Philosophy and Theology

In their *New England Journal of Medicine* article, "Physicians, Not Conscripts: Conscientious Objection in Health Care,"[1] Ronit Stahl and Ezekiel Emanuel argue that health care professionals who are unwilling to perform medical interventions to which they conscientiously object, such as abortion, should be forced to stop practicing medicine. They write, "Health care professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession."[2] What are their grounds for taking away rights of conscientious objection from health care professionals?

Stahl and Emanuel argue that an appeal to conscientious objection in the military historically justified and legitimated conscientious objection in health care. Consequently, they draw disanalogies between military service and health care to delegitimize conscientious objection in medical practice. According to Stahl and Emanuel, conscientious objection in health care differs from conscientious objection in the military in five important ways: "first, it objects to professional practices, not state-mandated conscription; second, it occurs within the context of a freely chosen profession; third, it allows selective objection to professionally accepted interventions; fourth, it accepts objection without external scrutiny; and fifth, it shields the objector from all repercussions and costs."[3] On their view, these five differences undermine the case for allowing health care professionals to decline to perform requested interventions.

1. Ronit Y. Stahl and Ezekiel J. Emanuel, "Physicians, Not Conscripts: Conscientious Objection in Health Care," *New England Journal of Medicine* 376.14 (April 6, 2017): 1380–1385, doi: 10.1056/NEJMsb1612472.

2. Ibid., 1383.

3. Ibid., 1381.

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The case of US Army corporal Desmond T. Doss calls into question much of Stahl and Emanuel's argument. The movie *Hacksaw Ridge*[4] tells the true story of Corporal Doss, who volunteered to serve in the infantry during World War II. Because of his personal beliefs as a Seventh-day Adventist, Doss refused to kill or even carry a weapon in combat. Consequently, he was assigned to serve as a medic. He received the Bronze Star for his heroic service on Guam and in the Philippines. During the Battle of Okinawa, Doss single-handedly lowered seventy-five wounded servicemen from Hacksaw Ridge to safety. He became the only conscientious objector during World War II to receive the military's highest award for valor, the Medal of Honor.

Cases such as Doss's undermine several key claims of Stahl and Emanuel's argument. First, Doss objected to normal professional military practices—for example, carrying weapons and killing enemy soldiers—and he was not subject to state-mandated conscription. Second, Doss freely chose military service. Third, Doss selectively objected to professionally accepted interventions by refusing to kill the enemy while still performing all other duties compatible with his religious beliefs.

Stahl and Emanuel suggest a fourth difference between military and medical conscientious objection. Unlike conscientious objectors in the military, medical conscientious objectors are not scrutinized about the sincerity of their beliefs. This difference makes sense. In the case of military service, someone may lie about his opposition to killing because of a fear of death or injury rather than a sincere ethical belief. The motivation to lie to avoid personal injury or death in battle is not present in the medical profession. There is a very obvious ulterior motive for lying in the case of military service but not in the case of medical service. Therefore, scrutinizing a claim of conscientious objection makes sense in the military but not in the medical profession.

And what of the fifth and final difference, that medical objectors are shielded from all repercussions and costs, but military objectors are not? If *Hacksaw Ridge* is to be believed, Doss certainly was not shielded from all repercussions and costs. In addition to being harassed and even physically assaulted, he was officially disciplined for his conscientious objection. It is questionable whether such treatment is justified even in the military. If it is not, then the precedent it sets cannot justify extending such costs into the medical profession.

In any case, is it true that health care professionals who conscientiously refuse to provide abortions are shielded from all repercussions and costs? No, conscientious objectors incur financial opportunity costs, because they do not receive the payment they would have received for performing abortions and they must forgo certain job opportunities, such as working for Planned Parenthood. Moreover, to the degree that abortion is a medically accepted practice, conscientious objectors risk social stigmatization in the profession. They may also jeopardize professional relationships with patients, colleagues, and hospitals. As things now stand, it is not accurate to claim that conscientious objectors in medicine do not suffer for their beliefs and actions.

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4. *Hacksaw Ridge*, directed by Mel Gibson (2016; New York: Lionsgate, 2017), DVD /Blu-ray.

Stahl and Emanuel suggest that "health care conscience clauses are one-sided, protecting only those who refuse to treat patients, not those who conscience compels them to provide medically accepted but politically contested care."[5] Is this claim true? In fact, existing conscience protections for health care professionals serve even those who do not invoke them. First, conscience protections serve many patients who seek out health care providers with whom they share ethical values and religious beliefs. Many patients feel more comfortable sharing private and intimate details of their lives (as can be so important in health care) with like-minded health care professionals. Such trusting relationships promote the well-being of patients.

Second, conscience clauses protect the diversity of the health care profession, a concern widely shared by people inside as well as outside the profession. Women, Latinos, and African Americans are, on average, more religious than white men. Religious belief and practice often, but of course not always, motivate conscientious objection. If we want a medical profession that reflects the religious and ethnic diversity of American society, then we should protect the conscience rights of health care workers. Taking away these protections will, in effect, make the medical profession more white, male, and atheistic.

Moreover, health care conscience protections for individuals and institutions aid everyone, especially the disadvantaged, by preventing higher health care costs. For example, "615 Catholic hospitals account for 12.5% of community hospitals in the United States and over 15.5% of all U.S. hospital admissions."[6] Countless other physicians, nurses, and health care professionals share the Catholic opposition to abortion. If these individuals are forced to provide abortions or stop providing health care, then many of these individuals and institutions will be forced out of the health care profession, as Stahl and Emanuel seem to desire. At a time when health care demand is increasing, the Stahl–Emanuel proposal would decrease health care supply. Higher costs and more difficulty in obtaining health care harm everyone, including women seeking abortions, who may find that their chosen doctors not only do not provide abortions but also do not provide cancer screenings, oral antibiotics, or asthma inhalers.

Stahl and Emanuel claim that the conscience protections do not protect those whose consciences impel them to provide requested interventions. The authors may have in mind doctors who work at Catholic hospitals and want to procure abortions. But there is an important way in which their case and the case of doctors who do not want to perform abortions are not analogous. There is a radical difference between not practicing medicine in a particular hospital and not practicing medicine at all.

Stahl and Emanuel remind their readers, "All [the] professional health care societies accept the same professional role morality: patients' well-being is their

5. Stahl and Emanuel, "Physicians, Not Conscripts," 1381.

6. United States Conference of Catholic Bishops, "The Catholic Church in America: Meeting Real Needs in Your Neighborhood," Catholic Information Project, 2006, available at https://www.supremecourt.gov/opinions/URLs_Cited/OT2010/09-751/09-751_3.PDF.

primary interest."[7] The authors note that the American Medical Association "insists that 'physician's ethical responsibility [is] to place patients' welfare above the physician's own self-interests.'"[8] But obviously, the primacy of the patient is not an exceptionless principle, as if every patient's interests trump every physician's interests in every case. It is in the interests of patients to have medical care provided for free, but doctors do not have an obligation to work only on a voluntary basis. It is in the interests of patients to avoid the hassle and expense of visiting the doctor's office, but physicians do not have an obligation to make house calls. It is in the interests of patients to have the doctor see them whenever they desire, but physicians do not have an obligation to always be available on request.

So how important are the interests of a doctor in not providing abortions? Well, most physicians who oppose abortion would see being forced to perform abortions as a much more serious infringement of their interests than making house calls, not charging patients for medical services, and providing medical advice after hours in social situations. House calls, free medical treatment, and mid-dinner consults are not matters of conscience for most people. They are not intrinsically evil or matters of grave ethical importance. So if we allow physicians to let their interests in a family dinner trump patients' interests in medical advice, we should not force a doctor to perform abortions if he or she thinks abortion is the intentional killing of an innocent human being.

If there is an actual or perceived conflict between doctor and patient, who determines whose interests should prevail? According to Stahl and Emanuel, "the profession, rather than the individual practitioner, elucidates the interpretation and limits of the primary interest."[9] It is odd that Stahl and Emanuel should appeal to professional standards to adjudicate conflicts between a patient's interests in getting an abortion and a health care professional's interests in not providing one, since the standard set by the American Medical Association contradicts the view they advocate. If the profession elucidates the interpretation and limits of the patient's interests, then health care professionals should be permitted to decline to perform abortions, since the AMA allows them to do so.

Stahl and Emanuel go on to argue that it is inconsistent for the AMA to both assert "fidelity to patients and respect for patient self-determination" and protect health care professionals who conscientiously object to performing abortions. On one hand, the AMA urges doctors to place patient well-being above self-interest and forbids doctors from rejecting patients on the basis of "race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care."[10] On the other hand, according to Stahl and Emanuel, the AMA contradicts itself, because "it permits physicians to refuse to

7. Stahl and Emanuel, "Physicians, Not Conscripts," 1381.

8. Ibid. The authors cite American Medical Association (AMA), "Patient–Physician Relationships," opinion 1.1.1, in *Code of Medical Ethics* (Chicago: AMA, 2016).

9. Ibid., 1382. The authors are referring to AMA, "Patient–Physician Relationships."

10. AMA, "Prospective Patients," opinion 1.1.2, in *Code of Medical Ethics*.

treat patients who are seeking care that is 'incompatible with the physician's deeply held personal, religious, or moral beliefs.'"[11] Is there really a contradiction?

In fact, Stahl and Emanuel create an apparent contraction in the AMA opinion by misconstruing the text. They conflate declining to provide a *treatment* with refusing to treat a *patient*. However, a doctor might decline to provide abortion but continue to treat the patient and care for her in a variety of ways. Stahl and Emanuel claim that the AMA "permits physicians to refuse to treat patients who are seeking care." But this assertion is not found in the AMA opinion, which addresses physicians' right to refuse particular *treatments*, not particular *patients*. The legal and professional protection of conscience rights has nothing to do with refusing to accept women or anyone else as patients. Stahl and Emanuel construct a contradiction only by misconstruing the AMA opinion.

Even they concede that the professional obligations of physicians do not always trump their self-interest: "This obligation is not unlimited, but exceptions are reserved for cases in which there are substantial risks of permanent injury or death."[12] Stahl and Emanuel mistakenly claim that professional codes reserve exceptions only for cases in which a patient risks death or permanent injury.

Moreover, the exceptions in these cases lend support to conscience protections. Socrates taught that it is better to suffer harm than to do it.[13] Moral heroes throughout the centuries have lived according to this principle. St. Thomas More, Dietrich Bonhoeffer, Gandhi, Martin Luther King Jr., and Nelson Mandela were willing to suffer and even die rather than violate their consciences. Like them, many people of good will would rather die than intentionally kill an innocent human being. If Immanuel Kant is right that conscience is an unconditional command, then there can never be any interest whatsoever that trumps the demands of conscience. If it is worse to do harm than to suffer harm, health care workers' interests in not violating their consciences are maximally strong, indeed stronger even than their interests in avoiding death. Thus, even given Stahl and Emanuel's stringent interpretation of the primacy of patients' interests, health care workers should be protected from being forced to violate their consciences. If the mere risk of permanent injury justifies putting the interests of a physician ahead of the interests of a patient, how much more does the certain harm to ethical integrity justify protecting health care professionals?

A final trouble with Stahl and Emanuel's case against conscience is that many justifications of conscience protections for health care workers do not depend on an appeal to conscience protections for those serving in the military. The authors neither reference these arguments nor even try to show that the analogy to conscience protections in the military is the only grounds for justifying conscience protections in

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11. Stahl and Emanuel, "Physicians, Not Conscripts," 1381.

12. AMA, "Prospective Patients," opinion 1.1.2(a), quoted in Stahl and Emanuel, "Physicians, Not Conscripts," 1382.

13. "Any wrong whatsoever done to me or mine [is] both worse and more shameful to the wrongdoer than to me the wronged." Plato, *Gorgias,* 508e, in *Plato in Twelve Volumes*, vol. 3, trans. W.R.M. Lamb (Cambridge, MA: Cambridge University Press, 1967).

health care. So even if they successfully had proven the disanalogy between military service and medical service, their case leaves these other justifications untouched.[14]

Precisely speaking, what is at issue in this debate is not the conflict of interest between a patient who wants an abortion and a doctor who does not want to provide it. Rather, the question is, should a patient be able to force a doctor to perform an abortion? The right to get an abortion (from someone) is not at issue. In the United States, millions of abortions have taken place since *Roe*. Even with the current conscience protections, abortion is a common surgery.

What are the practical implications of the Stahl–Emanuel rejection of conscience rights? Imagine a fifty-year-old Muslim gynecologist named Okina Makenzua who emigrated from Nigeria and now works in Los Angeles. She is the mother of three children whom she supports on her income alone. Despite living in a large metropolitan city, she is, as far as she knows, the only female Nigerian Muslim gynecologist in the area. She makes special efforts to serve the immigrant Muslim community. Likewise, Nigerian Muslim women make special efforts to come to her, because she shares their language, culture, and faith. They trust her, and she establishes a superb mutual understanding because of her shared background with them. Suddenly, the Stahl–Emanuel constraint is imposed on her: provide abortions or get out of medicine. She feels that she is too old and does not have the time and money to learn another medical specialty, such as radiology. Her children and ethnic community depend on her in unique ways. In Los Angeles, there are dozens of abortion providers, but because Dr. Makenzua does not provide abortions, she is suddenly forced out of her profession.

Whom does the Stahl–Emanuel rule benefit? It directly and gravely harms Dr. Makenzua and her children. It harms the local Muslim community, which is deprived of a physician who has a wonderful rapport with the recent immigrants. The Stahl–Emanuel restriction does not even benefit women seeking abortions, since there already are dozens of abortion providers in the area, and they lose the services of Dr. Makenzua, who is no longer available to provide gynecological exams, Pap smears, or anything else. The Stahl–Emanuel rule imposes severe and certain costs without proportional benefit.

If the US military had forced Private Doss out of military service, many men would have lost their lives on Hacksaw Ridge. If the Stahl–Emanuel rule forces Dr. Makenzua and health care professionals like her out of medical service, she will suffer and we all will directly or indirectly suffer. Banning Private Doss and banning Dr. Makenzua are wrong for the same reason. Conscientious objection in military service and in medical service benefits not only conscientious objectors but all whom they serve.

Christopher Kaczor

14. See, for example, chapters 12 and 13 in Christopher Kaczor, *A Defense of Dignity: Creating Life, Destroying Life, and Protecting the Rights of Conscience* (Notre Dame, IN: University of Notre Dame Press, 2013).

Philosophy Abstracts

American Journal of Jurisprudence

John Finnis, **Grounding human rights in natural law**, *Am J Juris* 60.2 (December 2015): 199–225, doi: 10.1093/ajj/auv013 • Of the published reviews of *Natural Law and Natural Rights*, one of the most, and most enduringly, influential was Ernest Fortin's review-article "The New Rights Theory and the Natural Law" (1982). The present essay takes the occasion of that review's latest re-publication to respond to its main criticisms of the theory of natural law and natural or human rights that is articulated in *Natural Law and Natural Rights*. The response deals with a number of fundamental or strategically important issues: the freedom of thought and/or the intellectual autonomy and integrity of work within an intellectual tradition that overlaps with a "faith tradition"; the hierarchies among the basic human goods; the place of virtue in the book, and the relation between rights and freedom, and rights and virtue; the unsoundness of the Straussian bifurcation between natural right and natural rights; whether natural law is only analogically law, and the relation between moral law and sanctions; and the possibility of true exceptionless negative moral precepts.

Melissa Moschella, **Natural law, parental rights and education policy**, *Am J Juris* 59.2 (December 2014): 197–227, doi: 10.1093/ajj/auu010 • This article argues that the parent–child relationship is the source of special obligations on the part of parents to direct the education and upbringing of their children. These special obligations correspond to the specific needs of children, and are the basis of parents' authority and the right to exercise that authority in accordance with the dictates of their consciences, relatively free from coercive state interference except in cases of abuse and neglect. Since parental authority is based on parental obligations, which in turn are based on the needs of children, protection of parental authority is also, by and large, the best way to protect the rights of children. Through an analysis of *Wisconsin v. Yoder* and in dialogue with liberal theorists, the article also explains why robust protection of parental rights is compatible with recognition of the state's interests in educating future citizens and in fostering the well-being of children.

Bioethics

Melissa Moschella, **Integrated but not whole? Applying an ontological account of human organismal unity to the brain death debate**, *Bioethics* 30.8 (October 2016): 550–556, doi: 10.1111/bioe.12258 • As is clear in the 2008 report of the President's Council on Bioethics, the brain death debate is plagued by ambiguity in the use of such key terms as "integration" and "wholeness." Addressing this problem, I offer a plausible ontological account of organismal unity drawing on the work of Hoffman and Rosenkrantz, and then apply that account to the case of brain death, concluding that a brain dead body lacks the unity proper to a human organism, and has therefore undergone a substantial change. I also show how my view can explain hard cases better than one in which biological integration (as understood by Alan Shewmon and the President's Council) is taken to imply ontological wholeness or unity.

Timothy F. Murphy, **What justifies a future with humans in it?**, *Bioethics* 30.9 (November 2016): 751–758, doi: 10.1111/bioe.12290 • Antinatalist commentators recommend that humanity bring itself to a close, on the theory that pain and suffering override the value of any possible life. Other commentators do not require the voluntary extinction of human beings, but they defend that outcome if people were to choose against having children. Against such views, Richard Kraut has defended a general moral obligation

to people the future with human beings until the workings of the universe render such efforts impossible. Kraut advances this view on the grounds that we are obliged to exercise beneficence toward others and on the grounds that the goods available in human lives are morally compelling. This account ultimately succeeds in making no more than a prima facie defense of human perpetuation because considerations of beneficence could override—in some cases probably should—override any duty to perpetuate human beings. While the goods of human life may be distinctive, they cannot serve as reason-giving in regard to their own perpetuation. Ironically, the exercise of beneficence may authorize the extinction of human beings, if it becomes possible to enhance the goods available to human descendants in a way that moves them away from human nature as now given. The defense of a morally obligatory and strictly human future remains elusive, even as it becomes morally desirable to work against Fateful Catastrophes, those human-caused events that threaten to extinguish existing lives already good and enriching for their bearers.

Christian Bioethics

E. Christian Brugger, **The first principles of the natural law and bioethics**, *Christ Bioeth* 22.2 (August 2016): 88–103, doi: 10.1093/cb/cbw002 • This essay elaborates a sound account of first principles of practical reason and demonstrates its relevance for bioethics. After correcting a misinterpretation of Aquinas, the essay argues that natural law theory is firstly concerned with the foundations of practical reason and thus suitable for use in bioethics. Practical reason, unlike speculative reason, is inherently related to the appetites (reason directed to action). The ends or goods with which it is first concerned signify desirable possibilities, which are grasped preceptively as goods to be done and pursued—such as life, truth, friendship, procreation and education of children, religion, and practical reasonableness. Their contraries are grasped as evils to be avoided. These goods constitute the intelligible origin of all purposeful behavior and are the basis for moral norms. Identifying what good or goods are at stake in bioethical questions and how those goods are influenced by actions, technologies, practices, and mindsets is foundational for doing bioethics well. Finally, they make intelligible the existence of ethical prohibitions. Notwithstanding the range of norms that bind only for members of special communities or groups, these core goods and the first principles specified by them are not relative to culture, groups, or individuals.

Melissa Moschella, **The wrongness of third-party assisted reproduction: a natural law account**, *Christ Bioeth* 22.2 (August 2016): 104–121, doi: 10.1093/cb/cbw008 • Children have an absolute right to be loved by their genetic parents and a strong prima facie right to be raised by them. This is because genetic parents, by virtue of their genetic connection to their children, have an intimate and permanent personal relationship to those children at the bodily level. As a result, the absence of genetic parents' love (understood as a high-priority commitment to the child's well-being) is a significant harm to children. This view presupposes that human beings are rational animal organisms. This essay provides a brief defense of this metaphysical premise, then explains the connection between that premise and the moral claim that genetic parents have an absolute obligation to love their genetic children. Except in cases of incompetence, this obligation can only be fulfilled by raising those children themselves. Donor conception is therefore always an injustice, because it intentionally deprives a child of the important right to be loved by his or her biological parents.

Stephen Napier, **Why are religious reasons dismissed? Euthanasia, basic goods, and gratuitous evil**, *Christ Bioeth* 22.3 (December 2016): 276–300, doi: 10.1093/cb/cbw012 • Many proponents of euthanasia eschew appeals to religious premises as good reasons for thinking that human life has intrinsic worth. The reasons offered are that religious reasons do not meet some theory-neutral epistemic standard. My first argument is to show that pro-euthanasia arguments fail to meet those same standards. In order to avoid this incoherence, the rejection of religious reasons is a function of thinking that such reasons are simply false. Arguing

against religious belief has typically fallen to the evidential argument from evil. My second argument is to show that the argument from evil must hold to a basic goods account of human life. Such an account is contrary to the view of human life held by most euthanasia proponents. So euthanasia proponents who reject religious belief on the basis of an argument from evil must hold to a contradictory view of human worth. One cannot both be a euthanasia proponent and reject arguments against euthanasia (that are based in part on religious premises). I explore ways to resolve this tension, but none save pro-euthanasia arguments.

Journal of Medical Ethics

Caitriona L. Cox and Zoe Fritz, **Should non-disclosures be considered as morally equivalent to lies within the doctor–patient relationship?**, *J Med Ethics* 42.10 (October 2016): 632–635, doi: 10.1136/medethics-2015-103014 • In modern practice, doctors who outright lie to their patients are often condemned, yet those who employ non-lying deceptions tend to be judged less critically. Some areas of non-disclosure have recently been challenged: not telling patients about resuscitation decisions; inadequately informing patients about risks of alternative procedures; and withholding information about medical errors. Despite this, there remain many areas of clinical practice where non-disclosures of information are accepted, where lies about such information would not be. Using illustrative hypothetical situations, all based on common clinical practice, we explore the extent to which we should consider other deceptive practices in medicine to be morally equivalent to lying. We suggest that there is no significant moral difference between lying to a patient and intentionally withholding relevant information: non-disclosures could be subjected to Bok's "Test of Publicity" to assess permissibility in the same way that lies are. The moral equivalence of lying and relevant non-disclosure is particularly compelling when the agent's motivations, and the consequences of the actions (from the patient's perspectives) are the same. We conclude that it is arbitrary to claim that there is anything inherently worse about lying to a patient to mislead them than intentionally deceiving them using other methods, such as euphemism or non-disclosure. We should question our intuition that non-lying deceptive practices in clinical practice are more permissible and should thus subject non-disclosures to the same scrutiny we afford to lies.

Journal of Medicine and Philosophy

John Matthewson and Paul E. Griffiths, **Biological criteria of disease: four ways of going wrong**, *J Med Philos* 42.4 (August 2017): 447–466, doi: 10.1093/jmp/jhx004 • We defend a view of the distinction between the normal and the pathological according to which that distinction has an objective, biological component. We accept that there is a normative component to the concept of disease, especially as applied to human beings. Nevertheless, an organism cannot be in a pathological state unless something has gone wrong for that organism from a purely biological point of view. Biology, we argue, recognises two sources of biological normativity, which jointly generate four "ways of going wrong" from a biological perspective. These findings show why previous attempts to provide objective criteria for pathology have fallen short: biological science recognizes a broader range of ways in which living things can do better or worse than has previously been recognized in the philosophy of medicine.

Patrick McGivern and Sarah Sorial, **Harm and the boundaries of disease**, *J Med Philos* 42.4 (August 2017): 467–484, doi: 10.1093/jmp/jhx007 • What is the relationship between harm and disease? Discussions of the relationship between harm and disease typically suffer from two shortcomings. First, they offer relatively little analysis of the concept of harm itself, focusing instead on examples of clear cases of harm such as death and dismemberment. This makes it difficult to evaluate such accounts in borderline cases, where the putative harms are less severe. Second, they assume that harm-based accounts of disease must be understood normatively rather than naturalistically, in the

sense that they are inherently value based. This makes such accounts vulnerable to more general objections of normative accounts of disease. Here we draw on an influential account of harm from the philosophy of law to develop a harm-based account of disease that overcomes both of these shortcomings.

Melissa Moschella, **Deconstructing the brain disconnection: brain death analogy and clarifying the rationale for the neurological criterion of death**, *J Med Philos* 41.3 (June 2016): 279–299, doi: 10.1093/jmp/jhw006 • This article explains the problems with Alan Shewmon's critique of brain death as a valid sign of human death, beginning with a critical examination of his analogy between brain death and severe spinal cord injury. The article then goes on to assess his broader argument against the necessity of the brain for adult human organismal integration, arguing that he fails to translate correctly from biological to metaphysical claims. Finally, on the basis of a deeper metaphysical analysis, I offer a revised rationale for the validity of the neurological criterion of human death.

Melissa Moschella and Maureen L. Condic, **Symposium on the definition of death: summary statement**, *J Med Philos* 41.3 (June 2016): 351–361, doi: 10.1093/jmp/jhw009 • This statement summarizes the conclusions of the Symposium on the Definition of Death, held at The Catholic University of America in June 2014. After providing the background and context for contemporary debates about brain death and describing the aims of the symposium, the statement notes points of unanimous and broad agreement among the participants, and highlights areas for further study.

New England Journal of Medicine

Ronit Y. Stahl and Ezekiel J. Emanuel, **Physicians, not conscripts: conscientious objection in health care**, *N Engl J Med* 376.14 (April 6, 2017): 1380–1385, doi: 10.1056/NEJMsb1612472 • Conscientious objection laws give health care professionals the legal right to refuse, on the basis of personal beliefs, to perform certain procedures or care for particular patients. The authors argue that professional societies should declare conscientious objection unethical.

Theoretical Medicine and Bioethics

Melissa Moschella, **Rethinking the moral permissibility of gamete donation**, *Theor Med Bioeth* 35.6 (December 2014): 421–440, doi: 10.1007/s11017-014-9314-4 • The dominant philosophical view of gamete donation as morally permissible rests on two premises: parental obligations are triggered primarily by playing a causal role in procreation, not by genetic ties, and those obligations are transferable—that is, they are obligations to make adequate provision for the child's needs, not necessarily to raise the child oneself. Thus while gamete donors are indeed agent causes of the children that their donation helps to bring into existence, most think that donors' obligations are discharged insofar as they know that competent others intend to care for those children. In this article, I call into question this dominant view by challenging both of its premises. Challenging the first premise, I argue that genetic parenthood is what primarily triggers parental obligations. Challenging the second premise, I claim that those obligations are non-transferable—i.e., that they are obligations not simply to ensure that someone will raise one's genetic child, but to raise that child oneself. The implication of my argument is that gamete donation is inherently wrong insofar as it involves acquiring non-transferable obligations that one has no intention of fulfilling.