Article

Spiritual Articulation and Conscientious Objection: Dynamics of Religious Diversity Management in Healthcare Practices in Argentina

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Abstract: This article delves into the dynamics of managing religious diversity within the healthcare field in Argentina. It focuses on the articulations between health practices and individual belief systems among healthcare professionals and users. Applying a comparative approach based on qualitative interviews, we draw conclusions that underscore the imperative of acknowledging the sociocultural diversity within our societies. This recognition is fundamental in cultivating healthcare environments that not only respect users' diverse worldviews but also healthcare professionals' religious perspectives. Our findings advocate for incorporating religious diversity management principles in healthcare, emphasizing the development of inclusive approaches in dealing with health, illness, and wellbeing.

Keywords: beliefs; conscientious objection; bioethics; medicine; religious diversity; healthcare

Citation: Irrazábal, Gabriela, and Ana Lucía Olmos Álvarez. 2024. Spiritual Articulation and Conscientious Objection: Dynamics of Religious Diversity Management in Healthcare Practices in Argentina. *Religions* 15: 652. https://doi.org/10.3390/rel15060652

Academic Editor: Christine A. James

Received: 1 April 2024
Revised: 6 May 2024
Accepted: 23 May 2024
Published: 27 May 2024

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1. Introduction

Ana María Acevedo first visited Vera's hospital on 9 May 2006, due to tooth pain, leading to a tooth extraction. She returned with pain, and later, a facial tumour was detected. Despite being prescribed antibiotics and undergoing further examination, her condition was not adequately addressed until she was urgently hospitalized in October. By 19 October, a significant abscess had developed. It was not until her transfer to a public hospital in Santa Fe that an internal tumour and an embryonic pregnancy were discovered. Faced with cancer and pregnancy, Ana Maria's treatment options were complicated. The treatment she needed was incompatible with pregnancy. She asked for a therapeutic abortion. The doctors at the hospital declared themselves as conscientious objectors. Due to their religious beliefs, they would not perform an abortion. On 26 April, while she was at the UCI, she underwent a caesarean section and gave birth to a baby girl, 22–23 weeks of gestation, who survived for 24 h (Carbajal 2018). Despite the urgency, her care was marked by delays, lack of communication, and administrative neglect, leading to her passing on 17 May 2007, after the late initiation of chemotherapy.

The death of Ana María emphasizes a profound challenge in managing religious diversity and personal beliefs within the healthcare context. Her case demonstrated that the consequences can be fatal when healthcare authorities and professionals fail to make conscious efforts to manage and respect the diversity of personal beliefs among both patients and professional's. The inability to provide treatment that aligns with individual needs and beliefs compromises the integrity of the healthcare system and, as this case attests, puts lives at risk: Ana María and her baby died. Furthermore, this case shows that the lack of management of religious diversity in the healthcare context has legal repercussions: there is a criminal lawsuit for the healthcare professionals involved in her

care including the general director and the head of the Oncology and Gynaecology services of the hospital, as well for Argentina as a country as there were rulings from the Supreme Court and International organisations considering the country as responsible for these deaths (RosarioPlus 2022; Brussino 2016; Carbajal 2018).

At that moment, managing religious diversity in healthcare system has become a public issue. On the one hand, the women's movement claims access to sexual and reproductive health, while healthcare professionals ask for the liberty of conscience when prescribing treatment. In the healthcare landscape, provincial governments have begun to manage lists of conscientious objectors to accommodate diverse religious needs within medical settings (Legislación en Salud Argentina 2010). On the other hand, non-Catholic religions have started to demand religious assistance, challenging legislation that only allows for the presence of Catholic chaplains in publicly funded hospitals. These catholic chaplains receive a salary as public servants and their jobs are supported by local governments (Irrazábal 2018). Amidst this, patients engage in spiritual practices during various treatments, often clashing with conventional biomedical practices (Olmos Álvarez and Johnson 2022). This situation underscores the connections between beliefs and health, highlighting the need for inclusive approaches to religious diversity management in healthcare environments.

In this scenario, we address the challenges of managing religious diversity within the healthcare field in Argentina by identifying two main dynamics for users and professionals. We refer to them as *positive dynamics*, which occur when there is an alignment between the knowledge and practices of religious beliefs and biomedicine (the dominant actor in the health field) that cooperate for the restitution of the user's health, and *negative dynamics*, which arise when tensions and conflicts lead to refusal or opposition to certain medical treatments and procedures. We also consider this dynamic as negative because they do not have a positive health outcome for the individuals. First, we introduce the state-of-the-art and conceptual framework. Then, we present the results, describing two types of management: (1) positive articulations and (2) negative articulations. Finally, we describe the materials and methods from which the data for this article are derived.

2. Beliefs and Health: State-of-the-Art and Conceptual Framework

The social sciences have been studying the relations among health, religion, and beliefs considering mainly two perspectives. The first focuses on the connections between culture and disease, while the second examines religious–spiritual processes (Olmos Álvarez 2018).

From the first point of view, the healthcare field is conceived dynamically, composed of a plurality of medical systems and processes that are not exempt from negotiations, disputes, and attribution of value and differential efficiencies. In this context, and from the users' perspective, health care is provided through the therapeutic interaction of various systems that seek to prevent, treat, control, and cure a given condition (Saizar 2006). These systems include biomedicine, traditional, religious, complementary, and alternative medicines, and, finally, self-treatment.[1] This classification extends the division the World Health Organization (WHO) introduced between traditional and alternative/complementary medicines (WHO 2013).

Biomedicine refers to a set of practices and meanings about health, associated with the scientific model and with global dissemination. Considered as the hegemonic medical model (HMM), biomedicine includes allopathic medicine and psychotherapies, and it is adopted by governmental entities for population health management (Menéndez 2020). The traditional ones are shamanism and *curanderismo*. The latter synthesizes ancient medical knowledge with popular traditional knowledge and practices and it is constantly reconfigured to adapt to local contexts (Idoyaga Molina 1997). Religious medicines or cures include notions and practices carried out in collective and individual cults and rituals both in institutional spaces and in specialist care; they are aimed at users' physical and spiritual healing (Idoyaga Molina 1997; Kleinman 1980). The classification continues with transnationally disseminated complementary/alternative medicines (CAM), including therapies such as reiki, reflexology, ayurvedic medicine, aromatherapy, and acupuncture,

not recognized by biomedicine as treatment (WHO 2013). The WHO has documented the growing use of these medicines as a global phenomenon to ensure that all people have access to care. Also, it supports their incorporation into health systems in different national contexts, considering their socio-cultural realities and following criteria of rational, respectful, and safe use (WHO 2013). The last category, self-treatment, represents the first therapeutic option for many people in most countries. It may involve the self-prescription of pharmaceuticals, traditional home remedies as well as treatments of various kinds including healing plants and foods. The number of medicines combined is related to cultural, social, and economic factors. Moreover, within these processes, both face-to-face and virtual sociability networks play a significant role, exposing the actors to diverse information and values. These interactions provide insights into alternative narratives about living with an illness, managing the sick body, or accessing health, while also validating the efficacy and legitimacy of other medical options.

The second field of work has focused on therapeutic practices and devices linked to different religious ontologies (Olmos Álvarez 2018). Some research, attentive to the intersections between religion, health, and politics, has delved into the interventions in the public debate on managing health and the body in the name of various religious confessions, giving rise to political–religious activism (Felitti and Irrazábal 2018; Johnson 2018; Carbonelli and Griera 2016; Defago et al. 2021). Along these lines, various analyses show that religions are authoritative voices in health matters and part of a space for exchange between religious, medical, and scientific actors where issues of sexuality and reproduction are discussed, especially contraception, abortion, and assisted fertilization (Felitti and Irrazábal 2018; Olmos Álvarez and Johnson 2022).

According to data from the National Survey of Religious Beliefs and Attitudes in Argentina conducted in 2019 by CEIL CONICET (Mallimaci et al. 2019), the moments in which Argentine believers turn to God are related to suffering (46.3%), the need for specific help (30.9%), and the moment of reflecting on the meaning of life (12.8%). This study affirms that people who reported having suffered from some health problem (4 out of 10 people) tend to resort to religious specialists and healers while also consulting the biomedical system. According to Catoggio et al. (2020), health emerges as the second most significant concern leading people to seek assistance from religious specialists. Additionally, substance abuse is highlighted as another factor prompting individuals to consult pastors and priests.

Considering that people articulate health and religion, the question remains about how secular organizations, particularly hospitals, negotiate and manage the heterogeneous and dynamic constellation of beliefs and religious–spiritual practices present in society.

In this regard, academic research also focused on the adequacy (or not) of public institutions to the growing religious diversity and on how this pluralism challenges the very functioning of these institutions and their different management models of religious diversity (Martínez-Ariño et al. 2015). Likewise, and for different socio-cultural contexts, research focused on studies of chaplaincies in healthcare contexts, analysing the shift from a model of chaplaincies—seen as Christian-centric—to one of multi-faith spiritual or religious assistance (Pais Bernardo 2016) where chaplains are understood as providers of spiritual comfort, compassion, and hope through spiritual services to those who live or work in the framework of secular institutions such as healthcare facilities (Irrazábal 2018) and prisons (Beckford and Gilliat-Ray 1998).

Before proceeding further with the analysis, it is important to note a particular aspect of the Argentine case. In the country, 62.9% of the national population identifies as Catholic, 15.3% of the population self-identifies as Evangelical (primarily as Pentecostal Evangelicals), and in the last ten years, people identifying as having 'no religion' has risen from 11.3% to 18.9% of the population (Mallimaci et al. 2019). Surveys have demonstrated a shift in Argentina's religious landscape at population level. However, in legal–institutional terms, only the Catholic Church remains prioritised in its bonds with civil national authorities (Esquivel 2016). Argentina's National Constitution guarantees freedom of worship but also

establishes that the Federal Government legally and economically supports the Roman Catholic Apostolic religion. This position allows the Catholic Church, as a central political leader, to influence the public debate concerning public health and civil rights policies (Esquivel 2016; Mosqueira and Prieto 2008). Regarding the healthcare system, current legislation only allows for the presence of Catholic spiritual care, centred on the figure of the chaplain, in publicly funded hospitals. By default, any patient requesting spiritual assistance will receive it from a Catholic chaplain unless they specify a preference for a minister of another religion, in which case authorization must be granted by the chaplain. In this context, there are attempts to institutionalise non-Catholic chaplaincies that dispute the monopoly of Catholic spiritual care within healthcare settings. Consequently, the growing religious diversity of the Argentinean population is not reflected in the management and organization of spiritual care (Irrazábal 2018). This discrepancy gives rise to tensions in healthcare practice concerning treatments contrary to religious beliefs, requests for alternative therapies, and dietary restrictions for religious reasons (Irrazábal 2018; Saizar 2006; Olmos Álvarez and Johnson 2022). These tensions often lead to discussions of conscientious objection, involving both patients' refusal of treatment and healthcare professionals' refusal to perform certain practices, as seen in Ana María Acevedo's case. Although different theoretical perspectives offer various definitions, there is a general agreement that conscientious objection implies individuals abstaining from actions or practices mandated by legislation that contradict their ethical or religious convictions (Blanco 2017).

Academic works on conscientious objection in Latin America focus on analysing its legal dimension, its limits, its various regulatory aspects, and jurisprudential analysis (Irrazábal et al. 2019). In addition, there is literature on conscientious objection to abortion from a bioethical perspective and conceptual studies from sociology and philosophy (Ramón Michel and Ariza Navarrete 2015). Concerning individual decisions, claims for autonomy appear as a tendency of certain sectors and social movements (Boltanski and Chiapello 2012) that often object to health issues on religious grounds (Irrazábal et al. 2019). The moral and political debate on the freedom to act or to refrain from acting on grounds of conscience—especially when there are legal or professional obligations that would require otherwise—continues to be a matter of debate.

Considering this, and without entering the debate, this article addresses the management of religious diversity within the healthcare field in Argentina. It focuses on two modalities that this management acquires depending on how health practices and personal belief systems are articulated: positive for healthcare users and negative for professionals.

3. Spiritual Articulation as Positive Management between Religious Beliefs and Biomedicine in Healthcare Users' Narratives

To learn about the processes of positive articulation between biomedicine and religious–spiritual beliefs, we focus on healthcare users' experiences, in particular, on the experiences of women with at-risk pregnancies and mothers of premature babies.

The conjunction "pregnancy at risk—the possibility of premature birth" placed families in a situation where the expected course, "pregnancy–delivery—bringing the baby home", was disrupted to give way to the "pregnancy–preterm birth" including an unexpected period of hospitalisation. Adding to this first inflection is the uncertain duration of the hospital stay, which is likely to be prolonged. For instance, one interviewee recounted being informed about this matter after an emergency caesarean section at 27 weeks of pregnancy: "Get used to the idea that you are going to leave here [neonatology] when you have had the baby".

The characterizations of this period combine surprise at the truncation of the ideal path because "it is difficult to go home without your child after waiting for months" with uncertainty about the future. Women experience incomprehension about what is happening. In this scenario, in what ways are religious beliefs and biomedicine articulated?

It is worth noting that the dynamics discussed occur in institutions organised by biomedicine as regulators of knowledge, roles, hierarchies, forms of action, and expecta-

tions. Given its socio-historical legitimacy and scientifically proven efficacy, social actors rely on biomedicine to understand the events that concern pregnant women and hospitalised new-borns and await indications for future events.

In the narratives of health system users, biomedical knowledge is initially perceived as disruptive, like "a bombardment of information", as a language spoken by others (health professionals) and filled with terms to describe characteristics and events that interrupt the expected course of pregnancy and birth. Associated with this, the form of care is defined by the prescriptions provided by physicians and carried out by the members of the health team. All actions are performed by third parties, while families perceive themselves as mere spectators.

However, there is an acknowledgement of scientific medicine that centres around the encounter with healthcare professionals and the expectations stemming from procedures and interventions during pregnancy and hospitalization. Our interlocutors emphasized and expressed gratitude continuously for the medical expertise and practices that facilitated the recovery of both mothers and children from hospitalization, ensuring their health. "I cannot critique medical standards because my child and I are both alive," remarked one interviewed mother.

Along with biomedicine, people resort to personal beliefs to give meaning and endure episodes of discomfort, suffering, and medical treatment. That is why we delve into these practices and explore the meaning-making processes and potentialities associated with them.

Possibly the most widespread action is prayer. In waiting rooms, beside cribs and incubators, and in hospital chapels, family members pray to link directly with sacred figures, to establish pacts and promises, and to make requests. One of our interlocutors said: "I am Catholic. I felt a refuge in religion; I was interested in being well for my son, and so I prayed to be able to calm my anguish before going in to see him".

Rosaries, small images, medals, stones, and holy cards often accompany these actions. Sometimes, people want to place them near beds, cots, and incubators for protection. These objects are "marked": they belong to the religious–spiritual order. Many of them have had two types of contact: one, with people socially ascribed to healing and curative powers such as healers and shamans, and two, with saints recognised by some institution (such as San Ramon Nonato the patron saint of the unborn, of pregnant women, midwives, and practitioners) or with popular saints (as the Gauchito Gil). Their role is to transmit the beneficial effects of these contacts established in collective rituals (masses or celebrations at public altars) or individual consultations (with healers and *curanderos*). These participations imply assuming specific commitments to perform certain practices (prayers, drinking holy water, and the use of certain objects) to restore health. We deal with actors, spaces, and practices that are understood as part of religious therapies.

We can distinguish two types of elements: those that encourage requests for help and those that diffuse thaumaturgical effects. Among the former are photos, booties, house keys, letters, personal documents, medical orders, and remedies. They are exhibited during the celebrations to bring them into contact with the sacred potencies and to charge them with the beneficial effects of the holy. Thus, scientific efficacy will be enhanced by adding another efficacy that finds its power in the spiritual–religious order, inaugurating a path of complementarity between them.

The second type of objects transfer thaumaturgical effects. Examples include medals and rosaries, holy water, ribbons, and stones. When they encounter these beings, they are imbued with healing potential. They can thus help the sick who will wear them, transmitting the acquired power to them and invoking protection as well as to their families, who participate in the health–disease-care process.

A mother, who underwent an emergency caesarean section due to preeclampsia and whose daughter was born at 24 weeks, said: "My mother went to San Ramon. She left an intention that was read at a mass. She brought me a holy card, which I accumulated with

those brought to me by friends and co-workers. I left them in my backpack so that they would accompany me."

Attending a shrine, participating in healing masses or consulting a *mãe de Santo* are not mutually exclusive events. Instead, they are all part of major therapeutic itineraries that, along with biomedicine, involve encounters, requests, and promises. Together, these actions help individuals envision a future and alternative reality amidst the uncertainty of hospitalisation.

This opens a range of religious options that provide a spiritual complement to medical knowledge. This possibility of constructing itineraries by articulating participation in biomedical and religious spaces is based on a view of the health–illness-care process that includes a spiritual level that integrates everyday experience and suffering and extends from the emotional and physical to a broader context.

We had mentioned that the moment of questioning the meaning of life constitutes one of the causes for approaching religious beliefs. Therefore, we should not overlook the fact that some people make pacts and promises with the sacred potencies because "nothing was left to do". Turning to religion can also be understood as the destination of the aforementioned itineraries. It will gain value and show its full potential by challenging the timelines of treatments and the certainties associated with scientific medicine. When physicians diagnose severe disorders, venture into complex scenarios, or prescribe invasive and prolonged treatments, they provide fertile ground for the "miracle" evidenced by numinous intervention.

Up to this point, we have presented the positive articulations between religious beliefs and biomedicine. Next, we address the negative articulations based on the issues of conscientious objection from the perspective of health professionals and linked to the relationship between health professionals and patients.

4. Issues of Conscientious Objection. Negative Articulations between Religious Beliefs and Biomedicine in the Health Professional–User Relationship

In daily healthcare practice, conscientious objection issues highlight the interrelationship between religious beliefs and health. These issues are particularly evident in the health professional–user relationship. According to Rivera-Flores and Acevedo-Medina (2009), users may object to treatment proposals by health professionals and, likewise, health professionals may object to patients' demaAcevednds, especially when these requests conflict with their religious beliefs. Both types of objections, those of professionals refusing to perform a practice established by regulations and those of patients—experienced as decisions of autonomy and freedom of conscience whether there is a legal obligation regarding them—require consideration. However, public debate usually only arises when professionals refuse to perform a particular medical practice (Rivera-Flores and Acevedo-Medina 2009).

In recent years, disputes over conscientious objection by healthcare personnel in Argentina and other countries in the region have been mostly linked to reproductive health issues, especially abortion (Rivera-Flores and Acevedo-Medina 2009). Reproductive health has been recognised in Argentina as an integral part of the right to health since 2003. In this framework, public health legislation included the free provision of contraceptives, emergency pills, and condoms. The right to abortion was added in 2021 after extensive public debate. For this reason, conflicts arose in the health field with professionals who, claiming conscientious objection, refused to comply with these prescriptions indicated by the health authority. In relation to abortion, there were numerous cases of women who were unable to access legal abortion and even died because of the refusal of health professionals to perform these practices (Irrazábal et al. 2019) as in the case of Ana Maria Acevedo presented at the beginning of this article.

Likewise, more closely linked to the patients' worldviews, we find objections to the mandatory vaccination plan (Irrazábal 2021). In the last decades and with a growing anti-vaccine movement, some families have demanded the implementation of an alternative vaccination plan, and there are even court rulings in Argentina that endorse or reject such

requests (Irrazábal et al. 2019). The growing claims for patients' self-determination and a model of care that is further away from paternalism create a space where personal decisions play an important role in the acceptance or refusal of treatment. Likewise, professionals' decisions are affected by demands or requests that, in the first instance, appear to be contrary to their convictions.

In addressing this matter, we focus on two situations within the healthcare professional–user relationship that require attention to prevent violations of both the patient's autonomy rights and the practitioner's: blood transfusions and abortion.

Concerning to the first situation, blood transfusions, it worth noting that patients are not legally obliged to accept them, yet they are a common treatment practice. However, some situations have even been brought to court. In the case of Bahamondez, Marcelo s/ medida cautelar (SAIJ 1993), the Argentina Supreme Court of Justice stated: "When there is conscientious objection to medical treatment, nothing can be reproached to the professionals and persons involved who respect the free decision of the person involved" (SAIJ 1993, p. 484) and even that "the absence of an express rule providing for the right to conscientious objection to blood transfusions is irrelevant" (SAIJ 1993, p. 484). Considering this, we analyse the case of blood transfusions in the context of "conscientious objection" because this practice appears as the refusal of a procedure that is part of common biomedical practice and recommended by a medical authority.

Regarding abortion, there is a significant amount of specialized literature that describes the tensions and conflicts related to this practice. Additionally, numerous studies highlight that conscientious objection in sexual and reproductive health is a transnational political strategy of religious groups that undermines women's rights in our region (Capdeville 2018). In this sense, conservative Christian religious organizations position themselves as democratic actors with secularized discourses to oppose sexual and reproductive policy (Vaggione 2016). In this context, issues of conscientious objection appear as part of a collective strategy against certain social rights by protecting the objector's freedom of conscience and opposing legal norms, thereby depriving them of effectiveness in practice. This results in the infringement of rights and the weakening of social gains not in favour of historically and systematically discriminated groups (Capdeville 2018).

Our analysis shows that, although there has been an increase in access to abortion in recent years up to the recent enactment of the Law on the Voluntary Interruption of Pregnancy, intra-institutional tensions arise from a patient's specific request for a legal termination of pregnancy, as Ana Maria Acevedo's case points out. The professionals consulted stated that, in general, individual objections are usually resolved and that complications arise when all the members of an entire service declare themselves as objectors. One physician recounted,

> "With regard to abortion, there has been resistance to termination of pregnancy in both gynecology and obstetrics. In general, the health reasons of the mother were always accepted when there was an indication for a therapeutic abortion. If the mother had a heart disease or other diseases that are negatively affected by pregnancy, it was accepted by both services, depending on the age of the pregnancy. The situation was very different in terms of rape, in that sense there was . . . a more restrictive attitude (. . .) Obstetrics has a head of service who is very Catholic, has ties, he is a practicing Catholic and so on, and he had a restrictive attitude on this issue. But I don't think the whole service is like that".

The issue of the refusal of blood transfusions by Jehovah's Witness patients is interpreted more as an issue of religious beliefs that have an impact on the health professionals involved, in particular, the refusal of parents to allow their children to receive blood transfusions if necessary. The care of Jehovah's Witnesses involves all health professionals, and conflicts have arisen, for example, with anesthesiologists, as Jehovah's Witness believers have declared themselves as conscientious objectors. In one of the case analysis workshops with professionals, in which the refusal of blood transfusions was specifically addressed, they told us,

"We work with Dr. (. . .) who is a very renowned hematologist and who has researched and applied the techniques that we accept. We have done some outreach work with the medical community, and we are working to attend the Congress of Anesthesiology so that we can talk to them, so that they can hear our position. There is no anesthesiologist in Argentina who wants to participate in surgery on a Jehovah's Witness. They are all conscientious objectors".

From the point of view of Jehovah's Witness patients, there is a generalized tension when it comes to providing care, especially in complex practices requiring surgical intervention. However, they inform us that, through a Liaison Committee with health institutions (Jehovah's Witnesses n.d.), they have managed to articulate networks of healthcare professionals and institutions respectful of their beliefs. These networks can provide care during surgeries and births according to a protocol oriented towards Jehovah's Witnesses patients and allow them to attend surgeries and births with a protocol of care oriented to Jehovah's Witnesses.

From health professionals' perspective, tensions arise not so much from a rejection of patients' religious beliefs, which they generally respect, but from the emotional impact on them of the decision not to receive a life-saving medical treatment or procedure. This is how one health professional recounts it:

"One of the cases I remember most that had a great impact on me was a pregnant patient with an ovarian tumour who needed an abortion. She specifically asked to be admitted here because of the pregnancy termination. But what happened was that she asked not to be transfused, and this caused a lot of concern".

Continuing with Jehovah's Witness patients, cases involving children and newborns in neonatology who may require blood transfusions often generate confusion among health professionals about how to proceed, and whether to prosecute the cases. The decision to refuse transfusion rests with the parents if the best interests of the child are at stake. While the tendency is usually to indicate transfusion in children, it remains a complex situation regarding the patient–professional relationship. There is a prevailing notion among professionals that if a Jehovah's Witness child undergoes a transfusion, they will be expelled by their community and will no longer be a member of the religion. A paediatric intensivist describes it as follows:

"I explained to her, I told her that we had to transfuse, otherwise the baby would die. The girl said yes, but do you know what the father made me do? It was the first time we had to do it: he asked me to write a note explaining the clinical reasons why we needed to transfuse the baby, including the hematocrit level. With that note, they approached the Jehovah's Witnesses, and they allowed the transfusion just like that . . . there was no judicial intervention whatsoever. Even some were saying that if that patient was transfused, he didn't belong to the community anymore, but she denied it, saying 'no way, they are not expelled from the community.' So, we didn't say anything. But . . . Jehovah's Witnesses . . . they're quite a challenge".

The above testimony shows how, when faced with a medical request for a blood transfusion, they were able to articulate with the religious group and achieve the necessary treatment for that patient. They are not always able to reach an agreement and health professionals feel "attacked" for indicating a transfusion and even must be on the defensive. In some circumstances, they proceed directly without consulting the family or the Liaison Committee counsellors:

> The doctor the Jehovah's Witnesses brought in didn't want us to transfuse him [the patient]. But he said to me "well, do whatever you think is necessary". And I told the doctor the truth: "if the boy is about to die, I'm going to transfuse him and I'm not going to say anything to the boy or to anyone else (. . .) I also thought . . . if this boy finds out . . . We transfused him with platelets.

In Argentina, conscientious objection is recognised for certain practices in different national (Ley 26.130 2006; Ley 26.529 2009) and provincial regulations as a fundamental right not to act against one's conscience as long as it does not affect third parties. According

to the specialised literature, conscientious objection should not be institutional. However, there are several initiatives in this sense from confessional health institutions and even in some regulations such as the National Programme of Sexual Health and Responsible Procreation (Ley 25.673 2003) that include the possibility for an institution to breach this law for confessional reasons (La Voz 2021).

Considering these issues, we find points of tension and conflict around the acceptance or rejection of certain biomedical treatments or procedures on religious grounds by either patients or health professionals. We call these tensions, which in some cases can be resolved in an articulated manner, negative articulations because depending on their development, they may infringe on the rights of third parties.

5. Materials and Methods

From an empirical point of view, this article integrates analyses of two research projects focused on the articulations between religions and health in the public sphere in the metropolitan area of Buenos Aires (Argentina). The first project, Religion and Health: Sacred Cosmologies, Trajectories, and Strategies for Seeking Personal Improvement in the AMBA, of an ethnographic nature focused on the processes of therapeutic articulation and complementarity and how therapeutic pluralism and religious diversity are intertwined. The second project, Genetics and Human Rights: Imaginaries, Beliefs, and Management of Health, Justice, and Identity in Recent Argentina, focused on the positions and motivations of health professionals in the performance of certain practices and/or medical genetics treatments.

Following a qualitative perspective, this article incorporates data from in-depth interviews, case analysis, and ethnography. The analysis is based on the results of 20 (twenty) individual interviews with female users of the healthcare system and health professionals. In the case of users, we performed 15 (fifteen) interviews among women aged between 28 and 40 years with risk pregnancies (chorioamnionitis, preeclampsia, and HELLP syndrome, among other pathologies) and mothers of premature babies (born in weeks 24–27) with hospitalisations longer than seventy days in the neonatology service of public and private hospitals in the AMBA. Concerning professionals, we also conducted individual interviews with practitioners of different services: neonatologists, obstetricians, and nurses. These in-depth interviews were conducted within the framework of an UNDAVCyT project. Upon their completion, they were integrated to be updated by the current projects focusing on the interactions between religions and health in the public sphere. In addition to these interviews, we drew material from a 385-page corpus resulting from six group discussion meetings that took place within a maternity hospital and a bioethics committee. In these meetings, specific cases were presented and addressed by healthcare professionals to discuss criteria, working methodologies, and epistemological foundations on decision-making and potential conflict resolution.

We focus on the aspects of the interviews where the positive and negative dynamics of managing religious diversity were recorded. We coded the transcripts of the interviews and group meetings using Atlas.ti software, allowing for an inductive analysis.

The fieldwork took place in the period 2018–2022 in different institutional contexts crossed by practices and meanings related to health: a public maternity hospital and two religious worship sites. Observation, direct engagement, and informal discussions were used in these sites.

This analysis is complemented by employing the comparative method characteristic of the social sciences (Nohlen 2012). In this context, the comparison is conducted within the cases surveyed by each project and between the cases of the two studies. According to Nohlen (2012), when applying the comparative method (a) through analogy, similarity, or contrast, the previously unknown is understood (pedagogical comparison); (b) it leads to discoveries or highlights the particularities of each case (heuristic comparison); and (c) by emphasizing differences precisely, it helps to systematize (systematic comparison) and discover broader categories or axes of analysis.

This approach allowed us to explore the religious diversity management within the healthcare field in Argentina. Throughout this article, we first dealt with users' experiences as part of the positive dynamics and then with the experiences linked to the user–health professional relationship that gives rise to conscientious objections. These were included in the negative dynamics.

6. Conclusions

In 2012, six years after Ana Maria Acevedo's death, another case shocked the public. Pablo Albarracini received five shots in the body and one in the head during a robbery. The doctors who attended to him indicated that, due to the seriousness of his condition, he required blood transfusions. However, his wife refused because of her husband's religious beliefs: Albarracini was a Jehovah's Witness and had signed a document expressing his rejection of this medical procedure.

Faced with this refusal, the patient's father turned to the courts to enforce a transfusion. The case reached the Supreme Court, which ultimately ruled favourably respecting freedom of worship and, consequently, Pablo's will. In the highest court's unanimous decision, it was argued: "Argentine law recognizes the right of every capable adult to make advance directives regarding their health, consenting to or refusing certain preventive or palliative medical treatments, and decisions concerning their health". Situations like the ones described happen continuously in healthcare settings and the way institutions address their management affects the lives of people seeking for their wellbeing.

In this article, we addressed the dynamics of managing religious diversity in the Argentinean healthcare field focusing on users and professionals as main actors of this field. Particularly, we delved into the modalities that these dynamics acquire depending on how health practices and personal belief systems are articulated. First, we identified spiritual articulations as positive management and carried out by users. These articulations showed a path of complementarity between biomedicine and religious and spiritual health-oriented practices enhancing the efficacies assigned to each resource. Secondly, we explored the negative dynamics of managing religious diversity in health professionals' daily practice and patient–professional relations through the concept of conscientious objection. These dynamics are deemed negative as they can potentially lead to the violation of third parties' rights during their development and resolution. In addition, we observed that patients, when faced with treatment options that conflict with their beliefs, tend to reject them. In certain faiths, individuals seek alternatives within the biomedical realm that align with their religious convictions.

Although the biomedical system is the main reference for treating health conditions, it is not always the first or the only option for people. In Argentina, as recent research points out (Catoggio et al. 2020; Irrazábal 2021), the biomedical system coexists with other alternatives that account for the various paths of care-prevention, healing and/or wellbeing. However, this coexistence may occur harmoniously between alternative forms and the biomedical system while others appear in the form of tension and conflict framed in situations of conscientious objection. In this case, it implies recognizing that people can object to issues or aspects of medical treatment they consider contrary to their moral or religious convictions.

These issues highlight that the increasing cultural and religious diversity within Argentine society is also reflected in the healthcare context. Consequently, differences of opinion on moral or religious grounds between healthcare professionals and patients are becoming more prevalent.

The resolution of these disagreements presents an opportunity to effectively manage sociocultural diversity within healthcare institutions (Cadge 2012). In the framework of contemporary democratic societies, healthcare within the biomedical system should prioritise an environment that respects the beliefs of patients and their families.

Additionally, fostering spaces for dialogue and exchange is crucial for addressing tensions arising from claims of conscientious objection. It is imperative to ensure access

to healthcare and uphold the rights of all individuals while providing the possibility for individual objection without infringing upon the rights of others.

Author Contributions: Conceptualization, G.I. and A.L.O.Á.; methodology, G.I. and A.L.O.Á.; formal analysis, G.I. and A.L.O.Á.; investigation, G.I. and A.L.O.Á.; resources, G.I. and A.L.O.Á.; writing—original draft preparation, G.I. and A.L.O.Á.; writing—review and editing, G.I. and A.L.O.Á.; project administration, G.I. and A.L.O.Á.; funding acquisition, G.I. and A.L.O.Á. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by CONICET, National Scientific and Technical Research Council, and FONCyT- Fondo para la Investigación Científica y Tecnológica under a research fundings PICT 2018 03091 and PICT 2019 04611.

Institutional Review Board Statement: This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of Hospital de Alta Complejidad El Cruce, Argentina (Resolution No. 69/2019).

Informed Consent Statement: Informed consent was obtained from all the subjects involved in this study.

Data Availability Statement: Data available on request due to restrictions on privacy and ethical issues under the personal data protection law of Argentina 25.326 (PDPA).

Conflicts of Interest: The authors declare no conflict of interest.

Note

[1] The classifications synthesized here are those made by different social scientists, including Good (1987); Idoyaga Molina (1997); Kleinman (1980); and Menéndez (2020).

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