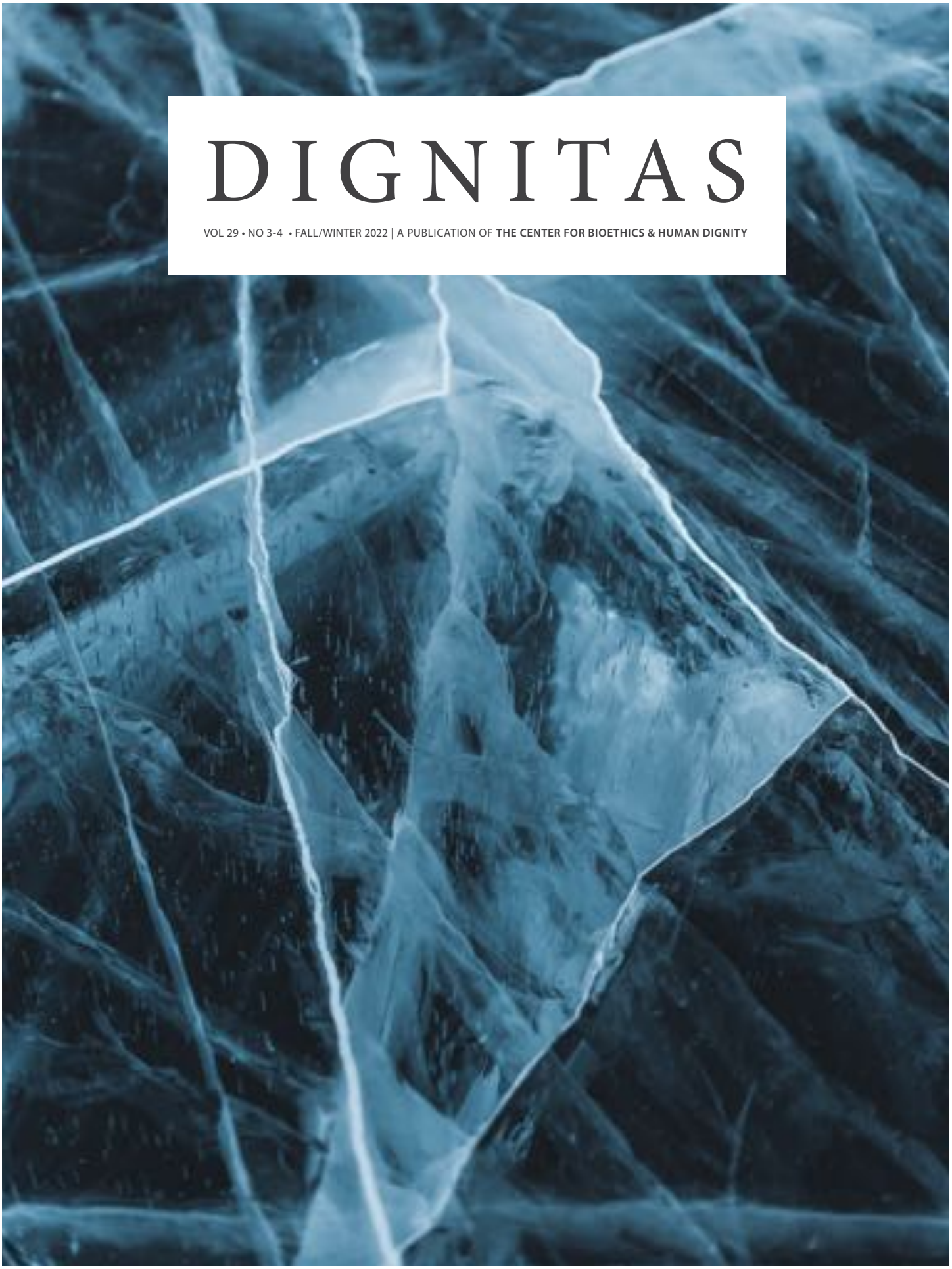

DIGNITAS

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EDITORIAL

Anna Vollema, MA | Managing Editor
Matthew Eppinette, PhD | Editor

The publication before you marks a transition for *Dignitas* in several ways. Not only does it usher in yet another year, but it will also be the last of the combined issues; the 2023 publication year will return to our regular quarterly publication cycle. In addition, *Dignitas* is shifting to themed editions. As a Center, we want to address bioethical topics on the forefront of societal change with core truths of the Christian faith. Thus, the themes chosen for this upcoming year represent either a rising concern within the domain of bioethics or an exploration of ideas necessary for groundwork as these issues continue to evolve. Because we see it as important to continue publishing sound scholarly work that may not fit one of these themes, space will be given in each publication for articles outside of the topic, and the final issue of the year will remain open. Thus, the themes for 2023 will be as follows:

- **Spring**: Genuinely Christian Engagement with Bioethics
- **Summer**: Bioethics and Socioeconomics
- **Fall**: What It Means to Be Human
- **Winter**: Open

This issue of *Dignitas* deals with matters of healthcare and conscience, and it includes a primer piece for our 30th annual conference on *The Christian Stake in Bioethics* Revisited*: Crucial Issues of Yesterday, Today, and Tomorrow* (June 22–24, 2023). In addition, Bryan Just has eloquently summarized key ideas from our 2022 annual conference. Heather Zeiger provides the last of the Covid Timelines for *Dignitas* as the 2023 publication will shift to matters of global health.

Joseph Dunne explores the question of why it is wrong to violate one's conscience, suggesting that many of the arguments typically used are based on subjective assertions that can just as easily be used to support superfluous or nefarious conscience-based decisions. He thus critiques arguments that support acting in accordance with one's conscience based on the notion that it is (a) identity conferring, (b) integrity maintaining, or (c) to act against it would pose a volitional impossibility. Opining instead that any argument we use to support obeying one's conscience must be able to override reasons not to obey it, he asserts that we must find an all-things-considered reason to obey.

Utilizing Richard Sorabji's work, Dunne defines conscience as the source of our beliefs regarding those actions and attitudes that may be wrong or not wrong, using our individual concept of morality to apply value beliefs to everyday decision making. This means that conscience is value neutral in that it is able to hold all beliefs pertaining to an individual's moral perception, making it void of a universal morality and also fallible.

With this definition in hand, he tackles the first of what he considers to be subjective reasons for adhering to one's own conscience. Some would argue that to act in a way that betrays what characterizes one's individuality would be morally problematic. Under such a conception, one's own personal morality plays an important part in setting him or her apart in society and therefore confers identity. However, Dunne suggests that the identity-conference argument is not able to override reasons to disobey conscience. Second, he tackles the position that listening to one's conscience is essential due to the need to remain internally consistent and integrous. Third, and finally, Dunne critiques the admission that adherence to one's conscience is necessary due to

Anna Vollema and Matthew Eppinette, "Editorial," *Dignitas* 29, no. 3–4 (2022): 1–2.

the psychologically catastrophic nature of working in opposition to one's determined aversions, a volitional impossibility with embodied consequences.

Dunne concludes his essay by demonstrating that even the combination of these three subjective reasons for obeying conscience could be employed both in support of a physician who is conscientiously opposed to performing an abortion and a physician who is conscientiously compelled to do so. Thus, one must employ some type of objective, all-things-considered reason to obey one's conscience in order to determine that one of the physicians has greater moral responsibility to obey her conscience than the other.

Andrew Kubick similarly explores conscience, specifically as it pertains to positive claims of conscience—the ability to commit an act one deems to be good—that conflict with the institutional identity of a governing healthcare organization. Natural law is central to Kubick's understanding of conscience. Through natural law, all of humanity has been given an impulse to do good, seek truth, and preserve human life, along with passing on these values to the next generation.

Building off of this, Kubick states that there are two distinct intellectual activities involved in responding to natural law: synderesis and conscience. Synderesis is the act of habitually listening to that moral voice, conscience its application to a specific moral dilemma. Citing St. Thomas Aquinas, he states that while synderesis cannot err, one can erroneously apply that moral voice—conscience can be wrong. This occurs not only because of corruption in values, but also merely through ignorance. Delineating three kinds of ignorance, each with carrying levels of moral culpability, he ultimately concludes that ignorance cannot be an excuse to disobey natural law.

Shifting specifically to positive claims of conscience, Kubick asserts that while a man is constrained to avoid evil, circumstances may reasonably keep him from committing an act he thinks to be good. Thus, while there should be much space given for people to act in accordance with what their conscience determines to be good, it is reasonable for a healthcare organization to reject some positive claims of conscience. This he evidences specifically within the Catholic healthcare system, showing how certain ethical commitments are what form institutional identity. As healthcare providers commit to work in that specific hospital system, they bind themselves to the guidelines which form such an identity. Thus, individual positive claims of conscience must be examined in light of larger institutional commitments.

The final piece in this issue is a re-publication from the early days of *Dignitas*. The late Edmund Pellegrino, writing nearly 20 years ago, highlights a shift in medicine from healing to enhancement. Defining enhancement as those procedures that seek "to increase, intensify, raise up, exalt, heighten, or magnify," he calls this movement "the end of medicine." Advances in biotechnology have caused this societal shift; however, Pellegrino does not relegate all biotechnologies to the realm of societal evils. He states that, as physicians navigate this new biotechnological world, they will need to discern between those procedures that (a) treat diseases, (b) meet the desire of patients to perfect some bodily or mental trait, and (c) redesign humanity both now and in the future. The author unequivocally affirms the use of these technologies in treating disease, stating that it honors the doctor's unchanging purpose to heal. Still, ethical questions remain. For instance, even for therapeutic purposes, he rejects those procedures that require the destruction or distortion of human life.

Pellegrino further clarifies his position, recognizing that even some therapies can be seen as enhancing human life in the sense that a disease has been cured and a person's life has inevitably become better. Yet these do not go beyond the natural ends of medicine. He contrasts this kind of enhancement with that of a woman who has no sickness, disease, or injury; she merely is discontented with her social lot in life based on whatever physical or mental "defect" she deems to be unsatisfactory. She therefore desires a procedure to help her fit or even surpass what she perceives to be societal standards.

Pellegrino points to greater moral ambiguity when it comes to things like ensuring healthy and bright children, yet still questions the means that are used to bring about such a result. Noting the existence within this shift of those who seek to define "patient" as anyone unhappy, he warns of grave consequences, not only for the world of medicine but for society as a whole. Yet an affirming contingent is growing, and the rejection of enhancement will inevitably meet great resistance as the seemingly insatiable need to satisfy all desires deepens in society. He suggests it may even lead to physicians being forced to perform enhancement procedures, seeing it within the *responsibilities* of the doctor to meet such "needs." Other physicians may themselves become convinced that it is the best good to perform such procedures.

This transition also poses new conflicts of interest. Where there is demand, there will inevitably be transactions, and Pellegrino worries that the thirst for advancement may cause the less integrous physician to perform unethical or dubious procedures merely for the monetary benefits. In conclusion, Pellegrino opines that a rush towards enhancement may distort our understanding of what it means to be human and shift societal focus from ethical interrogation to regulation and efficiency, with patient autonomy becoming the greatest good in medicine.

Undoubtedly, many with modern eyes will read Pellegrino's warning 20 years ago and see the fulfillment of some of his predictions. Indeed, the thirst for happiness only intensifies, patient autonomy has become primary, and physicians are increasingly pressured to give in to patient demands. His admonitions for the future display the necessity for core truths that can help gauge the ethicality of recent moves. This is the reason behind our asking questions like, "What does it mean to be human?" and "What is distinctively Christian bioethics?" Furthermore, it displays the purpose for choosing a conference theme of *The Christian Stake in Bioethics* Revisited*: Crucial issues of Yesterday, Today and Tomorrow.* With so much having changed within the world of bioethics, even within the realm of medicine as a whole, it is important that we continuously reevaluate what the Christian stake in bioethics is and that we remain committed to ethical interrogation, heeding Pellegrino's reprimand of slipping too far down the road of mere regulation and practicality.

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Why Is It Wrong to Violate My Conscience? Identity, Integrity, and Volitional Impossibilities

Joseph M. Dunne, PhD | Guest Contributor

Introduction

Before any serious reflection, most of us would likely agree that we should normally not violate our conscience by acting against its dictates and verdicts. But why do we endorse such an idea? When we begin to think through the possible reasons that we might have for agreeing with this pre-theoretical intuition, we may come to realize that we endorse such a view, for example, because we are familiar with how painful and damaging the pangs of a guilty conscience can be. We may come to realize that we endorse such a view because we know that violating our conscience is discouraged or else forbidden in our larger religious or moral tradition. For example, in the Christian tradition, many have interpreted Paul's words in Romans 14:22–23 as an imperative to act in accordance with the dictates of one's conscience insofar as it would be sinful and condemning to act contrary to what one otherwise approves. Still others might appeal to even further arguments or reasons for listening to the demands of their conscience. At the very least, highlighting this likely point of agreement raises an important question for us to consider: Why, exactly, shouldn't we violate our conscience? Why is it wrong for me to violate my conscience or wrong for you to violate yours?

In this piece, I work through a few answers that are sometimes offered in response to this question. More specifically, my central and fairly modest claim is that many of the subjective features that are usually associated with and appealed to in defense of conscience are insufficient to ground some sort of all-things-considered or absolutely overriding reason to obey the demands of conscience. The subjective features that I evaluate—and ultimately reject—as providing an all-things-considered reason for obeying our conscience are: (1) that conscience beliefs are identity-conferring beliefs; (2) that conscience beliefs are integrity-maintaining beliefs; and (3) that conscience beliefs are volitional impossibilities. Admittedly, these subjective features plausibly provide otherwise good, prima facie reasons to obey the demands of conscience that may nevertheless be defeasible and overridable by other, stronger reasons. But my central claim is that none of these subjective features considered in isolation or together seem to provide an absolutely overriding reason to obey conscience. In other words, they do not seem to provide us with a reason to obey conscience that overrides every reason to disobey conscience once all the considerations relevant to the decision are taken into account—hence, they do not provide an all-things-considered reason for obeying our conscience. If the central claim of this piece is correct, then whatever overriding reason(s) we have for obeying conscience must arguably be grounded in something beyond these subjective features.

Joseph M. Dunne, "Why Is It Wrong to Violate My Conscience? Identity, Integrity, and Volitional Impossibilities," *Dignitas* 29, no. 3–4 (2022): 4–9.

The Roe Case

To begin working through my central claim, and to place this discussion in a uniquely bioethical context, let us consider what I will call the Roe Case:

> A licensed OB-GYN physician refuses to perform an elective abortion or to refer her autonomously requesting patient because she is conscientiously opposed to providing (or else being, from her point of view, complicit with) an abortion in a setting where performing abortions is permitted by law (and referring is legally required for conscientious objectors), technologically possible, and—when performed—efficient at achieving its aims.

We can ask: Why would it be *morally* impermissible for this physician to act against what their conscience is disallowing them to do? At the very least, we should admit that the physician here has at least some reason to act against the demands of her conscience—even if they may not be very strong or compelling reasons. The physician is, after all, dealing with an autonomous patient request for a procedure that is permitted by law and, when conscientiously opposed, legally requires a referral. The question at hand, however, is trying to explore whether physicians like this have some sort of all-things-considered moral reason to obey their conscience that can override other, prima facie reasons like those highlighted. In other words: Does this physician have some sort of moral reason to listen to her conscience that trumps the many reasons she has to disobey her conscience? In many ways, this scenario simply raises the age-old question "Why be moral?"—or at least why should the physician do what she takes to be moral. Incidentally, this point plays on an important distinction between law and morality as well: The requirements or prohibitions of law do not always align with the requirements or prohibitions of morality even if they sometimes conceptually overlap with one another. Therefore, one may have an all-things-considered moral reason to obey their conscience that overrides even the demands of the law.

Conscience

Given the centrality of the concept of conscience to this discussion, it is important to begin by clarifying its very nature. Consider that, just as it was puzzling for the men of Athens to worship an unknown god in Acts 17, so too will it be similarly puzzling for us to understand why it is wrong to violate the dictates of an unknown voice or entity. So, in a Pauline-like effort to bring knowledge to what is otherwise unknown, I believe that it is appropriate to appeal to the work of professor Sir Richard Sorabji on the historical development of the concept of conscience. In his book *Moral Conscience through the Ages*, Sorabji presents what he takes to be the core or most central features of conscience as developed from its birth in the early Greeks all the way to the present—providing for his readers a stable set of descriptive features that have historically constituted the concept.

According to Sorabji's descriptive-historical account, conscience has been understood as the source of our beliefs "about what actions or attitudes had been in the past, or would be in the future, wrong or not wrong for him to adopt or not adopt in a particular situation."[1] Such beliefs are about oneself primarily and are value beliefs insofar as they are cognitive beliefs that can—and often do—produce affective responses in the form of "sentiments of approval or disapproval and painful or comforting sensations."[2] This underdeveloped yet innate capacity called conscience eventually produces such value beliefs in us by applying our moral values—whatever they are and however we hold them—to our actions and attitudes. In this way, then, value beliefs are something like the cognitive outworking of our antecedent moral values as applied to our actions and attitudes in various situations. Moreover, this also means that conscience has historically been understood as a *value-neutral capacity* (i.e., a capacity that can apply any and every moral value that its possessor happens to endorse) that is *fallible* and prone to error insofar as it can apply problematic values or else apply good values in problematic ways.[3]

With a clearer picture of conscience now at hand, we can again ask: Why, exactly, shouldn't we violate our conscience? Why is it wrong for me to violate my conscience or for the physician in the Roe Case to violate hers? Providing a compelling answer to this question becomes especially crucial in light of the fallibility and value neutrality of conscience. If many of us would likely agree that we should normally act in accordance with our conscience, but yet we also agree that conscience can—and often does—err, then what reasons do we have, if any, to listen to its dictates and verdicts over, say, the requirements of the law? Why would it be wrong to act contrary to our conscience that is so prone to error and is value neutral by nature? As I hope to show in what remains, many of the subjective features usually associated with and appealed to in defense of conscience are significantly weakened by the fallibility and value neutrality of conscience. In other words, because conscience is fallible and value neutral, none of its typically associated features—e.g., that conscience beliefs are identity-conferring beliefs, that conscience beliefs are integrity-maintaining beliefs, and that conscience beliefs are volitional impossibilities—seem strong enough to provide some sort of all-things-considered or absolutely overriding reason to obey conscience. As such, those that are sympathetic to protecting the rights of conscience will likely need to appeal to something more beyond an appeal to these subjective features that suffer from the fatal flaws of fallibility and value neutrality.

Identity

First, you might think that the wrongness of violating our conscience is, in some way, related to the wrongness of undermining our *identities*. You might think, for example, that we have strong reasons to act in accordance with who we are—to be yourself as they say—and that acting in a way that betrays ourselves is morally problematic. And perhaps the wrongness of this betrayal adequately explains the wrongness of violating our conscience. Elaborating upon the relationship that conscience and its verdicts may have with our identities, Alberto Giubilini notes that the

> subjective character of conscience delimits a sphere of personal morality that is an essential part of our sense of personal identity, understood as our sense of who we are and of what characterizes qualitatively our individuality (for instance, our character, our psychological traits, our past experience, etc.). My conscience is what makes me *this* particular individual in a society and cultural context that I want to keep separate from *me*.[4]

Similarly, Jocelyn Maclure and Charles Taylor define the convictions of conscience as "core beliefs and commitments . . . [that] include both deeply held religious beliefs *and* secular beliefs and are distinguished

from the legitimate but less fundamental 'preferences' we display as individuals."[5] In other words, the central idea here seems to be that conscience and its verdicts, in some sense, delineate or demarcate who I am as distinct from other things (e.g., society, culture, etc.) and are identified with the very core beliefs and commitments that constitute me—as distinct from, e.g., the more fleeting and fickle preferences that I may have. Therefore, perhaps we have a sufficient reason for obeying our conscience when conscience beliefs are understood as identity-conferring beliefs. We should obey conscience, then, because its verdicts are constitutive of our identity.

Although it is admittedly difficult to delineate the exact relationship between them, it nevertheless seems plausible to think that conscience and its verdicts are tied up with our identities in this relevant and significant way. Just consider, for example, how difficult it would be to talk about our identities and the beliefs and commitments that help to constitute them without referencing our conscience beliefs at all. Under the assumption that one's values, desires, goals, plans, core beliefs, commitments, and related psychic phenomena help to constitute one's identity, it is not clear how we can avoid talking about someone's conscience and its beliefs about what would or would not be wrong for them to do when talking about their identity. In other words, our value beliefs seem relevantly—if not significantly—constitutive of our identities. So, under the assumption that conscience beliefs are plausibly included in our larger set of identity-conferring beliefs, we can again ask: Does this feature provide an all-things-considered reason to obey our conscience?

Even if our conscience beliefs are identity-conferring beliefs, I am skeptical that this feature can provide an absolutely overriding moral reason for obeying our conscience. My argument for this conclusion is simple: That a belief or commitment is identity conferring simply does not provide us with an all-things-considered reason to obey it. To illustrate, consider the example of what I will call the *Superfan*. Many of us—fortunately or not—live around people like this Superfan whose beliefs and commitments concerning their favorite sports team are unashamedly identity conferring. Perhaps the identity-conferring nature of the Superfan's beliefs about and commitments to their favorite sports team provides some prima facie reason to act in accordance with them, e.g., by going to their games, buying their team jerseys, etc. But should the Superfan be able to override other, seemingly more important commitments with their identity-conferring beliefs and commitments to their favorite sports team because they are identity conferring? Imagine our Superfan trying to make this sort of identity argument to his soon-to-be-in-labor wife in order to attend a home game against their biggest rival. The point here is that, given the value neutrality and fallibility of conscience, the identity-conferring beliefs that it produces can be problematic and thereby fail to provide us with sufficient reason to obey them in the same way that the identity-conferring nature of the Superfan's problematic beliefs and commitments fail to provide them with sufficient reason to obey them. And the same point seems true even of the Roe Case: It seems difficult to say that the physician should obey her conscience because its verdicts are central to or constitutive of her identity. Appeals to identity seem defeasible, therefore, even though they may provide prima facie reasons for action.

Integrity

Second, and closely related to the first feature, you might think that the wrongness of violating our conscience is related to the wrongness of acting contrary to our otherwise integrated or consistent set of beliefs, values, and so forth. Acting against conscience becomes morally problematic under this view because it would make us inconsistent or self-undermining in some significant way. Perhaps it is wrong to violate the verdicts of conscience, therefore, because doing so would undermine our *integrity*: Disobeying our conscience would effectually dis-integrate our values, beliefs, and so on with our actions and attitudes—thereby splitting or splintering us in some morally repugnant way. Indeed, Sorabji notes that this notion of a split-self has historically been at the heart of possessing a guilty conscience: "Conscience originally involved the idea of a person split into two, with one self-hiding a guilty secret, and the other self-sharing it. The idea of conscience as involving a split person was to recur in different forms and with different rationales in Adam Smith, in Kant, and in Freud, and is found in the expression 'I could not live with myself.'"[6] So, perhaps we have a sufficient reason for obeying our conscience when conscience beliefs are understood as integrity-maintaining beliefs. We should obey conscience, therefore, because doing so helps maintain our integrity.

In response, we can begin by noting that the concept of integrity can come in both value-non-neutral and value-neutral forms. On the one hand, a value-non-neutral notion of integrity would involve a sort of consistency with or integration between true beliefs, good values, and right actions in the face of things like, e.g., self-interested temptations or reasons to the contrary. In other words, under a value-non-neutral understanding of integrity, you have integrity when you demonstrate a consistency between your right actions, true beliefs, and good values. This notion of integrity is captured, for example, in the common proverb that integrity involves doing the right thing—even when no one is watching. On the other hand, a value-neutral understanding of integrity merely involves a sort of consistency with or integration between your actions, beliefs, and values—whatever they may be and however you came to hold them. In other words, a value-neutral understanding of integrity only requires consistency or integration between your actions and the beliefs and values that you happen to hold regardless of whether they are right, wrong, good, bad, true, false, etc. To have value-neutral integrity, then, you only need to do the consistent thing, so to speak—even when no one is watching.

Importantly, even if acting in accordance with the verdicts of conscience is crucial for maintaining our integrity—understood as either a value-neutral or value-non-neutral concept—I am skeptical that this feature can provide an all-things-considered moral reason for obeying our conscience. To see why, first consider that, when integrity is value non-neutral (i.e., integrity means doing the right thing), having integrity may therefore be intrinsically good insofar as it definitionally involves true beliefs, good values, and right actions. But following our conscience in such cases would only be instrumentally good insofar as obeying it helps to achieve this intrinsic good. The reason for following our conscience, then, would not be some feature(s) intrinsic to conscience per se but

instead on its mere instrumental value of helping us acquire the intrinsic good of value-non-neutral integrity by pushing us toward the right thing through applying good values and producing true value beliefs within us.

Second, if integrity is value neutral (i.e., integrity means merely doing the consistent thing), then the intrinsic value of integrity becomes increasingly questionable—thereby making the instrumental value of following our conscience to achieve or maintain that integrity similarly questionable. When integrity is value neutral, all you really need to have is a consistent or integrated set of beliefs, values, actions, and so forth. Theoretically, you could have integrity under this view while possessing false beliefs and bad values and performing wrong actions. Perhaps we could say that this integrity-maintaining feature can provide a prima facie reason to act in accordance with the value beliefs of conscience—after all, there seems to be at least some value in refusing to split oneself. But should an *integrous Nazi*, for example, enjoy a license to act in accordance with their problematic conscience by appealing to a value-neutral notion of integrity? The point here is that, given the value neutrality and fallibility of conscience, a value-neutral notion of integrity being maintained by obeying such occasionally problematic value beliefs can also be morally problematic. So, just as appealing to (value-neutral) integrity seemingly fails to provide the integrous Nazi with an absolutely overriding reason to listen to their conscience, so, too does appealing to (value-neutral) integrity seemingly fail to provide the physician in the Roe Case with sufficient reason to obey their conscience. As above, appeals to integrity also seem defeasible even though they may provide prima facie reasons for action.

Volitional Impossibilities

Finally, and in tandem with the first two features, perhaps the wrongness of violating our conscience stems from the fact that its verdicts are something like *volitional impossibilities*. Here we can define volitional impossibilities as done so by Christian Miller: "It is *volitionally impossible* for a person to perform a given action if and only if psychologically the person is strongly averse to doing the action, and she also endorses this aversion."[7] The heart of this third feature is that it would be morally problematic to act in ways that would be as psychologically catastrophic as acting against the strong aversions that one endorses. So, perhaps we have a sufficient reason for obeying our conscience when conscience beliefs are understood as volitional impossibilities. We should obey conscience, therefore, because its verdicts are volitional impossibilities.

To clarify and better define the nature of volitional impossibilities, Miller draws upon a case developed over time in the writings of Harry Frankfurt. The first analysis of this case comes from Frankfurt's book *Volition, Necessity, and Love* published in 1993:

> Consider a mother who reaches the conclusion, after conscientious deliberation, that it would be best for her to give up her child for adoption, and suppose that she decides to do so. When the moment arrives for actually giving up the child, however, she may find that she cannot go through with it—not because she has reconsidered the matter and changed her mind but because she simply cannot bring herself to give her child away.[8]

The second analysis of this case comes from Frankfurt's essay "Reply to Gary Watson," published in the 2002 book *Contours of Agency: Essays on Themes from Harry Frankfurt*:

> [The mother] may recognize her discovery as a revelation not just of the fact that keeping the child is what is most important to her, but also of the deeper fact that it is what she truly wants to be most important to her. In [this] case, she is glad to be putting her need for the relationship above what is best by a measure that she now refuses to regard as decisive.[9]

The point is that Frankfurt's case suggests that volitional impossibilities are something like deeply held conscience value beliefs that are personally endorsed. "What is most important to her" evidences a deeply held value being applied to her actions, an "inability to go through with it" evidences a profoundly motivating value belief, and that "she wants it to be the most important thing to her" evidences her subjective endorsement of this value. By acting against her volitional impossibilities or deeply held value beliefs, the mother in this story would doubtlessly suffer from a catastrophized psychology that would inevitably manifest in embodied ways.

Nevertheless, even if the verdicts of conscience are volitional impossibilities that yield psychological and embodied consequences when disobeyed, I am similarly skeptical that this feature can provide an all-things-considered moral reason for obeying our conscience. My argument for this conclusion is also simple: That a volitional impossibility produces significant negative psychological and embodied consequences when disobeyed just does not seem to provide an all-things-considered reason to obey it. With respect to this feature, the value neutrality of conscience actually implies that we could suffer from false guilt, possess false value beliefs, and even come to regard moral requirements as volitional impossibilities. Just consider, for example, the hypothetical case of the *Guilty Worshiper* who suffers significant negative psychological and embodied consequences when they act against their strong and endorsed aversion to theism by worshiping the Creator of a sublime and captivating sunset. Of course, understanding the verdicts of conscience as volitional impossibilities may provide a strong, prima facie reason to act in accordance with them. However, just as appealing to the consequences that disobeying a volitional impossibility would produce fails to provide the Guilty Worshiper with an absolutely overriding reason to act in accordance with their value beliefs, so too does appealing to the consequences that disobeying a volitional impossibility would produce fail to provide the physician in the Roe Case with an all-things considered reason to act in accordance with her value beliefs. Appeals to volitional impossibilities—and the significant negative consequences of disobeying them—also seem similarly defeasible even though they may provide prima facie reasons for action.

Conclusion: The Dobbs Case

The fairly modest claim that I have defended up to this point is that many of the subjective features usually associated with conscience—namely, that conscience beliefs are identity-conferring beliefs, that conscience beliefs are integrity-maintaining beliefs, and that conscience beliefs are volitional impossibilities—are simply insufficient in themselves to ground some sort of all-things-considered reason to obey the demands of conscience. While these subjective features typically associated with conscience may

provide otherwise good, prima facie reasons to obey the demands of conscience, they nevertheless turn out to be defeasible and overridable reasons when evaluated under scrutiny. If this claim is correct, then whatever overriding reason(s) we may have for obeying conscience must be grounded in something other than these subjective features. However, let us suppose for a moment that you are still skeptical about the various cases that I have made against each feature and remain optimistic that, perhaps when taken together, this cluster of subjective features can provide something like a jointly sufficient, overriding reason to obey the verdicts of conscience.

In response to this challenge, let us conclude this piece by looking at an analogous case to the Roe Case—what I will refer to as the Dobbs Case:

> A licensed OB-GYN physician must perform an elective abortion or else refer her autonomously requesting patient because she is conscientiously compelled to provide an abortion in a setting where performing (and therefore referring for) abortions is not permitted by law yet is technologically possible and—when performed—efficient at achieving its aims.

We can ask: Why would it be morally wrong for the physician in the Roe Case to act against her conscience but not morally wrong for the similarly situated physician in the Dobbs Case to act against hers? In the Roe Case, the physician is conscientiously opposed to providing or else referring her autonomously requesting patient for an abortion in a setting where it is legal. But in the Dobbs Case, the physician is conscientiously compelled toward providing or else referring her autonomously requesting patient for an abortion in a setting where it is illegal. However, in both settings, the procedure of abortion is technologically possible and, when performed, efficient at achieving its aims. And, most importantly, each physician's conscience beliefs presumably are volitional impossibilities that are similarly identity conferring and integrity maintaining. Therefore, if we believe that, when taken together, this above cluster of subjective features can provide a jointly sufficient, overriding reason to obey the verdicts of conscience, then we must treat the Roe and Dobbs case the same by respecting the demands of each conscience. In other words, if we think that the cluster of subjective features discussed above provide a jointly sufficient, all-things-considered reason to obey the verdicts of conscience, then we must not only allow the Roe physician to abstain from aborting and referring, but we must also allow the Dobbs physician to abort or refer as well.

But this conclusion seems problematic and misguided given that the two cases seem morally distinct and should probably not be treated equally. More specifically, there seem to be compelling reasons to think that it is morally wrong for the physician in the Roe Case to act against her conscience but not morally wrong for the similarly situated physician in the Dobbs Case to act against hers. You might think, for example, that the Roe physician is permitted to follow her conscience while the Dobbs physician is not insofar as we should never be coerced to act against our negative claims of conscience (i.e., when conscience tells us what we cannot do) even though it is sometimes morally permissible to be prohibited from acting on our positive claims of conscience (i.e., when conscience tells us what we must do). The argument here is, roughly, that while being prohibited from being a perceived agent of good may leave you immune from moral culpability or blame, being forced to be a perceived agent of evil renders you morally culpable or blameworthy. Sorabji may have something like this in mind when he notes that this "connection with being in the *wrong* accounts for the *force* of, and respect for, conscience of others, for no one wants to be in the wrong. We do not have to look for something contingently and variably connected, such as its sometimes being central to people's identity, or causing intensity of feeling, or contributing to self-direction."[10]

Moreover, you might think that the Roe physician is permitted to follow her conscience while the Dobbs physician is not because the very act of abortion—understood as "*any act that either intentionally or unjustly ends the life of an unborn human being*"—is never morally permissible.[11] Thus, performing or else being complicit in such an action would always be morally wrong—regardless of what one's conscience might say. Finally, you might think that the Roe physician is permitted to follow her conscience while the Dobbs physician is not because the former physician's refusal is rooted in not acting inconsistently with, or else in contradiction to, her vocational commitment to the proper aim of medicine—that is, the objective good of patient health. To the contrary, the Dobbs physician may be acting inconsistent with, or else in contradiction to, her vocational commitment to the patient's health while instead aiming at something more conceptually capacious like well-being that may outstrip her expertise.

Whether one or all of these reasons adequately explain why the Roe physician should be permitted to follow her conscience while the Dobbs physician should not—a conclusion I am sympathetic to—the central point should be clear: The reason for permitting the former while disallowing the latter seemingly has nothing to do with any of the subjective features usually associated with and appealed to in defense of conscience that have been discussed throughout this piece. This point is reinforced by the fact that, while each physician's conscience beliefs are volitional impossibilities that are similarly identity conferring and integrity maintaining, there may be further, strong reasons to treat them differently. Therefore, this cluster of subjective features simply seem insufficient to ground some sort of all-things-considered reason to obey the demands of conscience—a conclusion that is especially clear given our rejection of the physician's demands of conscience in the Dobbs case. If it turns out that we do have some all-things-considered reason for obeying conscience, then it must be grounded in something other than these subjective features.

Notes

1. Richard Sorabji, *Moral Conscience through the Ages: Fifth Century BCE to the Present* (Chicago, IL: The University of Chicago Press, 2014), 217.
2. Sorabji, *Moral Conscience through the Ages*, 217.
3. "It is not conscience (at least not conscience in the core sense) that has to *supply* our values in the first place. St. Paul ascribes the inner law to God; a secular view should agree that conscience is never the original source of our values, even though particular decisions of conscience can lead to new reflection on general values, without being their original source. Conscience rather *applies* values to the conduct and thoughts of the individual." Sorabji, *Moral Conscience through the Ages*, 218.
4. Alberto Giubilini, "Conscience," in *The Stanford Encyclopedia of Philosophy* (Summer 2022 ed.), ed. Edward N. Zalta, https://plato.stanford.edu/archives/sum2022/entries/conscience/.
5. Jocelyn Maclure and Charles Taylor, *Secularism and Freedom of Conscience* (Cambridge, MA: Harvard University Press, 2011), 13.
6. Sorabji, *Moral Conscience through the Ages*, 36.
7. Christian Miller, *Moral Psychology* (New York: Cambridge University Press), 43.
8. Harry Frankfurt, *Volition, Necessity, and Love* (New York: Cambridge University Press, 1993), 111.
9. Harry Frankfurt, "Reply to Gary Watson," in *Contours of Agency: Essays on Themes from Harry Frankfurt*, eds. Sarah Buss and Lee Overton (Cambridge, MA: MIT Press, 2002), 163.
10. Sorabji, *Moral Conscience through the Ages*, 217.
11. Farr Curlin and Christopher Tollefsen, *The Way of Medicine: Ethics and the Healing Profession* (Notre Dame, IN: Notre Dame Press, 2021), 126. They continue: "All abortion so defined is morally impermissible, and likewise, no act is an abortion that accepts the death of an unborn human being as the justifiable side effect of an attempt to preserve the mother's life."

10

Who Decides? Resolving Conflicts between Individual Conscience and Institutional Identity

Andrew S. Kubick, PhD, MA | Guest Contributor

Introduction

Meet Jennifer. Jennifer is a physician who specializes in obstetrics and gynecology. She has served her patients in a Catholic hospital for four years and intends to continue her service there. One of her patients is named Emily. Emily is thirty weeks and six days pregnant. She has four other children whose ages range from three to eleven years old. At the most recent prenatal visit, Emily informed Jennifer that she and her husband have talked extensively and concluded that they are satisfied with their family size and do not wish to conceive any more children. Jennifer is sympathetic to Emily's request and recommends a tubal ligation following her scheduled cesarean section. Emily accepts the recommendation. By week's end, however, Jennifer is called into the Office of Hospital Administration and is reprimanded for suggesting a direct sterilization for her patient. She is reminded that all the medical professionals in her institution are required to follow the Ethical and Religious Directives for Catholic Health Care Services, and one such directive expressly prohibits direct sterilizations. Having listened patiently to the hospital administrator, Jennifer pleads for permission to perform the ligation, arguing that she knows Emily very well and thinks her wish to be sterilized is thoughtful and prudent given the circumstances. After nearly an hour of discussion, and having gained very little ground, Jennifer asks in frustration, where precisely is her right of conscience to do what she thinks is in her patient's best interest?

Many people are familiar with cases when a healthcare professional advances a negative claim of conscience, that is to say, when the professional refuses to perform or participate in a service that he judges is evil. Jennifer's case, by contrast, is an example of a positive claim of conscience, whereby a healthcare professional is inclined to commit an act that she judges is in her patient's best interest. History has shown that both negative and positive claims of conscience can result in coercion, discrimination, and even disciplinary action by those in authority. The following essay analyzes positive claims of conscience, especially in cases where those claims conflict with a hospital's institutional identity. What follows is a very brief glimpse into a complicated subject.

Natural Law

The Prophet Jeremiah proclaimed God's new covenant with the Israelites by sharing the words the Lord spoke to him, "I will place my law within them, and write it upon their hearts" (Jer 31:33). Seven centuries later, St. Paul the Apostle gave a nearly identical message to the Christian church in Rome. "[The Gentiles] show that the demands of the law are written in their hearts" (Rom 2:15). This law, written by God on the heart of man, is called Natural Law because it is inscribed in the very nature of man. It is Natural Law,

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revealed through human reason, whereby man encounters the Eternal Law that governs the whole of the universe, including the actions of all created beings.[1] Natural Law inclines man to commit the "proper acts" and seek the "proper ends"[2] desired by God, so that the man can live well in this life and experience beatitude in the next.

The truth that Natural Law is inscribed in the nature of *every* man is knowable through reason. Yes, the Jews to whom Jeremiah prophesied and the Gentiles who received St. Paul's letters are governed by this law, but so too are Muslims, Hindus, Sihks, agnostics, and indeed, even nonbelievers and atheists. It is rooted in their very being. Consider here whether the natural inclinations of man, identified by St. Thomas, rely on language, geography, culture, or era, or if the inclinations transcend them. St. Thomas wrote that man is inclined to do good and shun evil, to preserve human life (including his own), to reproduce and educate offspring, to seek transcendent truths, to live in community, to shun ignorance, and to avoid offending others.[3] While the intellect and will of fallen man can be disordered in its specification of the true good, or its movement to attain it can be morally flawed, human experience proves the naturalness of those inclinations transcends any one language, region, culture, or time.

There are instances in which a group passes down to its children norms or customs that are contrary to the inclinations of man. These instances—not rules, mind you—can occur on account of man's "reason [being] hindered from applying the general principle [that good is to be done, and evil avoided] to a particular point of practice, on account of concupiscence or some other passion . . . by evil persuasions, or by vicious customs and corrupt habits," according to St. Thomas.[4] Consider the Universal Declaration of Human Rights, which reasonable men call good and just. One hundred ninety-two countries have signed the Declaration since it was adopted in 1948. How well do the governments of those countries exercise power in accordance with articles of the Declaration? Do the failures of any one country, or a number of countries for that matter, render the Universal Declaration of Human Rights arbitrary, invalid, or in error? Certainly not. Likewise, some people and groups may act contrary to Natural Law, but that does not disprove its existence. Rather, it proves how blind man can be to its radiant light. And while some people in modern society claim that truth is subjective, such a claim is contrary to the existence of objectively good actions, and objectively evil actions, which Natural Law reveals. As C.S. Lewis wrote, "The effort to refute [Natural Law] and raise a new system of value in its place is self-contradictory."[5]

Synderesis and Conscience

Perhaps one of the most concise references to Natural Law comes from St. John Henry Newman: "He has within his breast a certain commanding dictate, not a mere sentiment, not a mere opinion, or impression, or view of things, but a law, an authoritative voice bidding him to do certain things and avoid others."[6] There are two distinct movements of the intellect contained in Newman's statement. They are synderesis and conscience. The habitual act of listening to the authoritative voice is synderesis, and the particular act of discerning how that voice's bidding applies to a specific moral dilemma is conscience. Or, as J. Budziszewski explained, "synderesis is the interior witness to universal basic moral law, the deep structure of moral reasoning. [Conscience] is the surface structure of moral reasoning, the working out of applications from the universal basic moral law."[7]

St. Thomas taught that synderesis cannot err, calling it a "permanent principle which has unwavering integrity, in reference to which all human works are examined."[8] Conversely, conscience can err. As previously cited, there are several causes of an erroneous conscience, for example, vicious customs and corrupt habits. Additionally, ignorance is another cause. There are classically three types of ignorance, each with differing degrees of moral culpability: antecedent, consequent, and concomitant. Antecedent ignorance precedes an act and cannot be reasonably dispelled. This is called invincible ignorance and involves the least moral culpability. Consequent ignorance can be reasonably dispelled, yet knowledge is obfuscated because the agent is negligent in his duty to know the truth. This is called vincible ignorance and the degree of moral culpability hinges on the extent of the negligence. Finally, concomitant ignorance describes an act that is committed regardless of knowledge. There, an informed conscience would not affect the agent's decision to commit an evil act because he nevertheless intends the end that is attained regardless of whether the means to attain it are good or evil. Concomitant ignorance involves the most moral culpability of the three.[9] Therefore, ignorance of the law—whether Natural Law or just positive law—should not be an excuse to act as one wishes. Moral culpability can very well remain.

Finally, man has a duty to form his conscience well. The Catechism of the Catholic Church teaches: "Conscience must be informed and moral judgments enlightened. A well-formed conscience is upright and truthful. . . . The education of conscience is indispensable for human beings who are subjected to negative influences and tempted by sin to prefer their own judgment and to reject authoritative teachings."[10] The right to act according to one's conscience is inextricably linked to the responsibility to form it well.

Negative and Positive Claims of Conscience

There are two types of conscience claims—a positive claim and a negative claim. A positive claim of conscience demands the freedom to commit an act that one's conscience judges to be good, and a negative claim demands the freedom to not commit an act that one's conscience judges to be evil. Modern focus has primarily been on the latter—negative claims of conscience. Abram L. Brummett described that focus as "asymmetrical," observing: "There is greater ethical, legal, and scholarly focus on negative, rather than positive, claims of conscience."[11]

Negative claims of conscience have been routinely safeguarded in American legislation and jurisprudence. Consider the Church Amendments of the 1970s that protected healthcare professionals and entities from coercion in response to their conscientious refusal to participate in abortion and sterilizing acts.[12] Or, the Religious Freedom Restoration Act of 1993 (RFRA) that states: "Government shall not substantially burden a person's exercise of religion . . . except . . . in furtherance of a compelling governmental interest and if the burden is the least restrictive means of furthering that interest."[13] Or the Supreme Court cases of *Little Sisters of the Poor v. Sebelius* and *Burwell v. Hobby Lobby*

Stores, Inc., to name a few. There remains a consensus, although routinely challenged, that man ought not to be coerced to commit an act that he judges to be evil. That consensus is rooted in Natural Law. Pope St. John Paul II wrote in this regard:

> The *negative precepts* of the Natural Law are universally valid. They oblige each and every individual, always and in every circumstance. It is a matter of prohibitions which forbid a given action *semper et pro semper,* without exception, because the choice of this kind of behavior is in no case compatible with the goodness of the will of the acting person, with his vocation to life with God and to communion with his neighbor. It is prohibited—to everyone and in every case—to violate these precepts.[14]

The late pontiff affirmed without equivocation that man is always and forever duty-bound to avoid evil, without exception.

However, the question is raised: Is man duty-bound *semper et pro semper* to commit acts he judges to be good, without exception? Turning again to Pope St. John Paul II, he wrote:

> In the case of the positive moral precepts, prudence always has the task of verifying that they apply in a specific situation, for example, in view of other duties which may be more important or urgent.[15]

> What must be done in any given situation depends on the circumstances, not all of which can be foreseen. . . . It is always possible that man, as a result of coercion or other circumstances, can be hindered from doing certain good acts.[16]

Therefore, the positive precepts of Natural Law remain "universally binding," but foreseen and unforeseen circumstances can impede a man from committing an act he judges to be good in certain situations.

Consider cases where a person is moved to commit an act that he judges to be good, but all the while resists that movement because of an external cause. A man who cannot swim resists the movement to dive into deep water to save someone who is drowning. A single mother with three young children who is moved to give money to a man living on the street but refrains because of her limited finances. Or a healthy man who is moved to donate blood but forgoes that act out of a vehement fear of needles. Are these people morally culpable for not committing an act they judge to be good in light of their circumstances? Truly, they are not. But another question then follows: What else can they do if not those acts? Can the man who is witnessing a drowning cast a life preserver to the victim or call for help? Can the woman direct the homeless man to the local food pantry or soup kitchen? Can she pray for him? Can the man who is paralyzed by fear seek counseling to overcome it? Can he volunteer at the American Red Cross or seek other ways of promoting the gift of life?

The freedom to commit an act that one's conscience judges to be good ought to be robust, and broadly protected under the law. Consider the example of RFRA, noted above. At times, however, external factors can impede the commission of an act that a man judges to be good. A just positive law, known professional standard, or mutually agreed-upon contract can prevent a person from acting in a manner that he judges to be good. However, the freedom to refuse to commit an act that one's conscience judges to be evil ought to be absolute.

Directives for Catholic Health Care

U.S. law, founded on the religion clauses of the First Amendment and upheld by numerous Supreme Court opinions, protects the freedom of religious institutions to organize, build, and practice according to the dictates of the faith they profess. Catholic healthcare institutions have done just that since 1727—with the founding of Charity Hospital in New Orleans[17]—up to the present day, where there are 668 Catholic hospitals and nearly 1,600 other Catholic healthcare facilities across the country.[18] Those institutions with a Catholic identity must abide by the rules promulgated by the United States Conference of Catholic Bishops, namely the Ethical and Religious Directives for Catholic Health Care Services (ERDs). The ERDs, now in its sixth edition, provide moral guidance to institutions and the professionals operating within their walls. There are seventy-seven directives in total, covering topics like professional-patient relationships, issues in care for the beginning of life, as well as for the seriously ill and dying. The Preamble to the ERDs explains the two-fold purpose: "First, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; and second, to provide authoritative guidance on certain moral issues that face Catholic health care today."[19]

Directive 5 recognizes the authority of the ERDs within Catholic healthcare institutions, and binds those who are employed by a Catholic institution to follow them. "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel."[20]

The diocesan bishop has the authority to oversee the implementation of the ERDs, because healthcare is an apostolate that falls within his canonical jurisdiction.[21] A fairly recent example of that jurisdiction occurred from 2009 to 2010 at St. Joseph's Hospital and Medical Center in the Diocese of Phoenix, Arizona. Bishop Thomas J. Olmstead was the local ordinary at the time. In that example, a twenty-seven-year-old woman with pulmonary hypertension underwent a direct abortion[22] during the eleventh gestational week of her pregnancy. Bishop Olmstead ordered an investigation into the matter, and that investigation concluded that Directive 45—which forbids any and all direct abortions[23]—was indeed contravened by the hospital. As a result, the hospital lost its Catholic affiliation, and ethics board member Sr. Margaret McBride was excommunicated *latae sententiae* for approving the abortion. Bishop Olmstead wrote in his official statement on the incident: "The direct killing of an unborn child is always immoral, no matter the circumstances, and it cannot be permitted in any institution that claims to be authentically Catholic." [24] His judgment on the direct abortion that occurred at a Catholic hospital within his diocese is clearly within his authority as bishop according to the Code of Canon Law.

Conclusion

Returning to Jennifer's question regarding her right of conscience to do what she thinks is in her patient's best interest, neither Natural Law nor the ERDs (within the context of Catholic healthcare) permit her to proceed with Emily's tubal ligation. First, an elective tubal ligation intended to sterilize a patient is contrary to the precepts of Natural Law because it is a mutilatory act that harms, often irreversibly, the function of a healthy body system that is neither diseased

presently nor is the cause or site of disease in the future. The aim is not to heal, but to mute the procreative significance of the sexual act; all the while a non-mutilatory, reversible, and ordered alternative is available should the couple have a well-grounded reason to use it.[25] The alternative is the fertility awareness-based method which, according to the American College of Obstetricians and Gynecologists and the National Health Service of the United Kingdom, is 95–99% effective if used consistently and correctly.[26] On the subject of the fertility-based method, even if not referred to by that name, Pope St. Paul VI wrote that controlling birth in this way "does not in the least offend the moral principles,"[27] which include the teaching "that each and every marital act must of necessity retain its intrinsic relationship to the procreation of human life."[28]

Jennifer is inclined to perform good acts, but she has judged the evil act of elective tubal ligation as good; therefore, she has an erroneous conscience. Jennifer may think she is duty-bound to commit this act and demand permission by making a positive claim of conscience, but her employment in a Catholic healthcare institution nullifies that demand. As Edmund Pellegrino wrote:

> The ethical content of the institutional conscience of particular hospitals is well known with respect to sterilization, abortion, euthanasia, assisted suicide, contraception, and cooperation through mergers with other institutions that accept those practices. Fidelity to these prohibitions is not negotiable. It applies to all who practice in these hospitals regardless of their personal beliefs. Catholic hospitals, like Catholic physicians, do not have the option of being "value neutral" or of separating religious from professional ethical precepts.[29]

Directive 5 binds Jennifer to uphold the ERDs in her current employment, and Directive 53 expressly forbids direct sterilizations.[30] Her positive claim of conscience is denied by those directives. The hospital administration has the responsibility to provide sufficient instruction about which practices in Catholic health care are unacceptable and why, as well as the "Church's teaching on responsible parenthood and in methods of natural family planning."[31] Even if the hospital had failed to sufficiently teach the ERDs, including the force behind them, as Pellegrino rightly noted above, it would be unreasonable for her to claim ignorance of the prohibition of direct sterilization in Catholic healthcare. Moving forward, Jennifer's advice to Emily must be in line with the institutional identity of the hospital and must not counsel her to commit an evil act nor refer her to a doctor who would accede to such a request.[32]

Jennifer is free in her personal life to accept or reject the truths contained in the ERDs—provided she does not cause scandal for the hospital by any such rejection—but she must nevertheless agree to follow the directives that flow from those truths within the scope and practice of her employment at a Catholic healthcare institution. Otherwise, she must seek employment elsewhere.

The aim of this essay is to better understand and resolve conflicts between individual conscience and institutional identity. While it is clearly written through the lens of Catholic health care, its conclusions can apply to other faith-based healthcare institutions. Christian (non-Catholic), Jewish, and Muslim healthcare institutions, for example, have the same freedom to establish a faith-based identity and require that their employees practice their profession in line with that mission, provided that the mission safeguards the dignity of the human person, administers life-affirming care, and upholds the Hippocratic oath to do no harm. And no healthcare institution, public or private, religious or secular, should mandate their employees to commit acts that they judge to be evil.

Notes

1. Thomas Aquinas, *Summa theologiae,* 2nd and rev. ed., trans. Fathers of the English Dominican Province (1920), I–II.91.1
2. Aquinas, *Summa theologiae* I–II.91.2.
3. Aquinas, *Summa theologiae* I–II, 94.2.
4. Aquinas, *Summa theologiae* I–II.94.6.
5. C.S. Lewis, *The Abolition of Man* (San Francisco, CA: Harper Collins, 2001), 43.
6. John Henry Newman, "Men of Good Will," *E-catholic 2000*, https://www.ecatholic2000.com/cts/untitled-287.shtml.
7. J. Budziszewski, "Conscience: What It Is and How It Works," Religious Freedom Institute: Medical Conscience Rights Initiative (2021), 2.
8. Thomas Aquinas, *Questiones Disputatae de Veritate*, trans. James V. McGlynn (Chicago: Henry Regnery Company, 1953), 16.II.
9. William Wallace, *The Elements of Philosophy: A Compendium for Philosophers and Theologians* (Eugene, OR: Wipf & Stock, 1977), 162.
10. *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: United States Conference of Catholic Bishops, 2000), n. 1783.
11. Abram L. Brummett, "Should Positive Claims of Conscience Receive the Same Protection as Negative Claims of Conscience? Clarifying the Asymmetry Debate," *Journal of Clinical Ethics* 31, no. 2 (2020): 136–42, abstract.
12. Church Amendments, 42 U.S.C. § 300a-7, https://www.law.cornell.edu/uscode/text/42/300a-7.
13. Religious Freedom Restoration Act, 42 U.S.C. § 2000bb-1 (1993), https://www.law.cornell.edu/uscode/text/42/2000bb-1.
14. John Paul II, *Veritatis Splendor* (Rome: August 6, 1993), n. 52.
15. John Paul II, *Veritatis Splendor*, n. 67.
16. John Paul II, *Veritatis Splendor*, n. 52.
17. Charles Kaupke, "The History of Catholic Health Care," *Orange County Catholic,* February 21, 2017, https://occatholic.com/the-history-of-catholic-health-care/.
18. U.S. Catholic Health Care: The Nation's Largest Group of Not-For-Profit Health Care Providers," Catholic Health Association of the United States (Washington, DC, 2021), https://www.chausa.org/about/about/facts-statistics.
19. Committee on Doctrine of the United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: United States Conference of Catholic Bishops, 2018), 4.
20. Committee on Doctrine, *Ethical and Religious Directives for Catholic Health Care Services*, n. 5.
21. United States Conference of Catholic Bishops Administrative Committee, *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*, 2nd ed. (Washington, DC: United States Conference of Catholic Bishops, 2020), 2–3.
22. Direct abortion is any procedure that directly and intentionally kills an unborn human being, either as a means to an end or as an end in itself. See *Catechism of the Catholic Church*, 2nd ed., n. 2271; and John Paul II, *Evangelium vitae* (Rome: March 25, 1995), n. 62.
23. Committee on Doctrine, *Ethical and Religious Directives for Catholic Health Care Services*, n. 45.
24. Thomas J. Olmstead, "Bishop Olmstead Statement in Response to Abortion Performed at St. Joseph's Hospital," *Catholic Culture*, May 15, 2010, https://www.catholicculture.org/culture/library/view.cfm?recnum=9323; Janice Hopkins Tanne, "US Hospital Loses Catholic Designation After Performing a Lifesaving Abortion," *BMJ* 341 (2010): 7437, https://doi.org/10.1136/bmj.c7434.
25. Paul VI, *Humanae vitae* (Rome: July 25, 1968), n. 16, https://www.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html.

26. "Fertility Awareness-Based Methods of Family Planning," The American College of Obstetricians and Gynecologists, November 2020, https://www.acog.org/womens-health/faqs/fertility-awareness-based-methods-of-family-planning; "Natural Family Planning (Fertility Awareness): Your Contraception Guide," National Health Service, April 13, 2021, https://www.nhs.uk/conditions/contraception/natural-family-planning/.
27. Paul VI, *Humanae vitae*, n. 16.
28. Paul VI, *Humanae vitae*, n. 11.
29. Edmund Pellegrino, "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective," *Fordham Urban Law Journal* 30, no. 1 (2002): 236, https://ir.lawnet.fordham.edu/ulj/vol30/iss1/13/.
30. Committee on Doctrine, *Ethical and Religious Directives for Catholic Health Care Services*, n. 53.
31. Committee on Doctrine, *Ethical and Religious Directives for Catholic Health Care Services*, n. 52.
32. Committee on Doctrine, *Ethical and Religious Directives for Catholic Health Care Services*, n. 73.

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Biotechnology, Human Enhancement, and the Ends of Medicine

Edmund Pellegrino, MD | Emeritus Fellow

Editor's Note: This article originally appeared as Edmund D. Pellegrino, "Biotechnology, Human Enhancement, and the Ends of Medicine," *Dignity* 10, no. 4 (2004): 1, 5. As we approach CBHD's 30th annual conference and a reexamination of our first conference theme, The Christian Stake in Bioethics, the late Dr. Pellegrino's piece displays well the continuing need for Christian voices in the ever-changing bioethical realm. Written nearly 20 years ago, the changes Pellegrino witnessed have not only continued, but quickened, shifting the world of medicine from healing to enhancement. CBHD remains committed to residing on the cusp of bioethical change while staying rooted in unchanging truths. For further exploration of the themes developed here, see CBHD's book, *Biotechnology and the Human Good*, available for purchase on Amazon.

The actual and promised capabilities of biotechnology have given prominence to a possible new end of medicine, "enhancement." Almost every present-day commentator underscores the difficulties, impossibility, or futility of any definition that seeks to distinguish enhancement from therapy.[1] Nonetheless, everyone eventually ends up using the term since no viable substitute has yet appeared. In short, no boundary between morally valid and invalid uses of biotechnology can be established without at least a working definition.

In this essay, my operating definition of enhancement will be grounded in its general etymological meaning, i.e., to increase, intensify, raise up, exalt, heighten, or magnify. Each of these terms carries the connotation of going "beyond" what exists at some moment, whether it is a certain state of affairs, a bodily function or trait, or a general limitation built into human nature. Enhancement is, as Fowler says, "a dangerous word for the unwary," but its use in some form seems inescapable.[2] For this discussion, enhancement will signify an intervention that goes beyond the ends of medicine as they traditionally have been held.

For medicine, the treatment/enhancement distinction cannot be avoided since physicians will play a central role whenever medical knowledge is used both to regain health and to go beyond what is required to regain health. To be sure, specialists in other fields are necessary if even the modest promises of biotechnology are to be realized. They will provide the basic scientific and technical expertise from which biotechnological enhancements will emerge. But physicians are crucial in the actual use of this technology with individual human beings.

Some physicians have already crossed the divide between treatment and enhancement, between medically indicated use and patient-desired abuse. There is already

Edmund Pellegrino, "Biotechnology, Human Enhancement, and the Ends of Medicine," *Dignitas* 29, no. 3–4 (2022): 15–17.

a need for physicians to reflect on the ethical implications of their involvement in the uses of biotechnology. This reflection centers on these loci: (1) the use of biotechnological advancements in the treatment of disease; (2) its use to satisfy the desires of patients and non-patients for enhancement of some bodily or mental trait, or some state of affairs they wish to perfect; and (3) more distantly, in the use of biotechnology to redesign human nature and thus to enhance the species in the future.

New treatments are the most promising use of biotechnology. They most closely conform to the clinical and ethical ends of medicine. The list of target diseases is long. Devising treatments for them is a legitimate and desirable individual and social good. Here, the physician functions in his time-honored role as healer. He has a moral obligation to stay informed and educated in the use of the new technologies.

The ethical questions are related to the means by which these new treatments are developed and applied. Genetic manipulations, cybernetics, nanotechnology, and psychopharmacology are in themselves not intrinsically good nor bad morally. Procedures, however, derived from the destruction of human embryos, distortions and bypassing of normal reproductive processes, or cloning of human beings, etc., are not morally permissible no matter how useful they might be therapeutically.

Within the traditional ends of medicine, the primary intention is the use of biotechnology to treat physical or mental disease. There is no question that the cure or amelioration of a disease process will also result secondarily in enhancement of the patient's life. Here the enhancement lies in the restoration of health or relief of symptoms undermined by disease. The patient feels "better" and regains functional capacity. He may be returned to his previous state of health, or to an even better state. This kind of enhancement follows therapy and is part of the aim of therapy—not "beyond" therapy but a result of it. This is different from enhancement as a primary intention. Here we start with someone who has no disease or obvious bodily malformation. She is considered "normal" in the usual sense of that term. Yet the person feels dissatisfied with her portion in life. She feels unfulfilled, at a social disadvantage or competitively deficient in some mental or physical bodily trait. She may want to augment a state to what she thinks is a normal level, or she may want something approaching perfection.

The motives, ends, and means of enhancement as a primary intention are morally variable. Some ends—like the desire for healthy, bright, and lovable children—are understandable. If the means that bring these states about do not themselves dehumanize their subjects, they might be within the legitimate ends of medicine, particularly preventative medicine.

On the other hand, many others will focus elsewhere, e.g., on the thrills of going farther, faster, with more endurance in athletic competition. Alternatively, they might want to enjoy the adrenalin surge of seeing how far the human body and mind can be pushed. Enhancement of this kind becomes an end in itself far beyond the healing ends of medicine in any traditional sense.

Some would extend the term "patient" to anyone unhappy, in any degree, with his body, mind, soul, or psyche. This would "medicalize" every facet of human existence. Were physicians to accept enhancement of this kind as their domain, the social consequences would be dire. The number of physicians needed would skyrocket; access by those with disease states would be compromised; research and development would become even more commercialized and industrialized. Research resources would be channeled away from therapy per se. The gap in access to therapy between those able to pay for the doctor's time and those who cannot would expand. To make physicians into enhancement therapists is to make therapy a happiness nostrum, not a true healing enterprise.

On the other hand, if any significant number of physicians were to decide that enhancement, as an end in itself, is not the physician's responsibility, enhancement therapy could become a field of its own "beyond" medicine. How these new therapists would relate to patients and physicians is unclear. Would they be simply those physicians willing to cooperate? Would they be persons in other fields—like sports trainers, psychologists, and naturopaths—who would attend to their own special spectrum of enhancement requests? What would these enhancement therapists do when serious, mysterious, or potentially lethal side effects appeared?

It is likely that outright rejection of enhancement would encounter strong resistance. Satisfaction of personal desires, freedom of choice, and "quality life" have, for many, become entitlements in a democratic society. Few will want restrictions placed on their choice of enhancement. Peer pressure, the drive of a competitive society, and market pressures will convince many physicians and ethicists that resistance is futile.

Given our society's incessant search for satisfaction of all its desires in this world, many will argue that enhancement is part of the physician's responsibilities—no matter what the profession thinks. The confluence of an ego-oriented culture sustained by social approval, peer example, and clever advertising will produce a cascade of demand.

Physicians will be drawn into enhancement practices for a variety of reasons. Some will see only good in it; some will accept it as "treatment" for the unhappiness and depression suffered by those who are not everything they want to be. Others will argue that physician involvement is necessary to assure safety and to permit better regulation of abuses. "What better way to treat the whole person?" some may add. "Isn't the patient the one who knows most about his own good?" Assertions like these suggest that failure to provide enhancement may become a breach of the physician-patient relationship or the physician's social contract.

Enhancement will also appeal to the physician's self-interest. A willing and paying clientele is certain to develop. Patients will be more eager to pay for the enhancement of the lifestyle they desire than for treatment of disease they did not want in the first place. Physicians can say they are doing "good" for their patients even while doing well for themselves.

The possibility and probability of a serious conflict of interests on the part of the physician cannot be ignored. Money can easily induce the physician to provide enhancement of dubious merit or marginal efficacy. More specific, for example, is the conflict that involves the team physician who is expected to do his part to produce a winning team. Enhancements of athletic performance are in worldwide use. Their deleterious side effects are well known. Who does the physician serve—the good of the patient,

the success of the team that pays his salary, or his own infatuation with athletic success?

Fundamental questions about how enhancement affects our concepts of the purposes of human life and the nature of human happiness will be buried by more immediate demand for happiness, fulfillment, and mental tranquility.[3] The modern and post-modern emphasis will be on effective regulatory measures, better techniques, and competent practitioners—not ethical restraint. Restraint or prohibition beyond prevention of abuses and harmful side effects is highly unlikely. Those who restrict freedom of choice will be seen as a danger to the realization of a higher quality of life for all. Any restriction will be interpreted as a violation of the physician's obligation to respect patient autonomy.

Many of us will take these to be specious arguments, which, if accepted, would make medicine the handmaiden of biotechnology and erode its traditional role in treating the sick. Counterarguments will be difficult given the powerful vectors of change in our cultural mores. Hopes for an earthly paradise are seemingly within reach for many people who no longer believe in an after-life. For them, extracting the maximum from personal enhancement is a seductive substitute.

Notes

1. Erik Parens, "Is Better Always Good?" in *Enhancing Human Traits: Ethical and Social Implications*, ed. Erik Parens (Washington, D.C.: Georgetown University Press, 1998), 1–28; Eric T. Jeungst, "What Does Enhancement Mean?" in: *Enhancing Human Traits*, 29–69.
2. H. W. Fowler, *A Dictionary of Modern English Usage*, 2nd ed., rev. Sir Ernest Gowers (New York: Oxford University Press, 1965).
3. Peter D. Krammer, *Listening to Prozac* (New York: Viking, 1993).

18

Integrity & Conscience: 2022 Conference Recap

Bryan A. Just MA | Event & Executive Services Manager

After two years of virtual conferences, those of us at The Center for Bioethics & Human Dignity were thrilled to return to gathering in person for *Integrity and Conscience: Bioethics and the Professions*! Meeting on the campus of Trinity International University from June 23–25, CBHD's 29th annual conference was a wonderful time of reconnecting with those we had only seen online.

Ekaterina Lomperis opened the conference by addressing "Conscience as a Theological Concept."[1] As she demonstrated, our ideas of religious freedom and rights of conscience are relatively modern developments. Early Christians often faced persecution, but they did not understand their loyalty to their faith as a matter of conscience or religious freedom. Rather, they understood standing for their faith as a core portion of their identity—to deny Christ was to deny being themselves. Even well into the Middle Ages there was no real "right to conscience;" those with different beliefs were excommunicated if not executed.

By the High Middle Ages there began a push for separating civil and religious authority, but unlike today, where the focus is on ensuring that the state does not exert undue influence on the church, the concern then was that the church (especially the papacy) was exerting undue influence on the state. It was not until the 16th century Protestant Reformation that modern conceptions of conscience rights and religious freedom began to take shape: "The record growth and spread of Protestantism throughout early modern Europe brought to the forefront practical questions of the political possibilities and limits of religious tolerance."

A second major way that the Protestant Reformation influenced the development of conscience was through the formulation of Protestant doctrine around good works. While Catholics believed that salvation came through grace and good works together, Protestants believed in salvation by grace alone through faith alone. This led Catholics to accuse the Protestants of "abandoning virtue." Martin Luther strove to counter this critique by developing a distinction betweenthe inner and outer person, with the conscience as part of the inner person. Luther would subsequently develop his theology of the two kingdoms in which he would make "the first theological argument for the separation of the church from the state and the freedoms of religious conscience, conceptualized by Luther through his theology of the inner *vis a vis* outer person."

In the midst of our often contentious debates about conscience today, Lomperis reminded us that "for Luther, free Christian conscience is simply one expression of a larger Christian spiritual liberty. . . . It is impossible to truly take this freedom away, as it is impossible to take away the Gospel, which establishes and sustains Christian freedom of conscience."

While Lomperis focused on the historical foundations for the freedom of conscience, Jeff Barrows looked at modern examples of coercion of conscience in his address "Conscience on the Front Lines."[2] Preferring to use the language of "conscience freedoms" over the commonly used "conscience rights," Barrows considered how we got to the point of needing to defend freedom of conscience, and he pointed to several fundamental shifts

Bryan A. Just, "Integrity & Conscience: 2022 Conference Recap," *Dignitas* 29, no. 3–4 (2022): 18–22.

in the history of medicine. When the foundational goal of medicine was to heal disease, doctors were seen as professionals. In recent times, however, the foundational goal has shifted to relieving suffering. With this shift, physicians lost their status as professionals and became seen as mere providers. Other transitions include the rise of autonomy as the guiding principle of medicine and the shift from viewing life as sacred to viewing it as merely worthy of respect.

With these changes in medicine have come new procedures and assumptions that weaken conscience freedoms. For example, a document on "The Limits of Conscientious Refusal in Reproductive Medicine" was deliberately written to prioritize refusal over rights. It asserts that conscience freedoms should be limited if they impose religious or moral beliefs, negatively affect a patient's health, are based on misinformation, or exacerbate social or racial inequalities. These criteria are extremely broad and can justify virtually any limit on conscience. The document also asserts that conscientious refusal cannot do anything to jeopardize the patient's wellbeing. By focusing on the patient's generic "wellbeing" rather than on health, disease, or healing, this physicians-as-providers model makes their purpose simply meeting patient desires, whatever they may be. Unfortunately, this document, which clearly exemplifies the shifts to which Barrows refers, reflects a growing belief that since physicians freely entered the field of medicine, they lack any conscience freedoms and must entirely abide by their patients' wishes.

Barrows concluded his presentation by overviewing several of the current threats to conscience freedoms, such as the 2016 addition to Rule 1557 of the Affordable Care Act that changed the definition of sex discrimination to include gender identity and pregnancy. This definitional change made physicians liable to accusations of sex discrimination if they do not provide or refer for services for gender transition or abortion. Another national-level threat to conscience freedoms comes from the federal government's changes to the HHS conscience rule. This rule came into being in 2008 and was meant to strengthen previously passed laws. Unfortunately, the rule has seldom been enforced, and while it was strengthened during the Trump administration, the Biden administration is preparing to either revise the rule or rescind it entirely.

There are also threats to conscience freedoms at the state and local level, such as physician-assisted suicide laws in California. Unfortunately, many cities and states are adopting definitions of sex discrimination similar to Rule 1557. There are those who are fighting to protect conscience freedoms, but in many cases, this is a losing battle. Barrows warned that many healthcare professionals will leave medicine if forced to practice against their conscience. He shared several ways that his own organization, The Christian Medical and Dental Associations (CMDA), is fighting to protect conscience freedoms, and he encouraged the audience to assist CMDA in their own states.

Saturday morning began with a lecture by Bart Cusveller focused on recent research he and his colleagues conducted regarding "Professional Integrity in Caring Professions."[3] Commonly, people think of two "slogans" when they think about professional integrity: "doing the right thing when no one is watching" and "integrity is like pregnancy; you either have it or you don't." While these might have some utility in other fields, Cusveller argued that they are inadequate for healthcare professionals.

Through numerous interviews with healthcare professionals, Cusveller and his colleagues found several traits that go together to make up professional integrity, which he described as "a quality of professional conduct such that the healthcare worker is personally involved in her professional position oriented toward the patient's interest." They found several key themes or "gravitational forces" that held the traits of integrity together: (1) agreement between what you think, say, and do; (2) boundaries between persons, roles, and relationships; (3) openness for evaluation of one's conduct by others; (4) responsible use of means, position, and information; and (5) fostering the wellbeing of the other. In each of these dimensions, transparency is key, hence the problem with doing the right thing when no one is watching; part of integrity is to have people watching and offering feedback and evaluation. Integrity thus takes on a social quality.

Why is integrity important? A major reason is trust—"a precondition for making oneself dependent or even vulnerable to the professional's expertise and ability to help depends on the professional's dependability." Integrity thus becomes a necessary condition for a caring relationship. This also helps us see why saying you either have integrity or you don't is incorrect. We can have differing degrees of trust, and that difference is based on the perceived integrity of the one we are trusting. We also recognize that there are degrees of failure of integrity as well: making an error in treatment or accidently sharing confidential information is a breach of integrity but is of a different degree than stealing from or sexually abusing a patient.

Cusveller and his colleagues found a number of attributes, attitudes, and actions that corresponded with the maintenance of integrity. Specifically, they found three main dimensions around which integrity is oriented: (1) the use of self (including such things as navigating personal/professional boundaries and resisting institutional pressures); (2) the use of position (including practices such as talking to, not about, others and making proper use of facilities and information); and (3) the orientation of service (including things such as trying to see things from the patient's perspective). Cusveller closed by reminding listeners that professional ethics does not exist on its own; it must be situated within "a comprehensive, normative worldview," one that stems from an encounter with the living God.

The Friday of the conference, June 24, 2023, proved to be a historic day in the U.S., as the Supreme Court announced their decision in the *Dobbs* case, which overturned *Roe v. Wade*. This announcement was met with great enthusiasm by the conference attendees, and before the next session Paige Cunningham graciously agreed to give a brief presentation on the decision, how it was argued, and its implications for U.S. law.

Following this, Ana Iltis spoke on "Conscience and Integrity in Research: Moving Beyond the Don'ts."[4] She lamented that very little has been written about conscience in research, and what has been written about integrity is often limited to a few specific areas: trust in methodology and findings, and avoiding falsification, fabrication, and plagiarism. While more has been done on specific topics like embryonic, stem cell, and animal research, even this is usually framed negatively—what should be avoided?

In contrast, Iltis asserted that there is much more to integrity and conscience in research than just "avoiding wrongdoing."

After defining conscience and integrity, Iltis provided several examples of how these concepts both constrain and compel research. Two examples come from the COVID-19 pandemic. The first involved the need for all of us, whether researchers or not, to be informed about how research works. As the COVID vaccines were rolled out, many people objected that they had been developed or tested with fetal cells sourced from abortions, and some refused to receive them because of their beliefs. While not weighing in on whether someone should take the vaccine, Iltis pointed out how many people's positions were inconsistent or based on misinformation. Many who opposed the vaccine on moral grounds had no idea how many other products, medical or otherwise, that they used had been developed or tested with cell lines replicated from other cells that were originated from fetal tissues from abortions. Others opposed the vaccine because they believed that ongoing abortions were necessary for their production or that certain vaccines contained fetal cells when this was not the case. All of these people were moved by their conscience, and many wanted to act in a way that demonstrated personal integrity, but their efforts were hindered by their lack of knowledge.

Another example concerns how many doctors (as well as the public) are suspicious of randomized controlled trials. People's reaction to these is often "how could you refuse an experimental treatment to someone who needs it?" However, sometimes this urge to provide whatever treatment we are able to offer gets in the way of doing what is truly best for the patient. During COVID, hydroxychloroquine was thought to be a promising treatment in the early stages of the pandemic, and many people clamored for it. Some physicians even went so far as to say that it had become the standard of care and used implicit appeals for conscience to say that this was something they absolutely needed to provide to their patients. The problem was, the "studies" that had been done proving hydroxychloroquine's effectiveness were all rushed, usually still preprints, and eventually shown to be faulty; hydroxychloroquine did not actually have an effect. By not doing research properly and awaiting final, peer-reviewed results, many rushed to judgments and provided a treatment that was not actually beneficial, and even had the potential to cause harm.

People's moral commitments can determine what kinds of research they will or will not pursue. We are familiar with certain common conscience claims (such as avoiding research that could promote abortion or makes use of embryonic cells or tissue), but there are other areas, such as research that could produce bioweapons, that investigators might avoid for conscience reasons. However, integrity and conscience can also propel research; some researchers make it their life's work to solve a particular problem or work with a particular population. Conscience and integrity not only influence what research people pursue, but how they go about it.

In many publications, appeals to conscience take place implicitly rather than explicitly, and Iltis provided the example of a study dealing with newborn genetic testing. The researchers were initially only going to report results to families when a mutation could result in a disease that could arise or be treated in childhood. However, one newborn had a hereditary mutation that would not affect them until adulthood, but it meant that one of their parents was at a greater risk for certain cancers. The researchers received permission to amend their study protocol and inform the parents of this finding. While the language of conscience was not explicitly used, this was clearly the impetus for changing the protocol, and Iltis recounted the anecdotal evidence of researchers telling her that it felt wrong for them to know information about someone and not tell them.

Outside of these examples, Iltis included numerous questions that researchers working with human subjects can ask about their own work, as well as some internal and external barriers to ethical research. Her goal with these, as with her other examples, was to show how conscience and integrity in research affects far more than just researchers. As she concluded, conscience and integrity are "not fringe concepts! They are mainstream sources of guidance; they are worthy of protection and promotion. They're not dirty words—conscience and integrity are meaning giving and obligation generating for all of us."

For the final session on Friday, Richard Zimmerman spoke on "COVID-19 Vaccination and Policy Making."[5] A former member of the CDC's Advisory Committee on Immunization Practices, Zimmerman was able to provide a first-hand account of how the organization weighs evidence and makes recommendations for vaccinations. He then went on to discuss some of the biblical and theological principles that apply to decisions about vaccination. From the Old Testament, he showed how God at times commands his people to engage in preventative measures for others' protection—for example, building a wall around the roof of their house so that someone cannot fall off (Deut 22:8). From the New Testament, he focused on the commands to love one another and promote justice.

Zimmerman then considered how these ethical principles applies to COVID-19 vaccinations specifically. After considering the data on COVID, he put together a syllogism:

Jesus commands us to love one another

Love is shown by protecting the life and health of others

Therefore, Jesus commands us personally to protect the health and life of others

COVID-19 is unhealthy and potentially deadly

Therefore, Jesus commands us to protect others against COVID

Against the objection that we do not need a vaccine because God is sovereign, Zimmerman countered that when you start with "God is sovereign," you can justify all manner of things. If God is sovereign, why put gas in your car, when he can ensure you get where you need to be anyway? Rather than being a sign of faith and trust, this excuse is an abdication of our responsibility and demonstrates a worldview of determinism that "leav[es] humans to dance on the strings of God as a grand puppet-master in the sky."

Zimmerman then considered COVID-19 vaccinations in relation to issues of conscience. How do we determine whether someone's objection is truly a matter of conscience or simply a case of "herd thinking"? Regarding the use of fetal cells in COVID-19 vaccinations, he posited that we can use Robert Orr's criteria for determining moral

complicity (timing, proximity, certitude, knowledge, and intent) to weigh whether someone has a legitimate claim to conscience. After considering all of these areas, he determined that for Christians there is no ground for conscientious objection to the COVID-19 vaccines available in the U.S. on the basis of their use of cell lines derived from abortions.

Finally, Zimmerman considered the principle of the least restrictive alternative and how that should be applied to vaccine mandates. He noted that in the case of the Center for Medicaid Services, a vaccine mandate was justified and fit the criteria of being the least restrictive means for obtaining their intended goals. Conversely, the OSHA attempt to mandate vaccines did not meet these criteria, and it demonstrated an overreach on the part of that organization. While he believes that the vaccine is a good idea for everyone, he argued that the pros outweighed the cons for a mandate for healthcare workers, but not for the rest of society.

Saturday morning opened with a talk from Kathy Schoonover-Schoffner on "Integrity, Conscience, and Current Ethical Burdens through the Lens of Nursing Ethics."[6] From events like the COVID-19 pandemic to the Russian war in Ukraine, nurses are consistently on the front lines of providing care. Schoonover-Schoffner provided several definitions of nursing, which encompasses "promoting health, the restoration of health, and advocacy." She then went on to summarize the history of nursing and the centrality of ethics to the development of the field.

Until the 19th century, nursing was not a desirable profession. However, much changed with the Civil War and the great need for skilled nurses it created. Dorothea Dix developed codes for nurses that transformed the perception of the field, and in 1873 the first schools of nursing were opened, where ethics and etiquette were a large part of a nurse's training. The *American Journal of Nursing* began in 1900, and much of the writing in that publication was about ethics. Between 1900–1964, over 100 textbooks and books on nursing ethics were published. From all of this, Nursing developed a "heritage ethics" that was based in virtue, relationship, and vocation.

This began to shift in the 1970s. Nursing education moved from hospital schools into the university, and in the process, much of nursing's heritage literature on ethics was lost, as it was not considered "scholarly" enough. In 1979, Beauchamp and Childress' *Principles of Biomedical Ethics* was published, launching principlism as the dominant paradigm of medicine and furthering the transition from nursing ethics to bioethics.

Despite this paradigm shift, nursing ethics still has an important and unique place in the contemporary world. Nursing ethics are not problem oriented, but "virtue-based, relationally-based, and vocation/calling oriented." It is a "preventative ethics," not fixated just on the problem at hand but on forming a relationship. Today, nursing ethics focuses on five main relationships: between the nurse and (1) the patient/family, (2) other health professionals, (3) the self, (4) the profession, and (5) society. Though the Code of Ethics for Nurses that lays out these relational principles is a bit of an anomaly in today's bioethics-dominated world, the heritage ethics of nursing still have much to teach us. When followed, its principles help nurses to advocate for patients, see them as whole persons, and build relationships with them—all tasks central to the vocation of nursing.

Saturday afternoon, Allen Roberts spoke on "Medical Error: Conscience and Integrity."[7] He began by talking about the nature of conscience and how it brings with it moral duties and obligations, then overviewed four cases of medical errors that he was either involved in or had made national news.

He then moved on to a history of medical error. Hippocrates is widely considered the father of medicine and made several comments on error. While the physician could not be held responsible for misfortune or the patient's illness itself, they were responsible for things they did wrong or inappropriately, as there are correct and incorrect ways of doing things. Moving to William Osler, the founder of modern medicine, he advocated for medicine as a high calling, and encouraged medical students and doctors to always take responsibility for what they did. Thus, the early 19th and 20th centuries were a time of "paternalistic integrity," and doctors were open about both successes and failures.

Due to several cases of failures making their way into tabloids, this era gave way to a period of "concealment, blame, and shame." Errors were hidden or denied whenever possible, and if one did come to light, blame was always shifted elsewhere. By the 1950s there were some quiet publications that discussed the harm this culture of silence caused. In the 1990s, surveys showed that 98% of patients wanted to be informed of errors, and that they were less likely to sue after being informed. The VA system eventually adopted policies of disclosure and risk reduction, and this was a major turning point. In 1999, the Institute of Medicine (IOM) issued a report titled "To Err Is Human: Building a Safer Health System." This led to enhanced knowledge on safety, structures of mandatory reporting, higher safety standards, and safety systems within healthcare organizations.

This IOM report was hugely influential and has shaped how health systems respond to medical error throughout the 21st century. There is far greater transparency and communication with patients and family about errors, reporting and investigation when errors occur, equitable and fair resolutions to preventable errors, including an apology, and continued improvements to keep errors from occurring again. All of these changes have been very good things and help to reduce medical errors. They have also led to acknowledgement of the "second victim" of medical errors—the one who actually made the error—and methods to care for them as well. However, with these changes has come a shift in responsibility from the individual to the organization or system. Greater understanding of medical errors has also highlighted many of the disparities in health care, as ethnic minorities, women, and members of the LGBTQ community are more likely to be the victim of a medical error.

Roberts concluded with some thoughts on the current approach to medical error, called "just culture." Patient safety has become a primary goal, but there is an acknowledgement that human error cannot be entirely eradicated. The focus is instead on creating systems that minimize and mitigate those human errors and that fairly assign accountability, as well as systems of restorative justice for both the patient harmed as well as the medical provider.

For the final session of the conference, Lauris Kaldjian spoke on "The Challenging & Joyful Task of Christian Integrity in

Healthcare."[8] He began has talk by considering several definitions of conscience from a Christian perspective, noting the paradox that conscience is both supremely binding on the individual and must be followed, but at the same time is fallible and subject to error and corruption. Thus, our consciences must be both well "formed and informed," and we must have humility regarding the conclusions of our consciences. From a purely philosophical perspective, conscience encompasses our "intellect, will, desires, and our ultimate goals," and includes the dimensions of "moral reasoning, morally directed emotion, and moral motivation."

Kaldjian went on to discuss the relation between conscience and integrity, the two of which he sees as being mostly interchangeable. He defined integrity as "a moral virtue that maintains the harmony and constancy of individual moral character and identity by ordering and integrating moral beliefs, virtues, principles, words, and actions across time and place, thereby motivating moral action and empowering moral agency." In thinking about integrity and conscience together, he concluded that "a claim of conscience communicates a moral concern that is (1) deep enough to involve our integrity (moral identity); (2) serious enough to require respect (conscience rights); and (3) serious enough to warrant examination (giving of reasons)."

From here, Kaldjian discussed five key domains of foundational belief and how conscience and integrity interact with them: (1) respect for life, (2) the concept of health, (3) duty to care as an act of love, (4) respect for freedom, and (5) respect for conscience. This brought him to the challenge of Christian integrity. Christians believe that we live in a fallen world, but also that God is active and present in our world and in our hearts. In the midst of our fallen world, it can be difficult to be salt and light in medical practice, and to give reasons for our moral beliefs. And yet, there is great value to us doing so. As Paul reminds us in 2 Corinthians 4:2, "by setting forth the truth plainly we commend ourselves to every man's conscience in the sight of God." We are to be witnesses (or martyrs) to our Christian beliefs in all aspects of our lives.

While being Christian witnesses may be difficult, we must remember the second part of the story—that God is active and in control, and whatever we do we do for him. When we speak up in matters of conscience, we remember that God is with us. Without understating how difficult conflicts of conscience can be, Kaldjian pointed to the joy that comes from integrity and following a well-formed conscience. When encountering a situation that could cause moral distress, keeping silent can lead to moral injury, compartmentalization, and burnout. However, if we instead use the situation to engage in moral communication, it can help us to clarify our own thoughts, open a way forward, and engage in conscientious practice. When we do what is right, we live in harmony with God, our soul is revived, and our heart rejoices. Even if we are persecuted and suffer for the sake of our conscience, we rejoice knowing that we are inheritors of the kingdom of heaven.

We at CBHD are deeply grateful to those who helped make our conference a success! Preparations are already underway for our 30th anniversary conference: *The Christian Stake in Bioethics Revisited: Crucial Issues of Yesterday, Today, and Tomorrow*. We have an excellent lineup of speakers, including Christina Bieber-Lake, PhD; F. Matthew Eppinette, MBA, PhD; Peter Jaggard, MD; Bryan Just, MA; Adam Omelianchuk, PhD, MA; and Scott Rae, PhD. We look forward to seeing you in Deerfield, June 22–24, 2023!

Notes

1. Ekaterina N. Lomperis, "Conscience as a Theological Concept" (plenary address, The Center for Bioethics & Human Dignity's 29th Annual Conference, *Integrity and Conscience: Bioethics and the Professions*, Deerfield, IL, June 23, 2022).
2. Jeff Barrows, "Conscience on the Front Lines" (plenary address, *Integrity and Conscience*, June 23, 2022).
3. Bart Cusveller, "" (plenary address, *Integrity and Conscience*, June 24, 2022).
4. Ana S. Iltis, "Conscience & Integrity in Research: Moving Beyond the Don'ts" (plenary address, *Integrity and Conscience*, June 24, 2022).
5. Richard Zimmerman, "COVID-19 Vaccination and Policy Making" (plenary address, *Integrity and Conscience*, June 24, 2022).
6. Kathy Schoonover-Schoffner, "Integrity, Conscience, and Current Ethical Burdens through the Lens of Nursing Ethics" (plenary address, *Integrity and Conscience*, June 25, 2022).
7. Allen Roberts, "Medical Error: Conscience and Integrity" (plenary address, *Integrity and Conscience*, June 25, 2022).
8. Lauris Kaldjian, "The Challenging & Joyful Task of Christian Integrity in Healthcare" (plenary address, *Integrity and Conscience*, June 25, 2022).

BIOETHICS NEWS STORIES

June 2022–October 2022

Heather Zeiger, MS, MA | Research Analyst

"Supreme Court Overturns Roe v. Wade; States Can Ban Abortion"

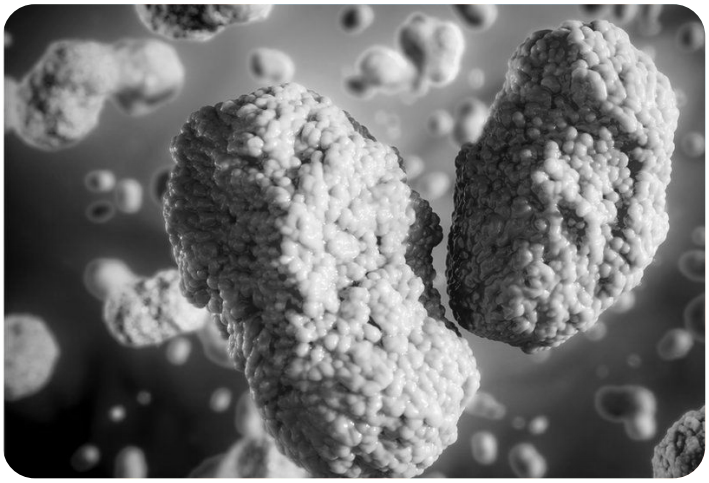
by Mark Sherman, *Associated Press*, June 24, 2022

> The Supreme Court has ended the nation's constitutional protections for abortion that had been in place nearly 50 years in a decision by its conservative majority to overturn Roe v. Wade. Friday's outcome is expected to lead to abortion bans in roughly half the states. (https://apnews.com/article/abortion-supreme-court-decision-854f60302f21c2c35129e58cf8d8a7b0)

On May 2, a draft of a Supreme Court opinion that would overturn *Roe v. Wade* and *Casey v. Planned Parenthood* was leaked to the media. Then at the end of June, the U.S. Supreme Court published their final opinion of the Dobbs case. The opinion, written by Justice Alito, says that the authority to regulate abortion returns to the states and their elected officials. Additionally, the opinion says that Roe's central rule is the viability line (i.e., abortion is legal until the point that a fetus can survive outside the womb), which no longer makes sense and is not used in other countries as a demarcation for legalization.[1] Before Roe and Casey were overturned, states already had varied abortion laws. Several states also had "trigger laws" in place for when Roe would be overturned. Several of those trigger laws have gone into effect and several states have had laws on their ballots.

Since June, news outlets have been reporting on the implications of the Dobbs case. The *Associated Press* reported that the European Union "overwhelmingly condemned" the end of constitutional protections for abortion in the U.S.[2] Several outlets reported that the demand for abortion pills has soared since Dobbs,[3] and that some people are getting the pills from overseas websites that distribute abortion pills without a prescription, violating U.S. FDA rules. This is different from telehealth organizations that prescribe and send abortion pills to patients in states where it is legal.[4]

Several groups have worried that period tracking apps and location data apps could be used to determine if a woman has broken the law,[5] and whether HIPAA laws imply that doctors do not have to turn over ultrasound and other medical information if asked to.[6] However, much of the news is speculation as to how laws in different states will be applied. This includes whether IVF will be regulated since it involves the destruction of embryos and how this will affect prenatal genetic testing, since this can be tied to abortion.[7] Additionally, some of the states have laws that need to be clarified so doctors and patients can know how best to handle difficult medical situations, including medical emergencies.[8]



"With Monkeypox Spreading Globally, Many Experts Believe the Virus Can't Be Contained"

by Helen Branswell *STAT News*, July 19, 2022

> It has been a mere nine weeks since the United Kingdom announced it had detected four cases of monkeypox, a virus endemic only in West and Central Africa. In that time, the number of cases has mushroomed to nearly 13,000 in over 60 countries throughout Europe, North and South America, the Middle East, new parts of Africa, South Asia, and Australia. (https://www.statnews.com/2022/07/19/monkeypox-spread-many-experts-believe-the-virus-cant-be-contained/)

"Monkeypox Appears to Recede, but Risks and Uncertainties Linger"

by Apoorva Mandavilli, *The New York Times*, September 26, 2022

> Nearly four months after the first report of monkeypox in the United States, the virus is showing promising signs of retreat, easing fears that it may spill over into populations of older adults, pregnant women and young children. (https://www.nytimes.com/2022/09/26/health/monkeypox-vaccine.html)

In May 2022 a man in the UK contracted monkeypox, a viral disease that is typically seen in Central and Western Africa. The man had recently traveled to Nigeria. Monkeypox causes sores to form on the body and is only spread through contact with the sores. Over the course of several months, the disease spread to over 90 countries, and, as of this writing, cases are still present in the U.S., although transmission has greatly declined. This outbreak of monkeypox, recently renamed "mpox" by the WHO,[9] spread predominantly through sexual contact and largely among men who have sex with men. In August, the U.S. declared the disease a public health emergency,[10] but the Department of Health and Human Services does not plan to renew that designation in January.

"Pig Organ Transplants Inch Closer with Testing in the Dead"

by Lauran Neergaard, *Associated Press*, July 12, 2022

> New York researchers transplanted pig hearts into two brain-dead people over the last month, the latest in a string of developments in the long quest to one day save human lives with animal organs. (https://apnews.com/article/pig-heart-transplant-nyu-c332493b-4d6232edcf9ca389df976de0)

"US Counts Millionth Organ Transplant While Pushing for More"

by Lauran Neergaard, *Associated Press*, September 9, 2022

> The U.S. counted its millionth organ transplant on Friday [September 9], a milestone that comes at a critical time for Americans still desperately waiting for that chance at survival. (https://apnews.com/article/science-health-organ-transplants-government-and-politics-308bfae0c70c3377d595b9a0a3a5a381)

Even though the U.S. celebrated its millionth organ transplant, there are still more than 105,000 people on the national organ donation list. The *Associated Press* reports that 17 people die every day waiting for an organ. One solution to the shortage of organs is to use pigs whose organs have been genetically modified by removing cell-surface molecules that signal to the human immune system to attack the foreign organ. In January, in a highly experimental trial, doctors transplanted a modified pig's heart into a man with terminal heart failure. The man died two months after the transplant, but not of heart failure. Trials with deceased human subjects were conducted in July to better understand how the body responds to genetically modified xenotransplantation. In both cases, researchers considered the results moderately successful, but more studies need to be done.

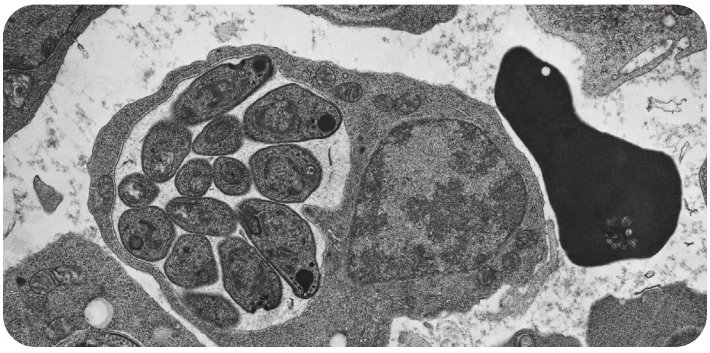
Along the same lines of intermingling humans and animals, in October scientists implanted human brain organoids into the brains of rats. The organoids successfully grafted into the rat brains.[11]

"Disturbing: Experts Troubled by Canada's Euthanasia Laws"

by Maria Cheng, *Associated Press*, August 11, 2022

> "Alan was basically put to death," his brother Gary Nichols said. "Disability experts say the story is not unique in Canada, which arguably has the world's most permissive euthanasia rules—allowing people with serious disabilities to choose to be killed in the absence of any other medical issue. (https://apnews.com/article/covid-science-health-toronto-7c631558a457188d2bd2b5cfd360a867)

Canada is set to allow people struggling with mental health to qualify for euthanasia in March 2023. Lawmakers are considering whether to allow euthanasia for "mature" minors. Unlike in the U.S. where physicians can write a prescription for deadly drugs but not administer them, Canada is one of several countries in which a medical professional (not necessarily a doctor in Canada) injects the drugs into the person wanting to die. Additionally, Canada does not have the safeguards in place to prevent coercion and discrimination against people with disabilities. The *Associated Press* reported several examples of people with disabilities being encouraged to choose euthanasia, including one story of a man who qualified for euthanasia because he had hearing loss. Last year three UN human rights experts said that Canada's laws seem to violate the UN's Universal Declaration of Human Rights.



"At Long Last, Can Malaria Be Eradicated?"

by Apoorva Mandavilli, *The New York Times*, October 4, 2022

> A more powerful malaria vaccine, developed by the Oxford team that created the AstraZeneca Covid vaccine, may be just a year or two away. Many experts believe it is this formulation, which has shown an efficacy of up to 80 percent in clinical trials, that may transform the fight against malaria. (https://www.nytimes.com/2022/10/04/health/malaria-vaccines.html)

"Malawi Starts Landmark Malaria Vaccination Drive," *BBC*, November 30, 2022

Malawi has begun vaccinating children as part of a world-first, large-scale campaign against malaria. The RTS,S vaccine—more than three decades in the making—was developed by pharmaceutical company GSK. (https://www.bbc.com/news/world-africa-63797178)

While great strides have been made to decrease global malaria infections, there are still more than 220 million cases per year, with over half a million deaths. More than 90% of those cases are in Sub-Sahara Africa, and the deaths are predominantly in children under 5. Last year, the WHO approved a vaccine by GSK, brand name Mosquirix, and this November Malawi began vaccinating children. The vaccine requires several doses, and it is only 40% effective after the full course.

In September the University of Oxford Jenner Institute, the same institute that developed the COVID-19 AstraZeneca vaccine, announced the results of trials in Burkina Faso for their R21 vaccine.[12] The vaccine showed 70% efficacy after 3 doses were given to children before 17 months and close to 80% efficacy after a booster shot a year later. The vaccine is made with newer technology and is cheaper to manufacture. The University of Oxford has a deal with the Serum Institute of India to make 100 million doses per year with the hope that they can begin deploying the vaccine at the end of 2023. BioNTech is also working on an mRNA malaria vaccine and other groups are developing monoclonal antibody therapies for malaria.

Most Accessed bioethics.com Posts:

"All Is Beauty" October 25 (https://bioethics.com/archives/66285)

Editor's Note: A film produced by Simons fashion that lauded euthanasia. The film has since been taken off the retail outlet's website and is no longer accessible at bioethics.com.

"Deadly Fungi Are Infecting More Americans" October 24 (https://bioethics.com/archives/66247)

"Think You've Never Had Covid-19? Think Again" July 25 (https://bioethics.com/archives/64446)

"Why More and More Girls Are Hitting Puberty Early" October 28 (https://bioethics.com/archives/66345)

"Antidepressants Don't Work the Way Many People Think" November 9 (https://bioethics.com/archives/66552)

Notes

1. The full opinion can be found at https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.
2. Raf Casert, "EU Parliament Condemns US Abortion Ruling, Seeks Safeguards," *Associated Press*, July 7, 2022, https://apnews.com/article/abortion-us-supreme-court-health-european-parliament-660014a8f37c31e33a0f4540a34f5bd6.
3. Oriana Gonzalez and Ashley Gold, "Abortion Pill Demand Soaring Following Roe's Demise," *Axios*, July 19, 2022, https://www.axios.com/2022/07/18/abortion-pills-mifepristone-misoprostol-demand.
4. Dominique Mosbergen and Vibhuti Agarwal, "Websites Selling Unapproved Abortion Pills Are Booming," *The Wall Street Journal*, August 21, 2022, https://www.wsj.com/articles/websites-selling-unapproved-abortion-pills-are-booming-11661079601.
5. Patience Haggin, "Phones Know Who Went to an Abortion Clinic. Whom Will They Tell?" *The Wall Street Journal*, August 7, 2022, https://www.wsj.com/articles/phones-know-who-went-to-an-abortion-clinic-whom-will-they-tell-11659873781.
6. Oriana Gonzalez, "HIPAA Faces Test in New Abortion Reality," *Axios*, August 10, 2022, https://www.axios.com/2022/08/10/abortion-bans-patients-hipaa-violation.
7. Andrew Joseph, "If Roe Is Overturned, the Ripples Could Affect IVF and Genetic Testing of Embryos, Experts Warn" *STAT News*, June 6, 2022, https://www.statnews.com/2022/06/06/roe-v-wade-preimplantation-genetic-testing-ivf-clinics/.
8. Adriel Bettelheim, "Emergency Treatment Law Becomes Focus of Abortion Fight," Axios, July 12, 2022, https://www.axios.com/2022/07/12/abortion-emergencies-hospitals-treatment.
9. Helen Bramswell, "WHO to Phase Out the Name 'Monkeypox' for "mpox," *Stat News*, November 28, 2022, https://www.statnews.com/2022/11/28/who-to-phase-out-the-name-monkeypox-for-mpox/.
10. Zeke Miller, Mike Stobbe, and Michael Balsamo, "US Declares Public Health Emergency over Monkeypox Outbreak," *Associated Press*, August 4, 2022, https://apnews.com/article/monkeypox-public-health-emergency-us-f336fc99abd57f0866a38b578d5bb44c.
11. Sara Reardon, "Human Brain Cells Implanted in Rats Prompt Excitement—And Concern," *Nature*, October 12, 2022, https://www.nature.com/articles/d41586-022-03238-x.
12. James Gallagher, "New Malaria Vaccine Is World-Changing, Say Scientists," *BBC*, September 8, 2023, https://www.bbc.com/news/health-62797776.

COVID NEWS TIMELINE

June 2022–December 2022

Heather Zeiger, MS, MA | Research Analyst

JUNE 2022

June 1: "Omicron Is Outrunning the Vaccines Designed to Fight It" (*Axios*)

June 2: "COVID-Fatigued Health Worker Are Mobilizing" (*Axios*)

June 10: "Coronavirus Infection During Pregnancy Linked to Brain Development Problems in Babies" (*Los Angeles Times*)

June 14: "FDA Advisors Back Moderna's COVID-19 Vaccine for Older Kids" (*Associated Press*)

June 14: "Pfizer's Paxlovid Study Fails to Answer Key Questions Over Benefit for Broader Populations" (*STAT News*)

June 15: "FDA Advisory Panel Votes Unanimously That Pfizer and Moderna Shots Be Authorized for Young Children" (*STAT News*)

June 17: "FDA Authorizes 1st COVID-19 Shots for Infants, Preschoolers" (*Associated Press*)

June 17: "Omicron Poses About Half the Risk of Long COVID as Delta, New Research Finds" (*NPR*)

June 28: "FDA Advisors Recommend Updating COVID Booster Shots for Fall" (*Associated Press*)

June 28: "The Omicron Subvariants BA.4 and BA.5 Have Together Become Dominant in the U.S., the C.D.C. Estimates" (*The New York Times*)

June 30: "Tweaked COVID Boosters in US Must Target New Omicron Types" (*Associated Press*)

JULY 2022

July 1: "COVID-19 Variant Boosters Won't Need New Clinical Trials for Clearance, FDA Says" (*The Verge*)

July 6: "U.S. Maternal Deaths Spiked Upwards During Pandemic" (*U.S. News & World Report*)

July 7: "US Allows Pharmacists to Prescribe Pfizer's COVID-19 Pill" (*Associated Press*)

July 7: "Doctors Are Clamoring for More Clarity on Paxlovid Prescribing Amid Covid-19 Rebound Concerns" (*STAT News*)

July 12: "Hopes of Covid-19 Reprieve Fade as BA.5 Subvariant Takes Over" (*The Wall Street Journal*)

July 14: "US Regulators OK New COVID-19 Shot Option from Novavax" (*Associated Press*)

July 21: "President Biden Tests Positive for Covid-19, But Has 'Very Mild Symptoms'" (*STAT News*)

July 22: "The Pandemic Isn't Over, But Most of U.S. States Formally Say That It's No Longer a Health Emergency" (*The New York Times*)

July 28: "China's Wuhan Locks Down District with One Million People" (*The Wall Street Journal*)

AUGUST 2022

August 5: "Exclusive: Over 1 Million Courses of Paxlovid Prescribed in One Month for First Time" (*Axios*)

August 8: "Most Parents Are Saying No to Covid-19 Vaccines for Toddlers" (*The Wall Street Journal*)

August 12: "CDC Drops Quarantine, Distancing Recommendations for COVID" (*Associated Press*)

August 19: "U.S. Plans to Shift Bill for Covid Shots and Treatments to Insurers, Patients" (*The Wall Street Journal*)

August 22: "FDA Authorizes Novavax Vaccine for Ages 12 to 17" (*Axios*)

August 22: "Fauci to Step Down After Decades as Top US Infection Expert" (*Associated Press*)

August 26: "Moderna Sues Pfizer and BioNTech Over Covid-19 Vaccine" (*STAT News*)

August 30: "Millions in New COVID Lockdown as China Keeps Strict Policy" (*Associated Press*)

August 31: "US Clears Updated COVID Boosters Targeting Newest Variants" (*Associated Press*)

August 31: "WHO: New COVID Cases, Deaths Keep Falling Nearly Everywhere" (*Associated Press*)

SEPTEMBER 2022

September 2: "FDA Authorizes Omicron-Targeted Booster Shots" (*MedPage Today*)

September 2: "'Game Changer' Paxlovid Turns Into Pandemic Enigma" (*Axios*)

September 6: "Pfizer Isn't Sharing Covid Vaccines with Researchers for Next-Gen Studies" (*STAT News*)

September 9: "Companies Are Dropping Vaccine Mandates" (*Axios*)

September 14: "WHO: COVID End 'in Sight,' Deaths at Lowest Since March 2020" (*Associated Press*)

September 15: "Donated COVID Drugs Start Flowing to Poor Nations—But Can't Meet Demand" (*Nature*)

September 23: "Major Covid Holdouts in Asia Drop Border Restrictions" (*The New York Times*)

September 26: "Pfizer Seeks to Expand Omicron Booster to 5-to-11-Year-Olds" (*Associated Press*)

September 27: "Canada Repeals Covid-19 Border Restrictions" (*The Wall Street Journal*)

September 30: "Sweden to Stop Offering Covid Jabs to Teenagers" (*Medical Xpress*)

September 30: "North Korea Launches Mass Covid-19 Vaccination Campaign" (*The Wall Street Journal*)

OCTOBER 2022

October 5: "100,000 Coronavirus Genomes Reveal COVID's Evolution in Africa" (*Nature*)

October 7: "Covid Defies China's Lockdowns, Creating Chaos Ahead of Top Meeting" (*The New York Times*)

October 7: "From BQ.1.1 to XBB and Beyond: How the Splintering of Omicron Variants Could Shape Covid's Next Phase" (*STAT News*)

October 7: "CDC Ends Daily Reporting of COVID Case and Death Data, in Shift to Weekly Updates" (*CBS News*)

October 13: "Europe Likely Entering Another COVID Wave, Says WHO and ECDC" (*Reuters*)

October 13: "FDA Authorizes Updated Covid-19 Boosters for Kids as Young as 5" (*STAT News*)

October 19: "Heart Risks, Data Gaps Fuel Debate Over COVID-19 Boosters for Young People" (*Science*)

October 19: "FDA Authorizes Booster Shot for Novavax's Covid-19 Vaccine" (*STAT News*)

October 20: "Panel Votes to Add COVID Shots to Recommended Vaccinations" (*Associated Press*)

October 31: "COVID 'Variant Soup' Is Making Winter Surges Hard to Predict" (*Nature*)

NOVEMBER 2022

November 4: "When Covid-19, Flu and RSV Meet. The Potential for a Tripledemic." (*The Wall Street Journal*)

November 7: "Study: Myocarditis Risk 2 to 3 Times Higher from Moderna Than Pfizer COVID-19 Vaccine" (*UPI*)

November 16: "'A Very Worrying Scenario': Internal Documents on India Covid-19 Vaccination Raise Troubling Questions about Approval Process" (*STAT News*)

November 16: "Hospitalized or Not, COVID Symptoms Persist in Many After 2 Years" (*MedPage Today*)

November 17: "New COVID-19 Subvariants Replace BA.5 as Most Dominant in the U.S." (*UPI*)

November 21: "Will Covid Boosters Prevent Another Wave? Scientists Aren't so Sure." (*The New York Times*)

November 22: "Real-World Data Show Updated Covid-19 Boosters Increase Protection Against Infection" (*STAT News*)

November 28: "China Protests Spread Over Government's Covid Restrictions" (*The Wall Street Journal*)

November 29: "Covid Becomes Plague of Elderly, Reviving Debate Over 'Acceptable Loss'" (*Washington Post*)

November 30: "Covid Evolution Wipes Out Another Antibody Treatment, Threatening the Country's Medicine Cabinet" (*STAT News*)

DECEMBER 2022

December 2: "Around 85% of Recent Covid Deaths Were among People Over 65. Why Have so Few Gotten Boosted?" (*NBC News*)

December 7: "China Eases Anti-COVID Measures Following Protests" (*Associated Press*)

December 8: "FDA Authorizes Updated Covid-19 Boosters for Youngest Children" (*STAT News*)

December 9: "Key Partner in Covax Will End Support for Middle-Income Nations" (*The New York Times*)

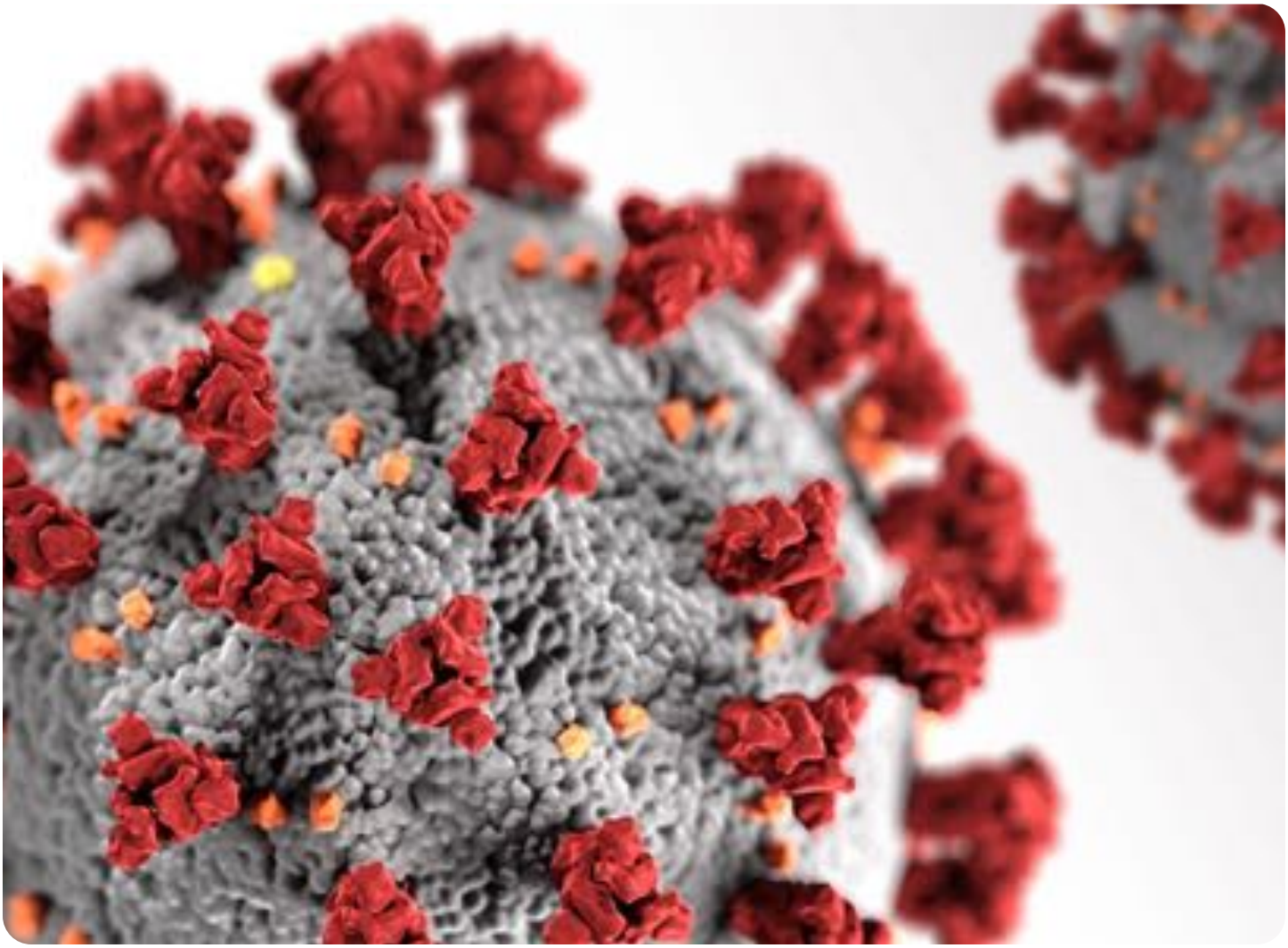
December 13: "Covid Vaccines Averted 3 Million Deaths in U.S., According to New Study" (*STAT News*)

December 15: "You Can Order Free COVID Tests again by Mail" (*NPR*)

December 21: "WHO 'Very Concerned' About Reports of Severe COVID in China" (*Associated Press*)

December 21: "Infectious Disease Board Recommends Hospitals Stop Screening Asymptomatic Patients for Covid-19" (*STAT News*)

December 30: "Medicare Keeps Spending More on COVID-19 Testing. Fraud and Overspending Are Partly Why." (*ProPublica*)



BIOENGAGEMENT

BIOFICTION

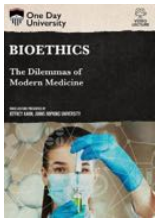
The Institute: A Novel
(Steven King, 2020).
Research Ethics, Human Enhancement, Morality, Horror/Sci-Fi

Codename: Freedom - Vanguard
(Apollos Thorne, 2022).
Metaverse, Artificial Intelligence, Nature of the Human Person, Sci-Fi

Station Eleven
(Emily St. John Mandel, 2014).
Transhumanism, Genome Editing, Sci-Fi Thriller

PRIMETIME BIOETHICS

The Peripheral
(Amazon, 2022).
Virtual Reality, Augmented Reality, Human Enhancement, Sci-Fi



Bioethics: The Dilemma of Modern Medicine
(One Day University/Dreamscape, 2021)
Global Biomedical Research, Beginning and End of Life, Reproductive Technologies, Transplantation, Genetics/Genome Research, Lecture

The Silent Sea
(Netflix, 2021)
Research Ethics, Genetic Modification, Cloning, Korean Sci-Fi

Readers are cautioned that these resources represent a wide spectrum of genres and content, and may not be appropriate for all audiences. For more comprehensive databases of the various cultural media, please visit our website at cbhd.org/resources/reviews. If you have a suggestion for us to include in the future, send us a note at research@cbhd.org.

BIOETHICS AT THE BOX OFFICE

Morbius
(Columbia Pictures/Marvel Entertainment, 2022, PG-13 for intense sequences of violence, some frightening images, and brief strong language)
Biochemistry, Genetic Alteration, Genetic Ethics, Horror/Sci-Fi

Avatar: The Way of Water
(20th Century Studies, 2022, Not Yet Rated)
Emerging Technology, Genetic Ethics, Neuroethics, Sci-Fi

The Father
(Lionsgate, 2021)
Dementia, Human Dignity, Memory Loss, Psychological Drama

UPDATES & ACTIVITIES

Theological Bioethics Roundtable

- CBHD hosted its bi-annual theological bioethics roundtable, this time engaging TEDS PhD students on Mary Shelley's classic, *Frankenstein*.

Staff Updates

- Bryan Just began his PhD in Church History at Trinity Evangelical Divinity School. He will continue to work for The Center as he progresses in his studies.
- Anna Vollema has been appointed as the new Research Scholar for CBHD. Having previously held the Robert D. Orr Fellowship, she will continue in this role until a new Orr Fellow is selected.

Staff Speaking Engagements

Matthew Eppinette:

- Presented a guest lecture on the ethics of surrogacy for a cohort of students seeking to become marriage and family therapists at Fuller Seminary. In addition, he presented lectures on the ethics of technology and the ethics of the body in sport for St. Paul's Theological College Malaysia.
- Led an interactive discussion on the U.S. Supreme Court's Dobbs decision overturning *Roe v. Wade* for the students and faculty of Trinity along with TEDS Assistant Professor of New Testament David Bryan.
- In October, met with the District Superintendents of the Evangelical Free Church to discuss ways in which CBHD might better support pastors in their ministry contexts.

Heather Zeiger:

- Went on the CBHD Bioethics Podcast to talk about fetal tissue research and Christian bioethics (you can listen to her podcast here: www.cbhd.org/podcast/fetal-tissue-research-christian-bioethics).
- Regular guest on Mornings with Carmen (on Faith Radio) to talk about the latest science and bioethics headlines.

Bryan Just:

- Presented at the Evangelical Theological Society conference on "Death in Song: A Comparison of End-of-Life References in Evangelical Music."
- Taught a Sunday school series on bioethics at Village Church of Lincolnshire.

The Bioethics Podcast

2022 in Review

- In the top 25% most shared globally.
- Top 15% most followed.
- Gained 84% more followers.

UPDATES & ACTIVITIES

Staff Publications

Matthew Eppinette:

- Submitted a chapter entitled "Will Posthumans be Persons? Taking the Transhumanist Goal Seriously" to *Taking Persons Seriously: Where Philosophy and Bioethics Intersect*. The book is being edited by CBHD Academy of Fellows members Mihretu Guta and Scott Rae and will be published through Wipf & Stock.
- Coediting, along with CBHD Senior Fellow Scott Rae, a special issue on the Church after Roe and Dobbs for the journal *Faith and Flourishing*.

Heather Zeiger (you can read any of these published pieces at https://heatherzeiger.com/):

- Regular contributor to Mind Matters News on the topics of ethics, China, and technology.
- Wrote an Intersections piece entitled "Why Was the 'Twitching Generation' So Popular on Bioethics.com?"
- Published an article in *Salvo* magazine, Summer 2022, entitled "Lines That Divide: Untangling Moral Complexities Related to Fetal Tissue Research."

Bryan Just:

- Wrote "Six Billion Tics: Social Media 'Influencers' & the Spread of Mental Disorders" and "Humanity 2.0: How to Think about Human Chip Implants" for *Salvo* magazine.

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Dignitas is the quarterly publication of the Center and is a vehicle for the scholarly discussion of bioethical issues from a Judeo-Christian Hippocratic worldview, updates in the fields of bioethics, medicine, and technology, and information regarding the Center's ongoing activities.