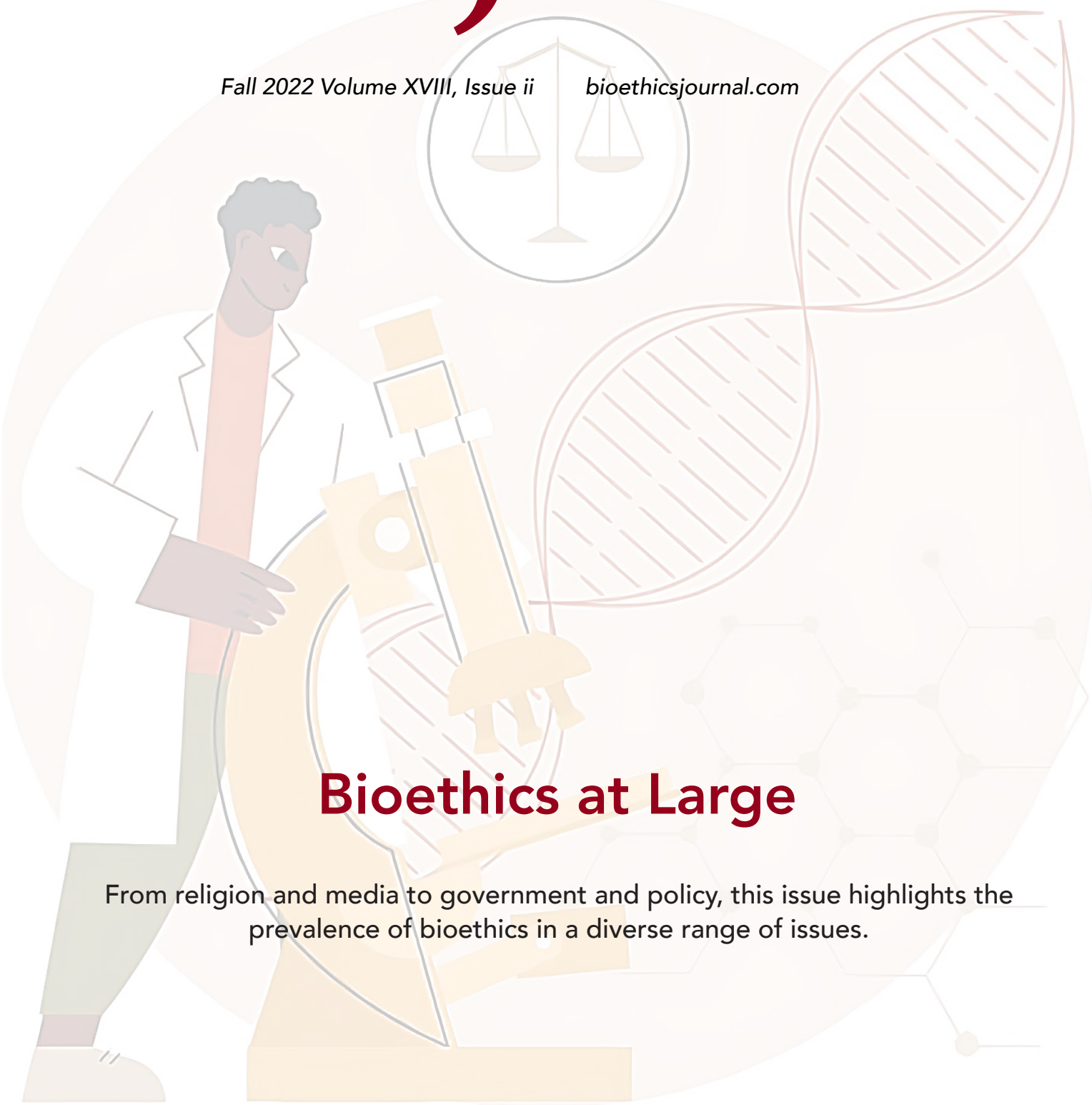
PBJ | PENN BIOETHICS JOURNAL

*Fall 2022 Volume XVIII, Issue ii* *bioethicsjournal.com*



# Bioethics at Large

From religion and media to government and policy, this issue highlights the prevalence of bioethics in a diverse range of issues.

# Penn Bioethics Journal



The Penn Bioethics Journal (PBJ) is the premier peer-reviewed undergraduate bioethics journal. Established in 2004, the Journal provides a venue for undergraduates to make contributions to the field of bioethics.

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Philadelphia, PA. ISSN: 2150-5462

# Content

# Letter from the Editors

Dear Readers,

It is our pleasure to present you with Volume XVIII, Issue ii of the Penn Bioethics Journal, entitled "Bioethics at Large." The articles in this issue highlight the prevalence of bioethics in a diverse range of issues, ranging from religion and media to government and policy.

The first article, "'The Opportunity to Turn Around': An Islamic Bioethics Approach to the Responsibility of Physicians to Care For Their Patients in the Face of War, Sickness, and Strife," evaluates whether it is ethical for medical professionals to leave their posts in times of crises. The authors use religious discourse to propose unified recommendations for the World Health Organization (WHO) and the United Nations.

The second article, "How Medicalization in Media Breeds Social Construction in Menopause," explores how mass media has scrutinized the aging of women, particularly those who experience menopausal symptoms. Author Julia Leigh Beilis argues that healthcare and media institutions need to reject fallacies surrounding menopause and create a more tolerant, accepting environment for older women.

The third article, "Diagnosing the Bumpy Landscape of Democracy: Phrenology's Prominence in Antebellum America," discusses the rise of phrenology and how the pseudoscience, coupled with scientific racism and spirituality, rose to prominence in antebellum America. Author Shaan Bhandarkar utilizes this recount of phrenology to analyze the evolution of American democracy and highlight shortcomings and contradictions between the nation's preached values and implemented practices.

Our Bioethics-in-Brief section covers current issues in the field of bioethics. In our first brief, Advait Thaploo explores the use of artificial human embryos, highlighting notable achievements and the host of bioethical questions unlocked by the dropping of the 14-day rule in 2021, which previously enforced that all human embryos must be stopped at 14 days. In our second brief, Caitlyn Chen examines the current discourse on abortion policy for migrant children. Many migrant children experience sexual violence in their home countries or during their migration and turn to the United States for abortion access; however, this access has been greatly limited since the controversial reversal of *Roe v. Wade*. Chen analyzes policies enacted by the Trump and Biden administrations to argue that access to abortion is a universal right and must be maintained despite a changing political climate.

We would like to thank our faculty advisor, Dr. Harald Schmidt, for his support during the editing and publication process. Additionally, we would like to thank our publisher and amazing team of editors, without which this issue would not have been possible. These past couple of years have been filled with unprecedented changes, and we are so proud of our PBJ community for rising to the challenge.

We hope you enjoy this latest issue of the Penn Bioethics Journal and that it inspires you to engage with the field of bioethics. Please contact us with any questions, comments, or ideas for collaboration at pbjeditorinchief@gmail.com.

Ella Atsavapranee and Amy Chen
Editors-in-Chief
University of Pennsylvania C'23

# Article

# 'The Opportunity to Turn Around': An Islamic Bioethics Approach to the Responsibility of Physicians to Care For Their Patients in the Face of War, Sickness, and Strife

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**ABSTRACT**

The COVID-19 pandemic has prompted necessary and urgent conversations pertaining to bioethics. Significant attention has been paid to the public's response to — and often ignorance of — public health mandates, but medical professionals continue to bear the brunt of the pandemic. They put themselves at risk in order to heal others; they hold the hands of those who would otherwise die alone; and they continuously uphold their duties to serve and protect, even in the face of criticism and vitriol. As a result of this immense pressure, medical professionals have exited the field in unprecedented numbers. At the same time, the war in Ukraine has further amplified — and complicated — discussions concerning the duties of physicians and nurses. Ukrainian medical professionals are tasked with not only confronting an ongoing global pandemic, but managing the physical and mental trauma of warfare itself. Thousands of Ukrainian soldiers and civilians, including children, have suffered injury or worse. Millions of Ukrainian citizens have fled, and millions more have been internally displaced. While the number of medical professionals who chose to remain in Ukraine is unknown, we may assume that they represent a selfless minority, with a significant number of physicians assumed to have left the country. Over the course of this article, we evaluate the question of whether or not it is ethical for medical professionals to leave their posts in times of crises, coupled with the ever-complex task of balancing one's responsibilities to others with their responsibilities to themselves. Our investigation specifically utilizes religious discourse to propose unified recommendations to guide the World Health Organization (WHO) and the United Nations in these difficult times. In particular, we give emphasis to Islamic thought and literature in order to provide a perspective that is not common in Western bioethics.

## INTRODUCTION

The emergence of the novel virus SARS-CoV-2, commonly referred to as COVID-19, and the subsequent global pandemic has elicited numerous debates and conversations pertaining to bioethics. As public health mandates restricted travel and shuttered businesses, the international community was forced to reckon with competing desires for individual autonomy and collective safety. The development of a safe and effective vaccine brought forth different challenges, namely inequitable resource allocation, individual and community vaccine hesitancy, and clashing perspectives on how to navigate variants of the virus. Altogether, the past two years have provided us with ample evidence that the issues at the center of bioethics are not restricted to specific groups nor isolated populations, but all of society.

Over the course of the pandemic, media and political attention alike has focused primarily on the merits and intensity of public health mandates, as well as the public's adherence, or lack thereof. However, the duty of medical professionals and the burdens that have befallen them have been largely overlooked. They have risked infection and death to care for their patients; they have rationed subpar protection and inadequate supplies; they have isolated themselves from friends and family; they have held the hands of the dying and alone. Even amidst discourse, anti-vaccination movements, and the politicization of health itself, doctors and nurses have neglected their own physical, emotional, and mental health in order to serve the public. At the same time, however, due to unprecedented pressures and stress, there has been a mass exodus from the medical field. The United States alone has observed the loss of at least 250,000 healthcare employees since February 2020,[1] and close to 25 percent of current healthcare workers say they are likely to leave the field in the near future.[2]

Against this backdrop, on February 24, 2022, Russian soldiers invaded Ukraine, escalating pre-existing tensions

[1] "The Employment Situation - April 2022 - Bureau of Labor Statistics," Bureau of Labor Statistics
[2] Chris Jackson, "American Healthcare Workers Persevering, but Remain Stressed "

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born out of the ongoing Russo-Ukrainian War. The 2022 rampage in Ukraine has been devastating, with the destruction of over 2,100 buildings and more than $600 billion ($USD) in property damage.[3] As the conflict, at the time of this article's writing, approaches the three-month mark, effectively every aspect of civilian life has been adversely impacted, with approximately 8 million Ukrainians — nearly a fifth of the national population — having been displaced.[4] The crisis has also claimed the lives of at least 46,000 people, with another 13,000 suffering severe, non-fatal injuries.[5] Coupled with the already urgent state of pandemic within Ukraine, the dual-edged conflict represents a confluence of separate humanitarian crises to which all people, but especially medical professionals, must respond.

Since the war's onset, we have no clear understanding of the state of the pandemic in Ukraine. Calculated estimates place the incidence at 5,000 new cases each day, as overcrowding within makeshift health centers, lack of sanitation, and limited healthcare supplies facilitate the rapid spread of infection.[6] And yet, we are unable to confirm case or mortality rates due to a lack of diagnostic testing, combined with a healthcare system that is understandably prioritizing traumatic injuries caused from warfare. Thus, the Ukrainian healthcare system is stretched incredibly thin, especially as medical professionals join the nearly seven million refugees who have fled Ukraine.[7]

Given this context, this paper seeks to evaluate if it is ethical for medical professionals to leave their posts in times of crises. Prior approaches have examined these issues through perspectives centered around mental health, socioeconomics, and nationality. Instead, our study will utilize the texts, literature, and teachings of Islamic tradition to not just answer this question, but also to propose unified recommendations to inform responses of the World Health Organization (WHO) and the United Nations. First, we will examine the current state of medical support in Ukraine and the obligations of medical professionals. Then, we will contextualize the Islamic tradition regarding warfare, medicine, and the patient-doctor relationship. Finally, we will propose recommendations for the World Health Organization, based on our research and existing case studies, to best support Ukrainian medical professionals.

## I. THE STATE OF THE HEALTHCARE SECTOR IN UKRAINE

The current reality for Ukrainian healthcare workers, hospitals, and patients is unequivocally and understandably grim, as the unique struggles incurred by the medical community are a reflection of the greater atrocities that have thus far defined the crisis. An external situation report from the World Health Organization, published on May 26 of this year, estimated that the escalation of the Russo-Ukrainian war had, at the time of the report's publishing, displaced approximately 8 million Ukrainian citizens– 18% of Ukraine's total population.[8] Of these internally displaced persons, 6.6 million have fled into countries surrounding Ukraine, with fifty-three percent of those refugees having found solace, solidarity, and shelter within the borders of Poland alone.[9] And yet, the crisis— and, by extension, the Ukrainian medical community at large— is haunted by those who were not so fortunate; whether they remained in Ukraine to fervently defend their families and homeland or simply did not have the means or time to escape, the war has (as of May 2022) claimed 3,988 civilian lives, coupled with 8,691 civilian casualties.[10] And as the war enters its thirteenth week at the time of this article's writing, all of these metrics are expected to increase— exacerbating the already-present pressures on and instabilities of Ukraine's health sector.

To contextualize the state of the current Ukrainian health sector is to address and abhor Russia's calculated attacks on health facilities, transports, personnel, supplies, and similar resources, which have collectively stood as the largest impediment to care. The WHO has reported twenty-one new attacks on healthcare institutions between May 19 and May 25 alone, with a total of 256 attacks carried out since the beginning of the invasion to May 2022.[11] These attacks have drawn international ire and condemnation, particularly as these devastating assaults targeted some of

[3] Tom Balmforth, Pavel Polityuk, and Terje Solsvik, "As Russia Intensifies Push for Donbas, Ukraine Rules out Ceasefire," Reuters
[4] Balmforth, Polityuk, Solsvik, "As Russia Intensifies Push for Donbas, Ukraine Rules out Ceasefire."
[5] Ibid.
[6] Dmytro Chumachenko and Tetyana Chumachenko, "Impact of War on the Dynamics of Covid-19 in Ukraine," ReliefWeb
[7] "Operational Data Portal," Situation Ukraine Refugee Situation
[8] World Health Organization, "Emergency in Ukraine: External Situation Report #13," 2
[9] "Emergency in Ukraine: External Situation Report #13," 2.
[10] Ibid.
[11] Ibid.

Ukraine's most vulnerable populations; for example, the world watched in horror on March 9 as the Russian Air Force bombed Mariupol's Maternity Hospital No 3— an institution simultaneously operating as a children's hospital and maternity ward.[12] At the other, equally detestable end of the spectrum, these attacks have given rise to grave tensions within Ukraine's medical supply chain, with a March 14 statement from the WHO articulating that hospitals are ill-equipped to even provide cursory care to the sick and wounded.[13] And, to place these onslaughts in the greater framework of international healthcare, explicit and implicit attacks on healthcare amidst situations of conflict— ranging from airstrikes and destruction of healthcare facilities and vehicles to kidnappings and arrests of healthcare workers— have been persistently on the rise across the world since 2016. Specifically, more than four thousand incidents of violence against healthcare in conflict areas were reported in the period between 2016 and 2020 alone.[14]

Simply put, disruptions have occurred in every facet and department of the Ukrainian healthcare system as a result of Russian brutality. However, Ukrainian physicians are engrossed in a two-pronged struggle against not just advancing Russian troops, who threaten their lives, the lives of their patients, and the conditions under which they are able to serve those patients, but also the ongoing COVID-19 pandemic. Prior to Russia's invasion, only thirty-six percent of Ukrainians had received their first vaccination, making the cramped, close-quartered conditions under which physicians must tend to their patients an almost assured recipe for COVID-19 spread, among other infectious diseases.[15] To mitigate these risks, outside organizations— most notably the WHO, Doctors Without Borders, and the International Medical Corps— have been delivering medical supplies and personnel to the areas most affected by the invasion, with 514 total metric tons of medical supplies delivered, ranging from trauma and emergency surgery supplies to essential medicines and refrigerators.[16] Moreover, the system is suffering from shortages elsewhere in the supply chain as well. Fuel shortages continue to pose problems both for the transportation of goods and keeping the power on for things such as refrigerators and electrical-powered medical equipment. Medicinal aid is not only arriving in Ukraine, however, as much of the medical aid set aside for the invasion is being delivered to the countries surrounding Ukraine, destined for refugees and displaced persons in need of medical care once they achieve relative safety.[17] The WHO and other non-governmental organizations (NGOs) have been assisting Ukrainian refugees crossing the border into Poland to increase the vaccination rates of Ukrainian refugees against COVID-19, measles, and polio, as well as delivering life-saving HIV/AIDS medicine to refugees dealing with these pre-existing conditions.[18]

## II. THE DUTY OF DOCTORS

In order to better understand the plight of Ukrainian physicians, one must develop a proper understanding of what is the expected standard of commitment and duty of physicians themselves. The duty of doctors has been outlined by the Hippocratic Oath, with its overarching principles present within and adapted by a wide variety of religions. By analyzing the original Hippocratic Oath and the Islamic adaptation side by side, we can begin to understand what Islam expects of all those who take on the role of the physician. The original oath requires doctors to promise that whatever homes they enter, they will "help the sick" and keep themselves "free from all intentional wrongdoing and harm".[19] However, this clause is the only one that explicitly discusses the physician's duty to serve their community. Regardless, pivoting to modern medical practice, there has been an emergence of explicit and equal emphasis on physicians keeping *themselves* protected in their duty to act with beneficence. For example, many medical training curricula, including that of the American Red Cross, teach first responders to ensure their own safety prior to that of their patients, as an injured physician is unable to provide others adequate and effective care. That said, one can extrapolate that Western medical practice teaches a degree of self-preservation that runs parallel to the Hippocratic Oath's focus on a physician's duty to serve their community.

Alternatively, Islam's adaptation of the Hippocratic Oath asks Allah to "give [doctors] the understanding that [theirs] is a profession sacred that deals with [Allah's] most precious gifts of life and intellect, [and]... make [them] worthy of this favored station with honor, dignity and piety so that [they] may devote [their] lives in serving mankind".[20] Unlike the original oath, which simply requires doctors to "help the sick," the Islamic version emphasizes the sanctity of life and honors the role of a physician as a *protector* of life. The adaptation also asks physicians to devote their lives to not just helping, but serving mankind, an arguably more powerful task— but does this oath ask physicians to *sacrifice*

[12] Mstyslav Chernov, "Pregnant woman, baby die after Russian bombing in Mariupol," AP News
[13] "WHO is working day and night to keep medical supply chains open and preserve Ukraine's health system," World Health Organization
[14] "Ineffective Past, Uncertain Future," Insecurity Insight
[15] "Coronavirus (COVID-19) Vaccinations," Our World in Data
[16] "Emergency in Ukraine: External Situation Report #13," 2.
[17] Ibid.
[18] Ibid.
[19] Jonathan Kopel. "The Hippocratic Oath across the interfaith spectrum." Proceedings (Baylor University. Medical Center) vol. 35,2 266-269.
[20] Ibid.

*their life* for mankind?

While the Islamic version of the Hippocratic Oath may not explicitly describe an obligation to society, as adopted by the Western version, by understanding the oath within the context of the physician's role in Islam, one can clearly see that this obligation to society is *even more explicit* in Islam than it is in Westernized nations. The answer to this question can be found in the Qur'an, the central religious text of Islam. One of the most cited sections regarding a physician's duty is the following: "Whoever killeth a human being, not in lieu of another human being nor because of mischief on earth, it is as if he hath killed all mankind. And if he saveth a human life, he hath saved the life of all mankind."[21] In fact, this quote is actually used in the Islamic version of the Hippocratic Oath to emphasize the role of a physician as the preserver of life. Scholars have simultaneously analyzed what it means to kill a human being, and Imam Sadegh quoted [the Messiah] about the responsibility of a doctor: "Whoever leaves curing the wound of an injured, inevitably is the partner of the person who landed the wound on his body. (Koleini 8/345)".[22] This quote not only suggests that a doctor is compelled to help an injured person, but that they are responsible for the harm caused if they don't. Furthermore, if they fail to treat someone, and that person dies, then the doctor is a "partner" in their death, which Islam considers a transgression to all of mankind. This logic seems to suggest that when inaction leads to harm, that inaction not only violates the principle of beneficence, but the rule of non-maleficence as well; by not doing good in such a scenario, one is causing harm to all of humanity. Furthermore, in addition to the requirement to treat patients, a physician also has a duty to "go to his patient (Haman)".[23] This quote suggests that the doctor is not allowed to select when they would like to treat their patient, and that they are always compelled to go above and beyond in order to seek out patients to serve.

## III. THE IMPORTANCE OF DOCTORS THROUGHOUT ISLAM'S HISTORY

To further situate the duty of doctors within an Islamic framework, one must take a step back and recognize the importance Islamic society has placed upon the history and development of medicine at large. During the period of the Dark Ages, when Islamic culture began making headway in broad expansion, a marked difference in their expansionism was the tolerance they expressed towards conquered populations, which is rooted within Islamic teachings' emphasis on the importance and the respect of learning from others for the betterment of society at large. This fostered a general atmosphere in which advances in both medicine and healthcare systems were permitted to flourish; for example, during this period of Islamic civilization, there was a finely-tuned adaptation towards how hospitals themselves operated that worked to set a standard within Islamic society. Specifically, the establishment of secular hospitals in the early-900s, where all were welcomed regardless of their race or religion, coupled with the management of the hospital being placed in the hands of the overseeing government, created a space where the well-being and needs of the patient were put first.[24]

This evolution of medical care also extended to the *quality of doctors* that Islamic society sought to preserve. In 931 A.D, the Caliph Al-Mugtadir from the Abbasid dynasty ordered the Chief Court Physician Sinan Ibn-Thabit, to screen the 860 physicians of Baghdad, mandating that only those qualified were granted license to practice.[25] This process was expanded to include other cities, such as Mecca, Medina, and Damascus, in order to simultaneously protect traveling pilgrims and prevent the spread of disease. This high standard set for hospitals and those working in them was bolstered by the prosperous people of this empire. For doctors, their role was held in high regard, as although anyone could study to become a physician, one was also expected to study philosophy, astronomy, art, and chemistry (among other subjects) before being accepted to train as a medical student.[26] In essence, Islamic society aimed to develop physicians into not just healers, but cultured individuals of wisdom and knowledge; this expectation is embedded within the very Arabic title of a physician, "Hakim," which translates directly to "sage."[27]

## IV. THE ISLAMIC PERSPECTIVE ON THE DOCTOR-PATIENT RELATIONSHIP

With the significance of the role of a physician within Islamic culture, practices, and beliefs thoroughly illustrated within the previous section, there is an additional scholarly undertaking that one must venture to make prior to discussing Islam's embodiment of the doctor-patient relationship and, by extension, prior to returning to the question of how physicians must weigh their responsibility to

[21] Quran 5:32
[22] Seyed Hassan Saadat, "A brief survey on Medical Ethics regarding the Holy Quran and Isalmic Hadith," International Journal of Medical Reviews, Volume 1, Issue 1 (2014): 11
[23] Saadat, "Medical ethics in Islamic literature"
[24] Fazlur Rahman, "Islam and Health/Medicine: A Historical Perspective" in *Health and Restoring: Health and Medicine in the World's Religious Traditions* ed. Simon & Schuster (New York: 1989), 159.
[25] Rahman, "Islam and Health/Medicine," 161.
[26] Rahman, "Islam and Health/Medicine," 162
[27] Ibid.

others against their responsibility to themselves in the face of war and illness. This undertaking refers to the need to consider whether the relationship between Islam and medicine identified within this article is the result of a series of Islamic beliefs *being applied* to the bioethical dilemmas facing today's physicians or, more profoundly, is an *intrinsic* relationship unique to Islam and the Quran's teachings as a whole. Indeed, scholar Felix Klein-Franke, quoted by Fazlur Rahman, summarized the inseparable connection between Islam and the medical perspective, believing that those who "[undertake] to deal with medicine in Islam [do] not take on a slender lateral path *on the side* of Arabic literature—his way, rather, leads him to the very heart of Islamic culture".[28] While the statement itself necessitates supplemental evidence, this evidence is precisely what has been brought forward in the previous section, and by extension serves as a concise basis from which to build the remainder of the argument that it is wholly unethical from an Islamic medical perspective for physicians, even in a time of great strife and crisis, to abandon their patients.

### i. The Obligation of Medical Treatment

First and foremost, in order to answer this question, the actual relationship between physician and patient through the lens of the Quran must be established, along with the limitations of this relationship. Immediately, one may turn to the broadly-interpreted Quranic verse 4.71, urging Muslims to "guard [themselves]" against any and all forms of danger. In this single verse alone, a precedent is set, detailing that the pursuit of medical treatment is obligatory upon *patients*, namely as a conduit to circumvent knowingly bringing harm upon one's self.

At the same time, the Quran asserts that Muslims "do not cast [themselves] into perdition".[29] While the interpretation of this verse may be perhaps even more varied from reader to reader than the previously mentioned verse, the understanding of this particular verse can be supplemented by a series of *hadiths* that explicitly forbid the desire and wishing for death. While there are thousands of *hadith* texts, the following text succeeds in articulating the topic from the ill patient's perspective themselves: "My Lord! Keep me alive so long as life is good for me and end my life if the end is good for me."[30] Through this proclamation, one is able to gather the implication that the final say in whether an individual lives or dies is a divine right that must be preserved as Allah's, rather than the purview of mortals. Akin to other religions throughout history, the assertion that a mortal individual has either more power or knowledge than the divine being to whom they serve and honor is strictly

forbidden, reinstating the idea that suicide is forbidden. Thus, failing to pursue medical treatment with the knowledge that treatment is *necessary and sufficient* for avoiding death would, by extension, constitute a "death wish" on the part of a Muslim patient, coupled with the understanding that a self-determined death goes against Islamic teachings.

All of this being said, the Quran and *hadith* literature paints an explicit picture of the patient's role in the Islamic doctor-patient relationship, namely as someone who is willed to seek out physicians for the sake of honoring the Quran's aversions to knowingly welcoming harm unto oneself. However, the included verses say very little, if anything at all, regarding the obligation on the part of the *physician* in the dynamic of medical treatment—which, of course, is at the heart of this article's central question. If acquiring treatment is obligatory from an Islamic perspective, is *providing* treatment obligatory as well? In order to answer this, additional passages of the Quran and *hadith* literature as a whole must be examined to reveal not just Islam's teachings on caring for others, but conversely, the practical roles of suffering that emerge when care is *not* acquired or provided.

### ii. The Caveat Underlying Suffering

Before addressing the topic of this subsection, it is necessary to acknowledge the important distinction between the Sunni and Shia within Islam, particularly as they are both employed throughout this article. Islam, as with any religion, is not a monolith nor should it be interpreted as such, and the two sects should be allocated equal degrees of respect and consideration. However, the Sunni and the Shia are known to largely agree on the fundamental tenets and pillars that uphold what Islam is at its core.[31] This being said, as the purpose of this article is to use Islamic beliefs to provide a more nuanced picture of the bioethical dilemmas intrinsic to a war plagued by a pandemic, rather than serve as a theological analysis, both Sunni and Shia *hadiths* are referenced within this text.

[28] Rahman, "Islam and Health/Medicine," 150.
[29] Quran 2.195.
[30] Rahman, "Islam and Health/Medicine," 158.
[31] Rahman, "Islam and Health/Medicine," 157.

With this in mind, while Sunni *hadith* dominates discussions that allow scholars and believers to navigate the role of medicine within Islam, the Shia *hadith* places a much more explicit emphasis on the functionality and practicality of suffering. Intrinsic to Shia *hadiths* is the sense that suffering plays a positive role in progressing and amplifying one's faith, which is most clearly seen through the common Shia *hadith* that one night's pain and sickness is better than forty years of worship.[32] While this may appear to contradict the previous section's assertion that failing to seek treatment is a betrayal of the Quran's teachings, this *hadith* operates under the assumption that one's suffering is not "unbearable," i.e. requiring medical treatment as to avoid death. Indeed, this specific class of suffering has been found to serve a trifecta of roles: a purgative role; a punishment role; and a "delayed gratification" role.[33]

Together, these three purposes of suffering combine in order to establish the idea that illness, as contextualized within Islamic culture, is a tool through which one is challenged and ultimately perfected by Allah.

However, in answering the question of suffering's role within Islamic teachings, yet another emerges: if to suffer is to be perfected, would that not make physicians' abandonment of patients ethical, as it would force patients to incur suffering and, by extension, catalyze Allah's "perfecting" of their beings through repentance? Furthermore, is death, when one is truly unable to acquire medical treatment, not the utmost form of suffering, and thus the most preferable and honorable in the eyes of Allah?

The answer to these questions, now, demands an Islamic perspective on the balance between suffering as a mechanism of piety and what constitutes a pious life.

### iii. The Prolongation of Life

Much of Western bioethics has underscored the intense, ongoing divide between whether or not preservation of life itself should be predicated upon *length* or predicated upon *quality*. This debate has largely manifested in national disputes pertaining to the right to refuse treatment (which is dictated by a patient's own prioritization of either life prolongation or actual symptom management), as well as the concepts of "inappropriate" care (which regards the question of if intended care will genuinely improve the patient's quality of life), and withholding care altogether (if care is deemed exorbitant, unnecessary, or harmful); the central tension within each of these issues is whether or not care should be delivered as a means of "staving off" death or as means of minimizing individual suffering. Islamic tradition, however, is explicitly concerned with the prolongation of life. As previously mentioned, Muslim followers are forbidden from praying for death, but this belief alone fails to encompass the full scope of how Islamic texts interpret the *purpose* of life itself—and, ultimately, how that purpose is sustained.

To begin broadly, a common saying within Islamic tradition is "May God give you long life," articulating that a long life is desirable and preferable. In the interest of digging deeper, one may look no further than the following Shia *hadith*, which, again, dissuades Muslims from committing suicide: "Let none of you [Muslims] desire death, for if one is a good person, *perchance one's goodness will increase*, and if one is evil, perchance they will get *the opportunity to turn around.*"[34] Here, the length of one's life is clearly equated to the amount of time they have to nurture and foster their "goodness", to practice and share the teachings of the Quran and Allah, and to broadly "do good;" even if one is considered an "evil" person, allowing their life to progress and evolve provides them with the opportunity to eventually do good themselves. Moreover, this *hadith* implies that the quality of one's life is analogous to the length of their life and the prospect of their life to positively impact others and the world in which they live. In Islamic tradition, the length of one's life and the quality of one's life are *one and the same.*

Having clarified the Islamic viewpoint of what truly constitutes a "good" life, one is able to return to the questions posed in the previous section of this article. While suffering is indeed considered a great act of piety and religious devotion in Islamic tradition, there lies a subtle implication that the suffering is to *stop* or be *alleviated*, such that the victim can act on the lessons they learned and positively contribute to society with greater fervor and enthusiasm. Allowing for a sufferer to learn such lessons, yet ultimately die, would make the role of suffering as a perfecting tool by Allah ultimately unsustainable—his most perfected creations would not live to spread his teachings or share his lessons with others.

With this final piece to the proverbial puzzle, one arrives at the conclusion that allowing a sufferer—or, in the context of this argument, a patient—to die would be to knowingly shorten their life and abruptly stunt their capacity to do good on the behalf of Allah, which is perceived as inherently immoral and wrong. Before making a final judgment that will sufficiently support this article's argument, one may look at Quranic teachings to see whether or not this is a generalizable duty to all Muslims—akin to the Parable of the Good Samaritan observed in Christianity, in which the obligation to help one's neighbor falls on *all* neighbors—or a responsibility that falls particularly heavy

[32] Rahman, "Islam and Health/Medicine," 157.
[33] Ibid.
[34] Rahman, "Islam and Health/Medicine," 158.

upon the shoulders of physicians themselves.

**iv. The Duty of the Physician from an Islamic Lens**

Now, one is able to return to the question of the obligation of treatment and, therefore, the bioethical manner by which physicians should uphold their roles as caregivers in the face of crises that will surely challenge any and all. Of course, it is necessary to address the counterarguments that are not purely born out of the Islamic perspective itself. For example, if one were to adopt a utilitarian approach to the physician's choice to remain at their proverbial post amidst conflict in Ukraine, it can be readily seen how one may urge a physician to flee. With nearly 400 Ukrainian medical centers having been destroyed in Russian attacks since the inception of the war, coupled with Ukraine condemned with the lowest overall COVID-19 vaccination rate in Europe, a utilitarian may advise the toiling physician to leave their Ukrainian patients condemned to the ever-present possibility of succumbing to either armed forces or illness itself– and practice in a location where the *physician's* life is protected.[35] Hypothetically speaking, that physician would be able to treat not only a greater number of patients in not being prematurely killed, but possess greater confidence that their efforts will truly be conducive to the protection and prolonging of their patients' lives.

The moral obligation of providing treatment, however, can be extrapolated from the words of the Messenger of Allah, as narrated from Ibn Umar: "The Muslim is the brother of his fellow Muslim; he does not wrong him or let him down. The one who meets the needs of his brother, Allah will meet his needs. Whoever relieves a Muslim of distress, Allah will relieve him of distress on the Day of Resurrection."[36]

Similarly, a different narration of this same message by Abu Hurayrah states:

"Whoever removes a worldly hardship from a believer, Allah will remove one of the hardships of the Day of Resurrection from him."[37]

Together, these narrations reveal that the announcement from the Messenger of Allah carries the weight of two vital conclusions related to physician obligation: the Islamic teaching that Muslims do not abandon their fellow Muslim, even when confronted with circumstances beyond their own responsibility or doing, and that by doing so, he who provides the aid will be personally rewarded by Allah. Thus, we can conclude that staying by the side of those in need, as is done by physicians when they undertake the aforementioned Hippocratic Oath, is not only the moral thing to do through an Islamic lens, but one of the greatest displays of faith one can express. As a reliever or a healer, the mortal physician dons a role that is traditionally preserved to Allah himself—that of both a promoter of creation and a preserver of life alike. It can finally be concluded that to abandon one's patients is not just to directly betray the teachings at the heart of the Quran, but to directly betray the unique relationship shared between Muslim physicians and Allah, one that is defined by a mutual, direct hand in the protection, prolongation, and preservation of human life.

## V. PHYSICIANS IN SYRIA: A CASE STUDY

The circumstances that would drive medical professionals to abandon their patients are rarely, if ever, reducible to a simple calculus with a clear moral outcome. While analysis of the Quran reveals a significant obligation for doctors, and individuals in general, to act in the interest of preserving the lives of others, the realities of war complicate conclusions for how best this can be achieved. An examination of the conflict in Syria reveals such complexity.

The Syrian War, now going into its eleventh year, began in 2011 over the perceived corruption of Syrian leadership, erupting from pro-democracy demonstrations and the violent response with which they were met by the incumbent administration.[38] One consequence of this war has been the devastation of medical infrastructure in Syria amid innumerable dead and injured. Countless Syrians have fled the country in the midst of the violence that threatened their well-being and those of their families, and doctors have been no exception. Syria, it is relevant to note, is a majority-Muslim nation, with over eighty-seven percent identifying with some denomination of Islam.[39] By the analysis of Islamic teachings provided above, it would seem that doctors guided by Islamic teaching are ethically bound to continue treatment of their patients even in times of war. Despite this, over ninety-five percent of doctors in major Syrian cities fled the country within the first two years of the crisis,[40] leaving approximately ten thousand patients for every doctor who chose to remain as death and injury tolls quickly mounted as the conflict continued to escalate. This rate of patient abandonment, while perhaps unsurprising on a greater human scale, is still at first glance contrary to Islamic ethical teaching. A deeper analysis of the complexities of war that can inform such a decision, however, offer the ambiguity necessary to excuse, and even justify, such a decision.

The factors that contribute to the decision to abandon

[35] Alessandra Prentice and Natalia Zinets, "Nearly 400 Ukrainian medical centres destroyed, damaged in Russian attacks: Zelenskyy," Global News
[36] "The reward of taking care of one who is sick," Islam Question & Answer
[37] Ibid.
[38] "Why has the Syrian war lasted 11 years?" BBC
[39] "Syrian Culture," Cultural Atlas
[40] Aryan Baker, "Syria's Health Crisis Spirals As Doctors Flee," TIME

one's patients and life calling are numerous and varied, as well as incompletely captured by a simple analysis of the doctor-patient relationship. Even if it is assumed that a doctor has an obligation to preserve the life of his or her patient by the means available to him or her, the calculus still cannot simply be limited to the immediate threats posed to the patient by their health status. In times of peace, a doctor is the person who stands between a person and the dangers posed by their illness. Times of war, however, are complex precisely in that they introduce external threats to patient well-being that can either compound or offset threats posed by injury or illness, as exemplified in Syria. The nature of violence being perpetrated by the Syrian government is distinct, among other factors, for its explicit targeting of medical centers and medical professionals, branding medical workers as enemies of the state. The Syrian government continues to systematically target medical centers in their attacks in hopes of eliminating what has become a backbone of continued Syrian resistance: the feeble medical infrastructure that continues to struggle.[41] This active persecution of healthcare workers has directly led to over six hundred documented attacks on hospitals and clinics, most with unspeakable casualties among both medical professionals and the patients they felt bound to serve.[42] The constant external threat both to the well-being of doctors and their patients introduces a wrench into the ethical calculus normally made clear by the doctor-patient relationship. If the continued presence of doctors is exactly the motivation for the continued targeting and bombing of patient centers, how does the utilitarian calculus work out for the net benefit a single doctor can provide his or her patients by remaining in Syria? As the Syrian government continues to obstruct them in their work, actively denying the wounded medical care through military interference and threatening the safety of medical professionals attempting to treat them, does the limited benefit doctors are able to provide the patient population significantly outweigh the potential threat they draw to those same patients through their continued resistance of the Syrian government? While arguments can be made to support either case, it is evident that the ethical calculus becomes significantly murkier than a binary choice between "abandonment" and staying. Further, if interpreted from an Islamic viewpoint, if a doctor is convinced of the tangible benefits they can provide when offering care unobstructed outside of Syria, can they be faulted for their decision to leave? Even after removing all obligations of medical professionals to their personal safety and well-being from the decision, it is clear that a situation of imperfect information renders both the decisions to leave and the decisions to stay ethically defensible, if not fully justified.

## VI. RECOMMENDATIONS TO WHO IN LIGHT OF ISLAMIC APPROACH TO WAR

### i. Islamic Perspective on War Coupled with Physician Duty

Islamic tradition, expanding upon the *hadiths* we have already referenced, implies that civilians and injured combatants alike are encompassed within the Islamic emphasis on caring for one's brother. However, the distinction that the suffering must be relieved of *a believer* can be applied here to muddy whether or not a Russian combatant may be considered akin, or alike, to Ukrainians. This being said, it is actually very important to address how Islamic tradition interprets war itself.

In the following verses from the Quran, we observe an eerie reflection of the crisis in Ukraine to that of the plight of religious persecution of Muslims, namely through the justification of war to "protect those who have been removed from their homes by force because they are Muslims,"[43] in self-defense, to "defend Islam (rather than to spread it),"and "to protect the innocent who are being oppressed."[44,45,46] While Islamic literature thus justifies the Ukrainian response to Russian encroachment, it complicates the role of a physician— largely regarded as an impartial healer—and whether or not caring for a combattant constitutes betrayal of the Qur'an. Indeed, for as Russia's attack on the Ukraine is unjustified by virtue of Islamic perspectives on war– explicitly, Russia did not fall victim to any of the aforementioned Islamic justifications for war prior to the February 24 invasion— Russian soldiers are all individual constituents that compose a monumental split away from the teachings of the Qur'an. As for assessing the physician's role in this framework, while the Hippocratic Oath implies that healthcare workers are morally obligated to serve society in a nondiscriminatory fashion, one must turn to the following fragment from a Quranic verse:

"... And do not assist each other in acts of *sinfulness* and *transgression*."[47]

As Russia's attack on Ukraine is unjustified, Islamic tradition urges us to ask whether or not a physician, in healing a Russian combatant, would be effectively allowing

[41] Baker, "Syria's Health Crisis Spirals As Doctors Flee."
[42] Ibid.
[43] Quran 22:40
[44] Quran 22:39
[45] Quran 22:40
[46] Quran 4:75
[47] Quran 5:2

that soldier to continue on their horrific mission– would that not constitute assisting Russia in "acts of sinfulness?" This, of course, is remarkably complicated, and the argument at large is much less clear than the physician's duty to civilians. Returning to fundamental Quranic verses, it can equally be inferred that physicians *do* possess a duty to combatants on the basis of shared humanhood and, by extension, are "neighbors" as creations of Allah, but meaningfully and thoroughly justifying such actions would necessitate an entire separate paper of its own.

### ii. Recommendations to the World Health Organization

Finally, it has been established that physicians do in fact have a sustained, ethical obligation and duty to care for their patients— even in the face of circumstances that may spell discomfort, suffering, or harm unto themselves— according to the Islamic viewpoint. However, for the physicians who act on that ethical obligation, they face life-threatening harm by the hands of not just foreign opposition, but from the patients they committed to serve in the form of infectious diseases, namely COVID-19. Thus, it is not enough to simply assert that physicians "must stay" without imploring that the World Health Organization respond to the crisis and plight of physicians in such a manner that *actively supports* and *lessens the unique burdens* they face. In other words, the WHO's next steps must explicitly make it "easier" for physicians to remain at their posts; even with the Islamic framework in mind, physicians cannot be tasked with or expected to bear the brunt of the crisis completely on their own. Here, we offer three distinct recommendations for the WHO that will directly support the longevity and sustainability of the Ukrainian physician's role.

Turning to Chapter II, Article 2 of the Constitution of the World Health Organization— which outlines the functions of the WHO— Function C defines the organization as committed to "[assisting] Governments… in strengthening health services," while Function I asserts that the WHO also has the capacity "to promote… the improvement of… housing, sanitation… or working conditions".[48] Together, these two functions work in tandem to address how to best support Ukrainian physicians. As previously mentioned within this article, Ukraine has fallen victim to repeated attacks on healthcare institutions, condemning healthcare workers to perform their duties in underground metro and subway stations, among other unsanitary locations.[49] Together, Functions C and I lead us to advise the WHO to invest in the widespread introduction of mobile clinics. These mobile clinics would:

1. Allow Ukrainian physicians to tend to their patients under more sanitary conditions;

2. Assist Ukrainian physicians in being able to transport themselves and their patients in the face of an attack, reducing the incidence of either abandonment or death;

3. Address regional scarcity of doctors where certain portions of the country may have been more aggressively attacked or understaffed.

At the same time, we acknowledge that the international increase in violent assaults against healthcare has also included the hijacking and bombing of mobile clinics, and while previous mandates to ensure the protection of these vehicles may have either failed or never written, the WHO must write into existence the ethical guideline that these mobile clinics cannot be targeted as hospitals and other health clinics have been.[50] While the pure existence of this mandate is not assurance that it will be followed, the writing of it would show a commitment to the lives and livelihoods of Ukrainian physicians and their patients. At the same time, the mandate would also ensure that those who enact such crimes will be brought to justice in the future.

Pivoting to Function O, which stands "to promote improved standards of teaching and training in the health… professions," we see it as necessary that the WHO work to bolster the training of Ukrainian civilians into medical aides or volunteers, with the ultimate goal of forming necessary interpersonal support networks that are conducive to the "staying power" of physicians.[51] To elaborate, in times of unparalleled hardship, physicians must be prevented from feeling as though their work is either futile or as though their struggles are unrecognized, which may lead to self-isolation or abandonment of the field. With a network of individuals all incurring the same responsibilities, hardships, and experiences, Ukrainian healthcare workers will have a semblance of community— a reminder that they are not alone.

Finally, on a related note, Function M outlines the WHO's dedication to "[fostering] activities in the field of mental health."[52] Tasked with serving society in the face of war and a pandemic alike, the stress currently imposed upon Ukrainian physicians exceeds the "stereotypical stressors" associated with entering the healthcare profession; explicitly, these physicians are tasked with navigating the pre-existing stressors of triage, resource allocation, and conflicting responsibilities against the new backdrop a substantial surge in patients and the near-constant threat of becoming the target of the next military attack. Thus, physicians must be assured accessible mental health services either during or after the war. While it would be unrealistic to expect physicians

[48] Constitution of the World Health Organization, 2.
[49] Doctors Without Borders, "Ukraine: Inside Kharkiv's subway stations, MSF mobile clinics care for those trapped by war," Doctors Without Borders
[50] "Ineffective Past, Uncertain Future," Insecurity Insight.
[51] Constitution of the World Health Organization, 3.
[52] Constitution of the World Health Organization, 3

to step away from their patients in order to receive meaningful mental health counseling, there must be safeguards and support readily available that allows for Ukrainian physicians to continue performing to the best of their abilities. If a physician is struggling, failing to address their needs (within the confines of the reality of the war, of course) only serves to hinder both the health of their patients and the quality of the care they can provide as a whole.

## VII. CONCLUSION

Over the course of this article, we have demonstrated how the use of Islamic literature and texts definitively supports the assertion that the abandonment of patients by physicians, even under the combined circumstances of war and an ongoing pandemic, as currently demonstrated in Ukraine, is ethically untenable. Recognizing this, we have also outlined actionable ways in which the WHO can support such physicians in maintaining this bioethical standard, namely through the use of mobile clinics, promoting the health training of willing civilians, and the introduction of accessible mental health services for physicians. Looking forward to areas of future research, one may seek to further explore the duty of a physician to enemy soldiers, as briefly discussed, or even alternatively explore the role and burdens imposed upon Russian physicians in the midst of the same crisis.

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# How Medicalization in Media Breeds Social Construction in Menopause

Julia Leigh Beilis*

Our mass media does not currently aid in creating menopause acceptance. If anything, it only perpetuates this idea that menopause means the aging woman needs medical intervention, such as using hormone replacement therapy to combat symptoms. Scholars in the aging field—especially those who specialize in menopause—contend that menopause is highly medicalized. The scholars I will be discussing, Margaret Morganroth Gullette, Stacey J.T. Hust, Margaret Lock, and Susan E. Bell, all argue that menopause cannot be reduced to a list of symptoms; rather, we should focus on the personal experiences of the aging woman through portrayals in modern media. Drawing from these scholars, I contend that showing menopause in a negative light in the media, particularly in marketing and magazine imagery, frames aging, menopausal women in an unpleasurable manner, which ultimately serves as a factor that instills a socially constructed distaste towards aging and menopause.

Medicalization plays a key role in how we view menopause in American society. In the medical field, well-established physicians and those in power make the rules, and when it comes to women's health and gynecology, menopause is no exception. Before delving into my argument, I wish to define what medicalization is with the help of the aging scholars I will be discussing in this paper, specifically Susan E. Bell and her article, "Changing Ideas: The Medicalization of Menopause." To understand this concept, Bell says that medicalization "occurs when a medical vocabulary or model is used to define a problem" and she also adds that only a small portion of professionals in the field, who she labels as the elite, act as "gatekeepers" or "formal supervisors" to protect what they believe is a medical fact (Bell 1987). Changes in how we delineate said problem are often viewed as a direct threat to the biomedical model. If we are to sharpen the scope of medicalization to just clinical practice, then "medicalization occurs when individual physicians define or treat patients' complaints as medical problems" (Bell 1987). For the sake of my argument, I am only going to discuss the latter definition of medicalization. To simplify it, the way illness perspectives shape our lives is negated in the biomedical model. Bell then pivots and mentions Smith-Rosenberg, who, in 1973, looks to the past and finds that physicians during the nineteenth-century viewed menopause as a "physiological crisis," which has the potential to develop into "tranquility or disease," and this ultimately depends on a woman's "prior behavior and her 'predisposition to malignancy'" (Bell 1987). This further perpetuates the idea that aging, especially in women, leads to some form of psychological and physiological dysfunction. This viewpoint paints the aging woman in a negative light and further preserves the concept that menopause requires medical treatments to ensure physical and mental stability. As a result, Bell's description of medicalization and her inclusion of Smith-Rosenberg's analysis of nineteenth-century medicine demonstrates how the social construction of menopause influences women to believe that medical interventions are necessary to combat the effects of aging and menopause.

Medicalization, by focusing on the pathology of a person's condition, relies on the biomedical model. The biomedical model's solution to oppose menopause symptoms is hormone replacement therapy. In particular, estrogen has been widely prescribed to women across the United States in an effort to subdue menopausal symptoms. Until 2002, a vast majority of women in the United States were prescribed estrogen replacement medication after reporting menopausal symptoms to their medical providers (National Institutes of Health). Although now proven to be dangerous to a woman's health status, many women have fallen prey to this therapy, and if "a specialist believed that menopausal symptoms were caused by a lack of estrogen, estrogen replacement therapy was the logical solution" (Bell 1987). Public health concerns have decreased the number of women using this therapy; however, many physicians and healthcare systems still view estrogen replacement therapy as a viable treatment for menopause. One such physician who further advocates for hormone replacement therapy as the medical norm is Robert T. Frank, a clinical gynecology professor at Columbia University's Vagelos College of Physicians and Surgeons. Frank compares menopause treatment to "the treatment of two deficiency diseases," and he goes as far to say that estrogen replacement therapy is "'a major triumph'" (Bell 1987). Frank's position on menopause is disempowering because it views a naturally-occurring

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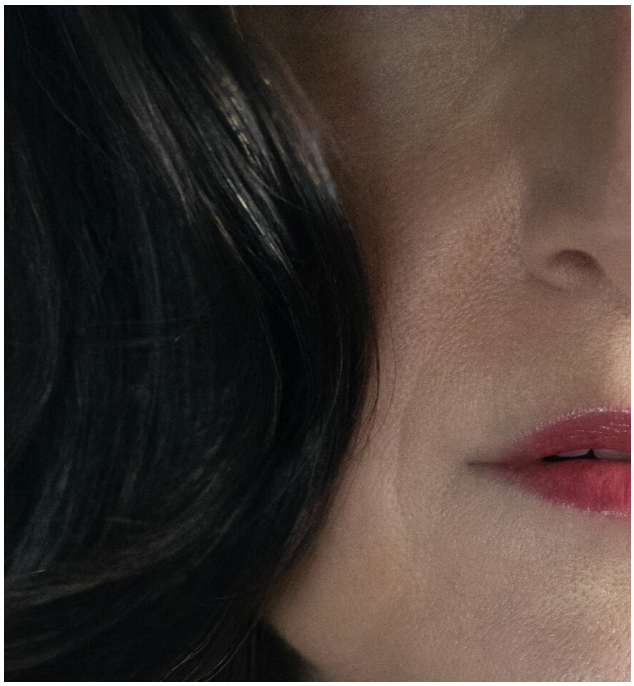

phenomenon as a pathological condition that requires medical treatment, and thus, the consideration of menopause as merely a set of physical symptoms demonstrates the negative elements of medicalizing menopause and how it takes away from a woman's holistic experience associated with aging. The viewpoint of doctors like Frank poses the risk of negating an aging woman's experiences, as it forgoes the psychological changes associated with menopause. Furthermore, it creates this sense that medical intervention must be the next logical step if a woman reports her symptoms to her healthcare provider. When healthcare providers medicalize their female patients' conditions, they further push this idea that menopause is associated with pathological abnormalities; however, this is not—and really should not—be the case. It is crucial to note that menopause is a normal, healthy process that all women experience as they grow older, not a physiological deficiency.

Healthcare institutions tout the endless list of supposed benefits of hormone replacement therapy, but there is no definitive way to prove that the benefits certainly outweigh the hazards surrounding this treatment. Physicians are not the only people or institutions perpetuating the medicalization of menopause—established hospitals are, too. The Mayo Clinic, in a 2020 article, promotes the use of estrogen to combat menopausal symptoms. Although the hospital concedes that there are potential health risks with hormone replacement therapy, they continue to argue that "[h]ormone therapy [is not] all good or all bad," and that this therapy can be tailored so that the benefits can outweigh the potential risks (The Mayo Clinic 2020). The North American Menopause Society, another resource for aging women, also argues for the benefits of hormone-replacement therapy. Hormone-replacement therapy can provide immense relief to those suffering from menopausal symptoms. There are "[l]iterally hundreds of clinical studies have provided evidence that systemic HT (estrogen with or without progestogen) effectively helps such conditions as hot flashes, vaginal dryness, night sweats, and bone loss," and hormone-replacement therapy is a fantastic treatment to help improve sleep, sexual relationships, and overall quality of life (North American Menopause Society). Despite these positive accounts for hormone-replacement therapy, this narrative, while highly medicalized, is also highly hazardous. Their articles negate the carcinogenic effects of estrogen replacement therapy while also neglecting the personal experiences of the aging woman. However, combined use of estrogen and progesterone in hormone replacement therapy is associated with an increased breast cancer risk amongst menopausal women, and solely using estrogen replacement therapy increases the chances of endometrial cancer (Genazzani et al. 2001). Apart from the medical aspects of the dangers surrounding hormone replacement therapy, the Mayo Clinic implies a medicalization of women's lives, as well as implicating that this is a universal treatment that will alleviate a shared list of symptoms, when this is not necessarily the case. Deducing menopause to a list of symptoms ignores the psychological impact this bodily change has on a woman's life. Medical care cannot be copy and paste—individuals will experience disease and illness slightly different from their fellow patients.

The debate of hormone replacement therapy continues with Margaret Morganroth Gullette's chapter "Hormone Nostalgia" in her book, Agewise: Fighting the New Ageism in America, where she delves into the idea that menopause is a biological and cultural phenomenon. Gullette is a staunch supporter of menopause's socially constructed elements, and she states that: "universal menopause is a false decline narrative like so many prospective cultural scripts" (Gullette 2011). Menopause is variable among our bodies and cultures, and how media represents it medicalizes the overall process by reducing it down to its symptoms rather than focusing on how it affects an individual's sense of self. Our media representation of menopause creates a sense that it is more monumental and newsworthy than it is, and Gullette uses hormone replacement therapy to exemplify this social constructionism. Before 2002 and upon their physician's insistence, women were compelled to use estrogen replacement therapy to offset what society viewed as a hormone imbalance. Additionally, Gullette contends that "faith in estrogen was so high that women's noncompliance was a major clinical preoccupation" (Gullette 2011). Therefore, not using hormone replacement therapy was a socially foreign concept, and as a result, the mounting pressure to conform to societal expectations pushed women to seek out and use these treatments.

Since 2002, our society continues to view menopause as a fearful period in a woman's lifetime. Although estrogen replacement has been proven to be threatening to a woman's

health, Gullette finds that "there are still too many articles about menopause and programs for educating women about it, and the troublesome menopause is still the one we hear about" (Gullette 2011). While modern perceptions acknowledge the health consequences of hormone replacement therapy, social attitudes—particularly in mass media—continue to perpetuate historical trends of negative associations for menopause. Media tends to represent menopause as a negative aspect of aging while also promoting preventative measures, such as exercise and medical interventions, to fight the supposed consequences of aging (Krajewski 2018). In other cases, there is also the viewing of menopause as something to avoid in its entirety when discussing aging in mass media. These media portrayals that Gullette and Krajewski discuss pose an issue—when our mass media still labels menopause in a cynical fashion, it tells women that this is something they should attempt to combat.

To continue this trend of social constructionism, Margaret Lock and Patricia Kaufert find that the symptoms of menopause must be a cultural phenomenon because menopause symptoms vary across several nations and cultures. Lock and Kaufert claim that even the definition of menopause is a construct and labeling it as a "woman's last menses does not 'fit' with an experience which most women describe as a prolonged process rather than a singular event" (Lock and Kaufert 2001). We expect a set list of symptomatic experiences when we think of menopause because society expects menopause to be a solely medical phenomenon; however, how the media portrays menopause makes us think this way. When women do not fall under these socially constructed categories, it breeds this sense of fear—as if going through menopause is not "bad enough"—now they have to consult their physician to see what else is wrong with them? Nonetheless, for a majority of women, going through menopause is alienating enough, but placing their symptoms into experiences into these distinct labels and boxes—that are socially constructed in their own right—also estranges them from society further. This list is highly medicalized, too, and further implies that some form of medical intervention or treatment is required so that women can place a socially accepted label upon themselves.

To pivot toward how our mass media represents menopause and aging women, Stacey J.T. Hust and Julie L. Andsager demonstrate the lack of menopause depictions through a formal experimental study and analysis. They find that women "over the age of 40 are largely absent from media imagery," and Hust and Andsager aim to discover how magazines frame menopause from the late 1980s to the mid-2000s (Hust and Andsager 2008). A lot has changed since the mid-2000s; however, it is still essential to acknowledge that media representation of women undergoing menopause is still lacking, and, nevertheless, needs to be improved upon. The way the media portrays topics, such as aging and menopause, shapes our culture and how we treat and view menopause in our society. News articles surrounding aging women in media focus on medicalizing menopause and the women's reproductive system, which is something that parallels Gullette's findings, too. Changing how the media frames menopause can help better inform women about their evolving bodies. The media is a thought-shaping tool and is a "powerful means of transmitting ideas and shaping thought," and the better we portray aging women and menopause in our media, the better society understands and accepts the naturally occurring changes within women's bodies (Hust and Andsager 2008).

As our society ages, the number of women going through menopause increases. Significant transformations in our society are occurring, and this continues to change as more women enter menopause. However, our mass media continues to view menopause in an unfavorable light, and "cultural beliefs, predominantly negative, contribute to the menopausal experience," thus making personal menopausal experiences for the aging woman less enjoyable (Hust and Andsager 2008). This media portrayal negates women who feel more liberated and dynamic after experiencing menopause, and this narrative tells women that negative experiences should be anticipated, and they need to know that there are medical options available to them to combat these negative experiences. Depicting menopause as a negative phenomenon is a social construction, and any woman who does not fit into this societally-determined norm is an outsider.

If we delve into ELLE magazine, a periodical that centers around young women's fashion and beauty, we can see a litany of anti-aging, and thus anti-menopause, advertisements sprinkled throughout the issue. Despite the magazine catering towards a younger audience and the inclusion of anti-aging advertisements, there is still a major deficit in the portrayal of the older population. Before I discuss the anti-aging skincare advertisements I discovered, I feel that it is essential that I define the guidelines in which I am considering something or someone to be "older." Any product that deals with preventing the physical effects of aging will be viewed as an anti-aging mechanism. Physical signs of aging will include, but certainly are not limited to: having an ailment that typically affects older populations (such as dementia), graying (or gray) hair, and visible wrinkles all over the face and body. One of the first advertisements of this issue of ELLE magazine centers around the ominously named "The Cream" and "The Serum" from luxury skin care brand Augustinus Bader. This skin care combination serves to reduce the appearance of wrinkles and fine lines, which are not a primary concern for ELLE's younger audience; however, this form of advertisement induces younger consumers into fearing what is inevitable: appearing older. Even though ELLE's readers may be in

their late teenage years to their late twenties, and they may have incredibly smooth and unwrinkled skin, they will still indulge and engage in preventative measures to reduce their chances of appearing as if they have aged. The lack of older women in these magazine advertisements, as well as promoting the use of anti-aging products as a precautionary course of action, are merely a vehicle to instill fear of aging and menopause in younger women. We associate aging with almost-catastrophic physiological effects, and this includes menopause and its associated symptoms. We also immediately equate aging to menopause, and this can feel like an attack upon aging women. Nearly half of women over the age of 50 in the United Kingdom "feel patronised by advertising," and a multitude of these women "believe they would cope better if [menopause was] addressed in a more positive, public way" ("Marketing's menopause" 2018). As a society, we erase the experiences of menopause in popular media, as if it is a taboo that must remain concealed. Whether it is television, film, social media, or print advertising, "74% believe ads fail to portray women in this phase of life with any sensitivity" ("Marketing's menopause" 2018). Including more age-inclusive and pro-menopause advertisements and articles and reducing the amount of anti-aging promotions will certainly alleviate the fears of young women when they think about menopause. Rather, they can view menopause in a much more positive light, such as viewing the process as a sign of maturity.

Our marketing can translate to how women express their fears of menopause. On question-and-answer websites, we can find a myriad of women attempt to explain their fear of growing older and the dangerous looming of menopause. Many women view aging as a loss of their youthful appearance, and thus attractiveness. In our society, younger women are "seen as having a higher value than [older women] which causes a great deal of stress and worry" (Medic8). Another fear is the loss of reproductive capabilities, and this depletion is associated with a sense of sadness and despair for their current situation.

Ultimately, by drawing from the arguments of Gullette, Bell, Lock, and Hust, menopause, when viewed in a cynical light in our media, tells aging women that they require medical intervention and treatment, thus producing an overall reluctance to age and experience menopause. Medicalization deeply shapes our mindsets in terms of how we view certain experiences, such as menopause and aging, and this ultimately damages our images of older women. How we view aging women causes us to associate growing older with the loss of function and physical appearance, and this is driven by our marketing, which highlights the importance of looking youthful. These representations push older women to using treatments, like hormone replacement therapy, to maintain some sense of their younger selves. These media portrayals also push medical professionals to promote the use of HRT, despite its carcinogenic effects. Coming to terms with the overall dangers of estrogen therapy to alleviate symptoms that arise from menopause further promotes menopause, and thus aging, acceptance. Additionally, expanding our marketing tactics and overall media representation of older women, particularly women experiencing menopause, can help alleviate this fear and educate our society about menopause's natural elements, such as its symptoms. This demedicalized education can help teach women more about their bodies, as well as decrease the stigma around menopause.

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# Diagnosing the Bumpy Landscape of Democracy: Phrenology's Prominence in Antebellum America

Shaan Bhandarkar*

In the annals of medicine, the brain is often considered to be the last frontier of anatomical inquiry. We still have so much to learn about this fascinating organ that governs our every movement and thought. Yet, the promising advancements of modern neurology and psychiatry belie a darker history of the study of the brain. Studies of the mind naturally interface with questions of human interiority and intelligence, and certain characteristics of the brain have been historically conceptualized as barometers of such social and intellectual metrics. In this mission, neurologists and psychiatrists have historically acted as arbiters of social and moral deviance. In their goal to objectively survey society's intelligence and morality, these practitioners merely projected their own racial and socioeconomic biases. Their work acts as a reminder that medical practice is inseparable from sociocultural contexts. To illustrate this point, I specifically chronicle the rise of the pseudoscience phrenology, an antecedent to fields like neurology and psychiatry, in antebellum America. After I depict the origins of the field, I argue that phrenology achieved public acclaim through its partnership with the evolving forces of scientific racism and spirituality in antebellum America. The rise of phrenology reflected the hypocrisy of a country that preached equality while actively endorsing slavery and oppression, the proponents of which armed themselves with the tools of phrenology to validate ideas of white supremacy. Phrenology further dovetailed with religious upheavals of the time by touting Calvinist ideals as a means of improving oneself and contributing more meaningfully to society (prosocial behavior). We see science and religion strangely coalesce in scenes of phrenological diagnosis such as the following.

In 1841, at a Congregational church near Gainesville, Massachusetts, the whole congregation fell silent in deference to a man of science now entering the house of God. Two volunteers stepped forward as he blindfolded himself before proceeding with his examinations. He caressed these men's bodies, running his hands up their spines and carefully tracing the outline of their skulls. His hand fixed on certain regions of the head, awing his clueless audience. Free from the constraints of his prejudiced human vision, his scientific knowledge lighted his way to the truth. The man systematically unlocked the secrets of the bodies and minds of these two men, divining their futures to assess their utility in society. To much applaud from the congregation, the first man was deemed a "harmonious, careful, upright man." Destiny and biology seemed to have collaborated to bestow this upstanding man upon the town. However, these forces seem to have conspired to create an altogether more sinister creation with the other volunteer. The second volunteer was determined to be "too low in Conscientiousness to be honest and just in his dealings, and too large in Secretiveness to be open, frank and truthful." These revelations shocked the congregation as the volunteers were related to each other and were believed to have shared "unblemished [social] reputations." Just as cryptically as the man of science entered the church, so he vanished after conveying his prophecies. Thus Nelson Sizer, a renowned American itinerant phrenologist, embarked again on his crusade as the interpreter of destiny and diagnoser of head bumps.[1]

Phrenologists frequently put on such theatrical displays in antebellum America. The Viennese physician Franz Joseph Gall first devised the field in the 1790s as "craniology" and then "organology," referring to localized mental functions in different parts of the brain (then referred to as "organs"). He conceived that the brain could be split into regions characterized by 27 "faculties" like Conscientiousness or Secretiveness.[2] Gall then asserted that the skull's shape reflected the shape of the brain and such special regions. Thus, phrenologists like Nelson Sizer engaged in "examinations" of people's heads to determine their behavior attributes by mapping protruding regions of the skull to the strength of certain "faculties." One of Gall's European colleagues, Johann Spurzheim, eventually reinvented the field as "phrenology" in the 1830s and spread its ideology across lecture tours at prestigious American institutions like Yale and Harvard. The intellectual vanguard of America lapped up these teachings. Inspired by Spurzheim's lectures, brothers Orson Fowler and Lorenzo Fowler assumed the mantle of leadership for the American phrenological movement. Along with Samuel Roberts Wells, the Fowler brothers established publishing companies in America and England.[3]

Historians mostly treat phrenology as a fringe science

[1] Christopher White, Minds Intensely Unsettled: Phrenology, Experience, and the American Pursuit of Spiritual Assurance, 1830–1880. Religion and American Culture: A Journal of Interpretation 16, no. 2 (2006): 227.
[2] Cynthia S. Hamilton, Am I Not a Man and a Brother? (Phrenology and Anti-slavery, Slavery & Abolition, 29:2 ,2008), 174.
[3] Ibid.

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that became a temporary vogue. However, phrenology profoundly influenced antebellum American society. Its pervasive influence in such a critical time period illustrates the nature of the nation's psyche, then muddled with all its convictions and self-doubts. Phrenology particularly captivated the American people of the time for several concrete reasons. Under the glossy veneer of exceptionalism lay an America riddled with confusion, hypocrisy, and internalized guilt. Phrenology redirected the nation's collective indiscretions onto a few individual Americans. The classification of Americans with defective mental faculties reinforced racial and other cultural prejudices. Far beyond its acclaim among medical practitioners, phrenology enabled the layperson to take action against fellow Americans blacklisted in phrenological examinations. The Fowler & Wells company published various phrenological journals, almanacs, and novels that could be comprehended by anyone. Phrenology thus advertised a role for the American people in amending how the private health matters of a few endangered the public safety of the nation. The field was the key to finally establishing a democratic utopia, inspiring patriotism in its devotees. Phrenology thus acquired a massive following of patriots in antebellum America for its revolutionary explanations of scientific racism, social deviance, and spiritual reassurance.

In fact, re-published by the Fowler & Wells company in 1842, Warren Burton's Uncle Sam's Recommendation of Phrenology to his Millions of Friends in the United States ties phrenology to patriotism. Burton's novel is illustrative of how phrenology assuaged the rising curiosity of antebellum society. As an American clergyman, Burton presents phrenology as a divinely ordained science bestowed upon the people as a gift. While also assuming the persona of Uncle Sam in this epistolary novel, Burton inspires his audience into assuming agency in their nation's matters. Burton refers to himself in the first-person plural ("we") and establishes an "air of fellowship" in a common goal.[4] A grand spiritually-affirmed destiny lay ahead for America; all the people needed to do was to seize that moment. Burton features different slices of antebellum American life in homes, schools, and the justice system. The antisocial agents disrupting these mechanisms could appear in any form. Burton prescribes vigilance, through understanding the faculties classified by phrenology, as the cure to America's ailments.

Although Burton claims that anyone is capable of lacking prosocial mental faculties, a recurring theme seems to be colored skin. Burton references the deficiency of moral and intellectual sensibilities in racial minorities as a given. When discussing the Reflective portion of the brain, a faculty crucial for making moral judgments, he claims that the "less civilized portions of mankind are deficient in the Reflective portions as designated by Phrenology. If you doubt, look at the Indian or the negro."[5] But as opposed to the incorrigible faculties of blacks and Indians, Burton presents that even deranged whites could be reformed through helping them exercise this Reflective region. However, Burton asserts a fluidity in the development of faculties for whites and a progressive improvement of the Reflective faculty as white children age. Beyond showing the double standards of phrenology, the notion also equates the mental faculties of blacks and Indians with white children. Contemporary phrenologist Marvin Wheat confirms to this effect that "the African brain never goes beyond that development in the Caucasian in boyhood."[6] This image particularly reinforced the infantilization of such populations as "primitives" deserving of, and in fact benefiting from, domination. Insights from the Reflective faculty thus supported key concepts that undergirded slavery and colonialism.

In light of phrenology's subsequent role as a moral justification of slavery, it is not surprising that Burton does propose one solution to the purported mental deficiencies of blacks: paternalism. In one anecdote, he depicts a black girl tripping on ice and dropping a basket only for a white woman to later help her up and deliver the basket. Burton narrates how the white woman takes in the girl as a lifelong "servant" and how it is astounding the white woman "lifted up the fallen of a despised race, and helped bear her burden back to her hovel-home."[7] He later cites this feat as a result of the white woman's bump on her skull near the Benevolence region. Burton thus portrays how phrenology could answer one of the greatest questions the founding fathers left in their wake: how could a nation priding itself on liberty monopolize the suffering of disenfranchised slaves? Burton refrains from using the word "slave" in his entire novel, instead opting for the term "servant" as if to suggest a voluntary decision.[8] The term "servant" also suggests a mutual benefit in the arrangement, that the black girl should be grateful to be solely compensated with the gifts of white civilization in exchange for lifelong servitude. Burton also uses phrenology to sanction slavery as an act of benevolence (reflected in the "Benevolence" region) and overall prosocial benefit, framing the black girl as a responsibility and burden. Yet, Burton intriguingly claims that abolitionists have excessive protrusions in the Benevolence region, to the point that their rational judgments could be compromised. He implies that freedom could do more harm than good, medicalizing his pro-slavery argument in accordance with phrenological principles. Contemporary pro-slavery physician Dr. Samuel Cartwright similarly

[4] Warren Burton, Uncle Sam's Recommendation of Phrenology to His Millions of Friends in the United States: in a Series of Not Very Dull Letters, (Harper and Bros., 1842), 7.
[5] Burton, Uncle Sam's Recommendation of Phrenology,(Harper and Bros., 1842), 249.
[6] Wheat, The Progress and Intelligence of Americans, 133-134.
[7] Ibid, 194.
[8] Ibid, 196.

conceived of "drapetomania," a purported mental disease that incited slaves to escape their masters to their own detriment. Phrenology as a medical concept likewise wielded pathologized the emancipatory aspirations of abolitionists of slaves and invalidated their ideals as irrational products of anatomical abnormalities. The field was evidently critical in masquerading racial propaganda as objective scientific insights.

Beyond its ideological appeal, we can also see that phrenology offered the perfect tool for furthering scientific racism in its implementation. For years, craniometry, the measurements of skull sizes and certain angles, dominated images of social Darwinism and racial hierarchies. However, inconsistencies in results frustrated scientists maintaining racial preconceptions: craniometry was too quantifiable and thus easily refutable. Craniometric techniques also required the brains of non-living human specimens most of the time to establish benchmark measurements.[9] Phrenology instead offered a subjective, non-invasive approach with more fluidity in interpretation. Beyond only constructing black-to-white gradations in morality and intelligence, scientific racists could use phrenology to target all their detractors from racial minorities to white abolitionists. They could justify their convenient critiques by diagnosing a deficiency in any one of the diverse faculties of the phrenological model (like excessive Benevolence in abolitionists). Scientific racists utilized phrenology to counter the moralistic arguments of the abolitionists, by dictating a biological basis of morality. Given the polarity of the pro-abolition North and pro-slavery South, scientific racism was further touted as a cultural adhesive that could reassure the nation of its deeds and reunite it before an irrevocable split. The famed Amistad trials from 1840-1841, which charged kidnapped Africans who were being illegally sold as slaves and killed their Spanish captors, rocked the nation with questions about race and freedom for all. While abolitionists won the case, phrenological examiners analyzed the Amistad captives and profiled "faults" in mental faculties that made them prone to violence.[10] They pathologized the Amistad captives' desire for freedom and used their narrative as a case study for emancipation, concluding that it would result in moral degeneration and the bloodshed of whites. Phrenologists even created wax "life masks" of the captives to put on display as a testament to this threat posed by emancipation. From the perspective of the people, phrenology could settle questions about the allotment of freedom that divided the nation in the antebellum period.

Outside of recapitulating racial stereotypes, phrenology posed a tantalizing model for social deviance. Phrenology asserted that anyone regardless of socioeconomic status or societal reputation could be predisposed to crime. The aforementioned prophecies of Nelson Sizer actually came true and the second man in the congregation committed a robbery. Burton further fleshes out this invisibility of mental

[9] Susan Branson, Phrenology and the Science of Race in Antebellum America (Early American Studies: An Interdisciplinary Journal 15, no. 1, 2017): 167.
[10] Branson, Phrenology and the Science of Race (Early American Studies: An Interdisciplinary Journal 15, no. 1, 2017): 170.
[11] Burton, Uncle Sam's Recommendation of Phrenology,(Harper and Bros., 1842), 18.

faculties, and phrenology's role as a revealer of inner truths. He starts out his first letter by describing a working-class man committing a trifling theft on Independence Day. As he is carried off to prison by the authorities, another man "dressed in the genteelest style of the day" gambled on horses and committed mass extortion in plain sight.[11] As Burton describes, "The very guardians of justice were dazzled… So here he was, Independenceing it like a champion, while that poor wretched trifle-taker just before him was going neck and heels to jail."[12] Burton posits that many antisocial agents detracted from America's greatness while masked in their class privilege. In line with ideals of Jacksonian democracy, Burton provokes the consciousness of the common man. He champions phrenology as the means for bringing the invisible aspects of the mind to the surface. Phrenology served as a social equalizer, exposing the inherent faults of rich Americans for all their wealth.

Another tenet of phrenology indicated that some mental faculties can degrade over time from atrophy, but also can be maintained and even recovered. As mentioned before, phrenology offered solace to deranged whites. The Fowler brothers once said that, "phrenology teaches you, not only the laws of mind in general, but the particular qualities of individuals, and also how they may be reached … phrenology not only points to the development, but also shows you how to arouse it." While phrenology more vehemently classified blacks as incorrigible, the American people associated phrenology with mental plasticity and an ability to improve oneself. Burton also claims that exercising certain mental faculties, as informed by a phrenologist, could produce gradual improvements in memory for academic purposes.[13] Thus, many Americans experimented with self-care regimens to improve one of the 27 faculties a phrenologist may have told they were lacking.[14] Social reformers also rallied around phrenology for causes like improving public schooling (as Horace Mann did) and treatment of the mentally ill and imprisoned (as Samuel Gridley Howe did). Phrenology offered hope for everyone to become a better version of themselves, in accordance with the self-help ethos of the antebellum period.

It is commonly speculated, even in modern models of medicine, whether spirituality has a  place in the field. Proponents point to the inescapability of spirituality in the context of sensitive issues like death, whereas opponents cite the prospect of objective scientific protocols being tainted by subjective religious limitations. Phrenology's implementation, for one, headlines a mutually-reinforcing relationship between science and religion to variable uses. The rise of phrenology coincided with radical changes to the religious landscape of America. The Protestant religious revivals of the era with the Second Great Awakening found an ally in the teachings of phrenology. While it may seem that secular ideas of science would contradict religious beliefs, phrenology uniquely prioritized religion as central to prosocial attitudes. Burton as a clergyman himself used his novel to communicate moral and theological agendas. He talks about the faculty of Veneration, a belief in the higher power and a sort of universal governing energy, that lies symbolically at the very top of the skull. Burton also politicizes belief in religion by saying that Veneration produces deference and an unbreakable trust that comprises the "quietness and stability of the government."[15] Burton emphasizes the importance of spiritual faculties as key to moral behaviors like temperance as well, again reinforcing religious movements.[16] Other believers in phrenology also thought of the field as a divinely-granted clue to the mysteries of the body and mind. A Universalist phrenologist once wrote that, "If we can know the condition of the physical organism at any time, we can therefrom determine the condition of the mind and …. the mysterious pathway to the court of the soul."[17] While many Protestant ideologies like Calvinism preached about a wrathful God and ideas of predestination, phrenology made the concept of God comfortably less transcendent and unveiled some clues to reaching such greater understandings. Both Calvinism and phrenology inspired followers to neglect class differences and instead focus on abstaining from sins, as in accordance with God's laws of nature demystified by the science of phrenology. Thus, phrenology (to a certain extent) seemed to be an empowering tool for introspection despite socioeconomic divides.

Yet this feel-good class solidarity stood in stark contrast with religious justification of racial hierarchies with phrenology. Phrenologist Marvin Wheat proposed that social hierarchy was always God's plan, saying that "no less in art than in science, are we, the Caucasians, rising from dust to fill that great destiny ordered in the creation of man, in the image and after the likeness of his Creator…if he [God] had intended all races to be possessed of the same understandings…it would have been as easy to have molded all after him, but it is evident that it was not."[18] Wheat suggests that Africans and Native-Americans lack the machinery (phrenological faculty) for rational and civilized thought. Relative to these supposed deficits, he makes it clear that he exalts Caucasians as a race made in God's image and destined for greatness in intellectual advancement. Caucasians like Wheat used phrenology to fuel notions that their domination of Africans and Native Americans was divinely

[12] Burton, Uncle Sam's Recommendation of Phrenology,(Harper and Bros., 1842), 19.
[13] Burton, Uncle Sam's Recommendation of Phrenology,(Harper and Bros., 1842), 35.
[14] Carla Bittel, Testing the Truth of Phrenology: Knowledge Experiments in Antebellum American Cultures of Science and Health.(Medical History 63, no. 3, 2019): 360.
[15] Burton, Uncle Sam's Recommendation of Phrenology,(Harper and Bros., 1842), 200.
[16] Leo P. Hirrel, Children of Wrath: New School Calvinism and Antebellum Reform, (University Press of Kentucky, 1998).
[17] White, Minds Intensely Unsettled, (Religion and American Culture: A Journal of Interpretation 16, no. 2 2006): 235.
[18] Wheat, The Progress and Intelligence of Americans, 133-134.

ordained. In this respect, phrenology's brand of scientific racism and its integration into an actual system of belief confirms potential dangers of religion's entanglements in medicine. The potential limitations and biases that religion may impose on medicine should be considered in conversations with their intersections with the historical and sociocultural context.

Historians have downplayed phrenology as a fringe science with a mass European following and minimal influence on America. Such perspectives vastly underestimate phrenology's wider acceptance among the common people of America. Historians have linked phrenology to scientific racism, but neglect how phrenology specifically rose in the immediate antebellum period despite being introduced worldwide in the 1790s. In an America about to face its most deadly litmus test, phrenology offered a means to stitch up divides with supposed objectivity. In reality, these "objective" examinations would be tainted by racial stereotypes and structural realities of America. However, phrenology did embolden social reforms for the treatment of other disenfranchised white individuals like the mentally ill and imprisoned. Along with the spiritual angle pursued by revivalist clergymen like Burton, phrenology offered a hybrid of science, morality, and spirituality as the patriotic cocktail of the era. Questions of these three aspects of human nature loomed over the antebellum period, creating the impetus for a field like phrenology to claim a spot at the front of human consciousness. Phrenology brought the previously invisible to the forefront, while placing more agency in the common man to watch over individual and collective health. While its diagnoses of bumps on human skulls may have been inaccurate, the rise of phrenology allows us to diagnose the bumpy landscape of American democracy for all its symptomatic shortcomings and radical changes.

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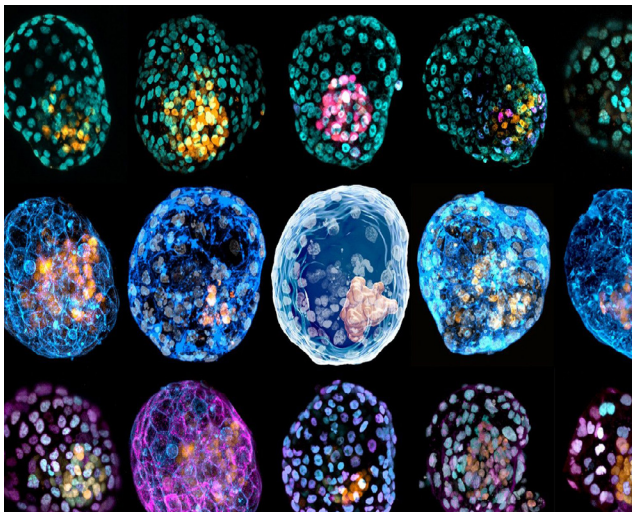
# Bioethics-in-Brief

## Artificial Human Embryos

Advait Thaploo



"I'm sure it makes anyone who is morally serious nervous when people start creating structures in a petri dish that are this close to being early human beings." Daniel Sulmasy, a bioethicist at Georgetown University, speaks of the so-called blastoids that have recently come out of an international collaboration of scientists studying human development (Stein, 2021).

Scientists have recently become increasingly interested in the early stages of embryonic development. Studying early human cells as they grow is vital for pharmaceutical testing, research into pregnancy losses, cell defects, and many other areas important to fetal health during early development.

A group of Austrian researchers led by Nicolas Rivron recently demonstrated that in a bath of carefully-selected chemicals, stem cells can form a structure closely resembling a blastocyst, a precursor to the embryo. Rivron and his colleagues inhibited key pathways involved in cell differentiation and proliferation, and watched as the stem cells formed analogs for a placenta, yolk sac, and body. As the blastoids developed, they closely mirrored expected maturation checkpoints of a normal blastocyst (Kagawa, 2021). After the scientists laid down a layer of hormonally-stimulated endometrial cells, the blastoid first rotated, and then implanted as it would into a normal uterus. Shortly afterwards, the group put pregnancy test strips into the cell wells, and they tested positive (STAT, 2021).

Rivron's group is not the first to construct an artificial embryo. Jianping Fu of the University of Michigan led a study in 2019 in which he made embryo-like structures from human pluripotent stem cells, sourced from adult skin cells. Similar to Rivron, he used a mixture of chemical signals to encourage the stem cells to copy an embryo's first differentiation step. His cells also demonstrated the primitive streak, a key step in human development that establishes the longitudinal head-to-tail axis. Fu designed a specific tool to culture these cells; traditional cell culture plates yielded disappointing results, succeeding only 5% of the time. Instead, Fu used a multi-channel system that loaded the stem cell colonies and chemical cocktail separately, allowing for precise delivery. Now, he reports over 95% efficacy (Subbaraman, 2021).

Scientists purport that these advancements in artificial embryo development will allow more ethical experimentation on early stage human cells. Alexander Clark, a stem-cell biologist at UCLA notes that synthetic embryos are particularly critical for observing the primitive streak, which he states is "one of the most important and least understood events in human life." Fu hopes that his synthetic embryos could be used by pharmaceutical companies to test early-stage drugs (Cyranoski 2019). If translating this work proves successful, preclinical testing for new drugs would see major improvements.

Current embryo culture efforts are hindered by the well-known 14-day rule, which states that human embryos must be halted at 14-days, approximately when the primitive streak forms. This rule was dropped in mid-2021 by the International Society for Stem Cell Research, with experiments past the limit being subject to proper ethics review. The policy relaxation opens the door for further questions about what constitutes ethical experimentation. Rivron's artificial embryos contain the elements necessary to develop into a fetus, so they likely will encounter legislative scrutiny. Indeed, Rivron, Fu, and other scientists have called for legislative limits on synthetic embryo development.

Scientists making artificial embryos face certain challenges going into the future. As technology becomes more advanced, the lines between natural and artificial are becoming blurred. Furthermore, advancements in the field are still very new; Rivron and his colleagues published their paper describing their model as recently as December 2021. As legislative bodies, funding entities, and peer scientists realize the potential of cutting-edge synthetic embryo technology, new limits will likely be placed. These legislative limits, if equally constricting for synthetic and natural stem cells, could prove damaging for the former. However, artificial embryo development is likely to benefit from perceived ethical advantages, such as the possibility of being sourced from adult stem cells, rather than using controversial discarded IVF embryos.

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# Abortion Policy for Migrant Children

## Caitlyn Chen

In June of 2022, the United States saw protests around the country after the Supreme Court overturned Roe v. Wade, a case that conferred the constitutional right to abortion (Planned Parenthood 2022). The repeal of this half-century legislation held many uncertainties for the future of reproductive rights and access to care. Juxtaposed with an equally polarizing topic in the United States, immigration, questions arose for pregnant migrant children seeking abortions. Increasingly restrictive abortion regulations largely impact migrant children who may experience sexual violence in their home countries or during their migration (ACLU 2022). Those from countries where abortions are banned turn to the United States for this procedure. The changing policies regarding this issue reflect the ethical dilemma of access to abortion for migrant children.

Under the Trump administration in 2017, abortion requests from migrant youth were issued for direct approval from the director of the Office of Refugee Resettlement (ORR), who at the time was E. Scott Lloyd, an anti-abortion lawyer on the basis of religious beliefs (Vazquez 2017). Under this policy, many migrant youth were prohibited from attaining abortions due to his denial of their requests. In many cases, Lloyd personally intervened, going as far as to issue an unnecessary ultrasound for an individual who had begun the medication abortion process in an attempt to coerce her into continuing the pregnancy (Amiri 2018) . Lloyd used his executive power to perpetuate his religious agenda through the institution of "crisis pregnancy centers"


with the purpose of discouraging abortions by religious means, such as prayer (Amiri 2018). His imposition of morality suppressed the freedom of choice for migrant youth.

Some politicians supporting Lloyd's actions take a paternalistic view on this matter, particularly as the issue concerns minors (de Saint Felix 2019). These individuals are of the opinion that children lack the capacity to make major decisions and therefore need to be protected from the negative consequences that may arise due to poor decisions. Therefore, they believe it necessary to confer decision-making power to an adult with the children's best interest in mind, in this case, who they took to be Lloyd. However, the benefits of motherhood are ambiguous: there is little evi-

dence of the advantage of motherhood versus abortion. In fact, given current medical data, the obligation for children to carry pregnancies to term is a violation of the principle of non-maleficence, which imposes the commitment to do no harm. The risk of death due to childbirth is fourteen times higher than by abortion (Raymond and Grimes 2012). For young mothers aged fourteen and under, the risk may be up to five times higher than mothers aged twenty to twenty-four (World Health Organization 2022). Teenage girls also face various complications in childbirth, such as infant mortality and disability as well as increased risk of HIV (Groves, et al. 2018). Therefore, policies that restrict abortion require individuals to take on significant medical risks against their will. Thus, the paternalism imposed by the Trump Administration's directive is unjustified and thereby conflicts with bodily autonomy.

In an attempt to remediate this conflict and those arising from the overturning of Roe v. Wade, on November 10, 2022, the Biden administration issued a directive for the ORR to provide abortion access to pregnant migrant youth (ACLU 2022). By this guidance, the ORR will place pregnant individuals away from shelters in Republican states with abortion restrictions and transfer individuals in these states if abortion services are requested (Weissner 2022). An implication of this policy regard the employees of the ORR, who may hold religious objections to abortion. Adversaries of this policy argue that this situation presents the converse effects of religious motivations of abortion restriction, wherein the obligations of the ORR staff engenders a moral conflict (Weissner 2022). Though employees are required to inform officials of pregnant youth, they are not expected to personally facilitate abortion access (Weissner 2022). Therefore, this policy is preferable due to its breaching of fewer interests.

The continued discussion around abortion access for migrant children is only small facet of the long-standing debates of pro-life vs. pro-choice. Policies tied to morality are inherently subjective. However, the rights of all individuals involved remain the same: bodily autonomy, freedom of choice, and access to healthcare. In the changing political climate of the United States, it is critical to maintain these universal rights in issuing future policies on abortion access for migrant children.

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