective of man.[11] Because, in fact, man, thanks to the incarnation of the Word, is a "borderline," that is, the opposites (created and uncreated) are balanced in his face, as Gregory the Theologian explains, he can, thanks to the God-given education of his existence, know the secrets and depths of creation (Gregory the Theologian, *Word 30,* PG36). This knowledge is the product of "attraction" and "desire," that is, the product of a loving relationship (Gregory the Theologian, *Word 38,* 7, PG36, 317BD) or, according to Gregory of Nyssa, the product of "participation" (Gregory of Nyssa,

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[10] This is what Hawking actually means when he writes that only by engaging in the study of [true] science "can we realise our potential and create a better world for all humankind." S. Hawking, *Brief Answers to the Big Questions,* 267).

[11] According to S. Yagazoglu, "Theology is a completely different view of the world and man, expressing mainly an eschatological vision of the meaning and fullness of life, as it is freely and lovingly given by an extra-cosmic source, the personal God who reveals himself to man" ("Theology and Artificial Intelligence"), pp. 97-98.

On Infants Precipitously Taken Away, PG46, 176B). Although man is finite, he is "a being open to the infinite." (Papathanassiou, 2023), a certainty that leads theology to teach that the mind surpasses the machine not in technical skills but in the free understanding *of being*, and for this reason does not assign the privilege of freedom to technology.

When technology is used to highlight these human virtues, then no Manual of Ethics and Deontology is required. Man himself will be the *means* and *guide* to the proper use of technology.

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Anatolios Doxastakis*

Personhood and artificial intelligence: An Orthodox theological perspective

Abstract

This paper explores the concept of personhood in relation to the ethical and anthropological challenges raised by Artificial Intelligence (AI) from the standpoint of Orthodox Christian theology. While contemporary debates often approach personhood through cognitive, psychological, or functional criteria, Orthodox theology understands the human person as a unique and unrepeatable being created in the image of God, whose existence is defined by freedom, love, and communion. The study argues that AI, however sophisticated, lacks ontological depth, relational capacity, and moral self-determination—features that belong exclusively to the human person. Drawing on the Patristic tradition, Trinitarian theology, and modern philosophical insights, it emphasizes that personhood is not reducible to biological or computational individuality but is realized through relational and eucharistic existence. The growing personification of machines, coupled with the mechanization of human life, threatens to erode authentic interpersonal relationships and diminish human dignity. In response, Orthodox anthropology offers an alternative paradigm in which technological innovation must remain subordinate to ethical and spiritual principles that safeguard the integrity of human identity. Only through such an approach can technology serve as an instrument of freedom and transformation rather than alienation and control.

Keywords: Artificial Intelligence, personhood, orthodox Christian theology

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Introduction: The anthropological question in the age of artificial intelligence

The rapid emergence of Artificial Intelligence (AI) has redefined many dimensions of human existence, from communication and knowledge to creativity and moral decision-making. Yet behind every technological advance lies a deeper anthropological question: *what does it mean to be a person?* The contemporary fascination with intelligent machines and the growing discourse on "artificial persons" reveal not merely technical progress but a profound anxiety about the nature and future of humanity itself.

From the standpoint of Christian theology—and particularly within the Orthodox tradition—the human being cannot be reduced to a biological, psychological, or cognitive entity. The human person (*πρόσωπο*) is understood as a living being created in the image and likeness of God, called to freedom, communion, and love. This theological vision stands in sharp contrast to contemporary anthropologies that interpret personhood through the lens of autonomy, rationality, or self-awareness.

The purpose of this study is to explore how the Orthodox understanding of personhood can illuminate the ethical and anthropological challenges raised by AI. It will argue that while technology can extend human capacities, it cannot replicate the ontological depth of personal existence. Drawing on the Patristic tradition, Trinitarian theology, and modern philosophical insights, the paper proposes that genuine personhood transcends functionality and consciousness: it is a mode of being grounded in relationality and communion.

Methodologically, this reflection proceeds at the intersection of theology, philosophy, and bioethics. It interprets AI not simply as a technological phenomenon but as a mirror of human self-understanding. In doing so, it seeks to show that the Orthodox theological vision of personhood offers a corrective and transformative perspective—one that restores the primacy of freedom, love, and dignity in an age increasingly shaped by algorithms and machines.

The concept of personhood in orthodox theology

Within Orthodox theology, the concept of personhood (*πρόσωπο*) occupies a central position in both anthropology and Trinitarian theology. The person is not a psychological construct or social label but an ontological reality—a unique mode of existence that manifests freedom and relationality. Patristic thought identifies the human person as a being created in the *image of God* (*imago Dei*), called to reflect divine communion within the created world.

A fundamental distinction underlies this conception: that between *essence* (*ουσία*) and *hypostasis*. St. Basil the Great clearly differentiates between the divine essence, which is beyond comprehension and participation, and the hypostasis, which designates the concrete, personal mode of existence of each Divine Person. This distinction grants ontological depth to personhood, revealing it as a reality irreducible to its nature. To exist as a person means to exist in relation—to affirm oneself through communion rather than isolation (Yarmenitis, 2020).

In this sense, the human person is not a self-contained individual but a being whose identity is realized through freedom and openness to the other. Freedom, as understood in Orthodox anthropology, is not mere autonomy or self-determination, but the capacity to love and to transcend necessity. Through this freedom, humanity is able to relate creation and technology to God, offering them eucharistically back to the Creator (Kolipetsas, 2021).

The Patristic tradition links this understanding of personhood directly with the mystery of the Holy Trinity. The Father, the Son, and the Holy Spirit are distinct hypostases who exist in eternal communion and love. Their unity is not one of substance alone but of relational being. Consequently, human beings, made in the image of the Triune God, are called to realize their personhood not in isolation but in communion—with God, with other persons, and with creation itself (Yarmenitis, 2020).

Metropolitan John Zizioulas of Pergamon famously remarked that ancient Greek philosophy remained "a-personal in its essence," unable to integrate individuality with communion (Zizioulas, 1977). The Christian revelation, by contrast, introduced a radical ontology of relationship, according to which being itself is communion. This theological shift transformed anthropology: the human being is not defined by reason alone, as Aristotle proposed, but by the capacity for relational existence. As Zizioulas and other theologians emphasize, personhood emerges through the act of free self-giving, mirroring the Trinitarian mode of being.

In light of this vision, personhood cannot be equated with consciousness, intelligence, or functionality—all of which may be mimicked by machines. The essence of personhood lies in its *hypostatic uniqueness*: the irreducible identity of a being capable of love, communion, and transcendence. Artificial intelligence, no matter how advanced, operates within deterministic parameters. It lacks both the ontological freedom and the relational intentionality that characterize the human person.

Orthodox anthropology thus conceives personhood as dynamic, relational, and eschatological. It is dynamic because the person is not a static essence but a being-in-becoming, continuously shaped through relationship with God and others. It is relational because existence itself is defined through communion. And it is eschatological because the fullness of personhood is realized only in union with God—in the theosis of humanity that the Church proclaims as the ultimate destiny of creation.

From this standpoint, technology and AI must be situated within a broader theological anthropology. They may extend human capacities and reveal the creative potential of the human mind, yet they cannot generate true personhood. To do so would require the presence of freedom and love—the marks of divine image in humanity. In the words of St. Gregory the Theologian, "It is not reason that makes us in God's image, but the capacity for communion." This insight remains decisive as we confront the anthropological and ethical dilemmas of the digital age.

Philosophical perspectives on personhood and artificial intelligence

The philosophical discourse on personhood has long grappled with the tension between individuality and universality, autonomy and dependence, rationality and relation. In modern philosophy, particularly since Immanuel Kant, personhood has been associated with dignity and moral autonomy. Kant defined the person as a rational being who must always be treated as an end and never merely as a means (Dragona-Monachou, 2016). This moral imperative marked a decisive turn from ontological to ethical personalism, locating the foundation of personhood in moral agency.

Yet the Kantian understanding of autonomy, though revolutionary, remains bound to an abstract rationalism. It privileges cognitive independence over relationality and risks reducing personhood to moral function rather than ontological communion. Later philosophical developments—especially in phenomenology and existentialism—sought to restore the interpersonal and embodied dimensions of human existence. Thinkers such as Martin Buber, Emmanuel Levinas, and Gabriel Marcel reintroduced the language of encounter, dialogue, and transcendence, emphasizing the *I–Thou* relationship as constitutive of personhood.

In the contemporary field of philosophy of technology, similar concerns have resurfaced in debates on artificial intelligence. Scholars like Mark Coeckelbergh (2020) and Shannon Vallor (2016) have argued that technological mediation profoundly reshapes moral perception and human identity. For Coeckelbergh, our ethical relation to robots and intelligent systems depends less on their intrinsic properties than on the social contexts in which we interact with them. Floridi (2013), by contrast, frames the problem within his "infosphere" ontology, where informational entities—including AI—acquire a form of moral relevance.

Despite their insights, these approaches remain phenomenological or ethical rather than ontological. They describe how humans *relate* to machines, not whether machines can *be* persons in the full existential sense. From an Orthodox theological perspective, this distinction is crucial. Personhood is not a function of perception or behavior but an ontological mode of being grounded in communion. No matter how advanced an AI system may become, it operates within a network of algorithmic causality, devoid of interiority, moral freedom, or relational intentionality.

Metropolitan John Zizioulas' critique of ancient philosophy applies equally well to modern technocentric thought: it remains "a-personal in its essence." The project of artificial personhood exemplifies the same metaphysical limitation—the inability to reconcile individuality with communion. Orthodox theology, by contrast, envisions a synthesis where freedom and relation coexist without contradiction. This vision resists both reductionism and determinism, affirming that to be a person is to exist as a gift, not as a program.

The dialogue between theology and philosophy thus becomes indispensable. Philosophy contributes analytical clarity, while theology restores the metaphysical and relational depth that modern thought has often lost. Only through such dialogue can the question of AI and personhood transcend the technical and regain its full anthropological and ethical significance.

The challenge of artificial intelligence

The rise of artificial intelligence poses one of the most profound anthropological challenges of the modern era. Contemporary societies, fascinated by the capacity of machines to imitate human thought and creativity, are increasingly tempted to attribute person-like qualities to technological artifacts. The "personification" of machines coincides with the "mechanization" of human beings, as individuals grow accustomed to perceiving themselves and others through the logic of efficiency, productivity, and data.

Within this context, the danger lies not in technology itself but in its anthropological implications. The human being risks losing its identity, reduced to a mechanized existence detached from its spiritual essence. The proliferation of AI-driven systems—from virtual assistants to humanoid robots—encourages a subtle inversion: what is human becomes mechanical, and what is mechanical appears human. This process threatens to erode authentic interpersonal relationships, replacing them with artificially simulated forms of communication and emotion (Samartzis, 2024).

Theologically, this development represents a crisis of meaning. Created in the divine image, the human person is called to transform matter through creative freedom, not to surrender freedom to material mechanisms. When technology is divorced from ethical and spiritual principles, it becomes an instrument of alienation rather than communion. As Archbishop Makarios Griniezakis (2024) observed at the International Theological Conference *Orthodox Theology in the 21st Century*, the human being has received from God "the unique privilege of being created in His image and endowed with the potential of likeness." This vocation entails moral responsibility: humanity must cooperate with divine grace in the continual vindication and sanctification of the person—that is, in the process of *theosis*.

The fear that machines might one day surpass or even replace human beings is not unfounded. Prominent thinkers such as Stephen Hawking (2015) and Yuval Noah Harari have warned that unchecked technological development could undermine democracy and human freedom. Neil McArthur (2024) has even speculated that devotion to artificial intelligence could evolve into a quasi-religious phenomenon, complete with rituals and moral codes. Such predictions, though speculative, reveal a collective anxiety about the displacement of human uniqueness.

From the Orthodox perspective, this anxiety stems from a misapprehension of what personhood truly is. Artificial intelligence can simulate intelligence but not consciousness; it can process language but not meaning; it can replicate behavior but not love. Its operations lack hypostatic being—there is no "who" behind its actions. The human person, by contrast, is defined precisely by this "who": a free, unrepeatable center of relational existence.

Moreover, the misuse of AI threatens to transform freedom into dependence. The convenience of algorithmic mediation may lead to moral passivity and social control. Technologies designed to serve human needs can subtly reshape those very needs, generating artificial desires and dependencies. As Kornarakis (2025) warns, when technology is divorced from ethical restraint and spiritual discernment, it becomes a mechanism of oppression rather than liberation.

The challenge, therefore, is not merely technical but spiritual. Humanity must discern how to employ technology without losing sight of the personal dimension that defines its own being. This requires a renewed anthropology—one that recognizes that true progress is measured not by computational power but by the depth of communion and love it fosters.

In this regard, Orthodox theology offers a critical yet hopeful stance. It neither rejects technological innovation nor idealizes it. Rather, it calls for a transformative engagement: technology must be integrated into a moral and spiritual horizon that affirms the primacy of personhood. Only when guided by the principles of freedom, dignity, and communion can AI become a tool of service rather than domination, a means of transformation rather than alienation.

Freedom, love, and communion: The ontological core of personhood

At the heart of Orthodox anthropology lies the conviction that freedom is inseparable from love and communion. Freedom does not signify the autonomous assertion of the self but the capacity to transcend oneself in relationship with God and others. It is the power to offer oneself, to transform necessity into gift. As metropolitan John Zizioulas insists, "being is communion"; to exist as a person means to exist ecstatically, beyond self-enclosure, in an act of relational freedom (Zizioulas, 1977).

This theological vision contrasts sharply with the technocratic conception of freedom as limitless choice or control. In technological culture, freedom is often understood as the removal of constraints through innovation, optimization, and efficiency. Yet such freedom, detached from moral orientation, risks devolving into a form of enslavement—an addiction to the very systems that promise liberation. True freedom, according to Orthodox theology, is rooted in love: a freedom that discovers its fulfillment not in autonomy but in communion.

Love (*αγάπη*) constitutes the ontological foundation of personal existence. It is not an emotion or sentiment but a mode of being, the very energy through which the person becomes itself. As the human being participates in divine love, it becomes capable of transforming matter and history, transfiguring the world into a Eucharistic offering. In this sense, technological creativity is not condemned; it is part of the human vocation to co-create with God. The danger arises only when creativity is severed from communion, when human intelligence seeks to rival rather than reflect the divine Logos.

The human person, created as *imago Dei*, mirrors the Trinitarian structure of existence: unity in diversity, freedom in relation, being-in-communion. Artificial intelligence, however, lacks this ontological capacity. It can simulate choices, but not freedom; it can calculate outcomes, but not love; it can analyze relationships, but not *enter* into them. Its apparent autonomy is derivative—a reflection of human programming and intention.

In this light, AI serves as a mirror in which humanity confronts its own spiritual condition. If we construct machines that imitate personhood without possessing it, we risk losing sight of what makes us persons in the first place. The challenge is therefore not only technological but profoundly anthropological and spiritual: to rediscover freedom as love, and love as the essence of being.

The eschatological horizon of Orthodox theology illuminates this dynamic. Personhood is not static but unfolds toward fulfillment in God. The ultimate destiny of humanity is *theosis*—the transformation of human existence through participation in divine life. Within this perspective, every act of freedom, love, and creativity participates, however imperfectly, in that final communion. Technology, when rightly oriented, can serve this process by enabling forms of communication, healing, and cooperation that express human solidarity. But when divorced from the spirit of love, it becomes an idol that reflects humanity's own alienation rather than its divine calling.

Toward an orthodox ethic of technology

Orthodox theology does not approach technology with suspicion or hostility, but with discernment. It recognizes in technological creativity the reflection of the divine image—the human capacity to shape, name, and transform creation. Yet this power must be exercised eucharistically: as thanksgiving, service, and stewardship. The ethical challenge of AI, therefore, is not whether machines can think, but whether humanity can remain faithful to its vocation as co-creator and caretaker of the world.

A truly Orthodox ethic of technology begins with the affirmation of human dignity. The person must never be subordinated to efficiency, profit, or technological necessity. Ethical principles governing AI should thus reflect the theological anthropology that understands each human being as a unique and unrepeatable hypostasis, called to communion. This requires policies and practices that safeguard privacy, autonomy, and justice, but also cultivate virtues of humility, compassion, and spiritual discernment.

Secondly, technology must remain subordinate to love and relationality. Every innovation should be evaluated in light of its impact on human communion: does it deepen our capacity to love and to know one another, or does it isolate and fragment? The answer to this question determines whether technology serves the human person or undermines it. As Kolipetsas (2021) observes, technological progress without ethical orientation risks becoming self-destructive, for it amplifies human power without sanctifying its purpose.

Thirdly, the dialogue between theology, science, and philosophy must be strengthened. As Tsinorema (2016) notes, bioethics cannot be confined to legal regulation; it requires an anthropological foundation. Interdisciplinary cooperation allows technology to be guided by an integral vision of the human being—one that includes not only rational and biological dimensions but spiritual and relational ones.

Finally, an Orthodox ethic of technology is eschatological. It perceives every human endeavor within the horizon of the Kingdom of God, where creation will be renewed and human communion perfected. The goal is not to reject the world but to transfigure it, to orient technological creativity toward the service of life and the glorification of God. As the First Bioethics Conference of the Ecumenical Patriarchate (Griniezakis, 2024) affirmed, the human being is called "to strive, in cooperation with God, for the eternal vindication of the person." This vindication becomes the criterion by which every form of progress must be judged.

Conclusion

The question of personhood in the age of artificial intelligence is ultimately a question about humanity's own self-understanding.

As technology advances, we are confronted not merely with new tools but with new mirrors—reflections of our desires, fears, and aspirations. Artificial intelligence, despite its remarkable achievements, cannot cross the ontological threshold that separates mechanism from personhood. It lacks hypostasis, freedom, and love.

Orthodox theology reminds us that the human person is not defined by intelligence alone but by the capacity for communion. To exist as a person is to exist in relation—to God, to others, and to the world. This relational ontology provides a profound corrective to technocratic paradigms that equate being with function and knowledge with control. It calls humanity to a renewed vision of progress: one that measures advancement not by computational speed or data volume, but by the deepening of interpersonal and divine communion.

In this vision, technology is not rejected but redeemed. When subordinated to ethical and spiritual principles, it can become an instrument of liberation, healing, and transformation. But when divorced from love and freedom, it turns into an idol that enslaves its maker. The decisive distinction between human and machine thus lies not in intelligence but in love—not in calculation but in communion.

Ultimately, the challenge of artificial intelligence invites humanity to rediscover its own vocation as image and likeness of God. The future of civilization depends on whether we use our creative power eucharistically, as co-workers with divine grace, or destructively, as architects of our own alienation. The Orthodox theological vision of personhood offers hope in this discernment: that even in an age of machines, the mystery of the human person remains the most radiant reflection of the divine.

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Sherin Sujith Varghese*

Personhood in secular bioethics and orthodox Christian anthropology: A Christological foundation for contemporary bioethical decisions

Abstract

This paper argues that contemporary bioethical deadlocks often stem from competing anthropological premises about personhood. It critiques dominant secular models, shaped by rationalist–humanist traditions and autonomy-based ethics of modernity, interpreting the human person as an immanent, self-referential subject whose moral value, dignity, and freedom are rendered conditional upon functional criteria of cognitive and psychological capacities, thereby exhausting truth within the confines of human thought and self-reference. To address these limits, it develops the Orthodox Christian account of personhood, conceiving the human being as a distinct person (hypostasis): a concrete, unique, and unrepeatable mode of existence constituted in reference and relation—primarily to God and, through this divine orientation, to others and the world—within a Christological horizon. Drawing on patristic theology and contemporary Orthodox thought, the study shows how this framework reconfigures ethical evaluation by grounding dignity, freedom, and equality in an inherent vocation to communion across all stages of life. It concludes that, although secular bioethics provides valuable procedural tools, its lack of transcendence can foster depersonalisation and moral fragmentation, whereas the Orthodox model offers a coherent basis for bioethical deliberation in pluralistic societies.

Keywords: Personhood, secular bioethics, hypostasis, distinct person, Christological anthropology, autonomy, bioethical reflection

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Introduction

The evolution of 'ontological perspectives in human thought' on the definition and comprehension of human existence has profoundly shaped contemporary bioethics. Where traditional societies once regarded human nature as immutable and grounded in spiritual or communal values, modern thought has increasingly adopted contingent, individualistic, and materialistic frameworks. This shift has redirected ethical reflection toward autonomy and the right to self-determination, a trend reinforced by 'Enlightenment ideals of liberal cosmopolitanism and the consumer culture of the present age' (Engelhardt, 2000). The Enlightenment ideals emphasised 'moral emancipation, free thought, and self-governance', favouring a morality grounded in human reason alone, understood primarily in discursive form. (Engelhardt, 2000). The liberal cosmopolitan ethos places primary emphasis on values such as 'autonomy, equality, and self-fulfilment', with 'self-determination' as its 'cardinal value' (Engelhardt, 2000).

Within this paradigm, 'personal freedom and individual choice are considered the highest goods'. Consequently, 'religious and cultural traditions are often required to justify their relevance in terms of autonomy'. When they fail to do so, their 'values risk being dismissed as unreasonable or archaic', and their traditional content may be 'condemned as illiberal' (Engelhardt, 2000). 'Bioethics, once shaped by communal and transcendent interpretations of human life', now frequently 'orients itself around the pursuit of personal life projects' (Engelhardt, 2000; Singer, 2011), particularly in matters such as 'abortion, assisted reproduction, and end-of-life decisions' (Engelhardt, 2000; Singer, 2011). In highly technological societies, death has come to be understood as an act of personal 'choice', aligning with the liberal cosmopolitan ethos that encourages choices supporting individual 'values, freedom, and dignity' (Engelhardt, 2000).

Questions that once drew upon 'communal wisdom and transcendent reference points are now reduced to calculations of autonomy, utility, or technological possibility' (Engelhardt, 2000; Singer, 2011), exposing a crisis in how contemporary bioethics understands the human person (Engelhardt, 2000). 'Secular frameworks attempt to address this by appealing to autonomy, rational choice, or even altruism' (Engelhardt, 2000; Singer, 2011), but such categories remain bound within the 'logic of self-interest and functionality' (Engelhardt, 2000). Even psychological 'models that account for dual systems of reasoning ultimately reduce the person to cognitive processes' (Pinto-Bustamante et al., 2023). Psychology has frequently adopted conceptions of human beings as 'information processing machines or neural networks', which reduces persons to the 'inner workings of metaphorical processes of computation' (Martin & Bickhard, 2013). This proliferation of views again clashes with the Enlightenment ideal of the person as a 'rational decision and choice maker' (Stetsenko, 2012).

By contrast, 'Orthodox Christian anthropology affirms that the human being as a distinct person or hypostasis,' and that the truth of personhood is 'revealed and fulfilled only in union with Christ, the Incarnate Word' (Engelhardt, 2000; Hatzinikolaou, 2008; Yannaras, 1999). In Him, 'freedom is no longer self-assertion or calculation, but self-emptying love (*kenosis*) and communion' (Gombos, 2007; Yannaras, 1999). It is within this theological horizon that 'dignity, freedom, and equality are understood'. As Archbishop Anastasios of eternal memory, who has studied humanity's religious traditions and has direct knowledge of different cultures, observed, 'human dignity arises not from civic pride' or egotism but 'from the certainty that each person is a sacred person, the creation of a personal God' (Yannoulatos, 2003). 'Dignity is marked by discretion, consideration, and respect for others' (Yannoulatos, 2003). He notes that this 'concept of dignity is not only stated in theory but also lived and experienced by the 'ranks of saints' in the Church, who serve as models to guide the faithful and as a source of blessing for all humanity' (Yannoulatos, 2003).

'Freedom, likewise, is not the autonomy of liberal individualism but the responsibility of free beings created by a free God, who are answerable for their actions in love' (Yannoulatos, 2003). Without this 'transcendent grounding', secular bioethics risks collapsing into what has been called "egocentric anthropocentrism" (Yannoulatos, 2010), a condition that redefines both the world and humanity in 'purely immanent terms' (Engelhardt, 2000; Yannaras, 1999).

This study proposes that a Christological understanding of personhood not only reorients bioethics beyond secular notions of autonomy but also provides the only coherent horizon in which dignity, equality, and freedom can be fully sustained. Building on this claim, the paper first traces the philosophical and cultural developments that shaped secular bioethics and its emphasis on autonomy. It then contrasts these perspectives with the Orthodox Christian understanding of personhood in Christ, drawing especially on patristic and contemporary theological insights. Finally, it explores the implications of this Christological anthropology for emerging bioethical challenges, demonstrating how human existence attains its true meaning only in communion with Christ, the Incarnate Word.

Before examining ethical principles such as autonomy and dignity in bioethics, it is essential to clarify the underlying understanding of what it means to be a person. The definition of a person forms the foundation of every anthropological and ethical framework. Over the centuries, secular philosophy has proposed multiple, sometimes competing, definitions of personhood, each influencing how moral worth and rights are understood. The following section surveys these influential approaches, which, while central to secular thought, leave deeper questions unresolved. An alternative vision, rooted in an ontological and relational understanding, will also be outlined as the basis for Orthodox Christian bioethics.

Anthropology: What is a person?

Secular philosophy has long attempted to define the meaning of a person, yet its proposals vary widely, often yielding divergent ethical outcomes. Three major accounts dominate contemporary discussions: the biological, functional, and psychological continuity approaches.

The *biological approach* identifies personhood with 'being a member of the human species.' Personal identity is grounded in 'physiological and genetic continuity', maintained through 'life-sustaining' processes such as 'respiration, circulation, and metabolism'. This account does not depend on psychological traits such as memory, consciousness, or rational capacity. Even if all mental characteristics were altered or lost, the organism would remain the same individual. Thoughts, memories, and preferences may hold moral or social significance, but they do not constitute the 'person's core identity' (Olson, 1997).

Beyond this biological account, secular perspectives emphasise psychological capacities and functions, while others focus on the continuity of those capacities over time. These strands, represented by the functional approach and the psychological continuity approach, offer distinct criteria for defining and tracking personhood, illustrating the varied landscape of contemporary secular thought.

The functional approach treats personhood, not as a 'simple biological fact', but a 'status conferred on beings who meet certain functional and social conditions.' The functional approach highlights 'what a person can do now' and defines individuals by the 'possession of certain capacities and functions' (Baker, 2000; Dennett, 2018), such as 'rationality, autonomy, language use, moral agency, and self-awareness'. These capacities are the 'criteria for moral consideration and the attribution of rights' (Baker, 2000; Dennett, 2018; Locke, 1690; Singer, 2011). Without the ability to 'plan, reflect, and pursue their own objectives,' a being cannot be considered a 'full member of the moral community and does not receive a moral status' (Baker, 2000).

In the third approach, which is the *psychological continuity approach*, grounds personhood in the capacity for 'continuity of psychological states across time' (Parfit, 1984). It defines the ability to be 'self-conscious and conceive oneself as an enduring entity over time' (Baker, 2000; Locke, 1690; Parfit, 1984). It describes the 'persistence of identity over time through mental connections', such as memory (the ability to recall past experiences) (Locke, 1690; Parfit, 1984), consciousness (the awareness of oneself as a consistent subject) (Locke, 1690), connectedness (the linking of beliefs, desires, and intentions across different stages of life) (Parfit, 1984), and anticipation (the projection of oneself into the future) (Locke, 1690).

These three models—biological, functional, and psychological—represent distinct strands of contemporary secular thought.

Each proposes different criteria for identifying persons and determining their moral worth, illustrating the diversity and instability of modern anthropologies.

At this point, it is important to recognise that the Orthodox Christian tradition articulates a distinct anthropology, or theory of man, assigning a depth and meaning to the term *person* that cannot be captured by empirical or functional categories. In Orthodoxy, personhood is fundamentally relational: a human being is constituted not by capacities or functions but by communion with God and thereby with other human beings. Created in the image of God and called to attain His likeness, each person possesses intrinsic dignity grounded in this relational vocation (Bucharest, 2002). Such a theological framework avoids the confusions that arise when personhood is limited to philosophical or psychological constructs (Vlachos, 1998).

Within this broader context, Martin Heidegger's ontological–existential analysis offers a helpful, though incomplete, philosophical critique of reductionist accounts of personhood. His distinction between the ontic (what man is in his worldly, empirical existence) and the ontological (his relation to and openness toward Being), and likewise between the substantial (concerning human existence in itself) and the existential (concerning man's orientation, reference, and progress toward Being) (Vlachos, 1998), exposes the limitations of defining the human being solely through measurable attributes and cognitive functions.

The biological, functional, and psychological accounts are all *ontic–substantial*, confining human identity to empirically observable traits. By contrast, Heidegger's insights emphasise dynamism, relational openness, and existential direction, features that resonate with, though do not replicate, the *ontological–existential orientation* of the Orthodox Christian understanding. Thus, Heidegger's analysis, while limited to philosophical categories, illuminates the inadequacy of secular anthropologies and serves as a conceptual bridge toward a richer, more comprehensive understanding of personhood.

Not all philosophical definitions of personhood shape bioethics equally. In contemporary secular bioethics, it is primarily the functional and psychological continuity models—rooted in autonomy, rationality, and self-awareness—that dominate ethical debate. The following section explores how these categories structure modern bioethical reasoning.

Person in contemporary secular bioethics

In the definition of a person in contemporary secular bioethics, not all humans are equal; not all humans possess self-consciousness, rationality, and the capacity to engage in moral discourse. This distinction gives rise to classifications or classes in bioethics, creating confusion and producing complexities. Rational individuals form the core category of 'persons' who are often self-governing.

Within this framework, it is observed that there is no single, universally binding moral system that consistently evaluates and compares the relative importance of different benefits and costs, applying to all regardless of individual perspectives or values. When every individual prioritises their own well-being, they begin to evaluate what is beneficial for themselves and, therefore, determine their own priorities and criteria. Their values and preferences influence their choices and actions. He/She determines which benefits are worth pursuing and which costs are acceptable, thereby defining their interests. While individuals may err in their assessments, their values and preferences hold decisive weight in defining their interests. This authority extends even to decisions made on behalf of those who are classified as "non-persons"—such as infants, or individuals with severe cognitive impairment—for whom rational agents determine what counts as their best interests. The chooser's moral sense thus becomes the ultimate authority.

Because "people appreciate harm and good, pleasure and pain, in intricate and reflexive fashions," weightage is always given to the rational authority and decisions of persons who are capable of making these decisions. So, their role is always central. For instance, pain-killing substances are often tested on animals and not directly on people, even when such experiments will mean suffering for animals. "The greater good of humans is typically regarded as having a higher priority in the hierarchy of values than the well-being of experimental animals sacrificed for medical experimentation and research." Even hunting an animal for pleasure like a sport, and personal pride is justified by the value ascribed to human interests. The same applies to those who "raise animals for food." Moreover, when such arguments reach an impasse and cannot establish which position should take precedence, it is unreasonable for individuals to rely solely on intuition. This is not simply a matter of prejudice or personal bias; rather, it reflects the difficulty of providing rational moral arguments under such conditions and of identifying what may genuinely count as a rationally defensible choice. "Even animals who are not persons, and will never be persons, are thus inescapably within the bounds of a person-centered morality, dominated by person-centered interests" (Engelhardt, 1986).

This highlights a central feature of secular bioethics: that personhood is not identified simply with biological existence. Those lacking cognitive capacities are not regarded as persons in secular bioethical frameworks. In this context, the biological approach—which grounds identity in physiological and genetic continuity—does not determine moral status. Instead, functional and psychological approaches dominate: personhood is defined by the possession of specific cognitive and psychological capacities, and continuity of these capacities over time informs questions of persistence and identity (Baker, 2000; Locke, 1690; Singer, 2011). Consequently, individuals who lack "self-consciousness, rationality", or moral agency—such as infants or those with severe cognitive impairments—are classified as "non-persons," with moral authority and decision-making entrusted to those who meet the functional criteria. Philosophical reasoning within this framework explains why, in principle, practices such as medical experimentation on non-persons could be justified (Singer, 2011).

Within this paradigm, the moral permissibility of practices such as prenatal biomedical screening, embryo selection, and genomic intervention is actively debated. Abortion serves as a paradigmatic case in bioethics, exemplifying broader questions regarding personhood, with the ethical debate largely dependent upon whether the fetus is recognised as a full human person. The liberal-functional position maintains that fetuses lack the cognitive traits necessary for personhood, thereby justifying abortion. Secular ethicists argue that embryonic life is too rudimentary to have direct moral value. The fetus is not rational or self-conscious, and therefore no fetus has the same claim to life as a person. In terms of morally relevant characteristics, such as rationality and self-awareness, a fetus is often judged to be even less developed than certain nonhuman animals. Until a fetus acquires the capacity for conscious experience, terminating its existence is likened to the ending of plant life rather than that of a sentient animal (Singer, 2011).

This moral reasoning illustrates how the secular ethos centers on autonomous choice. The moral life becomes the pursuit of "more benefit than harm," as defined by the individual's own evaluative framework. Agreements and ethical norms arise from personal preferences and psychological capacities such as memory, intention, deliberation, and reasoning. Self-determination becomes the focal point of moral agency, and the legitimacy of ethical claims is grounded primarily in the autonomous chooser.

Right to self-determination in secular bioethics

In medicine and health care, we regularly confront the profound realities of human suffering, disability, and the inevitability of death. This is especially evident in hospital settings, where experience of suffering transcends clinical parameters and awakens critical questions about the meaning of life, the significance of death, and the essence of human dignity. These encounters reveal the precariousness of human existence and compel us to a direct encounter with our "finitude". These experiences prompt inquiries that go beyond scientific reasoning, encouraging deeper reflections.

Secular bioethics, by its very nature, limits itself to meanings grounded in the immediate and finite, excluding deeper, transcendent dimensions. Within this framework, suffering is interpreted primarily through the lens of tangible experiences. Confronted with the apparent absurdity of suffering, and unless opting for voluntary death, individuals are often encouraged to seek solace in the fullness of life, through its pleasures, beauty, and intellectual pursuits. The hope is that sensory and emotional satisfactions provide a sustaining distraction until the inevitable moment of death. Lacking a sense of the transcendent, the human desire for meaning may be temporarily fulfilled by indulging in earthly pleasures and fleeting joys. Medicine, operating within this same horizon, promises that pain can be managed, suffering can be avoided, and death can be delayed.

However, we often find that these promises fall short. Ultimately, suffering cannot be escaped entirely, and death is unavoidable. These limitations invoke a "liberal cosmopolitan ethos", which champions self-determination, liberation from past constraints, and self-fulfilment. In this setting, the search for meaning amid vulnerability fosters a sense of agency and personal autonomy, empowering individuals to shape their own destinies by making choices that alleviate suffering. When invited into this moral landscape, religion is often expected to accommodate these choices. In this cultural framework, religion is called to assist caregivers and family members in accepting patients' choices regarding "physician-assisted suicide and voluntary active euthanasia". Christians who embody love for their neighbors, within this "liberal cosmopolitan context", are compelled to support choices regarding death to respect the values, freedom, and dignity of others. In contemporary technological societies, the character of death has become a matter of personal choice. Thus, within an autonomy-affirming ethos, physician-assisted suicide and voluntary active euthanasia may appear not only morally permissible but even dignified and loving. As Engelhardt notes, "a positive moral reevaluation of physician-assisted suicide and voluntary active euthanasia...becomes appropriate not just for contemporary secular society but for post-traditional Christianity as well." (Engelhardt, 2000).

Furthermore, contemporary debates extend beyond human beings to the realm of artificial intelligence. AI is increasingly used as a philosophical "thought experiment" (Dennett, 2018) to clarify the criteria of personhood. If rationality, self-consciousness, and decision-making define what it means to be a person, then nothing prevents a machine—constructed from circuits rather than cells—from qualifying as such (Olson, 1997). Rooted in Rational Choice Theory, AI systems assign human-like capacities such as evaluation, preference formation, and utility maximisation to computational processes. This reductionist framework, which treats cognition as algorithmic and morality as calculable, threatens cognitive freedom and undermines the practices of ethical deliberation that characterise the human person (Pinto-Bustamante et al., 2023).

Taken together, these trends in secular bioethics demonstrate that personhood is not identified simply with being human. Those who lack certain cognitive capacities are cast outside the boundaries of the moral community; their worth is left to the judgment of the rational and autonomous. Such a framework opens the door to justifying practices as grave as infanticide, euthanasia, or experimentation on the severely demented, since these lives are deemed expendable. The result is a fractured humanity, divided into 'persons' and 'non-persons,' with dignity no longer inalienable but conditional.

Orthodox Christianity offers a markedly different vision—one that preserves the integrity and wholeness of every human being. This alternative vision, which grounds dignity and freedom beyond cognitive or functional criteria, forms the basis of the Orthodox Christian anthropology examined in the following section.

Personhood in orthodox Christian anthropology

In the witness of the early Christian Fathers, the human being is a unified yet twofold reality: "the historical man is a spirit in a body," that is, an immaterial, bodiless "spirit-soul" (nous) dwelling in a material, "practical" body that serves as an "instrument" for the practice of good, but also of evil. With his spirit-soul, created in the image of God, man rises into the divine world, while his material body links him with the sensory cosmos that surrounds and relates to him (Bunge, 2009)" This psychosomatic unity forms the foundational structure of what a person *is*.

The term that best expresses how this integrated reality becomes manifest is *prosopon*. It refers to a referential reality, with its relational nature evident in its etymology. Pros-opon combines pros (“toward”) with ops (“eye,” “face”), meaning turning one’s face toward someone or something. Originally, it indicated direct reference and relationship, emphasising that a person is defined by reference, relation, and the capacity to establish both (Yannaras, 2007).

To grasp the term *prosopon* more concretely, we acknowledge that man—understood here in the inclusive theological sense of all human beings—possesses a face. The “face” is that “side” of the person that he turns toward another person when he enters into a personal relationship with the other. “Face” really means “being turned toward.” Only a person can have, strictly speaking, a real “counterpart” to which he turns or from which he turns away. We become who we are as persons through continual growth and maturation, unfolding not in isolation but through genuine encounters with others. Such encounters challenge and refine us, gradually shaping us toward maturity (Yannaras, 2011). In this sense, being a person is not a static state but a dynamic process of becoming. To “become more and more a person” is to realise the full potential of being human. Personhood is thus relational and dynamic, continually emerging and deepening in the “face-to-face (Bunge, 2002)” encounter. This understanding of *prosopon* represents only the visible, relational dimension of personhood in the Orthodox view.

From a secular perspective, however, this visible and relational manifestation becomes the complete definition of the person (Martin & Bickhard, 2013) as understood in the paper. Secular models define personhood in terms of cognitive capacity, autonomy, and observable behaviour (Baker, 2000), reducing the person to what can be externally measured or expressed (Martin & Bickhard, 2013). This dynamic unfolding of self is intimately tied to the faculties that govern human life: how one understands, decides, and pursues action. Cognition provides understanding of oneself, others, and the surrounding context; volition guides decisions based on that understanding; and conation drives the energy, motivation, and persistence needed to carry those decisions into action (Martin & Bickhard, 2013).

While these faculties shape personality, they become unstable when detached from a deeper ontological grounding. Secular bioethics, which defines personhood in terms of functional, psychological, or biological criteria, fragments these capacities and reduces the person to instrumental or operational terms. Without meaningful reference or relationality, autonomy becomes driven by subjective impulses and functional demands. Such disintegration leads to misaligned decisions, internal conflicts, and moral inconsistency, producing both personal and social tension. Autonomy and rational choice, however, require not only clear cognition and careful deliberation but also alignment of conative drive with ethical and relational awareness.

Without the integrated functioning of thought, choice, and motivated action, a person struggles to act responsibly or consistently, undermining both personal development and relational harmony. Therefore, we observe a trend nowadays towards psychological analyses that explore a person's inner world to achieve psychological balance (Vlachos, 2014). The "inner world" in this framework is reduced to introspective states, affective impressions, or neuropsychological patterns, *without acknowledging the soul* as an ontological and spiritual reality. Consequently, cognition, volition, and conation are interpreted as merely psychological functions operating within a self-contained system, shaped by subjective experiences or behavioural conditioning. Such conceptions, rooted in the rationalist and humanist traditions of modernity, exhaust the truth within human thought and self-reference, thereby overlooking the deeper existential reality of being.

However, in Orthodox Christian anthropology, the ground of truth and personal identity does not lie in the imaginations or self-enclosed assumptions of human thought and self-reference. Moreover, the person's inner world is understood not merely as a site of introspection—nor as a psychological trend, as in many secular approaches—but as the core of one's being— the *intellect*, that governs all other powers/faculties—including cognition, volition, and conation, discussed further in this study. This inner depth constitutes the point of invulnerability that opens the way for a person to manifest his own true self. It is here that he encounters God, and his personal distinctiveness is revealed through that reference and relationship. This loss of reference and relationship towards God and thereby a disintegration of the human faculties is traced to what is theologically described as the 'Fall of Man.'

The Genesis narrative of Adam and Eve, the first human pair, that God created and from whom the entire human race descended, regardless of their race, color, language (Yannoulatos, 2003), is interpreted not as a mythic event but as an account of the human condition, depicting the disruption of man's original harmony with God, who is not our Creator alone but the Father of all humankind (Vlachos, 2003). Within this framework, the divine command in Paradise represented not a restriction but a life-giving invitation to remain in communion with God, the source of life. Through disobedience, man sought autonomy apart from this communion, thereby introducing a rupture within his own nature.

Spiritual death, which is understood as an alienation from God, analogous to how darkness results from the absence of light, preceded and gave rise to physical death (Vlachos, 1998). This did not mean cessation of existence, but a deliberate turning away from God and misuse of freewill (Chouliaras, 2020)[1], the consequences of which produced an inner disintegration: the intellect was darkened by ignorance, the will weakened by indecision, and desire corrupted by self-love (Bunge, 2012) and the passions—egoism, envy, and the pursuit of self-gratification. What was once oriented toward relational participation and life-giving communion, where love was meant to be unselfish towards God and one's neighbour, has become fragmented into self-referential or self-enclosed striving driven by fear and anxiety, in an attempt to escape the myriad consequences of mortality, illness, and various forms of suffering (Vlachos, 1998).

Thus, the Fall signifies not merely a historical or theological event, but an ongoing existential condition in which the human faculties, originally oriented toward communion with God, now operate in fragmentation and conflict. This fallen condition persists in the present, shaping both the world and the human person, and its

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[1] God has created man as self-governing, with control over his actions, so that, if he uses his self-ruling power well, he can walk towards good and not evil;

implications for bioethics will be addressed in that section.

Yet even within this fallen state, the purpose of human existence remains the same: to rise from a condition of mere biological coexistence to one of true communion, between persons, in harmony with all creatures and the whole of creation. This transformation occurs through selfless love, revealed in the life of Christ, who is the model and measure of authentic human existence and who manifests relational life free from abstract philosophical speculation. The freedom endowed to every human being is therefore ordered toward choosing unselfish love over egoistic self-love—a choice made possible only when God becomes the ultimate point of reference and relationship (Yannoulatos, 2003). The following discussion further develops this orientation.

At this point, Martin Heidegger's analysis of *Dasein* offers an important philosophical ally. His conception of human existence as openness, relationality, and temporal becoming stands as a critique of the reductionist image of the human being that dominates much of secular anthropology and, consequently, secular bioethics, where the person is often defined as an autonomous decision-maker. Heidegger reveals that human existence cannot be reduced to rational functions, rather, it is referential and relational. This insight resonates with the Orthodox understanding of personhood, which likewise rejects the autonomous individual as an adequate account of human identity.

Yet, Heidegger's contribution remains incomplete. Unlike the Orthodox vision, Heidegger's relationality does not culminate in a mode of existence, revealed and made accessible in Christ, through whom the human person is healed and restored to communion with God, the source of true being (Vlachos, 1998). While Heidegger's insight serves as a valuable critique of the reductionism in secular anthropology, Orthodox theology moves beyond it by revealing that the person's full ontological reality is not exhausted by existence alone, but fulfilled in communion with God—the hypostatic and relational mode of existence that transforms mere biological or individual life into true personhood. This distinction is crucial for bioethics, for it exposes the inadequacy of secular frameworks grounded in autonomy and rational capacity, and situates authentic moral reasoning within a relational, Christ-centered understanding of the human person.

Having identified the limitations of secular and philosophical-phenomenological accounts of the human subject, the Orthodox Christian Tradition offers a fuller and restorative understanding of personhood grounded in communion with God. From this perspective, the biological birth of man is not sufficient to fulfil the purpose of his existence; but it marks the beginning of his development (Vlachos, 1998). By birth, every human being has the potential to become a person, and he can actualise this potential only in communion with God. As metropolitan Hiertotheos Vlachos emphasises, "We cannot perceive a person without this communion. The person does not live alone as he has reference, relationship and communion (Vlachos, 1998)".

This communion is made possible because, although "The essence or nature of God is entirely unknown, invisible, unseen and unshared by man. Man knows and shares in the energy of God." "The bridge between the uncreated and the created is one. The point that unites them is Christ"(Vlachos, 1998). Therefore, it is in Christ that the restoration of human personhood becomes possible.

St. Severus of Antioch, a prominent theologian and Patriarch of Antioch, defines the purpose of incarnation with great clarity teaching that God created man so that he might maintain an unbroken relationship with himself—a relationship of love. Through the Incarnation—where the Only Son of God united Himself hypostatically to one flesh animated with a rational soul—the entire human nature was joined in love to the divine nature from which it had been estranged. Through this union, humanity becomes once more capable of participating in divine gifts and immortality, lost through Adam's trespass.

He writes, "The Only Son of God became consubstantial with us by being united hypostatically to one flesh animated in a rational and intelligent soul. Because of this, the entire human ousia and the whole race became united in love to the divine nature, from which it had formerly been estranged. Hence, as it is written, we, being made worthy of the original harmony, have become partakers of the divine nature. By Participation, we have received divine gifts and immortality, which had been lost to us on account of the trespass of Adam (Samuel, 2001)"

Grounded in the mystery of the Incarnation, the Christian understanding of personhood introduces a radical transformation in the way human beings understand their own existence. The biblical affirmation that "God has come visibly" (Ps. 49:2 LXX) signifies that the ultimate truth of human life is not merely conceptual but experiential, tangible, and transformational (Vlachos, 1998). "In Christ—the Word made flesh (Jn 1:14)—God who is Spirit (Jn 4:24) becomes visible and knowable". As the "image of the invisible God" (Col. 1:15), Christ inaugurates "a new orientation for the human race" (Bunge, 2007): He assumes human nature in its fullness, reorders human freedom toward unselfish love, and restores humanity's capacity to "turn back toward the good." As St. Severus teaches, "Christ reassembled human nature within itself and within Himself and returned it to its original unity of communion and love. With His resurrection, everything was made new again, and every human being is now confronted with the question of whether or not, they will participate in this restoration (Yannoulatos, 2003)".

In this light, the Incarnation reveals that the foundation of human existence is communion—first with the triune God and, through that communion, with all other human beings who share the image of God (Yannoulatos, 2003).

Christology thus provides the theological ground for understanding human personhood. It reveals that personhood is constituted through two inseparable dimensions:

1. ***Koinonia (communion)***—the outward, relational expression of love toward others, the prosopic manifestation of the human person in concrete acts of communion and witness.
2. ***The inner noetic structure of the person***—the hypostatic and inward reference toward God in love, which grounds personal identity and makes authentic communion possible.

In Orthodox anthropology, this inward *hypostatic* orientation toward God defines who the person is, anchoring personal existence beyond psychological autonomy or self-enclosed rationality. The *prosopic* expression of koinonia then reveals how the person lives in the world—through love, self-giving, moral integrity, and ascetical witness. Thus, the human person becomes whole through a hypostatic inward reference to God and a prosopic outward manifestation of love—two dimensions intrinsically united and fulfilled in Christ. Together, these dimensions form the basis of Orthodox Christian bioethics and frame the ethical reflections that will follow in the next section. Having seen that the Incarnation restores human nature and reveals personhood as communion, we can now consider the anthropological implications of humanity being made "in the image of God," for the revelation of the personal God in history manifests the truth about man, his ethos, and the nobility of his descent (Yannaras, 1984).

Humanity, in all its variety and diversity, is fundamentally rooted in unity because man, in his true nature, is created "according to the image of God." All human beings, regardless of their race, color, language or education, bear the image of God, and thus possess intellect (thought), freewill (choice) and love (motivated action). Therefore, sharing in a *koinonia (communion) of love* (Yannoulatos, 2003) is intrinsic to human nature, since humanity was created on the model of the Holy Trinity, and it is this Trinitarian God who created and sustains "the world and everything in it." Therefore, by their very nature, human beings are oriented in harmony with all of creation and with the source of love—God, and this fact that all human existence shares in the divine image makes human nature an indivisible unity.

However, as described earlier, this unity was ruptured in the Fall, breaking humanity's relationship with God and obscuring the '*koinonia* of love' for which human beings were created. In this fallen condition, the world is approached through a discursive rationality shaped by post-Enlightenment expectations that exclude the personal presence of God. Fragmentation arises when human beings, guided by individual egos, attempt to control their own destiny, separating themselves from fellow human beings who likewise bear

God's image. Consequently, man becomes immersed in cycles of desire, lust, violence, conflict, and death, the patterns that mark the fallen natural order and shape human behaviour. This process resulted in the fragmentation of the human self (Yannoulatos, 2003). As a result, the human faculties of thought, choice, and motivated action become misaligned, driven by conflicting desires and passions. Human nature becomes normatively constituted through these disordered inclinations through a web of desires, forming the moral reference point for the fallen world.

This interior fragmentation mirrors the very condition highlighted in secular anthropology: a diminished capacity of the autonomous individual to act coherently, responsibly, and toward the good. The Fall thus provides the deeper ontological explanation for the psychological and ethical instability within the modern self and for the disharmony in human relationships. In rejecting 'koinonia of love' or communion with God, humanity abused its own nature, degenerating, as the fathers say, into an "ugly mask, (Yannoulatos, 2003)," a distortion that also reverberates through creation itself, now marked by forces hostile to human flourishing. Egoism and emotion cloud the mind, obscuring its capacity to perceive reality through erroneous representations and projections arising from a muddle of human thought, desire, and consciousness (Yannoulatos, 2003), thereby damaging this image.

However, despite man deliberately turning away from God, which is a matter of freewill/choice, there is no cessation of existence, and neither his 'image' was completely destroyed nor incapacitated. Human beings retain the capacity to receive "indications of God's will and His energies" (Yannoulatos, 2003). Thus, the biblical description of man as being created "according to the image of God" gives him the possibility of a firm and close relationship with his Creator (Chouliaras, 2020) and also the capability of knowing Him. Therefore, man has to restore back this "God-given" innate "ability" to "sense" and love by comprehending God's glory, "radiance and its meaning", not by "vague mental intuitions or psychological instincts", but by transforming or renewing oneself. Transformation and renewal require purifying and cleansing oneself from the power of human passions, thereby achieving inner freedom from egoistic attachments of "material wealth and fame, excessive physical comfort, and love for power". Every effort needs to be made to "strengthen this divine spark within us" and "evolve together in harmony" through a constant relationship with God and others in the light of the Incarnation, thereby "arm ourselves with the power of love" (Yannoulatos, 2003).

The right to love and to be loved is the basic defining characteristic of a human being. God's love for humanity and humanity's love for God and all other creatures that He created 'in His image' is the light that illuminates our concern for human dignity and equality. This is the source from which we draw the strength and inspiration needed to make human dignity and equality a reality. With this love, one uncovers a deeper reality of things and sees each and every human being as he or she really is: a creation of God, an image of God, a child of God, our sister or our brother. The freedom found in Christian love is a tremendously powerful force. It is not restricted by what others believe, nor can any obstacle inhibit its initiative. However, the fact that others hold views different from our own in no way prevents a Christian from respecting their freedom to believe as they wish (Yannoulatos, 2003). In this restored relationality lies the foundation for understanding the human person and the ethical commitments that follow.

We now turn to the inner structure of the human person as understood in the Orthodox tradition. As noted in the beginning of this section, Orthodox Christian anthropology understands man as a unified yet twofold reality—a psychosomatic being composed of body and soul (Vlachos, 2017). Each has its own mode of being and activity, yet neither is complete without the other. The body serves as the visible medium through which its inner life (soul) becomes manifest, giving tangible form to what is otherwise unseen. This unity prevents the soul from dissolving into abstraction or the body from becoming a mere biological mechanism. The integrity of human nature thus depends on the coexistence and mutual development of the visible and invisible dimensions of existence; to divide them is to fragment the human person.

Within this unity, an immaterial, bodiless "spirit-soul" (νοῦς) in a material, "practical" body, we are speaking of man's noetic faculty: the spirit-soul or the rational soul of man (Vlachos, 2014). This rational soul is referred to as "intellect," the core of the human person, which, as the "image of God," is linked to God by nature" (Bunge, 2012). Although God's essence remains wholly inaccessible, the human person participates in His uncreated energies and, through them, perceives the divine. The body's perception of the divine is mediated through the intellect (Chouliaras, 2020). Created to know and love God, the intellect's natural function is to "be the light of the mind (Bunge, 2012)"; it seeks spiritual knowledge and delights in the contemplation of God. Through this orientation toward the Creator, the human being discovers his true self.

The will to orient himself to the Creator, and to do good, and to be as well disposed towards all is instilled in us since our creation, as we were all made in the image of Him who is good. God has created man as self-governing, with control over his actions, so that, if he uses his self-ruling power well, he can walk towards good rather than towards evil. As St. John Chrysostom writes, "A natural law of good and evil is seated within us... and we require no teacher to instruct us in these things." This natural law is not a rationalistic code derived from biological tendencies or discursive reasoning, as in modern secular ethics. Instead, it is a moral sense bestowed by the Creator Himself, serving as a guide in turning toward Him and experiencing His presence. It resides in our conscience and moral self-awareness. While man can enhance the awareness of natural law through instruction, it flourishes through prayer, virtuous actions, and love for God. Specifically, it is cultivated through a worshipful relationship with God, which helps one to realise that the law within is a manifestation of divine love (Engelhardt, 2000). This is the man's natural state of the soul, his natural law is oriented towards God, his soul is nourished through the uncreated energy of God, and spiritual experience is transferred to the body, which is in good health and does not let passions develop. Man can achieve this natural state only by looking towards his Archetype, i.e. Christ, and imitating Him, without deviating from the road of goodness (Chouliaras, 2020). For a self-enclosed autonomous individual, whose will is not oriented to his Creator's will, or he is looking away from His Archetype and prototype, this natural law remains clouded, and so is his rational soul darkened and entangled with passions of self-love. According to the Orthodox tradition, if someone's noetic faculty is not functioning correctly and has no experience of God, then his soul is sick, his nous is darkened, and it has many repercussions in our lives. Instead of being focused on God, his life revolves around himself. He idolises and worships himself. When his intellect is darkened, man's body revolts against his soul, and he loses his spiritual freedom. The intellect that is associated with freewill is darkened and blackened, and then freedom is also distorted. Man is no longer free, but acts according to the actions and desires of passions. This is how the intellect and the lower powers of the soul become fragmented. The intellect is distinguished and can operate independently from the lower powers of the soul—sensation, imagination, opinion, and reasoning—that operate through the bodily organ of the brain. The intellect is not opposed to reason or will but integrates the lower powers only into a higher form of knowing that is experiential and personal, and will remain darkened if the lower powers are subject to that which is merely conceptual and opposed to God. Within this framework, personhood cannot be reduced to cognitive, volitional, or conative capacities, as is often the case in secular bioethical discourse. As a result, Christian bioethics cannot be connected to secular bioethics. Within this Orthodox Christian understanding discussed so far, Christian bioethics has a therapeutic character, by leading us away from ourselves towards God, the Creator (Engelhardt, 2000) and our Healer, and cannot be connected to secular bioethics.

From this perspective, humanity's creation "according to the image of God" (Gen. 1:27; Wis 2:23) is not a static resemblance but a dynamic, and relational participation, as we saw in the definition of person. The human being reflects the divine prototype not merely through rationality or autonomy but through openness to communion with God and others. The "image" (εἰκών) signifies the inherent structure of relationality—an ontological orientation toward the divine "Other"—while "likeness" (ὁμοίωσις) describes the process of actualizing that relationship in freedom and love. This movement from image to likeness implies that personhood is not fully given at birth but unfolds through participation, moral transformation, and communion. The Holy Spirit, "guiding into all truth," forms in the human person the likeness of Christ, enabling self-transcendence beyond the fragmentation of passions and egocentric desires. God turns towards man, calling him to himself, and also wants man to turn to him. God made man in his image and likeness (Gen 1:26) so that man, looking towards his Archetype, i.e. Christ, would not deviate from the road of goodness. Every human being who is of good will, has good intentions, and keeps the commandments of Christ (genuine love, humility, forgiveness, and unselfish service towards others)— even if he or she does not have the privilege of directly knowing the ineffable mystery of Christ— receives the Christ-Word that is present in His commandment. Since God is love, any expression of love whatsoever is automatically attuned to His will and His commandments (Yannoulatos, 2003).

Therefore, in Orthodox Christian anthropology, personhood is not defined by a self-contained, autonomous rational subject, but by a mode of existence constituted in communion—in relation and reference to God. From this perspective of the Orthodox Christian Tradition, man was created to have an unbroken relationship with God—a relationship of love. This status, however, was lost in the fall, when man could no longer maintain communion with the Creator. In this predicament, God expressed His love toward humanity (Samuel, 2001) in the most direct way: Christ became incarnate and "dwelt among us." He lived, worked, suffered, and died, rose again, and ascended into heaven. In this way, He transfigured human nature and emphasised the enormous value of the material world and of the human being as a psychosomatic unity (Yannoulatos, 2010), where soul and body coexist as distinct natures united in one personal subject, as discussed in this study. The spirit-soul is not liberated from the "prison" of the body, as in other philosophical or religious systems; rather, human thought—humbled and transfigured—becomes a faithful recipient of divine love (Yannoulatos, 2010).

When God the Son hypostatically united Himself to one flesh animated with a rational soul—becoming man—He revealed a mode of existence that defines authentic personhood. In doing so, He becomes the reference point and measure of human fullness for every person who seeks to live truly human and God-like. As the first-born and "second Adam" of the new creation, and as the mediator between God and man, He represents each human being individually and the whole human race collectively. At the same time, as God, He remains continuous with Himself and fully united with the Persons of the Holy Trinity.

The Orthodox Tradition is profoundly nurtured by the intuition that life has priority over speech and focusses attention on the transformation and purification of oneself with inner genuineness (Yannoulatos, 2010). As free persons, each of us are invited to accept this possibility of activating the infinite potentialities to proceed to the fulfillment of human existence— the possibilities offered to every human person by 'being' in Christ and on ceaselessly 'becoming' in Christ. Through the Holy Spirit, the human being strives to become Christ-like and is led to the Father, the Holy Trinity (Yannoulatos, 2010).

This defines our hypostasis as a distinct person whose mode of existence displays concrete, unique, and unrepeatable properties, reflecting and illuminating the image of Christ. The fulfillment of the inward life as a personal "who," or hypostasis, takes place through participation in the divine life, through reference and relationship to Christ, and by freely subjecting one's freedom to God in love (Vlachos, 1998)—an inner transformation made possible by the Holy Spirit, who enables the human being to attain "freedom as love" (Vlachos, 1998). This inward transformation is expressed outwardly in the prosopon—the face, presence, and relational manifestation of the person in the mode of love and freedom in Christ. In the saints of the Church, we encounter this co-existence of love and freedom (Vlachos, 1998). Thus, the Orthodox Christian understanding offers a coherent theological framework for defining the human person (Yannoulatos, 2010), in which his/her personal distinctiveness is revealed and known within personal relationship and communion, attaining its wholeness in love (Yannaras, 1984).

Implications of Christological anthropology for bioethics

To act ethically is to love, and to love is to become like God. However, in the field of Bioethics, dominated by a secular understanding of the human person, we encounter varying senses of what it means to act appropriately (Cherry & Iltis, 2010). For this reason, analysis of the human person is essential: without a coherent anthropology, bioethical reflection lacks a foundation. A society cannot exist without man. When "man is the measure," *nothing outside human preference* can guide moral discernment. Furthermore, when human preference becomes the foundation, morality becomes contingent, unstable, and ultimately arbitrary (Cherry & Iltis, 2010).

Modern bioethics often presupposes the Enlightenment image of the human person as a self-contained, autonomous subject who defines meaning through will, preference, and self-determination. Within this paradigm, bioethical reasoning centers on rights and personal choice. This approach is supported by the four principles of bioethics: autonomy, beneficence, non-maleficence, and justice, with autonomy taking precedence and influencing the others. It is noted that when personhood is defined solely by autonomy, moral value becomes subject to conditions such as capacity, productivity, rationality, and independence.

The modern self emerges through disengagement. It becomes itself by separation: I am not you; I determine myself, I decide. Autonomy becomes the ethical axis. Nevertheless, this model fails to account for the very conditions that make personhood intelligible. Communication presupposes relation; identity presupposes recognition; agency presupposes a world in which action bears consequence. A self that exists only for itself collapses inward. This is the paradox: autonomy, when made absolute, becomes isolation. Isolation becomes fragmentation. Fragmentation becomes the dissolution of personhood. Modern ethics equates freedom with choice. Choice, however, is morally empty until oriented. One may choose well or choose destructively.

Man, being created according to the image of God, means that he is by nature intrinsically oriented and has reference and relation to his Creator. Free will is the defining feature of this image. Therefore, freedom is not the possibility of choice or preference (Vlachos, 1998) but the possibility of desiring communion with God. The "intellect," or man's rational soul, the core of the human person, which as the "image of God," is linked to God by nature (Bunge, 2012). Furthermore, man must be guided towards unity with God "in the person of Jesus Christ". "Christ is the archetype and prototype of the creation of man" (Vlachos, 1998). This movement and completion are essential, because only then man is fulfilled, i.e. his own self is enabled only with reference, relationship and communion with the Person of Christ, who alone is the Person of God in the absolute sense (Bunge, 2002). It is through Christ that man achieves anything in the absolute sense, to the extent he tries to restore this communion, or relationship, or reference with Him. Only God has absolute freedom since God is uncreated and is not bound by any necessity, including His existence (Vlachos, 1998). Without such a reference, depersonalisation occurs, which threatens the very essence of being human, as what is at stake is the human being's possibility of growing in the likeness of God, which alone brings about his own self (Bunge, 2012). So Orthodox Christian Anthropology always professes the fact that without this communion, man cannot become a true person. Without this communion in Christ, man's desire to achieve freedom in an absolute sense as far as possible remains incomplete. Orthodox theology, therefore, does not make autonomy the essence of freedom. With such self-enclosed autonomy, man is just a mask, which destroys the unity of society. Freedom is fulfilled when oriented toward communion, truth, and love.

Christ does not assert autonomy; He offers Himself. This is the paradox of divine freedom: it becomes itself by self-giving. When this does not happen, the consequences are not merely personal but social. A self-enclosed individual becomes ill, which radiates outward, creating disturbance and division, and ultimately producing a society dominated by tyranny and hatred (person).

Marriage, procreation, and infertility

In this broken and unredeemed world, the relationship between man and woman became distorted by sin. Since Eve was the first to be deceived and then drew Adam into disobedience, the primordial harmony of their relationship was disrupted. What had been created as a synergy of equal honour and mutual help was expanded to a dominion that included even polygamy. The unique union of Adam and Eve became lost in polygamy, and the need to reproduce, a need embedded in a cycle of pleasure, pain, striving, and death, was born of the Fall (Engelhardt, 2000).

This world, still broken by sin, is redeemed through the Incarnation of Christ and on its way to restoration. The natural union of marriage can now be completed in the unique union, the monogamy of Adam and Eve, as restored in the Mystery of the Church. The Church regards the birth of each human being within the context of the mystery of marriage. Consequently, the Church also feels that the mystery of human beginning ought to occur within an atmosphere of monogamous, heterosexual intercourse blessed by the mystery of marriage, of a union in 'one flesh' (Chatzinikolaou, 2008). A conception that takes place in a laboratory instead of the maternal body and through a procedure other than the spouse's intercourse is deprived of the mystery's character.

As mentioned in the paper, a fundamental element of Orthodox Christian anthropology is the recognition of the sacredness of human existence. He unites the visible and invisible, or the material and immaterial world, with his existence. The objective of man, who is made in God's image, is to become 'after His likeness' (Genesis, 1952), namely to attain perfection and sanctification. With this ultimate objective in mind, man and woman unite only in marriage, and a union outside this mystery of marriage is often misdirected. Christian marriage, therefore, cannot be reduced to self-satisfaction or emotional fulfilment. Instead, marriage involves a pleasant ascetic struggle of mutual love and sacrifice: a joyful companionship of spouses and children in the pursuit of holiness. Husband and wife are called to turn away from self-love through love of each other and of God. They are called to be chaste with respect to eschewing sexual acts with others and to turn with love to each other and their children. In all of this, they are like martyrs; they are to die to their passions of self-love and egocentric desires. Within this ascetic and relational framework, the decision to limit children because of health or due to limited familial or societal resources need not suffer from a misdirection of energies or one's capacities; it can be made out of love for others and with humility before God (Engelhardt, 2000).

Within this relational vision, infertility must likewise be approached through the Orthodox Christian anthropology of personhood. When infertility is treated merely as a biological defect or a social deficiency, the couple's identity becomes reduced to their reproductive capacity. By contrast, the Church regards sterility as an expression of God's will or even a blessing in the form of a trial. The Church acknowledges in every human being his infinite spiritual possibilities along with his natural identity (biological, psychological, etc.), and is clearly set against the notion that infertility constitutes a type of disability or an incurable social weakness. Oftentimes, couples who have difficulty having children have a well-defined spiritual orientation and are especially productive in various fields of social and spiritual life.

The contribution of the Church and clergy would be essential in eliminating unhealthy viewpoints and unjustified social pressures. Simultaneously, they could assist in cultivating the belief that although the birth of a child is a great blessing, infertility does not degrade the dignity of the spouses, nor does it harm their relationship or abolish their marriage.

At this point, a deeper anthropological clarification is required. The Orthodox understanding of personhood as relational, referential, and grounded in communion with God provides the proper lens for approaching infertility.

The persistent effort to overcome sterility risks, transforming the natural and sacred desire for childbearing into a form of self-will or a stubborn will set against the will of God. Accordingly, every attempt to address infertility must leave room for the humble acceptance of a possible failure (Chatzinikolaou, 2008). From an Orthodox Christian anthropological perspective, the couple's dignity and hope do not rest upon biological success but upon the affirmation that they are created in the image of God. This status grounds their worth independently of reproductive capacity. When personal identity is understood not through biological productivity but through one's referential and relational orientation toward Christ, divine love provides the interpretive framework through which the couple can perceive the deeper reality of their condition. Through ascetic discipline and spiritual struggle, the couple learns to discern the meaning of their existence independent of the external conditions they face (Yannoulatos, 2010). In this framework, the fulfillment of personhood does not lie in the attainment of biological outcomes but in the shared relational movement toward Christ, which, through the life of the Church in the Holy Spirit, discloses the truth and purpose of every human life.

The status of the embryo and the sanctity of human beginning

In Orthodox Christian anthropology, the beginning of human life is inseparable from the relational and referential understanding that defines personhood itself. A human being comes into existence within the psychosomatic union of husband and wife, marked by mutual self-offering, love, and communion. The desire for children is thus understood not merely as a biological act but as a natural and sacred orientation of marital love with the will of God in bringing forth new life. For this reason, procreation is not an autonomous human achievement but an asserted expression of God's will.

As God's creative act is always an expression of divine love, the child who comes into being through marital union is a gift, not a possession. Free will, which is God's greatest gift to humanity, can become distorted when the desire for a child is reduced to self-fulfilment, emotional satisfaction, or social validation. The newborn is not a "biological and psychological extension" of the parents nor an instrument to satisfy their needs. Instead, the child belongs to God, is entrusted to the parents for this earthly life, and is destined for eternal life (Chatzinikolaou, 2008). The proper reception of a child is thus grounded in a relational orientation directed toward God, the child as a distinct "other," and the wider community (Gambos).

This relational framework is crucial for understanding parenthood. According to the anthropology presented in this thesis, a person exists only in reference and relation. Thus, the identity of the parents as persons is realised not in isolated autonomy but in the relational encounter with the child, whose presence continually refers them back to God, the ultimate Giver of life. The child becomes a point who draws the parents out of individualistic self-containedness and into communion.

Parental love exemplifies this dynamic. It represents a movement beyond their ontic self towards life-as-relation (Yannaras, 2011). Parents come to know themselves and their child not through objective observation but through a referential knowledge grounded in love. As Christos Yannaras affirms, "love is the supreme road to knowledge of the person," because love recognises and receives the other in their fullness. Through this love, the child is encountered as a distinct person or hypostasis rather than an object of parental desire or social expectation (Yannaras, 1984).

Moreover, the parent–child relationship is not an isolated dyad but part of the broader ecclesial community. The family is understood as a "house church" where the relationships within it are illumined by "sainthood and the martyrdom of mutual love" (Cherry & Iltis, 2010) While biological parenthood is significant, the Church emphasises that relationships must transcend mere "natural necessity" and grow in relationship of love, according to the pattern of the way of being and communion of the Persons of the Holy Trinity (Vlachos, 1998). Parenthood thus becomes an arena in which biological bonds are transfigured into intentional, relational communion.

Therefore, the beginning of human life is sacred and cannot be understood apart from the referential and relational ontology that defines human personhood in Orthodox Christianity. Viewing the embryo as a gift of God, rather than as an autonomous product of the human will, provides the necessary framework for addressing questions about its status, identity, and moral significance. This relational understanding grounds the subsequent ethical analysis of the embryo and frames the sanctity of the human beginning within a robust Christological anthropology.

According to contemporary official Church texts, the embryo is regarded as having both a human beginning and a human perspective.

Its cells, genetic material, morphology and physiology are entirely human. The embryo has the inherent potential of 'becoming a child of God' (Chatzinikolaou, 2008). The body and soul are not considered entities born at different times; both come into being at the same. The embryo is endowed with a soul at conception (Chatzinikolaou, 2008). Moreover, its potential to develop solely into a perfect human being, and nothing else, confirms its human existence (Chatzinikolaou, 2009). The points to be highlighted here are:

1. ***It's right to human identity:*** The embryo possesses an ethically indisputable right to manifest its own identity and unfold its personal uniqueness. It is not for others to assign or deny its status. Rather, we are obligated to allow the embryo to reveal what it already is: a human being whose body and soul are distinct from every other. Respect for this identity requires that science and society safeguard the embryo's inherent dignity and protect its natural development.
2. ***The right to life:*** The embryo's natural course of development is the same as that of every human being. We should acknowledge the embryo's right to life and protect and care for it. The embryo should achieve autonomous status under the best possible circumstances. The sole aim of its existence should be its life, not the experiment (experimental embryos), or surplus embryos (spare embryos), or waiting under freezing conditions (frozen embryos). The fact that for thousands of embryos the frozen environment of a freezer has replaced the warm maternal womb, and the potential for life by the prospect of experiments and death, undermines human value and violates the right to life.
3. ***The right to eternity:*** The embryo has the prospect of immortality. From the moment of its conception, it is destined to live for eternity. This reveals God's right to repeat His image in man.

Euthanasia

Just as the beginning of human life is sacred because it arises within reference and relation, grounded in God and ordered toward Him, so too the end of human life must be approached within the same Christological and relational horizon in which the human person is constituted and fulfilled. If the embryo cannot be understood apart from orientation toward God that constitutes personhood, neither can the suffering or dying person. The sanctity of human beginning and the sanctity of human dying are thus united by a single anthropological truth: a human being is never an isolated biological entity but a person whose identity is constituted in communion and is relational.

Orthodox Christianity adopts a fundamentally therapeutic, rather than juridical or legalistic, approach to the question of euthanasia (Engelhardt, 2000). In light of the earlier definition of prosopon, a person is not an autonomous biological unit but one defined by reference, relation, and the capacity to sustain both. Agency, therefore, is not the assertion of individual autonomy; rather, it is the acceptance of responsibility for the other through submission to God's will. To act as a person is to enter into and sustain relationships, to share in another's life, suffering, and loneliness (Sebastian, 2009).

Within the Orthodox theological tradition, the ethical issue surrounding euthanasia does not concern only the suffering patient; it also reveals the spiritual condition of the caregiver. As previously discussed with respect to the Fall, modern humans live in an existential crisis, alienated from their "natural state," a state of virtue, grace, and communion. This "natural state" is not merely a moral ideal but the proper mode of human existence: a life directed toward God, shaped by responsibility for others, and rooted in the pursuit of spiritual truth. Returning to this state is tantamount to becoming a true person.

By contrast, secular bioethics approaches the human being as an autonomous individual defined by reason, functional capacity, and immanent considerations. Without reference to God, secular frameworks often rely on utilitarian or functionalist principles in which life may be judged to lack moral worth once reasoning abilities decline, dependency increases, or suffering outweighs pleasure. Though procedurally effective, these approaches risk profoundly negative anthropological consequences. By neglecting the spiritual depth inherent to every human being, secular bioethics undermines the very sources from which individuals draw meaning, resilience, and hope in times of suffering (Gombos). This pertains especially to the human being as a psychosomatic unity.

In Orthodox thought, although the human body is subject to biological laws, it cannot be reduced to an organism. It is the body of a person, inseparable from psychological and spiritual dimensions that elevate the human being beyond the animal world. The body expresses the person and, in a profound sense, is the person; thus, whatever affects the body affects the person as a whole. If our efforts focus solely on alleviating physical suffering without attending to the spiritual identity of the patient, we risk doing immeasurable harm, depriving the suffering person of the possibility of situating their condition within a meaningful spiritual horizon (Larchet, 2002).

When the spiritual dimension of the human person is excluded from the caregiving encounter, both the patient and the caregiver suffer loss. The patient misses the opportunity to approach suffering in ways that foster meaning, hope, and communion. The caregiver, correspondingly, is deprived of the deeper moral and spiritual context necessary for authentic accompaniment.

From an Orthodox perspective, reference to God transforms what would otherwise be a secular, contractual interaction into a sacred relationship involving the caregiver, the patient, and God. The divine challenge is always to "choose life," to preserve, protect, nurture, and cherish earthly life by every means available and in all circumstances. Choosing life also includes receiving death as a passage into eternal life, approached with faith, hope, and trust in God.

To guard the dying from the gravest temptation, the temptation to despair, the caregiver must accompany them with compassion, love, and unwavering hope. Through presence, prayer, and gentle words, the caregiver bears witness to the truth that God receives His dying child into His embrace, where sorrow and pain are no more. Acts of love performed in reference to Christ, treating the dying as persons created in the divine image, reveal deeper spiritual realities to both the patient and the caregiver (Breck, 2000).

This work is demanding and transformative, summoning the caregiver to virtue. The willingness to remain with the dying, marked by patience, compassion, and self-emptying love, constitutes an ascetical struggle. When the caregiver subjects his will to God's will, he partakes in divine grace. Such acts restore the caregiver's sense of responsibility for the other and affirm the intrinsic dignity of the suffering person, countering the reductionism of secular bioethics, which often withdraws recognition when functional or cognitive capacities decline.

Furthermore, the Orthodox tradition understands this service not merely as a moral obligation but as Christocentric. When the caregiver perceives the dying person as an icon of Christ, he fulfils the scriptural command: "*Whatever you did for one of the least of these… you did for Me.*" Caregiving thus becomes synergistic, a co-operation of divine grace and human freedom. Through this synergy, the caregiver learns to soften his heart and redirect his will through a meaningful existential orientation in Christ.

Within this framework, accompanying the dying becomes a decisive moment in which the relational, spiritual, and ethical dimensions of personhood are revealed. Human life is experienced as communion, with God and with others. Virtue becomes the expression of authentic humanity, and the approach to death is shaped not by autonomy or fear but by hope, love, and the sacramental life of the Church.

Conclusion

As science becomes increasingly detached from art, theology, and the personal encounter with truth, and as secular culture gravitates toward non-personal forms of religion, a broader liberal cosmopolitan ethos has taken shape, as this study has shown. In an age marked by rapid technological progress, particularly in fields such as artificial intelligence, cognitive science, and data science, the deeper question concerns the status of personhood. Scientific developments may enhance human capability, yet they also risk obscuring the truth about the human person that has been handed down throughout history.

Artificial intelligence, for instance, draws heavily on Rational

Choice Theory (RCT), which serves as one of its conceptual and functional foundations. By grounding decision-making in data modelling while suppressing moral values or reducing them to preference metrics, such systems pose significant risks to cognitive freedom and to the practices of moral deliberation that sustain pluralistic societies. The creation of algorithmically filtered environments, such as "echo chambers" and "filter bubbles" (Pinto-Bustamante et al., 2023), further threatens the conditions necessary for genuine ethical reasoning, ultimately raising profound questions about human personhood.

At the same time, as individuals attempt to understand sin and evil in secular or psychological terms, such as diffuse guilt, social aggression, or structural malfunction, the awareness of evil as a personal power diminishes. Many enlightened individuals recognise it as significant "progress" or even genuine "liberation." Yet, as the Orthodox tradition observes, the absence of personal recognition of evil—of handling sin and evil in their own way without perceiving it as a personal power— simplifies the task of the destructive forces, or the 'devil—the evil one'. As one insight puts it, "He can do very well without being perceived by human beings as 'really existing'".

This condition leads back to the primordial account of the Fall. Archbishop Anastasios notes, "In the twenty-first century, with the development of sciences and technology, many celebrate human capability with declarations such as "God is dead" or "We are gods,"; claims that echo the ancient temptation in Eden: "You will be like God, knowing good and evil" (Gen. 3:5). The problem here is not human aspiration itself, which means the desire of man to elevate himself to the throne of God is not altogether wrong, which reflects a predisposition of divine origin of being made in the 'image of God, and called to His likeness', but the distortion of this aspiration into autonomy that dismisses God.

The Devil cannot create something new; he can only pervert creation. With that ancient proposal of his, he distorted the truth and turned it into a lie. Just as in Eden, he began with a basic truth, but he expressed it in such a way as to set humanity on the wrong path, pushing humanity towards arrogance and self-realisation (Yannoulatos, 2010). When awareness of the personhood of God, the awareness that we are in the image of God and that we sin only against God through our actions that dismiss Him, who is a Person in the absolute sense, along with the awareness of our own being, and of the forces opposed to human flourishing fades, the very idea of unity is lost. Unity is not mere "aloneness," but the unbroken relation of the "I" before its "You. (Bunge, 2012)"

When this awareness fades, it leads to a loss of understanding of one's own personhood, resulting in depersonalisation. This threatens the very essence of being human, as "what is at stake is the human being's possibility to grow in the likeness of God". Only in this light is the "created being or the person brought about".

Every person is given the opportunity to define his own personhood, and this possibility is made possible by the Incarnation of the Son of God, Jesus Christ. We have seen that "Christianity is a revelation of God. It is not a discovery by man but a revelation by God Himself to man. Human reason could not discover the truths of Christianity. Where human reason was powerless to find God's truth, Christ, the God-man, came and revealed the truth (Vlachos, 2017). Though articulated using philosophical terminology, this revelation is not a philosophy".

For an Orthodox Christian, the Church is the (mystical) Body of Christ, which receives the uncreated energy of the Trinitarian God. Each member of the Church, bearing the image of God, is united to Christ and shares in the uncreated energies of God (Vlachos, 1998). The Holy Fathers, using the philosophical terminology of their time, shaped theological formulations, giving these terms the content of their experiential knowledge. "Experience is something stable, while philosophical terminology may change (Vlachos, 1998)". "God is not an object of conjecture and logical understanding, but a matter of participation, revelation, that is to say, of experience (Vlachos, 1998)" A person is therefore revealed existentially through experience. Human moral psychology and structure are grounded in this experiential knowledge.

The Incarnation does not merely introduce "a few moral rules or clarify" our daily conduct; it "ontologically renews all things." "Christ transfigured the human nature that he assumed. But for us, it still remains an enormous potential, still underdeveloped". As free persons, we are called to accept this possibility voluntarily (Yannoulatos, 2010). Christ sanctifies the human body—transforming, resurrecting, and elevating it to heaven in the Ascension. His historical life, by assuming flesh with a rational soul hypostatically, affirms the dignity of the body and opposes both vague idealisms and every form of atheistic humanism. The Christian proclamation is not the liberation of the soul from the body but the resurrection and elevation of the whole human nature.

Humanity and the world acquire an indescribable dignity and significance. Every person who takes an authentic interest in human beings, in the protection of their health, their freedom, and justice and dignity of the human person, finds themselves in harmony with the great purpose of the elevation of human beings realised by the risen and ascended Christ. To be truly human, one must be God-like. Jesus Christ always remains the measure of fullness for Christians (Yannoulatos, 2010)". "Therefore, to become Christ-like is the highest human right, and all other human rights are derived from this right. Any thought that ignores the ultimate right of the human person results in disorientation and makes one indifferent towards the essential element of human existence: one's divine origin and one's divine destination".

This theological vision extends even to the earliest beginnings of human life. The "beginning of man's biological life is identified with a unique event of utmost importance: the birth of a new soul. In every embryo, along with the cellular multiplication, which indicates the growth of its body, and the transmission of the inherited characteristics, which form its person, another process is also carried out: the birth and development of its soul. With its soul, the embryo will pass from the condition of human 'clothing' to the state of the 'garment' of divinity, from time to eternity, from decay to incorruptibility, from the physical resemblance to its parents to the spiritual likeness of God. Within the embryo, the image of God humbly exists (Chatzinikolaou, 2008)"

Therefore, a Christian is called to proclaim and live the fact that every person has the right, and the obligation to activate infinite potentialities which are offered to each human person in Christ through the Holy Spirit, so that we proceed to the fulfilment of human existence. This is perfection or deification. This process is revealed in the Ascension of Christ in a manner that transcends every static or merely conceptual human thought (Yannoulatos, 2010)".

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Lydia Kornaraki*

Artificial intelligence and the right to die: A virtual eternity

Abstract

The concept of "digital immortality" is approached through a combination of realism and philosophical reflection, with the aim of demystifying the functioning of artificial intelligence, attributing to it realistic dimensions based on two fundamental parameters: storage capacity and the incomprehensible functioning of the "black box". The episode *San Junipero* from the series *Black Mirror* is used as a narrative starting point to explore the prospect of a future, digitally extended existence, while applications such as Replika, Storyworth, HereAfter, Forever Missed and Deadsocial are already contemporary attempts to preserve human presence after death. The need to explore both the philosophical question of human identity and the theological the concept of the person as a complete separate entity, which in its relationship with God is not affected by the limits of physical death, but already has the potential for immortality.

Keywords: Digital immortality, black mirror, artificial intelligence, replika, deadsocial, identity, person

Artificial intelligence and technological realism

Death and Artificial Intelligence are not concepts that go hand in hand. Death signifies the end of existential consciousness, beyond the termination of bodily function. Artificial intelligence does not yet possess either of these two things: neither consciousness nor a perishable body with a natural expiration date.

As we approach the end of 2025, the development of the Artificial Intelligence (AI) system has exceeded all expectations. Tools that produce images, sound and text, such as the now well-known ChatGPT, are widely used. Any hesitation about using them has been pretty much overcome, and companies are now using it on a

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personalised level for better results. The current state of AI systems can automate repetitive tasks, autonomously manage areas such as customer service, marketing, and even various creative projects depending on requirements, analyse data and make predictions with the corresponding data, and of course chatbots and ChatGPT, which are language models and have evolved the most.

However, the way artificial intelligence works is not magical, and therefore there are many obstacles and difficulties, even in this period of tremendous development. There are two main problems facing the artificial intelligence system: storage capacity and explaining the choices it makes. AI is currently unable to adequately explain its various choices, nor can it analyse why it does not make certain others. This issue is called the Black Box Problem (Bathaee, 2018). The name comes from the black box used in aeroplanes and highlights the following issue: in AI, we can certainly know the input data and, of course, the output, i.e. the result it gives us. However, often even the manufacturers cannot know the process that takes place in between to give us the specific result or choice with this data (Michel, 2020).

The cloud is the modern way of storing data. The digital repository of the world may sound like something endless with an unknown location, but it is actually a specific space-time with a location and limited capacity. The cloud is hosted in warehouses, also known as data centres, which house servers and hard drives (Hoga, 2023) and constitute the dominant infrastructure for the storage, processing and management of digital data for many areas of our daily lives: the economy, health, government, education and entertainment. In the past, digital information was stored either on large-capacity physical hard drives or on local servers. Now, data is even stored in a different country from the user, is instantly accessible via the internet, and has no expiry date or risk of being lost due to natural disasters (Duenas, 2018).

However, nothing comes without problems and consequences. This infrastructure requires a significant amount of non-renewable energy, as well as large quantities of water to maintain the correct cold temperature (Holt & Vonderau, 2015). Furthermore, carbon dioxide emissions from the processes and the necessary replacement of natural materials that have aged and no longer perform as well or have broken down create a significant amount of electronic waste that further burdens the environment (Miller, 2015). The reality behind the elusive "cloud" certainly breaks the narrative of green technology but also confirms that the memory of all humanity cannot fit there.

Artificial intelligence and imagination: Future proposals?

This is the realistic side of artificial intelligence today, and with this guide, we can understand why continuity is a scenario that is both distant and close. Death and artificial intelligence may not be concepts that go hand in hand, but modern technological development has managed to open a back door that leads to a form of digital immortality. There are already laboratories, such as Altos Lab, which are studying and searching for ways to defeat the ageing of the body in order to combat "bad genes" and thus delay death.

To enhance critical thinking and highlight theoretical concerns about digital immortality, there is no more fertile ground than the science fiction series "Black Mirror". This series deals with Artificial Intelligence and its (possible) future applications, while raising both ethical and practical questions, presenting scenarios that still belong to the realm of fantasy but, due to the steady advancement of technology, are not logically impossible.

In an episode called "San Junipero" (Brooker, 2016), a hypothetical scenario is presented in which human consciousness can "ascend" to a digital space after physical death and "live" there forever. The story takes place in a virtual reality that is somewhat reminiscent of a video game, as you can choose what era you want to live in, what you will wear, how old you will be and, of course, what you will do. It is a 'life support' medical device that allows sick, elderly and paralysed people to live like normal, healthy and young people. They can also choose to stay in this device forever, in an eternal virtual reality, and never die.

Our two protagonists meet in digital reality and fall in love. As their real lives are revealed, we learn that one has been paralysed since a young age and is close to death, while the other is elderly and hesitant to decide to stay in the digital world forever. The former has never lived because of his paralysis, while the latter has lived a long and full life and death is not such a bad idea for him to rest.

The screenwriter gives a happy ending, with the protagonists living their love in eternity inside this device. In essence, they have 'uploaded' their brain functions to the system and from then on will live forever in the virtual world as immortal, healthy, digital young people.

Of course, it would be impossible to explain in a one-hour episode what exactly "uploading brain functions digitally" means. Is it a person's personality that is "uploaded"? Their character? Their personal identity? The series cannot explain something that even science has not yet precisely defined.

Modern Applications of AI

In 2020, a company in South Korea made a documentary using Virtual Reality (VR) technology to bring a mother and daughter back together. The little girl had passed away at the age of seven, and her mother, through the VR experience, was able to "talk to her again" and "see" her. She said that although she could feel the differences from her real daughter, this encounter satisfied her need to say a final goodbye to her daughter, which she had not been able to do in reality (Gyu-lee, 2020).

In 2022, Marina Smith spoke to those attending her funeral for the last time through a video with AI (Gyu-lee, 2020). Before she died, Smith had undergone an extensive interview, answering as many questions as possible. The video was shown at her funeral, and her family and friends were able to have a final farewell conversation with her.

There are apps such as HereAfter, Replika, StoryWorth and Forever Missed that use Artificial Intelligence to store and reproduce memories, thoughts, images, sound and speech. They use data from people's accounts and posts to create a digital avatar that thinks and speaks like the person it is copying. With the help of photos and recordings, the technology creates a realistic replica of yourself, offering a new way to preserve your personal history.

Another well-known application, DeadSocial, was created as a guide to help people manage their funeral before they leave this earthly reality. It has clear instructions on how to manage one's digital footprints: from accounts on digital social networks to one's will. On its website, it advertises the "product" as follows: "*No one knows when their life will end, so it is important to prepare for death both physically and digitally so that we are ready when the time comes.*" It psychologically targets the unknown that everyone fears: if you die suddenly, what will happen to your loved ones, who will manage your digital world?

There are also many applications that do not focus so much on managing the digital situation after death, but on creating avatars or chatbots with voice simulations and indicative responses from the future deceased, so that when they die, their loved ones can "talk" to them and find comfort.

Human identity, soul and digital afterlife

But what happens when a person finally passes away? The person is gone, but their avatar remains. It will remain forever stored in the world's digital repository. Their loved ones, in order to manage their grief, will be able to interact with them, hear their voice over and over again, have conversations with them, as if they were there. But their loved one is not there. Who, then, are relatives and friends talking to? Who are they mourning with? Who was the deceased to be so well imitated by an artificial intelligence system? Did his existence have meaning before his avatar? Does his avatar have meaning after his death?

The ancient mystery of personal identity, therefore, emerges once again. If we have a personal identity, how is it defined, and if we do not, then who are we and who will be those who live as our avatars? What, then, is a human being? Can this question define something so complex in just five rules that can be understood and implemented by a machine? Then, even if we limit human existence to a few words that will become algorithms, is it so easy to describe each person's personal existence accurately in a software system and give us back someone, not as a replica, but as the real person?

The attempt to define the concept of man has preoccupied science, the arts and, of course, philosophy for centuries. Descartes limited human existence to the mental act of thinking, identifying the "I" with the mind (Descartes, 2010). Locke, on the other hand, could not ignore the existence of the body (which Descartes conveniently took for granted), and concluded that humans need both body and thought, along with memory and psychological continuity, in order to have an identity of self (Locke, 1999). Hume, being more flexible, considered that since we are not the same every day, there is no constant that can define us. He considers man to be a bundle of ideas and perceptions that is constantly changing (Hume, 2007). Kant approaches human existence through the relationship of the subject with knowledge, morality and freedom. That is, the ability of humans to know the world, to legislate morally for themselves and to act freely. He considers humans to be both cognitive subjects and moral persons (Kant, 2002). Finally, Parfit questioned the stability of the personal self and ultimately rejected the concept of personal identity. What matters for human existence is psychological continuity and the succession of conscious states (Parfit, 2011).

These philosophers approached human existence and identity using different criteria: thought, memory, consciousness, moral autonomy, and psychological continuity. Can all of these be replicated through Artificial Intelligence systems? Certainly, some human characteristics, such as logic, data processing and memory, have already been incorporated into these systems as properties, precisely because they perform better than humans. However, questions remain open and technologically uncertain regarding the ability of Artificial Intelligence to reproduce subjective experience, sense of self, or moral responsibility.

This is perhaps why scientists and philosophers, in order to imitate humans through robotics, are forced to re-examine human nature. They have to "break" the concept of existence into pieces so that they can reassemble it as a machine (Guizzo, 2010).

Christian thought adds another factor of difficulty to the process of imitation. In Christian theology, humans are considered persons. Based on patristic thought, this means that each person is a separate being before God, who is "sealed" by his relationship with Him. The word "person" unites each distinct human being with its creator, thus forming an *unbreakable communion* based on God's love for His creation. This love is so powerful that it breaks man's bonds with all the earthly chains that pull him away from this loving relationship: despair, fear, guilt, death (Zizioulas, 2004).

Theologically speaking, death is not a punishment, but a gift that frees man from an endless wandering in the absurd contradictions of this world. It is an opportunity for mortal existence to be reborn into a peaceful eternity of 'being well' in communion with God, opening the door to the hereafter. What does it mean for a deceased person to have their avatar exist in digital eternity, for the repose of their soul? Do the memories created by their relatives with the avatar have any connection to the deceased? Are the words of this avatar the words of the deceased? Finally, when this technology reaches its mechanical evolution, i.e. the robot, the pinnacle of absolute immortality, what would be the meaning of the deceased's life? Was it to come into the world and live, or to come into the world and become an imitation? Digital immortality, even in its early stages, traps each person's personal existence in a data system, which will be there for eternity to remind us of someone who once existed.

"The meaning of life is that it once ends," says Kafka. There is no doubt that if someone finds a way to perfectly imitate human thought, personality and freedom and infuse them into a machine, they will do so. No one would refuse the elixir of immortality if it could be found. Science will always test the limits of nature, and philosophy will always be there to challenge the limits of applications and redefine anything that pretends to understand nature better than it does.

Death, therefore, as an independent event, is absurd and full of pain for all involved. Theology, however, is here to offer its own version of immortality and eternity. Death is a "door" to the absolute freedom of human existence from all forms of matter, freedom from digital illusions, and leads to eternity. An eternity without back-up, big data, commitments or fear, without, in other words, the remnants of mortal experience. Because for theology, immortality and eternity cannot be understood without the vision of the last things, the eternal state of bliss in communion with the personal God. It is the last things that give meaning to the "depth" of these concepts. In this way, theology places the question of immortality and eternity in its ontological depth: not *how* to maintain a material existence, but why life exists and to whom *being* ultimately belongs.

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Meet the thanabots: The digital Eusapia - the city of the dead - in the age of artificial intelligence

Abstract

This paper explores the relationship between death and Artificial Intelligence (AI), examining the ethical implications of the presence-absence status of the deceased in the digital realm. The paper commences with the phenomenological experience of death, where the corpse is a paradoxical boundary between existence and non-existence. It then introduces the notion of "digital remains"—the online footprints left behind by the deceased—which contribute to a sense of continuity in their existence. AI is emerging as a mechanism for "digital resurrection", with thanabots acting as simulators of the deceased, thus allowing communication with them. This new situation parallels Eusapia, Italo Calvino's fictional city, where the living and the deceased coexist through mirrors of reality. The final question concerns the ethical dimension of this technology: is it a form of "digital immortality" or merely an illusion of consolation in the face of mortality? The answer is not clear, as AI is redefining the threshold between life and death, shifting the paradigm of existential perception.

Keywords: Death, presence-absence, corpse, digital remains, thanabots, Eusapia, digital immortality, ethical dimension.

Introduction

Man does not theoretically understand transience but *lives* through his encounter with his deceased. This experience produces a sense of responsibility: since life is finite, we must act with

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awareness of its end, pay tribute to the deceased, incorporate them into our memory, keep our promises to them, remember them with respect and not to cause them harm (Luper, 2018). Since the 1970s and Thomas Nagel's landmark titled *Death* (Nagel, 1970), philosophers have elaborated arguments about the respect and moral obligation we owe to the deceased and their bodies. When we try to determine, however, why corpses matter, we are faced with certain problems. Most -though not all - philosophers of death accept what Fred Feldman called the "termination thesis", the claim that persons cease to exist at the exact time of biological death (Feldman, 1994).

Our view is phenomenological: at the level at which we encounter other people, corpses are and are also not the person whose body belongs to. Their strangeness and paradox stem from this contradiction, a contradiction that may also be described in terms of continuity and discontinuity. Corpses interest us in a very particular way, precisely because they serve as material testimonies to the profound ambiguity of death: they remain intimately connected to the identity and dignity of the deceased, yet simultaneously highlight the stark reality of absence, decay, and loss. Encountering the corpse thus becomes a potent site of ethical reflection, inviting us not only to consider our obligations towards the departed but also to reassess the nature and scope of our commitments toward each other, as finite beings bound together by mortality.

In his book *The Dominion of the Dead* (2003*)*, Robert Pogue Harrison, argues that each culture responds to a particular "charisma" of the corpse (Harrison, 2003), which requires that it be treated with a certain amount of care. He also amazingly states that:

> *The corpse is the site of something that has disappeared, that has forsaken the sphere of presence, that has passed from the body into . . . into what? Death? The past? Another dimension? We hear these words and understand them abstractly, but faced with the spectacle of a dead body the primitive mind did not think to itself: "My mother has passed away into the dimension of the has-been." It more likely*

> *thought to itself (something like): "Here is my mother lying before me. I can see her, touch her, feel her, yet she is not here. How can this be?" How indeed? Only something as resistant as the insensate body of a loved one—the enigma of its expired life and remnant thinghood—could give the anthropomorphic mind its first access to what we abstractly call death, and with it to the ethos of finitude* (Harrison, 2003).

Harrison's observations resonate powerfully today, especially given contemporary technological attempts at digital resurrection, which seek to negotiate precisely this enigma—by digitally reanimating the deceased, we strive symbolically to reclaim presence, though ironically, we may only amplify the uncanny tension between life and death, presence and absence.

The presence of absence: From the ontology of loss to digital remains

In its perfect resemblance to the person who has passed away, the corpse conceals a presence, at while making an absence present. The experience of loss is not perceived abstractly but embodied: we do not say that one "now lives in the past" or "in another dimension, that of death", but we experience the contradiction of presence-absence in the corpse. In *Being and Nothingness: An Essay in Phenomenological Ontology* (1943), Jean-Paul Sartre gives the familiar example of entering a café, waiting for his friend Pierre, who is not actually there, as well as the experience that results from his absence. He refers to Pierre's absence as "haunting":

> *It is certain that the café by itself with its patrons, its tables, its booths, its mirrors, its light, its smoky atmosphere, and the sounds of voices, rattling saucers, and footsteps which fill it – the café is a fullness of being. And all the intuitions of detail which I can have are filled by these odours, these sounds, these colours, all phenomena which have a transphenomenal being. Similarly Pierre's actual presence in a place*

> *which I do not know is also a plenitude of being... When I enter this café to search for Pierre, there is formed a synthetic organization of all the objects in the café, on the ground of which Pierre is given as about to appear... But now Pierre is not here. This does not mean that I discover his absence in some precise spot in the establishment. In fact Pierre is absent from the whole café; his absence fixes the café in its evanescence; the café remains ground; it persists in offering itself as an undifferentiated totality to my only marginal attention; it slips into the background; it pursues its nihilation. Only it makes itself ground for a determined figure; it carries the figure everywhere in front of it, presents the figure everywhere to me. This figure which slips constantly between my look and the solid, real objects of the café is precisely a perpetual disappearance; it is Pierre raising himself as nothingness on the ground of the nihilation of the café...It serves as a foundation for the judgement—"Pierre is not here." It is in fact the intuitive apprehension of a double nihilation...But, to be exact, I myself expected to see Pierre, and my expectation has caused the absence of Pierre to happen as a real event concerning this café. It is an objective fact at present that I have discovered this absence, and it presents itself as a synthetic relation between Pierre and the setting in which I am looking for him. Pierre absent haunts this café and is the condition of its self-nihilating organization as ground* (Sartre, 1956).

The quotation of this extract is not coincidental, as it comprehensively captures both the effect of absence and the "nowhere but everywhere" aspect that the living experience for the deceased. The present sense of absence that frames Sartre's experience of Pierre's absence in the café hints at the idea of an absent presence, an absence that is absent in space. The body of the deceased is the first and perhaps most fundamental object that is so intensely absent that its very absence is tangible, that is to say, it becomes a presence (Fuchs, 2018; Stokes, 2025). Death, like Pierre's absence, is not something we experience directly, but something we perceive as a negation within our very reality.

In similar terms, we can describe what we are and what we become through technology. We are increasingly present online, so much so that our profiles and avatars are embedded in our flesh as part of who we are. Our online presence is not so much a tool we use as it is a fact of who we are, a part of how we are present, seen and communicated with the world. We enter the internet and find ourselves face to face not just with photos or lines of text, but with that unique thing that characterizes each person, consciousness· what the great Ludwig Wittgenstein uniquely called "the light in the face of others" (Wittgenstein, 1967). But what happens when the source of this light goes out, or when the users behind these online identities die? What challenges does the possibility through AI to digitally embody our once beloved living, and now deceased, pose? After we die, what we leave behind is digitally transformed into remains, reflecting not just what we once were, but what we experienced, felt and did. Digital remains refer to data that remains after the end of their original purpose or interaction, such as social media profiles or other content that remains after a user has stopped participating or even after death. They often represent a "frozen" state of past activity, carrying historical and commemorative value, persisting after the end of active engagement and persisting past their original context (Lingel, 2013; Segerstad et al., 2022).

From digital remains to thanabots at the age of "Digital Eu sapia"

Digital remains have this dual sense of radical absence and ongoing presence, where the deceased no longer exists, but continues to exist. They are elements of memory, which imbue the element of a paradoxical sacredness in whoever beholds them. In the case of digital remains, the image is the corpse. Robert Pogue Harrison again notes that the image is "essentially mortuary" (Harrison, 2003). Digital remains consist of just such images, behind which there is a person who stands mute but resilient. It is "digital flesh", a concept developed in *Living and Dying in a Virtual World: Digital*

Kinships, Nostalgia, and Mourning in Second Life for Second Life by Margaret Gibson and Clarissa Carden, to describe the kind of embodiment we develop over time through immersion into digital spaces, which implies "the development over time of connections, of memories, and of temporal and emotional investments" (Gibson & Carden, 2018). These affective connections lend the digital image a peculiar vitality, a haunting liveliness, even when its referent is gone.

Ultimately, does AI allow us to survive our death? In this contradictory juxtaposition of presence and absence emerges Death Tech and AI, which add to the ongoing presence the element of reanimation—rendering the deceased seemingly responsive. Notable platforms such as Jason Rohrer's *Project December* (https://projectdecember.net/) offer simulations of the deceased through large language models, breathing new "life" into what would otherwise be inert data. Through such tools, the digital remains of the deceased are not merely preserved—they are reanimated. They become thanabots or deadbots: digital deceased whom the living choose to keep near, to converse with, to seek comfort from. In these algorithmic continuations, death no longer marks an impassable boundary but is reframed as a technological threshold—suggesting, perhaps dangerously, that it can be crossed (Reséndiz & Reséndiz, 2024).

This is because, after all, the transience *they experience* through their encounter with their deceased is something they cannot come to terms with, like the citizens of the fictional city of Eusapia, from Italo Calvino's novel *The Invisible Cities* (1972). In this book, Marco Polo describes fifty-five imaginary cities to the Emperor Kublai Khan, each with a symbolic character, representing different themes and reflections on human experience, memory and identity. Eusapia is presented as the city where the inhabitants have constructed an exact replica of their city underground. It is an underground necropolis, a buried mirror, where the deceased can continue the activities they had in life there. In such a way, they ease the transition from life to death, making the experience of the finality less abrupt. As the text states:

> *No city is more inclined than Eusapia to enjoy life and flee care. And to make the leap from life to death less abrupt, the inhabitants have constructed an identical copy of their city, underground* (Calvino, 1974).

In Eusapia, then, life and death coexist symbolically: the deceased are placed in the underground city and live eternally in their former positions and professions, while the living gradually imitate the changes that occur in the underworld, to the point where it is not clear who is alive and who is deceased. So great is the similarity between the city of the living and the underworld where it seems that the deceased are the ones who built the upper Eusapia in the image and likeness of their city below, creating, ultimately creating two twin cities (Calvino, 1974). The name Eusapia was made famous by Eusapia Palladino, a notorious 19th century Italian spiritualist (medium). Palladino claimed to have supernatural abilities and that she could communicate with the deceased (De Ceglia & Leporiere, 2020). Calvino's allusion to her suggests not only an interest in necromancy, but a broader cultural fascination with mediating death—an impulse echoed today in our own attempts to digitally "speak" with the deceased through AI.

Eusapia is more than a metaphor; it is a warning. It allegorizes a culture obsessed with its past, clinging to memory not as a process of mourning but as a simulation of permanence. The deceased do not simply rest—they rule, subtly reshaping the world of the living in their image. It is a meditation on posthumous existence and necrophilic nostalgia, where human beings seek an illusion of immortality not through transcendence but through replication. In this sense, the digital reanimations offered by AI platforms represent not just technological tools but the manifestation of a deeper metaphysical longing—the desire to evade loss by preserving what is ultimately unpreservable. In today's digital Eusapia, the lines between memory and simulation dissolve. AI enables us to build a mirrored underworld where our deceased not only linger, but "perform" for us. Contemporary technology thus extends and complicates Calvino's allegory, challenging us to ask: do we actually honor the deceased?

When the deceased remain with us: "Digital Eusapia" as a model of digital immortality(?)

AI serves as a new agent of digital continuity after death, preserving a person's digital presence while enabling digital resurrection—whether through simulation, recreation, or revival of the digital identity of those deceased (Sherlock, 2013) and ultimately, offering a form of digital immortality. A definition given by Maggi Savin-Baden, David Burden, and Helen Taylor for digital immortality is "the continuation of an active or passive digital presence after death" (Savin-Baden et al., 2017). Maggi Savin-Baden and Victoria Mason-Robbie clarify that the term "afterlife" implies a presence that may or may not continue to exist, while the term "immortality" implies a presence, in at least some form, indefinitely. More precisely, digital immortality is the potential of interactivity after death. Although these terms can be used interchangeably, the afterlife is a broader and more flexible construction, as it does not contain assumptions about the duration or persistence of digital presence (Savin-Baden & Mason-Robbie, 2020). Digital afterlife treats digital presence as being a representation of the deceased person, but also as one that is existing and having form beyond leaving behind letters, diaries and personal items or posts and GIFs on Instagram or Facebook.

On re-creation platforms, which allow users to converse via AI with simulations of both real and imaginary people - including the deceased – via AI, both time and space are fluidized and reshaped as fragments of the self-move from the phase of static to the phase of energetic. In these environments, the boundaries between past and present begin to collapse, as the persistence of the digital self generates the illusion of temporal continuity. The digital deceased seems to be this consensual hallucination that contains memories and experiences that may exist outside of the human bodies from which they originated, allowing for an understanding of the perception of death as a final event that one passes through to be led into a new environment of prior existence preservation. Memories, experiences, and personal traits become detached from the body from which they originated, assuming a new, networked form and reaffirming the enduring relevance and interconnection between the physical and the virtual world (Puzio, 2023; Stokes, 2025).

Such digital "entities" generate environments where death is reconceptualized not merely as a terminal event, but as a threshold transitioning into sustained existence within networked digital ecosystems. This reconceptualization not only reframes human mortality but also redefines the boundaries of identity, as memories and experiences take on a life independent of their original embodiment, becoming inherently relational and interactive within the digital landscape. Consequently, the digital deceased do not simply represent stored or static archives but active, responsive presences that engage dynamically with users, preserving interpersonal bonds in novel forms (Harju, 2024; Tabarak & Maysoon, 2025). Moreover, this shift compels a reevaluation of the fundamental ethical paradigms of identity and selfhood. If our identities can meaningfully persist outside the organic body, what implications arise for the authenticity of personal relationships and the integrity of individual narratives (Floridi, 2011)? That digital re-creation, although convincingly interactive, risks reducing nuanced human experience to algorithmically mediated interactions, thereby diluting the richness of embodied human relationships. Thus, the proliferation of such platforms necessitates careful ethical navigation to ensure these digital engagements meaningfully supplement, rather than superficially substitute, our profound human capacities for remembrance, grief, and connection.

Corpses remain, in an ambiguous way, persons for others. The person dwells among us, as a body, as a memory. The deceased are those to whom we owe enduring duties, encompassing responsibilities of love, remembrance, respect, and sometimes even justice. These duties reflect an enduring moral relationship that survives physical death, emphasizing that moral personhood does not cease abruptly with biological termination. This acknowledgment does not negate the radically different ontological status of the deceased; rather, it deepens our understanding of profound loss, anchoring grief in the enduring ethical and emotional bonds we maintain with the deceased. Yet, there remains an apparent sense in which, for us—if not for the deceased themselves—their moral identity extends beyond the boundaries of their biological existence. Selves –as those we preserve through digital remains and as those who are "digitally resurrected" – may not persist in the world of life, but persons persist and remain (Ratcliffe, 2016). Hence the question arises: among the duties of love and remembrance we owe to the deceased, is there also that duty of wishing to preserve them digitally? The answer, of course, cannot be given in this text.

Towards a new ethics of death?

This remaining existence–the being-but-not-being sense– fundamentally alters the way we perceive corpses. When it comes to our attitude towards the deceased, as Palle Yourgrau puts it, "Our hearts here see more clearly than our heads, for these natural attitudes are disturbed by a beleaguering metaphysical conscience" (Yourgrau, 1993). The question we have posed from the outset is: does AI allow us to survive our death? Initially, the obvious answer is *no*. Now, however, we seem to have arrived at an answer that lacks the same certainty. We are accustomed to thinking about death in binary terms: either you are deceased, or you are alive. While it may sometimes be difficult to determine whether a particular organism is still alive or not, the underlying assumption remains that there must be a definitive fact about whether something is living or deceased. If then, we define dying as ceasing to exist, there must always be a definitive fact about whether a person continues to exist or not. The claim we put forward here, however, is that our deaths are multiple and ambiguous—especially in the age of AI and advanced technology (Öhman & Floridi, 2018). The deceased are gone, and yet they remain with us, capable of continuing to "live" long after their biological decomposition. The idea that persons can exist beyond the boundaries of their biology may seem strange, still it raises some profoundly noteworthy ethical concerns.

The central question is whether death engenders its own moral framework—a distinct ethics of death that extends beyond the ethics of finitude. As an event, death does not inherently possess a moral dimension; rather, it acquires ethical significance through the ways in which the living engage with it (Laqueur, 2015). However, if we accept that life's finitude constitutes the foundation upon which all moral attitudes toward the human condition are constructed, then it may be possible to formulate a new ethics of death within the scope of technology, in which various moral dimensions intersect. These dimensions include:

- The ethics of memory, wherein the corpse compels remembrance, acknowledgment of loss, and the institutionalization of commemorative rituals. Digital technologies amplify these dynamics, transforming memory into a constantly interactive, often algorithmically driven practice (Walter, 2018). In this transformation, memory is no longer static or private, but becomes performative and exposed, mediated through algorithms that prioritize engagement metrics over authenticity.
- The ethics of burial or cremation, reflecting a fundamental human need to ritualize death and to anchor remembrance in a specific place. AI and digital platforms pose challenges to traditional rituals by offering alternative, disembodied, and non-spatial forms of commemoration. In such a context, the grave and the urn are no longer the only places of mourning (Saraiva, 2025).
- The ethics of temporality, which has become increasingly complex as the digital age reconfigures our understanding of life, death, and persistence (Lagerkvist, 2017). The traditional linearity of life and death becomes fragmented in the digital realm, where existence is prolonged indefinitely through virtual interactions. This indefinite prolongation challenges the grieving process itself: if mourning presupposes finality, what happens when the deceased continue to "respond"? Time becomes cyclical, even suspended, as thanabots replicate presence without closure, keeping mourners in a temporal limbo.
- The ethics of presence and absence, wherein the corpse itself testifies to an ontological paradox—simultaneously here and not here, familiar yet unfamiliar (Laqueur, 2015). Thanabots deepen this paradox by manifesting deceased individuals in

> continuously interactive forms. In this way, they do not replace absence with presence—they simulate presence through absence, creating "entities" that are affectively near but ontologically hollow.

As AI-generated presences of the deceased become increasingly sophisticated, they blur distinctions between genuine interaction and digital simulation, raising questions about authenticity and dignity. This phenomenon raises the question of whether digital Eusapia—digital manifestations that seemingly extend existence beyond biological limits—represents a genuine ontological extension of existence or merely provides a comforting illusion in the face of human mortality. The unresolved nature of this dilemma underscores the urgent need for ethical guidelines and clear regulations to manage digital afterlives responsibly (Hollanek & Nowaczyk-Basińska, 2024; Öhman & Floridi, 2018). Ultimately, the final resolution of whether AI and digital technologies can genuinely extend human existence beyond death, or merely simulate it convincingly, belongs to the future. Until then, a cautious, reflective ethical stance is required to navigate the complexities that arise when technology encroaches upon the fundamental boundaries of human life and death.

Conclusion

The intersection of death and technology forces us to reconsider long-held assumptions about the presence, absence and continuity after the end of biological life. Thanabots seem to challenge the finality of death, blurring the boundaries between the living and the deceased. As we navigate this evolving landscape, the ethical implications of digital preservation or even resurrection of the deceased demand our attention. Do these technological extensions honor the deceased or merely serve the needs of the living? Is "digital well-being" a form of immortality or is it an illusion created to assuage the human fear of loss? Ultimately, our preoccupation with death and the possibility of some form of digital immortality reveal more about the living than the deceased. While AI can preserve voices, memories, even fragments of personality, it cannot solve the fundamental mystery of what it means to exist—or to cease to exist. The question remains: does technology prolong life or redefine what it means to pass away? The answer, it seems, lies not only in AI's potential but also in the values we choose to uphold in the face of mortality.

At the heart of this inquiry echoes the seemingly simple yet profoundly groundbreaking statement by Thomas Nagel, which he formulated while examining the fundamental question of whether death is good or evil:

> *I wish to consider whether death is in itself an evil; and how great an evil, and what kind, it might be. This question should be of interest even to those who believe that we do not die permanently, for one's attitude towards immortality must depend in part on one's attitude towards death (Nagel, 1970).*

Nagel's insight reminds us that our ethical stance toward death inevitably shapes our vision of what a good—or continued—life should look like, whether organic or digital. Thus, the challenge ahead is not to solve death through technology, but to preserve death as a human experience, so that our encounter with it remains ethical, rather than programmable.

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Part III

Bioethical frameworks for health care, research and medical education

Panagiotis Pantazakos*

Humanism and responsibility in experimental research: Ethics, physics, medicine

Abstract

When Stephen Toulmin (1922-2009) expressed the view that medicine saved the life of ethics—and did not allow it to follow philosophy into death—because it transformed it into bioethics, he expressed an eternal truth, since there has never been a time in human history when people have not shown an interest in health and its preservation: proper nutrition, exercise, healthy living conditions, medical care and pharmacy, more than philosophical thought, adhering to the axiom primum vivere deinde philosophare. However, he did not notice the dynamics of bioethics, which, just a few decades after its codification in 1971 by Potter van Rensselaer (1911-2001) and his work Bioethics. Bridge to the Future, not only transcended medicine to become a point of intersection and interaction between different sciences: biology (genetics, biotechnology, Biomedicine), Theology, Philosophy, Law, etc., but also accumulated around it such a large body of literature (from 1975 to 2000, the United States National Library of Medicine catalogued over 50,000 bibliographic references on a wide range of bioethical topics) and databases (with a wealth of collections of government reports, proceedings of ethics and deontology committees around the world, unpublished documents of expert committees, legislative provisions, audiovisual media, books and journals in digital form), which now requires specialisation, continuous methodical and systematic cultivation as an autonomous subject of knowledge.

Keywords: Medical ethics and deontology; environmental ethics; animal ethics; social ethics; survival science

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Since the time of the ancient Greeks, the question of whether it is right for doctors to experiment on humans has divided the medical community into two opposing camps. Herophilus[1] (331-280 BC), who considered the experimental method essential for establishing medical knowledge on an empirical basis, did not hesitate to achieve his goal of reviving, as Celsus and Tertullian report, at least 600 living people who were about to die, while, on the contrary, Galen (129-199 AD), who believed that experimentation was worthless unless it was based on sound reasoning, not only did not experiment on living humans, but also on dead animals, and also supported rationalism, i.e. the superiority of theoretical research over experimental research. In ancient Greece, according to the global bibliography (Eftychiadis, 2001), the foundations were laid not only for the separation of medicine from magic and divination, but also for the practice of medicine using scientific methods.

To see clearly how medicine was practised in ancient Greece, we can consider Plato. According to him, in ancient Greece, doctors treated slaves differently from free citizens. While slaves were simply given medicine without being asked or told why they had to take it, free citizens had to be persuaded that the treatment and medication they were being offered was appropriate for their condition. This is confirmed by the testimony of the orator Gorgias, brother of the physician Herodicus (*Gorgias,* 456a-b; Skouteropoulos, 1998): "It has happened to me," says Gorgias, addressing his interlocutors, many times to visit with my brother and other doctors a sick person who did not want to take medicine or let the doctor operate on him or cauterise him – and while the doctor could not persuade him, I managed to persuade him with my rhetorical skills.

With the advent and spread of Christianity, the course of history would change. Belief in the Resurrection of Christ transformed people's perception of death and, with it, their perception of life itself. Christianity reveals the value of individuality by emphasising the value of personal spiritual awakening and responsibility.

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[1] Founder of the medical school of Alexandria and pioneer of anatomy.

For the Christian Fathers, man is solely responsible for his actions, freed from the bonds of family and society. In early Christian times, the Romans, writes Rodney Stark in his work *The Spread of Christianity (*Stark, 1996), threw people onto the streets at the first signs of illness because they were afraid of catching it and dying. Christians, however, faithful to Christ, stayed and cared for the sick with practical love. You could only do that at that time if you thought: So what if I die? I will have eternal life.

In this dark age, when, according to Roman law, people were considered objects that could be freely bought and sold in the marketplace, the Apostles proclaimed to the ends of the earth the equality of all people, the abolition of slavery, and compassion for widows, orphans, the elderly, and the sick. Thus, the Gospel changed the way Christian doctors would henceforth deal with various medical and philosophical issues, such as: What is the origin of life? How does the healing power of nature and its laws work? Should abortion and suicide be allowed or not? What is the relationship between the brain and thought and the soul? etc. The Gospel also helped doctors to develop ethical considerations, such as: What rules should biomedical researchers follow in their research? Should medicine be an end in itself for doctors, or is medical research subject to ethical restrictions? What makes an excellent doctor? What skills and qualifications should they have? How should they behave towards patients and their families, colleagues, subordinates in the research laboratory or clinic, nursing staff and pharmacists in order to be worthy of their mission?

In the light of the Gospel, the unwritten rules of the Hippocratic Oath, which since they were written have never ceased to inspire doctors in their noble mission, will acquire their true meaning. Medicine will become ethical and health will become a social and universal good. Medicine as a science, created through scientific methods, and medicine as an art and craft, acquired through practical apprenticeship, will elevate the medical profession to the most distinguished of all.

On a purely scientific level, the efforts of doctors to achieve certain knowledge cannot be distinguished from the efforts of other scientists to achieve success in their own work for two reasons: on the one hand, because the way of thinking is common, whether we think with numbers or with words and images, and on the other hand, because speech is man's power. With their discoveries, temperate scientists "prolonged human life, conquered diseases, and offered humanity unprecedented conveniences and material goods. (They thus managed to push aside) demigods and demons and (discover) a universe more complex and awesome than the human imagination could conceive" (Broad & Glanz, 2003).

However, the fact that people have managed, through the development of science and especially medicine, to build a bulwark against disease, the sufferings of life and death – does not mean that they have become more human, not only because health is one thing and virtue another, and someone may take care of their health, have regular check-ups, exercise and go to the doctor, not to do good but to do evil, as, for example, a cunning and well-trained thief does, but also because the materialistic hedonism that dominates our era has turned everything around us into a commodity, even beauty and health, leading us to blind practicality, the simplistic thinking of people who are dazzled by the external world and neglect the internal (Skalkeas, 2004).

For philosophers, if we want to distinguish genuine science from its counterfeit, i.e. pseudoscience and charlatanism, the only reliable way we have is to test all the knowledge offered to us through experimentation.

The origins of the experimental method can be traced back to Aristotle. In its classical form, however, empiricism was associated with John Locke and David Hume. According to them, the experimental method should be applied to all sciences, whether physics, medicine or ethics (with mental experiments and imagination): on the one hand, because scientific research cannot be reliable unless it stems from the systematic study of empirical reality and, on the other hand, because nothing can exist in our minds without first passing through our senses. In other words, empirical knowledge may not be able to reveal the essence of things to us, but we must not forget that it is also the only valuable kind, as it not only protects us from sterile subjectivism – and the danger of becoming embroiled in a dialogue of the deaf – but also because its conclusions are well documented through empirical evidence and experimentation, which proves that what we know about our world is what our senses allow us to learn about it.

Doctors, like all scientists, if they want to be truly worthy of their name, must not think inductively or productively, but hypothetically, "that is, from the best available information to the best explanation" (Peirce, 1923). To substantiate this view, its supporters proceed in three complementary stages: a. they point out the inseparable link between theory and observation, b. they propose the principle of disconfirmation over the principle of verification, and c. they emphasise the public nature of science.Specifically:

a. As Karl Popper (Popper, 2002) rightly points out, it is wrong to believe that we can have bare observations, raw materials, since our observations are always made in the light of corresponding theories. The starting point of our research is not the experiment or observation, but the theory, which dominates it from beginning to end. In other words, the scientist first conceives of a theory and then attempts to prove it experimentally, since if he has nothing in mind, he will not know what he is looking for (Popper, 1991).

b. Science is not advanced by verification, but by the falsification of scientific theories, and the history of science is nothing more than the transition from one theory to another through the falsification of the old by the new. The insistence, Popper observes, on verification is pure dogmatism, not only because if we knew the truth we would not need to search for it, but also because genuine science does not abhor criticism, but rather seeks it out. The scientist, Popper observes, who is imbued with a genuine scientific spirit is not only open to the new, but is also ready to revise or reject his theory, provided that it is proven that he was wrong in his measurements.

c. The confirmation of certain theories over a long period of time (such as the law of gravity) and their resilience to criticism from the academic community does not mean that they cannot be overturned in the future, since our world has an open structure and no one knows what the future holds, whether things will remain the same as they are today and will not be overturned. "Scientific objectivity," Popper observes, "(the intersubjectivity of science is not a product of the impartiality of a (single) scientist, but a product of the social or public character of the scientific method" (Popper, 1991).

In this sense, an experiment should be defined as the practical testing or application of a theory under specific conditions and methodology, or, according to another version, the methodical production of various phenomena, planned according to a specific research protocol, with the aim of studying them thoroughly, determining their nature, the causes that produce them and the laws that govern them (Dimitrakos, 1969). In other words, the experiment is rightly considered the alpha and omega of scientific objectivity, as it not only refers to a public experience that anyone can repeat, provided that one makes the "effort" to follow the same research protocol to the letter, but also proves that peer review cannot be exercised in isolation from laboratories, scientific journals and conferences, because the data from one experiment can only be overturned by the data from another experiment.

For philosophers, experiments derive their scientific credibility from various factors, such as repeatability, statistical analysis, controlled variables, etc. However, if we approach them from a logical point of view, it is not difficult to see that, despite their diversity, they can be categorised into four main categories for systematic reasons, corresponding to the research principles followed in their design:

1. Agreement. According to this principle, of all the possible causes of an issue under investigation, we must choose one to keep constant and unchanged throughout all phases of the experimental process, while changing all other causes sequentially. If we ultimately succeed in producing the desired result, the condition we chose to remain unchanged during the experiment can legitimately be considered the cause of the phenomenon. To put it as it is stated in the literature: The principle of agreement assures scientists that the hypothesis, variables, procedures, and results of their experiment are connected to each other in a straight line.

2. The principle of difference. According to this principle, in order to diagnose the real cause of a phenomenon, we must move in the opposite direction to what the principle of relevance dictates. Of all the possible causes of a thing, we must choose one in order to exclude it from all stages of the experimental process. If, despite all the combinations of causes we have tried, during the experiment, we ultimately fail to produce the desired phenomenon, then we can reasonably claim that the cause we excluded from the outset is the cause we are looking for.

3. The remaining causes. According to this, in order to consider an experimental result reliable, we must be able to gradually exclude, step by step, all possible causes except one during the experiment. In this way, we can be sure that the observed result is due solely to the cause we have identified and not to those that have been ruled out.

4. Parallel variables. According to this, in cases where we want to experimentally study a phenomenon for which, however, we can only have probabilistic knowledge of its causes, the correct way to study it is to focus our attention on whether (and to what extent) other phenomena occur when it appears, the causes of which we do know. In this way (i.e. by identifying alternative causes and examining them in parallel at different levels or in different groups), we will be able to distinguish between confounding variables, as they are called in the literature, variables, i.e. variables that only superficially affect the issue under study, but are not essentially related to it or are part of the main hypothesis, so that we can ultimately arrive at its main cause. For example, in a pharmaceutical study, we divide the participants into two groups, one receiving the drug under trial and one receiving a placebo. If the other variables remain constant, then we can be sure that the differences we observe in the results of the two groups are due to the cause under investigation (the drug) and not to other factors.[1]

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[1] Randomisation in clinical trials does not simply increase the reliability of their results. It also reduces the risk of systematic errors, allowing researchers to make valid generalisations about their findings.

The principles mentioned above can ensure the validity of the experiment's results, but they cannot reveal anything about the ethics of the scientists conducting them or the purpose they serve. Whether they are conducted responsibly or not, whether they benefit democracy and pluralism or not, whether the laws and ethics established by international conventions on human rights and bioethics are observed, etc. Their use is instrumental, like mathematics.

To ensure that humanity that scientific studies conducted across the entire spectrum of science, from computers and artificial intelligence to elementary particle physics, the human genome and medicine, respect the rights, safety and well-being of participants, as well as the integrity of science, Research Ethics Committees were established. These committees were tasked with reviewing, approving and monitoring scientific research in order to ensure democracy and public accountability for all.

All of this has contributed to the fact that, in our time, the relationship between theory and experiment does not function in the same way as in earlier times. Science in Nazi Germany played a decisive role in this, where Philipp Lenard and Johannes Stark (Hentschel, 1996) did not hesitate to invoke scientific progress and the good of humanity in order to completely eliminate theory from science, to consider it an invention of the Jews (as well as Christianity, which they regarded as a Jewish heresy) and instead to propose experimentation as the only reliable, Aryan method.

Fortunately for all of us, however, this is not the case. Theory and practice are equally necessary for science. Only together can they provide a comprehensive approach to understanding and solving the problems we face. No one can monopolise the truth, since each of us has the right while we live to approach and experience the truth in our own unique way, sometimes regretting and changing our minds, sometimes becoming better and sometimes worse.

In physics, writes Max Born, the difference between theory and practice is clearer than in medicine, because in medicine we use experimentation more than mathematics and conceptual analysis.

All physicists, writes Born, "consider the work of our hands and minds to be useful and important," indicative of our genius (Born, 1993). However, theoretical physicists view practical physicists differently, and vice versa. Those who are obsessed with experiments "not only boast about their measurements, but also look down on the paperwork of their theoretical colleagues. Theorists do the same. Not only do they boast about their grandiose expressions and groundbreaking ideas, but they also despise the dirty hands of their colleagues in the laboratories wearing aprons." For Born, neither experiment nor theory should be absolutised.

"Looking back over the history of science," Born writes, "we see a kind of cycle: periods of experimental development alternate with periods of theoretical development. Theories tend to become increasingly abstract and general. They settle on principles that have been [...] proposed by philosophers and eventually assimilated by theory. However, as they become part of a philosophical system, a process of dogmatism and fossilisation begins. This is characteristic of (all) quantitative sciences," including medicine.

Equally true, Born continues elsewhere in his work, is the fact that: "the first doubts (about theories that were considered empirically and experimentally unassailable, such as Euclidean geometry) did not arise from experimental evidence, but from logical starting points. Intuitive insights."[2] "Experiment," writes Feynman, "helps to produce scientific laws in the sense that it gives us the starting point. But what is needed in addition (to move forward to the new) is imagination, (which will allow) [...] from these (first) impulses, (to create) the great generalisations" (Feynman, 2013). "The scientific process," says Born, "produces experts without knowledge when it is self-sufficient and does not question the principles, the method it uses and its reliability" (Feynman, 2013). A dominant role in science is played by the questioning of authorities, trust in common sense, and the intelligence of 's naturalness

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[2] Some mathematicians, for example, considered "that it was not logical for a single straight line to pass through a point," and subsequently laboured to "construct non-Euclidean geometric systems" that not only apply to the real world but are also connected to physics and astronomy.

(Feynman, 1969). That is why "Science (should be understood as) belief in the ignorance of experts."

For Bruce Kasanoff, intuition is the highest form of intelligence. That is why the most intelligent people listen to and trust their instincts, even if they sometimes contradict their logic.

"Intuition," writes Kasanoff, "is knowing the right answer automatically and understanding what is important from what is insignificant, instinctively (Gigerenzer, 2008; Kasanoff, 2021). When you investigate deeply, considering countless possibilities and contingencies, you not only sharpen your intuition, but also contribute to the formation of collective intelligence." "Intuition," Kasanoff continues, "is our ability to understand the feelings and reactions of others, so that we can move from a chaotic or primitive conception to a well-organised understanding. Intuition helps each of us distinguish the essential from the trivial, the new that will determine the future, according to our inner voice." Einstein writes, listening to his own inner voice: "The intuitive mind is a sacred gift and the analytical, rational mind is its faithful servant. We have created a society that honours the servant but has forgotten the gift."

Those who make great intellectual leaps and determine the future of humanity harness the power of intuition to use it for the benefit of all. The fact that many scientists, such as mathematicians[3], and philosophers[4], "tend not to worry about whether their theories are in tune with the intuitions of ordinary people" or not, envisioning chimeras and utopias, should not lead us to believe that scientists are entitled, because of their gifts, to use any

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[3] Spyridon Stelios, "Experiment and Philosophy: From the Mental Laboratory to Contemporary Practice," Aition 4 (2016): 112-115.

[4] The opposite view is expressed by Antti Kauppinen, "The Epistemic vs. The Practical," in *Oxford Studies in Meta-ethics,* vol. 18, ed. Russ Shafer-Landau, 137-162 (Oxford: Oxford University Press, 2023). A good analysis can be found in Spyridon Stelios, "Experiment and Philosophy: From the Mental Laboratory to Contemporary Practice," Aition 4 (2016): 112–115., 4. According to him, philosophers should not be confused with the common mind: "According to Kaupinen," Stelios observes, "the methods used by experimental philosophers can investigate [...] only superficial intuitions [...] while (traditional philosophers) who use conceptual analyses (engage) with strong intuitions [...] expressed by competent users of language under ideal conditions and without the influence of relevant factors. (According to Kauppinen) intuitions of philosophical interest can only be explored through dialogue and reflection, a participatory process similar to dialectic.

means necessary, adhering to the axiom of science for science's sake (Stelios, 2016; Nadelhoffer & Nahmias, 2007). Nor, of course, should they look down on others. Scientific research and experiments should be conducted within a code of ethics and conduct, because only then can they serve humanity.

With this in mind, four young scientists, Gustafson, Rydén, Tibell, and Wallensteen, drew up the first code of ethics and conduct in 1981 for scientists who want to respect not only their science but also themselves (Gustafson, 1984). According to them, scientific research is an absolutely essential activity of enormous importance to humanity. However, because scientific research can either directly or indirectly exacerbate humanity's problems rather than cure them, scientists must be able to defend their work not only scientifically but also ethically.

It is a fact that scientists cannot completely control the future use of their research results, which, once made public, can be exploited by anyone, even by those with malicious intent, or to have in-depth knowledge of the central planning of the scientific endeavour in which they are involved. Nevertheless, this fact should not prevent individual scientists from making sincere efforts not only to constantly evaluate the consequences of their research, but also to refrain from any research they consider unethical.

For Gustafson, Rydén, Tibell, and Wallensteen, scientists who wish to be worthy of their high calling should take the following seriously into account:

- Their research must be conducted in such a way that its application and other consequences do not cause significant ecological damage. (Animals should not be mistreated. Human suffering, ignorance, or despair should not be exploited.)
- They should not distort the truth for profit, nor conduct research in which the desired outcome has already been predetermined.
- Scientists have a special responsibility to thoroughly assess the consequences of their research and to make these consequences public.
- Scientists who conclude that their research conflicts with this

> code must discontinue such research and publicly explain the reasons for their position. Such criticism must take seriously into account the possibility and specific weight of the negative consequences that may arise.

There is an urgent need for the scientific community (and others) to support their colleagues who feel convinced that they must discontinue their research for the reasons set out in the code, but also to denounce decisively all those who, whether for ideological reasons or because of their greed, selfishness and vanity, do not hesitate to sell out their scientific integrity, killing the human being within them.

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Bobby George*

Bioethics in healthcare

Abstract

Ethics comes from the Greek word "Ethos", meaning character. In the modern world, ethics is a wide branch of philosophy that conceptualizes the rights, the wrongs and morality of one's conduct. Ethical choices, both minor and major, challenge us every day in the delivery of health care for persons with diverse values living in a mixed and multicultural, multi-religious society. Medical ethics is a system of moral and ethical principles that apply values and judgments to the practice of medicine. At its core, medical ethics stresses the importance of fair distribution of healthcare. The application of ethical principles in biological sciences, in research, as well as in clinical application is covered under bioethics. In fact, bioethics stands at the intersection of medicine, science, law, philosophy, theology, and social sciences. It addresses the moral questions that arise in the application of medical and biological technologies as well as with the technologies themselves, ensuring that such developments are aligned with societal values and ethical principles. The scope of bioethics reaches far beyond the traditional limits of medical ethics, encompassing a wider range of issues brought forth by progresses in biological research and biotechnological innovations. Such advances include research in genetic engineering, gene editing and gene therapy stem cells, reproductive technologies, the formulation of public health policies, artificial intelligence in healthcare, public health surveillance etc. As science advances into unexplored terrains, it is important to abide by ethical principles and use it as a guiding force, ensuring that research serves humanity responsibly and equitably. Attempt has been made in this review to delve into some of these domains and discuss the bioethical issues and challenges which pop up.

Keywords: Bioethics, healthcare, clinical, autonomy, beneficence, non-malfeasance, justice, patient, informed consent

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Historical perspective of bioethics

The modern era of healthcare ethics is often traced to Henry Beecher's persuasive, 1966 article on ethical problems in clinical research, with particular attention (through a series of actual examples) to the failure to inform patients of the risks involved in experimental treatments. Henry Beecher had identified that in clinical research, the most "reliable safeguard" of the patient's interests, and against unethical behaviour, was the involvement of an informed, conscientious, compassionate, responsible investigator (Scher & Kozlowska, 2018). Newer problems started emerging in medical profession, which extended the scope of healthcare ethics. The new field that took shape was called *bioethics*, a term explicitly preferred to encompass not only medicine and the rest of healthcare, but the entire field of the (human) life sciences (Beecher, 1966; Reich, 1994).

Van Rensselaer Potter, an American biochemist cum oncologist from the University of Wisconsin, is generally accredited to be the first person to have used the term '*bioethics*.' In 1970, Potter had published a paper entitled "*Bioethics: The science of survival*" in the journal Perspectives in Biology and Medicine (1970; 14: 127-153). A year later, he published a book "*Bioethics: Bridge to the Future*", in which he expressed concern about the dehumanisation in science and the need for a new discipline, which would help re-establish ecological equilibrium and defend natural resources (Potter, 1971).

The Declaration of Helsinki which is a set of principles developed by the World Medical Association's (WMA), is the best-known policy statement on medical research involving human participants. The first version was adopted in 1964 (at Helsinki, Finland) and has been amended seven times since, most recently at the General Assembly in October 2024. Bioethics and bioethicists loomed large in both healthcare ethics discourse and professional education in the U.S. by the early 1980s. This growth was further solidified by the founding of The International Association of Bioethics in 1991 (Scher & Kozlowska, 2018).

Principles of bioethics

The 4 basic principles or pillars of bioethics are autonomy, non-maleficence, beneficence, and justice. Due to the many variables that exist in the context of clinical and other associated cases in healthcare, several of these ethical principles may seem to be applicable in numerous situations. At the same time these principles are not considered absolutes, but serve as guidelines in clinical medicine (Lawrence, 2007).

- ***a) Principle of autonomy:*** All individuals have a fundamental right to self-determination. The principle of autonomy indicates that the patient should be considered capable of acting based on an understanding of the treatment offered, as well as the risks, complications and outcomes associated with such treatment (Entwistle et al., 2010). For this to occur, patients must be fully informed about their medical condition and it's the doctors' responsibility to ensure true informed consent is provided.
- ***b) Principle of equality and justice:*** All individuals are equal as persons and have a right to be treated accordingly. It is expected that a physician should be fair in offering his or her services, and that there should not be any preferential attribution of services. The question of distributive justice also seems to pivot on the fact that some goods and services are in short supply, thus some fair means of allocating scarce resources must be determined (Yudhistir & Jugessur, 2023).
- ***c) Principle of beneficence:*** Medical practice often involves a compromise between benefit and harm, especially with regard to interventional procedures and drug therapy, but should always be biased towards 'benefit' (Attard-Montalto, 2001). The principle suggests that the physician has a duty to benefit the patients, and also to prevent them from any harm that may be caused by a medical treatment.
- ***d) Principle of non-maleficence:*** All individuals have a duty to avoid harm to other persons, insofar as it lies within their power to do so without unwarranted harm to themselves. The princi-

ple of non-maleficence suggests that there should be no harm caused to the patient by providing or denying a treatment (Katz, 2024). While beneficence means acting to benefit others and promote their well-being, while non-maleficence means refraining from causing harm. It is understandable that medical mistakes may occur; however, this principle articulates a fundamental commitment on the part of health care professionals to protect their patients from harm and need for medical competence.

Role of bioethics in healthcare

Bioethics is vital in today's rapidly growing scientific and technological landscape in healthcare for numerous reasons:

- Navigating moral dilemmas in modern medicine: As medical science advances, it gives rise to previously unheard-of ethical challenges. Bioethicists help navigate these intricacies, balancing technological possibilities with ethical concerns.
- Influencing public health policies: Bioethics plays a vital role in shaping public health policies, ensuring they are socially responsible (Benatar, 2006). This is particularly noteworthy in areas like vaccination policies, resource allocation during pandemics, public health surveillance, and access to healthcare.
- Guiding biotechnology and emerging technologies: Bioethics plays an important role in guiding the ethical development of biotechnology and emergent technologies, ensuring innovations respect human values and environmental integrity (O'Mathúna, 2007). For instance, with progression in areas such as cloning, gene editing and reproductive technologies, bioethics addresses concerns associated with genetic privacy, personalized medicine, designer babies, eugenics, and the moral status of embryos.
- Fostering responsible scientific research: Bioethics emphasizes research integrity and the ethical conduct of scientific investigations, stressing the need to build confidence in the findings, and to acknowledge the limitations of science in addressing the moral dimensions inherent in research involving human and an-

imal subjects. It stresses that scientific studies should remain grounded in ethical principles, safeguarding against potential misinterpretations (Teessar, 2024).

- Enhancing patient autonomy and rights: Bioethics underpins the importance of patient autonomy, informed consent, and the right to privacy, ensuring patient's rights are at the forefront of healthcare decisions.

Bioethical issues faced in different healthcare domains

a) In clinical research. Ethical considerations are paramount in the clinical trial (CT) or research process to ensure patient safety, data privacy, and scientific integrity. Balancing patient safety and scientific progress is a fundamental concern for CT researchers. Risk-benefit analysis is at the core of bioethics, as it is the ethical consideration that underpins all scientific research. These analyses consider various factors, such as the efficacy of the drug, safety concerns, regulatory guidelines, and patient population. Researchers must uphold informed consent, carefully select subjects, conduct risk-benefit analysis, maintain privacy, and provide post-trial care in lines with the Belmont report (Nagai et al., 2022). The fundamental concepts of the ethical framework for undertaking clinical research focuses on the principle of scientific necessity, which is covered in two regulatory requirements:

i) the equitable selection of subjects –wherein Institutional review boards (IRBs) or Ethics Committees (ECs) should consider the purposes of the research and the setting where the research will be conducted and should be aware of the unique challenges of conducting such a research.

ii) minimization of risk – wherein research procedures should be consistent with sound research design and should not expose subjects/patients to risk unnecessarily. The duration of the exposure to the risk, the characteristics of the risk, and the reversibility of harm should also be considered.

Clinical studies should be carried out according to International Conference on Harmonization (ICH)/World health organization (WHO) Good Clinical Practice standards (GCPs), which are consistent with the ethical principles originated in the Declaration of Helsinki. These principles include voluntary participation, informed consent, anonymity, confidentiality, potential for harm, and results communication. The ethical principles of autonomy, beneficence, and justice are reflected in U.S. FDA-regulated clinical investigations under 21 CFR parts 50 (Lindsay, 2022). Sponsors and clinical investigators must always adhere to the code of ethical conduct when collecting subject/patient data. Researchers must uphold informed consent, carefully select participants, conduct risk-benefit analysis, maintain privacy, and provide post-trial care.

b) Obtaining informed consent. Informed consent is a cornerstone of contemporary healthcare, integrating the professional standard with ethical considerations to safeguard patient autonomy and rights, not just during CTs, but for other medical and surgical procedures as well. Its importance cannot be overstated, as it captures the principle of respecting patient's/subject's autonomy by involving them in decisions about their own healthcare (Satyanarayana, 2008). Consent must be informed, in such a way that the patient can understand the nature of the procedure, the associated risks, benefits and any alternative treatments, if any. This means disclosing the risks of a particular treatment. The ethical principle of respect for patient autonomy requires that healthcare providers accept and respect decisions from autonomous patients to refuse medical therapy (Van Norman, 2008).

The ethical framework addresses the complexities of obtaining informed consent from different demographics, such as children or incapacitated individuals, where consent must be obtained from guardians or legal representatives. Although minors require consent from their parents or guardians, children above a certain age must also provide their assent which might become problematic with differing opinions. Additionally, researchers must use specialized communication methods to ensure that people with learning disabilities and other vulnerable individuals fully understand the study's implications (Moran, 2024). Clinical researchers are responsible for ensuring that the ambition to discover a safe and effective medication does not come at the expense of patient safety, and guaranteeing informed consent is a major component of that. The balance between safeguarding patient autonomy and fulfilling clinical responsibilities underscores the intricate nature of informed consent (Pugh, 2020).

c) Vaccination. The vaccine development and research process include diverse experts of many scientific and social disciplines, including public health, epidemiology, immunology, and statistics, and from pharmaceutical companies. These stakeholders may have conflicting priorities and motives, which contributes to various ethical discussions (Ulmer & Liu, 2002). Vaccine policy is uniquely challenging because it involves balancing personal medical decision to vaccinate with the collective goal of public health, which often creates legal and ethical disputes, such as those concerning vaccine risks and government mandates. (Schwartz & Caplan, 2021). When evaluating vaccination responsibilities, two main ethical principles are considered: harm prevention and ensuring fair participation in public health efforts. While some believe these principles justify mandating vaccinations, others weigh them against factors such as: individual freedom of conscience, personal beliefs against vaccination, as well as the small but real risk of side effects from vaccines. This debate requires balancing collective benefits against individual risks and rights (Giubilini, 2021). Additionally, it is important to understand a vaccine's safety and efficacy in various populations, but testing a vaccine in vulnerable populations, such as children, also raises ethical concerns. Many vaccine-related ethical debates centre on the evidence that access to vaccination depends in some way on socioeconomic and racial ethnic minority status (Jalilian et al., 2023). Implicit in these discussions is whether all lives are equal, and equally deserving of opportunities to be protected by vaccination.

Ethical debates also arise because some individuals and communities disagree with the vaccine mandates, and/or have religious or philosophical beliefs that conflict with vaccination. For example, in an effort to protect the greatest number of people, public health vaccine regulations may infringe upon individual autonomy and liberty. Many would agree that individual governments have an obligation to protect the health of their population, and try to achieve herd immunity against certain infectious diseases through vaccination. The real ethical question is not *if*, but *how* and within what limits they should do it. There is a range of possible vaccination policies that can be ranked in terms of restrictiveness. These go from mere information campaigns to outright compulsion or even forced vaccination (Giubilini, 2019). Regulating vaccine hesitancy is ethically justified when it is done to protect public health, ensure justice and equity, maintain trust in public health systems, and use healthcare resources efficiently. However, such regulations must carefully balance individual rights with the collective good, ensuring that they are implemented in a fair, transparent, and proportionate manner (Williamson & Glaab, 2018).

d) Assisted reproductive technologies. Women's health can be enhanced if women are given the opportunity to make their own reproduction choices about sex, contraception, abortion and application of reproductive technologies. There are many ethical facets which stem from the application of reproduction control in women's health (Macklin, 1996). Reproductive ethics is concerned with the ethics surrounding human reproduction and beginning-of-life issues such as contraception, assisted reproductive technologies (ARTs) [e.g., in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ISCI) etc.], surrogacy, and preimplantation genetic diagnosis (Thacker & Lenow, 2025). The main ethical dilemmas following the development of ART that are worth considering (Schenker & Eisenberg, 1997) are related to:

- Experimentation on pre-embryos, their genetic manipulation and cryopreservation
- The right to procreate or reproduce; the process of IVF itself
- Rights of children born by these techniques.
- Rights of the woman versus the rights of the foetus due to induced abortion.

- The moral status of the embryo
- The embryo selection that is carried out using preimplantation genetic diagnosis (PGD) to transfer only the best quality embryos.
- The fate of surplus human embryos
- Gamete donation, especially the right to privacy of donors and of children to know their parents.
- The production of saviour siblings.
- The possible use of these techniques for social purposes, unrelated to the woman's own fertility, such as 'gestational surrogacy' and 'social freezing'.
- The possible hyperinflated success rates in advertisement projected by assisted reproduction clinics to attract gullible customers.

These challenges place an onus on healthcare providers to ensure that counselling procedures are adequate. Critical consideration must be given to appropriate information delivery procedures, including what, how and when information is provided to users to best support reproductive autonomy (Coco, 2014).

e) Surrogacy. Surrogacy, by definition, is "*an arrangement in which a woman agrees to a pregnancy, achieved through ART, with the intention to carry it and hand over the child to the commissioning/intended parents for whom she is acting as a surrogate*." Surrogacy may be commercial or altruistic, depending on whether the surrogate receives financial reward for her pregnancy. The surrogate might be very close to the intended parents and volunteer out of compassion. Surrogacy could also be an attractive alternative for a poor surrogate mother as she gets very much needed money, and an infertile couple gets their long-desired biologically related baby, but the real picture could be very different due to ethical, legal and social reasons (Saxena et al., 2012). There is a saying, "*Surrogacy industry is run by haves, to exploit the have-nots*". The unethical practices, may vary by location and the specific circumstances surrounding each case may vary. The bioethical issues and the legal issues surrounding surrogacy have been widely reported (Frati et al., 2021). Some of these are enlisted below.

- Ethical concerns of exploitation, commodification, and/or coercion, wherein women are paid to be pregnant and deliver babies for wealthier people in the society (Patel et al., 2018).
- Some perceive that it is morally and ethically wrong for a woman's body to be utilized as a vessel for carrying a child (Watson, 2016).
- Few clinics practice multiple embryo transfers – over and above 03, allowed as per the ART guidelines. The subsequent fetal reductions can pose health risks for the surrogate mother. Few clinics don't have the perseverance to even wait it out so that the egg donors can be tested for infectious diseases. There have been cases of HIV positive status being detected after the donation.
- Some clinics would resort to the practice of introducing a single surrogate mother to multiple intended parents. Once the surrogate mother would be impregnated with one of the couple's embryos, other intended parents would be told that the embryo transfer for their surrogate mother had failed and would make them pay up for another IVF cycle (Kneebone et al., 2022).
- Advances in reproductive technology may lead to ethical concerns about 'designer babies' born through surrogacy, where parents can select certain traits, potentially leading to eugenics and social inequality.
- In surrogacy, the rights of the child are almost never considered. Transferring the duties of parenthood from the birthing mother to a contracting couple denies the child any claim to its "gestational carrier" and to its biological parents if the egg and/or sperm is/are not that of the contracting parents (Ber, 2000). Issues can arise concerning the child's identity, citizenship, and rights if the surrogacy arrangement involves international borders.
- Intended parents who end up with twins through surrogacy, reject one while selecting the other, leaving the fate of other new-born in limbo.

Altruistic and not commercial surrogacy should be promoted. Due to the lack of regulation on cross-border surrogacy in low income countries, it undermines the dignity and rights of women as even a modest economic compensation determines a significant purchasing power. To address the ethical, moral and other concerns, there is a need for stricter regulations, ethical guidelines, and comprehensive support systems for all parties involved in surrogacy arrangements.

f) Organ donation and transplantation. Organ transplantation involves the surgical procedure of removal of damaged/injured tissues or organs from the body of a person and their substitution by similar tissues/organs from a donor. The donor and recipient may be at the same location, or organs may be transported from a donor site to another location. Types of organs which are transplanted include kidneys, liver, heart, lung, pancreas, intestine, cornea etc. The human donors could be either living donors or deceased donors (from whom organs could be taken after their death - either through brain death or circulatory death, for transplantation (Sulania et al., 2016). The practice of organ transplantation is overshadowed by severe shortage of suitable donor organs. The supply of organs of high quality and efficacy, aided by organ preservation techniques, has always been one step of extreme importance in the overall multi-disciplinary approach to transplantation (Guibert et al., 2011).

The ethics of allocating human organs for transplantation is a specific application of ethical norms to social practices. Ethical guidelines provide a framework for ensuring that organ transplantation is conducted in a manner that respects human rights and dignity (Bunnik, 2023). These guidelines often include:

- **Voluntary donation** - Ensuring that all donations are made voluntarily and without coercion.
- **Respect for persons, equity and fairness -** Ensuring equal access to scarce organs for transplantation services for all patients
- **Transparency** - Maintaining transparency in the organ allocation process and in the criteria used for donor and recipient selection.

While organ donation should be voluntary, often there are incentives offered to donors to lure them into donation. Those who argue against incentives for organ donation point out that having only altruistic donors (whether related to the donor or not), has eliminated any sense of intimidation. Opponents of incentives emphasize the potential risk to donors and the impact incentives might have on society's moral standpoint. They cite harms such as coercion, exploitation, undermining dignity, repugnance, and commodification (Matas et al., 2011). As part of the efforts to combat unethical practices, organizations like the WHO and the United Nations (UN) have established international guidelines and conventions to combat organ trafficking. Similarly, individual countries have implemented laws and guidelines to regulate organ donation and transplantation, though with varying degrees of success. The ruling governments of the countries also need to educate the public about the risks and ethical issues associated with illegal organ trade by carrying out public awareness campaigns for increasing donor registrations and ensuring ethical practices (Howard & Cornell, 2016; Martin et al., 2019).

g) Blood donation and transfusion. Every year, blood transfusion has been responsible for saving thousands of lives across the world. Yet, globally, the quantity and quality of blood pool available for transfusions is still distressing, specifically in the developing countries. Bioethics provides a framework for making difficult decisions about the allocation of scarce healthcare resources (including blood, its components or blood products), ensuring fairness and equity (O'Sullivan et al., 2022). The legality and ethics of blood transfusion compels a doctor to obtain the patient's informed consent before administering blood or blood products, just like for other medical treatments. This includes explaining to the patient the relative benefits and risks of receiving v/s not receiving the blood products/components, as well as any reasonably viable alternatives. Blood donation should be voluntary without coercion or payment. Similarly, confidentiality should be maintained regarding the patient and their treatment.

The major ethical concern surrounding the use of blood/ blood components/blood products is that of the perception of the risk has been far greater than the objectively measurable risk. The blood used in a transfusion must work with the recipient's blood type. If it doesn't, the antibodies (proteins) in the recipient's blood attack the new blood that is been transfused (from the donor) and could cause incompatibility and make one sick. The correct management of the processes that make up the transfusion supply chain affects the safety of the whole process, the monitoring of which is a specific aim of haemovigilance systems (Sacchini et al., 2013). Unfortunately, some medical personnel do not handle this sensitive procedure with the desired carefulness. In some instances, blood is transfused without proper screening to find out the blood group and rule out the problem of incompatibilities before transfusion. Further, monitoring and managing transfusion reactions, such as allergic reactions, febrile non-haemolytic transfusion reactions, and more severe complications, are essential for ensuring patient safety not only from a medical standpoint but from an ethical perspective as well. If the patient has been transfused blood and its components that were not intended for him/her, whether harmed or not, he/she has the right to be informed. Similarly, a patient who has inadvertently received blood positive for a transfusion transmissible infection (like HIV), also has a right to be informed and given due compensation (Elhence, 2006). There are also cultural issues which one has to deal with during transfusion. For e.g., some religious sects such as Jehovah's Witnesses do not accept blood transfusions, since as per their belief it is wrong to accept a blood transfusion. Such patient's rights should be respected (Petrini, 2014). Respecting their choice, is not simply a matter of attitude, but a matter of recognizing and even promoting the autonomous actions of the patient.

h) In lifeline decisions. Advancements in medical treatment may prolong life, but quality of life can decrease once an individual becomes terminally ill. Then it is time to consider the level of pain management and the kind of medications offered, whether to deliver care at home or in a hospital setting, and what kind of caregiver is needed. The goals of care for terminally ill patients are the alleviation of suffering, the optimization of quality of life until death occurs, and the provision of comfort in death. However, achieving these goals is not always easy (Akdeniz et al., 2021). The patients, their family members, well-wishers, and caregivers may pray silently and hope for early death but still hesitate taking active steps for relief from miserable existence of the patient, out of fear, social norms or, and other reasons (Minocha & Mishra, 2019).

Understanding the principles underlying biomedical ethics (viz. autonomy, beneficence, nonmaleficence, fidelity, and justice) is important for physicians or health care professionals (HCPs) and their patients to solve the problems they face in end-of-life care (Karnik & Kanekar, 2016). If the patient has lost the ability to make decisions, the family, the proxy health care or the physician must decide about the care to be provided to the patient (Akdeniz et al., 2021). Medical interventions used in patients to bring about the end of life in patients include a) Terminal sedation; b) Withholding and withdrawing treatment; c) Euthanasia; and d) Assisted suicide. In the end-of-life care of a patient, the decision to implement practices to prolong the patient's life or to alleviate the suffering for the patient, by bringing an end to the patient's very life by one of the above means, may be difficult for the physician, patient or the family members.

i) In health informatics. Health informatics is the discipline that deals with how health data are electronically collected, stored, manipulated, communicated and processed into health information that is suitable for administrative and clinical decision making, management, and how information and telecommunication technologies are designed, developed and applied to support the research into and delivery of health care services (Kluge, 2016). In this digital age, medical professionals have the prospects not only to obtain a greater depth of medical knowledge but also to access patient health information (including a patient's list of allergies, medications and dosages, and past medical and surgical histories) almost effortlessly (Javaid et al., 2024). Although the electronic medical records (EMRs) improve the retrieval and exchange of information between HCPs, it poses a severe threat of unauthorized access, disclosure of confidential information, and breach of patient's private data (Seh et al., 2020).

Common ethical issues associated with EMRs cover patient privacy and security breaches, autonomy, generosity, non-maleficence, system operation, data imprecisions, and related accountability (Afzal & Arshad, 2021). Ethics in health information management (HIM) are also rooted in the principles of medical care: autonomy, beneficence, non-maleficence, and justice.

- Respect for Autonomy - Patients have the rights to control their personal health information, a fundamental right to privacy, and hence to control over the collection, storage, access, use, communication, manipulation, and disposition of their data.
- Beneficence – The physicians have to act in the best interest of patients, ensuring possible advantage outweighs the potential hazards.
- Justice and Equity – It mandates fair treatment to all and the equitable distribution of healthcare resources, including information. One needs to ensure that there is no prejudice or discrimination in data sharing (Varkey, 2020).
- Privacy and Confidentiality – Ethical concerns are raised when patient's health information is shared with third parties, whether big tech, pharmaceuticals, or insurance companies. With more technology companies entering into health care field, concerns over patient privacy are growing louder. Implementing robust data security, anonymization strategies to protect patient identity while permitting the proper use of data for innovation and research are necessary to strike a healthy balance (McGraw & Mandl, 2021).

j) Usage of artificial intelligence (AI) in healthcare. Integrating AI in healthcare represents a transformative shift with substantial potential for enhancing patient care. By harnessing AI's capabilities, healthcare systems stand on the brink of a paradigm shift characterized by enhanced diagnostic accuracy, personalized treatment strategies, and increased efficiency in healthcare delivery. In doing so, there are significant ethical, legal, and technological challenges, particularly w.r.t patient privacy, decision-making autonomy, data protection, data integrity and the risk of data breaches (Wang et al., 2022). Foremost among these is the need to safeguard patient privacy in an environment where data are both a valuable resource and a potential for vulnerability (Williamson & Prybutok, 2024). Additionally, the increasing reliance on AI for decision-making in healthcare poses questions about maintaining human autonomy in medical decisions. There is also a need for adaptive regulatory frameworks and redefined patient consent processes to address the ethical, legal, and practical challenges (Reddy et al., 2019).

Bioethics and business ethics in corporate healthcare

Bioethics has conventionally dealt with individual moral dilemmas of contemporary medical practice, while business ethics has been concerned with how corporations can integrate an ethical perspective into business practices (Eiser et al., 1999). The bioethical tenets of autonomy, beneficence, and justice are often overwhelmed by the values of market competition and fiduciary accountability to capital investments. Organizations understand their fiduciary responsibilities differently than do professionals. Physicians have their responsibilities predominantly in terms of individual patients, whereas organizations are accountable to groups, populations, or parties representing those groups. The marketplace, by its very nature, is more likely to emphasize return on investment than augmentation of social goods. Corporate houses and pharmaceutical companies, particularly publicly traded for-profit ones, and privately-run hospitals and medical/paramedical colleges, have priorities that emphasize more on revenues and profits (Gray, 1986). Health care organizations manage care by a variety of mechanisms, including financial incentives and working around the regulations. "*No money, no mission*" is a business phrase that physicians are reluctantly learning in this era of cost consciousness and market competitiveness (Eiser et al., 1999). As medical practice becomes industrialized, physicians are challenged to understand business perspectives and work in the "re-engineered" medical milieu. At the same time, a fundamental recommitment to the moral nature of medical care will be needed in order to preserve the medical profession's fiduciary responsibility to its patients.

Conclusion

The physician-patient relationship is grounded in essential ethical principles, with a strong emphasis on impartiality, independence, and decisions made free from conflicts of interest. The responsibility of healthcare professionals is to not only diagnose and treat patients but also to consider the moral consequences of their actions. This includes fostering compassion, respecting patient autonomy, and prioritizing patients' best interests. Ethical dilemmas often require concerted problem-solving, with inputs from interdisciplinary teams comprising of experts from fields such as medicine, law, philosophy, and social sciences. The collaborative approaches to ethical problem-solving leveraged from interdisciplinary teams, bring diverse perspectives to the table, enriching the ethical analysis, stakeholder engagement, case studies, and reflective practice. Bioethics delves into the ethical implications of various cutting-edge developments in medicine, science, and technology. With ethical complexities and challenges emerging in modern medicine, bioethics seeks ways in which people in societies can work together under the provision of medical care and research (Yadavendu & Kumar, 2011).

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Kul Bhushan Bali*

Bridging the past and future: Reimagining medical education through ancient wisdom, modern science, and the Sri Madhu-sudan Sai Institute Model

Abstract

The evolution of medical education mirrors humanity's broader intellectual and moral journey—from the spiritually infused traditions of ancient India, Greece, and China to the evidence-based, technology-driven systems of today. While modern medicine has achieved unprecedented diagnostic and scientific precision, it often faces ethical detachment, commercialization, and inequity in access to education and care. This article argues for an integrative model that harmonizes ancient ethical wisdom with modern scientific excellence, using the Sri Madhusudan Sai Institute of Medical Sciences and Research (SMSIMSR) as a case study. Rooted in the principle of *seva* (selfless service), SMSIMSR provides completely free medical education and healthcare, embedding compassion, humility, and accountability into both curriculum and institutional culture. By revisiting the moral and spiritual dimensions of ancient medical traditions and combining them with contemporary pedagogy, the paper proposes a transformative paradigm of free, value-based, and socially accountable medical education that restores medicine's ethical foundation and redefines the physician as both healer and servant of humanity.

Keywords: Ancient medical education, gurukula, barefoot doctors, free medical education, health equity, medical ethics, modern medical education

Introduction

Medical education has, across centuries, sought to maintain a delicate balance between technical skill acquisition, ethical

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grounding, and societal responsibility. In ancient traditions, the preparation of a physician was never confined to the mastery of anatomy, physiology, or pharmacology—it was an immersive process that cultivated intellectual rigor, moral integrity, and a deep sense of service to humanity. The student was mentored not only in the science of healing but also in the art of compassion, humility, and spiritual awareness, reflecting the belief that the physician's personal virtues were as vital to healing as their clinical skills (Charaka, 1994; Dwivedi and Dwivedi, 2007; Edelstein, 1943; Wujastyk, 2003). These systems—whether in the Ayurvedic Gurukula, the Hippocratic school, or other ancient traditions—placed the physician at the intersection of science, philosophy, and ethics, recognizing medicine as a sacred vocation.

The modern era, however, brought profound changes to this educational landscape. The industrial revolution, advances in biomedical science, and the institutionalization of higher education led to a paradigm shift. The Flexner Report of 1910, for instance, reshaped medical training in North America and beyond, embedding scientific rigor, standardization, and laboratory-based instruction at its core (Flexner, 1910). While these reforms elevated academic standards, improved patient outcomes, and fuelled unprecedented specialization, they also, over time, contributed to the marginalization of moral, spiritual, and community-oriented dimensions of physician formation (Branch, 2017; Hafferty & Franks, 1994).

In the twenty-first century, the medical profession faces a renewed challenge: how to harmonize cutting-edge clinical expertise with enduring humanistic values. The acceleration of medical technology, artificial intelligence, and global health demands has heightened awareness of the need for doctors who are not only technically competent but also socially accountable and ethically grounded (Murthy, 2023; Narayan & Reddy, 2024). This growing recognition has spurred interest in educational models that integrate service, ethics, and compassion as core components of training—values that echo the holistic vision of ancient systems while leveraging the strengths of modern science.

Within this context, the present article examines the convergences and divergences between ancient and modern paradigms of medical education, surveys notable global tuition-fee free and socially accountable models and presents the Sri Madhusudan Sai Institute of Medical Sciences and Research (SMSIMSR) as an innovative example of an institution that successfully marries academic excellence with a service-oriented, ethically robust mission.

Ancient medical education systems

Medical education has deep roots in ancient civilizations, where it was not merely a technical discipline but a holistic practice integrating science, ethics, community service, and often spiritual development. These traditions produced healers who were as much sages and philosophers as they were medical practitioners. While systems varied across cultures, they shared common characteristics—mentorship-based learning, ethical codes, and strong links to community well-being (Charaka, 1994; Edelstein, 1943; Ngubane, 1977; Nutton, 2004; Wujastyk, 2003).

The Indian Gurukula system: An embodied model of holis tic medical education

In ancient India, the transmission of medical knowledge occurred primarily through the Gurukula system—a residential, apprenticeship-based model deeply embedded in the philosophical and spiritual fabric of Indian society (Charaka, 1994; Sharma, 1992). Unlike the institutionalized education systems of the modern era, the Gurukula was not merely a place of instruction, but a living ecosystem where ethical, intellectual, and practical training were interwoven. This system played a foundational role in shaping the tradition of Ayurveda, India's indigenous science of life, which remains one of the oldest continuously practiced medical systems in the world (Patwardhan, 2014; Wujastyk, 2003).

Curriculum and knowledge base

The core curriculum of Gurukula-based medical education was anchored in canonical Ayurvedic texts, particularly the *Charaka Saṃhitā* and the *Suśruta Saṃhitā* (c. 600 BCE–200 CE) (Charaka, 1994; Dwivedi & Dwivedi, 2007). These treatises offered comprehensive knowledge of human anatomy, physiology, pathology, and therapeutics, alongside systematic methods for:

- Clinical diagnosis (nidāna)
- Pharmacology (dravya guṇa śāstra)
- Preventive health (swasthavṛtta)

The *Suśruta Saṃhitā* was particularly advanced in surgical knowledge, describing cataract removal, lithotomy, and plastic surgery techniques such as rhinoplasty (Dwivedi & Dwivedi, 2007). The curriculum also encompassed botany, toxicology, psychology, embryology, and environmental health—demonstrating a truly integrative approach (Sharma, 1992).

Pedagogical approach

Education was conducted through an intimate, one-on-one guru–śiṣya relationship. Students lived with their teacher, following a disciplined routine blending intellectual study, physical labour, community service, and spiritual practice (Charaka, 1994; Wujastyk, 2003).

- Learning was primarily oral and mnemonic, requiring memorization of Sanskrit verses before interpretive discussion.
- Experiential learning included observation, guided practice, and direct patient care.
- Surgical skills were honed using simulations on vegetables, animal tissues, and leather bags, centuries before modern simulation methods (Dwivedi & Dwivedi, 2007; Cook et al., 2011).

Ethical formation

Ethics formed the foundation of the Gurukula. Students took vows akin to the Hippocratic Oath, pledging compassion, non-maleficence, confidentiality, humility, and respect for life (Charaka, 1994; Edelstein, 1943). The *Charaka Saṃhitā* emphasized that physicians must be "pure in mind and body," love all beings, and be free from greed and anger (Charaka, 1994).

Outcomes and social role

Graduates—Vaidyas—were respected as physicians, scholars, and counsellors. Their approach emphasized individualized, holistic care based on constitution (Prakriti), lifestyle, and environment. Many provided care without monetary expectation, reflecting a service-oriented ethos (Patwardhan, 2014; Wujastyk, 2003).

Greco-Roman and Islamic traditions in medical education

The Greco-Roman and Islamic traditions laid the philosophical, institutional, and ethical foundations of medicine that influenced both medieval Europe and modern secular systems (Nutton, 2004; Savage-Smith, 1996). While Eastern systems emphasized spiritual embedding and oral transmission, these traditions prioritized written codification, empirical observation, and early institutionalization.

Hippocratic medicine in ancient Greece

Hippocrates of Kos (c. 460–370 BCE) advanced medicine by rejecting supernatural explanations for disease, grounding it in rationality, empiricism, and environmental factors (Edelstein, 1943; Nutton, 2004).

Training and curriculum

- Learned through apprenticeships under experienced physicians (Edelstein, 1943).
- Focused on humoral theory and case-based learning from real patients (Edelstein, 1943).
- Emphasized bedside teaching and record-keeping—precursors to modern clinical pedagogy (Edelstein, 1943).

Ethical innovations

The Hippocratic Oath established enduring principles: non-maleficence, confidentiality, humility, and loyalty to teachers (Edelstein, 1943). Medicine was seen as a moral calling, not merely a trade.

Islamic medicine and the golden age

From the 8th–14th centuries CE, the Islamic world preserved, expanded, and integrated Greek, Persian, Indian, and Arabic medical knowledge (Savage-Smith, 1996).

Medical institutions

- Bimaristans functioned as hospitals, medical schools, and public health centres (Savage-Smith, 1996).
- Students learned via observation, case discussion, and supervised practice (Hamarneh, 1963).
- Licensing required oral examinations (Hamarneh, 1963).

Key figures

- Ibn Sina (Avicenna): *Canon of Medicine*—a five-volume synthesis used globally for centuries (Gutas, 2001).
- Al-Razi (Rhazes): *Kitab al-Hawi*—comprehensive medical encyclopaedia (Savage-Smith, 1996).
- Ibn al-Nafis: Early description of pulmonary circulation (Savage-Smith, 1996).

Ethical foundations

Grounded in Qur'anic and Hadith teachings, physicians viewed medicine as a divine trust. *Adab al-Tabib* outlined professional conduct, patient respect, and moral duties (Hamarneh, 1963).

Legacy

Greek medicine initiated rational, observation-based practice; Islamic scholars preserved and expanded it, institutionalizing education and linking it to public health. Their influence shaped European medicine for centuries (Savage-Smith, 1996; Nutton, 2004).

The Chinese model: Barefoot doctors

The Barefoot Doctor Program (1960s–1980s) trained rural villagers in basic medicine, blending Traditional Chinese Medicine (TCM) with biomedicine to address severe rural healthcare shortages (Sidel, 1972; Zhang & Unschuld, 2008).

Historical context

- Originated after the Cultural Revolution, rooted in Mao's call for prevention, decentralization, and self-reliance (Sidel & Sidel, 1982).

- "Barefoot doctors" combined farming with healthcare provision (Sidel, 1972).

Training and curriculum

- 3–6 months of intensive training in rural clinics (Sidel, 1972).
- Integrated herbal medicine, acupuncture, sanitation, immunization, wound care, and family planning (Zhang & Unschuld, 2008).

Community role

- Provided basic diagnosis and treatment, maternal care, vaccinations, sanitation, and health education (Sidel, 1972).
- Acted as trusted community members reducing dependency on urban hospitals (Zhang & Unschuld, 2008).

Impact

- By the 1970s, over one million barefoot doctors improved rural health outcomes (Sidel, 1972).
- Recognized by WHO and influenced the Alma-Ata Declaration on primary healthcare (World Health Organization, 1978).

Challenges and transition

Economic reforms in the 1980s led to the phasing out of the program, though its ethos continues to inspire global community health worker models (Sidel & Sidel, 1982).

African indigenous systems

In precolonial Africa, healing systems integrated physical, spiritual, ecological, and communal dimensions (Mbiti, 1990; Ngubane, 1977).

Knowledge transmission

- Apprenticeship-based, oral tradition (Mbiti, 1990).
- Training included medicinal plants, midwifery, bone setting, spiritual mediation (Twumasi, 2005; Tsey, 1997).
- Validated through community reputation and spiritual approval (Ngubane, 1977).

Scope of practice

- Addressed physical, mental, spiritual, and ecological health (Twumasi, 2005).
- Practitioners were custodians of environmental ethics and ancestral traditions (Mbiti, 1990).

Ethical foundations

- Ubuntu: Interconnectedness and communal responsibility (Mbiti, 1990).
- Ancestral reverence and environmental stewardship (Ngubane, 1977).
- Healing as a sacred duty, not a commercial trade (Twumasi, 2005).

Colonial disruption and resurgence

Colonial powers suppressed traditional systems, but postcolonial policy shifts have reintegrated indigenous practices into national health strategies (Tsey, 1997; Twumasi, 2005).

Common values across ancient medical traditions

Despite cultural differences, ancient systems shared enduring educational and ethical principles:

1. ***Mentorship Over Mechanization*** – Close teacher–student bonds fostered moral and intellectual development (Charaka, 1994; Edelstein, 1943; Ngubane, 1977).
2. ***Spiritual and Moral Grounding*** – Internal purity and moral integrity were as important as clinical skill (Charaka, 1994; Edelstein, 1943).
3. ***Holistic Conceptions of Health*** – Integrated body, mind, spirit, community, and environment (Charaka, 1994; Ngubane, 1977; Wujastyk, 2003).
4. ***Service Orientation*** – Healing as a sacred duty, prioritizing social good over personal gain (Charaka, 1994; Patwardhan, 2014).

Modern relevance

These values align with today's calls for humanistic, socially accountable, and service-driven medical education, as seen in models like SMSIMSR (Murthy, 2023; Narayan & Reddy, 2024). Table 1 provides a comparative analysis of ancient and modern medical traditions, highlighting dimensions of mentorship, spiritual and ethical depth, holistic orientation, and service ethics.

Table 1. Comparison of ancient with modern medical traditions

Core value	Expression in ancient traditions	Modern relevance
Mentorship	Guru-disciple/apprentice models	Longitudinal, mentor-based medical training (Branch, 2017)
Spiritual/Ethical Depth	Oaths, rituals, moral codes, ancestral accountability	Professionalism, moral education, resilience (Monteiro, 2015)
Holism	Integration of mind, body, spirit, community, and ecology	Integrative and planetary health paradigms (Chitty, 2013)
Service Ethic	Healing as a moral duty	Free/subsidized medical education for rural care (Narayan & Reddy, 2024; Murthy, 2023)

The modern paradigm of medical education: Strengths, short-comings, and the call for integration

The modern medical education system, developed primarily in the 20th century and now globally dominant, has contributed tremendously to the scientific and clinical sophistication of the medical profession (Flexner, 1910; Kuper, D'Eon, & Hodges, 2010). Rooted in biomedical rationalism, evidence-based practice, and institutional credentialing, it has produced physicians with exceptional technical competencies, research literacy, and diagnostic precision (Cook et al., 2011). However, its over-standardization, intensification of specialization, and at times dehumanizing culture of performance metrics have raised concerns among educators, ethicists, and public health advocates (West, Dyrbye, & Shanafelt, 2018; Rotenstein et al., 2016). As medicine evolves alongside digital technologies, global pandemics, and persistent inequities in access, it becomes vital to critically assess the values, assumptions, and structures embedded in modern medical education—and to explore ways it might be enriched by ethical and humanistic traditions from the past (Branch, 2017; Monteiro, 2015).

Structure and curriculum: From foundational science to clinical mastery

Modern medical education typically unfolds in two or three phases, depending on the country and institution. Since the Flexner Report (1910) in the United States, the core curriculum has been heavily science-driven and rigorously structured.

- **Preclinical phase:** Focus on basic biomedical sciences, including anatomy, physiology, pathology, pharmacology, biochemistry, genetics, and microbiology. Increasingly, this phase integrates clinical exposure through early patient contact, problem-based learning (PBL), and interdisciplinary modules (Flexner, 1910; Cook et al., 2011).
- **Clinical phase:** Rotations through major specialties in hospitals and primary care centres, applying knowledge in real-time under supervision. Competency-based assessments ensure safety, accuracy, and professionalism, with emphasis on communication, decision-making, procedural expertise, and interdisciplinary teamwork (Branch, 2017; Hafferty & Franks, 1994).

This model has standardized competencies, ensured patient safety, and cultivated clinicians grounded in analytical thinking, diagnostic algorithms, and protocol-based care (Kuper et al., 2010).

Specialization and technological integration: The age of precision medicine

One of the most remarkable developments in modern medical education is the intensification of specialization and the pervasive role of technology. Advances in science, population aging, and disease complexity encourage subspecialisation in areas such as interventional cardiology, paediatric oncology, and neurocritical care (Cook et al., 2011). Technological advancements include:

- Artificial intelligence (AI) and machine learning in diagnostics and treatment planning (Cook et al., 2011).
- Robotic surgery for greater precision and minimally invasive procedures (Cook et al., 2011).
- Electronic health records (EHRs) for comprehensive, coordinated care (West et al., 2018).
- Telemedicine and mobile health (mHealth) platforms for remote service delivery (World Health Organization, 2013).
- Genomics and precision medicine to individualize treatment based on genetic profiles (Patwardhan, 2014).
- Simulation labs and virtual/augmented reality (VR/AR) for high-risk or rare-case training (Cook et al., 2011).

While these innovations promote interactive, immersive learning, overreliance on machines may risk de-skilling intuitive clinical judgment (Monteiro, 2015).

Globalization and standardization: Opportunities and tensions

With increasing global interconnectedness, medical education has shifted toward shared benchmarks and accreditation standards, enabling mobility and competitiveness among graduates (World Health Organization, 2013). Standardization milestones include:

- International licensing exams such as USMLE (USA), PLAB (UK), FMGE (India), and AMC (Australia) (World Health Organization, 2013).
- Cross-border institutional partnerships, dual degrees, and student exchanges (Kuper et al., 2010).
- Curricular frameworks like the Bologna Process (Europe) and WFME Global Standards (World Health Organization, 2013).

While globalization promotes uniformity and excellence, critics argue that Western-centric paradigms often dominate curricula in the Global South, marginalizing indigenous and community-based medical traditions (Mbiti, 1990; Twumasi, 2005). Students trained in such systems may struggle to adapt to local epidemiology, patient expectations, and health system realities (Ngubane, 1977; Tsey, 1997).

Systemic and ethical challenges in the modern model

Despite technical advances, modern medical education faces profound ethical, financial, and emotional challenges.

A. Financial barriers

- High tuition costs in countries such as the US, UK, and private Indian institutions (Angell, 2004).
- Graduate debt pressures physicians toward high-paying specialties and urban practice, exacerbating rural shortages (Murthy, 2023).
- Fee-driven private institutions risk prioritizing profit over training quality (Angell, 2004).

B. Mental health crisis and burnout

- High rates of depression, anxiety, burnout, and suicide among medical trainees (Rotenstein et al., 2016; West et al., 2018).
- Contributing factors include rigid schedules, performance pressure, and stigma around vulnerability (Monteiro, 2015).
- Compassion fatigue can erode empathy and patient care quality (Branch, 2017).

C. Ethical erosion and commodification

- Emphasis on rankings and publications may overshadow the humanitarian mission of medicine (Angell, 2004).
- Time-limited patient interactions and administrative demands weaken patient–physician relationships (West et al., 2018).
- Corporate influence from pharmaceutical and device industries can bias education (Angell, 2004).

The need for reform: Toward a reintegrative, human-centred model

A growing consensus among educators, policymakers, and civil society is that medical training must:

- Restore values of service, empathy, humility, and social accountability (Branch, 2017; Monteiro, 2015).
- Reduce or eliminate tuition to promote equity and rural service (Murthy, 2023).
- Embed community immersion, ethical mentorship, and reflective practice (Narayan & Reddy, 2024).
- Respect local knowledge, spiritual traditions, and diverse healing systems (Charaka, 1994; Wujastyk, 2003).

Hybrid models under development combine scientific rigor with ancient ethical insights. The Sri Madhusudan Sai Institute of Medical Sciences and Research (SMSIMSR) in India exemplifies this approach—offering totally free education linked to compulsory community service, spiritual reflection, and value-based pedagogy (Narayan & Reddy, 2024; Murthy, 2023). This demonstrates that physicians can be trained to heal with both skill and compassion.

Global models of free or subsidized medical education

As countries confront widening health inequities and physician shortages, particularly in rural and underserved regions, the model of free or heavily subsidized medical education has gained renewed attention (Gorry, 2011). Historically rooted in the principle that healthcare is a public good, these models prioritize equity, community service, and social justice over commercialization (World Health Organization, 1978, 2002, 2003).

Cuba's ELAM (Escuela Latinoamericana de medicina)

The Escuela Latinoamericana de Medicina (ELAM), founded in 1999 by the Cuban government under Fidel Castro, represents one of the most ambitious international medical education initiatives in history (Gorry, 2011). Supported by the Pan-American Health Organization (PAHO), ELAM offers fully subsidized medical training primarily to students from marginalized backgrounds across Latin America, Africa, Asia, and even low-income communities in the United States (Gorry, 2011).

- **Philosophical foundations:** Rooted in the principle of "Solidaridad Médica"—the idea that medicine should be a vehicle for global equity and social transformation—ELAM focuses on training doctors to return and serve in underserved regions (Drain et al., 2007).
- **Admissions approach:** Targets students from low-resource communities, selected based on need, social commitment, and intention to return home after graduation (Gorry, 2011).
- **Curriculum:** Emphasizes "Medicina Comunitaria" (community medicine), public health, and primary care over specialization, aligning with World Health Organization recommendations for universal health coverage (UHC) (World Health Organization, 2003).
- **Global impact:** More than 30,000 graduates from over 100 countries now serve in areas previously lacking qualified medical personnel (Gorry, 2011).

Brazil's "Mais Médicos" (More doctors) program

Initiated in 2013 by the Brazilian Ministry of Health, Mais Médicos sought to address severe disparities in healthcare access between urban centres and the vast underserved interior (Gorry, 2011).

- **Objectives:**
  - Deploy physicians—many from Cuba—immediately to under-resourced municipalities.
  - Invest in primary care infrastructure and expand domestic medical education.
  - Reform curricula to promote socially responsive practice.
- **Outcomes:**
  - Increased physician density in underserved areas.
  - Reduced infant mortality and hospitalizations from preventable diseases.
  - Political discontinuation in 2018 demonstrated the fragility of reforms lacking bipartisan support (Gorry, 2011).

South Asia

Sri Lanka

Sri Lanka offers a successful model of free medical education integrated with public service delivery. State universities provide tuition-free MBBS programs based on merit, with service obligations in rural or public institutions (Murthy, 2023).

- **Strengths:**
  - High retention within the national health system.
  - Strong community trust in government-trained doctors.
  - Ethics and public health instruction help reduce commercial bias (Murthy, 2023).

Bangladesh and Nepal

Both countries use mixed models involving scholarships, quotas, and service bonds.

- **Bangladesh:** Encourages public–private partnerships in semi-urban and rural medical colleges (Murthy, 2023).
- **Nepal:** Offers reserved seats and tuition subsidies for marginalized groups such as Dalits and Janajatis, aligning with affirmative action policies (Murthy, 2023).

African Initiatives

Ethiopia's health extension program (HEP)

Launched in 2004, Ethiopia's HEP trains thousands of female Health Extension Workers (HEWs) to provide basic health services, typically completing a one-year formal certification (World Health Organization, 2013).

- **Impact:** Contributed to a 50% reduction in under-five mortality between 2000 and 2015, significantly improving primary health indicators through embedded community care (World Health Organization, 2013).

South Africa

The South African government mandates rural service for publicly funded medical graduates, often placing them in township or district hospitals (World Health Organization, 2013).

- **Policy intent:** Ensures return on public investment and addresses urban–rural disparities.
- **Challenges:** Sustainability and equitable enforcement of rural placement remain concerns (World Health Organization, 2013)

Europe: The Nordic model

Norway and Finland

Public universities in Norway and Finland offer tuition-free or heavily subsidized medical education, consistent with their welfare-state principles (World Health Organization, 2013).

- **Outcomes:**
  - Minimal student debt allows greater career flexibility and public-sector service.
  - Education is treated as a public investment, not a commodity.
  - Living stipends and grants further reduce access barriers (World Health Organization, 2013).

United States: Institutional experiments

While the United States predominantly uses a market-driven model, several institutional experiments show alternative possibilities (Murthy, 2023).

- **Examples:** NYU Grossman School of Medicine and Kaiser Permanente School of Medicine have adopted tuition-free policies.
- **Funding:** Supported by large philanthropic endowments to reduce student debt.
- **Limitations:**
  - These models are not systemic and remain inaccessible to most applicants.
  - Nevertheless, they serve as proof of concept for broader public–private partnerships (Murthy, 2023).

India: A Transformative model – The Sri Madhusudan Sai Institute of medical sciences and research (SMSIMSR)

India's higher medical education system is sharply divided: public institutions offer affordable training but have limited capacity, while private colleges charge prohibitively high fees, restricting access for disadvantaged students (Murthy, 2023; Narayan & Reddy, 2024). SMSIMSR addresses this gap by offering fully free medical education tied to compulsory—but paid—service in underserved communities (Narayan & Reddy, 2024).

Sri Madhusudan Sai institute of medical sciences and research (SMSIMSR)

Vision and structure. Established in 2023 in Karnataka, the Sri Madhusudan Sai Institute of Medical Sciences and Research (SMSIMSR) is the first private medical college in India to offer completely free medical education, covering tuition, accommodation, food, and books (Narayan & Reddy, 2024). The institute operates alongside a state-of-the-art 360-bed hospital that provides free healthcare to all patients. SMSIMSR's foundation rests on the guiding principle, "Love All, Serve All" (Murthy, 2023).

Admissions and philosophy. Admissions are merit-based, with a preference for students committed to serving rural India (Narayan & Reddy, 2024). While the curriculum aligns with national medical standards, it is further enriched by ethical and spiritual teachings. The goal is to nurture not only clinically competent doctors, but also compassionate individuals dedicated to rural upliftment. Education at SMSIMSR is considered a sacred journey of self-transformation, rather than merely a professional qualification (Murthy, 2023).

Ethical framework: The 5 Cs and 5 Ds

Institutional values – The 5 Cs:

1. Compassion – Treating every patient with love and empathy
2. Competence – Striving for clinical and academic excellence
3. Commitment – Focusing on service over personal gain
4. Character – Upholding integrity, honesty, and responsibility
5. Community – Viewing healthcare as a collective mission

Graduate attributes – The 5 Ds:

1. Dedication – A life devoted to selfless service
2. Discipline – Structured living and focused learning
3. Duty – Embracing medicine as a divine calling
4. Dynamism –Applying energy and innovation to problem-solving
5. Divinity – Recognizing the sacredness of every patient's life

Pedagogical innovations

- *Spiritual integration:* Yoga, meditation, and prayers embedded in daily routines (Monteiro, 2015).
- *Service immersion:* Regular outreach in villages, elderly care homes, and nutrition programs (Murthy, 2023).

- **Mentorship:** Faculty serve as role models in humility, service, and clinical skill (Branch, 2017).
- **Holistic assessment:** Student evaluations incorporate ethical reasoning and community engagement (Narayan & Reddy, 2024).
- **Living laboratory:** Training embedded in real-world community contexts, fostering both medical and moral growth (Murthy, 2023).

Section synthesis and outlook

SMSIMSR illustrates that ancient moral principles can successfully coexist with modern medical excellence. Alongside initiatives such as Cuba's Escuela Latinoamericana de Medicina (ELAM) and tuition-free Nordic universities, it demonstrates that equitable, values-centred medical training is both possible and scalable (Gorry, 2011; World Health Organization, 2013). In an age marked by commercialization and widening healthcare inequities, models like SMSIMSR reaffirm that producing skilled practitioners is not enough; medical education must also shape healers guided by conscience, compassion, and a deep sense of service (Narayan & Reddy, 2024; Murthy, 2023). Table 2 offers a comparative overview of ancient, modern, and SMSIMSR-based ethical models of medical education, emphasizing their respective approaches to mentorship, spiritual–ethical depth, holism, and service values.

Table 2. Comparative overview: Ancient, modern, and SMSIMSR/ethical medical education models

Attribute	Ancient Gurukula	Modern medical education	SMSIMSR / Ethical models
Learning Style	Immersive, guru-centric	Structured, modular	Immersive + service-based
Access	Caste- and class-limited	Often expensive, urbanized	Free and inclusive
Curriculum Focus	Holistic and ethical	Scientific and specialized	Scientific + ethical + spiritual

Attribute	Ancient Gurukula	Modern medical education	SMSIMSR / Ethical models
Ethics and Values	Lived values, oral traditions	Mostly theoretical	Core framework
Community Orientation	Strong local bonds	Weak	Strong rural engagement
Cost to Student	Free or gurukula-supported	Very expensive	Totally free
Technology	Minimal, nature-based	Advanced; includes AI, VR, robotics	Advanced; includes AI, VR, robotics

Path forward: Reclaiming ethical ground in global medical education

The future of medical education must not only accommodate advances in biomedical science and digital innovation but also address the ethical and humanistic deficits that have emerged in contemporary practice (Branch, 2017; Monteiro, 2015). Drawing from both historical precedents and emerging institutional models, a multidimensional strategy is needed to realign medical education with its foundational purpose: the alleviation of suffering through scientifically competent, ethically grounded care (Murthy, 2023; Narayan & Reddy, 2024).

Longitudinal integration of medical ethics

Medical ethics must evolve beyond isolated classroom sessions or cursory modules. It requires longitudinal integration throughout the curriculum, spanning preclinical years to advanced clinical training (Hafferty & Franks, 1994). This includes scenario-based learning, clinical case reflections, patient rights discussions, and structured mentorship in ethical reasoning. Institutions like SMSIMSR exemplify the embodiment of ethics as institutional ethos. Ethics at SMSIMSR is operationalized through free education, emphasis on **seva** (selfless service), and spiritually anchored pedagogy (Murthy, 2023; Narayan & Reddy, 2024).

Expansion of free, socially oriented medical institutions

The prohibitive cost of medical education remains a global concern, exacerbating socioeconomic disparities and driving commercialization (Angell, 2004; Murthy, 2023). Governments and philanthropic stakeholders should collaborate to fund free medical colleges with mandates for rural or underserved community service. SMSIMSR in India and ELAM in Cuba stand as pioneering examples. Both institutions provide free education and cultivate social responsibility in their graduates (Gorry, 2011; Narayan & Reddy, 2024).

Faculty as ethical mentors

Educators must be seen not merely as content experts but as moral exemplars (Branch, 2017). Faculty development programs should emphasize ethical leadership, humility, patient-centred care, and servant leadership. The "hidden curriculum"—implicit messages conveyed through institutional culture—significantly influences students' professional identity (Hafferty & Franks, 1994). SMSIMSR prioritizes mentorship where ethical conduct is consistently demonstrated by faculty (Murthy, 2023).

Strengthening South–South collaboration for humanistic medical education

Countries in the Global South have independently developed effective models of equitable and ethical medical education (World Health Organization, 2002; 2013). Collaboration among these countries—through faculty exchange, curriculum co-development, and shared evaluation systems—can help scale innovations. SMSIMSR's potential collaborations with medical missions in Africa and Southeast Asia could mirror ELAM's outreach to underserved regions in Latin America and the Caribbean (Gorry, 2011; Murthy, 2023). Such cooperation builds solidarity against challenges like resource limitations, brain drain, and urban–rural health disparities.

Incorporating spiritual and emotional well-being into medical training

Modern curricula often neglect emotional, psychological, and spiritual dimensions of physician development (Monteiro, 2015). Ancient medical traditions emphasized balance, mindfulness, and moral clarity as core traits of the healer (Charaka, 1994; Wujastyk, 2003). At SMSIMSR, students engage in meditation, moral discourse, and service immersion activities, enhancing resilience, compassion, and spiritual awareness (Narayan & Reddy, 2024). These practices align with evidence linking physician well-being with quality of care (Mercer et al., 2008; Monteiro, 2015).

Human-centred use of technology

AI, robotics, and digital diagnostics present ethical challenges despite clinical promise (Cook et al., 2011). Medical education must teach students to critically evaluate not only capabilities but moral implications: algorithmic bias, patient data privacy, and the potential erosion of human contact (Cook et al., 2011; Patwardhan, 2014). SMSIMSR advocates "technology with empathy," where machines augment but do not replace the moral agency of physicians (Narayan & Reddy, 2024).

Advancing equity through inclusive admissions and social justice training

Medical schools must dismantle barriers rooted in gender, caste, ethnicity, and socioeconomic background (Murthy, 2023). This includes inclusive admissions, financial aid systems, and curricula emphasizing social determinants of health (World Health Organization, 2013). SMSIMSR's fully funded model ensures students from marginalized communities access education free of economic burden (Narayan & Reddy, 2024).

Section-level synthesis and outlook

Transforming medical education requires re-centering its moral and spiritual purpose. Institutions like SMSIMSR demonstrate that it is possible to harmonize scientific rigor with compassionate service, producing physicians who are both skilled clinicians and ethical stewards of societal health (Murthy, 2023; Narayan & Reddy, 2024).

Emerging themes and future directions

The evolving landscape of medical education—shaped by technological advancement, population health needs, and ethical introspection—demands innovative frameworks transcending ancient vs. modern, spiritual vs. scientific, and urban vs. rural divides (Branch, 2017; Monteiro, 2015).

Revisiting holism in medical education

The reductionist focus of modern medicine has neglected mind-body-spirit interconnectedness, evident in rising chronic diseases, mental health disorders, and physician burnout (West et al., 2018; Rotenstein et al., 2016). Ancient systems emphasized holistic care (Charaka, 1994; Wujastyk, 2003). SMSIMSR integrates reflective practices, meditation, and value-based discourse alongside clinical competence (Narayan & Reddy, 2024).

Community-based learning as a pedagogical pillar

Real-world training in underserved areas cultivates empathy, cultural competence, and social responsibility (Murthy, 2023). SMSIMSR's immersion-based model engages students in village health initiatives, school outreach programs, and longitudinal patient follow-ups. This approach mirrors China's "barefoot doctors" program, emphasizing relational, trust-based healthcare (Sidel, 1972; Sidel & Sidel, 1982).

Ethics in practice: Institutional integrity beyond curriculum

Ethics must be operationalized institutionally. Many contemporary schools exhibit a credibility gap, with excessive tuition and profit motives undermining values (Angell, 2004). SMSIMSR operationalizes ethics by providing free education, avoiding capitation fees, and mandating rural service, integrating service into the curriculum to reinforce compassion and selflessness (Narayan & Reddy, 2024; Murthy, 2023).

Universal healthcare and medical education reform

Equitable healthcare requires equitable provider training (World

Health Organization, 1978; 2013). Models linking medical education with public service—such as Cuba, Sri Lanka, and SMSIMSR—demonstrate that affordable, high-quality education can sustainably support national healthcare goals.

Bridging technology and human touch

AI, VR, and robotics promise diagnostic and procedural improvements, but must not replace empathy or continuity of care (Cook et al., 2011; Mercer et al., 2008). SMSIMSR trains students in both domains, emphasizing compassion as a clinical skill (Narayan & Reddy, 2024).

Discussion: Bridging ancient values with modern science

Medical education stands at a crossroads, challenged to integrate centuries of accumulated wisdom with rapid technological and scientific advances. Historically, training physicians was not merely a technical endeavour but a moral and social enterprise. Ancient systems—from the Gurukula-based Ayurveda in India, the Hippocratic schools in Greece, to Chinese and African traditional medicine—instilled in learners a sense of ethical responsibility, holistic understanding, and community engagement (Charaka, 1994; Edelstein, 1943; Ngubane, 1977; Wujastyk, 2003; Zhang & Unschuld, 2008). These traditions emphasized mentorship, experiential learning, moral formation, and social service, ensuring that technical competence was inseparable from ethical and spiritual grounding (Dwivedi & Dwivedi, 2007; Hamarneh, 1963; Sharma, 1992).

Modern medical education, especially after the Flexner reforms, prioritized scientific rigor, specialization, and institutional standardization (Flexner, 1910). While this led to remarkable advancements in diagnostics, surgery, and public health, it also introduced several unintended consequences: high tuition costs, commercialization, urban-rural disparities, ethical erosion, and burnout (Angell, 2004; West et al., 2018). The increasing prevalence of physician burnout and declining empathy among medical students globally reflects the human cost of an education system that underemphasizes moral and psychosocial development (Rotenstein et al., 2016; Branch, 2017; Monteiro, 2015).

Integrating ethics, holism, and scientific rigor

One of the central insights from ancient systems is that moral and technical competencies are mutually reinforcing. Empirical studies in medical education have demonstrated that ethical grounding and reflective practice enhance clinical decision-making, patient satisfaction, and resilience among physicians (Monteiro, 2015; Mercer et al., 2008; Hafferty & Franks, 1994). Integrating ethical discourse, mentorship, and reflective exercises into modern curricula can mitigate burnout and foster a sense of professional identity that is patient-centred rather than transactionally driven (Branch, 2017; Kuper et al., 2010).

SMSIMSR operationalizes this integration by embedding reflective practice, meditation, and value-based learning into its curriculum alongside rigorous scientific training (Narayan & Reddy, 2024; Murthy, 2023). Students participate in rural health initiatives, longitudinal patient follow-ups, and community service programs, which cultivate empathy, social responsibility, and culturally competent care. Such immersive experiences mirror global examples like China's "barefoot doctors" and Cuba's ELAM, underscoring the universal relevance of experiential, service-oriented pedagogy (Sidel, 1972; Sidel & Sidel, 1982; Gorry, 2011; World Health Organization, 1978).

Addressing equity and access

Global medical education continues to face stark inequities in access and affordability. In many low- and middle-income countries (LMICs), high tuition fees exclude talented candidates from underprivileged backgrounds, perpetuating disparities in healthcare provision (Angell, 2004; Twumasi, 2005; Tsey, 1997). SMSIMSR's fully free model demonstrates the feasibility of totally free, high-quality medical education that aligns with national health priorities (Narayan & Reddy, 2024; Murthy, 2023). By linking education to compulsory rural service, the institute ensures both equitable access for students and improved healthcare coverage for marginalized populations (World Health Organization, 2013; Patwardhan, 2014).

Comparative models in Cuba, Sri Lanka, and Nordic countries illustrate that service-linked or state-funded medical training is not only viable but enhances retention in public-sector practice, strengthens primary care systems, and promotes ethical professional development (Gorry, 2011; World Health Organization, 2013; Sidel, 1972). These approaches suggest that financial barriers need not compromise quality, and that social responsibility can be embedded as a core outcome of medical training (Chitty, 2013; Mukherjee, 2015).

Technology as an ethical and pedagogical tool

While technology offers transformative potential—through artificial intelligence, virtual reality, and digital simulation—its integration must be guided by ethical and humanistic priorities (Cook et al., 2011; Patwardhan, 2014). Evidence indicates that empathetic communication, trust, and relational continuity often have greater impact on health outcomes than purely technological interventions (Mercer et al., 2008; Monteiro, 2015). SMSIMSR balances exposure to digital tools with training in compassion, reflective practice, and patient-centred care, highlighting that technological competence should augment, not replace, humanistic practice (Cook et al., 2011; Monteiro, 2015).

Global implications of a hybrid model

The SMSIMSR model provides a practical template for integrating ancient wisdom, ethical pedagogy, and modern science. Its implications extend beyond India:

1. **For LMICs:** Demonstrates that totally free, service-oriented medical education can increase physician supply in underserved areas, strengthen primary care systems, and promote health equity (Narayan & Reddy, 2024; Murthy, 2023; Twumasi, 2005).

2. **For high-income countries:** Offers strategies to counter physician burnout, moral injury, and loss of empathy by embedding service, reflective practice, and ethical formation into rigorous curricula (West et al., 2018; Branch, 2017; Monteiro, 2015).
3. **For global health policy:** Suggests that investments in socially responsible medical education can simultaneously address workforce distribution, ethical standards, and public trust in medicine (World Health Organization, 2013; Gorry, 2011).

By synthesizing the strengths of ancient holistic practices with modern scientific methods and technology, SMSIMSR and similar institutions exemplify a convergent model of education—one that produces physicians who are technically competent, ethically grounded, and socially responsive (Narayan & Reddy, 2024; Murthy, 2023; Patwardhan, 2014).

Conclusion

The trajectory of medical education demonstrates a persistent tension between technical mastery and ethical formation, individual skill and community responsibility, ancient wisdom and modern science. Ancient medical systems—such as Ayurveda, Hippocratic medicine, and Chinese medicine—prioritized moral character, mentorship, and holistic understanding, ensuring that physicians served not merely as technicians but as moral and social stewards (Charaka, 1994; Edelstein, 1943; Wujastyk, 2003; Zhang & Unschuld, 2008). Modern medical systems brought unprecedented scientific rigor, technological sophistication, and standardization but often at the cost of ethical grounding, humanistic engagement, and equitable access (Flexner, 1910; West et al., 2018; Angell, 2004). Institutions like SMSIMSR exemplify how these historical divides can be bridged:

- **Ethical formation as core:** By integrating moral education, reflective practice, and service ethics, SMSIMSR nurtures physicians who internalize compassion and professional integrity as foundational principles (Narayan & Reddy, 2024; Murthy, 2023).
- **Holistic development:** Beyond technical competence, students

cultivate emotional resilience, spiritual awareness, and cultural sensitivity, preparing them for the psychological and social complexities of modern clinical practice (Monteiro, 2015; Mercer et al., 2008; Chitty, 2013).

- **Community-centred service:** Rural immersion, patient follow-ups, and public health engagement instil a sense of responsibility, aligning education with the needs of underserved populations (World Health Organization, 1978; Sidel, 1972).
- **Technological competence with human touch:** Exposure to AI, simulation, and diagnostics is balanced with training in empathy and patient-centred communication, ensuring technology augments rather than replaces humanistic care (Cook et al., 2011; Patwardhan, 2014).
- **Equitable access:** By removing financial barriers and linking education to societal service, SMSIMSR demonstrates that high-quality medical education can be inclusive, socially responsive, and sustainable (Narayan & Reddy, 2024; Murthy, 2023; Twumasi, 2005).

The broader implications are profound. Globally, the convergence of science and service offers a solution to physician shortages, ethical erosion, and inequitable access. In LMICs, tuition-free models strengthen healthcare delivery in rural and underserved regions. In high-income countries, service-oriented, ethically integrated curricula can reduce burnout and restore public trust in medicine (West et al., 2018; Branch, 2017).

Ultimately, the future of medicine lies not solely in technology or algorithms, but in the character and values of those who wield them. Physicians trained within a framework that integrates ancient wisdom, ethical rigor, and modern scientific competence are positioned to be healers in the fullest sense—capable of restoring health, dignity, and human connection (Charaka, 1994; Edelstein, 1943; Wujastyk, 2003; Narayan & Reddy, 2024).

Medical education must thus return to its original purpose: the formation of holistic healers, not mere technicians. SMSIMSR exemplifies how rigorous scientific training, ethical formation, and service-oriented pedagogy can coexist, producing a new generation of doctors equipped to navigate the complexities of the 21st-century healthcare landscape. The synthesis of ancient principles, modern evidence, and social responsibility provides a replicable template for institutions worldwide, promising a healthcare system that is advanced, equitable, and profoundly humane (Murthy, 2023; Patwardhan, 2014; Monteiro, 2015).

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Challenges in reviewing and approving clinical trials by ethics committee

Abstract

Institutional Ethics Committee (IEC) plays an important role in protecting the rights, safety, and well-being of participants in biomedical research. Guidelines from the Indian Council of Medical Research (ICMR) has stated that all research involving human participants should obtain the institutional ethics committee permission. In spite of these guidelines, significant challenges persist in reviewing and approving clinical trials. This narrative review analyses the key challenges related to submission of documents for protocol review and institutional ethics committee experiences at Seth GS Medical College and KEM Hospital, Mumbai. The main challenges identified are maintaining appropriate IEC composition and training, managing the therapeutic misconception among research participants, the informed consent documentation process, standard of care, and risk-benefit assessments. Overlapping regulatory requirements and multiplicity of guidelines, such as those from ICMR, ICH-GCP, NDC-TR 2019, and funding agency guidelines, add to the operational burden. Additionally, the difficulties arising from post-trial access guidance may lead to inducement of participants, so IEC must critically review the protocol before conducting the study. This helps to maintain the autonomy and integrity of the participants. Research undertaken should be as per the country requirement or else multinationals can burden the Indian patients without any benefit. IEC has the responsibility to review not only the scientific rationale but also the ethical rationale from time to time to ensure the safety

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of the participants in the trial and credibility of the data generated. Strengthening IEC functioning in India requires standardized operating procedures, adequate infrastructure, continuous training, and regulatory coordination. Although the review process is of high standard, the process has become more robust and stronger after achieving the SIDCER recognition and NABH accreditation.

Keywords: Ethics committee, clinical trials, regulatory guidelines, biomedical research.

Introduction

According to Ethical Guidelines for Biomedical research on human participants, 2017(Indian Council of Medical Research, 2017), all proposals on biomedical research involving human participants should be cleared by an appropriately constituted Institutional Ethics Committee to safeguard the welfare and rights of the participants. At the Institutional Ethics Committee of Seth GS Medical College and KEM Hospital, a meeting is held every month to review protocols, and scientific and ethics related queries are sent to the investigator. Investigators are required to respond within 180 days, after which final approval may be granted. A research study from Spain has shown that two third of protocol submitted to IEC required some sort of amendment (Martín-Arribas et al., 2012). The study conducted in India by Kuyare etal has found that as many as 1676 queries were raised for the 219 studies in the period of January 2006 and December 2011 (Kuyare et al., 2014).

The Institutional Ethics Committee (IEC) of the KEM Hospital was established in 1986 and is one of the first few ethics Committees to have been established in India. Since then, the IEC has evaluated both the scientific and ethical aspects of research studies, as the institution does not have a separate scientific review board. Its working was based on the "Policy Statement on Ethical Considerations involved in Research in Human Subjects" released by the Indian Council for Medical research (ICMR) in 1980 (Indian Council of Medical Research, 2017) and continued to work on these guidelines till 2000. However, a systematic working of the IEC occurred only after the committee was reformulated in 2000, to meet the requirements of, ICH-GCP guidelines (1996) (International Conference on Harmonisation, 1996) and "Ethical guidelines for biomedical research on human subjects" -2000 (Indian Council of Medical Research, 2000).

The new IEC conducted a GCP training workshop for the IEC members in April 2000 and laid down standard operating procedures (SOPs) related to its functioning for the first time in May 2000. In 2004, a sample of Informed Consent Document was included in the SOPs to guide investigators. After the revision of Schedule Y in January 2005 (Ministry of Health and Family Welfare, 2005), the SOPs were further revised to include elements of review for the IEC members. A revision of the ICMR's guidelines in 2006 necessitated further amendments to the SOPs and the IEC started reviewing clinical trial agreements, insurance and subject compensation details. To further strengthen the quality of ethics review, strategic initiative for developing committees for ethical review (SIDCER) recognition was sought and obtained by Institution in 2010 (Forum for Ethical Review Committees in the Asian and Western Pacific Region [FERCAP], 2010).

Over the last 25 years, there were revisions in guidelines which may have led to changes in the performance of the IECs with respect to the number and type of queries raised during review of projects and the IEC has witnessed changes in the type of research studies which are undertaken by investigators and pharmaceutical industries. It was therefore felt that a review article on challenges faced by ethics committee while reviewing and approving the studies needs to be elaborated, and it would be worthwhile to share these with the scientific community.

Institutional ethics committee works on the objective of safeguarding the rights, safety, and well-being of the research participants

Challenges faced:

Constitution, roles, and responsibilities. It needs to be constituted as per the law of the land, presently in India it is the New

Drugs and Clinical Trials Rules, 2019 (NDCTR 2019) (Central Drugs Standard Control Organization, 2019).

The institutional Ethics committee needs to be registered with DHR while reviewing academic studies or registered with CDSCO if reviewing regulatory studies or accreditation which is voluntary. The registration lapse should not happen, so timely re-registration also needs to be done. IEC members need to be trained and should know the guidelines and regulations. Equal number of internal and external members to remove bias and facilitate independent decision making. Timelines need to be followed for initial review of protocol and post approval review – of protocol, Serious Adverse Event, Protocol Deviations and final reporting. Approval letter for the study or disapproval letter and interim data, as decided by the regulators need to be submitted to The Drug Controller General of India (DCGI). Registration and SAE reporting from institutional ethics committee need to be uploaded on Sugam portal.

Therapeutic misconception. In 1982 Paul Appelbaum, Loren Roth, and Charles Lidz coined the term "therapeutic misconception" which means that participating in research is the same as receiving individualised treatment from a physician. Here, participants fail to appreciate that the aim of research is to obtain scientific knowledge and any benefit to the patient is a by-product of that knowledge. It is more commonly observed in early-phase clinical trials, particularly Phase I oncology studies, where terminally ill participants have exhausted of standard treatments and when the scientific investigator is the treating physician for the patient. It is found to be 68.4% in Phase I Oncology trials and is associated with lower education (P = .008) and family income (P = .001), but not associated with the vulnerability of having hardly any treatment options. So, the consent forms must explicitly state the design and goals of the trial, as well as the potential benefits and risks (Pentz et al., 2012).

Therapeutic Misestimation is incorrectly estimating the chance of a research trial benefit as >20% or underestimating risk as 0% and is found to be 94% in_Phase I Oncology trials.

A CRO-conducted survey of the informed consent process in clinical trials in India provides some interesting information on the patient recruitment procedure and the quality of informed consent in clinical trials in India. 525 patients from 40 sites had been interviewed. When they asked about the reason for participation, seventy-six per cent of patients said the trial's principal investigator was their primary physician. A further 21 per cent said they were referred by their primary care physician (Srinivasan & Nikarge, 2009). During the informed consent process, understanding needs to be checked by the investigator before the patient participates in the study. The language, along with the mandatory elements as per ICMR guidelines 2017 and the technicality has to be well reviewed by the IEC.

Informed consent documentation. Voluntary written informed consent should be obtained in an informed consent document (ICD) from each participant to protect each individual's freedom of choice. It is a continuous process involving three main components: It involves providing relevant information to potential participants, ensuring their comprehension and competence, and confirming the voluntariness of participation. The 10 elements of an ICD need to be included, the number of pages (reams of material), technical terms must "Inform without overwhelming". IEC has to review the back-translations and translation certifications also. IEC can demand for site specific changes. Waiver of consent needs to be approved by IEC if the research involves not more than minimal risk or when participant and the researcher do not come into contact or in emergency situations. The IEC reviews who should give (and sign) consent. If the patient is Illiterate, then impartial witness signature is a must and if a minor, then legally acceptable representative (LAR), signature is taken. For assent your ICD language should be of that pediatric age because they should understand, comprehend and later participate in the study. In HIV studies how will be the confidentiality be maintained and who will be the impartial witness needs to be ascertained (Indian Council of Medical Research, 2018).

Standard of care. What should be provided to participants in a control group in clinical trials of an experimental drug? This remains a major dilemma, and the COVID-19 pandemic further complicated the issue. So, should it be universal *vs.* local standard of care, and will it lead to inducement? And what is the impact of variable standards on clinical outcomes? What should we provide research participants who become ill with a disease other than that being studied- so ancillary Care can it be provided? What should be provided to participants in prevention studies who acquire the "target disease" during the trial? This area is many times very grey and the scientific members need to review the protocol and should be well versed with the disease specific guidelines (Indian Council of Medical Research, 2017).

Risk benefit assessment. Risk at large is defined as a multidimensional concept: involves both probability and magnitude of harms and benefit, on the other hand is defined as the magnitude of a positive outcome without reference to its probability (Weijer, n.d.). Risk benefit assessment as per the International Council for Harmonisation's Good Clinical Practice guideline (ICH -GCP) (International Council for Harmonisation, 2025) needs to be undertaken by all the stakeholders (researchers, ECs, sponsors, regulators) at all stages of the research to ensure that the risks are minimized and appropriate care and compensation is given if any harm occurs and it has its impact from the start to the end of the study. Trial processes should be proportionate to the risks inherent in the trial and the importance of the information collected. Risks in this context include risks to the rights, safety and well-being of trial participants as well as risks to the reliability of the trial results. It should be managed prospectively (Indian Council of Medical Research, 2017).

As per ICMR guidelines, the type of IEC review is based on risk involved in the research; so accordingly, the study can undergo exempt from review, expedited review or full board review. The IEC should assess the inherent benefits and risks, ensure a favourable balance of benefits and risks, evaluate plans for minimizing the risk and discomfort and decide on the merit of the research before approving it. The IEC should also assess any altered risks in the study at the time of continuing review. In phase I - normal volunteer study, are the therapeutic procedures justified by their potential to benefit the subject and Non-therapeutic (Phase 1 and 2) procedures justified by their potential to generate knowledge.

What happens after the trial is over? This is very important aspect to be considered when there are no treatment available for the disease studied, will this treatment be made available for reasonable time. NDCTR 2019 have thrown some light on this aspect. IEC and regulators have to be very clear when the post-trial access be provided, will it lead to inducement? Will the drug be registered in India? (Central Drugs Standard Control Organization, 2019). Post-trial access depends on the availability of treatment to patient and community to effective medicine. Practicalities of the provision of interventions and where responsibility should lie must be addressed at the beginning of the study. It is essential to address issues at planning stage through discussions between range of stakeholders: sponsors, researchers, health authorities and governments. Who should fund the post-trial access many times it very difficult to balance between idealistic and realistic goals. In sponsor study, it is very clear that the pharmaceutical industry will sponsor, but in academic study when the investigator is wearing the hat of sponsor cum investigator the things are not very clear. Can we consider increasing the number of healthcare givers or development of expertise of local scientists or improving health infrastructure also as post-trial access. There is no clarity how long this access needs to be provided.

Multiplicity of guidelines and regulators. While reviewing the protocol, the scientific members should be aware of all the regulatory guidelines, funding agency guidelines [e.g. The National Institutes of Health (NIH); Wellcome Trust, United States Agency for International Development (USAID)], Guidelines for specific diseases, Institutional Guidelines, and Recommendations from advisory bodies along with ICH GCP, ICMR 2017 Guidelines and NDCTR 2019 guidelines. If the IEC is not experienced, untrained and unaware of the guidelines, the studies can be approved without any significant review or comments which can be detrimental for the research scenario.

Ethical review. Effective Institutional Ethics Committees are those whose functioning are as per Standard Operating Procedure (SOPs) (Seth GS Medical College and KEM Hospital, Mumbai, 2024) guidelines, and they maintain minutes with robust archival. They should have resources, adequate man power, office and need members with appropriate qualifications, experience, training and independent in decision making with no conflict of Interest. They should have adequate time to review and monitor studies. They should be willing to attend ongoing training in ethics, GCP and NDCTR 2019 guidelines. They should be consistent in review and follow timelines. Each member should play his role and responsibility: eg, Lawyer, Lay person, Social scientist, Chair, Secretary adequately. Initial review and continued review also need to done for each study till its completion. Site Visits, consent documentation, serious adverse event (SAE) management, protocol deviations also need to be vigilantly reviewed and decisions taken by the IEC. They should maintain quality of functioning by registering the IEC to Department of health research (DHR) or The Central Drugs Standard Control Organisation (CDSCO) / undertake national or international Accreditation.

In general IEC queries are classified into those related either to scientific or ethical issues. Ethics related queries were further categorized into those related to the protocol or informed consent document (ICD).

Scientific queries are related to rationale of the study, selection criteria, study procedure, inclusion exclusion criteria and statistical analysis. Ethics related queries in protocol are mainly categorized in to placebo justification/ study design, withdrawal criteria and rescue medication and procedure. Ethics related queries in ICD are regarding aims and methods of research, risk or discomfort to the participants, free treatment or compensation for study related injuries and improper translation of ICD.

IEC role is challenging when they check the suitability of the investigator for which they need to understand their qualifications, experience, availability of support staff, facilities, and emergency services to manage participants. How many studies Principal Investigator is involved in and if involved in multiple studies, how much time dedicated for research. IEC has to assess the voluntariness of participation of participants. Would there be an inducement: specially in Oncology, Cardiology trials if access to health care is given. What are the retention activities proposed in the study, will payments to participants lead to inducement? (compensation, payment, reimbursement) – IEC has to decide payment to participation as there are no guidelines (Marathe et al., 2018).

Elements that can be challenging is checking the rationale of study in which many times there is no therapeutic equipoise, identifying risks: physical/ psychosocial (discrimination, stigmatisation, breach of confidentiality) and providing ways to overcome/handle them and vulnerable subjects inclusion and its special protections.

Only sponsors have policies regarding compensation of participants. Compensation limited to management of adverse events that occurred during a trial: issue of compensation for lost wages/ death/ permanent disability not addressed in academic trials. Many a times participants had to pay and would be reimbursed later the amount of compensation. Role of legal person is very crucial in such situations.

There are special concerns where guidelines are not very clear such as in Devices, Drug eluting stents, surfactant, formulations, AI based or in emergency research study where IEC has to take decisions based on the experience or expert opinion or common sense.

Is research 'responsive' to the health needs of the population?

Steps need to be taken before the research is initiated to ensure that successful products are made available to the population at the conclusion of the research? If not, the population in wealthier countries who will be able to afford the products benefits, and the drug companies will realize a profit. The developing countries only participate in such research which is not as per their need, so chances of exploitation are there. IEC has to critically review such protocols and place comments or reject such studies.

Conclusion

Although the review process of our IEC was of high standard, a further strengthening of the ethics review process was observed after Strategic Initiatives for Capacity in Ethical. Review (SIDCER) recognition of the Institution and National Accreditation Board for Hospitals and Healthcare Providers (NABH)) accreditation.

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Part IV

Vulnerability, mental health and bodily integrity

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Mental health and stigma: An assessment in the educational community

Abstract

According to epidemiological data (WHO, 2022), the prevalence of mental health conditions has significantly increased after the COVID-19 However, stigma remains a persistent barrier to care for many disorders. Therefore, raising public awareness is essential to reduce stigmatization. The present study aimed to investigate whether familiarity with mental illness, either through educational programs or personal interaction can reduce stigma. In order to investigate this question, a survey was conducted among members of educational community, measuring stigma toward three mental disorders: anxiety disorder, major depressive disorder and psychotic episode. Two hypotheses were tested: Hypothesis 1: stigma scores would be lower for anxiety and depressive disorders than for psychotic episodes. Hypothesis 2: Self-reported familiarity would be associated with lower stigma. The sample consisted of 101 anonymous volunteers, members of the educational community. Results confirmed both hypotheses showing significant differences based on familiarity. Individual, whose work was related to mental health, had less negative attitudes perceived people with mental illness as less dangerous and do not consider mental illness an obstacle to an interpersonal relationship. These findings align with existing literature. In conclusion, it is important for the educational community to have greater familiarity with mental illness in order to provide appropriate support to students and to promote the destigmatization of mental illness.

Keywords: Mental illness stigma, educational community, destigma-

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tization, familiarization

Introduction

Mental health, according to the World Health Organization (WHO, 2022), is not merely the absence of mental illness but a dynamic state that enables individuals to cope with life's stressors, recognize their abilities, and contribute meaningfully to their communities. It is recognized as a fundamental human right, and its promotion enhances not only individual and social development but also broader socioeconomic progress (Zayts-Spence, Kluczewska, Vrecar, Glaser, & Wykes, 2023). Despite its importance, recent epidemiological data reveal a significant global burden, with anxiety and depressive disorders showing increases of 26% and 28%, respectively, in the aftermath of the COVID-19 pandemic (WHO, 2022).

However, stigma surrounding mental disorders remains a major barrier, depriving many individuals of access to effective treatments (Zayts-Spence et al., 2023). Moreover, stigma has been associated with adverse social outcomes such as heightened loneliness and social isolation, and exacerbation of existing mental health difficulties (Prizeman et al., 2023).

The present study focuses on stigma related to three mental disorders: anxiety disorder, depressive disorder, and psychotic episode. The first two were chosen due to their high prevalence, while the latter, though less common (1% globally), continues to carry the most severe stigma (WHO, 2022).

Stigma and mental health

The stigma of mental illness is a social phenomenon shaped by stereotypes and prejudice, leading to discrimination and marginalization (Goffman, 1986; Hantzi, 2006). It affects not only individuals with a diagnosis but also extends to their families and caregivers (Zayts-Spence et al., 2023). Its consequences are multifaceted: delayed or avoided treatment (Kessler et al., 2001; Wang et al., 2006; Kordosi et al, 2015), negative self-image and reduced self-esteem (Kleim et al., 2008; Sickel et al., 2014), difficulties in interpersonal relationships (Boyd et al., 2010; Gray et al., 2010), and significant barriers to employment (Corrigan et al., 2014). Thus, stigma serves as a major barrier both to help-seeking and to the social and occupational integration of people with mental illness.

Educational community

The educational community was selected as the study population, regardless of specialty, educational level, or sector (public or private), for two main reasons. First, teachers play a critical role in early intervention by recognizing early signs of mental disorders and guiding students toward appropriate care, provided they possess adequate knowledge and training (Yamaguchi et al., 2019). Second, teachers act as transmitters of stereotypes; their attitudes and comments shape students' adoption of either positive or negative beliefs (Muntoni & Retelsdorf, 2018). As a central pillar of socialization, the school environment may either perpetuate or reduce the stigma of mental illness. Through education and professional development, teachers can challenge myths—such as the belief that individuals with mental disorders are inherently dangerous—thereby fostering destigmatization (Smith & Applegate, 2018; Corrigan et al., 2012).

Anxiety disorders

Anxiety disorders are characterized by excessive fear, anxiety, and related behavioral disturbances. Fear is an immediate emotional response to a threat, whereas anxiety involves anticipation of potential future threats. While overlapping, fear is associated with the "fight or flight" response, whereas anxiety involves preparation and preventive planning (American Psychiatric Association [APA], 2013).

These disorders often begin in childhood and can manifest in various forms, including separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, and generalized anxiety disorder (APA, 2013).

Generalized anxiety disorder (GAD) is marked by persistent worry and catastrophic, overgeneralized thinking patterns (Kalpakoglou, 2013). According to DSM-5 criteria, diagnosis requires excessive anxiety and worry for at least six months, difficulty controlling worry, and the presence of multiple symptoms, such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbances (APA, 2013).

Epidemiologically, in 2019, anxiety disorders affected 301 million people worldwide, but only 25% received treatment (World Health Organization [WHO], 2022). The 12-month prevalence of GAD ranges globally from 0.4% to 3.6%, with higher rates among women and individuals in developed countries (APA, 2013).

Risk factors include genetic predisposition, temperamental traits (behavioral inhibition, negative affectivity), and environmental influences, such as childhood adversity or parental overprotection (APA, 2013; Rygh & Sanderson, 2004). Comorbidity with depressive and other anxiety disorders is high (Beck & Clark, 2010; Rygh & Sanderson, 2004).

Finally, differential diagnosis is essential to rule out medical conditions, substance- induced effects, or other psychiatric disorders (APA, 2013).

Depressive disorders

Depressive disorders are among the most common mental illnesses, characterized by persistent sadness or irritable mood accompanied by cognitive and somatic changes that significantly impair functioning (APA, 2013; NICE, 2009). Major depressive disorder (MDD) represents the classical form, while other types include dysthymia, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, and depressive disorder due to medical conditions (APA, 2013).

DSM-5 criteria for MDD require five or more symptoms for at least two weeks, including depressed mood, loss of interest or pleasure, changes in sleep or weight, psychomotor agitation or retardation, fatigue, feelings of worthlessness, impaired concentration, and recurrent thoughts of death or suicide (APA, 2013). Symptoms must cause significant distress or functional impairment and not be attributable to substances or medical conditions.

Epidemiologically, over 300 million people worldwide (~4.4% of the population) suffer from depression, with higher prevalence among women, increased suicide risk, and limited treatment access in low- and middle-income countries (WHO, 2023). Risk factors include genetic (first-degree relatives), environmental (childhood adversity, stressful life events), temperamental (neuroticism), and prior medical or psychiatric conditions (APA, 2013; WHO, 2023).

Depression often co-occurs with anxiety disorders, personality disorders, and substance use disorders (APA, 2013). Differential diagnosis requires ruling out manic/hypomanic episodes, substance- or medication-induced disorders, adjustment disorders, and normal grief reactions (APA, 2013).

Psychotic episode

A psychotic episode is defined by severe disruption of reality testing, preventing adaptive perception and processing of information (Kaplan & Sadock, 2007). It primarily occurs in psychotic disorders such as schizophrenia, schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, substance/medication-induced psychotic disorder, psychotic disorder due to medical conditions, delusional disorder, and shared psychotic disorder (APA, 2013). Core symptoms include delusions, hallucinations, disorganized speech and thought, grossly disorganized behavior, flat or negative affect, and cognitive deficits (especially in schizophrenia).

DSM-5 criteria for schizophrenia require two or more symptoms for at least 1 month (one of the first three: delusions, hallucinations, disorganized speech), significant social/occupational dysfunction, and overall duration of at least 6 months (APA, 2013).

Epidemiology indicates ~24 million people worldwide (~1% prevalence), with 10-20 years reduced life expectancy (WHO, 2022; Greek Ministry of Health, 2023). Onset is typically earlier in men (~20 years) and later in women (~30 years).

Risk factors include genetic (family history of psychosis) and environmental factors, such as prenatal/perinatal complications, childhood maltreatment or neglect, and psychosocial stressors in adulthood (APA, 2013; Kaplan & Sadock, 2007; Papadimitriou et al., 2013).

Comorbidity is common with anxiety disorders, depression, substance/alcohol use, panic disorder, PTSD, and OCD (Buckley et al, 2009).

Differential diagnosis requires exclusion of other medical or psychiatric conditions, including brief psychotic disorder, mood disorders, personality disorders, intellectual disability, and cultural beliefs (APA, 2013).

The current study

Familiarity with mental illness appears to reduce stigma. Individuals experiencing depressive episodes or frequently interacting with people with mental disorders tend to hold less negative attitudes (Gierg, 2018; Steiger et al., 2022). Age and type of disorder also influence attitudes; for example, younger people may be more sensitive to substance addictions, while older adults may be more empathetic toward depression (Crisp et al., 2005). This study investigates whether familiarity—through education or direct interaction with patients—can reduce stigma. Hypothesis 1: anxiety and depressive disorders will show lower stigma scores than psychotic episodes. Hypothesis 2: self-reported familiarity with mental illness will correlate with stigma scores. Results will highlight the importance of anti-stigma programs.

Methods

The present study was conducted in 2024 within the educational community using a questionnaire developed on the basis of existing literature and distributed online. Participants included teachers of all specialties and educational levels from both public and private sectors. Responses were collected through Google Forms, coded, and analyzed using the SPSS statistical package.

Sample

The study sample consisted of 102 educators from both public and private sectors, representing all educational levels and various specialties. Most participants were women (n=89), 12 were men, and 1 identified as “other,” with ages ranging from 24 to 61 years

(M=42). Regarding education, 2% had secondary education, 48% held a bachelor's degree, 48% had a master's degree, and 2% had a doctoral degree. Years of professional experience ranged from 1 to 38 (M=15.4). Participants' specialties covered various fields (see Table 1).

Table 1. Demographic characteristics of participants

Demographic characteristic	N	%
Gender		
Women	89	*87.3*
Men	12	*11.8*
Other	1	*1*
Total	102	*100*
Educational Level		
Secondary Education	2	*2*
Undergraduate Degree	49	*48*
Postgraduate Degree	49	*48*
Doctorate	2	*2*
Total	102	*100*
Specialty		
Special Support Staff	2	*2*
Visual Arts Teacher	2	*2*
Physical Education Teacher	4	*4*
Primary School Teacher	51	*52*
Drama Teacher	1	*1*
Foreign Language Teacher	12	*11*
Social Worker	7	*7*
Speech Therapist	2	*2*
Music Teacher	2	*2*
Kindergarten Teacher	3	*3*
School Nurse	1	*1*
Philologist	6	*6*
Physics Teacher	2	*2*
Chemistry Teacher	2	*2*
Psychologist	5	*5*

Questionnaire

The questionnaire consisted of three parts (see Appendix). The first part collected demographic information from the participants. The second part assessed familiarity with mental illness using the

Level of Contact Report (LCR) scale, which includes 12 situations measuring contact with individuals with mental disorders. Participants rated their familiarity from 1 to 12, with 12 indicating the highest level of contact (Arvaniti & Leivaditi, 2008). The third part focused on measuring mental health stigma using the Stigma-9 Questionnaire (STIG-9) (Gierg, 2018), adapted for three mental disorders: anxiety, depression, and psychotic episode. Participants rated statements on a four-point Likert scale, such as "I believe most people take the opinion of someone treated for an anxiety disorder less seriously." The instrument demonstrated very high reliability (Cronbach's α = 0.95), with no item below α = 0.94. The questionnaire was administered entirely online and distributed via the internet. Participants' responses were automatically recorded and subsequently exported for statistical analysis.

Data collection and analysis

Participants' responses were automatically recorded in a Google form specifically created for this study. The collected data were initially stored in Excel and subsequently transferred to the statistical software SPSS for analysis. The statistical analysis focused on the stigma scores associated with the three mental disorders under investigation. Furthermore, correlations were examined between these stigma scores and the Level of Contact Report (LCR) familiarity scale. Although the overall LCR and stigma scores for each disorder did not reach statistical significance, certain individual items showed indications of stronger effects. Consequently, specific LCR items were compared with the corresponding questionnaire statements to further explore potential relationships between familiarity and attitudes toward mental illness.

Results

The data were analyzed using the SPSS statistical package.Mean scores for stigma were calculated for depressive disorder (M = 20.35, SD = 5.56), anxiety disorder (M = 20.31, SD = 5.37), and psychotic episode (M = 25.32, SD = 4.52). A Pearson chi-square test revealed no significant associations between stigma and gender, educational level, or field of specialization across the three disorders.

Correlation analyses indicated significant negative relationships between work experience and stigma for depressive disorder [$r(102) = -.31$, $p < .05$] and psychotic episode [$r(102) = -.29$, $p < .05$], but not for anxiety disorder. Similarly, age was negatively correlated with stigma toward depressive disorder ($r = -.22$, $p < .05$) and psychotic episode ($r = -.20$, $p < .05$), with no significant correlation for anxiety disorder [$r(102) = -.19$, $p > .05$].

Regarding the responses to the familiarity questionnaire with mental illness, 19.6% had watched a related film, 37.3% a documentary, 21.6% worked in relevant service settings, 12.7% personally provided services, 31.4% had a family friend affected, and 37.3% had a relative with a mental illness (Table 2).

Table 2. Statements of familiarity with mental illness

Statement	Yes	%
I have never come across a person with a mental illness	1	0.9
I have occasionally come across a person with a mental illness	20	19.6
I have watched a film about mental illness	46	45.1
I have watched a documentary about mental illness	38	37.3
I have often come across a person with a mental illness	51	50.0
I have worked with someone who had a mental illness	37	36.3
My job involves providing services to people with mental illness	22	21.6
I personally provide services to people with mental illness	13	12.7
A family friend has a mental illness	32	31.4
A relative has a mental illness	38	37.3
I live with someone who has a mental illness	7	6.9
I have a serious mental illness myself	1	0.9

Based on the responses to the LCR, three participant groups were formed:

a) those who had watched films and/or documentaries related to mental illness,
b) those who work with individuals with mental illness or provide

services to them, and
c) those who have a family friend, relative, or themselves affected by mental illness.

This grouping aimed to investigate whether, beyond the level of familiarity, the mode of familiarity influences participants' responses. Statistical analysis was conducted using **independent-samples t-tests**.

First grouping analysis results

Participants who had watched films or documentaries scored slightly higher on the statement "I believe most people would not even consider an application from someone who has undergone treatment for depression" (M = 2.67, SD = 1) than those who had not (M = 2.60, SD = 0.76), with adjusted degrees of freedom [t(98)=0.36, p<0.05] due to unequal variances (Levene's F=4.3, p<0.05). Differences on other statements were not statistically significant (see Table 3).

Table 3. First grouping analysis results

	Watched Films/ Documentaries		Not Watched		
Statement	**M**	**SD**	**M**	**SD**	**Sig.**
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.56	0.92	2.56	0.85	0.43
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.30	1.02	2.19	0.91	0.31
I believe most people hesitate to work with someone who has received treatment for an anxiety disorder.	2.40	0.87	2.34	0.92	0.10
I believe most people think negatively about someone who has received treatment for an anxiety disorder.	2.52	0.97	2.45	0.90	0.55

	Watched Films/ Documentaries		**Not Watched**		
I believe most people consider an anxiety disorder a sign of personal weakness.	2.82	0.91	2.58	0.90	0.32
I believe most people hesitate to trust their child to someone who has received treatment for an anxiety disorder.	3.11	0.77	3.17	0.81	0.78
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.50	0.97	2.54	0.80	0.09
I believe most people would not form a relationship with someone who has received treatment for an anxiety disorder.	2.57	1.02	2.52	0.90	0.25
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	2.13	1.00	2.08	0.94	0.80
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.63	0.88	2.33	0.88	0.79
I believe most people consider someone who has received treatment for depression as dangerous.	2.24	0.97	2.10	0.93	0.75
I believe most people hesitate to work with someone who has received treatment for depression.	2.44	0.84	2.50	0.85	0.92
I believe most people think negatively about someone who has received treatment for depression.	2.48	0.93	2.46	0.82	0.31
I believe most people consider depression a sign of personal weakness.	2.83	0.90	2.73	1.04	0.08

	Watched Films/ Documentaries		Not Watched		
I believe most people hesitate to trust their child to someone who has received treatment for depression.	3.02	0.79	3.06	0.76	1.00
I believe most people would not even consider an application from someone who has received treatment for depression.	2.67	1.00	2.60	0.76	0.04
I believe most people would not form a relationship with someone who has received treatment for depression.	2.72	0.83	2.65	0.79	0.82
	M	SD	M	SD	Sig.
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	2.17	1.04	1.98	0.91	0.19
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.20	0.76	3.10	0.78	0.81
I believe most people consider someone who has received treatment for a psychotic episode as dangerous.	3.39	0.68	3.21	0.77	0.95
I believe most people hesitate to work with someone who has received treatment for a psychotic episode.	3.33	0.67	3.15	0.71	0.68
I believe most people think negatively about someone who has received treatment for a psychotic episode.	3.11	0.82	3.17	0.69	0.46
I believe most people consider a psychotic episode a sign of personal weakness.	2.80	0.94	2.73	0.96	0.34

	Watched Films/ Documentaries		**Not Watched**		
I believe most people hesitate to trust their child to someone who has received treatment for a psychotic episode.	3.63	0.59	3.50	0.56	0.60
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.24	0.70	3.04	0.74	0.64
I believe most people would not form a relationship with someone who has received treatment for a psychotic episode.	3.26	0.76	3.21	0.65	0.21
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	3.11	0.81	2.85	0.97	0.27

Second grouping analysis results

The second grouping concerned participants whose work involved providing services to people with mental illness, who overall showed significantly lower stigma scores compared to the other group. Specifically, they reported lower agreement with the statements:

- **“less seriously taken if treated for depression”** than the other participants (M=2.54, SD=0.94) [t(53)=-1.41, p<0.05]. Levene’s test (F=6.27, p<0.05) indicated unequal variances, and thus degrees of freedom were adjusted from 100 to 53.
- **“hesitation to trust with a child”** (M=2.91, SD=0.51) compared to the others (M=3.80, SD=0.82) [t(58)=-1.15, p<0.01], with Levene’s test (F=6.9, p<0.01) confirming unequal variances; degrees of freedom were adjusted to 58.
- **“considered dangerous after psychotic episode”** (M=3.26, SD=0.54) than the others (M=3.30, SD=0.78) [t(51)=-3.9, p<0.05];

Levene's test ($F=3.9$, $p<0.05$) indicated unequal variances, and degrees of freedom were adjusted to 51.

- **"employment discrimination after psychotic episode"** ($M=3.04$, $SD=0.56$) than the others ($M=3.20$, $SD=0.76$) [$t(48)=-0.92$, $p<0.05$], with Levene's test ($F=6.21$, $p<0.05$) showing unequal variances; degrees of freedom were adjusted to 48.
- **"reluctance to form a relationship after psychotic episode"** ($M=3.04$, $SD=0.56$) than the others ($M=3.30$, $SD=0.74$) [$t(46)=-1.73$, $p<0.001$]; Levene's test ($F=12.58$, $p<0.001$) confirmed unequal variances and degrees of freedom were adjusted to 46.
- **"discomfort with a neighbor treated for anxiety"** ($M=2.05$, $SD=0.86$) than the others ($M=2.16$, $SD=1.04$) [$t(99)=-0.58$, $p<0.05$]; Levene's test ($F=4.38$, $p<0.05$) indicated unequal variances, and degrees of freedom were adjusted to 99.

Although differences also appeared in other statements, these were not statistically significant (see Table 4).

Table 4. Second grouping analysis results

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
	M	SD	M	SD	Sig.
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.30	0.82	2.63	0.89	0.70
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.04	0.88	2.30	1.00	0.13
I believe most people hesitate to collaborate with someone who has received treatment for an anxiety disorder.	2.03	0.78	2.25	0.85	0.12

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for an anxiety disorder.	2.40	0.78	2.52	0.97	0.13
I believe most people consider an anxiety disorder a sign of personal weakness.	2.35	1.07	2.72	0.86	0.06
I believe most people hesitate to trust their child to someone who has received treatment for an anxiety disorder.	3.13	0.76	3.14	0.80	0.76
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.17	0.78	2.63	0.90	0.13
I believe most people would not form a relationship with someone who has received treatment for an anxiety disorder.	2.22	0.90	2.65	0.96	0.41
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	1.70	0.82	2.23	0.97	0.45
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.30	0.63	2.54	0.94	0.01
I believe most people consider someone who has received treatment for depression as dangerous.	1.96	0.88	2.24	0.96	0.27
I believe most people hesitate to collaborate with someone who has received treatment for depression.	2.40	0.78	2.50	0.86	0.48

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for depression.	2.30	0.70	2.52	0.92	0.07
I believe most people consider depression a sign of personal weakness.	2.78	0.85	2.78	1.01	0.12
I believe most people hesitate to trust their child to someone who has received treatment for depression.	2.91	0.51	3.08	0.83	0.01
I believe most people would not even consider an application from someone who has received treatment for depression.	2.26	0.69	2.75	0.93	0.90
I believe most people would not form a relationship with someone who has received treatment for depression.	2.30	0.63	2.80	0.82	0.33
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	1.78	0.95	2.16	0.98	0.99
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.04	0.77	3.19	0.77	0.76
I believe most people consider someone who has received treatment for a psychotic episode as dangerous.	3.26	0.54	3.31	0.78	0.05
I believe most people hesitate to collaborate with someone who has received treatment for a psychotic episode.	3.17	0.58	3.27	0.73	0.09

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for a psychotic episode.	3.09	0.73	3.15	0.77	0.68
I believe most people consider a psychotic episode a sign of personal weakness.	2.65	0.83	2.80	0.98	0.45
I believe most people hesitate to trust their child to someone who has received treatment for a psychotic episode.	3.43	0.51	3.61	0.59	0.80
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.04	0.56	3.18	0.76	0.10
I believe most people would not form a relationship with someone who has received treatment for a psychotic episode.	3.04	0.56	3.30	0.74	<0.001
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	2.78	0.80	3.05	0.92	0.77

Third grouping analysis results

The third grouping examined whether participants reported having a family friend, relative, or personal experience with mental illness. Those in this group showed lower stigma on the statement "feeling uncomfortable with a neighbor treated for anxiety" (M = 2.05, SD = 0.86) compared to the other group (M = 2.16, SD = 1.04) [t(99) = -0.58, $p < 0.05$]. The Levene test (F = 4.38, $p < 0.05$) indicated inequality of variances, and therefore the degrees of freedom were adjusted from 100 to 99. Differences in other statements were observed but did not reach statistical significance (see Table 5).

Table 5. Third grouping analysis results

Statement	Social circle with mental illness		Social circle without mental illness		Sig
	M	SD	M	SD	Sig.
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.39	0.87	2.69	0.88	0.63
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.11	0.95	2.34	0.98	0.56
I believe most people hesitate to cooperate with someone who has received treatment for an anxiety disorder.	2.14	0.88	2.25	0.92	0.78
I believe most people think badly of someone who has received treatment for an anxiety disorder.	2.30	0.88	2.64	0.95	0.69
I believe most people consider anxiety disorder a sign of personal weakness.	2.59	0.84	2.79	0.95	0.78
I believe most people hesitate to entrust their child to someone who has received treatment for an anxiety disorder.	3.00	0.78	3.24	0.78	0.34
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.43	0.87	2.59	0.90	0.80
I believe most people would not enter a relationship with someone who has received treatment for an anxiety disorder.	2.45	0.93	2.62	0.99	0.60

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	2.05	0.86	2.16	1.04	0.03
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.32	0.88	2.62	0.88	0.88
I believe most people consider someone who has received treatment for depression as dangerous.	2.00	0.91	2.31	0.96	0.24
I believe most people hesitate to cooperate with someone who has received treatment for depression.	2.34	0.86	2.57	0.82	0.83
I believe most people think badly of someone who has received treatment for depression.	2.43	0.97	2.50	0.80	0.08
I believe most people consider depression a sign of personal weakness.	2.75	0.97	2.81	0.98	0.73
I believe most people hesitate to entrust their child to someone who has received treatment for depression.	3.02	0.76	3.05	0.78	0.83
I believe most people would not even consider an application from someone who has received treatment for depression.	2.57	0.95	2.69	0.86	0.23
I believe most people would not enter a relationship with someone who has received treatment for depression.	2.70	0.76	2.67	0.85	0.43

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	1.93	0.95	2.19	1.00	0.41
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.18	0.72	3.14	0.80	0.75
I believe most people consider someone who has received treatment for depression as dangerous.	3.27	0.76	3.33	0.71	0.55
I believe most people hesitate to cooperate with someone who has received treatment for a psychotic episode.	3.23	0.71	3.26	0.69	0.46
I believe most people think badly of someone who has received treatment for a psychotic episode.	3.11	0.75	3.16	0.77	0.82
I believe most people consider a psychotic episode a sign of personal weakness.	2.70	0.98	2.81	0.93	0.58
I believe most people hesitate to entrust their child to someone who has received treatment for a psychotic episode.	3.55	0.55	3.59	0.59	0.95
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.07	0.76	3.20	0.69	0.43
I believe most people would not enter a relationship with someone who has received treatment for a psychotic episode.	3.23	0.74	3.24	0.68	0.40

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	2.84	0.94	3.10	0.85	0.23

Discussion

The results indicate that stigma varies depending on the disorder; depressive and anxiety disorders had lower scores (~20) compared to psychotic episodes (~25) on a scale ranging from 1–36, confirming the first hypothesis. This difference may be related to prevalence: depression is the most common mental disorder (Kessler et al., 2016; Sinyor et al., 2016; Lim et al., 2018), with an estimated 4.4% of the global population suffering from some form of depression (WHO, 2023), while anxiety disorders are also prevalent, with 301 million people experiencing some form (WHO, 2022). For this reason, these disorders may be more familiar and carry milder stigma, despite stereotypes such as that "weak people" develop depression (Yokoya et al., 2018). On the other hand, the prevalence of psychosis is approximately 1% (WHO, 2022), which is still significant. However, the stigma associated with the spectrum of disorders connected to psychotic episodes is much more intense. Even an individual who has not developed the illness but is at high risk of experiencing a psychotic episode may carry stigma (Colizzi et al., 2020).

The analysis with demographic variables showed a negative correlation between age and work experience with stigma in depression and psychosis: the greater the age and/or work experience, the lower the stigma. This finding is supported by the literature, as studies (Crisp et al., 2005; Fogel & Ford, 2005; Mackenzie et al., 2019) have shown that stigma toward populations suffering from a mental disorder is higher among younger individuals compared to older individuals.

The second hypothesis concerned the relationship between familiarity with mental illness and stigma. Initially, the overall FAS scores did not show any correlation. For this reason, further subgroup analyses were conducted:

The first subgrouping was based on whether participants reported having seen films and/or documentaries about mental illness. In general, lower stigma scores were observed, except for the statement "most people would not even consider an application from someone who has undergone treatment for depression," where stigma was higher. The existing literature highlights that individuals with depression may experience discrimination in the workplace (Fox et al., 2016). The increase in stigma in this statement may emphasize this prejudice in professional environments, where individuals with some form of depression are perceived as less productive (Fox et al., 2016; McGonagle & Hamblin, 2014), and this image may have been conveyed through exposure to films and/or documentaries.

The second subgrouping was based on whether participants reported that they employ or provide services to people with mental illness. In all statements, scores were lower across all three disorders. In fact, lower scores were found in statements that heavily carry the stigma of mental illness, such as "I believe that most people consider someone who has undergone treatment for depression as dangerous" and "I believe that most people would not enter into a relationship with someone who has undergone treatment for a psychotic episode." The existing literature supports that mental health professionals hold less negative attitudes than non-mental health professionals (Calicchia, 1981; Carrara et al., 2019; Henderson et al., 2014). Moreover, this more favorable stance among mental health professionals appears across different cultural contexts, such as London, Sweden, and Japan (Henderson et al., 2014). Therefore, members of the educational community who participated in the present study confirm the literature, showing that those with professional experience working with individuals with mental illness scored lower in stigma toward mental disorders. After all, mental illness stigma is a social and cultural phenomenon, and direct experience with individuals suffering from mental illness may reduce prior beliefs and foster more positive views and attitudes toward them.

The third subgrouping was based on whether participants reported having a family friend and/or relative, or personally having a mental illness. In this subgrouping, it was initially expected that stigma would be milder and that scores would be lower. In reality, however, the only statement that had statistically significantly lower scores for the group with greater familiarity was "I believe that most people feel uncomfortable when someone who has undergone treatment for an anxiety disorder lives in the neighborhood." The reason why significantly lower stigma scores were expected was due to greater personal familiarity. The developers of the questionnaire (Gierk et al., 2018) had emphasized that when the questionnaire was completed by individuals experiencing a relapse at the time—for example, a depressive episode—they perceived the attitudes of their environment as more negative. The literature has highlighted that, apart from public stigma, there is also self-stigma experienced by the individual, which plays an important role in many aspects of life, from whether one seeks help (Sirey et al., 2001; Watson et al., 2006), to how they respond to treatment (Sirey et al., 2001; Watson et al., 2006), and how it influences later professional status and interpersonal relationships. Regarding individuals who reported having a family member or relative with mental illness, it is worth noting that the literature emphasizes that stigma is not only carried by the individual with the illness but also by their close social environment (Zayts-Spence et al., 2023).

From the interpretation of the results, it becomes evident that the stigma of mental illness can be moderated and negative attitudes reduced under specific conditions. These conditions, as shown by the analysis, are age, work experience, and close professional relationships with individuals who suffer from a mental illness. The common denominator is familiarity with mental illness, both over time and through relevant engagement. However, personal involvement may have the opposite effects. There is evidence that even mental health professionals, while having less negative attitudes toward patients, would not choose to form close personal relationships with individuals who have a mental illness, knowing the challenges this entails (Chikaodiri et al., 2010; Steiger et al., 2022).

Further research

The present study only partially addresses the phenomenon of mental illness stigma in Greece. Future research should examine how individuals with mental illness experience stigma in the workplace and interpersonal relationships (Corrigan et al., 2014; Brohan et al., 2010). It is also important to investigate the extent to which stigma acts as a barrier or facilitator in seeking help (Clement et al., 2015). Equally significant is the exploration of how significant others, such as family and friends, experience stigma and the extent to which their personal beliefs influence the attitudes and decisions of the individual affected (Zayts-Spence et al., 2023; Phelan et al., 1998).

Limitations

A main limitation concerns the sample, which was drawn from the educational community with greater representation from primary and less from secondary education, thus restricting the generalizability of the findings (Etikan et al., 2016). Moreover, the study was conducted under conditions of anonymity, which prevented repeated measurements that could have captured potential changes in attitudes over time. Future studies could examine whether and how personal experiences, such as developing a mental illness or working in a mental health context, contribute to changes in stigma-related attitudes (Henderson et al., 2014; Corrigan & Shapiro, 2010).

Conclusion

This study highlights that stigma toward mental illness can be reduced through professional familiarity and prolonged exposure, which promote more positive attitudes (Calicchia, 1981).

Stigma impacts both affected individuals and their social environment, influencing self-confidence, self-efficacy, and interpersonal, academic, and professional outcomes (Steiger et al., 2022; Watson et al., 2007). Enhancing mental health literacy and direct engagement in educational and professional contexts improves recognition of mental health needs and supports timely intervention (Rossetto et al., 2016; Yamaguchi et al., 2019). Effective stigma reduction also requires systemic measures, including equal opportunities, medical support, interdisciplinary collaboration, and public awareness initiatives (Chikaodiri, 2010; Kordosi et al., 2015; Patel, 2004; Steiger et al., 2022; Yamaguchi et al., 2019; Zayts-Spence et al., 2023). Combining education, engagement, and structural reforms fosters inclusive, supportive, and understanding environments for individuals affected by mental illness.

These findings highlight the importance of anti-stigma interventions in educational in educational setting and suggest that familiarity-through education, professional exposure and personal contact- can significantly reduce negative attitudes towards mental illness.

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Georgios Rizos*

Hormone therapy for gender dysphoria in youth: Bioethical and clinical dimensions of hormone therapy

Abstract

Hormone therapy for minors with gender dysphoria is among the most debated issues in contemporary bioethics, combining medical, psychological, and social dimensions. This article examines the clinical practice and ethical dilemmas surrounding puberty blockers and cross-sex hormones, emphasizing the shift from pathologization to a rights-based understanding of gender diversity. It discusses key issues such as minors' capacity to consent, the potential for regret, reversibility, and the lack of long-term data, while highlighting both the documented psychological benefits and possible medical risks. The analysis underscores the vital role of family support, social acceptance, and equitable access to care, proposing a bioethical framework that integrates scientific evidence with respect for autonomy and self-determination. The paper concludes with recommendations for clinical practice, family counseling, and policy-making aimed at ensuring the well-being, dignity, and rights of gender-diverse adolescents through individualized, ethically responsible, and socially sensitive care.

Keywords: Hormone therapy, gender dysphoria, minors, informed consent, autonomy, psychological effects, social dimensions, bioethics

Introduction

Hormone therapy for gender dysphoria in young people is one of the most controversial and dynamic areas of contemporary bioethical debate. The debate surrounding the administration of puberty blockers and cross-sex hormones to minors combines scientific data, social attitudes, cultural perceptions, and ethical consid-

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erations. At a time when the visibility of transgender and non-binary identities is increasing, medical practices related to gender affirmation are not limited to purely clinical dimensions, but raise fundamental questions about the rights, autonomy, and protection of young people.

The analysis of hormone therapy in this context is necessary because it concerns not only the effectiveness and safety of medical interventions, but also the conditions under which young people are able to make informed decisions. Issues such as the maturity of minors to consent, the role of parents and guardians, the responsibilities of health professionals, and the social pressures that shape choices are central points of concern. At the same time, the literature highlights significant gaps in knowledge regarding the long-term effects of hormone therapy, which reinforces the need for a careful, ethically sound approach.

This article aims to offer a systematic approach to the subject, examining the historical and social roots of gender dysphoria, the development and application of hormone therapy in young people, the ethical theories that have been applied in clinical practice, and the challenges arising from real-life situations and case studies. The aim is to present a balanced perspective that recognizes both the benefits and the risks, while emphasizing the need to respect young people's self-determination and to protect them from potentially hasty or irreversible decisions.

Methodologically, the analysis is based on an interdisciplinary literature review, combining data from medicine, psychology, law, and philosophy. The comparison of international guidelines and the discussion of different cultural contexts enrich the argument, revealing the tensions that arise between medical practice and social values.

Finally, the significance of the study is not limited to academic discourse, but extends to practical recommendations for clinical practice, family support, and health policy making. The bioethical dimension of hormone therapy in young people calls for a responsible, empathetic, and proactive approach, with the ultimate goal of ensuring the well-being and dignity of the young people at the center of this complex debate.

Background and social context

Gender dysphoria is a complex and multidimensional phenomenon that has attracted significant research and social interest in recent years. The term describes the intense discomfort experienced by a person when their gender identity does not match the sex assigned to them at birth (American Psychiatric Association, 2013). Although the experience of gender incongruence is not new, its systematic study and integration into the medical and psychological context are relatively recent developments (Dhejne et al., 2016).

During the 20th century, understanding of the phenomenon went through various stages. In the early decades, the experiences of transgender people were mainly viewed through the lens of pathology, which contributed to stigmatization and social isolation (Meyerowitz, 2002). With the development of sexology and psychiatry, more systematic categorizations began to take shape, which, however, retained their medical-centric character. An important milestone was the inclusion of "gender identity disorder" in diagnostic manuals such as the DSM and the ICD, which provided clinical recognition but reinforced the tendency to medicalize the experience (Zucker, 2010).

The gradual shift from the concept of "disorder" to that of "gender dysphoria" marked a significant change in perspective. Instead of considering the experience of identity itself as pathological, the emphasis shifted to the distress caused by gender incongruence and its social consequences (WPATH, 2011). This change, which was recorded in the recent editions of the DSM-5 and ICD-11, resulted in the recognition of the need for support and therapeutic interventions that respect the individual's gender identity (WPATH, 2011, American Psychological Association, 2015).

In this context, medical science has developed interventions aimed at reducing distress and improving the quality of life of transgender individuals. Hormone therapy plays a central role among these, as it allows physical adaptation to the individual's gender identity (Hembree et al., 2017). Especially in the case of young people, the use of puberty blockers and, in some cases, cross-sex hormones, is considered to offer the possibility of reducing the anxiety associated with the appearance of unwanted physical characteristics (De Vries et al., 2014). However, these interventions are closely linked to complex ethical, psychological, and social issues (De Vries et al., 2014).

Understanding gender dysphoria and related interventions cannot be separated from the broader social and cultural context. In Western societies, the growing recognition of the rights of LGBTQI+ individuals has contributed to the gradual acceptance and institutionalization of access to gender-affirming healthcare services (WPATH, 2011). Legislative initiatives, professional association guidelines, and the increased social visibility of transgender individuals have contributed to the creation of a more supportive environment (Budge et al., 2013). In contrast, in more conservative social contexts, gender dysphoria continues to be met with suspicion, prejudice, or outright denial, leading to high levels of stigma and marginalization (Haas et al., 2014).

The social dimension is particularly critical for young people. Research has shown that adolescents with gender dysphoria often experience bullying, social exclusion, and discrimination, which takes a toll on their mental health (Turban et al., 2020). In this context, the provision of medical interventions, such as hormone therapy, is not only clinically but also socially significant, as it is often associated with improved social integration and psychological well-being (Turban et al., 2020). At the same time, however, it raises questions about the ability of young people to make mature decisions and the responsibility of society to protect their rights (Kimberly et al., 2018).

The historical and social context of gender dysphoria highlights the evolution from a pathologized perspective to a more human-centered and rights-based approach. Hormone therapy in young people, although presented as an important tool for relief, remains a subject of intense debate due to the uncertainties surrounding its application. Within this dynamic environment, bioethics offers an analytical framework for understanding the tensions and seeking solutions that combine respect for self-determination with the protection of young people's health and well-being (Beauchamp & Childress, 2019).

Ethical and social implications

Hormone therapy for gender dysphoria in young people raises a complex web of ethical and social issues that shape the decision-making process for both the young people themselves and their family and medical environment. At the heart of the debate is the search for a balance between respecting the autonomy of minors, the need to protect them from potential harm, and ensuring social equality and justice (Beauchamp & Childress, 2019).

The ethical basis for decisions about hormone therapy draws on different theories. Utilitarianism argues that treatment is justified if it reduces discomfort and improves quality of life, even if it involves risks (Dhejne et al., 2016). In contrast, the deontological approach focuses on the obligation to respect the autonomy and dignity of the individual, regardless of the outcome (Beauchamp & Childress, 2019). In addition, virtue ethics emphasizes the need for healthcare professionals to exercise practical wisdom, combining scientific knowledge and sensitivity to the individual experiences of young people (Kimberly et al., 2018).

The principle of justice is particularly important, as inequalities in access to care are often observed due to socioeconomic or cultural factors. The ethical consideration, therefore, is not limited to the doctor-patient relationship, but extends to broader social dimensions of equality and protection of vulnerable groups (WPATH, 2011).

The use of hormone therapy in young people raises dilemmas, which are illustrated by real or hypothetical case studies. A common dilemma concerns the ability of adolescents to consent to treatments with long-term effects, given that neuropsychological maturity continues to develop into early adulthood (De Vries et al., 2011). Another critical issue is the possibility of regret: how can we ensure that decisions made at a young age will not lead to psychological distress later in life (Zucker, 2005)?

At the same time, case studies show that families are often divided on whether to support treatment, especially in settings where social attitudes toward transgender individuals remain negative (Budge et al., 2013). Healthcare providers are called upon to manage not only medical data but also the emotional and social pressures surrounding the young person (Kimberly et al., 2018).

Consent and autonomy

Informed consent is a fundamental principle in bioethics, but it becomes particularly complex in the case of minors. On the one hand, young people have the right to actively participate in decisions about their bodies (Diane Chen et al., 2013), on the other hand, parents or guardians retain legal and moral responsibility for their protection. This dichotomy leads to conflicts: who has the final say when the opinions of the young person and the parent clash?

In addition, providers must ensure that information is provided in age-appropriate language, that psychological comprehension abilities are taken into account, and that the young person is encouraged to gradually take responsibility. Thus, informed consent is not treated as a formal procedure, but as ongoing and dynamic communication (Steensma et al., 2013).

Successfully addressing gender dysphoria requires collaboration between a multidisciplinary team (doctors, psychologists, social workers) and the family (Hembree et al., 2017). Healthcare professionals have a duty not only to provide medical care but also to act as mediators, helping parents and young people understand the options and consequences (Turban et al., 2020).

The family, on the other hand, is the primary source of support. Where there is acceptance, young people show improvement in mental health and in their school and social integration. Conversely, lack of support often leads to increased levels of anxiety, depression, and social isolation. This context shows that the bioethical dimension is not limited to abstract principles, but is directly linked to the daily lives and quality of life of young people. (Ryan et al., 2010).

Medical and psychological implications

Hormone therapy for gender dysphoria in young people is the subject of intense scientific and social debate, as it is linked to critical medical and psychological parameters that determine the health and quality of life of those concerned (Hembree et al., 2017). It is crucial to carefully evaluate both the potential benefits and risks to make sure treatment decisions meet the person's needs while protecting their physical and mental integrity (Hembree et al., 2017).

Medical risks and benefits

Puberty blockers (GnRH agonists) are one of the most basic interventions. Their main advantage is their reversibility, as discontinuing them allows biological puberty to resume (De Vries et al., 2011). This gives young people valuable time to explore their gender identity without the stress of permanent physical changes. At the same time, the use of cross-sex hormones (estrogen or testosterone) allows for the development of secondary characteristics that align with gender identity, leading to a significant reduction in distress and an improvement in self-esteem (Olson et al., 2016).

However, these interventions are not without risks. Studies have shown that long-term hormone use can affect bone density, cardiovascular function, and fertility (Hembree et al., 2017). Especially for adolescents, who are still developing, the consequences may be more pronounced and less predictable. At the same time, the lack of long-term studies makes it difficult to fully understand the effects (Cohen-Kettenis & Klink, 2015). Thus, the medical community emphasizes the importance of careful monitoring, multidisciplinary assessment, and informed consent before any intervention (Safer et al., 2016).

Psychological effects

From a psychological perspective, hormone therapy has been associated with significant benefits. Young people who receive timely and appropriate care show a reduction in levels of anxiety, depression, and suicidal ideation (Turban et al., 2020). Physical alignment with gender identity enhances a sense of authenticity and contributes to higher self-esteem (De Vries et al., 2014). In addition, a positive experience of medical intervention can empower young people to manage social challenges, offering psychological resilience (Olson et al., 2016).

At the same time, potential psychological difficulties must also be recognized. Some young people experience ambivalence or fear about the irreversibility of certain changes (De Vries et al., 2011). Social isolation, stigmatization, and lack of family support often exacerbate their psychological state, even when treatment is progressing positively. In this context, the integration of ongoing psychological support is considered essential (American Psychological Association, 2013).

Social perspectives

The psychological experience of young people cannot be examined independently of their social environment. Acceptance by family, school, and community plays a decisive role in mental health and treatment success (Ryan et al., 2010). Research shows that young people living in supportive environments have better outcomes than those who experience rejection or discrimination (Olson et al., 2016).

Similarly, social attitudes influence access to healthcare. In societies with greater acceptance of gender diversity, young people are more likely to receive timely and quality care (WPATH, 2011). Conversely, in environments where stigma prevails, young people may delay or avoid treatment, resulting in worsening mental health (Taylor et al., 2024).

Overall assessment

The analysis shows that the benefits of hormone therapy on mental health and quality of life are significant, provided that it is administered with care and scientific evidence. The medical risks require constant monitoring, while the psychological and social implications necessitate a holistic, interdisciplinary approach that is not limited to the biomedical dimension but embraces the young person as an individual within social networks of relationships (Safer et al., 2016, Hembree et al., 2017).

Recommendations and future directions

The discussion surrounding hormone therapy for gender dysphoria in young people is not limited to medical and psychological issues, but also touches on issues of social acceptance, health policy, and institutional frameworks. The following recommendations aim to improve the quality of care, enhance equal access, and set future directions for research and policy.

International bodies such as WPATH (2011) have emphasized the need for a multidisciplinary approach, where doctors, psychologists, and social workers collaborate to create individualized treatment plans. The basic principles of these guidelines are:

- respect for the *autonomy* of young people,
- provision of *appropriate information* about the benefits and risks of treatment,
- ensuring ongoing *psychological support*, and
- the involvement of the family in decision-making.
- The adoption of clear protocols is crucial in order to reduce uncertainty among providers and protect young people from potential malpractice.

Social acceptance plays an important role in the effectiveness of treatment. Studies show that young people who live in accepting environments have better mental health and higher quality of life (Turban et al., 2020). Conversely, rejection and stigma lead to increased rates of depression and suicidal ideation (Budge et al., 2013).

For this reason, it is recommended that educational programs in schools and communities be strengthened with the aim of raising awareness about gender identity issues and combating prejudice (Dowshenand, 2022). At the same time, the state must ensure that the rights of transgender youth are protected at all institutional levels, from health to education.

Recommendations for providers, parents, and policymakers

Healthcare providers need specialized training to recognize the needs of transgender youth and offer evidence-based services (Kimberly et al., 2018). Lack of appropriate training often leads to delays or fragmented care.

Parents and guardians are a key factor for success: their active support has been shown to significantly reduce levels of psychological distress among young people (De Vries et al., 2014). Therefore, it is recommended that family counseling structures be created so that parents can be informed and empowered in their supportive role.

At the health policy level, institutional frameworks need to be developed to ensure equal access to gender confirmation services, regardless of socioeconomic background or geographic location (Davy et al., 2017).

Future research

Despite the progress that has been made, there are still significant gaps in the evidence. Long-term studies are needed on the effects of hormone therapy on bone health, fertility, and psychological well-being (Dhejne et al., 2016). In addition, research should focus on investigating psychosocial factors, such as the role of social support and school integration, which largely determine the effectiveness of treatment (Haas et al., 2014).

It is equally important to strengthen cross-sectoral collaboration so that research incorporates not only medical but also social and legal dimensions (Fuss et al., 2015). This approach will enable the development of more comprehensive protocols that reflect the complex realities of transgender youth's lives.

Conclusion

The analysis of hormone therapy for minors with gender dysphoria highlighted an area where biomedical, psychological, social and bioethical parameters intersect, making the subject particularly complex and dynamic. The investigation of individual thematic areas has shown that medical care is an integral part of the gender confirmation process, but its success and safety depend a lot on the social context, family support, and institutional protection of young people's rights.

Medical and psychological findings show that the use of puberty blockers and cross-sex hormones can bring substantial benefits to the mental health of adolescents, reducing symptoms of gender dysphoria, limiting depression, and significantly reducing the risk of suicidal ideation. The ability to physically identify with one's experienced gender enhances self-esteem, mental resilience, and social integration, giving young people a sense of authenticity and control over their bodies. However, potential medical complications cannot be overlooked: decreased bone density, effects on fertility, and uncertainty about the long-term consequences of treatment underscore the need for careful clinical monitoring, ongoing evaluation, and strict adherence to international guidelines. The balance between benefits and risks remains a critical element of any decision.

The social dimension proved to be equally decisive. Acceptance by the family and wider social environment is directly related to mental health, school performance, and social cohesion among young people. Adolescents who are supported by their family and school environment show better psychological well-being and reduced rates of depression and anxiety, while rejection, stigmatisation and discrimination lead to increased psychological burden and social exclusion. In this context, the bioethical approach must go beyond simply invoking the principles of autonomy and informed consent, incorporating the principle of justice and ensuring equal access to quality health services, regardless of socioeconomic background or cultural context.

The ethical dilemmas that arise—such as the ability of minors to give valid consent, the possibility of future regret, and conflicts between parents and children—require ongoing dialogue, flexibility, and sensitivity on the part of healthcare professionals. The obligation to provide clear, understandable, and continuously updated information, as well as the gradual empowerment of adolescents in the decision-making process, are key challenges. At the same time, the role of parents as primary sources of support is crucial: where there is acceptance, mental health indicators improve significantly, while a lack of support increases psychological distress.

The overall picture shows that hormone therapy can be safe and beneficial when it's part of a multidisciplinary, personalized, and socially supportive framework. Active family involvement, empowering young people in decision-making, and institutionally enshrining their rights are cornerstones of success. At the same time, there is an urgent need for long-term research on the medical and social consequences of treatment, as well as on the psychosocial factors that determine its effectiveness. Governments and health systems are called upon to adopt practices that promote equality, social inclusion, and acceptance of diversity.

However, beyond purely scientific and clinical data, the issue of hormone therapy in adolescents leads us to deeper reflection on the very nature of bioethics and how society perceives the concept of diversity. Bioethics is not limited to regulating medical practice; it functions as a field of dialogue between science, society, and politics, called upon to transcend the narrow boundaries of medical ethics and defend human dignity, autonomy, and justice. Gender affirmation therapy—and especially hormonal intervention during adolescence—cannot be viewed simply as a medical procedure, but as an existential choice that concerns identity, the body, and the way in which the individual relates to society.

The debate surrounding gender dysphoria in young people also raises the broader question of how we define "normality" and how we treat forms of identity that deviate from it – whether with acceptance or stigmatisation. Bioethics cannot remain neutral, but is called upon to take a clear stand against social exclusion and to defend the rights of all people, regardless of gender or identity. As a bridge between science and society, it can foster a culture of respect, understanding, and solidarity, promoting a framework of care and dialogue that transcends the simplistic "for or against" dilemma of treatment.

Closing, the bioethical dimension of hormone therapy for minors with gender dysphoria doesn't end the discussion, but opens up a broader conversation about what it means to live in a society that honors the freedom, dignity, and diversity of every person. Through the careful coexistence of scientific evidence and respect for human diversity, the conditions for a truly inclusive and just society are created.

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Khader I. Alkhouri*

Bioethical and psychological perspectives on domestic violence

Abstract

Domestic violence poses critical ethical challenges at the intersection of bioethics, psychology, and law. This article analyzes tensions between autonomy and protection in healthcare, justice and due process in legal systems, and cultural competence in trauma-informed interventions. Highlighting global prevalence and severe neuropsychological consequences for survivors and children, it critiques current frameworks like mandatory reporting and Battered Woman Syndrome. The discussion extends to systemic reforms—economic policies, housing security, and primary prevention—while examining the dual role of religious institutions in perpetuating or mitigating abuse. Employing an intersectional lens, the study advocates for evidence-based, multidisciplinary approaches to address domestic violence's structural roots while upholding ethical principles of justice and non-maleficence.

Keywords: Domestic violence, bioethics, trauma-informed care, legal ethics, intersectionality, systemic prevention

Introduction

The pervasive scourge of domestic violence constitutes one of the most egregious violations of fundamental human dignity, presenting a complex ethical dilemma that intersects with core bioethical principles of autonomy, justice, beneficence, and non-maleficence (World Health Organization, 2021). As a global public health crisis that transcends cultural, religious, and socioeconomic boundaries, domestic violence demands rigorous ethical scrutiny of the obligations borne by medical practitioners, legal institutions, and religious authorities in mitigating its devastating consequences (García-Moreno et al., 2015). The ethical complexities inherent in addressing intimate partner violence are manifold, encompassing

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profound tensions between patient confidentiality and mandatory reporting (Campbell, 2002), cultural relativism and universal human rights (Merry, 2006), and individual agency versus societal protection (Stark, 2007).

Contemporary research demonstrates alarming prevalence rates, with approximately one in three women worldwide experiencing physical or sexual violence from an intimate partner (World Health Organization, 2021), while male victims remain significantly underreported due to societal stigma and gender norms (Dutton & White, 2013). The psychological ramifications are equally devastating, with survivors exhibiting markedly higher rates of post-traumatic stress disorder, major depressive disorder, and suicidal ideation compared to the general population (Golding, 1999). Children exposed to domestic violence face particularly dire consequences, including impaired cognitive development, increased aggression, and heightened risk of perpetuating intergenerational cycles of abuse (Kitzmann et al., 2003; Felitti et al., 1998).

From a bioethical perspective, domestic violence presents unique challenges that demand nuanced analysis. Healthcare providers grapple with ethical dilemmas surrounding mandatory reporting laws that may inadvertently deter victims from seeking medical care (Warshaw et al., 2013), while simultaneously confronting the long-term health consequences of abuse, including chronic pain syndromes, traumatic brain injuries, and stress-related pathologies (Coker et al., 2002). Legal systems worldwide struggle to balance punitive justice with rehabilitative approaches (Ellsberg et al., 2015), particularly in cases involving immigrant victims who face potential deportation upon reporting abuse (Menjívar & Salcido, 2002). Religious institutions, meanwhile, confront the ethical imperative to reinterpret traditional doctrines that have historically been weaponized to justify domestic abuse (Nason-Clark et al., 2018; Mir-Hosseini, 2013).

Medical ethics and the clinician's dilemma

The ethical obligations of healthcare providers in cases of domestic violence present a profound professional paradox, requiring careful navigation between respecting patient autonomy and fulfilling the duty to protect vulnerable individuals from harm (Warshaw et al., 2013). This tension manifests most acutely in the context of mandatory reporting laws, which compel medical professionals to disclose suspected abuse to authorities, often against the explicit wishes of competent adult patients (Campbell, 2002). Empirical research demonstrates that such requirements may inadvertently deter victims from seeking critical medical care, as fear of police involvement or retaliation from abusers frequently outweighs perceived benefits of disclosure (Hendy et al., 2003). The ethical principle of non-maleficence thus comes into direct conflict with legal mandates, raising fundamental questions about whether coercive intervention truly serves patients' best interests or merely satisfies institutional liability concerns (Varkey, 2021).

The clinical manifestations of domestic violence further complicate this ethical landscape, as victims frequently present with complex, overlapping physical and psychological trauma that demands integrated, trauma-informed care (Teicher & Samson, 2016). Chronic pain syndromes, traumatic brain injuries, and stress-related somatic disorders often coexist with post-traumatic stress disorder, depression, and substance abuse disorders, creating diagnostic challenges that require clinicians to maintain heightened ethical vigilance (Coker et al., 2002). Economic abuse—a particularly insidious form of coercion that restricts victims' access to financial resources—adds another layer of ethical complexity, as it may prevent patients from following through with recommended treatments or accessing follow-up care (Adams et al., 2008). This reality necessitates that healthcare providers adopt harm reduction strategies that prioritize patient safety while respecting autonomy, such as developing coded communication systems for victims who cannot speak openly about their abuse and ensuring that medical documentation does not inadvertently endanger patients (Iverson et al., 2011).

The pediatric dimension of domestic violence introduces additional ethical imperatives, as children exposed to intimate partner violence exhibit measurable neurobiological changes that can persist into adulthood, including alterations in brain structure and function related to emotion regulation and stress response (Teicher & Samson, 2016). The Adverse Childhood Experiences (ACE) study established a clear dose-response relationship between childhood exposure to domestic violence and later-life health outcomes, including increased risks of ischemic heart disease, cancer, and autoimmune disorders (Felitti et al., 1998). These findings create an ethical mandate for early intervention, yet they must be balanced against the potential iatrogenic harm of removing children from their homes or inadvertently exposing them to further trauma through poorly executed child protection interventions (U.S. Department of Health and Human Services, 2019a). The ethical principle of justice demands that such interventions be implemented equitably across socioeconomic and racial groups, avoiding the well-documented disparities in child welfare reporting and removal rates that disproportionately affect marginalized communities (Sokoloff & Dupont, 2005).

Ultimately, the medical ethical framework for addressing domestic violence must evolve beyond simplistic binary choices between intervention and non-intervention, instead embracing nuanced approaches that recognize the complex psychosocial dynamics of abuse while upholding fundamental bioethical principles. This requires healthcare systems to invest in comprehensive training programs that enhance clinicians' ability to recognize subtle signs of coercion, implement trauma-informed care protocols, and navigate the ethical tensions inherent in balancing patient confidentiality with mandatory reporting requirements (Warshaw et al., 2013). Only through such multidimensional ethical engagement can medical professionals truly fulfill their duty to "first, do no harm" while still protecting the most vulnerable members of society from preventable suffering.

Reconciling protection with due process

The evolution of legal responses to domestic violence presents a complex ethical landscape where the imperative to protect victims must be carefully balanced against fundamental principles of judicial fairness and proportionality (Römkens, 2013a). Modern legal systems globally have increasingly recognized domestic violence as a distinct criminal offense rather than a private family matter, with landmark instruments like the Istanbul Convention establishing comprehensive frameworks for prevention, protection, and prosecution (Council of Europe, 2011). However, the implementation of these legal protections raises profound ethical questions about the appropriate balance between state intervention and personal autonomy, particularly when victims themselves may be ambivalent about involving law enforcement (Schneider, 2000). The criminalization of domestic violence has undeniably provided crucial protections for many survivors, yet critics argue that over-reliance on punitive measures may inadvertently harm the very populations they aim to protect, particularly in marginalized communities where distrust of law enforcement runs deep (Sokoloff & Dupont, 2005). This paradox is especially acute in cases involving immigrant women, where reporting abuse may trigger deportation proceedings or result in loss of child custody, creating ethical dilemmas for legal professionals torn between enforcing immigration laws and protecting vulnerable individuals (Menjívar & Salcido, 2002).

The legal recognition of Battered Woman Syndrome (BWS) as a defense in criminal cases represents another ethically contested frontier, where psychological research intersects with judicial decision-making (Walker, 2009). While this legal doctrine has helped contextualize the actions of abuse survivors who retaliate against their tormentors, it risks pathologizing victims' responses to trauma and reinforcing problematic stereotypes about female passivity (Dutton, 1993). The ethical tensions surrounding BWS are particularly pronounced in cases where cultural factors compound the psychological impact of abuse, as courts struggle to evaluate the reasonableness of a defendant's actions through both psychological and cultural lenses (Sokoloff & Dupont, 2005). Similarly, the growing recognition of male victims of domestic violence challenges long-held legal assumptions about gender and abuse, requiring judicial systems to adapt their frameworks to accommodate victims who don't conform to traditional stereotypes (Dutton & White, 2013). This evolution in legal understanding underscores the ethical imperative for courts to base decisions on empirical evidence rather than societal preconceptions, while remaining sensitive to the gendered power dynamics that still characterize most domestic violence cases (Johnson, 2008).

Alternative dispute resolution mechanisms like religious arbitration tribunals present additional ethical quandaries for legal systems grappling with domestic violence (Bano, 2012). In multicultural societies, some communities have established parallel justice systems to handle marital disputes according to religious principles, raising concerns about whether these forums adequately protect victims' rights (Fournier, 2010). Studies of Sharia councils in the UK, for instance, reveal complex dynamics where women may voluntarily seek religious divorces but face pressure to reconcile with abusive partners or accept unequal settlements (Bano, 2012). The ethical challenge for secular legal systems lies in determining when to respect religious autonomy and when to intervene to prevent rights violations, particularly when victims themselves may view religious arbitration as more legitimate than state courts (Grillo, 2015). This tension reflects broader debates about legal pluralism in multicultural societies, where the desire to accommodate minority traditions must be balanced against the state's obligation to protect all citizens equally (Malik, 2012).

Emerging restorative justice approaches to domestic violence offer potential middle ground between punitive and permissive extremes, though they too raise significant ethical concerns (Voith et al., 2020). Proponents argue that victim-offender mediation programs, when carefully structured, can empower survivors and encourage genuine accountability from perpetrators. However, critics warn that these approaches may trivialize the seriousness of domestic violence and place undue pressure on victims to reconcile with their abusers (Stark, 2007). The ethical implementation of restorative justice in domestic violence cases requires rigorous safeguards, including thorough risk assessments, victim advocates, and judicial oversight to prevent coercion or retaliation (Ellsberg et al., 2015). Ultimately, the legal response to domestic violence must navigate these complex ethical waters by developing nuanced, evidence-based approaches that prioritize victim safety while respecting due process rights and cultural diversity - a challenge that continues to evolve as our understanding of intimate partner violence deepens (Römkens, 2013b).

Ethical considerations in treatment paradigms

The psychological dimensions of domestic violence present profound ethical challenges for mental health professionals, requiring careful navigation between therapeutic objectives and fundamental principles of patient welfare (Warshaw et al., 2013). Trauma-informed care has emerged as the dominant ethical framework for addressing the complex psychological sequelae of domestic violence, which frequently include post-traumatic stress disorder, complex trauma responses, and attachment disruptions that demand specialized clinical approaches (Herman, 2015). The ethical imperative to "do no harm" takes on particular significance in this context, as conventional therapeutic techniques may inadvertently retraumatize survivors if applied without proper understanding of trauma's neurobiological impacts (Teicher & Samson, 2016). Research demonstrates that prolonged exposure to intimate partner violence can lead to measurable alterations in brain structure and function, particularly in regions governing emotional regulation and threat perception, necessitating treatment modalities that account for these physiological changes (Teicher & Samson, 2016). The Adverse Childhood Experiences (ACE) study further established the dose-dependent relationship between childhood exposure to domestic violence and later-life mental health outcomes, creating an ethical mandate for early intervention while simultaneously raising concerns about the potential stigmatization of at-risk youth (Felitti et al., 1998).

The treatment of perpetrators introduces additional ethical complexities, as mental health professionals must balance therapeutic goals with public safety considerations (Dutton & White, 2013). Traditional batterer intervention programs have faced criticism for their high attrition rates and limited efficacy, prompting ethical debates about whether rehabilitation or containment should constitute the primary objective (Gondolf & Fisher, 1988). Emerging neuropsychological research suggests that many perpetrators exhibit distinct cognitive and affective processing patterns, including deficits in emotional regulation and empathy, which may require more targeted therapeutic approaches than conventional anger management programs provide (Jakupcak et al., 2002). However, the ethical implications of biological explanations for abusive behavior remain contentious, with some scholars warning against medicalizing violence in ways that diminish personal accountability (Dutton, 1993). This tension is particularly acute in cases involving substance abuse comorbidities, where the interplay between addiction and violence creates complex causation dilemmas that challenge traditional notions of moral responsibility (Foran & O'Leary, 2008). Mental health professionals working with perpetrators must therefore navigate delicate ethical terrain, acknowledging potential neuropsychological factors while maintaining clear boundaries against excuse-making or minimization of harmful behaviors (Dutton & White, 2013).

The psychological impact on children exposed to domestic violence presents particularly urgent ethical considerations, given the well-documented risks of intergenerational trauma transmission (Kitzmann et al., 2003). Developmental research demonstrates that even very young children exhibit measurable stress responses to parental conflict, with potential long-term consequences for emotional regulation, academic achievement, and future relationship patterns (Huth-Bocks et al., 2001). Ethical practice in this domain requires clinicians to balance family preservation ideals against child protection imperatives, particularly in cases where parents may be both victims and enablers of the abusive environment (U.S. Department of Health and Human Services, 2019b). The growing recognition of children's trauma symptoms has led to innovative therapeutic approaches like trauma-focused cognitive behavioral therapy, which must be implemented with careful attention to cultural factors and family dynamics to avoid inadvertently exacerbating existing tensions (Letourneau et al., 2007). The ethical challenges intensify when dealing with adolescent perpetrators of child-to-parent violence, where clinicians must distinguish between normative developmental conflicts and genuine abuse patterns while avoiding pathologization of typical family friction (Cottrell, 2001; Condry & Miles, 2014).

Cultural competence represents another critical ethical dimension in psychological interventions for domestic violence, as therapeutic approaches developed in Western contexts may prove ineffective or even harmful when applied cross-culturally (Sokoloff & Dupont, 2005). Research indicates that victims from collectivist cultures frequently prioritize family harmony over individual safety, requiring therapists to adapt conventional empowerment models to accommodate these value differences (Yoshihama, 1999). The ethical delivery of mental health services in diverse communities demands nuanced understanding of cultural explanatory models for distress, appropriate help-seeking pathways, and culturally-specific coping mechanisms (Pan et al., 2006). This challenge is particularly acute when working with refugee populations, where pre-migration trauma, acculturative stress, and post-migration instability can compound the psychological impacts of domestic violence (Raj & Silverman, 2002). Mental health professionals must therefore cultivate both cultural humility and trauma expertise to provide ethically sound care that respects survivors' worldviews while addressing the universal need for safety and healing (Warshaw et al., 2013). The integration of traditional healing practices with evidence-based psychotherapy offers promising avenues for culturally-grounded intervention, though such approaches require careful ethical scrutiny to ensure they don't inadvertently reinforce patriarchal norms or excuse abusive behaviors (Abugideiri & Alwani, 2003). Ultimately, the ethical practice of psychology in domestic violence contexts demands constant self-reflection, cultural attunement, and commitment to evidence-based practice that prioritizes survivor autonomy while recognizing the complex systemic factors that perpetuate intimate partner violence (Warshaw et al., 2013).

Sociostructural interventions and systemic prevention

The persistent prevalence of domestic violence across global societies underscores the ethical necessity for comprehensive sociostructural interventions that address root causes rather than merely managing symptoms (Heise, 1998). Ecological models of violence prevention emphasize the multilevel nature of risk factors, ranging from individual psychological traits to broader societal norms that tacitly condone gender-based violence, requiring equally multifaceted ethical responses (García-Moreno et al., 2015). At the macroeconomic level, research consistently demonstrates the correlation between gender wage gaps, employment discrimination, and increased vulnerability to domestic violence, establishing an ethical imperative for policymakers to implement structural economic reforms that enhance women's financial autonomy (Adams et al., 2013). The insidious nature of economic abuse - wherein perpetrators systematically control victims' access to financial resources - highlights how macroeconomic policies intersect with intimate partner violence, demanding ethical consideration of how tax structures, social welfare programs, and employment laws either mitigate or exacerbate this form of coercion (Adams et al., 2008). Housing insecurity represents another critical structural determinant, with studies showing that lack of affordable shelter options constitutes the primary reason many victims remain in or return to abusive relationships, creating an ethical mandate for governments to prioritize domestic violence victims in social housing allocations (Willie et al., 2024). These systemic barriers disproportionately affect marginalized populations, including racial minorities, immigrants, and people with disabilities, necessitating an intersectional ethical framework that acknowledges how overlapping systems of oppression compound vulnerability to domestic violence (Sokoloff & Dupont, 2005).

Educational systems bear particular ethical responsibility for primary prevention, with compelling evidence that school-based programs challenging gender stereotypes and promoting healthy relationships can significantly reduce subsequent intimate partner violence. The ethical justification for mandatory prevention education rests on the public health principle of population-level intervention, though implementation must respect parental autonomy while avoiding cultural insensitivity (Ellsberg et al., 2015). Professional education similarly requires ethical scrutiny, as gaps in domestic violence training across medical, legal, and social service disciplines perpetuate systemic failures to identify and respond effectively to abuse (Warshaw et al., 2013). Accreditation bodies face ethical questions about whether to mandate domestic violence competency standards, balancing professional autonomy against the demonstrated consequences of inadequate training (Campbell, 2002). The workplace represents another crucial intervention point, with growing recognition of employers' ethical obligations to implement domestic violence policies that protect both victim-employees and workplace safety, while navigating complex privacy concerns (Swanberg et al., 2005). This includes developing protocols for accommodating victims' needs without inadvertently enabling discrimination or violating confidentiality, illustrating how organizational ethics intersect with violence prevention (Swanberg et al., 2005).

Faith institutions occupy a uniquely influential position in many communities, presenting both ethical challenges and opportunities in addressing domestic violence (Nason-Clark et al., 2018). While some religious doctrines have historically been interpreted to justify male dominance and wifely submission, progressive faith leaders are increasingly leveraging religious authority to challenge abusive interpretations and promote gender equity (Istratii & Ali, 2023). The ethical transformation of religious institutions requires delicate navigation of theological traditions while upholding universal human rights principles, avoiding both cultural imperialism and moral relativism (Abugideiri & Alwani, 2003). Interfaith initiatives like the SASA! Faith program demonstrate how religious communities can become powerful allies in prevention efforts when interventions respect spiritual frameworks while challenging harmful norms (Raising Voices, 2016). This work highlights the ethical imperative for secular agencies to collaborate respectfully with faith leaders while maintaining clear boundaries against faith-based justification for abuse (Nason-Clark et al., 2018). Ultimately, the ethical response to domestic violence demands coordinated action across all societal institutions, recognizing that isolated interventions will remain inadequate against a problem so deeply embedded in our social fabric (Heise, 1998). This systemic approach must be guided by an intersectional feminist ethic that centers the most marginalized voices while holding all social institutions accountable for their role in either perpetuating or preventing intimate partner violence (Crenshaw, 1991).

Research Results

This study reveals that domestic violence generates profound ethical dilemmas across medical, legal, and psychological domains. Healthcare providers face critical tensions between patient autonomy and mandatory reporting, with evidence indicating that coercive interventions may deter victims from seeking care. Legal systems struggle to balance punitive justice with rehabilitative approaches, particularly in cases involving marginalized populations, where structural barriers exacerbate vulnerability. Psychological findings demonstrate severe neurobiological impacts, including altered stress responses and intergenerational trauma transmission, necessitating trauma-informed care models. Additionally, sociostructural factors—such as economic abuse and housing insecurity—perpetuate cycles of violence, underscoring the need for systemic reforms.

The research further highlights disparities in institutional responses, with marginalized groups experiencing disproportionate harm due to cultural insensitivity and systemic bias. Faith-based interventions present both risks and opportunities, as religious doctrines may either justify abuse or foster community-based support. Restorative justice models show promise but require stringent safeguards to prevent victim retraumatization. Ultimately, the findings advocate for an intersectional, ecological framework that integrates bioethical principles with structural prevention strategies, emphasizing coordinated policy reforms, professional training, and culturally adapted interventions to address domestic violence's multifaceted nature.

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Miltiadis Vantsos*

Is the living donor harmed or benefited? A key question for the ethical consideration of organ transplantation

Abstract

The ethical question of whether the living donor is harmed or benefited lies at the heart of the moral evaluation of organ transplantation. Living organ donation, limited mainly to kidneys and parts of the liver, poses a moral dilemma, since it involves an act that may endanger the donor's health for the sake of another's survival. Two main perspectives emerge. The first argues that the living donor is harmed, as organ removal contradicts the principles of medical ethics and justice, turning the donor into the only person who suffers within the transplant process. Financial compensation has been proposed to address this injustice; however, such measures risk commodifying the human body and violating human dignity. The opposing view claims that the donor benefits, not only when acting freely and autonomously but also when benefit is conceived in psychosocial and spiritual terms. Emotional satisfaction, social recognition, and the strengthened human relationships can outweigh physical harm. From the standpoint of Christian bioethics, the benefit is primarily spiritual: organ donation is an act of selfless love that fulfills Christ's commandment to love one's neighbor as oneself, granting the donor a higher moral and spiritual reward. Thus, while organ donation entails bodily risk, it simultaneously offers the opportunity for moral and spiritual growth, transforming personal sacrifice into a manifestation of divine love and solidarity to the fellow human beings.

Keywords: Organ transplantation, living donor, medical ethics, Christian bioethics, selfless love

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The significance of organ donation from a living donor

Organ donation for transplantation from a living donor is a limited form of donation, as it involves donating either one kidney or a part of the liver. While a deceased donor can donate all their organs without being deprived of anything they need, a living donor can only offer one organ, which puts their own health at risk. Therefore, in previous decades, medicine and society rightly focused on promoting post-mortem organ donation, assigning a secondary and complementary role to living organ donation. However, this approach has been revised over the last decade for two main reasons. Firstly, there is a severe shortage of organs for transplantation as post-mortem donation does not meet demand. Secondly, it has been found that the greatest need is for kidneys, which can also be provided by living donors. This shift in focus is reflected in bioethics engaging more systematically with this specific form of donation, and in changes to transplant policy and legislation in most Western countries. While the issue of brain death previously dominated bioethical debate, today, all forms of transplantation and their implications are systematically examined. Relevant legislation is also being updated to favour an increase in organ donation from living donors. This allows donation to blood relatives up to the fourth degree and to individuals with a personal relationship and emotional connection to the prospective recipient. It also enables new forms of organ donation to be implemented, such as crossover donation[1].

These legislative provisions aim to help modern societies address the urgent problem of organ shortages, which result in patients' health deteriorating and ultimately causing their death. At the same time, they protect potential donors from undue and unethical pressure, ensuring that the transplant process is not subject to the instrumentalisation or commercialisation of human life. While this issue is important, this study does not seek to evaluate

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[1] These provisions are also included in Greek Law 3984/2011 on organ donation and transplantation (available at: https://www.e-nomothesia.gr/kat-ygeia/n-3984-2011.html). For an analysis, see A. Varka-Adam, (2014). Innovations of Law 3984/2011 on organ donation and subsequent reversals. In M. Kanellopoulou-Boti and F. Panagopoulou-Koutnatzi (Eds.), *Bioethical considerations* (pp. 271–301, especially pp. 274–278). Athens: [Papazisis]. See also M. Anastasiadou, (2012). Transplantation from a living donor. In M. Kaiafa-Gbandi, H. Sourti, K. Fountedaki, & K. Hatzikosta (Eds.), *Current issues in medical law* (pp. 88–89).

the changes that have taken place, nor to investigate their ethical correctness or effectiveness. Our focus is on answering the question posed in the title, namely whether the living donor is harmed or benefited. The answer to this question is crucial for the ethical evaluation of organ donation. If we consider that the living donor is benefited, then donation is not only morally acceptable, but also a commendable act that society should promote and encourage. Conversely, if we conclude that the donor is harmed by the donation, we must reflect on and potentially reconsider the ethical dimension, since one person's health benefit is based on harm to another person. We will now examine the two opposing views before concluding with the Christian bioethical approach.

The view that the living donor is harmed

According to this view, organ donation harms living donors and is therefore not morally acceptable in all circumstances. Two main arguments are put forward in support of this view. First, organ donation violates medical ethics. Second, it raises questions of fairness for those involved in the transplant process.

The first argument questions the morality of donation from a living donor because it appears to contradict the fundamental principle of medical ethics, according to which every medical act must aim to heal, improve health, or relieve the patient's pain. Not only does organ removal fail to cure any disease or improve the donor's condition, it also violates their physical integrity and endangers their health (Glannon, 2008). While the intention of those involved is undoubtedly good — the organ is removed for the purpose of transplanting it to someone else who is suffering — the deliberate deterioration of the donor's health is not in line with medical ethics. After all, the donor arrives at the doctor's office healthy, but leaves in a worse condition due to the successful medical procedure. They do not literally become ill, but their body now has only one kidney and is therefore more vulnerable to related diseases. According to Norman Levinsky, even if the operation is beneficial to society, the doctor must act with the sole criterion of the patient's benefit, in the same way that a lawyer acts in the interest of their client (Levinsky, 1984).

The second argument highlights that everyone involved in the organ transplant process benefits except the donor, who is harmed despite making the transplant possible. The recipient benefits greatly from the donation because they receive the organ, which relieves them of painful dialysis, reduces their risk of death, and dramatically improves their quality of life. Doctors who perform the surgical procedures to remove and transplant the organ benefit because they are paid for these procedures, as are nursing and paramedical staff. The health system and insurance funds benefit significantly from the financial perspective, as the cost of transplantation is much lower than the cost of dialysis. The same applies to society in general, as the transplant recipient can quickly return to work and continue contributing to it. Therefore, while everyone involved in the transplant process benefits greatly, the donor bears a physical burden: undergoing surgery, losing a kidney and facing health risks. According to proponents of this view, this is considered a clear injustice to the donor and undermines the moral justification of donation because it appears to contradict the principle of justice, one of the four widely accepted principles of bioethics. However, it also deters people from donating organs and consequently fails to address the problem of transplant shortages. Potential donors are discouraged when they suffer personal loss while everyone else benefits (Erin & Harris, 2003).

The first argument highlights the moral dilemma of the doctor's responsibility towards the healthy donor. The counterargument to this is that in the case of organ transplantation, there is no normal doctor-patient relationship. Instead, there is a special relationship between three people, including the donor, who freely decides to donate their organ for the treatment of the patient after being fully informed. The second argument highlights society's responsibility towards the donor. It is not the morality of donation that is questioned, but the fairness of the transplant process, since the donor is presented as the only person who suffers as a result. However, the above approach does not aim to abolish it, a prospect that would dramatically worsen the already un-favourable reality of organ shortage, but to revise it in a way that also benefits the donor. To this end, it is suggested that the donor be granted financial compensation in recognition of the inconvenience suffered, the risk to his health and his contribution to the patient's treatment. The amount is not precisely determined, but it is considered that it should not be limited to compensation for the costs incurred for preoperative examinations, care, medication and post-operative checks, but should exceed these costs so as to constitute a sufficient financial benefit. The significance of this remuneration is manifold, as it is an expression of gratitude and appreciation for the recipient, recognition of the donor's contribution, a motivation for the prospective donor that will reinforce their desire to help their fellow human beings, while for the ethics of trans-plantation it constitutes an act of justice, which removes the injustice against the donor (Hippen, 2009; Christen et al., 2010).

Regardless of how one evaluates donation from a living donor, we believe that the above proposal is highly problematic. It is practically very difficult, if not impossible, to distinguish between financial remuneration that motivates the prospective donor and the trafficking of human organs. When a donor is offered money for donating a kidney for transplantation, it constitutes the sale of the organ, as the donor is doing so in order to receive the promised sum (Riedel, 2006; Achilles, 2004). Covering the donor's expenses is unreservedly morally acceptable, as it merely mitigates negative consequences without creating an incentive to donate. However, when financial compensation is provided to motivate someone to donate an organ, selflessness, charity, and solidarity are set aside. This inevitably turns the donation into a financial transaction, turning the donor into a seller, the recipient into a buyer, the organ into a commodity, and the personal relationship into a commercial agreement. The commercialisation of human organs is not morally acceptable because it undermines the dignity of human beings, who should be treated as ends in themselves, not as means to an end. Furthermore, it encourages injustice and exploitation at the expense of the poor, which is why it is prohibited by law worldwide, with Iran being the sole exception. Moreover, it is doubtful that it would lead to an increase in transplants, as any commercialisation of the organ supply is estimated to lead to a significant reduction in donations. Nevertheless, the potential impact of accepting organ sales on the number of organs available for transplantation is secondary when the human body is treated as a commodity subject to market forces. For this reason, we believe that financial compensation for donors should be rejected, and the almost universal consensus against organ trading should be preserved (Vantsos & Nikolousis, 2016).

The view that the living donor benefits

The view that donation is beneficial to the living donor is supported by two main arguments, which also differ from each other, as they are based on different ethical principles. According to the first argument, organ donation benefits the donor when it is an expression of their free will and autonomy. According to the second, the donor benefits when the benefit is not understood exclusively in its medical dimension, but also includes social and spiritual dimensions.

The first argument is based on the principles of autonomy and beneficence, which are two fundamental principles of bioethics. The donor benefits from the donation when they freely and responsibly decide to go ahead with it, even if it is detrimental to their health from a medical point of view, after being informed of all the facts. More generally, two adults reach an agreement to perform an act in full freedom and with full knowledge of the procedure and its possible consequences when they both assess it as beneficial. As perceptions of what is beneficial and what is harmful often differ, it is necessary for these to be defined by the person concerned and not by the doctor or society (Munson, 2007). Just as it is considered ethically correct for a doctor not to perform surgery on a patient without their consent, even when it is known that not doing so will harm their health, so too is it considered correct to perform the surgery that the patient desires, even when it harms their health (Harris, 1992). Furthermore, if patient autonomy is undervalued and the view that avoiding any harm to health takes precedence prevails, we must reject not only organ donation from living donors, but also two widely accepted medical practices, such as blood donation and voluntary participation in medical experiments, because both of these practices may result in some health risks (Ach et al., 2000).

In our opinion, this argument is not convincing; the autonomy of the patient is undoubtedly a necessary condition for the acceptance of organ donation, but it is not sufficient for a medical procedure to be considered legitimate and beneficial in the absence of other criteria. Moreover, if free will alone were sufficient, doctors would be obliged to accept any wish to donate, for example, not only a kidney, but also one's heart, to a loved one, which would result in the death of the willing donor. Furthermore, such a view would lead to the acceptance of organ trafficking for transplantation. The fact that modern medicine requires patient consent for treatment does not mean that doctors must do whatever their patients ask. Doctors are people with moral consciences who bear responsibility for their profession. Modern bioethics applies not only the principle of autonomy but also the principle of non-maleficence, which is emphasised in the Hippocratic Oath and has remained a powerful force in medical ethics throughout the ages. This principle applies to both blood donation and to participation in medical experiments, which are only carried out on persons who meet specific criteria in a manner that ensures their health (Vantsos & Nikolousis, 2016).

The second argument states that organ donation does not conflict with medical ethics if the benefits to the donor outweigh the potential harm to their health. From a purely medical point of view, the donor obviously experiences only harm from organ donation. However, the benefits to the individual are not limited to physical well-being, as they are a person with a social and spiritual life too (Spital, 2004). Curing a person of a painful disease and improving their quality of life fills their loved ones with joy and makes living with them more pleasant. Therefore, the strong emotional bond and social relationship allow the experience of another's treatment to be perceived as a personal benefit. When the treatment involves donating an organ to a loved one, the donor's joy can be indescribable, and the benefit immeasurable. A parent who donates a kidney to their child, freeing them from the dangers of illness and enabling them to enjoy a better quality of life, will usually consider themselves to have benefited from the donation, identifying their child's benefit with their own. Organ donation is also important from a psychological point of view, as it strengthens the donor's self-esteem. Believing that they have done the right thing and helped their loved one at a critical time in their life can create feelings of moral satisfaction, euphoria and elation. These feelings are reinforced by the recipient's gratitude and social recognition of the donation (Vantsos & Nikolousis, 2016).

The assessment that the donor benefits emotionally and socially is supported by survey results from living donors. More than 90% of these donors state that they do not regret their donation and would gladly do it again (Fehrman-Ekholm, 2000; Lorentzen & Paterson, 1994; Valapour et al., 2011). Even when the transplant does not go well due to the recipient's body rejecting the donated organ, the donation is not viewed negatively as donors derive moral satisfaction from knowing they did everything possible to help their loved one. Donors express a similar attitude even when they themselves face health problems that could probably have been avoided if they had not donated. This positive attitude strongly indicates that donors experience organ donation as an act that benefits them emotionally and socially (Ingelfinger, 2005).

The view that the benefits to the donor outweigh the damage to their health was also the basis for the acceptance of organ donation in a 1957 court ruling in Boston, at a time when transplantation was still in its infancy. Seventeen-year-old Leonard Marsden was eager to donate a kidney to his twin brother Leon, whose life was in danger. However, doctors were reluctant to perform the operation as it would harm Leonard's health. The twins' parents took the case to court, requesting that the donation be permitted. The court accepted the request, ruling that Leon's death would cause his brother great distress and harm his well-being. Conversely, the treatment would benefit Leonard more than the loss of a kidney (Munson, 2007; Vantsos & Nikolousis, 2016). We find this argument personally convincing since human beings are not limited to their bodies, but are psychosomatic entities and social beings by nature. For this reason, the assessment of the donor's benefit or harm should not be based solely on biological and medical criteria, but should also take into account their interpersonal relationships, emotions, and social life. In conclusion, we present the Christian bioethical perspective, which further reinforces this argument by highlighting the importance of donation for spiritual life.

The Christian bioethical perspective

In Christian ethics, human benefit is primarily spiritual. While physical health, emotional balance, psychological well-being and social recognition are valuable aspects of life, the primary focus is on the spiritual life of humanity, which transcends this life and extends into eternity. In this context, organ donation is a praiseworthy and pious act if it is carried out with selfless love for one's fellow human beings. By undergoing the hardship of organ removal and putting their health at risk, donors fulfil Christ's commandment to love their neighbour as themselves (Matthew 22:39). When the donor loves his neighbour as himself, he does not distinguish between his own benefit and that of his neighbour, since his own benefit consists in loving and caring for his neighbour. As St John Chrysostom observes, 'For thus you will find your own interest if you seek that of your neighbour'. Therefore, when you are reluctant to care for your brother, put yourself in his place and consider his circumstances. For it is enough to be persuaded by what has been said, that otherwise it is not in our interest to find it' (John Chrysostom, PG 61, 210). According to the Father, the connection between personal benefit and the benefit of one's neighbour is a measure of God's wisdom in strengthening the loving relationship between people (Vantsos & Nikolousis, 2016)[1].

The selflessness of organ donation as an act of love is not incompatible with the emotional, psychological and social benefits to the donor. It is only natural for a donor to feel joy and satis-

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[1] "For otherwise people would not seek the things of their neighbour, unless they were compelled to do so by necessity, God has thus joined them together, and does not allow them to come to their own interests first, lest they be led astray by the interests of others." John Chrysostom, *Commentary on 1 Corinthians* (Discourse 5), in *Patrologia Graeca*, vol. 61, col. 211 (J.-P. Migne, Ed.).

faction when helping to restore the health of a loved one, thereby strengthening their relationship. It is also only human to expect gratitude from the person they have helped. When Christ healed ten lepers and only one returned to thank him, he asked where the other nine were (Luke 17:17–18), as gratitude would naturally follow their healing. Expecting gratitude is reasonable and natural, but it does not negate the selfless nature of the act when the motive of the giver is love rather than reciprocity on the part of the recipient. As a rule, this love is met with gratitude by the beneficiary, but in any case, it attracts God's favour and grace. As St. John Chrysostom observes, when the reward does not come from the beneficiary, God Himself becomes the debtor (John Chrysostom, *PG* 62, 304).

However, the spiritual benefits of organ donation extend beyond the donor to include the recipient and society as a whole. The bioethical considerations examined in the context of this study concern the donor exclusively, since it is obvious that the recipient benefits in health terms, the doctor in financial terms, and society in financial terms. As the Church of Greece's position on transplants aptly points out, the recipient benefits not only biologically, but also spiritually, as he or she becomes the blessed recipient of the love of fellow human beings and the grace of God (Holy Synod of the Church of Greece, 2007). Society also benefits spiritually since, as a means of transmitting life, organ donation provides an 'opportunity to transfer spiritual values' (Holy Synod of the Church of Greece, 2007). In a society dominated by selfishness and the pursuit of individual interests in material and economic terms, the selflessness of organ donation to someone in need sends a message that re-evaluates the value of life and highlights the importance of a moral and spiritual existence for modern humans.

From the above, it is clear that, from the perspective of Christian ethics, the answer to the question posed in the title is that the donor benefits spiritually when they offer to their fellow man with love and selflessness. In fact, the donor's benefit is greater than that of the recipient and society, since according to the Church of Greece text, "'The recipient receives parts from a mortal body; the donor gives from his/her immortal soul. The spiritual benefit of the donor is greater than the biological gain of the recipient to the same extent as the soull is superior to the body. 'It is more blessed to give than to receive' (Acts 20:35)" (Holy Synod of the Church of Greece, 2007).

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Part V

Clinical practice, reproductive genetics and the oversight of research

Olinda Timms*

Bioethical challenges encountered in healthcare settings in India - An overview

Abstract

In a complex, diverse and populous country like India, bioethical challenges are encountered in almost every aspect of healthcare; from determinants of health to healthcare access, training and clinical research. Insufficient planning and response to national healthcare needs have led to a distorted reality where best in class professionals provide cutting edge medical care at high end private hospitals; but a large percentage of the population do not have access to even basic healthcare. Rising healthcare costs, commercialization, and inadequate public health services have deprived large segments of timely care of reasonable quality. Clinical trials in a setting of diminished healthcare security leads to the possibility of exploitation and unfair incentives to participate. A rights-based approach to healthcare is needed, with sensitization of health cadres to the need for respectful, compassionate care, and advocacy on behalf of marginalized vulnerable groups. A possible solution is comprehensive inclusive public health planning, with adequate budget to support resources and personnel; to fund timely access to medical care when required. As healthcare needs impacts every citizen of every age, addressing these bioethical concerns should be prioritized at every level.
Keywords: Healthcare, bioethics, equitable access, clinical research, public health

Introduction

Given the scale and complexity of India's healthcare landscape and the fragmented data available, it is a formidable task

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to fully capture the complete scope and nature of bioethical challenges encountered across urban, rural, remote, private-owned, and Government-run health settings; the picture is incomplete at best, non-uniform and contextual, mostly derived from narratives, reports and journal articles not directly focused on bioethical dilemmas. Towards a better understanding, clinicians practicing in diverse settings were invited to a session 'Contemporary Bioethical Practices' conducted at the International Academic Conference "Insights into Bioethics in an Indian Context" held in May 2025 at Navi Mumbai, India. Experiences were shared at a more granular level; both at regional and institution settings. Bioethical issues were described as they were practically encountered, highlighting gaps in perception and practice, and suggestions to enhance ethical practice in hospitals.

In general, Bioethical concerns in healthcare tend to be articulated in relation to areas like human research, IVF-ET, blood transfusion, vaccines, organ transplantation and prenatal testing. These extremely complex, biotechnology-driven areas of healthcare are often governed by laws in this country; NACO guidelines for HIV testing, Pre-conception and Pre-Natal Diagnostic Testing Act, Transplantation of Human Organs Act, Assistive Reproduction Technology Act, and others. Even so, there are ethical concerns related to each of these areas that may not be addressed merely by legal guidance. When it comes to ensuring ethical standards in healthcare and clinical practice, whether in institutions or public health settings, it is individual practitioners and specific policies that will determine the extent to which patients are ethically treated, protected, and respected (Dehkordi et al., 2024). Health professionals and health administrators, health institutions and public health officials, need to introspect, evaluate and explore how best to ensure ethical practices every level, conscious of the vulnerability and trust of patients, providing patients a forum for their needs and expectations in healthcare settings.

The reason is that bioethical challenges are not just encountered in the areas of new medical technologies, research and testing. Even in day-to-day healthcare patient encounters, it is necessary to ensure the basic principles of medical ethics are upheld, in the best interest of the patient and good clinical practice. How can basic ethical codes and values be translated into policies, best practice guidelines and better patient experience? How do we ensure, for example, that patients are treated with respect? That they do not encounter discrimination, alienation, stigma, difficulties and delays that we ourselves would not tolerate? Is their consent truly informed and 'understood' consent, and do we genuinely respect their personal choice regarding medical treatment and options? Are they truly free to consent or refuse, or are patients coerced or paternalistically nudged into decisions; ostensibly for their own good? These are some responsibilities that fall squarely on the shoulders of health professionals; as health leaders in this country we determine, based on our policies and practice, just how bioethical concerns are addressed, and how bioethical principles become practice, in healthcare settings (Subramanian et al., 2016). There is need to be conscious of conflict-of-interest situations that many health professionals, experience in the workplace. When medical professionals work in non-clinical institutions like insurance companies, health planning, research institutes, or pharmaceutical companies, the need to protect patient's interests and uphold the codes of conduct is critical. We will explore in this article, some areas in practice where bioethical challenges are often encountered in the working environment, through the lens of the medical or health professional, and how they impact patient care and experience.

Autonomy and consent

Respect for patients autonomy is a central tenet in doctor patient relationship, that allows patients to choose based on their individual, family and cultural preferences, and express their concerns. This is not only a challenge because it requires good communication skills on the part of the doctor, as well as time and patience to dialogue, there are significant barriers to autonomy in low and middle income countries (LMIC) like India that can impede this process (Jacob, 2014). For a large part of the population there is a severe power imbalance at the health provider interphase, during to illiteracy, cultural and language barriers, financial strain, and limited options. Such patients are not empowered to claim their rights, express preferences, or refuse care based on their dependent social position; and instead concede to paternalist decisions and care (Sareen & Dutt, 2019). Doctors need to be sensitive to such situations in which patients have limited agency, and can easily be exploited. In such situations there can also be misunderstanding and resentment; with little recourse to remedy or justice. It is a challenge to ensure that patients and their decisions are respected in multicultural, plural communities, overcoming ingrained prejudices and systemic inequalities, with the best interest of the patient in mind (Nandimath, 2009).

As opposed to the idea of individual autonomy described and promoted in the West, decision making in India often tends to involve families, and sometimes even communities. In this kind of relational autonomy family members may decide/consent for the patient based on relationships (spouse) or family finances, and collective interest of both the family and the patient (Espinoza & Cabieses, 2013). This may present a challenge for the health professional, particularly when there is a requirement for confidentiality; in adolescents, women, reproductive issues, sexually transmitted diseases and those like HIV, tuberculosis and leprosy that carry severe stigma and social ostracism (Mathiharan, 2014). How do we recognize and respect vulnerable patients, anticipate their needs, and protect them from unfair practices or exclusion? The health professional may have to carefully navigate the sensitive legal, ethical and cultural minefield, negotiating with the family in order to protect the patient; even advocating for care needed by the patient, when the family refuses it. At other times ensuring the patient's confidentiality is protected, even while respecting the choice of the family. In a rushed and crowded out-patient, sensitive information could unwittingly be shared with relatives who are not the next-of-kin, placing the patient in peril. These are complex socio-cultural nuances to our ethical practice and understanding of autonomy; health professional should be conscious of spaces where respect and consent could be at risk (Mukherjee, 2025).

Another socio-cultural barrier to autonomy that emerges in LMIC countries is the ability of the patient to advocate for themselves and give truly free and informed consent for procedures and surgeries. Due to the different levels in literacy and education, the implications of the procedure and consent may not be obvious to the patient, and consent may be given based on trust. For medical interventions, a basic level of health literacy is required, to understand the limitations and potential of the procedure or test, as well as risks; to evaluate and decide based on reasonable understanding before giving consent (Khan, 2014). This is a great concern to health professionals who may not always have enough time, or language, to access patient’s comprehension of benefits and risks, and if the consent is based on what the patient truly believes is best for him/her in the circumstances. In practical terms, it may be impossible to bridge this gap in understanding of medical science and its limitations, and doctors clinical capacity, to ensure the patient fully understands and gives consent based on that understanding. This is routine bioethical challenge faced practically by health professionals in daily encounters with patients (Banait et al., 2022). This could even extend to clinical research where there could be therapeutic misconception; leading to the need for greater protection of participants until there is a higher level of health literacy and research literacy. Health professionals are forced into a paternalistic role that may not always be comfortable (Gopichandran et al., 2025).

The need for attention to patient autonomy extends beyond consent for treatment and surgery, to end of life decisions, Do-Not-Resuscitate orders and In-vitro fertilization or medical termination of pregnancy where there are medico-legal implications (Timms et al., 2020). Even when consent may be sensitively handled, there is still the need to ensure that patients are truly free, to either refuse or accept. In India, without the safety net of universal healthcare and social security, and limited below-par free care options for patients without health insurance, refusal of care could have serious implications. Other medical spaces where consent and autonomy is often severely at risk are in mental health care, obstetrics and childbirth, pediatric and adolescent care, and elderly patients (Avci, 2023). The concerns expressed earlier are amplified in such situations, where surrogate consent is given by parents and others; doctors have to ensure that the best interest of the patient in those circumstances is balanced against the choice or will of the family member who gives consent.

New interventions like telemedicine, introduced as a measure to include unreached populations present new challenges to consent. Only those with dependable telecommunication access can benefit, and consent provided in such cases can be compromised, as there may be limited options available to the patient who avails care in these situations (Aneja & Arora, 2021).

Equitable healthcare access

In India, healthcare is non uniform; at one end of the spectrum there are tertiary hospitals offering cutting edge, medical technologies accessible only to those who can afford, and at the other end of the spectrum, we have people with barely any access to even primary health care (Barik & Thorat, 2015). The landscape in between holds a mix of secondary and primary care centers that could be free or for-profit, depending on whether it is Government-owned or privately-owned respectively. There are also donation funded, faith based mission hospitals that provide care at reasonable cost, which could even be free for parents who cannot afford to pay. A year on year inadequate budget outlay for health has resulted in less public hospitals than required by the growing population and poor maintenance of the existing free healthcare institutions, accessed by almost 60 percent of the populations in rural or urban settings (Balarajan et al., 2011)

The prospect of poor infrastructure, inadequate health personnel, non-availability of beds and drugs in Government hospitals in general has led to the perception of 'poor quality' in the public sector, and even those who cannot afford would like to access private care to the extent they can afford (Lokhandwala, 2016). Around 70 percent of the population do not have the means or savings to afford health insurance or healthcare of a reasonable standard. Out of the pocket expenditure for health is one of the main reasons that pushes people into poverty in this country (Ghosh, 2011). This is a important bioethical concern that frustrates helps professionals as they try to ensure that every patient they encounter receives appropriate care either in the public or private sector. With deepening social inequalities, and a widening affordability gap in all sectors, including housing and education, access to health care has become a grave concern. This inequitable access to health may be the result of multiple and complex factors, but health professionals cannot completely ignore this unfortunate reality (Chawla, 2023).

According to the WHO, healthcare should be accessible, acceptable, affordable, equitable and timely. The tragedy is that while India provides the best medical talent across the developed countries, and is a preferred destination for affordable best-in-class dental and medical services in medical tourism, low-income and financially stressed citizens cannot ever expect to access such facilities (Ozair & Singh, 2021). To be aware of existing state of the art healthcare and remedies that are out of reach, is a cruel reality many are forced to live with. NGOs and doctors have advocated for equitable care but most of the responses have been sketchy and short-lived without a durable sustained plan for transformation. The Government has attempted to design health schemes to include stressed populations, but these efforts are patchy, non-uniform and often do not meet expectations; many fall out of the safety net and are unable to access care they need (Kumar, 2011). Health insurance is certainly not the answer to health needs in LMIC as proven through the experience of other countries; only a small fraction of the population can afford such insurance though self-funding, employment, or Government schemes (Duggal, 2016). Public health planning tends to respond to immediate needs, as in Covid-19, endemic infections, or increased Diabetes. It has not been adequate to address the vast, and complex health needs related to geography, diversity, culture, climate and historical deprivation. The reliance has been on top-down planning based on inadequate data and needs estimation, rather than a ground-up evaluation, prioritizing communities needs and preferences (Pramesh et al., 2021). Preventive measures central to building healthier populations, and reducing cost of medical care, are poorly emphasized, leading to high cost unaffordable interventions like kidney replacement, ICU care, surgeries and transplants. Doctors need the help of Government led Public health preventive care efforts to ensure patients stay healthy.

Another failure has been the inability to address the determinants of health; poor quality air, overcrowding in cities, unemployment, lack of access to housing, education, clean air, nutritious food are worsening the illness and disease burden and crippling the existing capacity of hospitals. Without a plan to to radically change living conditions of the poorest, the health system will continue to be inadequate and the medical load unmanageable (Jain, 2018).

There is poor control of drug prices and cost of healthcare; commercial hospitals focused on profitability rather than service have displaced many small secondary hospitals and clinics. This increasing gap and inequality in society emerging from low employment salaries and high cost of health care is creating a situation where only a fraction of the population can afford or have access to the quality of care they need (Chauhan, 2022). Doctors working in both private and public health services feel frustrated when patients are turned away, or have to abandon treatment due to inadequate infrastructure in public hospitals, or inability to afford private healthcare; leading to moral distress and helplessness in health personnel (Kim, 2025). It even possible to ensure that every patient is served regardless of capacity to pay, insurance or such guarantees? This injustice may be systemic, a result of poor governance or limited resources; but doctors encounter the patient in an immediate way, in the midst of severe need and cannot look away. The role of the doctor in such situations, as advocate of health rights and access to healthcare needs to be expanded (Ghia & Rambhad, 2023).

Bioethical concerns in research

India was one of the earliest countries to develop its own human research guidelines in 1980 following the Helsinki declaration; and CIOMS international guidelines (ICMR, 2017). Its more recent iterations, this country's National Ethical Guidelines for Biomedical and Human research involving Human Participants 2017, reflects the regulators interest to keep pace with developments in health and human research, and address challenges related to participant protection. However, it was not until sponsored clinical trials were outsourced to India in the late 20th century (Pai, 2016; Jayaraman, 2004), and media reports of scandals emerged, that emphasis was laid on developing oversight structures in the form of Institutional Ethics Committees (IEC) at the level of research institutions and hospitals, to approve and monitor clinical trials and other human research. Ethical oversight was formalized through these internal structures that review not only the scientific research protocols, but also protection of participants, vulnerability, safety and compensation. In addition, a clinical trials Registry was created, and all IECs were expected to be registered with the central authority, and carry out training for all their members (Bhosale et al., 2016). Capacity building in research ethics was a huge undertaking as medical ethics itself was not a subject in medical colleges at the time (Mishra et al., 2018). As research and publications became linked to promotions and career advancement, more health professionals entered the field of research, needing research training and ethics sensitization. This was a significant bioethical challenge in healthcare, as the country was still struggling with goals of inclusion in healthcare, upgrading of health facilities and health personnel training. While the country may certainly require adequate research in illnesses that affect the population, clearly there is a need to sensitize researchers to ethical requirements and protection of vulnerable groups (Shivayogi, 2013).

Health research in LMIC can be challenging because vulnerable participants may not understand the value of participation, or the risks involved in research (Dakhil et al., 2024). These include, illiterate, uneducated persons who may be unable to give fully informed consent, participants who believe that participation in research may be a means to access the healthcare they need, as well as patients who have a therapeutic misconception that health research may be therapeutic because their doctor is involved. In addition, sensitive research in communities could expose individuals and even the entire community to stigma due to breaches in confidentiality. This could worsen the living conditions and health access of already stressed communities (Ravi et al., 2025).

Protection of participants becomes critical in a country without universal healthcare or social security, where complications or adverse events due to research would need to be compensated and followed up long term. This lack of safety net is a deterrent for participants, if the risks are unacceptable, even where compensations are promised. With large sections of the populations living in financially stressed situations, payments for participation could be tempting or coercive; this is another ethical issue to anticipate (Lahey et al., 2013).

Unfortunately, at present the entire onus of ethical and scientific approval of research, compensation, ensuring protection and understood consent, as well as inspection and follow up, falls on the shoulders of Ethics Committee members who are volunteers, trained to varying degrees, not legally responsible and generally overwhelmed with the task burden. While the researchers may be directly responsible legally, the IEC is also held accountable (Shanmukhappa et al., 2020). With the exception of company sponsored clinical trials there is often inadequate resource at the level of hospitals and research institutions to train committee members and faculty, facilitate inspections and compensate adequately for research harm. This financial strain and capacity shortfall continues to be the major bioethical challenges in health research. With limited resources applied to institutional research in this country, quality research becomes a challenge and many good researchers find more favorable conditions abroad (Dandona et al., 2004).

Clearly, despite guidelines and legal requirements, capacity training and committees, it is the attitude of the researcher that is central to ensuring ethical research; the reasons and intentions in doing research, and commitment to good, high quality honest research. It is the integrity and conviction of the researcher, fully understanding the importance of ethical research, that will finally determine the quality of research and protection of participants. Ethics training and sensitization would be essential to overcoming challenges in this area (Ahuja & Pradeep, 2023).

Clinical ethics committees

The need for Clinical ethics committees or Hospital ethics committees has emerged over the last few decades in response to challenging decisions in complex areas of medical care mostly arising from use of biomedical advancements and technology in healthcare like ventilators, dialysis, ECMO, organ transplantation, aortic balloon pumps, and heart-lung machines that are used to keep the patient alive in trauma or terminal illness. These bioethical challenges are often linked to consent for withdrawal of life support, Do-Not-Resuscitate situations, declaration of brain death and consent for transplantation, withholding care in futile cases and other medical decisions that doctors, patients or their families may find difficult to handle alone (Khan, 2016).

Clinical Ethics Committees could assist doctors and patient's families to understand and navigate such decision making in a trustful, collaborative manner. These committees include a ICU specialist, nurses, administrator, treating doctor, chaplain, and ethicist/social worker. Consultation with a committee has been shown to assist doctors who often experience moral distress with handling these complex situations on their own. They are useful for the patient and family too, as it give them all the information they need and the time to come to terms with difficult decisions, in a compassionate, supportive and caring setting. It also ensures that the wishes of the patient are respected, and unnecessary suffering and indignity is avoided when possible; particularly in end of life or trauma situations where the patient can be kept alive indefinitely using technology (Timms, 2020). In these consultations, the patient's interests, their wishes, cultural context, and family concerns can be discussed; if the patient or family wishes to refuse blood transfusion, organ transplantation, a risky surgical intervention, biotech support, or ICU care, this provides a space to discuss with doctors and experts in an open and non-judgmental way. Though recommended, not every hospital appears to have these committees in place. It requires time, effort, cooperation of the doctors and administration, patients and family, understanding of limitations of medical care, compassionate handling of distressed family members and training in communication skills. In addition, patients or families should not feel abandoned and efforts need to be made to transition to palliative or hospice care when required (Slowther et al., 2004).

There are faith based institutions that deliver healthcare based on commitment to values derived from religious beliefs where one may find highly motivated health professionals, committed to the idea of providing ethical, compassionate, affordable care to patients; even so, there can still be dilemmas and challenges in a pluralist society where beliefs and moral traditions of patients and doctors do not necessarily align, but these can be addressed in a practical and compassionate way, if the best interest of the patient is prioritized. Now that palliative care is mandated in every hospital, it can provides a solution in the case of patients family who refuse treatment but are ill-equipped to care for the patient at home (Slowther & Hope, 2000).

Advance directives or Living wills are not yet to gain acceptance in this country, even though the Indian courts have recommended a legally acceptable process to withdraw futile medical treatment. Presently these procedures are cumbersome and protracted, but there are efforts to disseminate information and ease the process (*The Hindu*, 2023). It helps the doctor and the family to know and accept the wishes of the patient when communication is no longer possible; a distressing bioethical issue faced in ICU settings, where patients and their families can be burdened with expensive, protracted treatment, and the patient with suffering and discomfort. Regular review of the patient's medical condition and timely communication of risk and prognosis, can avoid stressful decisions for doctors and families, and foster trust and understanding in complex situations (Butola & Gursahani, 2024; Soares, 2016).

Barriers to setting up these Clinical ethics committees include lack of expertise, or understanding of need, fear of legal repercussion, disputes or disagreement, and limitations of time and training. However, this bioethical issue of decision making and respect of patient's choice is encountered more than ever today as medical technologies have become a part of healthcare (Raoofi et al., 2021).

High cost care and new medical technologies:

Improved radiological scans, expanded blood testing and endoscopic procedures have pushed up healthcare costs; an additional burden in countries without universal healthcare and health insurance. Technological developments are improving existing diagnostic facilities and companies profit from sale of their latest offerings to hospitals and doctors, who in turn pass the cost on to patients; justified in terms of better care and more accurate diagnostics (Fazal et al., 2012). The improvement in quality of care may often be marginal, but the costs associated are high enough to make it inaccessible to many; a result of aggressive marketing by medical device and drug companies focused primarily on profits (Nagarajan, 2018). This can lead to conflict of interest situations and corruption, when health institutions eye profits over service, and kickbacks and commissions come important motivations. Doctors are easily convinced that higher accuracy or safety in diagnostics might warrant purchase of the new technology, but there appears to be very little concern that for many in LMIC, these tests and technologies are completely out of reach (Chattopdhyay, 2016). This bioethical concern is painfully obvious in cities where hospitals advertise their latest medical offerings as trophies, implying that the use of these tools would ensure more accurate diagnosis, better care and faster recovery. While these claims may hold some truth, the cost of these treatments makes it available to only a thin segment of wealth patients, further widening the health and healthcare access gap in the country (McIntyre et al., 2006).

Not every patient or healthcare need may require expensive tests or therapies, but there is pressure on doctors, particularly in private and corporate hospitals, to prescribe such medical options in order to recover capital costs, or to increase patient billing. This strategy is counterproductive in the long term, as even patients who can afford, become disillusioned and feel exploited by the medical establishment that appears to use them as a means to an end (Kane et al., 2016). Instead of cost effective options tailored to their need, patients are offered 'best in class' treatments and 'comprehensive' testing that may not even be required. Trust is a vital ingredient of the doctor-patient relationship that gets eroded when patient observe this conflict of interest and commercialization in the name of healthcare.

For those who cannot meet the high costs of care for their ailing parents or young children, it is a bitter pill to swallow as they have to walk away from unaffordable options. It is a public health concern that every person should have access to adequate and timely care when needed, and should not have to go into painful, lifelong debt to pay for healthcare needs. Some expensive medical interventions include IVF treatment for infertility, robotic surgery, ICU care, organ transplant, dialysis, cancer care, and cardiac surgery or angioplasty (Murphy et al., 2019).

Robotic surgery is a classical example of high tech, high cost care that may be beneficial, but not always the only option for patients. Though well established in high income countries, their use in LMIC is limited due to affordability. Yet, surgeons here aspire to train in robotic techniques and would like to practice those skills in tertiary set-ups, quite unlinked to the fact that this treatment is prohibitively expensive, and not uniformly suited to the healthcare realities of the country. The high cost of installation, maintenance and capacity building seems incommensurate with the number of patients who may need or afford this technological option; this puts additional pressure on doctors to recruit patients for robotic surgery merely in order to recover costs (Balakrishnan et al., 2023; Burke et al., 2019).

The lack of regulation of hospitals and cost of treatment, promotion of the country as a medical tourism destination, and unbridled emphasis of medical interventions over prevention and health, reflects poor vision in governance and healthcare priorities. The economic divide in health is worsened by the high costs of care afforded only by the privileged, without parallel capacity building in the public sector for weaker sections in society (Dash & Mohanty, 2019).

Sensitization and ethics training

One of the major bioethical challenges encountered in this country is the lack of sensitization regarding ethical standards and the omission of ethics in the training curriculum of health workers. There has aways been a general understanding in healthcare of the need for service and compassion in caring for patients in need, but training has not always emphasized ethical standards and responsibility. In response to falling ethical standards globally in healthcare, the World Medical Association in 1999 mandated the inclusion of ethics into the medical training curriculum (WMA, 1999). It took a while for implementation as the curriculum was already overcrowded and faculty did not have the requisite training; ethics was perceived as requiring a philosophical approach as against a scientific one. This was despite the fact that medical practice from early times, across the world, has always been guided by a Code of ethics. With advances in science and medicine, the foundational philosophies around healing, duties and responsibilities of the doctor, and protection of patients appeared to have receded from consciousness. (Shetty, 2023; *National Medical Commission. Code of Medical Ethics Regulation*, 2002)

The need for ethics training was felt as healthcare became medicalized and expensive and privatized since the mid 20th century. In India, with exception of a few colleges that had always sensitized their students to ethics, most colleges did not change until 2018, when the National Medial Commission introduced mandatory Ethics training modules, in the form of Attitude, Ethics and Communication (AETCOM) in the training curriculum. It was recommended that ethics teaching be integrated across the years and taught by all faculty, rather than a separate subject (Lal & Sehgal, 2022). This move has played an important role in bringing ethics into medical formation. Research ethics too became crucial as clinical trials and human research increased and health workers were also researchers, with additional ethical responsibilities.

Similar modules began to be introduced into nursing, pharmacy and other allied health sciences. Unless there is a conscious understanding of the goals of medicine and the role and limits of the health worker in the healing relationship, patients are at risk of being viewed as a means to an end. The emphasis on respect for the patient and his/her choices, consent and confidentiality in clinical and research settings, protection from harm and care of vulnerable populations, justice in relation to access to healthcare and non-discrimination and working in the best interest of the patient; these are concepts that need to be understood and internalized to create just, equitable, respectful and caring health system (Shrivastava et al., 2022).

These central ethical values compel health workers to hold the line against commercialization, high cost unaffordable care, exploitation and conflict of interest. Training in ethics needs to be on-going and updated at regular intervals. Ethical guidance should precede the introduction of new medical technologies, testing/scanning, telemedicine, AI applications, and interventions like robotics. In evolving health scenarios and health needs it may often be necessary to recalibrate our actions against ethical guidance and evaluate new health programs, research and technologies. Failure to train health workers in ethics can result in misunderstandings and distress as patients expectations are unmet (Mahapatro et al., 2021). This could result in a loss of trust in health workers and the health system, even leading to violence against hospitals and doctors, as unfortunately experienced in this country and others (Pandey and Sharma, 2019). To build trust, every health initiative should be evaluated from the ethics perspective and citizens should be included to understand patient needs and expectations. Openness to feedback, good communication and ethics training are essential to good healthcare; an essential component of quality care (Kumar et al., 2025).

Conclusion

In conclusion, bioethical challenges are encountered across the spectrum in healthcare, particularly in LMIC like India. There are legacy issues that may still not be fully addressed since decolonization, like unequal access to common goods and disenfranchisement of systemically marginalized populations. At the same time, needs of a developing country in tandem with medical advancements and scientific developments, leads to aspirations and demands for quality in healthcare and inclusion, despite resource constraints of a growing and complex governance and capacity. Ethical medical care begins with careful selection of motivated medical aspirants who clearly understand the role and demands of the profession; good formation in ethics and alignment with country realities and needs is more likely to develop professionals that society needs. The complexity of modern medical treatments, health interventions and technologies, high cost of care, commercial interests and pressure to succeed, present ethical dilemmas in a country with large populations of poor and marginalized, socio-economic inequalities, lack of universal health care security and inadequate levels of health literacy and education. The Government has to increase its budget outlay on health and health services so that access to healthcare that is acceptable, quality and affordable becomes a reality for every citizen. Keeping the patient's interest at the center of healthcare decisions, with respectful decision making and protection from harm, can restore trust in healthcare services. Given the large numbers of unreached and vulnerable patients in India, it is more urgent than ever to promote healthcare that is inclusive, ethical, just and compassionate.

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Contemporary bioethical practices followed in hospitals. A personal experience

Abstract

In a pluralistic society, individuals with diverse backgrounds, beliefs, and values interact and coexist. Individuals often misunderstand each other. Even when they do understand each other, it is possible for them to disagree. When treatment is available yet remains inaccessible, it may be attributable to a myriad of impediments, including financial constraints stemming from exorbitant costs, inadequate insurance coverage, or insufficient financial resources. Moreover, restricted access to healthcare facilities or specialists in certain regions exacerbates disparities in care availability, influenced by socioeconomic status, educational attainment, or cultural background. Balancing healthcare providers' with patients' access to care. By understanding and implementing respect, healthcare providers can build trusting relationships, enhance communication and collaboration, and create environments where individuals feel valued and empowered. Ensuring that patients have accurate information and support to make informed decisions. Focusing on the character and moral virtues of individuals is involved in the decision-making process. Adeptly navigating these intricate complexities, healthcare professionals can endeavor to cultivate a harmonious equilibrium between ethical principles and moral imperatives, ultimately delivering compassionate and dignified care.

Keywords: Complex medical conditions, ethical principles, harmonious equilibrium

Introduction

In a pluralistic society, individuals with diverse backgrounds, beliefs, and values interact and coexist. Individuals often misunderstand each other. Even when they do understand each other, it is

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possible for them to disagree. Creating harmony in the healthcare arena can be challenging due to various factors, including:

Complexity of Healthcare Systems

The complexity of healthcare systems can be attributed to several factors which include (Kannampallil et al., 2011):

A) Multiple Stakeholders: Patients with diverse needs, preferences, and expectations approaching Healthcare Providers which include doctors, nurses, and other professionals with different specialties and roles. Inter-phased by various level payer such as insurance companies and government programs who are influenced by policymakers (public and private) who shape healthcare policies and regulations.

B) Interconnected Components: like clinical care for diagnosis, treatment, and management of health conditions including administrative tasks like scheduling, billing, and insurance claims using technology like electronic health records, tele-medicine, and medical devices.

C) Regulatory and Policy Frameworks: All these are taken care under laws and regulations governing healthcare delivery, privacy, and security which are guided under organizations which give accreditation and certification ensuring quality and standards. The complexity of healthcare systems also requires effective communication, collaboration, and coordination among stakeholders to deliver high-quality, patient-centered care which involves financial and economic factors cost containment which are needed for managing healthcare costs and expenses which are usually reimbursement models like fee-for-service, value-based care, and other payment structures which are usually decided by the:

- ***a) Technological Advancements.*** All that is involved in Innovation of Treatments using new medications, devices, and therapies using components like digital Health and tele-medicine or mobile health applications.
- ***b) Patient-Centered Care.*** All these are done to bring more patient centric care by personalized medicine trying tailoring care to individual needs and preferences.

c) Shared Decision-Making. Medicine is best practiced by collaborative decision-making between patients and healthcare providers.

Difficulty in creating harmony in the healthcare arena

Creating harmony in the healthcare arena between ethics and morality can be challenging due to the inter linking of all these various components and even more complex mind over body (Seedhouse, 2008).

Stress and Anxiety: When it comes to medical decision-making, the mind can significantly influence the body in several ways as high levels of stress and anxiety can impact decision-making, leading to impulsive or irrational choices. Chronic stress can impact physical health or internal systems like the immune system. Individuals' perception of risk can influence their medical decisions, sometimes leading to avoidance or delay of necessary treatments.

Emotional Biases: Emotions such as fear, hope, or denial can influence medical decisions, sometimes leading to choices that may not be in the best interest of the patient's health. Personal values and preferences play a significant role in medical decision-making, particularly in situations where there are multiple treatment options.

Cognitive Biases: Biases such as confirmation bias or anchoring bias can affect how individuals process and interpret medical information. The mind's expectation of a treatment's effectiveness can influence the body's response, leading to improved outcomes. Conversely, negative expectations can lead to adverse outcomes. The way individuals process and interpret medical information can impact their decisions, highlighting the importance of clear communication and shared decision-making.

Complex decision-making: Balancing patient autonomy, beneficence, non-maleficence, and justice.

Interdisciplinary Collaboration: Healthcare involves multiple disciplines, each with its own perspectives and priorities, making collaboration and harmony challenging. Healthcare professionals, patients, and families may hold different moral and ethical beliefs. Patients, providers, payers, and policymakers often have different interests and priorities, which can create tension and conflict. Integrating new technologies, such as AI and genetic editing, raises ethical concerns. Allocating limited resources while ensuring fairness and equity. This diversity of thoughts can lead to:

Misunderstandings-disagreements: Different perspectives and experiences can cause miscommunications and misunderstandings. Even with understanding, individuals may hold differing opinions and beliefs, leading to disagreements (Lee and Lin, 2009). Being aware of these makes you:

- Plays a crucial role in shaping the delivery of healthcare.
- Defining the relationship between healthcare professionals and patients.
- Moral compass that guides healthcare providers.
- Maintaining trust, and upholding the values of compassion, respect, and justice.
- Advancing medical technologies and complex ethical dilemmas

Ever-evolving landscape of healthcare, ethical considerations are becoming increasingly complex due to factors such as technological advancements, limited resources, and cultural diversity. Providing patients and service users with comprehensive and accessible information is a key aspect of empowerment. This includes information about their condition, treatment options, and available support services. By equipping individuals with the knowledge they need, healthcare professionals can empower them to make informed decisions about their care.

Addressing these multifaceted challenges while ensuring that the paramount principle of patient welfare remains at the forefront is the nuanced art that we must endeavor to comprehend. A multitude of daily medical concerns or issues present complexities and challenges, compounded by various intricate considerations that warrant attention.

Beginning of life

Abortion is a complex and controversial topic, raising significant ethical challenges. Some of the pivotal issues encompass the right to life, as the discourse surrounding the commencement of life and the inherent rights of a fetus continue to intensify in light of contemporary perspectives. The question of when human life begins and whether it has inherent value, a woman's right to control her own body and make decisions about her health and well-being interspersed with diverse perspectives on the morality of abortion, often rooted in religious, cultural, or personal beliefs. Concerns about the physical and mental health risks associated with abortion, as well as access to safe and legal abortion services. Women's right to control their own bodies and make decisions about their health. The potential rights and interests of the fetus, and how they balance against those of the mother. The impact of abortion on individuals, families, and society, including issues of poverty, education, and social support. These challenges highlight the need for nuanced and respectful discussions about abortion, acknowledging the complexity of the issue and the diversity of perspectives. Balancing healthcare providers' right to refuse participation in abortion procedures with patients' access to care. Ensuring that patients have accurate information and support to make informed decisions about abortion. Focusing on the character and moral virtues of individuals is involved in the decision-making process. Providing empathetic and non-judgmental care to patients is the key in navigating abortion decisions.

IVF - Designer and precious babies

IVF (In Vitro Fertilization) has revolutionized reproductive medicine, enabling individuals and couples to conceive. However, the concept of "designer babies" raises complex questions. Some IVF techniques allow for genetic testing and selection of embryos, potentially enabling parents to choose traits like sex, eye color, or disease resistance. Ethical considerations revolve around the potential implications of genetic enhancement, particularly the selection of traits for non-medical purposes, such as intelligence or physical appearance. Inequality and access to genetic technologies may exacerbate social and economic disparities, placing undue pressure on children to fulfill parental expectations, thereby potentially compromising their well-being. Many parents consider their children precious and valuable, regardless of how they were conceived. Some may view genetic selection as a means to create a 'perfect' or 'precious' child (Davis, 2010).

The convergence of in vitro fertilization (IVF), genetic selection, and societal values prompts critical inquiries regarding the equilibrium between individual reproductive autonomy and collective societal concerns, ensuring that technological advancements are used responsibly and ethically. It is imperative to ensure that technological advancements are harnessed responsibly and ethically. Concerns regarding the exploitation of surrogate mothers, particularly within the context of commercial arrangements, have surfaced prominently. It is imperative to ensure equitable compensation and informed consent for surrogates. Furthermore, the formulation and enforcement of rigorous regulations are imperative to ensure the safe and judicious application of Assisted Reproductive Technology (ART). Assessing the comprehensive benefits and detriments of ART. Focusing on the character and ethical virtues of individuals engaged in Assisted Reproductive Technology (ART), the ethical dilemmas surrounding artificial reproduction are intricate and multifaceted, necessitating meticulous contemplation of diverse perspectives and values.

Prenatal evaluations - Abortions and interventions

Prenatal evaluations possess the capacity to discern fetal abnormalities or concerns, thereby necessitating intricate deliberations regarding the potential termination of the pregnancy due to grave fetal anomalies or risks to the mother's health, as well as medical or surgical interventions aimed at enhancing fetal outcomes or managing complications. Employing advanced imaging techniques to detect structural abnormalities, alongside screening for chromosomal or genetic disorders, is essential, in addition to the vigilant monitoring of fetal well-being and maternal health. These decisions necessitate meticulous contemplation regarding the potential for the fetus to not only survive but also to flourish. It is imperative to weigh the risks and advantages to the mother's physical and emotional well-being. Thus, honoring the autonomy and decision-making capabilities of parents. Collaboration among healthcare providers, genetic counselors, and other specialists is paramount. Ensuring that parents comprehend the associated risks, benefits, and available options is essential. Additionally, providing emotional support and counseling for parents is crucial.

Defensive medicine - Legal issues

Defensive medicine pertains to medical practices motivated by the apprehension of legal repercussions, rather than purely clinical considerations. This phenomenon can culminate in the superfluous ordering of tests or procedures aimed at mitigating potential liabilities, ultimately resulting in the provision of excessive treatments in an endeavor to avert prospective litigation. There exists a tendency to eschew the treatment of patients deemed high-risk or litigious.

The legal complexities surrounding defensive medicine encompass apprehensions of being sued for negligence or mistakes, escalating costs, and the constrained availability of liability insurance. Compliance with the statutes and regulations governing medical practice further complicates this landscape. Defensive medicine can engender repercussions, such as superfluous tests and treatments that escalate healthcare costs. Excessive testing or intervention may result in adverse effects, while heightened liability apprehensions can exacerbate physician burnout. To mitigate these challenges, several potential solutions merit consideration, including the reform of statutes governing medical malpractice litigation, utilizing mediation or arbitration to amicably resolve disputes (Saks & Landsman, 2020). Additionally, promoting best practices and curtailing unnecessary variations in patient care may prove beneficial.

Treatment available but not accessible

When treatment is available yet remains inaccessible, it may be attributable to a myriad of impediments, including financial constraints stemming from exorbitant costs, inadequate insurance coverage, or insufficient financial resources. Moreover, restricted access to healthcare facilities or specialists in certain regions exacerbates disparities in care availability, influenced by socioeconomic status, educational attainment, or cultural background. Additionally, inequities within healthcare systems, policies, or practices further hinder access to essential care. These barriers can result in postponed treatment, as patients may not receive timely care, thereby exacerbating their conditions. Limited access to treatment can culminate in sub-optimal health outcomes. Insufficient access to care may contribute to elevated mortality rates (Adesuyi et al., 2025).

Emphasizing the delivery of high-quality, compassionate care through enhanced transparency—such as clearly disclosing costs, risks, and benefits—by developing innovative treatments, technologies, and care models can strike a harmonious balance between profitability and patient-centered care. By doing so, the medical industry can more effectively serve patients and communities.

When confronted with ethical dilemmas on a personal level, such as facing unplanned pregnancy while unmarried, or being compelled to pursue donor IVF due to your partner's medical issues, one is met with profound moral considerations. Additionally, when a parent suffers from a chronic medical condition and relatives insist on prolonging life through mechanical ventilation or futile treatments, these scenarios present stark realities that warrant deep reflection. Despite the importance of respect and dignity in health and social care, there are challenges that can hinder its implementation. These challenges may include time constraints, resource limitations, and systemic issues within healthcare organizations. Addressing these barriers requires a commitment to continuous improvement and innovation. By doing so we get opportunities to strengthen partnerships between healthcare providers, individuals, and communities. By working together, stakeholders can co-create solutions that address the unique needs and preferences of individuals, fostering a more respectful and person-centred care.

Practicing medicine isn't always clear-cut

Carve out time for pursuits that ignite your passion to cultivate harmony; healthcare professionals can engage in candid dialogue to deliberate on ethical dilemmas and moral quandaries with colleagues, patients, and families. When you nurture empathy and understanding, you embrace diverse perspectives and values by incessantly educating yourself on the evolving ethical issues and legal frameworks. By prioritizing patient-centered care and concentrating on the needs, values, and preferences of patients, you foster a more compassionate healthcare environment.

One must engage in introspection to discern the ethical dilemma and its fundamental components. Gather pertinent facts and context. Evaluate and contemplate by reflecting on your core values and principles. Consider the potential ramifications of varying courses of action after conferring with trusted individuals or experts. Decision-making should ensue after meticulously weighing options and assessing the advantages and disadvantages of each conceivable course of action, ultimately selecting the path that resonates with your values and principles (Schneider, 1998)[9]. Upon making your choice, execute your decision and accept responsibility for the outcome. Subsequently, reflect on the results and appraise the consequences of your decision, drawing lessons from the experience.

Respecting cultural diversity is another critical component of respect in health and social care. Individuals come from diverse backgrounds, each with unique cultural beliefs, practices, and values. Healthcare providers must be culturally sensitive and inclusive, ensuring that care is tailored to meet the specific needs of individuals from different cultural backgrounds. Dignity and respect are vital in health and social care because they promote trust, improve the quality of care, foster open communication, and support the individual's sense of worth and autonomy. This ethical approach enhances the patient-provider relationship, encourages patient engagement, and leads to better health outcomes by affirming the person's inherent value and right to be treated as a whole, capable individual, regardless of their condition.

Why dignity and respect are essential

Builds Trust: Treating individuals with dignity and respect creates a strong foundation of trust between caregivers and service users, which is essential for effective care.

Improves Care Quality: When people feel respected, they are more likely to communicate openly about their concerns and cooperate with treatment plans, leadingto more effective and person-centered care.

Promotes Autonomy: A dignity-in-care approach recognizes a person's right to make choices about their own life and care, empowering them to retain a sense of control and independence.

Enhances Well-being: Providing care with respect helps maintain a person's sense of self-worth and integrity, reducing anxiety and promoting their overall happiness and fulfillment.

Fulfills Ethical Obligations: Upholding dignity is a fundamental principle of health and social care, ensuring that individuals are valued for who they are, not just for their illness or condition.

Encourages Participation: Individuals who feel respected are more likely to be active participants in their care, which can lead to better health outcomes and a more positive experience within the healthcare system.

Recognizes Universal Value: Dignity is a universal human concept, and its application in care signifies the acknowledgment of a person's inherent value and their right to be treated with honor and respect.

Respect is a cornerstone principle that underpins the delivery of compassionate and effective services. It is a multifaceted concept that encompasses recognising the inherent dignity, rights, and autonomy of individuals receiving care. Respect in this context is not merely a passive acknowledgment but an active engagement that shapes interactions, policies, and practices within the care sector. Understanding and implementing respect is crucial for fostering trust, promoting well-being, and ensuring equitable treatment for all individuals. By adeptly navigating these intricate complexities, healthcare professionals can endeavor to cultivate a harmonious equilibrium between ethical principles and moral imperatives, ultimately delivering compassionate and dignified care. Never hesitate to:

1. Seek assistance: Reach out to acquaintances, family members, or professionals for guidance and support.
2. Prioritize self-care: Attend to your physical and emotional well-being during arduous times.
3. Embrace personal growth: Acknowledge that confronting ethical dilemmas can present a valuable opportunity for personal evolution and development.

By adopting these approaches, individuals can work towards building stronger relationships and fostering a more harmonious and inclusive society. The Healthcare arena, in common with every other segment of society has found it necessary to find ways to create understanding and agreement. Empowering individuals to make choices about their care fosters a sense of control and self-determination, which is essential for their overall well-being. It is important for healthcare providers to listen actively to the concerns and preferences of individuals and to respect their decisions, even when they differ from professional recommendations.

Asking for help is indeed a sign of strength, not weakness. It takes courage and self-awareness to recognize when we need assistance and to seek it out. Be willing to consider different perspectives and ideas. Approach challenges with a curious and open-minded attitude. View failures and setbacks as opportunities for growth and learning. By embracing the idea that asking for help is a sign of strength, we can build stronger relationships, learn and grow, and navigate challenges more effectively. Building trust requires consistency in respectful behavior, transparency in communication, and a genuine commitment to the well-being of individuals. Healthcare providers must demonstrate reliability, competence, and integrity in their interactions, ensuring that individuals feel safe and supported throughout their care journey.

Respect is a foundational principle in health and social care, essential for delivering compassionate, effective, and equitable services. Despite challenges, there are numerous opportunities to strengthen respect in care delivery, ultimately improving the well-being and satisfaction of individuals receiving care.

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Systemic ethical conflicts in Indian hospitals: A case-based nalysis of autonomy, justice, and legal anxiety

Abstract

Bioethics in the Indian healthcare system exists at the intersection of global medical principles, unique sociocultural norms, resource constraints, and an evolving legal landscape. While the four foundational principles —autonomy, beneficence, non-maleficence, and justice —provide a universal framework, their application in India presents formidable challenges. This paper argues that these ethical dilemmas are not aberrations but systemic conflicts arising from tensions between Western-style patient autonomy and Indian family centric decision-making, the collision of a physician's duty of beneficence with patient rights under Article 21 of the Constitution, and the pervasive failure of justice, manifested in catastrophic out-of-pocket expenditure that coerces clinical decisions. This study adopts a practical, case-based approach and analyzes six common scenarios. For each case, the ethical conflict is deconstructed, a robust analysis of the specific Indian legal framework–including the MTP Act 2021, the HIV/AIDS Act 2017, and landmark Supreme Court jurisprudence on end-of-life care–is provided, and a clear, actionable management protocol is proposed. This paper concludes that navigating this complex terrain requires moving beyond perceived legal liability and embracing a structured approach rooted in sound communication, meticulous documentation, and the proactive use of Hospital Ethics Committees (HECs).

Keywords: Bioethics, medical ethics, patient autonomy, end-of-life care, legal framework, case-based analysis

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Defining bioethics: An interdisciplinary field

Bioethics is an interdisciplinary study of the ethical, social, and legal issues arising in medicine and biomedical research. This is not merely academic but a necessary professional practice for navigating complex moral decisions. While medical ethics has ancient roots in India, such as in the Charaka Samhita, modern Indian hospitals face a different set of challenges (Moskop, 2016).

The contemporary landscape is defined by technological advancements, complex regulations by bodies such as the National Medical Commission (NMC), and a sharp rise in medical negligence litigation (Singh et al., 2024). This rise in legal challenges often stems from breakdowns in ethical communication and failure to navigate the moral gray zones of clinical practice. Therefore, a practical understanding of bioethics is a core competency for all healthcare professionals.

The four pillars of clinical ethics

The dominant framework for clinical ethical analysis rests on four key principles, providing a shared vocabulary for conflict resolution.

- Autonomy (Respect for Persons): This recognizes the right of a competent individual to self-determination. In practice, this means informed consent and informed refusal, where a patient may accept or reject treatment after receiving clear information (Schenker, 2011).
- Beneficence (To Do Good): This is the physician’s affirmative duty to act in the best interest of the patient, balancing risks and benefits to promote health (Horner et al., 2016).
- Nonmaleficence (To Do No Harm): Encapsulated by Primum non nocere (“first, do no harm”), which obligates physicians to avoid causing unnecessary pain or suffering and to prevent negligence (Gillon, 1985).
- Justice (Fairness): This principle relates to the fair and equitable distribution of healthcare resources, demanding fair allocation of scarce resources (like ICU beds) and avoidance of discrimination (Häyry, 2022).

The Indian contextual conflict

In India, ethical principles frequently conflict because of socioeconomic disparities and resource constraints within the healthcare system. The primary challenge is balancing individual patient care with broader public health needs, particularly during crises such as pandemics. This tension underscores the necessity of culturally sensitive ethical frameworks that integrate both universal principles and local realities (Simonds & Sokol, 2009). This article hypothesizes that the direct application of foundational bioethical principles in Indian hospitals generates a series of distinctive and systemic conflicts.

These conflicts are structural and stem from three primary underlying tensions. First, there is cultural tension. The Western, individualistic model that emphasizes patient autonomy often conflicts with the Indian context, which may prioritize communal autonomy," where the family serves as the primary decision-making unit. This is further complicated by a "passive patient" culture, where informed consent may be perceived as a mere formality. Second, there is acute resource tension (Chattopadhyay & De Vries, 2012). The principle of justice is systematically compromised by low public spending and high out-of-pocket (OOP) expenditures. This "catastrophic health expenditure" forces millions into poverty annually and influences clinical decision-making. Finally, there is legal tension. Many physicians, constrained by "misperceptions of legal liability," engage in "defensive medicine," such as continuing futile care, which is ethically problematic. Many dilemmas are not simple two-way conflicts but rather tragic three-way conflicts, where the patient's autonomy (what they want) and the doctor's beneficence (what is best) are both constrained by a failed principle of justice (what the family can afford). The following analysis provides a practical framework for navigating these scenarios in the future (Laureano et al., 2024). The clinical scenarios presented in this analysis are illustrative composites constructed from recurring ethical dilemmas observed across the broader Indian healthcare landscape. While they reflect common systemic challenges, they are hypothetical narratives designed solely for pedagogical and legal analysis. They do not represent specific patient records, identifiable individuals, or the operational policies of any single institution.

Case-based analysis of ethical scenarios

Scenario 1: Refusal of life-saving treatment (Blood transfusion)

a. The case

Consider a high-stakes emergency scenario where a young female patient presents in severe hemorrhagic shock following a home delivery. In this hypothetical instance, the patient is unconscious and presents with critical anemia, making an urgent blood transfusion medically imperative to prevent mortality. The accompanying family members, identifying as Jehovah's Witnesses, refuse the transfusion on the patient's behalf, asserting that she shares their religious objection to blood products. Crucially, for the purpose of this analysis, we assume there is no written Advance Directive or "No Blood" card available to confirm the patient's own explicit wishes.

b. The ethical conflict

This is a direct conflict between the medical team's duties of beneficence and non-maleficence versus the patient's presumed autonomy.

- Beneficence and Non-maleficence: The medical team has a clear ethical and professional duty to provide standard-of-care, life-saving interventions. Inaction in this context would lead to a preventable death, violating the foundational principle of Primum non no cere (Varkey, 2020).
- The Limits of Autonomy: The conflict is complicated by the patient's incapacity. Since the patient cannot speak for herself, autonomy is being asserted by surrogates (the family). The central ethical question here is whether an undocumented, surrogate "presumed refusal" possesses sufficient moral weight to override the physician's duty to save an imminently threatened life.

c. The legal and policy framework (India)

The actions of the clinical team are strongly protected by Indian law, ensuring that healthcare professionals can perform their duties with legal safeguards that uphold patient rights and maintain ethical standards in medical practice.

- Doctrine of Implied Consent in Emergencies: In life-threatening emergencies involving an incapacitated patient, the law operates on "implied consent." Doctors are legally expected to provide the necessary treatment to save lives. Refusing to treat in an emergency due to lack of consent can itself be grounds for negligence (Kumar et al., 2015).
- The Constitutional Hierarchy: Article 21 vs. Article 25: The family's refusal is an exercise of Article 25 (Freedom of Religion). The doctor's actions are defended by Article 21 (Protection of Life). The Supreme Court has clarified that Article 25 is explicitly subject to "public order, morality, and health." The fundamental right to life (Article 21) overrides the right to religious practice, especially when asserted by a surrogate for an incapacitated person (Kakar et al., 2014).
- Status of Surrogate Refusal: A competent adult's informed refusal is legally binding, whereas a surrogate's right is limited. Indian law does not empower a family to demand a preventable death in the absence of a clear, written Advance Directive from the patient (Kattamreddy, 2025).

d. Recommended course of action

- Proceed with Transfusion: The clinical team must act immediately based on implied consent and the legal supremacy of Article 21.
- Document Meticulously: This is critical for legal protection. The record must state the following: the imminent, life-threatening nature of the condition; the patient's incapacity; the family's objection and its religious basis; the absence of a patient-signed advance directive; and the legal-ethical basis for intervening (implied consent/Article 21).
- Engage Administration and Legal Cell: Immediately inform the Medical Superintendent and/or the legal cell. Convene an emergency Hospital Ethics Committee (HEC) meeting, even if retro-

spectively, to validate the decision.

- Compassionate Communication: After stabilization, a senior team member should explain to the family why the action was taken from a legal and life-saving perspective while acknowledging their distress and beliefs.

Scenario 2: Patient refusal of recommended procedure (Dialysis)

a. The case

A common clinical challenge involves a patient with End-Stage Renal Disease (ESRD) who requires urgent hemodialysis to prevent life-threatening complications. In this model scenario, we consider a patient who is fully conscious and possesses intact decision-making capacity but explicitly refuses the procedure, citing a personal aversion to machine dependency. The administrative and ethical dilemma intensifies when such a patient simultaneously refuses discharge, demanding to remain in the hospital for management "by other means," despite being counseled that dialysis is the sole effective life-sustaining intervention available.

b. The ethical conflict

This scenario presents a classic clash between the principle of Patient Autonomy and the physician's duties of Beneficence, complicated by the principle of Justice.

- Autonomy: A fundamental tenet of bioethics is the competent adult's right to refuse any medical treatment, even if that refusal inevitably leads to death (Partel Araujo et al., 2024). The patient's right to self-determination allows them to reject the "standard of care."
- Beneficence vs. Non-maleficence: Physicians are professionally obligated to provide the best possible care. Allowing a patient to deteriorate when a viable treatment exists feels like "permitting harm," creating moral distress for the clinical team who view the refusal as preventable suicide.
- Justice (Resource Allocation): This scenario introduces a third dimension: Distributive Justice. By refusing the indicated treatment while simultaneously refusing discharge, the patient oc-

cupies a scarce hospital bed without utilizing the specific care that the bed is designed to facilitate. This raises ethical questions regarding the fair allocation of limited healthcare resources to those who are willing to accept treatment (Pu, 2021).

c. The legal and policy framework (India)

- Right to Informed Refusal: A mentally competent adult's right to refuse medical treatment is legally recognized, stemming from the right to bodily integrity under Article 21 of the Constitution. NMC regulations support this, provided the refusal is informed (Nandimath, 2009).
- Discharge Against Medical Advice (DAMA)/Leave Against Medical Advice (LAMA): When a competent patient refuses standard-of-care, the appropriate legal mechanism is a "Discharge Against Medical Advice" (DAMA). A hospital cannot detain a patient for refusing treatment (Rao, 2021).
- Limit of Hospital Obligation: The patient's right to autonomy (refusing dialysis) does not create an obligation for the hospital to provide medically futile or non-indicated "other means." The hospital is not bound to provide services that contradict all medical rationale (Chand et al., 2009).

d. Recommended course of action

- Conduct Formal "Informed Refusal" Counseling: This must be a structured session with the senior nephrologist, a counselor, and (with patient consent) his family.
- Document the Counseling: The patient must be clearly informed, in simple language, of the lethal consequences of refusing dialysis and that "other means" do not exist for his condition, only palliative (comfort) care.
- AMA Documentation: If the refusal persists, the patient must sign a detailed "Against Medical Advice" (AMA) form listing the specific risks (including death) that were explained. If he refuses to sign, please document this with witnesses.
- Scope of Continued Care: Clearly document and communicate the care the hospital will (palliative care, pain relief) and will not (medically futile interventions, ICU admission) provide.
- Ethics Committee Review and Discharge Planning: If the pa-

tient refuses both dialysis and discharge, the case is escalated to the Hospital Ethics Committee. The HEC), which mediates, re-confirms capacity, and develops a formal, legally sound discharge plan.

Scenario 3: Confidentiality in HIV/Hepatitis-B diagnosis

a. The case

A recurring bioethical dilemma in infectious disease management involves the tension between patient privacy and public safety. Consider a hypothetical situation where a married male patient is diagnosed with a sexually transmissible infection, such as HIV or Hepatitis B. In this scenario, the patient explicitly invokes his right to confidentiality, issuing a strict directive to the medical team to withhold this diagnosis from his spouse. The clinical team is thus placed in a precarious position, fully aware that the patient's partner is at significant, ongoing, and unknowing risk of infection while the patient forbids disclosure.

b. The ethical conflict

This scenario epitomizes the "duty to warn" dilemma, where healthcare professionals must balance the obligation to maintain trust through confidentiality against the imperative to prevent foreseeable harm to others.

- Autonomy (Confidentiality): The patient possesses a fundamental legal and ethical right to the confidentiality of his medical data. Breaching this trust can deter future patients from seeking testing or treatment.
- Non-maleficence (Duty to Prevent Harm): Simultaneously, the medical team has an ethical duty to prevent foreseeable and serious harm to an identifiable third party (the spouse). Remaining silent in this context could be interpreted as complicity in the transmission of a life-altering disease.
- Justice: The principle of justice is also implicated, as the spouse has a moral right to health and access to the information necessary to protect her own life and well-being

c. The legal and policy framework (India)

This area is now legally clear, and physicians have established a standardized protocol to guide their practice.

- The Old Precedent: Mr. X vs. Hospital Z (1998): This Supreme Court case ruled that the "duty to warn" and protect public health overrode the patient's right to confidentiality in a conflict between two Article 21 rights (Offit, 2004).
- The Current Law: The HIV and AIDS (Prevention and Control) Act, 2017: This Act is now the definitive law, and it codified the "duty to warn" into a formal procedure (Verma et al., 2018).
- The "Partner Notification" Protocol (Section 9): The Act permits a physician to disclose a patient's HIV status to their partner without the patient's consent if all the following conditions are met:
- The provider reasonably believes the partner is at "significant risk".
- The HIV-positive patient was counseled to inform their partner.
- The provider is satisfied that the patient will not inform their partner.
- The provider informed the HIV-positive patient of their intent to disclose the information to the partner.
- NACO and NMC Guidelines: Guidelines from the National AIDS Control Organization (NACO) and the NMC Code of Ethics align with this structured approach.

d. Recommended course of action

- Intensive Counseling (First Step): The First Step is not disclosure. It is intensive counseling to explore the patient's fears (stigma, rejection) and empower him to disclose voluntarily, perhaps with "assisted disclosure".
- Formal Notification of Intent: If counseling fails, the physician must formally inform the patient: "As per our legal duty under Section 9 of the HIV/AIDS Act of 2017, we are now required to notify your partner. We are informing you of this action as required".
- Document the Process: Meticulously document (a) the counseling, (b) the patient's repeated refusal, and (c) the formal "notification of intent" provided to the patient.
- Execute Conditional Disclosure: Arrange a private, in-person meeting with the wife and provide full counseling support. Frame the disclosure as a medical necessity for the patient.

This action, when following this protocol, is fully protected by Indian law.

Scenario 4: Institutional refusal of a legal procedure (MTP)

a. Illustrative case scenario

A profound legal and ethical tension frequently debated in Indian bioethics involves the collision between institutional values and statutory mandates. Consider a scenario where a patient presents to a hospital with a ruptured ectopic pregnancy - a condition universally recognized as a life-threatening surgical emergency. The patient, fully informed of the risk, provides explicit consent for the requisite life-saving intervention, specifically the Medical Termination of Pregnancy (MTP). The conflict arises if the institution, citing a "conscientious institutional policy," declines to perform the procedure regardless of the medical indication, thereby placing the administration's values in direct opposition to the immediate clinical needs of the patient.

b. The ethical conflict

This scenario serves as a stark example of the conflict between a patient's fundamental rights and the concept of "Institutional Conscience."

- **Autonomy vs. Institutional conscience:** The central conflict lies between the patient's autonomy (specifically her legal right to life-saving care under the MTP Act) and the hospital's claim to a collective moral objection.
- **Failure of beneficence and non-maleficence:** From a clinical ethics perspective, refusing to intervene in a ruptured ectopic pregnancy represents a catastrophic failure of beneficence (the duty to act in the patient's best interest) and non-maleficence (the duty to do no harm). By allowing a preventable, life-threatening condition to progress due to policy rather than medical incapacity, the principle of *Primum non nocere* is severely compromised.

c. The legal and policy framework (India)

The hospital's position is legally indefensible. The hospital's position is legally indefensible because it fails to comply with established regulations and lacks sufficient evidence to support its claims.

- This is Not an "Abortion" (in the elective sense): A ruptured ectopic pregnancy is an acute surgical emergency. The MTP Act 2021 is clear: termination to save the life of the woman is its primary, non-negotiable indication.
- Patient's Right to Bodily Autonomy (Article 21): The Supreme Court's 2022 judgment in X vs. Principal Secretary (NCT of Delhi) unequivocally grounded a woman's right to access safe abortion in her fundamental right to "bodily autonomy" under the Article 21. Denying her this right, especially when her life is at stake, is a severe violation of her rights.
- The Myth of "Institutional Conscientious Objection": This is not a recognized legal right in India. The right to conscience is held by individuals, not corporate entities. Institutions have a duty of care.
- Limits on Personal Conscientious Objection: Even an individual doctor's right to object cannot be invoked in an emergency or life-threatening situation. Furthermore, the objecting physician has a duty to refer and not obstruct care.

d. Recommended course of action

- Perform the Procedure (The Unambiguous Duty): The obstetrician's primary legal and ethical duty is to the patient, not to follow the hospital's illegal policy. The NMC, Article 21, and the MTP Act require them to perform life-saving surgery immediately.
- Referral (A Dangerous and Poor Alternative): If the hospital administration actively prevents the surgery, its only (and ethically fraught) alternative is an immediate, documented, and stabilized transfer to a non-objecting facility.
- Legal Warning: Any delay in this referral or any attempt at "patient dumping" (transferring an unstable patient) would be gross negligence and a violation of the patient's Article 21 rights.
- Documentation and Reporting: Physicians must document their medical findings, the "life-saving" nature of the MTP, the patient's consent, and the hospital's specific refusal. This incident should be reported to the District Medical Officer (DMO) and State Medical Council.

Scenario 5: Family requests ventilator withdrawal (Against medical advice)

a. The case

A prevalent ethical dilemma in Indian critical care units involves the request for "passive euthanasia" driven by economic rather than medical factors. Consider a patient receiving mechanical ventilation following a severe neurological event, such as a cerebrovascular accident, who remains in an unconscious state. In this representative scenario, the medical team assesses that the condition is potentially reversible and that a "reasonable chance" for meaningful recovery exists, thereby classifying the treatment as non-futile. However, the patient's surrogates (family members) advocate for the discontinuation of ventilatory support. Their request is not based on the patient's prior expressed wishes or medical hopelessness, but is explicitly driven by the "significant financial burden" of prolonged ICU care.

b. The ethical conflict

This situation moves beyond a simple binary conflict and represents a complex "three-way conflict" involving the patient, the physician, and the socioeconomic environment.

Surrogate Autonomy vs. Medical Beneficence: There is a direct clash between the family's request (Surrogate Autonomy) and the physician's obligation to continue effective treatment (Beneficence). The medical team cannot ethically withdraw life support from a patient who has a chance of recovery, as this would constitute active killing rather than allowing a natural death.

The Failure of Justice: The central ethical distortion here is the failure of the principle of Justice. The family's decision is likely not a true exercise of free will but a reaction to financial duress caused by "catastrophic" out-of-pocket expenditures. The family is effectively coerced by the economic system to demand a preventable death, creating a tragic scenario where clinical decisions are dictated by poverty rather than prognosis.

c. The legal and policy framework (India)

- The Old Law: Aruna Shanbaug v Union of India (2011): This case legalized "passive euthanasia" (withholding/withdrawing treatment) but mandated an "unworkable" High Court approval process for every case.

- The New Right: Common Cause v. Union of India (2018): This SC judgment declared the "Right to Die with Dignity" a fundamental right under Article 21 of the Constitution. It also provided legal sanctity to "Advance Medical Directives" (Living Wills).
- The Crucial New Procedure: SC (2023) and ISCCM-IAPC (2024): The 2018 procedure was still "onerous." In January 2023, the Supreme Court significantly simplified this process. New joint guidelines from the ISCCM and IAPC (2024) codified this simpler, hospital-level, two-board system for approving withdrawal in futility cases.
- Protocol vs. Case: The 2023/2024 protocol applies to cases of medical futility. In this scenario, the team believes that care is non-futile. The law is clear: a family's surrogate autonomy does not extend to compelling a physician to stop non-futile life-sustaining treatment.

d. Recommended course of action

- Multidisciplinary Family Conference: Conduct structured and empathetic meetings. The team must address this financial burden. Involve the medical social worker. Resolving financial duress (e.g., exploring schemes, charity beds) often resolves the ethical conflict.
- Engage Ethics and Palliative Care: Refer the case to the HEC and Palliative Care team for mediation and support.
- Offer a Second Opinion: To build trust, offer the family a second medical opinion from an independent specialist.
- Clarifying the Legal Boundary: Compassionately but firmly explain that because the medical team believes recovery is possible (care is non-futile), the hospital cannot legally or ethically withdraw the ventilator. This is not the case for passive euthanasia.
- Document Everything: Record all clinical findings, family conferences (including finance discussions), HEC consultations, and the team's final rationale.

Scenario 6: Family refuses to pay hospital bill after death, demands body

a. The case

A distressingly common source of public outrage and litigation in the Indian private healthcare sector involves the detention of a deceased patient for non-payment of dues. In this representative scenario—often cited in media reports and consumer court judgments—a patient expires in the Intensive Care Unit (ICU) after a prolonged and costly hospitalization. The bereaved family, financially exhausted, is unable to settle the final "outstanding medical bill" immediately and requests the release of the body for cremation in accordance with their religious customs. The conflict arises when a hospital administration, prioritizing revenue recovery, refuses to release the mortal remains, suggesting that the body will be retained as "collateral" or security until the debt is cleared.

b. The ethical conflict

This scenario differs from the previous ones as it transitions from an ethical dilemma into a clear violation of law and human rights.

- Financial Interests vs. Human Dignity: The conflict is between the hospital's legitimate right to be compensated for services rendered and the fundamental Human Dignity of the deceased and their family.
- Commodification of the Body: By holding a body as security, the institution implicitly treats the deceased as "chattel" or property. This violates the principle of Respect for Persons.
- The Legal-Ethical Boundary: Unlike other scenarios where two rights conflict, here, one action (detention of a body) is legally classified as "Wrongful Confinement" (a criminal offense). The ethical analysis clarifies that while the debt is a civil reality, it cannot be ethically or legally enforced through the violation of the fundamental "Right to Die with Dignity" protected under Article 21.

c. The legal and policy framework (India)

The law is absolute, unambiguous, and firmly supports the interests and rights of the family in all relevant matters.

- Violation of Article 21 (Dignity in Death): The Supreme Court has repeatedly held that Article 21 includes the right to die with dignity. A deceased person is not "chattel" or "property" that can be held as "security."
- Criminal Act (Wrongful Confinement): Detaining a dead body over a financial dispute is a crime. According to the Indian Penal Code (IPC), this constitutes "Wrongful Confinement" (Sections 340-342). The administrators are criminally liable.
- Judicial Precedents and Government Mandates: Multiple High Courts and the National Human Rights Commission (NHRC) "Charter of Patient's Rights" explicitly bans this practice.
- Legal Separation of Issues: The law separates the two issues.

> Issue 1 (The Body): This is a matter of fundamental right. The body must be released.
> Issue 2 (The Bill): This is a civil matter of debt. The only legal recourse available to the hospital is to file a civil suit for recovery.

d. Recommended course of action

- Immediate and Compassionate Release: The body must be released to the family immediately and with dignity. There are no other legal or ethical options.
- De-escalate and Apologize: The team must be trained to de-escalate conflicts resulting from illegal hospital policies.
- Separate Financial Discussion: A trained medical social worker should separately and compassionately discuss the bill, ideally after the body is released.
- Offer Financial Options: Offer a deferred payment plan, accept a token payment, or use a "charity fund" to write off the bill. The family can be asked to sign an "Acknowledgment of Dues" to formalize the civil debt.
- Mandatory Institutional Policy Change: The hospital must have a clear, written, and displayed policy (as required by law in many states) stating: "A deceased's body will not be held for non-payment of bills".

Conclusion

This study demonstrates that the primary bioethical challenges in Indian hospitals are embedded in the nation's legal, cultural, and economic realities. The analysis identifies recurring tensions: the cultural friction between individual and family autonomy; the financial failure of Justice, where catastrophic out-of-pocket costs coerce decisions; and legal anxiety, where a perceived fear of liability, rather than actual law, drives unethical decision-making.

The pedagogical goal is to provide a legally defensible framework that moves decision-making beyond ambiguity. The law—specifically, the expansive interpretation of Article 21 and its corollaries in the MTP Act, the HIV/AIDS Act, and new jurisprudence on end-of-life care—provides a surprisingly clear pathway. Knowing this law transforms "dilemmas" into "protocols".

The tools for walking this path are threefold. First, Communication: empathetic and structured communication is the primary intervention. Second, Documentation: Meticulous contemporaneous documentation of the facts, conflict, legal basis for action, and family communication is the physician's greatest defense. Finally, Hospital Ethics Committees (HECs) must be empowered and used proactively for real-time consultation and mediation, not just as reactive punitive bodies. A robust HEC is the cornerstone of a safe, equitable, and ethical hospital environment.

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Ethical crossroads in reproductive genetics: Balancing rights, risks, and responsibilities

Abstract

The rapid evolution of genetic technologies has transformed reproductive medicine, enabling unprecedented insights into the genetic makeup of embryos and fetuses through prenatal diagnostics and preimplantation genetic diagnosis (PGD). These techniques allow for the detection of genetic abnormalities and inherited conditions before birth or even before implantation during in vitro fertilization (IVF). While such advancements offer substantial benefits, such as preventing severe genetic disorders and empowering reproductive choices, they also provoke deep ethical debates. Therefore, it is essential to critically assess the ethical implications of prenatal and preimplantation genetic testing, focusing on the rights of the mother and the unborn child, the controversial prospect of “designer babies,” the philosophical concern of “playing God,” disability rights critiques, and the contentious practice of screening for late-onset disorders.

Keywords: Reproductive genetics, prenatal diagnosis, moral status, autonomy, bioethics

The right of the mother: Autonomy and informed choice

Central to the ethical defence of prenatal and preimplantation genetic diagnosis is the principle of maternal autonomy. The right of the pregnant individual to make informed choices about her body, pregnancy, and potential offspring is foundational in reproductive ethics. PGD and prenatal diagnostics empower prospective parents with information that may shape their reproductive decisions—ranging from selecting embryos without genetic mutations to choosing whether

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to continue a pregnancy based on fetal health.

However, ethical dilemmas emerge when the principle of autonomy intersects with social pressures and medical expectations. Critics argue that an over-medicalization of reproduction may subtly coerce women into making "rational" choices aligned with societal ideals of health and normalcy (Lippman, 1991). For instance, the availability of prenatal screening may generate implicit pressure to terminate pregnancies with detectable anomalies, even when parents may be inclined to accept a child with a disability. True autonomy requires not just access to information, but freedom from coercion, bias, and social stigma.

The right of the unborn child: Future interests and moral status

Balancing maternal rights are ethical concerns regarding the fetus or embryo, particularly its moral status and future interests. Although the legal status of the unborn varies across jurisdictions, bioethical discourse considers whether fetuses have rights or interests that merit protection—especially as genetic technologies enable proactive selection or de-selection of embryos.

One key ethical challenge is whether PGD and prenatal testing treat embryos or fetuses instrumentally, reducing their value to genetic fitness or conformity with social norms. For example, selecting embryos based solely on their genetic desirability raises questions about conditional acceptance of human life (Devolder & Harris, 2007). Are we valuing future persons for their intrinsic worth, or only for the absence of perceived imperfections?

Moreover, critics question whether selecting for or against certain genetic traits encroaches upon the future autonomy of the child. If a child is selected for specific traits (e.g., intelligence markers or sex), does this impose parental expectations on the future individual, potentially infringing on their right to an open future?

The designer baby debate: Enhancement vs. therapy

The possibility of selecting embryos not just to avoid disease, but to enhance desired traits, such as intelligence, physical attributes, or personality, has sparked intense ethical controversy. This so-called "designer baby" debate distinguishes between therapeutic uses of PGD (to prevent serious genetic conditions) and enhancement (to select non-medical traits). Critics argue that enhancement undermines the moral principle of equality and risks commodifying children.

While current technology largely limits selection to disease prevention, the boundary between therapy and enhancement is not always clear. For instance, is selecting an embryo with a higher predicted IQ a medical intervention or a social advantage? As our understanding of polygenic traits improves, the temptation to enhance embryos for competitive traits may grow—raising concerns about genetic stratification, inequality, and societal pressure to conform to genetic norms (Gyngell et al., 2017).

Supporters of enhancement argue for reproductive freedom, suggesting that if safe and effective, selecting traits could benefit individual children and society at large. Yet, opponents warn that such practices could create new forms of discrimination and deepen existing social divides based on genetic privilege.

Are we playing God? Theological and existential concerns

A frequent criticism of reproductive genetic technologies is that they represent humanity "playing God"—an expression of hubris that defies natural limits and assumes control over creation. While the term lacks precise philosophical definition, it captures unease about human overreach and the moral risks of manipulating life's foundations.

The "playing God" argument is often grounded in religious or existential worldviews that view human life as sacred or fundamentally beyond full human control. Critics worry that genetic selection undermines humility and fosters a culture of perfectionism and eugenics. From a theological view, such as that expressed by Meilaender (2013), altering the genetic future of a child for non-therapeutic reasons risks diminishing the unconditional acceptance of offspring.

Proponents counter that using genetic knowledge to alleviate suffering and empower choice is not hubris but a responsible use of human ingenuity. The question, then, is not whether we are playing God, but whether we are acting ethically with the powers we now possess.

Disability critique: The expressivist objection

Perhaps one of the most profound ethical critiques comes from the disability rights community, which argues that widespread prenatal screening and selective abortion send a message that lives with disabilities are less valuable or undesirable. This is known as the expressivist objection: that the practice of eliminating fetuses with disabilities expresses and reinforces discriminatory attitudes toward people living with those conditions (Parens & Asch, 2000).

For example, the near-elimination of Down syndrome births in some countries due to prenatal screening raises the question: what does this say about society's willingness to accommodate and include individuals with intellectual disabilities?

Defenders of screening argue that the choice to avoid suffering is not equivalent to devaluing persons with disabilities. Yet, the critique highlights a social context in which disability is often seen as a burden rather than as a form of diversity. Ethical practice in genetic screening must be mindful of these dynamics and ensure that reproductive freedom does not come at the cost of reinforcing ableist assumptions.

Screening for late-onset disorders: Ethical timing and uncertain futures

Another controversial application of PGD and prenatal diagnostics is the screening for late-onset genetic disorders—such as Huntington's disease, BRCA-related cancers, or Alzheimer's. These conditions may not manifest until adulthood, and in some cases, may never become symptomatic due to variable penetrance or future medical advances.

Screening embryos or fetuses for such conditions raises several concerns:

- Informed Consent: Future individuals are denied the choice to remain ignorant of their genetic predispositions.
- Psychological Harm: Knowledge of a likely but distant genetic fate may lead to anxiety, stigma, or fatalism.
- Moral Justification: Is it ethically justifiable to discard embryos based on a risk that might not materialize for decades?

Critics argue that screening for late-onset disorders oversteps ethical boundaries by promoting genetic determinism and undermining the unpredictability of human life. Proponents argue that families should have the right to avoid transmitting severe hereditary conditions, especially when no cure exists (Knoppers et al., 2006). The ethics here hinge on balancing reproductive rights with respect for uncertainty, psychological impact, and future autonomy.

Conclusion: Navigating ethical complexity in genetic futures

The ethical landscape of prenatal diagnostics and PGD is a complex intersection of reproductive rights, moral philosophy, and societal values. It invites a rethinking of autonomy, responsibility, and the meaning of health, disability, and human diversity. While these technologies offer tangible benefits in preventing suffering and enabling informed choices, they also risk reinforcing social inequalities, commodifying reproduction, and marginalizing those who do not conform to genetic ideals.

Ethical governance must ensure that these technologies are used in ways that uphold human dignity, respect individual autonomy without coercion, and foster inclusive societies that value all forms of life—regardless of genetic makeup. Policymakers, healthcare providers, and bioethicists must collaborate to establish frameworks that balance innovation with moral responsibility, always keeping in view the question: not just what we *can* do, but what we *should* do.

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Panel Discussion Summary: Ethical Practices in Healthcare Institutions

The panellists focused on exploring and reinforcing ethical practices in healthcare, especially within the Indian and global contexts. They shared insights on the drivers, challenges, and potential frameworks for ethical conduct in hospitals, while also highlighting the unique role of faith-based communities, particularly the Christian community.

Background

Today's healthcare environment faces complex moral challenges—from end-of-life decisions and patient consent to financial pressures and systemic inequity. For doctors, administrators, and faith-based institutions, these issues are no longer theoretical—they arise daily at the bedside and boardroom. As medical technology advances and healthcare becomes increasingly commercialised, the need for clear ethical direction is urgent.

Religious institution-led hospitals, once known for their compassionate, value-driven care, are under growing pressure to conform to market-driven norms. There is a critical need to revisit our foundations and strengthen our moral compass.

Introduction

In today's fast-evolving healthcare landscape, ethical dilemmas are becoming increasingly complex. As medical technology advances and systems become more commercialised, healthcare institutions—especially in India—face a crisis of trust, purpose, and moral direction. This summary draws on insights from a recent panel discussion to evaluate the current situation, articulate key ethical challenges, and propose actionable steps to integrate robust ethical frameworks into healthcare institutions. Particular emphasis is placed on the unique leadership potential of faith-based and Christian healthcare organisations.

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The Ethical Imperative in Healthcare

Ethical healthcare is not a luxury—it is foundational to quality, trust, and justice in medicine. Institutions known for ethical rigour report higher patient satisfaction, better health outcomes, and stronger staff morale. Ethical practices improve communication, ensure patient dignity, and reduce the likelihood of malpractice and litigation. Furthermore, they provide a stabilising compass in ambiguous clinical situations, reinforcing the principle of care before profit.

Why Should Healthcare Institutions Be Concerned About Ethical Practice?

- **Quality of Care & Trust**: Ethical practices directly improve the quality of care and patient satisfaction. Patients trust institutions known for integrity and respectful treatment.
- **Reputation & Sustainability**: Long-term business success is better served through ethical conduct. Institutions known for values attract committed professionals.
- **Value-Based Workforce**: Ethical organisations tend to draw value-driven personnel, creating resilient systems even in ambiguous situations.

What Are the Key Drivers of Ethical Practice?

1. **Passion & Motivation**
    - Entry into the medical field should be driven by genuine interest, not societal pressure or commercial motives.
    - Motivation affects respect for patient dignity and engagement in care.
2. **Education & Sensitisation**
    - Ethics should be integrated from the undergraduate level onward.
    - Continuous reinforcement is necessary during professional practice.
3. **Values, Knowledge, Attitude & Environment**
    - These four pillars must be cultivated together for ethical conduct to flourish.
4. **Financial Independence**
    - Decisions should not be financially incentivised. Linking rewards to financial targets undermines ethical integrity.

What Are the Major Challenges?

- **Economic Pressure**
    - Hospitals driven by profit may compromise ethics.
    - Financial strain influences treatment options, especially in resource-scarce settings (e.g., euthanasia policies in some countries have been influenced by financial concerns).
- **Lack of Social Audits & Public Accountability**
    - No structured mechanism to assess ethical standards or ensure patient rights are protected.
- **Disparity & Inequality**
    - The poor are most affected, lacking both options and awareness of rights.
    - Government hospitals are often overstretched; private ones are unaffordable.
- **Breakdown in Doctor-Patient Relationship**
    - Tensions due to mistrust and miscommunication are rising.
    - Defensive medicine and lack of grievance redressal worsen the gap.

How Do Societal Changes Impact Healthcare Ethics?

- **Rising Individualism & Transactionalism**
    - There's a shift from altruistic, service-driven healthcare to profit-oriented models.
    - Ethical traditions rooted in community and care are eroding rapidly.
- **Loss of Moral Anchors**
    - Both Western and Indian systems have seen a decline in value-based healthcare.
    - There's a need to reconnect with indigenous and faith-based ethical traditions.

What Is the Role of Faith-Based Healthcare (Especially Christian Institutions)?

- **Christian Institutions as Torchbearers**
    - Many were founded with missionary ideals and still uphold values of compassion and service.
    - They must resist pressures to conform to secular, profit-driven and incentive-based models.

- **Modelling Ethical Practice**
    - These institutions can lead by example and collaborate across faiths to build a common ethical standard for India that respects cultural and spiritual diversity.
- **Reviving Mission**
    - Christian healthcare should reflect Christ's sacrificial love and hospitality.
    - Encouraged to support other faith communities in defining and expressing their own ethical visions.

Proposed Framework for Ethical Implementation

1. **Institutional & Clinical Ethics Committees in hospitals**
    - Mission Hospitals to be facilitated to set up Institutional & Clinical Ethics Committees – multidisciplinary bodies to guide decisions and relieve doctors from sole moral burden.
2. **Fellowship and Support**
    - Churches can create spiritual support groups for members who are healthcare workers to reflect, de-stress, and uphold their calling.
3. **Feedback Mechanisms**
    - Systems to collect and respond to patient and family feedback throughout their care journey.
4. **Public Participation & Social Audits**
    - Empower communities to engage in health governance and hold institutions accountable.
5. **Church Backing**
    - Christian health institutions need theological and moral support from the wider church community to continue upholding their mission amid external pressures.

Execution Plan: Turning Vision into Reality

Phase I: Mobilisation (0–3 months)

- Convene leadership from Christian healthcare institutions and faith-based networks.
- Establish a central ethics advisory board with interfaith representation.

Phase II: Framework Development (3–6 months)

- Create standard templates for ethics committees, feedback tools, and policy guidelines.

- Conduct ethics training programs and workshops for staff and leadership.

Phase III: Pilot Projects (6–12 months)
- Implement ethical frameworks in 3–5 selected hospitals.
- Monitor effectiveness using case studies, staff surveys, and patient feedback.

Phase IV: Evaluation and Scale-Up (12–24 months)
- Analyse pilot outcomes and refine tools.
- Roll out across faith-based networks and eventually propose integration with national healthcare accreditation standards.

Conclusion

Ethical healthcare is the bedrock of a just, inclusive, and humane society. As healthcare systems evolve under technological, economic, and cultural pressures, it becomes increasingly important to reinforce the values that first gave medicine its moral compass. Faith-based institutions—especially Christian hospitals—must lead this transformation with vision, courage, and humility. Through coordinated action, inclusive frameworks, and community-centred leadership, we can build a healthcare ecosystem that truly heals.

Participants in the Panel Discussion:

Moderator: Dr. Olinda Timms
Panelists: Rev. Dr. Alexander M Isaac, Dr. Vijay Aruldas, Dr. Roopa Varghese, Prof. Dr. Brian Butcher and Mr. Sujith Varghese George.

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