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FROM THE EDITOR

Reproduction, Inequality, and Technology: The Face of Global Reproductive Health Ethics in the Twenty-First Century

Global reproductive health has seen a paradigm shift since the turn of the twenty-first century. Although initially focused in the 1980s on a global reduction in maternal mortality through access to trained practitioners in connection with the Safe Motherhood Initiative [1], the field has quickly moved into new terrain. Now, global reproductive health attends to new issues, such as the use of assisted reproductive technologies (ARTs), as well as new manifestations of older problems, such as the effects of emerging infectious disease like Zika and Ebola on perinatal health [2]. The bioethics of reproductive health is no exception; innovations in theory and practice have arisen in a dynamic biomedical landscape. With the fluidity of movement of disease and technology due to global economics and the gradual breakdown of nation-state borders, there is no longer a split between the domestic and the international; the local is global, and vice versa [3-5].

Yet the elephant in the room when it comes to global reproductive health care and bioethics has to do with inequality [6]. Health resources and technologies—and the geospatial movement required to access them—have consistently been a target of analysis by biomedical researchers and bioethicists alike [7]. However, other questions of inequality—particularly as it relates to its incorporation into research methodology, medical education, and health policy—have yet to be the subject of a cohesive bioethical analysis that takes into consideration the important changes in reproductive health over the past 20 years [2]. The recent election of President Donald J. Trump has signaled a reification of a conservative political agenda, both on the global and domestic scale; whether by curbing access to or funding of abortion-related services or limiting the role of transgender people in the military, sexual and reproductive health are once again at the fore of political, bioethical, and popular discussion [8].

If people across the world require reproductive health services as a fulfillment of their reproductive rights, then how has this goal gone astray? [9]. How can a bioethical perspective unveil hidden inequalities in the construction of global reproductive health as a field? And, ultimately, how can practitioners use bioethics to improve care and education of caregivers in settings of structural violence? This issue of the *AMA Journal of Ethics* explores the complex ethical environment of global reproductive health with a focus on "local" aspects of reproductive health inequalities to ask crucial questions about

how the global health landscape can evolve to provide high-quality reproductive health care in the twenty-first century.

One ethics case considers the complex role of ARTs in global health. Marcia C. Inhorn and Pasquale Patrizio examine a case of provision of low-cost but less effective ARTs in rural areas of Lebanon, where low-intensity civil conflict continues in the wake of the Syrian refugee crisis of 2013. Arguing that standards of care for infertility will need to vary with resources and sociopolitical context, they contend that by reaffirming a human right to fertility, funding and other resources can be used to improve technology and access to infertility services.

Two articles discuss bioethical issues concerning medical education in the area of global reproductive health. Nicholas Rubashkin and Nicole Minckas respond to a case of a medical student rotating abroad who witnesses an episode of "obstetric violence" [10], broadly defined as the intentional "appropriation of the body and reproductive processes of women by health personnel" [11]. Rubashkin and Minckas consider the student's moral distress and options for intervening as well as the ethical underpinnings of those options. Importantly, they argue that educational institutions have an obligation to support students who witness obstetric violence and to prepare them for rotating abroad. And Sara Whetstone and Meg Autry discuss an educational curriculum for resident physicians with both a didactic and an experiential component that focuses on the provision of reproductive care in low-resource settings locally and globally.

Three articles focus squarely on Western biomedicine, with attention to unique policy issues in the United States. Amy G. Bryant and Jonas J. Swartz focus on the problem of crisis pregnancy centers (CPCs), or nonprofit, pseudo-clinical organizations that claim to provide perinatal health services but instead serve as vehicles for anti-abortion counseling [12]. Bryant and Swartz argue that even if some CPCs are technically legal, they are unethical entities because they purport to offer medical services when, in fact, they do not offer a full-range of care options or perspectives. Examining illicit opioid use during pregnancy, Nancy D. Campbell shows how, historically, the medicalization of maternity and criminalization of addiction have served to expand biomedical surveillance of drug-using pregnant women. She argues that in the age of evidence-based medicine, biomedical surveillance should only be conducted to provide quality care and in accordance with the principles of nonmaleficence and respect for patient autonomy. And Margaret Mary Downey and Anu Manchikanti Gomez show how physicians can use the framework of "structural competency" to analyze and seek to change social structures that contribute to health disparities.

Finally, three articles look at the crucial issue of research in reproductive health, arguing for a more nuanced approach to understanding structural violence against pregnant women. Claire Wendland examines the use of perinatal statistics in Malawi and the

United States, focusing primarily on the ethical bias towards hospital births for which statistics on perinatal mortality are readily available. Specifically, she demonstrates that the focus on perinatal health indicators by both policymakers and clinicians obscures factors that are critical to maternal and child health, such as the quality and the sociopolitical context of care. Christina Krudy and Kavita Shah Arora examine the contradictory findings of two clinical trials on antenatal corticosteroids for reduction of perinatal morbidity in the setting of preterm delivery, one conducted in low- and middle-income countries and the other in the US, to highlight the need for understanding of cultural and health care contexts when extrapolating study findings. And Kacey Y. Eichelberger, Julianna G. Alson, and Kemi M. Doll examine the long-standing problem of incorporating race as a variable in studies of preterm birth outcomes. They argue that when race is used as a categorical variable in research, it should be understood not as a genetic or biological construct, but rather as a biosocial concept—as an "approximation of the complex historical and ongoing lived experience of systematic, institutionalized discrimination."

In this month's podcast, interviews with Dorothy Roberts, Nadia Sawicki, and Stacie Geller further illuminate the much higher rates of maternal mortality among black women than white women in the United States [13]. This phenomenon argues for a more thorough evaluation of health care services and appropriate statistical methodology to adequately capture cases [13]. While Roberts illuminates the historical context behind the numbers, Sawicki examines ethical tensions between maternal and child health, particularly "fetal consequentialism"—the idea that the birth of a healthy baby outweighs potential harm to the mother. Finally, Stacie Geller discusses what clinicians, policymakers, and students can do to rectify inequalities and improve maternal outcomes in the US.

All of the scholars who have contributed to this month's issue of *AMA Journal of Ethics* take a critical stance towards reproductive health in the global and local setting by focusing attention on the sociohistorical, economic, political, and gendered contours of quandaries in both research and clinical practice. Whether by re-evaluating obstetric violence in Argentina or considering the opioid epidemic in the United States, the need for a decisive review of the bioethics of reproductive health lies at the heart of this issue. Especially in our current political climate, I hope that this collection of papers will start conversations and drive debates on the need for a holistic, bioethically situated approach to reproductive health.

References

1. The Safe Motherhood Initiative. *Integration.* 1992;(34):23.
2. Starrs A. Preventing the tragedy of maternal deaths: a report on the International Safe Motherhood Conference. http://documents.worldbank.org/mwg-internal/de5fs23hu73ds/progress?id=-

XrYhfIM6IIsot_Y3bh99NdYKlI3_Xm7hunK3YWDtnY,&dl. Published February 1987. Accessed January 22, 2018.
3. Inhorn MC, Shrivastav P, Patrizio P. Assisted reproductive technologies and fertility "tourism": examples from global Dubai and the Ivy League. *Med Anthropol*. 2012;31(3):249-265.
4. Petersen LR, Jamieson DJ, Powers AM, Honein MA. Zika virus. *N Eng J Med*. 2016;374(16):1552-1563.
5. Johnson JL. Bodies don't sleep, neither do babies: experiences at the only maternity hospital isolation unit in Sierra Leone during the 2014 Ebola epidemic. *Am J Obstet Gynecol*. 2015;213(5):739-740.
6. Farmer P, Kim JY, Kleinman A, Basilico M, eds. *Reimagining Global Health: An Introduction*. Berkeley, CA: University of California Press; 2013.
7. Biehl J, Petryna A, eds. *When People Come First: Critical Studies in Global Health*. Princeton, NJ: Princeton University Press; 2013.
8. Harris LH. Rethinking maternal-fetal conflict: gender and equality in perinatal ethics. *Obstet Gynecol*. 2000;96(5)(pt 1):786-791.
9. United Nations Entity for Gender Equality and the Empowerment of Women. *Beijing Declaration and Platform for Action: Beijing+5 Political Declaration and Outcome*. New York, NY: United Nations; 1995. http://www.unwomen.org/-/media/headquarters/attachments/sections/csw/pfa_e_final_web.pdf?la=en&vs=800. Accessed January 22, 2018.
10. Pérez D'Gregorio R. Obstetric violence: a new legal term introduced in Venezuela. *Int J Gynaecol Obstet*. 2010;111(3):201-202.
11. Organization of American States; Follow-Up Mechanism to the Belém do Pará Convention (MESECVI). *Second Hemispheric Report on the Implementation of the Belém do Pará Convention*. Washington, DC: Follow-Up Mechanism to the Belém do Pará Convention; 2012:38.
12. Rosen JD. The public health risks of crisis pregnancy centers. *Perspect Sex Reprod Health*. 2012;44(3):201-205.
13. Molina RL, Pace LE. A renewed focus on maternal health in the United States. *New Engl J Med*. 2017;377(18):1705-1707.

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