



PHILOSOPHY AND THEOLOGY

In November 2007, the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) issued committee opinion 385, titled “The Limits of Conscientious Refusal in Reproductive Medicine.”¹ The committee enumerated a series of recommendations that “maximize accommodation of an individual’s religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.”² These recommendations include the following seven provisions:

1. In the provision of reproductive services, the patient’s well-being must be paramount. Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.

¹ American College of Obstetricians and Gynecologists (ACOG), Committee on Ethics, “The Limits of Conscientious Refusal in Reproductive Medicine,” opinion no. 385, November 2007, http://www.acog.org/from_home/publications/ethics/co385.pdf. This opinion has generated several critiques. See, for example, American Association of Pro Life Obstetricians and Gynecologists, “Response to the ACOG Ethics Committee Opinion #385,” February 6, 2008, http://www.aaplog.org/responsetoacogethicscommittee385_2-6-08.pdf; and Dr. Bob Orr of the Christian Medical and Dental Association, “Critique of ACOG Committee Opinion # 385,” <http://www.cmda.org/AM/Template.cfm?Template=/CM/HTMLDisplay.cfm&ContentID=10375>.

² ACOG, “Limits of Conscientious Refusal,” 2.

3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.³

In order to justify these recommendations, the opinion of the committee appeals to a definition of conscience as "the private, constant, ethically attuned part of the human character. . . . An appeal to conscience would express a sentiment such as, "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night."⁴

Certain elements of the definition of conscience proposed by the ACOG committee are unobjectionable, such as the desire to avoid inner discord and the "ethically attuned" aspect of conscience which hints at a response to something objective. A concern for patient well-being is certainly laudable. However, on the whole, the foundation of the seven ACOG recommendations as well as many of the recommendations themselves are at odds with a sound understanding of ethics and conscience and furthermore fail to appreciate, or respect, the genuine pluralism that exists about the nature and claims of conscience.

The committee's understanding of conscience reflects a particular philosophical view, one that can hardly be taken as self-evident. It is not made clear in the document

³Ibid., 5.

⁴Ibid., 2.

why this peculiar account of conscience (perhaps originating with Thomas Hobbes) was adopted, nor why this one philosophical view of ethics and conscience should be imposed on the entire membership of the ACOG. With Hobbes, the ACOG guidelines presuppose that ethics is ultimately a matter of the private emotions and sentiments rather than a matter of common rationality and practical wisdom, as Plato, Aristotle, Cicero, Thomas Aquinas, Immanuel Kant, John Henry Newman, and Simon Solovey-chik held. The difference between a properly formed conscience and a malformed conscience consists in part in that a properly formed conscience reflects an ethical soundness which is not an idiosyncratic private taste, but rather may be a communally, publicly shared judgment precisely because it is based on shared rationality.

In the ACOG opinion, conscience reflects not one's best judgment at the conclusion of a process of moral deliberation from fundamental moral principles about what is right and wrong all things considered (*ultima facie*), but a feeling that is merely a matter of a provider's personal experience of loss of self-respect. "Although respect for conscience is a value, it is only a *prima facie* value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance."⁵ The committee opinion thus construes claims of conscience as *prima facie* values that can and should be "overridden" by the agent in light of other moral considerations. When this idiosyncratic desire not to feel shame is set against the well-being of a patient, naturally the patient's well-being trumps the private, sentimental desire to keep one's hands clean. The ACOG conception of conscience as a *prima facie* guide contradicts, for example, the proximate supremacy of conscience as an unconditional command (Kant), a magisterial dictate (Newman), and the famous dictum of conscience, "were its might equal to its right, it would rule the world" (Butler). Sophocles in *Antigone*, Socrates in the *Crito*, and Aquinas in the *Summa theologiae* (I-II, Q 19.5) all testify that an agent's best ethical judgment—the judgment of conscience—simply cannot be overridden.

Not only is the ACOG's definition of conscience only one among many understandings of conscience and hardly representative, but also its peculiar definition is problematic in two additional respects. First, there is no reason why conscience must be constant, for people can and should change their consciences to accord with the truth as best as they can determine it. Second, the violation of conscience does not necessarily lead to emotional turmoil or subjective feelings of guilt ("If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night"). A violation of conscience makes the agent objectively guilty for having knowingly and willingly done something against the agent's best ethical judgment. Being guilty in this sense is fully compatible with a wide range of emotional reactions. The wicked sometimes sleep soundly.

The idiosyncratic foundation of the ACOG document's recommendations is not only philosophically (and theologically) problematic from a diverse variety of perspectives (such as those represented by Sophocles, Socrates, Aquinas, Kant, Butler, Newman, and Solovey-chik), but the recommendations themselves are also

⁵Ibid., 3.

highly objectionable. “Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request.”⁶ A pro-life physician could follow the letter of this recommendation and refer a patient to another pro-life doctor. However, if construed (as seemingly intended by the committee) as a duty to refer to a doctor who has no conscientious objection to abortion, this recommendation proposes a duty to cooperate in the wrongdoing of another by not merely providing what is needed to commit wrongdoing, but by helping patients precisely in their wrongdoing. It would indeed be absurd to say, “I would have a guilty conscience if she did ‘x.’”⁷ However, it is not at all absurd to say, “I would have a guilty conscience if I helped her to do ‘x.’” Conscience may or may not demand that one rebuke or obstruct other providers, but it surely demands that one not formally assist in the wrongdoing. This becomes intuitively clear when we substitute for “x” something uncontroversially evil. Would it really “absolve” a physician from guilt if he did not personally prescribe a drug in order for a patient to commit date rapes, but rather helped the rapist achieve his goal by referring him to another doctor to fill the prescription? It is true that some patients would still do “x” even without a referral. However, formal cooperation in the wrongdoing of others is not eliminated simply because the wrongdoer is intent on doing wrong regardless of the cooperation given.

One would have strong reason to suspect that the ACOG has chosen its definition of conscience precisely to yield the specific recommendations that it wanted, given that the ACOG’s previous policy positions would imply a very different understanding of the nature, scope, and claims of conscience. Previously, the ACOG has championed the individual judgment of the physician about what counts as medically indicated for a patient in particular circumstances as a buttress against laws criminalizing abortion procedures. On this view, if a particular physician believes it is in the best interest of the health of the woman to have an abortion, then this judgment qualifies the procedure as legal under the guidelines set by *Roe v. Wade* and *Doe v. Bolton*. In the words of the ACOG statement of policy on abortion (reaffirmed in 2004), a partial-birth abortion “may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the woman, and only the doctor, in consultation with the patient, based on the woman’s particular circumstances can make that decision. . . . The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.”⁸ It would seem then that the judgment of the individual physician about what is medically indicated trumps any sort of universalized ruling that abstracts for the particularities of the situation as understood by the physician chosen by the patient. However, some physicians in conscience refuse to provide contraceptives or perform abortions because, having

⁶Ibid., 5.

⁷Ibid., 2.

⁸ACOG Statement of Policy, “Abortion Policy,” January 1993 (reaffirmed July 1994), 3; available at <http://www.sdhealthyfamilies.org/media/pdf/ACOGAbortionPolicy.pdf>.

examined the empirical evidence,⁹ in their judgment these practices are contrary to the well-being of their patients. In these cases, when an affirmation of the autonomy of a physician in determining medically indicated care might result in an abortion not being performed, opinion 385 overrides the judgment of the treating physician in favor of “standard care” as determined by the ACOG, a kind of legislative body.

The ACOG opinion not only unfairly limits a doctor’s liberty in action but also infringes on a physician’s freedom of speech. In other contexts, the ACOG has argued against “gag rules” that inhibit a physician from communicating to the patient about what is, in the physician’s judgment, relevant for making sure the patient can give informed consent and proper treatment. “Serious ethical problems arise if organizational rules (so-called “gag rules”) preclude such disclosures.”¹⁰ However, in opinion 385, physicians may not even communicate their own views about treatment unless they parrot “professionally accepted characterizations of reproductive health services.” Freedom of speech is therefore sharply curtailed, since doctors are expressly forbidden “to argue or advocate” views that dissent from ACOG committee policy. Such physicians are also forced, even in contexts where such matters may not be at issue, to make their views known to patients, and yet at the same time the new ACOG gag rule forbids them to indicate why they hold these views.

The flawed understanding of conscience accepted by opinion 385 actually commits the ACOG, by extension and analogy, to positions that reasonable people would in other circumstances find repugnant. This may be seen by substituting other practices for abortion and contraception. The same rules, for example, adopted in a different cultural and legal milieu, would only allow a conscientious objector not to perform female genital mutilation (FGM) so long as the objector were forced to refer patients to those who do perform female genital mutilation, and as long as someone else were available. If the physician responds that female genital mutilation goes against his conception of good medicine, not only must the physician act in certain circumstances against what he believes is medically indicated, but the objector must also mouth to the patient or guardian “professionally accepted characterizations” of the practice, as understood in the predominant cultural and enforced legal milieu without “use of their professional authority to argue or advocate” against FGM.

⁹See Royal College of Psychiatrists, “Position Statement on Women’s Mental Health in Relation to Induced Abortion,” *Times Online*, March 14, 2008, <http://extras.timesonline.co.uk/abortion.pdf>. See also Thomas W. Strahan, *Detrimental Effects of Abortion: An Annotated Bibliography with Commentary*, 3rd ed. (Springfield, IL: Acorn Books, 2001); Elizabeth Ring-Cassidy and Ian Gentles, *Women’s Health after Abortion: The Medical and Psychological Evidence*, 2nd ed. (Toronto: deVeber Institute for Bioethics and Social Research, 2003); and C. Kahlenborn et. al., “Oral Contraceptive Use as a Risk Factor for Premenopausal Breast Cancer: A Meta-analysis” *Mayo Clinic Proceedings* 81.10 (2006): 1290–1302.

¹⁰ACOG Committee on Ethics, “Ethical Decision Making in Obstetrics and Gynecology,” opinion no. 390, December 2007, 6, http://www.acog.org/from_home/publications/ethics/co390.pdf.

Would such rules, for the physician practicing in places where FGM is legally and culturally accepted, provide an adequate protection (let alone “maximize accommodation”) for the doctor conscientiously objecting to FGM?

Consider examples closer to home. A physician working in a correctional facility is asked to facilitate giving a lethal injection to a prisoner on death row. The physician firmly believes that capital punishment is immoral and further, having closely followed this prisoner’s case, is convinced the condemned is actually innocent. However, let us suppose that state law allows only employees of the correctional facility to be in the room during the execution, and since he is the only physician employed in the prison, according to the principles for conscience set by the ACOG, the physician has a duty to execute the prisoner. Likewise, in places where euthanasia or physician-assisted suicide is legal, similar conscience guidelines would require physicians opposed to these practices to kill or help kill their patients if no other physician is available.

Part of the argument made by the ACOG is that the obligations undertaken by the physician’s acceptance of his role as physician (and the privileges this entails) bind the doctor more firmly than the judgment of conscience. However, it in no way follows that undertaking certain obligations vacates the demands of conscience. Ironically, the committee report would undermine the autonomy of physicians to an even greater degree than a military oath to obey superior officers limits the autonomy of soldiers. A man volunteering for military service freely takes an oath to obey his superior and receives all the privileges and responsibilities that come with that oath. But let us suppose his lawful superior orders him to do something that the soldier considers to be immoral. In the understanding of conscience imposed by the ACOG committee, a soldier could disobey an order only if there were other soldiers available to carry it out. If not, then the soldier has a duty to carry out the order that he considers immoral. Surely, however, the demands of conscience must not be gerrymandered by the availability of less enlightened and conscientious people.

One of the concerns of the committee is that the exercise of conscientious objection not create or reinforce racial discrimination or socioeconomic inequalities in society. However, the ACOG opinion itself encourages unfair discrimination against anyone who refuses to take innocent human life, including many religious believers, particularly Catholics. Any Catholic who accepts the teaching of the Church will be unable to practice medicine in accordance with the recommendations of the committee. Like any intentional killing of innocent human beings, performing abortions violates Catholic teaching, and indeed when knowingly and willingly done, the agent who procures an abortion “incurs an automatic (*latae sententiae*) excommunication” (can. 1398). Circumstances—such as practicing medicine in a remote location—might lead to a situation in which a Catholic doctor is the only physician available to perform an abortion, and under the rules of the committee would therefore be required to do so. In a more typical case, the committee opinion seems to require a conscientious objector to refer a woman for abortion to a provider who will perform the abortion. In other words, it requires the conscientious objector to cooperate in the abortion. As Bishop Rene H. Gracida notes, “Accomplices are also subject to the penalty of excommunication if the abortion would not have been

committed without their efforts (canon 1329.2).”¹¹ Thus, if the referral were really needed in order to perform the abortion, the one making the referral would seem to share in the penalty of automatic excommunication. And if the referral were not really needed in order to secure the abortion, it is difficult to see why the physician should be required to perform a superfluous act, other than to mislead a patient about the physician’s views on abortion.

Conscientious Catholic physicians cannot act in accordance with the committee’s regulations. The committee view creates a professional environment discouraging if not prohibitive to Catholics and certain other faithful Christians who oppose abortion. Thus, in effect, opinion 385 also reinforces prejudice and discrimination against ethnic minority groups who are disproportionately Catholic and Evangelical, such as Latinos and African-Americans.

The many difficulties occasioned by opinion 385 could be reasonably avoided, and the legitimate autonomy of both patients and doctors secured, by recognizing the proper scope of liberty on all sides. Physicians have the autonomy to determine what is in their view medically indicated for the patients they serve, and to determine whether they are willing to provide this service; patients have the autonomy to reject or accept any options offered by their physicians as well as the freedom to choose their physician. Either side may misuse their autonomy, but as a *prima facie* starting point this seems much preferable to the one-sided emphasis on patient autonomy found in the committee opinion. Physicians should not be cast into the role of medical automatons forced to perform actions contrary to their best ethical and medical judgments.

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¹¹ Bishop Rene H. Gracida, D.D., “Choose Life, Not Death! A Pastoral Letter on Abortion and Excommunication,” September 8, 1990, <http://www.priestsforlife.org/magisterium/gracida.htm>.

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Bioethics

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**An Ironic Reductio for a
“Pro-Life” Argument:
Hurlbut’s Proposal for
Stem Cell Research**

Kevin C. Elliott

William Hurlbut, a Stanford University bioethicist and member of the President’s Council on Bioethics, proposed a solution to the current impasse over human embryonic stem cell research in the United States. He suggested that researchers could use genetic engineering and somatic cell nuclear transfer (i.e., cloning) to develop human “pseudo-embryos” that have no potential to develop fully into human persons. According to Hurlbut, even thinkers who typically ascribe high moral status to human embryos could approve of destroying these “pseudo-embryos” for the sake of harvesting human embryonic stem cells. The author argues, first, that an argument based on the “paradox of the heap” (an argument that many “pro-life” thinkers employ to defend the notion that human embryos have high moral value from the moment of conception) challenges the ethical legitimacy of Hurlbut’s proposal. Second, he argues that this conflict may illustrate a reductio ad absurdum for this “pro-life” argument rather than being a problem for Hurlbut’s proposal. As a result, the paper challenges the “pro-life” strategy of arguing that one should respond to uncertainty about the moral status of developing embryos by being morally “cautious” and granting all human embryos full moral status from the moment of conception. It appears that one is faced with a complex series

of choices (about where to draw the moral line between entities that are human persons and entities that are not), and a strict moral “cautiousness” about this series of choices may ultimately lead to absurdity.

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Proxy Consent and Counterfactuals

Yujin Nagasawa

When patients are in vegetative states and their lives are maintained by medical devices, their surrogates might offer proxy consents on their behalf in order to terminate the use of the devices. The so-called “substituted judgment thesis” has been adopted by the courts regularly to determine the validity of such proxy consents. The thesis purports to evaluate proxy consents by appealing to putative counterfactual truths about what the patients would choose, were they to be competent. The aim of this paper is to reveal a significant limitation of the thesis, which has hitherto been recognized only vaguely and intuitively. By appealing to the metaphysics of counterfactuals, the author explains how the thesis fails to determine the validity of proxy consents in a number of actual cases.

**Should We Prevent Nontherapeutic
Mutilation and Extreme
Body Modification?**

Thomas Schramme

In this paper, the author discusses several arguments against nontherapeutic mutilation. Interventions into bodily integrity, which do not serve a therapeutic purpose and are not regarded as aesthetically acceptable by the majority—for example, tongue splitting, branding, and flesh stapling—are now practiced but are still seen as a kind of “aberration” that ought not to be allowed. He rejects several arguments for a possible ban on these body modifications. The author finds the common pathologization of body modifications, Kant’s argument of duties to oneself and the objection from irrationality all wanting. In conclusion, he sees no convincing support for prohibition of voluntary mutilations.

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**Is It Time for Bioethics to
Go Empirical?**

Chris Herrera

Observers who note the increasing popularity of bioethics discussions often complain that the social sciences are poorly represented in discussions about things like abortion and stem cell research. Critics say that bioethicists should be incorporating the methods and findings of social scientists, and should move toward making the discipline more empirically oriented. This way, critics argue, bioethics will remain relevant, and truly reflect the needs of actual people. Such recommendations ignore the diversity of viewpoints in bioethics, however. Bioethics can gain much from the methods and findings from ethnographies and similar research. But it is misleading to suggest that bioethicists are unaware of this potential benefit. Not only that, bioethicists are justified in having doubts about the utility of the social science approach in some cases. This is not because there is some inherent superiority in non-empirical approaches to moral argument. Rather, the doubts concern the nature of the facts that the sciences would provide. Perhaps the larger point is that disagreements about the relationship between facts and normative arguments should be seen as part of the normal inquiry in bioethics, not evidence that reform is needed.

**Journal of
Applied Philosophy**

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**Consciousness and the Moral
Permissibility of Infanticide**

*Nicole Hassoun and
Uriah Kriegel*

In this paper, the authors present a conditional argument for the moral permissibility of some kinds of infanticide. The argument is

based on a certain view of consciousness and the claim that there is an intimate connection between consciousness and infanticide. In bare outline, the argument is this: it is impermissible to intentionally kill a creature only if the creature is conscious; it is reasonable to believe that there is some time at which human infants are not conscious; therefore, it is reasonable to believe that it is permissible to intentionally kill some human infants.

**Journal of Law,
Medicine & Ethics**

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**Ethical Implications of Physician
Involvement in Lawsuits on
Behalf of the Tobacco Industry**

Jess Alderman

The statements of physicians who serve as expert witnesses for the tobacco industry reveal subtle but significant problems. Some expert testimony obfuscates the important issues, and some initially reasonable statements later evolve into extreme positions during cross-examination. Such statements fall into a “gray area” of professional ethics, potentially misleading juries and adversely affecting professional integrity. Medical associations can and should strongly enforce professional standards that do not tolerate tobacco industry influence on physician expert witnesses.

**Jewish Perspectives on the Use of
Preimplantation Genetic Diagnosis**

Mark Popovsky

This article presents an analysis of the ethical considerations raised by preimplantation genetic diagnosis (PGD) from a Jewish perspective. It weighs the Jewish imperatives to pursue good health against a number of harms that may follow from the expanded use of PGD technology, including increased medical risk to the mother, the destruction of embryos, and possible emotional harm to the

child born from this procedure. It pays special attention to the potential harms that may befall those in society who do not have access to PGD or who choose not to employ it.

the proposed duties; their value thus extends beyond the adversarial context in which they might first be thought to arise.

Journal of Medical Ethics

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Do Patients Have Duties?

H. M. Evans

The notion of patients' duties has received periodic scholarly attention but remains overwhelmed by attention to the duties of health care professionals. In a previous paper the author argued that patients in publicly funded health care systems have a duty to participate in clinical research, arising from their debt to previous patients. Here the author proposes a greatly extended range of patients' duties, grounding their moral force distinctively in the interests of contemporary and future patients, since medical treatment offered to one patient is always liable to be an opportunity cost (however justifiable) in terms of medical treatment needed by other patients. This generates both negative and positive duties. Ten duties—enjoining obligations ranging from participation in health care schemes to promoting one's own earliest recovery from illness—are proposed. The characteristics of these duties, including their basis, moral force, extent, and enforceability, are considered. They are tested against a range of objections—principled, societal, epistemological, and practical—and found to survive. Finally, the paper suggests that these duties could be thought to reinforce a regrettably adversarial characteristic, shared with rights-based approaches, and that a preferable alternative might be sought through the (here unexplored) notion of a "virtuous patient" contributing to a problem-solving partnership with the clinician. However, in defining and giving content to that partnership, there is a clear role for most, if not all, of

The Declaration of Sydney on Human Death

Calixto Machado et al.

On August 5, 1968, publication of the Harvard Committee's report on the subject of "irreversible coma" established a standard for diagnosing death on neurological grounds. On the same day, the twenty-second World Medical Assembly met in Sydney, Australia, and announced the Declaration of Sydney, a pronouncement on death, which is less often quoted because it was overshadowed by the impact of the Harvard Report. To put those events into present-day perspective, the authors reviewed all papers published on this subject and the World Medical Association web page and documents, and corresponded with Dr. A. G. Romualdez, the son of Dr. A. Z. Romualdez. There was vast neurological expertise among some of the Harvard Committee members, leading to a comprehensible and practical clinical description of the brain death syndrome and the way to diagnose it. This landmark account had a global medical and social impact on the issue of human death, which simultaneously lessened reception of the Declaration of Sydney. Nonetheless, the Declaration of Sydney faced the main conceptual and philosophical issues on human death in a bold and forthright manner. This statement differentiated the meaning of death at the cellular and tissue levels from the death of the person. This was a pioneering view on the discussion of human death, published as early as in 1968, that should be recognized by current and future generations.

Ethical Reflection on the Harm in Reproductive Decision Making

Ged M. Murtagh

Advances in reproductive technologies continue to present ethical problems concerning their implementation and use. These advances have preoccupied bioethicists in their bid to gauge our moral responsibilities

and obligations when making reproductive decisions. The aim of this discussion is to highlight the importance of a sensibility to differences in moral perspective as part of our ethical inquiry in these matters. Its focal point is the work of John Harris, who has consistently addressed the ethical issues raised by advancing reproductive technologies. The discussion is aimed at a central tenet of Harris's position on reproductive decision making—namely, that in some instances, giving birth to a worthwhile life may cause harm and will therefore be morally wrong. It attempts to spell out some of the implications of Harris's position that the author takes to involve a misplaced generality. To support this claim, some examples are explored that demonstrate the variety of ways in which concepts (such as harm) may manifest themselves as moral considerations within the context of reproductive decision making. The purpose is to demonstrate that Harris's general conception of the moral limits of reproductive autonomy obscures the issues raised by particular cases, which in themselves may reveal important directions for our ethical inquiry.

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**On the Argument That
Enhancement Is "Cheating"**

M. Schermer

One frequently used argument in the discussion on human enhancement is that enhancement is a form of cheating. This argument is well known in relation to doping in sports, but recently it has also been used with regard to cognitive enhancement in the context of education and exams. This paper analyses the enhancement-is-cheating argument by comparing sports and education, and by evaluating how the argument can be interpreted in both contexts. If cheating is understood as breaking the rules in order to gain an unfair advantage over others, it can be argued that some enhancements are a form of cheating. This problem of cheating is, however, relatively easy to remedy by either changing the rules, or by instituting controls and sanc-

tions. This does not, therefore, constitute a categorical objection to enhancement. A further analysis of the intuitions behind the enhancement-is-cheating argument, however, shows that if sports and education are understood as "practices," with their own internal goods and standards of excellence, some potential problems of enhancement can be articulated. These concern the internal goods and standards of excellence that are characteristic of specific practices. Seen from this perspective, the important question is how enhancement technologies might be embedded in specific practices—or how they might corrode them.

New Blackfriars

Volume 89, Number 1019
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**Holding On to the Hand of God:
Edward Schillebeeckx on the
Mystery of Suffering**

Robin Ryan, C.P.

The experience of human suffering presents an ongoing challenge to believers who seek to sustain their relationship with God in the face of the tragedies of human history. Edward Schillebeeckx, O.P., is a seminal Christian thinker who has made a conscious attempt to take into account the harsh reality of suffering in his systematic theology. Rejecting theoretical attempts to reconcile belief in a good, all-powerful God with the reality of evil and suffering, Schillebeeckx employs the categories of narrative and memory in his articulation of a Christian response to evil and suffering. He tells the story of Jesus as the story of God. The God who is disclosed in the ministry, death, and resurrection of Jesus is the God who is "pure positivity"—the source of life and the opponent of evil and suffering. God's action in and through Jesus provides clues to the way in which God is present and active in the lives of suffering human beings. This revelation summons Christians to become people of memory and of praxis.

**Obstetrics &
Gynecology**

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**ACOG Committee Opinion No. 385:
The Limits of Conscientious Refusal in
Reproductive Medicine**

*American College of
Obstetricians and Gynecologists
Committee on Ethics*

Health care providers occasionally find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practice, they must provide potential patients with accurate and prior notice of the personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might have a negative impact on the patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Philosophy

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Moral Status in Virtue Ethics

John Hacker-Wright

The author's contention is that virtue ethics offers an important critique of traditional philosophical conceptions of moral status as well as an alternative view of important moral issues held to depend on moral status. He argues that the scope of entities that deserve consideration depends on our conception of the demands of virtues like justice; which entities deserve consideration emerges from a moral view of a world shaped by that conception. The deepest disputes about moral status depend on conflicting conceptions of justice. The author advocates a conception of the virtue of justice that can account for the cases that pose problems for the legalistic views of moral status and discuss what ideal moral debate looks like on this view.

**Proceedings of the
American Catholic
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**The Beginning of Individual
Human Life**

Anthony Kenny

This paper explores the issue of when human life begins, giving special attention to the thought of St. Thomas Aquinas. Aquinas's position is contrasted with the position defended by many Catholics today. After considering the evidence and a variety of arguments, the author suggests that the individuated human being begins to exist at roughly fourteen days after the moment of conception.—Abstract compiled from text.