Cambridge Quarterly of Healthcare Ethics (2023), 1–8
doi:10.1017/S0963180123000178

CAMBRIDGE UNIVERSITY PRESS

ARTICLE

Teaching Bioethics Today: Waking from Dogmatic Curricular Slumbers

Leonard M. Fleck

Center for Bioethics and Social Justice, College of Human Medicine, Michigan State University, East Lansing, MI USA
Email: fleck@msu.edu

Abstract

The *Dobbs* decision has precipitated renewed medical, political, and professional interest in the issue of abortion. Because this decision handed responsibility for regulation of abortion back to the states, and because the states are enacting or have enacted policies that tend to be very permissive or very restrictive, the result has been legal and professional confusion for physicians and their patients. Medical education cannot resolve either the legal or ethical issues regarding abortion. However, medical education must prepare future physicians for caring for patients seeking abortion-related services. Physicians must be prepared to interact appropriately (sensitively and with integrity) with patients or colleagues whose views on abortion differ significantly from their own. This essay describes our educational effort to achieve that objective. The motto that governed this exercise was "No Easy Answers."

Keywords: Abortion; *Dobbs* decision; integrity-preserving compromise; mutual respect; professional ethics

Philosophical bioethicists are inclined by training to argue for what they judge to be the most rationally defensible ethical or policy judgment aimed at resolving some controversial bioethical issues. In certain environments, that might well be the right approach to finding the best resolution to one of our bioethical controversies, whether the permissibility of physician aid-in-dying or the genetic editing of embryos for enhancement purposes. The general idea would be that rigorous, vigorous, and honest debate is the best way to find the most ethically defensible view regarding such matters. However, in other environments, such as the physician–patient relationship, such an approach would be entirely inappropriate, even potentially harmful. What is needed instead is an ethically reasonable modus vivendi, a way of being mutually respectful, mindful of professional integrity, and sensitive to the values and life choices of patients regarding medical interventions that are the focus of intense social disagreement. Abortion is the most obvious example of the sort of situation that we have in mind.

Some curricular background: The *Dobbs* decision

I have been teaching in the College of Human Medicine at Michigan State University for almost 40 years. Over the years, one or more students would ask why a discussion of the ethics of abortion was not formally included in our curriculum. There has always been ample discussion of a broad range of ethical issues in our curriculum. Abortion was not among those topics. When I would inquire of senior administrators in the college, as well as other faculty members, the most common reason given for this absence was that it was too divisive an issue. It would only elicit emotional responses that would set groups of students against one another. This was something that would have to be worked out in the privacy of the conscience of each student. That was safe; that would not be disruptive. However, the Supreme Court's *Dobbs* decision required us to wake from our curricular dogmatic slumbers.[1]

The consequences of the *Dobbs* decision will reverberate for many years across many areas of medicine.[2] The *Dobbs* decision overturned the 1973 *Roe v. Wade* decision which had established a constitutionally protected privacy right and liberty right for women to choose an abortion under a limited range of circumstances. Reversing that decision meant that it was up to individual states to set their own policies regarding accessibility to abortion. The *Dobbs* decision involved a case that was brought from the state of Mississippi. The statute involved referred to the fetus as an "unborn human being." Justice Samuel Alito, the author of the *Dobbs* opinion, stated that the Court was not affirming that the description of the fetus as an "unborn human being" was the legally correct description. However, what his opinion did permit was for individual states to affirm that view as legally correct and enforceable from as early as the moment of conception. The practical implication of that permission for these states was that abortion under all circumstances would be illegal, even if sustaining a pregnancy put the life of the mother at risk.

In states with the strictest abortion laws that included criminal penalties for physicians, many physicians will find themselves faced with conflicts between their ethical obligations as physicians and legal challenges they would have to defend against if they did what was ethically required of them. One example, not uncommon, would be a woman presenting in the Emergency Room with a miscarriage and a risk of either sepsis or bleeding out.[3] Perhaps it was a natural miscarriage, something completely unexpected for entirely unknown reasons. Or perhaps this was a botched effort at abortion, maybe a medical abortion (illegal in that state) gone awry, or maybe the proverbial "coat hanger" attempt to abort. In the ER itself, there would be no way to distinguish among these possibilities. If the ER physician does what is medically necessary to manage the miscarriage to prevent serious potential harm to the woman, he/she will have acted in his/her best interest. But, if it is discovered that the miscarriage was related to an illegal abortion, the physician could be faced with criminal penalties for assisting in the completion of an abortion. Legal jeopardy can be minimized if the ER physician waits until the woman has either bled out sufficiently or provided clear evidence of sepsis so that a true emergency exists. The physician could then act, maybe with a good result, maybe not, but his/her legal self-interest would not be at risk (though his/her ethical and medical integrity would be flawed).

Another example would be related to a medical abortion using that two-pill combination [mifepristone–misoprostol] that can be used during the first 10 weeks of a pregnancy. States with the strictest anti-abortion laws would certainly forbid access to medical abortions. Medical abortions require a prescription and physician counseling. Physicians in states with those strictest laws would certainly not put themselves at legal risk by writing such a prescription. Still, they could (and should) provide a patient with the information needed for accessing that option across state lines, by mail, or through some Internet connection. However, that too might represent a legal risk if aggressive prosecutors motivated by aggressive governors were to track down such information. Further, some state legislatures are seeking to find ways to prosecute physicians in more permissive states who would have written the scripts for a medical abortion in their state.[4]

The examples given here can be multiplied many times over. The point of these examples is that they made it very clear that abortion-related ethical and policy issues, as well as matters of professional practice, needed to be part of the medical school curriculum. Still, in discussions with our curricular leaders, it was clear that we did not want an acrimonious debate about the ethics of abortion or the moral status of the fetus. Matters of professional practice in the face of deep social disagreement and legal uncertainty are what need to be addressed. How are physicians with permissive or restrictive beliefs regarding abortion supposed to interact with patients who have permissive or restrictive beliefs regarding abortion? And how are they supposed to interact with their professional colleagues who have strong beliefs regarding abortion that are opposite to their own? Where does professional and ethical integrity fit when these issues must be addressed in very specific clinical contexts?

Bioethics education without easy answers

The motto of the Center for Bioethics and Social Justice is "No Easy Answers."[5] We took that as our guiding maxim in constructing a 90-min educational session. Roughly half that time was in a large group;

the other half was in two small group sessions with nine faculty preceptors to moderate the discussion. There was one required reading for everyone (discussed below) and five additional readings that the students were expected to accomplish from a list of 12 possible readings. In addition, detailed preparatory directives and background explanations for what we were doing and what we were hoping to accomplish were part of a curricular website for this session.

What follows is the actual introduction that we used for this session. "For various segments of our population, an increasing number of medical procedures are judged objectionable for political, cultural, ethical, or religious reasons. In a liberal, pluralistic, democratic society, a society that is respectful of diverse value systems and that respects the liberty rights of individuals to construct lives congruent with their personal values, so long as the exercise of those rights does not threaten public values or public interests, what sort of policies regarding controversial medical technologies should be judged fair and reasonable and respectful of the rights of all? Keep in mind that if the State forbids access to some medical technology or procedure, the State will use its coercive powers (fines and prison) to enforce that restrictive policy, thereby depriving every one of the freedoms to access or use that technology or therapy. In a liberal society, a society with strong respect for individual liberty, this will require substantial justification so that reasonable citizens can accept those restrictions as reasonable."

This introduction was followed by the following explicit objectives for the session. "The purpose of this exercise is to have medical students and faculty (1) struggle with the social and ethical complexities of abortion-related issues (no easy answers) and (2) seek to articulate reasonable compromises with respect to the formulation of any relevant public policies or matters of professional practice. (3) The goal is to develop practical skills in having respectful conversations among those who disagree with one another regarding these ethically controversial medical practices. This includes conversations with patients as well as your peer health professionals. Among the things that need to be kept in mind is that these issues involve considerable factual, conceptual, and ethical uncertainties that nevertheless require the formulation of public policies as well as policies that will govern professional practice."

In my actual introduction to the session, I called everyone's attention to a few key points. First, we were going to avoid *arguing* about whether abortion in a range of complex circumstances should be thought of being either ethical or unethical, legal or illegal. We were simply going to accept social facts that there were these deep disagreements. Second, the *Dobbs* decision was going to have broad and uncertain legal, political, ethical, and medical consequences for the practice of medicine, largely depending upon the state in which you (future physicians) might choose to practice. Third, those consequences would affect many areas of medicine, not just obstetrics and gynecology. Fourth, if you believe that "mutual respect" is ethically and professionally necessary when faced with these deep and pervasive social disagreements, then what should that mutual respect look like in clinical practice, in your professional relationships, and in your relationships with patients who did not share your point of view? Fifth, we need to ask ourselves whether we imagine at some point in the future that all these disagreements regarding abortion would have been resolved to the satisfaction of everyone. If we see that as a complete pipe dream, what follows from that when it comes to making ethical and policy judgments?

The ethics of abortion: Complexity and uncertainty

For the first small group discussion, we asked all the medical students to complete a survey several days before the session itself. We gave them a list of 17 circumstances in which the issue of abortion would arise.

1. Medical abortion at 6–10 weeks
2. Surgical abortion at 10–16 weeks
3. Plan "B" after rape or incest
4. To save the life of the mother (any stage)
5. Abortion after 20 weeks

6. Any destruction of the embryo after conception
7. Abortion of trisomy-13 or − 18 fetus
8. Abortion for gross brain malformation
9. Abortion after 10 weeks for family size
10. Abortion prior to 10 weeks for an illicit affair
11. Abortion for a 15-year-old with parental permission
12. Abortion at 12 weeks; cancer treatment
13. Abortion at 12 weeks; relationship failure
14. Abortion with Plan "B"; contraceptive failure
15. Abortion at 10 weeks due to job/insurance loss
16. Abortion at 10 weeks due to teratogenic drug
17. Discarding embryos related to IVF

We gave the students five choices for each of those items: (1) always illegal; (2) always legal; (3) always unethical; (4) always ethical; and (5) uncertain. The "uncertain" option received only a small percentage of votes. We might see that as significant. The directives we gave them for this exercise were the following: "Should all behavior in a liberal, pluralistic society judged to be unethical also be judged to be illegal (with relevant laws enacted to establish that illegality)? The abortion issue is raised in a large range of circumstances. Some individuals who regard the embryo/fetus from the moment of conception as an "unborn human being" would regard abortion (embryo or fetal destruction) under all circumstances as being unethical and should be made illegal. Other individuals might regard abortion (embryo/ fetal destruction) as a decision that should never be illegal but is always a matter to be decided in the privacy of the doctor–patient relationship. The ethics of any such choice should be a matter of individual conscience. Still, others will be committed to a mix of decisions and distinctions. Where do you fit?" Again, I remind the reader that the point of this exercise was not to initiate any debate. We wanted to display the range of opinions visually and succinctly within the class. These results might roughly mimic the distribution of opinion in the larger society. We also wanted the medical students to think about the distinction between ethical judgments and law in a liberal, pluralistic society. Lying, for example, is clearly unethical in a broad range of circumstances. But it is only illegal in a very limited range of circumstances, such as lying under oath in a court of law. We wanted students to reflect on that distinction. Why is not all unethical behavior also illegal? How is that relevant to abortion?

There were other background facts we wanted students to have in mind for this first small group discussion. According to a recent Pew Research Center survey,[6] relatively few Americans hold absolutist views on abortion: Only about 1 in 5 say it should be legal in all cases, and less than 1 in 10 say it should be illegal without exception.[7] The question we must ask ourselves is: Why is there not a very clear, very sharp division of opinion in this matter? Greasley[8] provides us with one useful explanation. "Getting people to think clearly about abortion as an independent question in morality can be especially difficult in the case of those whose attitudes are inextricably linked to their views about legitimate sexual relations, traditional notions of the family, or the belief that all humans are made in the image of God. Perhaps more so than anything else, the fact that the abortion issue is so deeply intertwined with ideas about ethical sexual behavior is especially liable to muddy the waters with those who have strong views about such things, the drive toward enforcing perceived sexual morality and punishing deviance being so universal and, apparently, irresistible" (p. 1). She adds a bit later, "Perhaps it is especially difficult for someone staunchly committed to women's equality to consider the possibility that abortion is seriously immoral, given how much sex equality suffers when reproductive rights are denied" (p. 5)[9] Ronald Dworkin has written in this regard, "There is no biological fact waiting to be discovered or crushing moral analogy waiting to be invented that can dispose of the matter [whether an embryo or fetus is a person with a right to life.]"[10] There is too much factual, conceptual, and ethical complexity embedded in an equally complex social context to expect some reasonable resolution of these disagreements.

With the above background in mind, we required the medical students to read a recent *New York Times* essay, "When does life begin?"[11] That article begins with the story of Tina Mody, who had used IVF to become pregnant. She was thrilled to be pregnant. "This is my daughter, she thought. She named

her Maya." But as she was going for her 16-week pregnancy appointment, she started to bleed. She lost her baby. She did not lose a fetus. She lost her daughter, Maya. The rest of the article captures some of the complexity and many of the emotions associated with pregnancy, and with the choice to end a pregnancy. We told the medical students ahead of time that we would ask each in turn in the first small group session what they saw as the "take home" message from the article. Here are some responses: It is a personal decision; It is not black and white; It should not be a political question; It is not a pure scientific question; There is a range and complexity of belief regarding the embryo/fetus; Development is a progressive continuum; Not all women feel the same about being pregnant in complex social and medical circumstances; When does responsibility for a life begin and end? Must we all answer this question the same way? These are comments that initiated that conversation. What we ultimately hoped the medical students would embrace is the idea that this cacophony of views regarding abortion reflected the ethical and social complexity of the practice itself, that individuals expressing these different views across the entire spectrum were not irrational, insensitive, thoughtless, indifferent, unethical, or corrupt. Recognizing this becomes the basis for respectful tolerance toward those with whom we might disagree regarding the ethics of abortion.

Clinical practice: Mutual respect and ethical disagreement

That conclusion set the stage for our second small group session. That session focused on several clinical scenarios which were distributed among the small groups. Again, this is the directive given to the students for this small group session: "We are asking you to think about how you would counsel a patient of yours in the future considering abortion if you yourself were conscientiously opposed to abortion for ethical reasons in almost all circumstances. Note: If you take a more permissive position with respect to abortion, then we are asking you to consider what you would regard as a reasonable enough, responsible enough, and appropriate enough response by a medical colleague who took a very conservative position regarding abortion. The broad question has to do with your obligations *as a physician* counseling a patient whose views regarding abortion are opposite to your views. How do you counsel a patient with views very different from your own without violating your own views of right and wrong regarding abortion in specific circumstances AND without wanting to impose your views on your patient?" Here are some of the clinical scenarios we used.

1. A 27-year-old woman who has been your patient for 5 years comes to you asking for a script for a medical abortion. She is 5 weeks pregnant. How would you respond if you were opposed to abortion in almost all circumstances? Would it matter if the pregnancy were a result of a casual sexual encounter? Would it matter if she wanted to hide this pregnancy from her husband? Would it matter if the pregnancy were a result of contraceptive failure, and this couple could not afford a fourth child? Will you write the script for that medical abortion? Will you refer her to a colleague whom you know will write that script? Would you seek to dissuade her from seeking an abortion? What would that sound like?
2. A 36-year-old woman has been your patient for 10 years. She is 16 weeks pregnant. She has been informed that the fetus is trisomy 13. Trisomy 13, also called Patau syndrome, is a chromosomal condition associated with severe intellectual disability and physical abnormalities in many parts of the body. Individuals with trisomy 13 often have heart defects, brain or spinal cord abnormalities, very small or poorly developed eyes (microphthalmia), extra fingers or toes, an opening in the lip (a cleft lip) with or without an opening in the roof of the mouth (a cleft palate), and weak muscle tone (hypotonia). Due to the presence of several life-threatening medical problems, many infants with trisomy 13 die within their first days of life[12]. She is seeking your advice with respect to how to respond to this situation. How would you respond if you were opposed to abortion in almost all circumstances? Would you seek to dissuade her from obtaining an abortion? What would that sound like? Would you refer her to a colleague who would provide her with the abortion services she might desire?

3. A couple have been your patients for 5 years. They sought genetic testing because of family history concerns. They learned they were both carriers for cystic fibrosis. They want to have a child of their own, but they do not want to risk having a child with cystic fibrosis. With the improved treatments available today, people with cystic fibrosis, on average, live into their mid to late 30s. They come to you to discuss options. Are you going to explain to them the option of preimplantation genetic diagnosis and IVF, given your opposition to abortion and your concerns regarding the creation of excess embryos with IVF? Are you ethically obligated to at least provide them with information regarding the option of preimplantation genetic diagnosis [PGD]? Would you provide a referral to a physician who could provide PGD?

My guess is that a significant number of our medical students take a more permissive view regarding abortion in a broad range of circumstances. The grid exercise we used for the first small group would seem to confirm that. We were asking them to see these clinical situations from the perspective of one of their colleagues who took a much more restrictive view. I remind the reader that the guiding maxim for this exercise was "no easy answers." It was easy (we discovered) for many of these students to say, "I would just refer to one of my colleagues who was more comfortable with addressing their requests." However, we did not give in. Preceptors pointed out that for many of these physicians, this would look like they were cooperating with evil. This is not something with which they would be ethically comfortable. Further, these were patients with whom they had a significant established relationship. Would they have the right to try to persuade these patients to give the matter some additional thought? What were the words they would use to present their own concerns as physicians with these more restrictive views? Some students said that professionalism required them to be as objective as possible, i.e., just explain to these patients in a medically objective way the risks and benefits of the relevant options. Again, that sounds like a simple way out, in the abstract. Hence, students had to be pressed to articulate what that conversation might sound like. In Case 3 above, the fundamental question is whether a physician *as a physician* could withhold even mentioning the option of PGD. The knowledge and skills possessed by physicians are a product of substantial public investment. What should that imply regarding how that knowledge and those skills are used? Withholding that knowledge and those skills in other clinical circumstances for racist or homophobic reasons would be clearly unethical. What should that imply regarding clinical conversations about abortion with patients?

We did provide the preceptors with a second possible case for discussion, which the medical students did not have in advance. "If a physician is caring for a patient who is 8 weeks pregnant but has now been diagnosed with an aggressive cancer, and if that patient has a strong Right-to-Life view but the physician has a more permissive view, how much effort may that physician put into seeking to persuade that woman to sacrifice the pregnancy in order to begin aggressive cancer treatment that might otherwise have deleterious effects on that fetus?" This flips the scenarios above because it is the patient who now has a more restrictive view regarding abortion. The physician has a more permissive view. The patient does not want to die from her cancer; she wants treatment. But she does not want to give up the pregnancy. That treatment would pose significant risks to the fetus. Those risks might not necessarily include fetal death, but they might include significant lifelong disabilities for that future possible child. The physician in this case wants to respect patient autonomy, wants to maximize the likelihood of saving the life of the mother, and wants to avoid having the mother make a choice that would result in possible lifelong harm to that future possible child. These are all ethically worthy goals. Should that physician make a very strong effort to persuade the mother that she should either sacrifice the fetus or pursue aggressive cancer treatment but not seek to continue the pregnancy and seek cancer treatment? Again, what would it sound like for that physician to objectively present the risks and benefits of the possible options, with no effort to suggest an ethically preferred option? Would a physician justifiably feel that her ethical and professional integrity had been inappropriately compromised if she simply did this very objective presentation of risks and benefits, fearful for the well-being of that future possible child? A tragic outcome is inevitable in this latter case. What then is the appropriate ethical response by the physician? Keep in mind that the patient in this case might already have a name for her baby (not her fetus), as in the *New York Times* article above.

Integrity-preserving compromise as a modus vivendi

Martin Benjamin has introduced into the ethical and bioethical literature the notion of integrity-preserving compromise.[13] Benjamin takes seriously that there are circumstances, more common than we might be willing to acknowledge when we are faced with rationally irreconcilable moral conflict. What we are often enough faced with in clinical circumstances is factual uncertainty, ethical complexity, a plurality of ethically respectable values that cannot all be reconciled with one another, and disagreement with other persons with whom we will need to continue to have a cooperative or therapeutic relationship. These are other persons who we respect, who we recognize as being ethically thoughtful and sincere. We have a need to protect our own ethical integrity, but we recognize that they too have a need to protect their own ethical integrity. These are the circumstances that warrant integrity-preserving compromise.

There are no formulas for achieving integrity-preserving compromise because the circumstances that elicit this need are typically quite unique. Sensitivity, a willingness to be a careful listener, mutual respect, and profound empathy for the ethical struggles of the other are all necessary. As I write, I am mindful that our current cultural environment is largely lacking in these virtues. Still, for the last 15 min of our session, we listened in a large group to some of the responses regarding the clinical scenarios in a small group. We (faculty organizers) made no effort to "conclude" the session with some simplistic ethical directives. There are no easy answers for crafting these integrity-preserving compromises.[14]

Notes

1. Anderson A. Kant, *Hume, and the Interruption of Dogmatic Slumber*. New York: Oxford University Press; 2020. Readers trained in the history of philosophy will quickly recognize Kant's awakening from his dogmatic slumbers because of his reading of Hume. "Hitherto it has been assumed that all our knowledge must conform to objects. But all attempts to extend our knowledge of objects by establishing something in regard to them a priori, by means of concepts, have, on this assumption, ended in failure. We must therefore make trial whether we may not have more success in the tasks of metaphysics, if we suppose that objects must conform to our knowledge." Kant I. *Critique of Pure Reason.* 2nd ed., preface; 1787.
2. Paltrow LM, Harris LH, Marshall MF. Beyond abortion: The consequences of overturning Roe. *American Journal of Bioethics* 2022;22(8):3–15. Rubin R, Abassi J, Suran M. How caring for patients could change in a *Post-Roe v. Wade US. JAMA* 2022;**327**(21):2060–2. Cohen IG, Daar J, Adashi EY. What overturning Roe v. Wade might mean for assisted reproductive technologies in the US. *JAMA* 2022;**328**(1):15–16. Harris L. Navigating loss of abortion services—A large academic medical center prepares for the overturn of *Roe v. Wade. New England Journal of Medicine* 2022;**386**(22):2061–4. Adashi EY, Cohen IG. EMTALA after *Dobbs*: Emergency reproductive health care in the balance. *Annals of Internal Medicine* 2023; 176(2):268–69. doi:10.7326/M22-3222. Bermas BL, Blanco I, Blazer AD, Clowse ME, Edens C, Ramsey-Goldman R, et al. Overturning *Roe v. Wade*: Toppling the practice of rheumatology. *Arthritis and Rheumatology* 2022;**74**(12):1865–7. Palaniappan A, Blitzer D, Bacha EA, Anderson BR. Overturning *Roe v. Wade:* Increased prevalence and economic impacts of congenital cardiac defects. *Journal of the American College of Cardiology* 2023;**81**(7):703–4. This list represents just a small sampling of the likely effects of the *Dobbs* decision on many areas of medicine. Abortion is not limited to obstetrics and gynecology in its potential effects.
3. Boodman E. In a doctor's suspicion after a miscarriage, a glimpse of expanding medical mistrust. *Stat News* 2022 June 29. In a doctor's suspicion, a glimpse of budding medical mistrust over abortion (statnews.com). See also Cha EA. Physicians face confusion and fear in post-Roe world. *Washington Post* 2022 June 28. New abortion bans leave physicians in gray area in post-Roe world – *The Washington Post.*
4. Bazelon E. Risking everything to offer abortions across state lines. *New York Times Magazine* 2022 Oct. 4. The doctors risking everything to offer abortions across state lines – *The New York Times* (nytimes.com).

5. Howard Brody, MD, PhD, a former director of our Center and well-known grandfather in bioethics, deserves credit for introducing this motto. It clearly has the virtue of inducing intellectual humility, which is much needed in the debates regarding abortion.
6. See https://urldefense.com/v3/__https:/s2.washingtonpost.com/36d4b80/6280dd99956121755a7c190a/596adb0f9bbc0f403f865c5a/12/72/6280dd99956121755a7c190a__;!!HXCxUKc!xBC9DTKdvkDhhM_3fF3LwppBwwsqnfiextuMLviNSWPsB_hCr1Vj7-YVy8yB4tB4CedyYK9yT2YHSx4dew$.
7. Hartig H. Wide partisan gaps in abortion attitudes, but opinions in both parties are complicated. *PEW Research Center* 2022 May 6, available at https://www.pewresearch.org/fact-tank/2022/05/06/wide-partisan-gaps-in-abortion-attitudes-but-opinions-in-both-parties-are-complicated/?utm_campaign=wp_week_in_ideas&utm_medium=email&utm_source=newsletter&wpisrc=nl_ideas.
8. Greasley K, Kaczor C. *Abortion Rights: For and Against*. New York: Cambridge University Press; 2018.
9. See note 8, Greasley 2018. Kristin Luker made a similar point several decades ago in her book *Abortion and the Politics of Motherhood* (University of California Press, 1984). She observed how various views regarding abortion are tied up with complex social and political views and practices that are integral to the identity of individuals. To change their views would require, not just a change in intellectual beliefs, but a change in one's social identity, i.e., giving up one's evangelical identity to become an atheist or vice versa.
10. Dworkin R. *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*. New York: Vintage books; 1994:10.
11. Dias E. When does life begin? *New York Times* 2022 Dec. 31. When does life begin? The question comes into focus Post-Roe – *The New York Times* (nytimes.com).
12. National Library of Medicine. Trisomy-13. 2022. Trisomy 13: MedlinePlus genetics.
13. Benjamin M. *Splitting the Difference: Compromise and Integrity in Ethics and Politics*. Lawrence, KA: University of Kansas Press; 1990.
14. This session was exclusively designed to address the professional challenges physicians faced in caring for patients with whom they disagreed regarding the matter of abortion. The larger challenges will be generated by state policy regarding abortion and its potential effects on the professional integrity of physicians and other health professionals. That challenge cannot be met by individuals as individuals. That requires a coordinated response from representatives of the medical profession as a whole. In this regard, see Serchen J, Erickson S, Hilden D, for the Health and Policy Committee of the American College of Physicians. Reproductive health policy in the United States: An American College of Physicians brief. *Annals of Internal Medicine* 2023. doi:10.7326/M22-3316.

Cite this article: Fleck L. M (2023). Teaching Bioethics Today: Waking from Dogmatic Curricular Slumbers. *Cambridge Quarterly of Healthcare Ethics*: 1–8, doi:10.1017/S0963180123000178