A Patient's a Person, No Matter How Small: Maternal-Fetal Medicine's Call for a Postliberal 'Cardinal Virtues Bioethics'

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The remarkable promise of maternal-fetal medicine, offering prenatal diagnosis, fetal surgery, and in utero therapeutic strategies, is hindered by the inability of modern bioethical approaches to recognize the personhood and patienthood of the unborn child. This leads to not only semantic contradictions but also philosophical conflict with the foundational human good of life. This thesis provides grounds for a rejection of Beauchamp and Childress' principlism and the autonomy-dominated bioethical framework which, if not expressly authorized by *Principles of Biomedical Ethics*, has naturally descended from it. At the root of this model's shortcomings is not that the wrong principles were specified, that too many principles were specified, or that too few principles were specified. Instead, the prevailing liberal headwinds of political philosophy are the true culprits, beating back the ship of bioethics sailing along the promising tide of effective fetal screenings, surgeries, and therapies that elevate the status of the in utero child. Live-and-let-live liberal bioethics is, regrettably, not letting the weakest and most vulnerable humans live.

Pro-life advocates who wish to defend the sanctity and dignity of all human life, from conception to natural death, need a new bioethics. Clinicians who seek the good of a mother and her unborn child while pioneering prenatal and neonatal therapeutic approaches, which revolutionize the prospects of infants with congenital defects, need a new bioethics. Patients across the lifespan and the physiological states need confidence that they are being treated in pursuit of life and health; they, too, need a new bioethics.

Cardinal virtues bioethics is that new bioethics. Developed from the natural law theory of Aquinas, Finnis, Eberl, and others, it provides a new set of mid-level principles—justice, prudence, fortitude, and temperance. In accord with recent bioethical texts—from Gomez-Lobo, Keown, Curlin, and Tollefsen—it articulates the goods which ought to be particularly pursued in the practice of healthcare and its relational associations. In parallel with Deneen's postliberal political theory, it goes beyond criticisms of liberalism to image a new polis and a new virtue ethics model normatively centered on the common good.

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Preface

This thesis represents the culmination of years of dialogue, reading, writing, and revision. While it is impossible to thank all those who have made an impact on this work, there are several individuals without whom this thesis simply would not exist. I am deeply grateful for the support of my Thesis Advisor, Dr. Michael Deem. In his Philosophy of Medicine course, I was a sophomore attempting to intellectually catch as much knowledge as I could from my seminar peers. Since then, I have spent afternoons in Dr. Deem's office attempting to physically catch as many books as he could throw at me to broaden my horizons, challenge my opinions, and improve my writing. I am a better scholar because of it. Thanks also to Jeanne Elkin, Theresa Hagan Thomas, and Christopher Tollefsen for serving on my thesis defense committee and offering their time, expertise, and support throughout the final stages of this work to ensure philosophical soundness and clinical relevance.

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1.0 Introduction

"Prudence is knowledge of what we should seek and avoid, temperance is the curb on the lust for fleeting pleasures, fortitude is strength of mind in bearing with passing trials, justice is the love of God and our neighbor which pervades the other virtues, that is to say, is the common principle of the entire order between one man and another."[1]

Eight centuries ago, St. Thomas Aquinas turned to these words of St. Augustine, his predecessor by nearly a millennium, to elucidate the nature of the cardinal virtues and their role in the cultivation of the good life. In 2024, this thesis turns to the words of St. Thomas Aquinas, as considered and applied by scholars of the classical and new natural law traditions, to chart a new course for bioethics. This new course—a postliberal 'cardinal virtues bioethics'—is particularly responsive to the marvels of fetal surgical and therapeutic approaches which have transformed prenatal healthcare capabilities. However, it seeks to account for tough cases across the lifespan and endure amid the steady march of biomedical and technological advancements. How can natural law and virtue ethics foundations apply to the twenty-first century context? They appeal to the unchanging nature of the human person, the orientation of human reason, and the search for the common good. How can an approach grounded in ancient wisdom be considered a *new* course? Everything old is new again; amid modern sociopolitical sensibilities, Aristotle, Augustine, and Aquinas are downright countercultural. How can a cardinal virtues bioethics succeed in a

[1] Aquinas, *ST* II-II, Q[58], A[8].

landscape where strong challenges to the dominant principlist framework from all sides, including virtue ethics and communitarianism, have failed to gain traction? By coupling natural law tradition with burgeoning postliberal political theory, this approach does not attempt to squeeze common-good commitments into the autonomy-exalting hegemony of liberalism. On the contrary, it observes liberalism's collapse under the weight of its own autonomy-laden commitments and builds a bridge to a future in which states, communities, and professions are no longer value-neutral but instead exercise discernment—distinguishing between good and evil, right and wrong, moral and immoral, healthful and unhealthful—to promote human dignity and enhance social solidarity. As a review of maternal-fetal medicine, its modern technological developments, and its attendant internal contradictions exemplifies, an alternative to principlism is urgently needed. This cardinal virtues bioethics offers a compelling alternative, with special focus on elevating the dignity and the good of physicians, patients, and polis.

1.1 The History of Maternal-Fetal Medicine and Fetal Intervention

Maternal-fetal medicine, a subspeciality of obstetrics and gynecology (OB/GYN), cares for expectant mothers and their unborn children, with particular concern for the management and treatment of complex pregnancies. With bioethical questions ranging from typical concerns about clinical trial patient enrollment to unique considerations of who exactly the patient is (or the patients are) in this context, the field offers a rich clinical and bioethical landscape from which to engage in a broad analysis of Tom Beauchamp and James Childress' prevailing principlist framework. Even the first sentence of this subsection raises a lexical question with much deeper ramifications—is the biological entity in the mother's womb to be called an *embryo*, a *fetus*, an

unborn child, a *potential person*, a *person with potential*, or something else entirely? It is difficult to discuss physicians' obligations to this biological entity without first having some conception of *who* or *what* that entity is. The personhood of an *unborn child* sounds natural, while the personhood of an *embryo* gives many pause. Does the *person* in the womb have *potential*, or is the *personhood* of the entity in the womb itself just *potential*? Subsequent sections will return to these debates, but it is important to first introduce the landscape of maternal-fetal medicine, how it developed, and where it is headed.

The modern age of fetal study began in the nineteenth century, with fetal guinea pig models used by Nathan Zuntz and William Preyer to assess fetal movements, developmental physiology, and embryology. By the 1920s, operations on these nonhuman fetuses began in earnest, assessing the importance of the uterine location for proper development, the effects of ischemia on the developing fetal animal, and—critically—the ability for healthy, normal delivery following in utero surgical intervention (Jancelewicz & Harrison, 2009). In parallel, geneticists were developing methods of detecting disease prior to its clinical manifestations. Philip Levine's 1939 case report connecting Rh factor to erythroblastosis fetalis (EBF) quickly led to antenatal blood tests to determine the risk of EBF in a given pregnancy. In the 1950s, the adoption of amniocentesis marked the first "invasive medical test…used to assess disease in the fetus" (Lantos & Lauderdale, 2015, p. 98). Later joined by chorionic villus sampling (CVS), these methods allow for early detection of genetic disorders and other pregnancy complications, informing both parents and healthcare providers of the anticipated needs of the child upon birth. By the 1970s, maternal-fetal medicine gained recognition as a distinct field and developed the associated institutional markers such as professional societies and research conferences (Menard, 2013). At the heart of the specialty, thus construed, was a commitment "not simply to keep the pregnant woman as healthy

as possible but also to assess the health and well-being of the fetus in order to make more informed choices about the optimum timing and mode of delivery" (Lantos & Lauderdale, 2015, p. 101). However, just as in adult cases where diagnosis is followed by therapeutic intervention or treatment, maternal-fetal medicine is not merely a watching-and-waiting field. The development of invasive procedures marked a turning point in the teleology of prenatal care.

As the field of maternal-fetal medicine took shape throughout the twentieth century, prenatal diagnosis and *in utero* therapeutic intervention were transformed from the content of science fiction to the center of clinical orthodoxy. Sir William Liley attempted in utero transfusion for a case of severe hydrops fatalis in 1961, ushering in the current age of fetal intervention for human patients. In 1972, glucocorticoid therapy was employed prenatally to promote lung maturation and surfactant production, seeking to decrease respiratory distress syndrome mortality following premature birth (Jancelewicz & Harrison, 2009). Improved surgical technologies and control of anesthesia not only promoted better outcomes in the traditional fields of pediatric surgery and adult surgical specialties but also made possible the correction of fetal pathologies prior to birth. In the 1980s, Dr. Michael Harrison's fetal treatment center at the University of California, San Francisco (UCSF) became the global leader in fetal interventionism. From experimentation in the late 1970s to the first open fetal surgery in 1981 targeting a case of fetal hydronephrosis, Harrison—the father of fetal surgery, still affiliated with UCSF's growing Fetal Treatment Center—demonstrated the possibility of technical success in fetal operations, produced evidence to support such operations' safety for mothers, and started important conversations about the need for more precise surgical technology and more nuanced patient selection criteria. Liley and Harrison both participated in the first meeting of the International Fetal Medicine and Surgery Society (IFMSS) in 1982, where practitioners agreed on "peer-reviewed publication before media

exposure, attempting intervention only for lethal diseases in which the pathophysiology and natural history were understood, and strict adherence to ethical guidelines" (Jancelewicz & Harrison, 2009, p. 233). In the earliest months of human fetal surgery, its leaders realized not only the power and promise of the field but also the need for ethical norm-setting and self-governance.

1.2 The Promise of Fetal Intervention

Since the initiation of fetal surgery at UCSF to the present day, three key trends have governed the development of the field: "(1) the move from anatomic repairs to physiologic manipulation…(2) the move from open surgery by hysterotomy to less invasive fetoscopic techniques…and (3) the move from clinical descriptions and retrospective analysis to proper randomized controlled trials" (Jancelewicz & Harrison, 2009, p. 234). Improved genetic and genomic analysis has paved the way for more detailed and accurate assessment of congenital conditions, while modern imaging technologies aid in early and accurate diagnosis of in utero pathophysiology. Fetal repair of myelomeningocele, a severe form of spina bifida in which incomplete neural tube closure permits amniotic fluid access to developing nervous system elements, is among the most well-studied and widely implemented prenatal surgical procedures. The Management of Myelomeningocele Study (MOMS) Trial was a large-scale randomized controlled trial initially published in 2011 which has since led to spin-off projects attempting to further characterize outcomes and risks to both open repair and fetoscopic repair interventions. Compared to postnatal surgical repair, fetal intervention resulted in a decreased need for placement of a cerebrospinal fluid shunt by postnatal age 12 months and in improved mental development, motor function, and independent ambulation scores by postnatal age 30 months. However, mothers

undergoing prenatal surgery in the MOMS Trial experienced higher risk of pregnancy complications such as pulmonary edema, preterm delivery, and spontaneous labor (Sharma & Tsibizova, 2022a). The MOMS Trial exemplifies the inter-institutional advancement of fetal surgery while characterizing the health outcomes and needs of both mother and baby.

While myelomeningocele fetal repair is one of the most common fetal surgical techniques, the field of fetal therapy is a growing and highly promising discipline. Most mothers are familiar with some forms of noninvasive management of fetal conditions, such as maternal folic acid supplementation to minimize risk of severe neural tube defects (Sharma & Tsibizova, 2022b). In addition to such preventative measures, however, there is increasing hope in minimally invasive therapeutic approaches. One such well-studied approach, dexamethasone administration, may be indicated in female cases of congenital adrenal hyperplasia. Notably, initiation of dexamethasone is most effective in promoting normal urogenital development when administered at or before the ninth week of pregnancy, highlighting the importance of early prenatal screening and intervention (Sharma & Tsibizova, 2022b). A 2022 case report in *The New England Journal of Medicine* reported a successful use of enzyme replacement therapy to treat infantile-onset Pompe disease, a lysosomal storage disease marked by significant organ damage beginning in utero. Enzyme replacement therapy, with administration of alglucosidase alfa injection through the umbilical vein, was conducted between weeks 24 and 34 of pregnancy. Following delivery, the treated child—who was treated with immune tolerance induction and continued enzyme replacement therapy—displayed normal motor activity and muscle tone, electrocardiogram results, and accumulated glycogen levels (Cohen et al., 2022).

Phase I clinical trials are beginning not only for in utero enzyme replacement strategies but also for in utero gene therapies. With accelerating CRISPR/Cas9 technology and gene therapy

vectors, the possibility of altering somatic gene expression to reduce clinical manifestations of inherited pathologies is very near. Sickle cell disease, for which adult gene therapies are beginning to gain Food and Drug Administration (FDA) approval, is "an excellent candidate for in utero fetal gene therapy, because the disease is monogenic, causes irreversible harm, and has life-limiting morbidity" (Shanahan et al., 2020, p. B9). Whether delivering a normal beta-globin gene or driving constitutive activation of fetal hemoglobin gamma-globin gene, clinicians have a selection of gene therapy targets when treating sickle cell disease. The underdeveloped fetal immune system provides optimal immunotolerance for transgene products and viral vectors. Stem cell abundance and high replication rates in the fetus suggest more effective gene therapy during this period than at neonatal or later timepoints. The smaller circulation in utero also "implies that a lesser volume of fetal gene therapy product would be required;" this is a critical consideration as concerns about off-target effects remain (Shanahan et al., 2020, B12). Addressing an inherited disease or congenital condition in utero also seeks to get ahead of burdensome clinical manifestations, developmental defects, or systemic syndromes secondary to the condition of interest. This can "not only improve the predicted life expectancy of…patients, but it would also eliminate chronic suffering for patients, including many children and adolescents" while presenting "limited risk of the potential procedure for the pregnant person" (Shanahan et al., 2020, B16-B17). However, the optimal treatment window for sickle cell disease and other fetal gene therapy targets appears to lie within the first trimester, further underscoring the need for wrap-around prenatal care from the earliest days of pregnancy to ensure timely counseling and initiation of relevant treatment.

1.3 The Contradictions of Fetal Intervention

Despite the immense promise of fetal surgery and therapy approaches, ethical hesitations abound. Some concerns—such as worries about the extension of somatic gene therapies to germline gene editing or 'designer babies' trends—are well-intentioned and warrant considerable scholarship, which is not the primary focus of this thesis. A separate class of concerns focuses on the ways in which these approaches contradict *a priori* commitments to an autonomy-driven bioethics. Fetal intervention not only offers potentially life-saving care but also treats the unborn child as a patient in union with, while still distinct from, the mother. However, this forces uncomfortable conversations in a society increasingly permissive of abortion, in vitro fertilization, and other practices which challenge the moral status of the unborn child.

The Society for Maternal and Fetal Medicine special statement by Shanahan et al. (2020) discussed in the previous section, while describing the high rewards and low risks of in utero fetal gene therapy for sickle cell disease, cannot bring itself to defend fetal therapy as an affirmative good. Clinical trial study designs must "respect the patient's decision to elect termination of the pregnancy rather than enroll in a research study" and "respect the patient's decision to terminate the pregnancy after their role as a voluntary participant" in the study (Shanahan et al., 2020, B15). Fetal therapy is just one more potential, autonomous action, apparently morally equivalent to all other potential courses of action, including but not limited to abortion. The fetus has enough patient-like characteristics that the Society can investigate therapeutic strategies and propose specific interventional windows, but it does not have enough patient-like characteristics that the Society finds termination of a pregnancy in violation of the Hippocratic command to do no harm. The Society's statement also takes issue with federal research regulations requiring paternal consent to enroll in fetal intervention research; it is "not compatible with the ethical principle of

respect for autonomy" for unspecified reasons and "does not acknowledge the breadth of joint parental decision-making" (Shanahan et al., 2020, B16). Respect for autonomy is critical, on the Society's account, but is not extended to the father; because he is not physically connected to his child in the most literal sense, it is inappropriate to fully recognize his claim to weigh in on potential intervention. This position is not intrinsic to rational bioethical consideration. It stems from external normative frameworks of family organization and relations.

Frank Chervenak and Laurence McCullough, both professors of obstetrics and gynecology, have spent decades attempting to appropriately thread prenatal care through the vanishingly small *a priori* needle of autonomy and abortion rights. They argue that the "concept of the fetus as a patient," while useful in assessing the risks and benefits of prenatal intervention, "should not be understood in terms of the independent moral status of the fetus," because philosophical and theological approaches differ in their responses to this proposed status (Chervenak & McCullough, 2002, p. 10). Instead, focus should be on "whether the fetus is reliably expected later to achieve the relatively unambiguous moral status of becoming a child" (p. 10). They provide no account of what constitutes this *becoming* process, when one knows such a process has begun, and when one knows such a process is complete. Chervenak and McCullough do not even consider the possibility of rationally assessing which philosophical or theological approach has the correct view on the moral status of the fetus; they throw up their hands and suggest there is nothing that can be said about the intrinsic worth of the fetus. Their methodology offers two pathways to patienthood for the unborn child; either viability or "the decision of the pregnant woman to continue a previable pregnancy to viability and thus to term" would grant personhood on their account (p. 11). In two adjacent hospital rooms, each having a woman in her twelfth week of pregnancy with high risk of fetal neural tube defects due to genetic factors or folic acid deficiency, nothing can be said about

the similarity of these two entities in utero until learning if each mother confers the status of patienthood on her unborn child. If both cases are developmentally identical, but only one mother confers patienthood status, the physician must engage in "directive counseling for fetal benefit" in that room but non-directive counseling in the room next door (Chervenak & McCullough, 1996, p. 115). For the physician, this is—at best—disorienting and inconsistent; for the unborn children, this is remarkably dangerous.

In case there was any doubt about the subjectiveness of their approach to fetal patienthood, Chervenak and McCullough (2002), addressing conditions for fetal intervention clinical trials, insist that the "decision to enroll in a clinical study of fetal surgery does not mean that the previable fetus irrevocably has the status of being a patient because before viability the pregnant woman can withdraw the status of being a patient from her fetus" despite previously conferring that status upon her unborn child (p. 11). It is difficult to imagine an analogous case in which a surrogate decision-maker could consent to an intervention for a patient, a clinical team could conduct that intervention, and then the clinical team could be forced to acknowledge the capacity for patienthood that existed when they conducted the intervention no longer exists based solely on the whim of the surrogate decision-maker. For researchers of maternal fetal medicine "to get the cleanest results about outcomes for fetuses and future children, one would not want any pregnancies in which fetal surgery occurred to result in elective abortions" but "it might be desirable to prevent, through abortion before viability, adverse outcomes for fetal surgery" (p. 11). Since accommodating these two trial participation criteria would eliminate large swaths of the population on both sides of the fetal patienthood issue, the authors recommend no abortion-related exclusion criteria for fetal surgery research participants. However, these discussions about clinical trial enrollment are indicative of the clinical treatment of unborn children more broadly,

accompanied by a throwing up of hands and insisting that all positions—those which intervene to treat disease in a fetus and those which terminate the life of the fetus—are equally permissible and valuable options.

Because patienthood and personhood have close statutory connections, there was once hope that a better scientific understanding of viability would solve these ethical dilemmas, providing clear evidence about cut-off points for functioning as both a patient and a person (Lenow, 1983). However, this quickly prompted concerns about state-compelled fetal surgery for the benefit of the fetal patient if such cut-off points and patienthood thresholds were made explicit. The jurisprudential framework of *Roe v. Wade* simply would not work, for if "the state has a compelling interest only after the point of viability, and thus cannot act until that point, then the state has missed the opportunity to do the greatest good for the fetus while causing the least amount of trauma to the fetus and the mother" (Newkirk, 1998, p. 498). Prioritizing autonomy over a unified conception of the good, cases of maternal-fetal conflict are held up as encroachment upon the inviolable mother rather than concerns to address within the context of a holistic maternal-fetal dyad. Echoing Chervenak and McCullough, others have argued that "medical professionals have beneficence-based obligations to fetuses not merely derivative of the concerns of their pregnant patients," but such obligations apply only "for pregnancies that are going to be continued" (Lyerly et al., 2008, p. 42). Lyerly et al. are concerned not only about attempts to extend physicians' fiduciary duties to the fetus but also about the resultant separation of the fetus from the pregnant mother, thereby "obscuring the physical and social relationship between pregnant woman and fetus, the ways that maternal and fetal physiologies and welfare are linked, and perhaps most problematically, the woman herself" (p. 1). This latter point would be a phenomenal concern, if only the authors appreciated a social and metaphysical relationship between the pregnant woman

and the fetus, such that the permissive approach to abortion irreparably obscures and severs this link. Instead, they reject a "rights-based nature of obligations toward early life" and express concerns about providing even dependent moral status for the fetus, worrying about the case in which one seeks to "categorize the fetus as a patient even as one counsels killing it for the sake, not of its own well-being…but for the continued well-being of another," the mother whose life is in danger but who nevertheless wishes to continue the pregnancy (p. 1). This case, a canonical instance for the application of a principle of double effect, is referenced to challenge not just the patienthood terminology employed but also the obligation-based connotations embedded therein.

It is indeed difficult to reconcile the complex factors in the case cited by Lyerly et al. while retaining all contemporary bioethical and sociopolitical commitments, but for a different reason than that provided by the authors. These contemporary commitments hold that danger to the life of the mother is not necessary to grant a wish to not continue the pregnancy. However, to be able to kill something—as Lyerly et al. characterize abortion—implies that the thing is currently living. So, the fetus which can be killed is a fetus which is alive. It is a living member of the human species. Attempts to avoid acknowledging this, especially through claims of 'patienthood without personhood,' are neither practical nor justifiable. An examination of legal frameworks from states with varied political climates—from Texas to Vermont—reveals that they nearly all include *person* or *individual* in their legal definitions of *patient*, which challenges the notion that fetal patienthood can be accepted without coming to a explicit conclusion about fetal personhood (Texas Occupations Code: Physician-Patient Communication, Tex. Occ. Code §159.001, 2017; Bill of Rights for Hospital Patients and Patient Access to Information, 18 V.S.A. § 1851, 2019). It also challenges the even more sweeping claim by McCullough and Chervenak (2018) that "there are no metaphysical requirements, such as being a person, for a human being to become a patient and

therefore for the fetus to become a patient" (p. 40). In the context of American state statutes, there is at least a strong presumption that the patient is a person, a presumption which McCullough and Chervenak do not overcome with normative appeals to the claimed lack of personhood of anencephalic infants.

For a physician to counsel the killing of his patient seems to be in violation of professional and fiduciary duties; for a physician to counsel the killing of a person that is not his patient seems to be conduct similar to accessory to murder. Here enters the attempted distinction between *personhood* and *patienthood*. In defining the dependent moral status of the *embryo*—note again the word choice—Chervenak and McCullough (2021) also foreclose the possibility of fetal personhood, which they tie to solely independent moral status. In doing so, they rely on the divisibility of the embryo in cases of twinning. However, Stephen Napier (2013) offers a helpful retort to such arguments: if entity E is divided, resulting in entities F and G, one can say that "for all we know, E = F or E = G" (p. 42). This acknowledgment, coupled with the interest in protecting human life, is sufficient for the argument "that prefission embryos may not be killed since they are identical to an individual human being" (p. 42). However, because of the "competing accounts of the moral status of prenatal living human beings" by religious traditions, the Chervenak-McCullough school of thought returns to its patienthood distinction as the appropriate clinical consideration (Kurjak et al., 2009, p. 343).

In *Roe v. Wade*, the Supreme Court gave credence to the anti-prenatal personhood determination camp in the American public sphere. As O. Carter Snead (2020) notes, Justice Blackmun's decision "prohibiting the state from extending the protections of personhood to the unborn and declaring the moral status of the fetus to be a question proper only to private reflection…implicitly decided the matter of prenatal personhood in the negative" (p. 138). This

jurisprudential framework "bears little relation to the reality of human procreation and pregnancy…with lives integrated and intertwined to a degree like no other human relationship" (p. 140). However, in a post-*Dobbs* environment, the question can and will become open for debate once again. Opponents of abortion, sensing that the development of fetal surgery and therapy as an independent field represents a monumental leap in reframing the object of prenatal care, worry about keeping the telos of such efforts on saving and facilitating life of both mother and child, not on creating or distorting life. The maternal-fetal medicine field, while doing good work, is not free from blame in this matter, as "it was not uncommon for the pregnant woman to be described as, variably, the 'uterine environment,' the 'recovery room,' [or] a 'natural incubator' for the fetus," thereby semantically obscuring the personhood of the mother (Lyerly et al., 2008, p. 2). Life-affirming bioethics seeks to walk the tightrope of supporting cutting-edge biomedical research that expands the fetal viability window while moving beyond viability as the marker or justification of life. Expanding the fetal viability window allows physicians to save more lives but does not change when life itself begins. A life-affirming bioethics must be prepared to make some societally unwelcome normative claims about the value of the human person, from conception to natural death, if it seeks coherence and logical completeness.

Issues of personhood and patienthood appear to turn on questions we cannot answer, but, more accurately, they are questions many do not want to admit that we *can* answer. As amici curiae for neither party in *Dobbs v. Jackson Women's Health Organization*, the 2022 landmark Supreme Court case which overturned *Roe v. Wade,* a group of seventy biologists presented evidence that the "fertilization view is widely recognized—in the literature and by biologists—as the leading biological view on when a human's life begins" (Brief for Biologists as Amici Curiae Supporting Neither Party, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 3). Ninety-

one percent of 4,993 biologist survey respondents agreed that "[t]he end product of mammalian fertilization is a fertilized egg ('zygote'), a new mammalian organism in the first stage of its species' life cycle with its species' genome" (p. 26). However, just sixty-eight percent of the same survey population answered an open-ended question regarding the time of the beginning of a human life aligned with the fertilization view, illustrating reticence to apply a widely-held scientific position to the sociopolitical powder keg of abortion. This biological position is not new; Jérôme Lejeune, the pioneer of prenatal diagnosis for Down syndrome, was vehemently opposed to elective or therapeutic abortion, especially on the basis of genetically inherited conditions such as that which his diagnostic test identified. He equated an abortion-permissive society to prior regimes of infanticide following observation of congenital abnormalities at birth (Karamanou et al., 2012). This biological position is also not limited to this cohort of a few thousand biologists captured in the *Dobbs* amicus brief's statistics. A recent Columbia University interview with Vincent Duron, MD, the institution's Co-Director of Fetal Therapy, describes "operating on two patients" (Columbia Surgery, n.d.). The Association of American Medical Colleges—an organization which insists on describing the 'maternal' entity in maternal-fetal medicine as the *birthing person*—still refers to the 'fetal' entity in such care as "[t]he tiniest patients" (Weiner, 2023). These articles affectionately describe favorable outcomes from in utero intervention and the now-preteens experiencing normal childhoods with all the folksy connotations of *patient*, but Chervenak and McCullough's approach insists that these children would not have been patients at all if their mothers had not reversibly conferred that status upon them.

Diana Begović (2021) breaks from Chervenak and McCullough, advocating for some limited conception of fetal patienthood "without having patient rights" (p. 313). She admits that, at least for practical purposes, the fetus appears a great deal like a patient. Furthermore, she relies

on the scholarship of Susan Mattingly to review a model which does not "deny the possibility of fetal patienthood" but instead suggests "a family-oriented model of illness and treatment which focuses on relationships, protection, dependence and care" (p. 306). However, to accept this in full voice would be to introduce a 'threat' of personhood. Thus, Begović desires an "*ethical* boundary between fetuses and born-alive, fully formed humans," but admits that "further work"—presumably both biomedically and ethically—is necessary to determine the appropriate boundary (p. 314). For her, this boundary would incorporate a view that personhood and patienthood cannot be reliably known categories but, instead, that they develop in response to social conditions, technological capabilities, and other influences from one's sociocultural milieu. We must avoid definitions, on Begović's account, out of fear that they might 'threaten' maternal autonomy. Once again, this handwashing of normative claims and retreat to relativism does not offer much assistance in clinical decision-making.

Yet, for these scholars' reticence to forward any normative claims which might protect the fetus, they are not hesitant to forward normative claims which might cause harm to the fetus. Coutelle and Rodeck (2002) admit that safe, effective, and accessible fetal somatic gene therapy would extend the timespan over which such therapy could be delivered, presenting it as a prenatal-*and*-postnatal approach to provide additional preventative care throughout early life. Furthermore, they suggest that "it would be preferable to abortion and certainly much less demanding and expensive" than the current practice of pre-implantation embryo selection during in vitro fertilization protocols (p. 671). However, assessing the risks of in utero gene delivery while maintaining full commitment to fetal dependent moral status, they provide a very disturbing picture of risk-benefit calculation (p. 672):

> *However, the main reason that fetal gene therapy, in contrast to adult gene therapy, is not yet at the stage of clinical trials [at the time of writing in 2002] has in our opinion, very little to do with all the perceived dangers of fetal gene therapy per se. This reason is the known inefficiency of almost all present gene therapy approaches, in contrast to a 100% effective preventive alternative, namely abortion!*

Abortion prevents disease in the same way that automobile theft prevents the owner from getting into a car accident. Such commitment to a culture of death, shrouded in concern for maternal autonomy exalted above all other considerations, may actually prevent advances that promote life. It is far more appropriate to say that abortion is the 0% effective alternative—if the goal is birth of a viable child. Of course, this is not the goal of such scholars. This view also seems to be the goal of only a subset of clinicians. Is it because the rest of clinicians have expert perspectives which render them especially sensitive to maternal autonomy? Is it because they have seen hard cases and are shaped by these experiences? It seems far more likely that institutional gatekeepers are ensuring the furtherance of the approach proposed by Coutelle and Rodeck at the expense of this life-affirming view. Blustein and Fleischman (1995) correctly note that "[p]hysicians have moral responsibility for actions, recommendations, and counseling offered to patients" and that "it would constitute an assault on physician integrity to require moral accountability and yet insist on value neutrality" (p. 22). Unlike many modern scholars, they commendably admit the role of moral conviction in the professional and clinical realms. However, because a woman might elect to terminate a pregnancy on the basis of a prenatal diagnosis, pro-life maternal-fetal medical specialists are ethically compromised to an unsuitable degree, in the eyes of Blustein and Fleischman. Even if they provide the result of a diagnostic test, in response

to which a mother may decide to abort her unborn child, providing this result might constitute "assisting in abortion" to such a degree that pro-life clinicians would be hesitant to disclose all prenatal screening findings in a balanced manner (p. 25). While this strains the imagination, no consideration is given to the fact that a pro-abortion maternal-fetal medical specialist—perhaps even one who believes it is not only morally justified but morally better or right to abort a child with a congenital disease rather than facilitate its burdensome living existence, holding opposite but equally deeply-held personal moral convictions when compared to those of the pro-life clinician—might be similarly compromised in her presentation of prenatal screening results to the pregnant mother. Instead, bathed in altruism and defending the integrity of every physician, these authors politely suggest that pro-life clinicians ought to get lost (p. 26):

> *…we are not persuaded that a physician with strong pro-life convictions can be a participant in the practice of maternal-fetal medicine without betraying her or his integrity. We respect the attempts of thoughtful pro-life maternal-fetal physicians to reconcile their deeply held moral or religious beliefs with their profession's standards of care, but it may be best for all concerned if individuals with strong objections to abortion avoided the practice of modern perinatal medicine.*

With advice like this, is it any wonder that appeals to the opinions of professional medical societies and specialty organizations often aid the cause of pro-abortion perspectives? This openly hostile environment is the clinical setting into which a cardinal virtues bioethics must enter. Its normative claims must be defensible, its decision-making processes must be rational, and its commitment to the dignity of all life must be unshakeable.

1.4 Neonatal Euthanasia, the Clinical Inverse of Maternal-Fetal Medicine

While physicians at UCSF, other American medical centers, and hospitals around the world have pioneered live-saving fetal interventions that forestall or prevent the unfolding of the natural history of disease for congenital conditions, Eduard Verhagen, MD, JD, PhD, has led the charge for the codification of neonatal euthanasia in the Netherlands. The Groningen Protocol—published in 2005 by Verhagen—sets forth a course of action for offering and conducting neonatal euthanasia, using a five-criteria approach (Verhagen, 2014, p. 297):

> *The protocol describes five major criteria that make euthanasia permissible: (1) diagnosis and prognosis must be certain; (2) hopeless and unbearable suffering must be present; (3) a confirming second opinion by an independent doctor must be obtained; (4) both parents must give informed consent; and (5) the procedure must be performed carefully, in accordance with medical standards.*

Its defenders argue that the extreme nature of the cases which satisfy all five criteria justifies a departure from both the general sense that it is wrong to kill and the particular intuition that it is wrong to kill newborns. The Groningen Protocol is, then, morally permissible in their view as long as all participating parties who can communicate—here excluding the neonate—judge neonatal euthanasia to be a good (Tedesco, 2017). No consideration is given to the view that neonatal euthanasia, or any sort of life-ending intervention, is not treatment at all but instead an act that goes against the ends of medicine—namely, life and health—such that it could not possibly be a good (Curlin & Tollefsen, 2021). Additionally, even if one relies on the protection of the quintet of procedural guidelines enumerated above, this purportedly ‘strong’ five-criteria wall

against abuse of the Groningen Protocol has already begun to crumble. How, exactly, suffering is measured to be unbearable in a neonatal patient who cannot verbally communicate the intensity of such experiences is not well-established. Furthermore, a shift "from the belief that parents have an inherent right to determine their children's medical care; to the understanding that, while parents may be helpful in determining the treatment of their offspring, their authority operates principally as a means of serving these children's welfare," has led some to suggest that parental informed consent ought not to hamstring the physician who believes it is in the child's best interest to receive neonatal euthanasia (Appel, 2009, p. 478).

Interestingly, neonatal euthanasia has declined in the Netherlands since the adoption of the Groningen Protocol, from twenty cases annually to just two cases in the five-year period following publication of the protocol. This sounds promising, but it may actually be due to a more sinister phenomenon. The expansion of the range of permissible clinical actions may be so drastic that physicians now classify euthanasia-like interventions—such as administration of paralytic medications and opioids—as merely palliative care (Verhagen, 2014). Verhagen's recommendation is not a halt to this process until rigorous investigation may be conducted in all cases where neonatal euthanasia is offered and consented to prior to administration. Instead, he prescribes some additional surveys for clinicians about end-of-life practices. He offers no reflection about what the more death-permissive regime allows or how it fundamentally alters the nature of the physician-patient relationship by expanding the scope of potential interventions. This view relies on the fundamental belief that death can, at least in certain cases, be a good to be desired and pursued in the clinical context. However, even Chervenak and McCullough think this protocol goes a bit too far; it is "clinically unnecessary, unscientific, and unethical" (Chervenak et al., 2009, p. 199). What they fail to recognize is just how closely their own equivocation on prenatal

personhood and patienthood is linked to the Groningen Protocol's dismissal of claims regarding the dignity of the human person.

The perinatal field is at a crossroads. At one end, surgical and therapeutic interventions are being developed which offer hope for unborn children with congenital diseases to live unburdened by the most severe clinical manifestations of these conditions. At the other end, abortion and neonatal euthanasia are accepted, if not openly lauded, as legitimate practices of medicine. Many of the cases reported through Groningen Protocol procedures involve spina bifida—the neural tube defect for which in utero surgical approaches have been remarkably well-studied and well-tolerated in the MOMS Trial (Verhagen, 2014). The bioethicists who opine on maternal-fetal medicine claim to stand above normative assessments but rely on a consensus that there is at least a possibility that abortion and neonatal euthanasia may be goods, or appropriate ends, of clinical medicine. One arm of the field is attempting to cure; another arm is attempting to kill. The central similarity between the two camps is a continued commitment to ethical analysis relying on the same principlist bioethical microscope. Perhaps its lens is broken. To understand how this situation came to be, one must step back several decades to examine the bioethical substructure of the modern literature.

2.0 The 'Georgetown Mantra': Must We Keep Chanting It?

As elucidated in the foregoing section, maternal-fetal medicine and fetal interventionism have twisted themselves into pretzel-like knots attempting to accommodate modern scientific capabilities while retaining commitments to the prevailing bioethical narrative. Perhaps counterintuitively, to respond more appropriately to the genesis and implementation of novel prenatal care strategies, one must first look backward to understand how this prevailing bioethical narrative rose to prominence. In 1979, Tom Beauchamp and James Childress published the first edition of *Principles of Biomedical Ethics*, setting forth a framework for bioethics which has come to define the field in the eyes of philosophers and practitioners alike.

Writing in the aftermath of World War II Nazi atrocities and the United States federal government's Belmont Report, Beauchamp and Childress attempt to provide a set of mid-level norms which can govern bioethical decision-making in modern, pluralistic societies. These principles—beneficence, non-maleficence, justice, and respect for autonomy—are designed to represent the "universal norms of the common morality [which] comprise a small set of all actual and possible norms" but which can be integrated within any previously-adopted moral theory or community-specific commitments to morality (Beauchamp & Childress, 2001, p. 3). Beauchamp and Childress' principlism—referred to as the 'Georgetown mantra' by some of its critics—is "not grounded in a more foundational account of human nature, the human good, virtue, rational agency, a social contract, or some other bottom-level normative concept" (Shea, 2020, p. 443). The lack of this grounding will be the focal point of the following sections.

The work of Beauchamp and Childress is foundational to American bioethics of the last half-century. Speaking of *Principles of Biomedical Ethics*, David DeGrazia (2003) insists that one

"would be hard-pressed to find a text that has been more influential and more frequently cited" (p. 219). Indeed, Beauchamp and Childress' admirers have gone so far as to propose the Nobel Peace Prize as a suitable compensation for their work (Gillon, 2003). Despite this veneration, however, legions of detractors have lined up to take their shot at Beauchamp and Childress' form of principlism.

Among these critics are Bernard Gert and K. Danner Clouser (1990), attacking the "ritual incantation [of the Georgetown mantra] in the face of biomedical dilemmas," who dismiss the usefulness of principlism as a method of doing bioethics, regardless of the principles which may be added to, removed from, or replaced in the existing framework (p. 219). In particular, Gert and Clouser take issue with the structure of *Principles of Biomedical Ethics* and its chapter-by-chapter presentation of disjointed commentary on an ethical topic, such as justice, as a "firmly established and justified" principle handily synthesized for clinical application (p. 222). Instead, they suggest that one who turns to Beauchamp and Childress for ethical guidance "has looked at and weighed many diverse moral considerations, which are superficially interrelated and herded under a chapter heading named for the 'principle' in question" (p. 223). Their response approaches many of the right notes, especially in their charge that "principlism lacks systematic unity…[s]ince there is no moral theory that ties the 'principles' together, there is no unified guide to action which generates clear, coherent, comprehensive, and specific rules for action nor any justification of those rules" (p. 227). They express concern about the tendency for one following Beauchamp and Childress to tend toward relativism in both the application of the principles to a given case and the justification of the final decision in that case. However, Gert and Clouser offer no particular path forward; that will be the eventual aim of this thesis through a virtue-based approach. Principles might be justifiably derived from these virtues, so it is not clear that Gert and Clouser's criticisms ought to

foreclose all forms of principlism. For now, it is enough to say that, without a commitment to coherent moral theory, Beauchamp and Childress have identified the *wrong*—or at least not the *exclusive*—set of bioethical principles.

The following sections evaluate each of the four principles forwarded in *Principles of Biomedical Ethics*, but they intentionally do so out of the order in which they are presented by Beauchamp and Childress. The first three principles discussed here truly all depend on—and have been dangerously subjugated to—the final consideration of autonomy, which might now be more appropriately considered 'exaltation of autonomy' than 'respect for autonomy.' None of these principles is intrinsically objectionable but, without being tethered to a coherent moral framework, the principles introduce more questions than they resolve and are left vulnerable to the dominant force of sociopolitical liberal commitments.

2.1 Non-maleficence

This high-level tour of Beauchamp and Childress' principlism begins with non-maleficence. Non-maleficence instructs that "[o]ne ought not to inflict evil or harm" (Beauchamp & Childress, 2001, p. 115). At first glance, this appears entirely unproblematic; it coheres with the well-known Hippocratic Oath instruction to 'do no harm.' However, without an underlying moral framework to which all principlists are committed, it is not easy to identify what constitutes *evil* or *harm*. Beauchamp and Childress admit as much, claiming that "[t]hough *harm* is a contested concept, everyone agrees that significant bodily harms and other setbacks to significant interests are paradigm instances of harm" (p. 117). In the realm of bodily harms, these include killing, causation of pain or suffering, and incapacitation. However, in this attempt to define harm by

example, more questions arise. What interests are *significant* other than bodily integrity or health? What would constitute a *setback* to such interests? Is the person whose interests are impacted the only one who could characterize what sets back those interests? If so, this appears to be impermissibly subjective for the clinical context. Other examples provided by Beauchamp and Childress include causing offense and depriving others of the goods of life. Again, the familiar questions arise in the face of this unsatisfactory approach. What constitutes *offense*? Can only the person who experiences the *offense* determine its offensiveness? In a culture of microaggressions and heightened interpersonal sensitivity, this would appear to hamstring the physician to a remarkable extent. A consideration of the *goods* of life seems not just plausible but necessary. Without appealing to a fundamental definition of the nature of the human person and of the good life, it is difficult to put any more concrete guidance behind a general mandate to observe non-maleficence.

Beauchamp and Childress (2001) carefully "construe harm exclusively in the…nonnormative sense of thwarting, defeating, or setting back some party's interests" (p. 116). Even if healthcare providers and a given patient were to agree that a specific intervention did not thwart, defeat, or set back that patient's specified interests—health and pain minimization, perhaps—it is not clear that the standard of non-maleficence has been met. Who are the parties whose interests must be considered? It might be only the patient. This seems possible but somewhat limiting. It might include immediate family members. This seems plausible, but the patient's interests might be weighted more heavily than those of others drawn into the fold of considered parties. It might include an employer, who is financing either paid parental (maternity or paternity) leave or abortion travel and procurement. This seems far too broad and vulnerable to perverse economic incentives. However, without a clear understanding of role-based duties, it is

hard to provide a nonnormative justification for any specific scope of parties whose interests ought to be taken into account.

Return to the case of neonatal euthanasia under the Groningen Protocol. Both parents, their physician, and a clinician consulting for a second opinion all agree on a course of action that involves neonatal euthanasia based on a determination of hopeless and unbearable suffering. Does the administration of neonatal euthanasia adhere to the principle of non-maleficence? Despite being accepted by bioethicists and practitioners citing the Georgetown mantra, it is not self-evident that it does. Beauchamp and Childress (2001) focus largely on cases of withholding treatment, withdrawing treatment, declining extraordinary treatment, and administration of sustenance technologies. However, in their treatment of life-ending conditions, they consider a rule of double effect formulation in which, "[i]f the physician directly kills the patient to end the patient's pain and suffering, he or she intentionally causes the patient's death as a means to end pain and suffering" (p. 129). This seems to be the case in neonatal euthanasia. Beauchamp and Childress ultimately reject this double effect analysis, citing—at least in part—its inability to address cases in which "the central matter in dispute is whether an effect such as death is bad or good for a person" (p. 132). This is a valid criticism of double effect reasoning when it is divorced from a more substantive underlying philosophical framework. However, Beauchamp and Childress also cannot resolve this matter in dispute within their principlist framework. They claim that "[s]uffering and loss of cognitive capacity can ravage and dehumanize patients so severely that death is in their best interests" such that "physicians…do not act wrongly in assisting competent patients to bring about their deaths" or in conducting physician-assisted suicide when appropriate decision-makers for an incompetent patient request it (p. 151). When is the ravaging and dehumanization *so severe* that it warrants euthanasia? Who gets to decide? Causing death is not

always an evil act, from the perspective of Beauchamp and Childress, because "to not help such persons in their dying will frustrate their plans and cause them a loss, thereby harming them" (p. 148). Note the weight given to such persons' autonomous plans. What if others contended that causing the death of an innocent person is always an evil act? Could Beauchamp and Childress productively counter this perspective from within their framework, or would they abandon their defense of euthanasia on the grounds of non-maleficence and instead take up shelter in the citadel of autonomy?

Farr Curlin and Christopher Tollefsen (2021) offer such a view in *The Way of Medicine*. They argue that, because the "end of medicine is health" and euthanasia protocols "involve actions that intend the death of the patient," it follows that these protocols are "distinctly contrary to the end and the vocational commitment of medicine, and for this reason alone, they have no place in the profession" (p. 173). Indeed, despite the principles of non-maleficence, "the seemingly absolute demands of human rights—against acts such as…killing the innocent—cannot be absolute after all within a framework like principlism" (Curlin & Tollefsen, 2021, p. 43). This ought to concern even liberal-minded contemporary scholars. For biomedical ethics, Curlin and Tollefsen's perspective need not even cover claims that *all* killings of innocent people are wrong but may merely argue that, as a profession, healthcare ought to be interested in defending life and health. For a physician, causing death is an impermissible act because it is not within the class of acts which fall under the umbrella of 'being a physician.' Beauchamp and Childress do not agree with Curlin and Tollefsen on this matter of first principles; the former use non-maleficence to sanction euthanasia protocols, albeit with several enumerated constraints and regulatory structures, while the latter use non-maleficence to reject euthanasia protocols. If they cannot agree on what constitutes *harm*, they cannot agree on what the non-maleficent physician must do. The principle

of non-maleficence serves as a conversation piece in bioethical discourse but does not facilitate unambiguous decision-making without appeals to prior ethical commitments.

2.2 Beneficence

Beneficence holds that "[o]ne ought to prevent evil or harm…remove evil or harm…[and] do or promote good" (Beauchamp & Childress, 2001, p. 115). It also covers all "*action* done to benefit others," which Beauchamp and Childress attempt to separate from a parallel virtue of benevolence cultivated within the actor (p. 166). In short, beneficence is summarized as "an obligation to help others further their important and legitimate interests" (p. 166). Once again, anodyne statements mask practical inapplicability. What interests are *important*? What interests are *legitimate*? Who gets to decide? Could there be beneficence obligations to the self, or are they limited to *others*? How broad might this scope of relevant *others* be? A reliance on autonomy might dictate that the important and legitimate interests are those which the patient declares to be important and legitimate. Encouraging physicians to delegate responsibility for these determinations to their patients seems to be an abdication of professional roles. One general rule of beneficence presented by Beauchamp and Childress is a command to "[p]revent harm from occurring to others" (p. 167). These definitions and rules of beneficence thus turn on the same contested nature of *harm* which posed problems for the application of the principle of non-maleficence above.

A second general rule of beneficence involves an instruction to "[p]rotect and defend the rights of others" (p. 167). In maternal-fetal medicine, who is, or are, the *other(s)* to whom physicians ought to be beneficent? This returns to debates about personhood and patienthood

which are not satisfactorily addressed in the contemporary literature. Suppose one believes in a right to life, from conception to natural death. Would Beauchamp and Childress recognize conduct in keeping with this belief as conduct exhibiting beneficence? This seems doubtful, given their praise for a structure of legal abortion resting on a right to privacy. This assertion of a right to privacy extends back to an exaltation of autonomy in the Beauchamp and Childress account, for "rights of privacy are valid claims against unauthorized access that have their basis in *the right to authorize or decline access*…[and] are justified by rights of autonomous choice that are correlative to the obligations expressed in the principle of respect for autonomy" (p. 296). The selection of the *other* to whom one is professing beneficence—the mother or her unborn child, or both—cannot be justified within the bounds of Beauchamp and Childress' principlism.

Interestingly, some scholars trace back the contested view of fetal status—whether "it is an entity that can be disposed of" or whether "it is a being that has interests or/and rights and therefore needs protection"—to the "separation of the fetus and the pregnant woman" by modern medical technologies which screen, test, and otherwise visualize and speak of the unborn child as separate from its mother (Frith, 2018, p. 21). Materialist discussion of *unborn bodies* and anti-relational claims of *maternal-fetal conflict* certainly feed this dispute. However, these same scholars—relying on dominant principlist narratives—pursue the wrong remedy. They worry that "allowing fetal interests is a 'foot in the door,' so to speak, to giving the fetus priority over the woman" (Frith, 2018, p. 23). In other words, the solution to the relationship-alienating notion of maternal-fetal conflict is not to pursue, based on role-based duties and dependency, a unified concept of the condition of pregnancy, its unique case of one life nurturing another, and its role in the formation of the family, the foundational societal unit. Instead, the purportedly beneficent solution is to decide the maternal-fetal conflict in favor of the maternal side while explicitly

declining to "seek to justify a particular position on the status of the fetus and, correspondingly, on what is and is not an appropriate treatment of the fetus" (Frith, 2018, p. 23). It seems dubious that a school of thought can both wish to not opine on the appropriateness of various interventions on a fetus and criticize fetal patienthood claims for curtailing mothers' ability to autonomously decide in favor of a particular intervention on a fetus, namely abortion. At least implicitly, Frith categorizes abortion as one appropriate treatment of the fetus.

In cases of fetal surgery, Angus Clarke (2018) has recognized the problem with the Chervenak and McCullough approach in terms of beneficence obligations. An "attempt to evade the debate about the moral status of the embryo by claiming that we can have obligations to be beneficent toward the fetus without any assumption that the fetus has rights" quickly meets a dead end without additional normative commitments (p. 123). Instead, to provide any answer regarding how to proceed in the clinic, Chervenak and McCullough treat fetal patienthood as "the gift of the mother" and "ascribe greater weight to the interests of the mother than the fetus" while only attending "seriously to the interests of the fetus if the mother has already demonstrated her commitment to the fetus/pregnancy" (p. 123). This leads to a rather confusing view regarding the telos of prenatal screening.

One argument suggests that, amid increasing fetal therapeutic approaches, "future prenatal screening will more often lead to findings relevant for improving pregnancy outcomes in the interest of mother and child," such that "screening can be regarded as primarily aimed at prevention as prenatal beneficence" (Dondorp & de Wert, 2018, p. 150). Not wishing to strengthen the moral position of the unborn child, however, these authors suggest that "talk about 'the fetus as a patient,' if meant as a normative statement rather than an observation of empirical fact, is problematic" (p. 150). Instead, the beneficence concern should be for the *future* children who, "*if* they come to be

born…will *then* have interests that should already count during pregnancy" (p. 150). A physician conducting prenatal screening is acting out of beneficence for the mother and for some entity which is not now a patient but might become a child, in which case he should then have been given treatment according to Beauchamp and Childress' principle of beneficence before he would also have been given a claim to Beauchamp and Childress' principle of autonomy. The semantic distinction of the *future* child is carrying a great deal of weight on this head-spinning account, which claims that "the interests of the future child are not at stake in termination decisions" because it is not a future child which is being terminated (p. 151). However, it is the termination—not the decision to terminate—which most directly prevents the entity in utero from remaining a future child. Replacing *future child* with *unborn child* in this argument, as a pro-life bioethicist might seek to do, challenges the assertion that there are no termination-decision-independent interests for the entity in utero.

Birth, in the telling of Dondorp and de Wert, would entail a process of a *future child* becoming a *real child*—which does not seem plausible given the continuity of the entity being born and the change in only the location of that entity. A glass of lemonade is not a future glass of lemonade when it is in the refrigerator to chill, only to morph into a real glass of lemonade when taken out for a sip. Anticipated growth and development also seems inadequate in defense of this distinction. When a farmer plants his fields, he says he is planting 'corn' or 'barley,' not 'future corn' or 'future barley.' The language here turns on the implicit assumption that a pregnant woman who intends to abort the baby in utero is not a mother; notably, *pregnant woman* is the term nearly exclusively used by advocates of this position. A *future* child indicates a *future* maternal relationship; the nature of procreation makes this implausible. Even using a fundamentally materialist framework, the *pregnant woman* is genetically and physically related to the baby in

utero. No alternative relational term seems to capture the situation as adequately as *mother*, but *mother* relies on the existence of a *child* of whom the woman is the mother. This child exists as much in the *present*, in utero, as he is expected to exist in the *future*, barring medical catastrophe or abortion. The *future child* distinction made in Dondorp and de Wert's account of prenatal beneficence is impossible to achieve on the grounds of Beauchamp and Childress' principlism alone.

For those scholars, such as Anna Smajdor (2011), who find the "spectacle of a woman undergoing open fetal surgery…undoubtedly disturbing," they think this way precisely because they treat the fetus as the only patient toward whom the intervention is oriented, even as principlists reject strong beneficence or patient rights obligations toward the fetus (p. 90). Operating from the same principlist framework which animates Chervenak and McCullough, Smajdor wonders if it is "ethically acceptable to impose the risks of surgery on someone who stands to derive no clinical benefit," either the mother or the twin of the fetus for whom the surgery is being performed (p. 90). Her concept of beneficence is limited to the potential clinical benefits; there is no non-normative justification for ignoring the potential relational benefits for mother-child or sibling interactions. Perhaps the consideration of only clinical factors appropriately constrains the sphere of influence of the medical field. However, this claim is undermined by other scholars operating in the same liberal principlist tradition. Julian Savulescu (2004) has stretched the concept of beneficence almost beyond recognition through an articulation of *procreative beneficence*. This approach holds that beneficence should extend to selection for factors such as sex and intelligence, such that "couples should select embryos or fetuses which are most likely to have the best life, based on available genetic information, including information about non-disease genes" (p. 413). Here, again, normative judgments must be made. How is the *best* life identified? Savulescu turns

to “the life with the most well-being,” but it is not clear this must be the identification standard or that there is a uniform understanding of *well-being* (p. 419). More difficult to answer is the question of how this *best* life is predicted to be most *likely*. Regardless, Savulescu reluctantly renders his concept of procreative beneficence subservient to procreative autonomy, such that “couples [who] wish to select a child who will have a lower chance of having the best life…should be free to make such a choice” (p. 425). For principlists, the focus of beneficence can be as narrow as the clinical benefit to the single living entity (which may or may not be either a patient or a person in utero) in whom the pathology is located or as broad as potential well-being throughout the future lifespan. Mid-level principles in the absence of foundational normative claims leave the clinician adrift.

2.3 Justice

For Beauchamp and Childress (2001), justice has both formal and material principles. The minimum formal principle instructs that “equals ought to be treated equally” (p. 227). Various material principles might instruct equality based on need, merit, or contribution or, alternatively, equality of share regardless of identity or external factors. Conflicts among these material principles “indicate the vital need for both specification and balancing of these principles,” which will be discussed in more detail in a subsequent section (p. 230). Suffice it to say that the term *justice* alone does not offer very much guidance to the clinician. To whom must the clinician do *justice*? To the patient alone? That would turn on a rich normative understanding of who the patient is or who the patients are, which, as previously discussed in terms of maternal-fetal medicine, is not an easily agreed-upon definition. To the taxpayers and insurance holders financing the

provision of healthcare? This seems liable to be influenced by perverse economic incentives. After surveying various theories of justice, Beauchamp and Childress focus on arguments for and against the concept of a right to healthcare and other questions of allocation and rationing, but their treatment of what it entails for a specific clinician to act justly in a specific case is incomplete.

In a hotly debated 2023 federal district court memorandum opinion and order, Judge Matthew Kacsmaryk of the Northern District of Texas forwarded one approach to analysis of justice claims which Beauchamp and Childress' modern defenders are unlikely to appreciate. In *Alliance for Hippocratic Medicine et al. v. U.S. Food and Drug Administration et al.*, Kacsmaryk stayed the Food and Drug Administration's (FDA) controversial approval of mifepristone, a pharmaceutical progesterone blocker used as an abortifacient. Kacsmaryk agreed with the plaintiffs' contention that the FDA action was "'likely to result in individual injustice' or cause 'irreparable injury'" on the basis of maternal side effects, complications, psychological trauma, and post-traumatic stress following induction of the abortion (p. 29). However, Kacsmaryk also went beyond the claims of the plaintiffs to note that "said 'individual justice' and 'irreparable injury' analysis also arguably applies to the unborn humans extinguished by mifepristone—especially in the post-*Dobbs* era" (p. 29-30). Kacsmaryk notes, as this thesis repeatedly has, the importance of the language employed in discussing the preborn entity at issue (p. 2):

> *Jurists often use the word "fetus" to inaccurately identify unborn humans in unscientific ways. The word "fetus" refers to a specific gestational stage of development, as opposed to the zygote, blastocyst, or embryo stages…Because other jurists use the terms "unborn human" or "unborn child" interchangeably, and because both terms are inclusive of the multiple gestational stages relevant to the FDA Approval, 2016 Changes, and 2021*

Changes, this Court uses "unborn human" or "unborn child" terminology throughout this Order, as appropriate.

Firmly in favor of prenatal personhood arguments, Kacsmaryk extends a requirement for justice to an entity for whom modern bioethical scholars deny personhood, patienthood, or both. On the opposite end of the spectrum, abortion advocates have identified a new euphemism for their cause célèbre—*reproductive justice*. Making its most high-profile debut among the *Dobbs* case's amicus curiae briefs, it claims that "abortion access is a key element of racial justice, and…the denial of abortion access is a form of racial subordination" (Brief for Reproductive Justice Scholars as Amici Curiae Supporting Respondents, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 1). This perspective "seeks to protect and further the ability and rights of women to have or not have children, and to parent their children with dignity" (p. 6). Within the realm of parenting children with dignity appears to fall killing children via abortion, illustrating just how easily justice is manipulated without a coherent grounding. How race-neutral abortion regulations are coupled to racial injustice is not the point of this section or this thesis. The ability of the advocates of this position to contend that legal abortion restrictions constitute "manifestations of obstetric violence"—an interesting turn of phrase in light of Judge Kacsmaryk's rather graphic review of the method in which mifepristone expels the unborn child—is of greater interest to this discussion of justice (Schott et al., 2024, p. 52).

The reproductive justice framework has three rights-based prongs: "the right *not* to have a child," "the right *to* have a child," and the right to parent a child with dignity" (Brief for Reproductive Justice Scholars as Amici Curiae Supporting Respondents, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 28). Note the order of these prongs, in which contraception and abortion are placed ahead of childbearing and childrearing. The reproductive

justice scholars' concept of impermissible coerced motherhood once again relies on an implausible contention that a pregnant woman is not the mother of a child she intends to abort. The living status of either a mother or her child does not change the relationship, genetically or metaphysically. Jean Finnegan Biden is President Joseph Biden's mother, even though the former is deceased and the latter is alive. Joseph Biden is Beau Biden's father, even though the former is alive and the latter is deceased. Mary Ball Washington is President George Washington's mother, even though both are deceased. The family trees remain intact. The very language of a *having* a child poses a problem here. Colloquial parlance renders *giving birth* and *having a child* equal (such that 'she gave birth to our daughter on Saturday' and 'she had our daughter on Saturday' function interchangeably). However, upon conception, parents *have* a child. A right not to have a child exists regardless of abortion regulations; except in tragic cases of rape, the exercise of the autonomous decision to have, or at least accept the possibility of having, a child is not impeded by such regulations. Justice, without consistent metaphysical moorings, is vulnerable to misrepresentation through the dominant lens of autonomy.

Justice, in the last two years alone, has been used to propose and justify both unborn humans' right to be protected against chemical abortifacients and pregnant mothers' right to use such chemical abortifacients and other methods of abortion. Both diametrically opposed camps could cite Beauchamp and Childress' exposition of justice with equal validity, though they interpret that principle through vastly different worldviews with incompatible *a priori* commitments. Even Rawls' comprehensive theory of justice, regardless of its other merits, is limited in its utility in prenatal cases, for the first principle of justice holds that "each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others" (Rawls, 1999, p. 53). Differing perspectives on personhood will

yield differing outcomes upon Rawlsian justice analysis, because they restrict or expand the realm of *others* against whose basic liberties an individual person's liberties are to be balanced. Mid-level principles are insufficient once again.

2.4 Respect for Autonomy

Having examined the inability of the first three principles forwarded by Beauchamp and Childress (2001) to guide bioethical analysis without the incorporation of foundational, normative claims from outside the principlist framework, this section turns to the most fertile and frequent point of criticism aimed at the *Principles of Biomedical Ethics*—the principle of respect for autonomy which so often leads decision-makers astray or, at minimum, encourages the clinician's hand-washing of moral judgments. As reviewed in the preceding sections, the indeterminate nature of the principles, coupled with sensitivity to avoid paternalism, often leads to excessive deference to claims of autonomy. Defenders of the principlist model find this critique "an especially annoying criticism," but their standard response illustrates once more the insufficiency of the principlist approach (Shapiro, 1999, p. 71):

> *Whether the focus on autonomy is overdone depends on the meanings of "autonomy" and their locations in a value hierarchy. To the extent that autonomy rests on opportunities to pursue one's preferences, deference to it in given areas may depend on the intensity with which these preferences are generally held.*

In defending principlism, in which respect for autonomy represents a quarter of the theory forwarded by Beauchamp and Childress, Shapiro admits that principlism has supplied no singular meaning of *autonomy*. It does not follow directly from principlism that the intensity with which autonomous preferences are held should determine the weight given to these preferences; it is when bioethics fails to weigh in on the goodness or badness of these preferences that their intensity becomes a necessary deciding factor. Still, it is not only Beauchamp and Childress' contemporary defenders who take on critics of the respect for autonomy principle. In editions of *Principles of Biomedical Ethics* after the first, the authors felt the need to "firmly deny" the criticism "that the principle of respect for autonomy overrides all other considerations" and affirmatively claim that they mean for this principle to not be overly individualistic, reason-focused, or legalistic (p. 57). Perhaps, in their original presentation of the principles, they are correct. There is no *prima facie* command that autonomy should necessarily run roughshod over other identified principles. However, functionally and historically, this is exactly what has occurred. It is not entirely their fault; "a liberal, constitutional political context places autonomy at the center of any decision-making process" (May, 2002, p. 13).

Framing the principle of respect for autonomy through both negative and positive obligations, and suggesting that respect for autonomy "can sometimes be overridden by competing moral considerations," Beauchamp and Childress (2001) admit that the "principle of respect for autonomy does not by itself determine what, on balance, a person ought to be free to know or do or what counts as a valid justification for constraining autonomy" (p. 65). If a physician wishes to understand how this principle ought to be applied in the case of a given patient, he does not get much assistance from Beauchamp and Childress.

All of the preceding debates about abortion as a paragon of reproductive justice or a violation of unborn humans' right to life ultimately return to a similar argument in both public discourse and bioethical literature—namely, that "an abortion autonomously decided by prospective parents in consultation with health care professionals can be ruled neither mandatory nor forbidden, but only permissible on the grounds of procreative freedom, a right/interest of individuals widely granted special moral weight" (Nuccetelli, 2017, p. 450). This is not merely the view of one author but, instead, represents "[t]heorists of different moral persuasions [who]…converge on acknowledging the special moral significance of this individual liberty" (p. 450). Indeed, Beauchamp and Childress (2001) themselves "defend a principle of respect for autonomy with a correlative *right* to choose" (p. 61). Interestingly, the pro-abortion movement of the last half-century has grasped onto this *right to choose* as a rallying cry, rooting the movement in a fundamental exaltation of autonomy. Abortion is an expression of "reproductive autonomy" (Yamin, 2023, p. 187). A request for an abortion is an autonomous request for "health care," just like a request for a vision screening or a mammogram (Brief for American College of Obstetricians and Gynecologists, American Medical Association, et al. as Amici Curiae Supporting Respondents, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 31).

Louise King, an assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School who provides abortions at Brigham and Women's Hospital, defines her practice through the lens of three of the four Georgetown mantra principles but fundamentally roots her clinical considerations in autonomy (Powell, 2022):

> *…I look primarily to autonomy and beneficence in the context of doing good for the patient. That might mean upholding that person's choice not to proceed with what is still a very dangerous proposition, namely carrying a*

pregnancy to term and delivering. If someone says to me, "I'm pregnant and do not wish to be pregnant," for a multitude of reasons, I support that decision, because the alternative of carrying to term is risky. I want to protect that person's bodily autonomy. From a reproductive justice standpoint, I want to support persons who have uteri in making decisions…

It is clear where King falls in the prenatal personhood and patienthood debates, but it is quite telling that she defines her role as a physician primarily on the basis of doing good as determined by the patient's autonomous conception of the good rather than by any prevailing standard of the good that her position within the vocational profession of medicine allows her to apply. Her commentary on the beginnings of life—an issue on which the majority of biologists express adherence to the fertilization view—is even more telling (Brief for Biologists as Amici Curiae Supporting Neither Party, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022). King herself does not belief that life begins at conception. However, she presents a remarkably disjointed approach to how the polis ought to deal with such a contested question (Powell, 2022):

I don't think that science can tell us definitively when life begins. Life is a broad term and includes a variety of living entities…Ultimately, "when life begins" isn't the right question because it's unanswerable. The question then must be: How do we as a society come up with a compromise that upholds the autonomous rights of the persons in front of us who may become pregnant, who may have excessive risks associated with a pregnancy, or who may simply not wish to be pregnant, that also observes whatever our society's agreed-upon understanding is of when a protected entity exists.

In a semantic attempt to acknowledge interests of both the mother and the fetus, King speaks strongly of the mother's autonomous rights but merely concedes that one ought to "observe whatever" society determines as prenatal protection standards. Autonomy clearly wins the day on this account, but the internal inconsistency is notable. King has a personal and professional belief on when life does *not* begin, but science is not a domain which can offer a definitive answer on the subject. On this latter point, she is at least partially right—if humans are both body and soul, then science can answer questions about the body, but questions of ensoulment might be better left to other fields, such as philosophy and theology. However, these disciplines are not welcome in the refined, rational public square of the present day. Society should not expect a clear answer on *when life begins*, according to King. Instead, it should turn its attention to *when a protected entity exists*, because that is a question for which there is apparently some already *agreed-upon understanding*. King's example of such an agreed-upon understanding is Massachusetts' Roe Act, which protects abortion for any reason until the beginning of the third trimester of pregnancy, at which point cases of lethal fetal anomalies or risk to the life of the mother may still be considered for abortion (Powell, 2022). This agreed-upon understanding relies on the unscientific notion that a switch flips between the last day of the second trimester and the first day of the third trimester which initiates the existence of a protected entity. Is this protected entity alive? If so, what features make it alive on the first day of the third trimester which were not present on the last day of the second trimester? If not, why is it a protected entity? What is a protected entity in the first place? It is not clear that any agreed-upon understanding, other than practical legislative compromise, has arrived at the standard set forth in the Roe Act. Law ought to follow bioethics, not the other way around.

Even if one looks to the law for agreed-upon understandings, an analysis of current legal frameworks surrounding other end-of-life cases does not suggest that society has a clearly defined understanding of who counts as a *protected entity*. In such cases, "you will find (if the reformers are to be believed) that your right to autonomy does not give you the right to be assisted in suicide unless you are ill *enough* or suffering *enough*, or depressed severely and incurably *enough*—in each case 'enough' in the view of somebody else, other people" (Finnis, 1998, p. 1131). It is unlikely that all clinicians agree on what constitutes *enough* in a given case, let alone what general standards ought to be used to judge what constitutes *enough* in all cases of a given disease or class of diseases. Determinations of *enough* are not grounded in autonomy; any claims to a principlist analysis would involve balancing beneficence and non-maleficence, and such a balance is highly subjective. There is something sensitive about 'traditional' end-of-life cases which seems to uniquely displace autonomy at the center of clinical decision-making, perhaps hinting at an inclination toward protection for the dignity of human life, if only modern bioethics facilitated the language to express this commitment without fear of being labeled a paternalist. Regardless, the mere existence of a statute, law, executive order, or judicial opinion does not suddenly make something *ethical*; King abdicates the medical profession's responsibility to proactively inform such governance with reflective, considered, and scientifically-sound biomedical ethics.

Turning back to the particular case of maternal-fetal medicine, Kurjak et al. (2009) suggest (p. 346):

> *The previable fetus…has no claim to the status of being a patient independently of the pregnant woman's autonomy. The pregnant woman is free to withhold, confer, or, having once conferred, withdraw the status of being a patient on or from her previable fetus according to her own values and beliefs.*

> *She is free to determine for herself whether she wishes to view her fetus(es) as having independent or dependent moral status, e.g., by adhering to the moral theology of her faith community. The previable fetus is therefore presented to the physician as a function of the pregnant woman's autonomy.*

This is not merely employing autonomy as one factor among many in bioethical decision-making. It is not merely balancing autonomy with other principles. It is not merely giving autonomy some greater weight than other principles. It is using autonomy alone to foreclose discussion of a potential right to life, to force a broken link between the *living entity-person-patient* connection which would otherwise demand that the maternal-fetal physician tend to the good of his maternal patient and to the good of his fetal patient, abiding by "the shared notion of well-being in medical ethics…[and] the understanding of the good of health that can be shared by all" (Haker, 2017, p. 86). On this account, the physician can have no commitment to the *previable fetus* without the approval of the *pregnant woman*.

Note once again the diction employed by Kurjak et al. We may be used to *fetus* by now, but the repetition of *pregnant woman* (or *pregnant person*, or *persons who have uteri*, as Louise King offers) avoids the word *mother* like a landmine (Powell, 2022). Using this relational title might then imply some relation between the *pregnant woman* and her *previable fetus* such that her individual autonomy is to be exercised in concert with some maternal duties. Even the popularization of the term *significant other* to connote a husband, wife, boyfriend, or girlfriend follows this trend. In marriage, two may become one, but this term ensures each is still an *other*. Feminist scholarship regarding personhood and relationality, especially in the mother-child interaction, might provide a more nuanced rhetorical lens through which to analyze maternal-fetal medicine (Morgan, 2020).

A proper accounting of human relationships is critical, for it is "hard to see how the right not to remain a biological parent [as reproductive justice scholars and others frame from right to an abortion] can be squared with the legal and ethical responsibilities that biological parents are thought to have to their vulnerable, dependent children" (Kaczor, 2018, p. 635). The rights which attend to a relational role tend to stem from the duties attached to that relational role. A teacher's ability to make students take an examination is derived from her duty to ensure students learn given concepts. A parent's right to homeschool a child or send him to private school is an extension of his duty to ensure that his child is educated most thoroughly. A parent's right to not remain a parent, by ending the life of his or her child, contradicts her duty to protect and secure the health and well-being of her child. Autonomy thus decouples rights from duties; these floating *rights* are easily extended to align with an individual's autonomous *preferences*.

Nevertheless, if "the idea of moral certainty and telling others what to do is arrogance and moral colonialism," then it follows that we ought to "change the medical model from one of paternalism to one of patient autonomy" (Klugman, 2018). However, the introduction of this model has dire consequences for those without full ability to exercise autonomous judgment, for, "in a culture that sees full moral standing as depending on something like autonomy, fellow members of the human family who are not autonomous in any meaningful sense don't appear to have the same moral standing" (Camosy, 2015, p. 938). Maternal autonomy is the cornerstone of arguments in defense of abortion; the unborn child, regardless of consensus on its moral status, cannot be said to have an equal claim to patient autonomy. Neonates have no more functional patient autonomy; the Groningen Protocol enters the NICU in response. Beauchamp and Childress (2001) also recognize that "obligations to respect autonomy do not extend to persons who cannot act in a sufficiently autonomous manner (and cannot be rendered autonomous) because they are

immature, incapacitated, ignorant, coerced, or exploited" (p. 66). This is unobjectionable, but—in an atmosphere which advances the consideration of autonomy above all others—places at risk those who cannot act in a sufficiently autonomous manner if their interests come into conflict with those of a more fully autonomous agent.

On a purely consequentialist account, current myopic autonomy-based considerations might actually hinder health. Some suggest that "offering prenatal diagnosis without free access to safe and legal abortion services…may be deemed unethical on the grounds of social and distributive justice, in additional to raising questions about the pregnant person's autonomy" (Brown & Koenig, 2021, p. 937). If a pregnant mother is unable to abort her unborn child upon learning of its particular genetic or anatomical condition, her autonomy is not sufficiently respected, the argument claims. Prenatal diagnosis—with the increased possibility for prenatal therapeutic intervention—might then need to be withheld in order to protect the mother's autonomy. Ignorance may be bliss, but it is not ethical in this context. Prenatal diagnosis might prompt a mother to consider the relatively weak position of her unborn child—especially if she learns of a specific diagnosis—and her own parental duties to protect and safeguard that child, especially against those who would harm him or her on the basis of an uncontrollable physical trait.

These are not merely tenuous slippery-slope arguments, for a "single-minded focus on exploring and expressing the inner depths of the atomized self does not, within its own normative framework, include robust categories of community and cooperation for the sake of others" (Snead, 2020, p. 91). Snead offers two important reflections here. Humans are social creatures, and the exaltation of antisocial autonomy itself represents a normative framework forwarded by those who cling to principlism precisely because of its purported lack of reliance on normative

claims. Moreover, the "failure of expressive individualism to respond to the reality of embodied human lives regarding their mutual dependence, integrated constitutive goods and histories, and shared *unchosen* obligations to one another" is underappreciated in the present literature (Snead, 2020, p. 94). While autonomy focuses on a right to choose, it neglects the rights, duties, and obligations which flow from unchosen but intensely natural human relationships. More will be said about the cause of this phenomenon and potential remedies in subsequent sections, but it is important to note that, while autonomy can *be* good when appropriately contextualized as Snead suggests, it is not a *good* itself. The proper exercise of autonomy is not simply doing whatever one wishes but, instead, acting autonomously within social arrangements to act in pursuit of goods, the identities of which are determined by an account of human nature.

2.5 Specification and Virtues in the Beauchamp and Childress Model

One would be remiss to describe the philosophy of Beauchamp and Childress without mentioning one of the many ways in which the Georgetown mantra has been massaged to provide a more workable framework with which to analyze cases—specification. Specified principlism, of which David DeGrazia (1992) is a particularly vocal advocate, suggests that "reflective equilibrium establishes the *framework* of principles and more specific rules, which is then applied to cases (although principles and rules are subject to further revision in the light of reflection on cases)" (p. 520). Moving from this concept of reflective equilibrium—whether wide or narrow—to specific case-based application, DeGrazia employs casuistry and discursive justification with one or more top-level principles to permit "the drawing and explication of relationships between norms of different levels, relationships usually irreducible to 'derivation' or 'entailment'" (p. 523).

At first glance, this approach seems promising; it recognizes that the four principles alone do not solve cases where principles coincide, conflict, or otherwise obscure clear unanimity in judgment. However, this approach relies on principlism—a framework of mid-level principles without underlying normative commitments—so heavily as a starting point that "[*t*]*he entire network of principles and their specifications becomes the theory*" (p. 528). There is no need to decide between rule-utilitarianism and rule-deontology, for example, because principlism is equally compatible with each of them. Focus on the case at hand rather than the murky *a priori* theoretical foundations, specification instructs, and treat the principles as mere starting points in ethical analysis. DeGrazia seeks "to maximize critical tools that do not depend on tradition," but, as far as the origins of the principles are demanded by some skeptics, points to whatever foundational theory "justifies the most general principles" (p. 531). This specified principlism resolves one of the major issues of Beauchamp and Childress' approach; it provides a workable pathway for clinicians to apply the four principles with facility in given cases. However, in so doing, it accepts these four principles at face value, practically foreclosing inquiry into their validity by calling for a foundation which accommodates these principles rather than for principles which stem from a solid foundation.

One foundational theoretical approach is virtue ethics, and consideration of the virtues is not absent from *Principles of Biomedical Ethics*. Beauchamp and Childress (2001) admit that, "[i]n professional life, the traits that deserve to be encouraged and admired often derive from role responsibilities" (p. 30). They approach the subject only tepidly, promoting *encouragement* and *admiration* of virtues but no stronger commands. Among the important, or focal, virtues for the healthcare professional are compassion, discernment, trustworthiness, integrity, and conscientiousness. Just like the four principles, none of these focal virtues is objectionable in

isolation, but they leave much to be desired for the clinician attempting to implement them at the bedside. Discernment includes "the ability to make judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like" (p. 34). What considerations are *extraneous*? What attachments are too *personal* to count? What are *the like*? The exaltation of autonomy has also limited the range of normative judgments that physicians are instructed to make. Conscientiousness is "a form of self-reflection on and judgment about whether one's acts are obligatory or prohibited, right or wrong, good or bad" (p. 38). It may be clear, at least legally, what acts are obligatory or prohibited. However, to assess rightness, wrongness, goodness, and badness, one needs the sort of bottom-level ethical commitments which Beauchamp and Childress intentionally do not provide. They also suggest virtue analogues for the principles they outline—such as benevolence, corresponding to beneficence—but how exactly these are to be implemented except as attentiveness to the related principle is, as is so often the case, not readily apparent.

In short, one could hardly find any of Beauchamp and Childress' principles objectionable in isolation. Promote patients' well-being or goods, avoid harming patients' well-being or goods, act justly, and respect patients' autonomy. Indeed, sometimes these principles can be applied, assessed, and balanced in a way that produces a cogent answer. Alexander Kon's (2007) analysis of the Groningen Protocol relying largely upon the theory and language of principlism offered by Beauchamp and Childress is an exemplary case. Notably, this case takes as the physician's primary duty the duty "to never harm his patient (unless such harm is necessary to ultimately benefit that patient)," elevating non-maleficence and beneficence above autonomy in a case where the patient cannot be said to possess autonomous decision-making capacities (p. 458). The ultimate conclusion is that one can never know if an intervention performed on a neonate is actually

euthanasia because there can be no conclusive understanding of the neonate's experience of suffering, so the Groningen Protocol and related attempts to mainstream neonatal euthanasia should be abandoned. The right outcome in this particular case is achieved, but similar logic would likely give way to autonomy-driven considerations in cases of adult euthanasia.

The principlist approach can also lead to absurd false equivalencies. When the ability to terminate a pregnancy via abortion is defined as the autonomous "decision to become pregnant"—a decision which, at least implicitly or probabilistically, had to have been made (or foreclosed, in extreme and tragic cases such as rape) prior to the procurement of an abortion—the *right to choose* is stretched to remarkable lengths (Brief for Over 500 Women Athletes et al. as Amici Curiae Supporting Respondents, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 21). Female athletes, including the players associations of American women's basketball and soccer teams, supported Jackson Women's Health Organization in the *Dobbs* case by contending that "the next generation of women athletes must be guaranteed bodily integrity and decisional autonomy in order to fully and equally participate in sports" (p. 2). Bringing life into the world—or extinguishing it—is just one autonomous decision on par with deciding whether to play basketball or soccer. If the intensity of the personal preference to play basketball is sufficiently high, a physician following Beauchamp and Childress' account of autonomy would be instructed to give deference to this autonomous decision. This system allows for no ranking of goods based on the telos of human life or the metaphysics of human nature.

When the composite of Beauchamp and Childress' four principles forms *the* foundation of bioethics—especially within a sociopolitical milieu supporting deification, rather than sanctification, of the self—questions arise that are simply unanswerable without a lower-level framework of ethical analysis. Who are *persons*? Who are *patients*? What goods are truly *good*?

To whom or to what is *justice* owed? Autonomy fills the vacuum created by these uncertainties. Even in Kon's example, much is still left to be desired. His repudiation of the Groningen Protocol is based on an inability to determine the subjective suffering of the infant in question, but it is not clear why this should be the measuring stick. If we were to construct a suffering-ometer that could ascertain and rate—or, even better, qualitatively describe—the subjective state of the infant, this seems to be enough to make the Groningen Protocol at least tenable on Kon's account. This reduces the decision about implementing euthanasia to a mere balancing calculation. It suggests we can say nothing more fundamental or enduring about the dignity of the life at issue. This should concern all bioethicists interested in defending the human person. How we have arrived at such a crossroads of irresoluteness should concern all members of the polis.

3.0 Liberalism, the Culprit: Why We Have Identified the Wrong Principles

Modern bioethics has developed around Beauchamp and Childress' four key principles—beneficence, non-maleficence, justice, and respect for autonomy—but leaves much to be desired. Beneficence and non-maleficence set an uninspiring 'floor' of care for the patient below which a practitioner must not go. Justice in reference to rights, without associated duties, is divorced from concepts of a just God or a just society, rendering subjective and vapid determinations. Autonomy has been carried to remarkable extremes, such that any expression of authority or moral clarity is denounced as paternalism in disguise. Academic bioethics, held out as a guiding light, is actually leading practitioners and patients astray. We can, and must, do better. First, however, we must identify and examine the underlying culprit—namely, liberalism. The political philosophy, which has promoted a "fundamental right to the dignity of autonomy" and "the state's fundamental duty to be neutral with regard to the many disparate visions of the good life," so encourages a live-and-let-live societal 'norm' that it forecloses meaningful conversation about the state's ability—and, by extension, the healthcare field or any other public enterprise's ability—to encourage duty-based action or promote normative human goods oriented toward human flourishing (Finnis, 1993, p. 562).

Pointing the finger at liberalism is far from novel; even the most ardent supporters of Beauchamp and Childress and the derivative bioethical analysis have been doing so, albeit with favorable connotations, for some time. In the famous Philosopher's Brief—filed by major philosophical names such as Rawls, Nagel, and Dworkin in response to the 1997 Supreme Court cases of *State of Washington v. Glucksberg* and *Vacco v. Quill*—the amici curiae argued in favor of a constitutional right to physician-assisted suicide. To restrict or prohibit physician-assisted

suicide would be an unconstitutional infringement on, essentially, the exercise of a right to autonomous decision-making (Weithman, 1999). Their central argument held that "liberal democratic governments cannot legitimately prevent citizens from acting on their most fundamental liberty-interests in the name of a conception of the good which those restricted could not reasonably be expected to endorse as free equals" (p. 550). At best, liberalism allows for commentary about—but not public action in pursuit of—goods. A physician-patient relationship can pursue health, through treatment, or death, through euthanasia. As long as the pursuit is considered a good by the patient, reflecting a 'liberty-interest,' the matter is closed for the liberal philosopher. For the amici curiae, Curlin and Tollefsen's (2021) approach in *The Way of Medicine*, holding up life and health as two human goods with specific relationships to medical practice, would be considered just one more of the infinitely many accounts of the good for which liberal public actors ought to express no favoritism. However, permitting euthanasia and, more broadly, death as a good to be sought through medicine is in direct contradiction to views which hold life as a good of medicine.

The natural outgrowth of this liberal approach is the current refrain chanted by pro-abortion activists: *my* body, *my* choice. This is a false bioethics, on the most practical account. The fact that this is *my* brain does not mean that I will be permitted to make *my* choice to receive a lobotomy; there remain some obvious limitations on choice. This is a false anthropology, for *I* am body *and* soul, on the basis of which a fuller accounting of human nature can be offered (Eberl, 2020). This is a false politics, for *I*—body and soul—exist in a societal context infused with duties and obligations in addition to rights. Most critically for this thesis, it is a false understanding of the maternal-fetal relationship, in which two bodies are intertwined on both physical and metaphysical levels. This section explores what features of modern liberalism contribute most heavily to these

false perspectives—and why this modern liberalism declines to classify anything as *false* in the first place.

3.1 Euphemisms, Thought Experiments, and Getting to the Point

In attempting to describe and ethically analyze complex cases—especially the unique conditions of conception and pregnancy—philosophers routinely talk around the issue with colorful imagery that is not readily reducible to clinical reality. The case provided by one signatory of the Philosopher's Brief, Judith Jarvis Thomson, regarding the famous violinist serves as the most well-known example, but thought experiments abound from all sides of the fetal personhood, abortion, and neonatal euthanasia debates—including, but not limited to, Boonin's case of the hedonist, Bernstein and Manata's allusion to spelunking, and Beckwith's case of the cardiac defect clones (Blackshaw, 2022). While allusion and metaphor have been philosophers' tools since time immemorial, it will be more helpful in the following sections to speak directly about the real, special, unique conditions of conception and pregnancy. Of course, this requires some unified understanding of the human person. Even Francis Beckwith (2006), who traffics in some of these thought experiments, identifies the central problem—namely, that Thomson and Boonin's metaphors depend on "a view of the person that isolates the individual from other persons except as those relationships arise from the individual's explicit choice," which is a "liberal and minimalist understanding of autonomy and choice" (p. 199). As thought experiments are lobbed back and forth, these more fundamental disagreements about the very nature of the human person, the ends of medicine, and the goods of life are masked; the two sides talk past each other in a language of allegory without ever addressing such tremendously critical questions head-on. For

the sake of clarity, the following sections will refrain from thought experiments and instead discuss *concepts* at the level of foundational theories and mid-level virtues. Clinical cases, thought experiments, or other testing grounds for this theory may be introduced at a later date; straightforward diction is most desirable for the first articulation of this approach.

3.2 Debating Life While Committed to A 'Live and Let Live' Society

Principles of Biomedical Ethics demonstrates a commitment to providing ostensibly workable bioethical guidelines in the midst of seemingly unworkable disagreements on bottom-level theory (Pelligrino & Thomasma, 1993, p. 187):

> *Beauchamp and Childress recognized the difficulties of attaining agreement on the most fundamental foundations of ethics: the nature of the good, the ultimate sources of morality, and the epistemological status of moral knowledge. To bypass these problems, they…opted for prima facie principles, that is, principles that should always be respected unless some strong countervailing reason exists that would justify overruling them*.

Notably, even this description of the Beauchamp and Childress approach has a limitation. What countervailing reasons are sufficiently *strong* to justify overruling the *prima facie* principles? Nevertheless, Beauchamp and Childress are correct about the *difficulty* of attaining agreement on bottom-level principles, but they are wrong to abandon this difficult task. Their focus on achieving a workable product—something that can, at least nominally, be applied unobjectionably in the clinic—"may neglect practice, the way in which the rules and principles can effectively be

interpreted and implemented" (van der Burg, 1997, p. 104). They abandon this difficult task precisely because of an *a priori* liberal command to avoid imposing any conception of the *good* or an *ought* on the autonomous authority of the individual. As a result, their theory is adrift, consisting of four "mid-level principles that are not grounded in a more foundational account of human nature, the human good, virtue, rational agency, a social contract, or some other bottom-level normative concept" (Shea, 2020, p. 443). This is not because Beauchamp and Childress cannot provide such a grounding but, instead, because they do not believe they have the authority to impose such a foundational account. Yet, if principlism is unwilling to admit a concept of the good or an account of human nature, it is a house built upon sand. It is clear that "[w]e must know *something* of the meanings of self and freedom (for autonomy), harm (for non-maleficence), goodness (for benevolence), and the common good (for justice)" and, without bioethics articulating such knowledge, a physician's "judgments will assume some controversial understanding of human nature and its good, whether he realizes it or not" (Beckwith, 2014, p. 474). Of course, principlists do *know* something of these concepts. They do not want to *express* or *dictate adherence to* knowledge of these concepts. What could prevent one from wishing to promulgate his concept of the good, precisely for the public good? Liberalism. What promotes the modern default understanding of human nature as autonomous will and of its good as autonomous decision-making freedom? Liberalism.

To criticize the liberal underpinnings of modern bioethics, it is important to develop an understanding of the core tenets of liberal theory. Citing Robert Talisse, Donald Beggs (2009) introduces five elements of liberalism which summarize its commitment to the individual (p. 222-223):

(1) The individual is the fundamental ontological unit of political theory;

(2) the moral good of each individual is prior to the goods of groups;

(3) the moral autonomy of individuals should be the source of their conceptions of the good;

(4) the state may violate an individual's (negative) liberty only to prevent or redress unjustified harms to others;

(5) the state must be neutral with respect to its citizens' conceptions of the good.

Of course, the first challenge for liberalism is that individuals live in families, in communities, in societies, and in nation-states. Inasmuch as modern liberals are willing to admit such relational existences, they cite the intangible and distant 'global community' (Yamin, 2023). However, this concept requires even greater attention to be paid to *why* this sense of community is important; we are not sitting down to dinner, going to the grocery store, or electing political leaders immediately as members of this global community. One potential explanation is that members of the global community share a fundamental human nature wherein the dignity of human life is enough to grant one membership in this community and its associated protections. However, previous sections of this thesis have illustrated liberals' inability to admit or sanction life as an intrinsic good.

Deference to autonomy has made the entire project of bioethics feeble, and this deference to autonomy is the product of liberalism. If, "by holding autonomy as a foundational issue," bioethics "provides recommendations of *better* and *worse* choices but usually avoids telling others what is *right* and *wrong*," it is abdicating responsibility for the actual decision made (Klugman,

2018). Some ethical framework must stand in the gap, but all ethical frameworks are not the same. We must have some way of determining whether that decision made is *right*—or, at minimum, whether it should be *legal*—and whether the ethical framework used to reach that decision is *right*. If the field of bioethics as currently constituted cannot do that, it seems rather unhelpful in mediating ethical issues that arise having biological significance—the original role set out for the field.

For the maternal-fetal and pediatric clinical contexts, this is especially risky. To the extent that these clinical disciplines carve out their own subfields of biomedical ethics based on the limited developmental stage and decision-making capacity of the young patient, they run into the same liberalism-based issues but face the additional hurdle of implementing some necessary *paternalist* tendencies for patients still under the authority of *parents*. Decision-making in these contexts often centers on conversations of children's best interests—balancing benefits and drawbacks of given courses of action with respect to beneficence, since autonomy cannot be given free reign in a patient population not fully autonomous—but "there is no widely agreed-upon definition of this important concept" (Carnevale & Mangavidze, 2016, p. 4).

The academy's in-vogue responses to the post-*Dobbs* landscape from liberal bioethics and health law perspectives are typified by the University of Pittsburgh's Greer Donley. In perhaps a striking example of *liberal neutrality*, Donley and Jill Wieber Lens (2022) demand that we engage in a campaign of "[n]ormalizing all pregnancy outcomes" (p. 1723). A live birth, a Caesarian section, an ectopic pregnancy, a miscarriage, a mifepristone chemical abortion, and a surgical abortion are all *normal*. Perhaps a partial-birth abortion is as well. What is the goal of this puzzling move? It is simply to assert, from ideological commitments, that abortion is natural, for "[w]hen pregnancy loss is normalized, abortion is no longer 'an abrupt interruption before a natural goal is

reached' that 'subverts nature.' To the contrary, it is just one of the many ways pregnancies end before birth" (p. 1723). Philosophers concerned about biomedical technology's increasing dominion over nature might do well to note this legal approach's total rejection of nature. Intriguingly, Donley criticizes the reproductive justice movement for its hesitancy to embrace cases of "miscarriage and stillbirth" under its advocacy umbrella, "presumably due to fears related to personhood" (p. 1726). She admits that one need not be an expert to discriminate among these cases; these *fears* relate to everyday people awakening to the danger of an autonomy-centered pro-abortion movement which needs to hide the reality of elective abortion among the tall grass of difficult prenatal cases. There can be no objective commentary on the good or the natural when one's commitments to autonomy "are rooted in a hedonistic mentality unwilling to accept responsibility in matters of sexuality, and they imply a self-centered concept of freedom, which regards procreation as an obstacle to personal fulfilment" (John Paul II, 1995, para. 13). Donley and Lens do not suggest a retreat away from morality; they propose entering abortion into the sphere of moral and accepted behaviors. A house divided against itself cannot stand, and a society which—legally or culturally—attempts to exalt abortion will have an increasingly difficult time justifying other cases where life is protected by the state, as in the tight (but gradually loosening) regulations surrounding physician-assisted suicide (Weithman, 1999).

In a forthcoming article, Donley and Caroline Kelly (2024) trace the development of abortion legislation following *Dobbs*, finding that "[u]nlike antiabortion states, which made their definitions longer and more complicated to exclude more types of care, abortion supportive states moved in the opposite direction: definitions became broader and simpler" (p. 54). In other words, pro-life states have adjusted pre-*Roe* abortion statutes in keeping with modern medical realities and the sensitivity of the distinction between *elective* abortion and *medically necessary* abortion

or removal of an already-dead fetus, while pro-abortion states have gone all-in for unfettered access to terminate the life of an unborn child. Donley and Kelly's assessment of the situation is that such "broad definitions without any exclusions would be alarming in states that ban abortion, as they would almost certainly cover and prohibit other important types of reproductive healthcare," but are well-founded in the pro-abortion states in which they are currently codified (p. 55). A broad definition of *abortion* is good only when that which falls within the scope of the definition is sanctioned, not proscribed. The definition modulates to fit political purposes; stepping over the border from Minnesota to Iowa and back again should be accompanied by changes in the definition of *abortion*, as long as the variable definition adopted in each state permits the most pregnancy terminations possible given the political realities of that state. Donley and Kelly have no qualms about admitting this openly, calling for "broad protections and broad definitions" which embrace "blurry boundaries between miscarriage and abortion and between therapeutic and elective abortion" as "both accurate and destigmatizing" (p. 72-73). This depends not on a polis of rational agents but on a society of intellectual dullards who will fall for this conflation of terminology. Live-and-let-live liberalism has paved the way for a live-and-celebrate-death-via-abortion society. 'Safe, legal, and rare' is now 'good, laudatory, and normal,' such that, within a few decades, the façade of liberal neutrality has crumbled in our midst.

Speaking of end-of-life issues, Bruce Jennings (2000) offers a useful commentary for cases across the bioethical spectrum involving the false hope of liberal neutrality. The dominant liberal framework categorizes end-of-life debates as an intractable struggle between the autonomous patient, or her delegated decision-maker, and the protectively paternalistic healthcare sector. The liberal ought not to impose any conception of the good on the patient but instead ought to promote that patient's ability to pursue his conception of the good free from coercion by caregivers, family

members, or public influence. An alternative framework would propose and publicly promote a strategy of end-of-life care that is "humane, respectful, and dignified" (p. 126). Liberal neutrality is not neutrality between these two frameworks but, instead, neutrality among individuals' conceptions of the good within the first framework, as "liberal neutrality is itself a normative ethic" (p. 100). Commentaries about end-of-life care do not revolve around some "private conception of the good from which we need liberal neutrality to protect us" but instead represent "a tenet of public reason and moral sense" (p. 126). Jennings takes the work of Ronald Dworkin as an exemplary case of liberal neutrality. Dworkin's view of liberal neutrality forecloses consideration of public goods beyond a shared good of unfettered, autonomous decision-making. For, if the sanctity of human life is a good but the polis cannot agree on a definition of life, the solution is to refrain from entering any definition of life into the public square. Such a definition would impermissibly infringe on the autonomy of others in their ability to equally valid and permissible definitions of life. No definition is *right*. No definition gets the stamp of approval from sociopolitical authority. The lowest common denominator is pursued through an approach of liberal neutrality and, in so doing, this approach represents no neutrality at all.

In reality, however, every perspective, definition, or act must fundamentally be either permitted or proscribed. The result of false liberal neutrality comes courtesy of a sitting United States Senator: "If you don't support abortion, don't get one" (Duckworth, 2024). Discussion of *public* goods is firmly off the table. This is not neutrality about whether abortion is right or wrong; it rejects the position that abortion has any reproachable moral valence and, by extension, supports the position that abortion is at least permissible. If abortion is permissible, it need not be right, but it must not be wrong. Liberal neutrality, if it exists at all, lies between a commitment that abortion is good and a commitment that abortion is morally neutral. It stands in opposition to any

commitments that abortion is bad—for the unborn child, for the pregnant mother, or for the society which sanctions it.

John Finnis (1994) lodges such a criticism against Stephen Macedo, who emphasizes respect for persons as a principle which should be overridden only in cases where public justification for such overriding can be provided using rational grounds that can be widely accepted. Macedo's recommended approach to abortion policy reveals the inconsistency of principlism as applied in the purportedly rational and non-discriminatory liberal context. Regulation of abortion should be governed by "'principled moderation,'" in which the pro-abortion and anti-abortion positions are evaluated and the stronger position dominates the implemented public policy (p. 703). However, the stronger position should "'give something'" to the weaker position for having advanced a strong, but not quite the strongest, case (p. 703). What purports to be a departure from liberalism reads very similarly to the arguments of the Philosopher's Brief. Finnis' counterargument to this approach is particularly valuable (p. 703-704):

> *...if the better case is that what the abortions in dispute deliberately seek to kill are living human persons, then, however "well reasoned" the contrary arguments may be, it will be a grave wrong to the unborn that the right to deliberately kill them is the "something" to be "given" away to show our "respect" for people who had denied the reality of the unborn's existence, nature, and rights. But if the better case were some contrary (what?), then the loss of "autonomy" or "liberty" given away to honor the pro-life reasoners would involve no deliberate assault on mothers but merely an extension of those restrictions on intentionally destructive individual action which are the very first duty of government and the very basis of the common good.*

The determination of which case is stronger, in order to select the dominant governing framework and identify the concessions which must be made, is a public-sphere decision, and "in this matter the responsibility of governments is to reach the *right* answer" (p. 704, emphasis added). Liberalism, and its false conception of liberal neutrality, would suggest that no one answer is *right* at all. In practice, however, an appeal to public justification and *principled moderation* is an abdication of governing responsibilities.

Because Macedo is still working within the palette of *liberal* justice, he ends up with a seemingly new portrait that is in fact just a rearrangement of the same problematic shades. Liberalism separates the person from the community and the polis; it suggests an adversarial relationship between the person and the state rather than a principle of subsidiarity. While liberal government appears to abandon its responsibility to identify the *good* and the *right*, it still must necessarily set some boundaries of conduct. Policy must be made, in favor of one perspective or another. In effect, the individual is separated from this discernment of *goods* and *rights* by a false sense that the liberal government is making considered judgments on behalf of all autonomous individuals in the polis. If every individual in the polis takes this perspective, then no individual in the polis is actively involved in these judgments. A live-and-let-live approach necessarily forms a society which tolerates abortion, euthanasia, and other abuses against human goods of life and health. Through this toleration, liberalism has picked a winner, whether its advocates wish to admit it or not.

3.3 Confronting Ethical Questions: Liberalism Can't Answer or Won't Answer?

None of the foregoing issues involves a matter of which questions liberalism can and cannot answer; they are instead matters of which questions liberalism will and will not answer explicitly. Liberalism shudders at the thought of providing an account of the goods of human existence, or even those intrinsic to medical practice, but "it cannot do without any conception of the good life" (Haker, 2017, p. 98). Its conception of the good life, as illustrated by Martha Nussbaum's "list of capabilities to which everybody should be entitled," is precisely leaving "it to every individual to determine the content [of her own good life] on her own" (Haker, 2017, p. 98).

In the previous section, it was suggested that, if the field of bioethics as currently constituted cannot provide an account of *right* and *wrong*—of *good* and *bad*—it seems rather unhelpful in mediating ethical issues. However, by deference to autonomy, liberalism asserts that "[a]n autonomous choice is a right choice," with its rightness coming as a product of its expressive authenticity (Curlin & Tollefsen, 2021, p. 67). Curlin and Tollefsen quote Justice Anthony Kennedy, in *Planned Parenthood v. Casey*, to illustrate this deference to autonomy within a liberal framework: "'At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life'" (p. 67). Even if one agreed that each has the liberty to *define* his own meaning, some standards must be implemented to proscribe certain conduct justified on the basis of such a self-defined concept. If one finds the meaning for his existence in certain antisocial expressions—such as in the carrying out of terroristic threats or acts—it is highly unlikely that Kennedy and those aligned with him would prevent government from encroaching on this sincerely-held and self-defined concept of existence.

Autonomy is not only the *right choice* but is also the *greatest good* in the prevailing liberal bioethical framework. Rather than adopting the view that "autonomy makes a person better off

only insofar as it is directed toward instances of…basic goods" such as life and health, liberal theory demands allegiance to autonomy as an intrinsic good, regardless of the ends to which it is oriented (Curlin & Tollefsen, 2021, p. 70). In critiquing the 'conservative bioethics' of the President George W. Bush era, Ruth Macklin (2006) goes further than denouncing bioethics which attempts to define goods. She is, at least nominally, opposed to bioethics conducted with goals in mind. These "new conservatives have an explicit 'mission,'" articulated in terms stressing body-and-soul hylomorphic human identity and awe-filled respect for the inherent dignity of human life (p. 37). According to Macklin, liberal bioethics in the age of principlism proceeded without any mission in mind; it pursued liberal neutrality even in the telos of the field. Just five pages later, however, Macklin asserts that, "[a]s a liberal, humanitarian bioethicist," her "chief concerns lie in striving for greater social justice within and among societies, and reducing disparities in health, wealth, and other resources among populations in the world" (p. 42). If this is not a *mission,* what is?

Among liberal bioethicists, there is also a remarkable attempt to dissociate the practice of medicine from the identity of the practitioner, as if one navigates between two states of being depending on whether a stethoscope hangs around his neck. Perhaps, it is conceded, an obstetrician can hold an ethical stance against acts such as abortion that stems from religious convictions (Kurjak et al., 2009). This is permissible, as long as that ethical commitment is not brought to bear on the practitioner's obstetric work. A pro-life OB/GYN acts solely as a professional in the clinic and solely as a private person outside of the clinic, on this interpretation. He might be allowed to withdraw from a case in which a woman requests an abortion in order to follow his conscientious objection to the practice; this is his own exercise of autonomous decision-making. However, when obstetricians "invoke the professional mantle [in public discourse], their contribution must be

governed in its moral content by secular obstetric ethics" (Kurjak et al., 2009, p. 347). They can only "join the political fray as interested lay persons or citizens, with no special or authoritative perspective as obstetricians on the abortion controversy" (p. 347). No equivalent concerns are raised about pro-abortion obstetricians who might weigh in *as obstetricians* in support of abortion rights (Brief for American College of Obstetricians and Gynecologists, American Medical Association, et al. as Amici Curiae Supporting Respondents, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022). Their personal opinions cohere with the dominant perspective of secular medical ethics and, thus, it is permissible for them to receive the backing of their secular medical institutional credibility. Liberal neutrality has a strangely non-neutral perspective on what public sphere justification is permissible in bioethical discourse.

Sections 4.1 and 4.2 will explore this phenomenon further through the lens of postliberal political philosophy.

3.4 One Response to Liberal Principlism: Care Ethics

Many dominant philosophical revolutions against Beauchamp and Childress, and against the consequences of liberalism more broadly, continue to coronate autonomy. However, care ethics, largely informed by feminist theory, offers a strong critique of liberal principlism's undue focus on the atomized individual. Susan Mattingly (1992) criticizes conceptions of maternal-fetal medicine which treat "the fetus as an independent patient" while "continuing to regard the pregnant woman as a compound patient incorporating the fetus," resulting in claims of "conflict between the duty to benefit the fetus and the duty to respect the woman's autonomy" (p. 17). As we have seen, liberal bioethics nearly unanimously resolves such conflicts in favor of the autonomy interest.

Mattingly, however, suggests joining "the professional-patient relationships to the two patients [mother and fetus] almost as closely as if they were a single compound commitment to one compound patient" (p. 18). Indeed, there is a compound entity interested in such a commitment—the family which comprises both mother and unborn child—which is a foundational civic unit often overlooked by liberal commitments. It is notable that this feminist framing integrates at least some sense of the physician's professional *duty*, a term largely absent from liberal discourse. Furthermore, Mattingly identifies the true driver of modern maternal-fetal 'conflict' narratives; it is not "any changes in the fetus or in the maternal-fetal relationship but…a change in physicians—in how they think about and relate to their patients in pregnancy" due to improved prenatal screening and intervention capabilities (p. 14).

However, many existing care ethics approaches seem compatible with prior autonomy-based structures while simply providing a moderating influence. They offer valid criticisms but fail to chart a new path forward. The influence of a feminist emphasis on *liberation* renders care ethics a dressed-up version of liberal bioethics, still focused on concepts such as reproductive autonomy. Discussing prenatal diagnosis, Carolyn McLeod (2002) points out that "[c]onventional wisdom has it that 'good mothers' do not risk giving birth to a child with a disability…but how good could they be as mothers if they could terminate pregnancy in the second trimester" (p. 143). Furthermore, she recognizes that a second-trimester abortion "is a heartless act for any mother, according to the dictates of a different segment of her community" (p. 141). From these comments alone, it is not clear whether McLeod recognizes the motherhood of the pregnant woman regardless of whether her unborn child is desired or scheduled for termination. If she does, it would mark an improvement over the semantics of strict principlists previously encountered in this thesis. However, the preceding quotes—focusing on how women *could be* as mothers or how a *segment*

of the community would consider her a mother—appear in a chapter entitled 'Improving Respect for Patient Autonomy,' tempering expectations for any improved anthropological account of pregnancy. McLeod criticizes both pro-life images of fetuses and pro-abortion disregard for maternal-child physical and emotional connection early in pregnancy for undermining women's "bodily integrity in pregnancy" (p. 156). McLeod's approach to care ethics demands, just like the liberal principlists, that no view of the anthropology of pregnancy should be imposed on women. Thus, clinicians must "be sensitive to the many ways that women might interpret pregnancies they lost or that they purposefully ended"—as if these two cases are entirely morally equivalent, as Donley's scholarship would advocate—and must not assume anything about how pregnant women view their pregnancies, for these "assumptions can promote distrust in women's own perceptions of miscarriages or abortions, and that can interfere with autonomous behavior" (p. 160). This is a step further down the false path of liberal neutrality than even principlism demands. We must not only refrain from assessing any normative judgment of actions or decisions but must also accept and protect all *perceptions* as equally valid and good. The perception of an unborn child as a pathological invader of the maternal body and the perception of the same unborn child as a growing, developing human person are to be equally permissible and sensitively accepted by healthcare providers.

On the most extreme end of this spectrum, however, care ethics improves on liberal bioethics in at least one major respect—it explicitly admits that we can, and ought to, define a conception of the good. Care ethics dispenses with concerns about personhood, for its "relational approach sees our obligations and rights emerging from our relationship, rather than our legal status" (Herring, 2019, p. 13). For a view like this to promote holistic maternal-fetal well-being, it must recognize the *maternal* relationship in the prenatal context.

However, care ethics thusly construed has been used to classify abortion as a good by limiting the obligations of the maternal relationship to cases in which the option of abortion has already been declined by the mother. This is effectively Chervenak and McCullough's argument in favor of limited fetal patienthood by maternal gift; it simply bypasses the terminology of *patienthood* and *personhood*, shrewdly refusing to get bogged down in these contested and murky waters. In a journal ostensibly dealing with *human rights*—but apparently not terribly committed to a right to life—Jonathan Herring (2019) distinguishes between "wanted pregnancies," which "are caring, and therefore of the highest moral value," and "unwanted pregnancies," which "lack moral value as these involve coerced care, which may well impede other wanted caring relationships" (p. 14). Herring rejects the choice-based pro-abortion claims of liberal bioethics but defines unwanted pregnancy as "bodily interference," returning a body-only metaphysics to the abortion debate (p. 24). On this account, pregnancy is a good if it is wanted *and* abortion is a good if it is wanted, in cases of unwanted pregnancies. It is difficult to distinguish this from the autonomy-oriented liberal bioethics which holds that the fundamental good is individuals' ability to pursue their autonomously defined goods. Whatever valid care ethics-based criticisms of liberal bioethics Herring introduces are undermined by the anticipated result of this approach to abortion.

In policy and clinical decision-making, this view of an ethics of care can be realized, at best, through a live-and-let-live, or abortion-permissive, polis that resembles the false liberal neutrality regime of existing principlism. At worst, however, it goes further than liberal principlist bioethics in lauding abortion as an affirmative good out of a misguided sense of what it means to *care*. Rather than condemning the absence of care shown by a mother who decides to end the life of her unborn child, this 'care ethics' approach suggests no valid relationship existed precisely

because of the absence of care. Despite care ethics' plausible criticisms of prevailing liberal philosophy, this is an unsatisfying solution.

4.0 The Only Way Out is Through: A Postliberal Approach to Principlism

This thesis' previous rehearsal of criticisms against Beauchamp and Childress' principlism is nothing especially new. Just as their principlism has been the mainstay of bioethical theory for the last half-century, it has also been the chief punching bag for proponents of alternative approaches from all directions. Postliberalism, however, will supply such criticism by targeting the underlying substructure of liberalism rather than the *prima facie* construction of Beauchamp and Childress' approach as four mid-level principles without any deeper, lower-level commitments. To the extent that any single, coherent underpinning exists for the Georgetown mantra, it is a commitment to liberalism. Postliberalism attacks this underpinning in a head-on fashion.

Beyond contributing to arguments *deconstructing* liberal principlism, this postliberal critique offers two unique and fundamental pillars for a more *constructive* criticism. First, postliberalism considers liberalism not as a cultural given or a societal milieu in which bioethics must function but instead as a *political* philosophy—subject to patterns of political change—which, for as long as it reigns illiberally supreme, destines tepid specifications, modifications, or addendums to Beauchamp and Childress' philosophy to the same inevitable fate of the parent principlist framework. Bioethics is inherently linked to health law and *policy*-making and, thus, can never rush too far ahead of current legal and clinical realities. Planting new seed on rocky ground produces the familiar disappointing yield. With that understanding, however, postliberalism's second new contribution is a broader vision of a new *polis* beyond liberalism, tilling the fields for the eventual fruits of a new bioethics. Rather than accepting the inevitability and perpetuity of postmodern liberalism—which "unlike classical liberalism, does not support any

thesis concerning human nature, because it does not even try to solve the problems connected with this notion"—postliberalism attempts to provide a thorough, public accounting of the nature of the human person, the goods of human societies, and the obligations of human relationships (Szahaj, 2005, p. 66).

4.1 Postliberalism as Liberalism's Critic

Modern postliberal thinkers—including Adrian Pabst, Adrian Vermuele, and Patrick Deneen—have generated a great deal of public attention, across the ideological spectrum, for their presentation of a political theory that is simultaneously new, in its movement beyond modern liberalism, and old, in its appeal to a traditional common-good governance that seeks to cultivate associational virtue and restore subsidiarity to the polis. In particular, Deneen's recent texts for popular audiences—*Why Liberalism Failed* (2018) and *Regime Change* (2023)—represent the most approachable introduction to postliberal philosophy and will be presented here as the exemplary exegesis of far more esoteric scholarship. Postliberalism coheres with many of the preceding critiques of liberalism outlined in this thesis but digs deeper to assess the self-cannibalism of modern liberal regimes.

The primary thesis of Deneen's (2023) work is that "[l]iberalism has generated its own undoing," as an inherently volatile, progress-oriented, self-centered theory (p. 3). Calls for *pluralism, choice,* and *diversity* are foundational to the adherents of modern liberalism but are also foundational to their undoing. For a society whose "primary allegiance is…celebration of liberal pluralism and diversity, shaping homogenized and identical adherents of difference," liberalism produces "pervasive indifferentism" (Deneen, 2018, p. 89). As a result, commitments to human

nature, family, local life, and relational responsibility are abdicated in favor of autonomy. Rejecting these central, community-based aspects of culture is essential to the promulgation of liberal authority, for "to recognize continuity with nature, the debts and obligations attending the flow of time and generations, or a strong identity with one's place was to limit one's experience and opportunity to become a self-making author" (p. 90). Self-determinism must be unfettered, especially by obligations to future generations—as is made apparent by liberal bioethical commitments regarding maternal-fetal medicine, abortion, and neonatal euthanasia. Liberal individualism forfeits stewardship of the natural world, the polis, and the family in favor of single-minded stewardship of the self. However, the autonomous self—separated from community and interpersonal association—is powerless in the face of liberal hegemony, "subject to the sovereign trajectory of the very forces today that are embraced as the tools of our liberation" (p. 15).

This volatile arc toward liberation is rooted in a perversion of liberty itself. Just like Beauchamp and Childress' principles, an account of liberty, appropriately conceived, is not inherently a bad project. However, once "thought to involve discipline and training in self-limitation of desires, and corresponding social and political arrangements that sought to inculcate corresponding virtues that fostered the arts of self-government," liberty now is synonymous with indulgence and a notion that nothing except the individual will should govern the self (p. 23). Today it is wholly anathema to speak of moderation, self-restraint, and deference to the divine or to the greater human good. Liberty from authority is slavery to the base passions of the self. This liberty of modern liberalism comprises "anthropological individualism and the voluntarist conception of choice" and "human separation from and opposition to nature" (Deneen, 2018, p. 30). Perhaps nowhere are these commitments more clearly and unapologetically advanced than in the 'pro-choice' movement which so distorts the natural maternal-fetal relationship that it

sanctions the termination—in physical terms—of this relationship, even though—in metaphysical terms—this relationship can never be terminated. This alienation of mother from child—and the general alienation in the biomedical literature of father from child, as well as any other family or community relationships at play in cases of prenatal care or abortion—is required for liberalism's citizenship of the self.

In the construction of liberal political regimes, "other affiliations had to recede in centrality and importance, replaced instead by an increasingly fungible identity of individual self. The trajectory from a perception of oneself as a subject of God, to one's identity as membership in a nation, and finally to one's essence as *self*" traces the decline of the self-governing polis and the inward retreat of societal commitments (Deneen, 2023, p. 223). As the vast majority of citizens pursue atomized interests, a new expert class arises and defines the only public-sphere *good* as the rooting out of universal goods from public life (p. 228):

> *What takes the place of a public order toward the good becomes the concerted effort to eliminate every last vestige of any claim to an objective good. Instead, the political order becomes devoted—with white-hot fervor—to the eradication of any law, custom, or tradition that has as its premise that there are objective conditions of good that require public support. Instead, the whole of the social, economic, political, and even metaphysical order must be re-founded on the basis that individual preference must always prevail.*

No society healthily persists on the basis of individual preferences alone, for these preferences will inevitably come into conflict with one another. The concept of maternal-fetal conflict presents cases in which two parties' interests conflict but, since only one party has the capacity to express her preferences, liberal bioethics and politics has shown remarkable deference

to those expressed preferences (Lenow, 1983). More broadly, human "flourishing [requires] more than individual choice in a world" in which there is "freedom to marry, but fewer people wed," "freedom to have children, but birth rates plummet," and other cases in which "[p]ublic goods widely available have been overwhelmed by private privations" (Deneen, 2023 p. 234). Freedom is not merely insufficient but dangerous to human flourishing if one has not learned how to be free—taming the base passions, pursuing the greatest human goods, and fulfilling the obligations which render one's relationships strong and one's polis healthy.

Postliberalism directly challenges the persistent march toward self-centeredness and its attendant emptiness which has accompanied the development of liberalism. It proposes a common-good approach with focus on the common formation of virtuous members of this polis, and this is to be achieved through ordinary, relational interactions and structures (Deneen, 2023, p. 113):

> *A healthy polity rests on foundations of widespread moral virtue developed through informal social institutions such as family, community, and church, as well as the formal legal establishment of a well-constructed government that erects "sufficient restraint upon their passions." The true "rights" of citizens are not reducible to individual rights but must foremost consist in the right to be well governed, a right that rests on an intergenerational capacity to develop virtues. The flourishing of individuals thus requires associational rights—rights not merely as liberties to do as one wishes, but rights to governance that restrains and directs damaging acts of freedom.*

Drawing from Edmund Burke, Deneen articulates a concern for the tyranny of the individual over the individual's true good. Liberalism exhibits so grave a concern for the tyranny

of the government over the individual that it has rejected, at least nominally, all associations which might exert some controlling and guiding force over the individual—family, religious traditions, the subsidiarity of local governance, and other proximal influences by which the individual may consider himself shaped and in which the individual may consider himself involved in shaping others. However, postliberalism recognizes that individuals' good is promoted most wholly not by deference to individuals' wills but by the formation of political and community structures that promote the common good.

The communal features of this sketch of postliberalism recommend it favorably for bioethical application based on the foregoing criticisms of liberal principlist bioethics. Its version of conservatism is *common-good conservatism*. It acknowledges that humans have the rational capacity to select, from among a buffet of teleological options, those which are *good*. Furthermore, it acknowledges that this good can be *common*—the good is not merely that each individual has the autonomous ability to define his own goods but is, instead, good for all people by virtue of their nature as humans and their cooperation as members of a cohesive society. Stemming from this last point, the governing structures of such a society can, in the postliberal view, acknowledge, support, incentivize, and defend this common good. The four key features of liberalism—conquest of nature, timelessness, placelessness, and borderlessness—are at work in principlist bioethics and are clearly rebuked in postliberal analysis (Deneen, 2018). Concerns about conquest of nature are most immediately relevant to cases of prenatal screening, surgery, and therapy, but discussion of borderlessness is also highly applicable to the unraveling of liberal bioethics. Borderlessness refers not just to the American southern border or to globalist tendencies; it captures the transgressive nature of modern liberalism, which extends to the very understanding of good and bad upon which

the natural law and the virtuous polis depend. In an age of *living my truth*, the good itself has become borderless.

Critically, postliberalism's chief attack on liberalism—the theoretical wrongness and practical failure of its wholesale abdication of public goods at the altar of individualism—aligns with prevailing concerns about the autonomy-oriented outgrowths of liberal principlist bioethics. Deneen suggests that the pro-abortion movement is a natural product of even certain readings of classical liberalism, in which family "duties and formation would increasingly be seen as a burden upon personal autonomy, rather than a core institution of civilization" (Deneen, 2023, p. 73). The liberal "commitment to abortion on demand," in spite of declining birth rates which threaten not only family life but also the massive welfare programs which rely on an endangered demographic pyramid, stems from the development that "[c]hildren are increasingly viewed as a limitation upon individual freedom" (Deneen, 2018, p. 38-39). Postliberalism also pinpoints the fallacy of liberal neutrality, realized in the modern American context of sociocultural elites in academia, entertainment, and bureaucratic administration (Deneen, 2023, p. 29):

> *Such exercise of power is best understood as the enforcement of a distinct set of values and commitments that ultimately advantage the position and status of the ruling class, but—in keeping with liberalism's original mistrust of oppressive government—does so increasingly through the auspices of nonpublic institutions that stand outside and beyond the control of purportedly governing publics.*

Liberalism, in attempting to govern the polis, has itself become ungovernable. Once authority by relational association is vacated, the larger state steps into the power vacuum; liberalism both "understands liberty as the condition in which one can act freely within the sphere

unconstrained by positive law" and creates "more need to regulate behavior through the imposition of positive law" following the removal of softer and more accountable forms of local control (Deneen, 2018, p. 37-38). Those who make the positive law (or, perhaps, the bioethical principlism), themselves beholden to deference to the autonomous will, promulgate guidance which is in opposition to, or at least not practically reducible to, the cultivation of virtue. Liberalism "pretends to neutrality, claiming no preference and denying any intention of shaping the souls under its rule," but it allows the self-destructive forces of the unchecked autonomous wills to negatively shape these souls (p. 5). Postliberalism will not be neutral; it will doggedly pursue the common good.

In defense of his common-good approach, Deneen (2023) leans on Aristotle's instruction that "those who *use* what experts make or design, or whom expert decisions *affect*, are often more likely to be better judges of the benefits and shortcomings of those decisions, plans, or products than the experts themselves" (p. 110). The philosophical architects of the Georgetown mantra and their successors are such a class of experts. However, with liberal commitments to the autonomous will, they do not wish to impose *too much* and instead put forward four principles without any cohesive underpinning that renders them universally justifiable or practically implementable for their users in the clinic.

Liberalism is lauded for its restricted view of state action and its ability to secure freedoms for individuals previously under the reign of tyrants. Self-determination—through personal convictions, economic industry, and exercise of political power—certainly seems more appealing than the alternative oppressive sociopolitical structure. However, a false dichotomy is presented here. Personal convictions are derived from the influence of parents, teachers, religious leaders, and varied texts. One's economic industry is sustainably profitable in a free-market system only

as long as there are others willing to buy the good or service produced by such industry. The exercise of political power is conducted en masse; one vote in one precinct alone has very little impact. The cooperative nature of human existence is indisputable, and a state which is not oriented to affirmatively promote such cooperation and channel it toward mutual public goods will inevitably become oriented against such public goods in order to preserve its own authority. Liberalism holds that "the individual should be the basic unit for political thought;" postliberalism rejects the tyranny of the autonomous will and insists on a society based on interwoven duties, responsibilities, and obligations (Herring, 2019, p. 9).

At least in this narrow lane, postliberal criticism of dominant bioethical approaches coheres with Ezekiel Emanuel's critiques. Emanuel—certainly not to be accused of harboring conservative or postliberal sensibilities—suggests a communitarian approach to bioethics. However, Emanuel dreams of this communitarian approach *within* liberal political structures, such that he approaches the same autonomy-based dead ends that other principlism critics—such as care ethicists—have faced. He simply does so at a level of political organization which is nominally one step removed from the individual; instead of autonomous individual wills, he ultimately advocates for the dominion of autonomous community wills. However, a *community* in Emanuel's account is a group of people who freely join to form that community precisely because of the alignment of their autonomous wills. In practice, this results in a disintegration of society into infinitesimally small 'communities'—in name only—which is not only impractical for the delivery of healthcare services but is also antithetical to the relational nature of human existence. In this model, disagreements do not have to be resolved through reason and discourse; they are resolved through separation into politically and ethically homogeneous communities, for "since we live in pluralist societies, we must tolerate many different communitarian responses to these problems, each driven

by a commitment to a particular conception of the good life" (Daniels, 1992, p. 42). As greater numbers of atomized communitarian responses arise, it is increasingly difficult to sketch the continuity of the original pluralist society.

This progressive prescription for bioethics, while echoing elements of the subsidiarity-oriented policy vision normally expected from scholars operating in the Catholic tradition through Emanuel's community health programs approach, simply cannot bring itself to commit to any normative framework except the claim that society at large ought to have no single normative commitment structure. If "different communities have fundamentally different values, 'Let a thousand flowers bloom'" (p. 43). Some of those flowers may be spotless orchids, but others may be thorny roses or Venus flytraps. Neither the liberals in the school of Beauchamp and Childress nor the communitarians in the school of Emanuel would allow us to pick the orchids alone for our bioethical bouquet.

4.2 Postliberalism as Conservatism's Critic

Modern conservatism—or, more appropriately, classical liberalism—does not fare significantly better under the lens of postliberal critique. Conservatives "stress the need for scientific and economic mastery of nature but stop short of extending this project to human nature," (Deneen, 2018, p. 36). However, if humans are relational and depend on their existence within place and time for the cultivation of associational virtues, tinkering around the periphery of nature is bound to impact human nature. In the political sphere, "conservative liberalism's valorization of the autonomous individual as the normative ideal of human liberty"—whether through small-

government libertarianism or pull-yourself-up-by-your-bootstraps economic sentiments—reinforces the hegemony of autonomy-laden principlism in bioethics (p. 56).

Thus, postliberalism helpfully allows one to include the more recent phenomenon of 'conservative bioethics' within the scope of its criticism. Conservative bioethics, a field admittedly defined more by its critics than its purported contributors, largely indicates any bioethics done by members of the President's Council on Bioethics during the George W. Bush administration. This loose association of scholars vaguely operating in the 'conservative' sphere is a perfect model of conservative ineffectiveness, for "[u]nlike liberalism [and liberal bioethics]—which, for all its manifold meanings, can point to a distinctive philosophy, particular philosophical architects, and enduring principles—conservatism [and conservative bioethics] is not infrequently described as more of a mood or a disposition" (Deneen, 2023, p. 66). Indeed, the format of the President's Council and its reports permitted, and often intended, its members to merely crystallize discourse from diverse perspectives about major bioethical issues at the dawn of the twenty-first century. However, to the extent that the output of the Council and its members is relied upon today—by proponents or critics—as a 'conservative' wellspring of bioethics, such a view inaccurately implies that this Bush-era scholarship and its intellectual successors have coalesced around particular normative claims and policy proposals.

While some modern scholars with an orientation toward relationships and obligations have produced good work rebutting the worst excesses of the autonomy-driven biomedical establishment—exemplified by Farr Curlin and Christopher Tollefsen's (2021) Way of Medicine approach of identifying and pursuing in the clinic those human goods most particular to the physician-patient relationship, including life and health—many have conducted bioethical analysis solely in response to liberalism rather than charting a new path forward or attempting to conserve

anything of meaning and value. As a result, this reactionary scholarship is shaped by liberalism and attempts to apply dainty bandages to the gaping wounds of liberal principlism.

Nevertheless, bioethics done by scholars with diverse theoretical commitments under the banner of a center-right chief executive and their intellectual successors has become a popular punching bag for principlists. For bioethicists committed to not opining on the *rightness* or *wrongness* of decisions, these philosophers have few qualms about expressing just how 'wrong' conservative bioethics has been (Macklin, 2006; Yamin, 2023). The postliberals, too, have no shortage of criticisms for those working in this 'conservative' tradition, for postliberalism is, in large part, a criticism of modern conservatism's ineffectiveness as a result of its retreat to classical liberal positions. Rather than conserving anything at all, the modern conservative movement involves "a commitment to a slower rate of change—albeit largely in the social domain—while, at the same time, insisting upon conditions of accelerating change in the economic domain" (Deneen, 2023, p. 67). Unfettered by concerns about proclaiming rightness and wrongness, the postliberals might hold that bioethics and related health policy analysis conducted within the modern conservative intellectual tradition—even beyond the 'conservative bioethics' of the Bush President's Council—is walking, instead of running, in the wrong direction.

Shell-shocked by the 2024 Alabama Supreme Court decision in *LePage v. The Center for Reproductive Medicine, PC* regarding destruction of embryos produced through in vitro fertilization (IVF), conservatives abandoned the issue of embryonic personhood, traveling down the path of legally protected IVF permissibility and into the waiting arms of dominant postliberal criticisms. Texas Governor Greg Abbott, a social conservative and self-described pro-life Republican, offered these comments in a CNN interview just days following the decision (Boyette & Mascarenhas, 2024):

> *I have no idea, mathematically, the number of frozen embryos. Is it one, ten, one hundred, one thousand? Things like that matter. What I don't know is, families who may have frozen embryos, what happens if they were done so that a mother could have a pregnancy but, after those embryos were frozen, the mother passes away? What happens then? What happens if, after the embryos are frozen, the mother and the husband get a divorce?...These are very complex issues, where I'm not sure everybody has really thought about what all the potential problems are and, as a result, no one really knows what the potential answers are.*

This sounds like IVF is an unchecked problem, in Texas and across the country. It seems like there is an abundance of outstanding bioethical questions which ought to be considered before any IVF treatments are legally sanctioned. It also appears there is some misplaced focus; if we have a unified concept of the nature of the human person, it should not matter whether there are two or two million frozen IVF embryos, for each has equal dignity and value. What is the final policy solution from Abbott in the face of these bioethical and biological unknowns? IVF helps people have more children, and conservatives should implement policies that promote family formation and having children, so Texas will protect access to IVF at some point—but the issue is not an urgent one for the Texas legislature.

This is indiscernible from the fallacy of liberal neutrality. There are significant outstanding bioethical concerns, and the response is to maintain the status quo in which IVF is conducted throughout the State of Texas. This is neutrality between permitting IVF and more overtly supporting IVF through legislation, but it is clearly opposition to more substantive restrictions on IVF. The political conservative movement, which lent initial credence to the nascent 'conservative

bioethics' movement, has not had the wherewithal to stand committed on electorally difficult issues of life. For postliberals, this is not surprising, for "'conservatism' is largely a variable label reflecting a relativist stance that cannot, in fact, lead to commitments or efforts to conserve anything substantive" (Deneen, 2023, p. 67-68).

Abbott's approach is not merely that of a pandering politician; it is mirrored in serious bioethical literature. Blackshaw and Colgrove (2020) address the question of IVF and embryo adoption, at least in part, with an appeal to the continuing march of technology. Since "ectogenesis is developing rapidly," they argue "it may be that in a few years it is possible to gestate surplus embryos without requiring a human uterus. Of course, there may be ethical issues with doing so, but nonetheless, ectogenesis is a possibility well worth exploring" (p. 859). *Of course* is doing a lot of work in this statement. More broadly, Blackshaw and Colgrove are arguing against the pro-life obligation to adopt and gestate frozen embryos and why such commitments should not be taken so literally or seriously when a wide reflective lens is applied to pro-life bioethics. They assess "numerous other strategies for saving frozen embryos that are likely to be far more effective" but never reflect on that fact that, perhaps, if this is a serious bioethical debate, one ought to first examine why there are embryos requiring *saving* in the first place (p. 860). They pursue paragraphs of dollars-and-cents accounting of the most cost-effective forms of altruism toward embryos or other lives in danger throughout the world while accepting the liberal premise that IVF will continue to produce frozen embryos needing to be *saved*.

A successful common-good bioethics which seeks to defend the dignity of human life must shroud itself in a more well-constituted political theory than modern conservatism can offer. Bioethicists working in the liberal milieu have come to similar conclusions (Beckwith, 2014, p. 481):

> *The promise of personal and corporate liberty on the matters of abortion and contraception—as asserted in* Roe *and* Griswold*—now seems like a ruse. What initially appeared as perfectly consistent with the secular bioethicist's promise of worldview neutrality—a call for respecting diversity and contrary visions of the good life—seems now to be about permanently eradicating from the public conversation one understanding of the good, the true, and the beautiful—the Classical Tradition—and replacing it with another.*

Postliberalism anticipates the ruse, attacks its liberal underpinnings, and moves forward to a new political philosophy which may accommodate a new bioethics focused on restoring, to the public square and to the clinic, a conception of the good in accordance with natural law and flourishing of body, mind, and soul. Instead of liberalism's "liberation of the individual from particular places, relationships, memberships, and even entities," this new philosophy must liberate relationships from the tyranny of the individual will and the false promise of liberal neutrality (Deneen, 2018, p. 15).

4.3 Postliberalism as Natural Law's Companion

Patrick Deneen draws heavily on the work of Aquinas in outlining a *mixed constitution* to govern a postliberal order, restraining the excesses of the elite by the everyday virtues of the masses and calling on the elite in Christian charity to steward the polis in the realms of both money and morality. He recounts favorably Aquinas' "virtuous mixed regime in which 'the many' are apt to govern themselves in accordance with good custom that functions as law, while selecting leaders

who are apt to 'tolerate' good custom in accordance with the common good" (Deneen, 2023, p. 133). He also focuses on how natural law channels human actions to good ends through limitations (Deneen, 2018, p. 34):

> *Humans were understood to have a telos, a fixed end, given by nature and unalterable. Human nature was continuous with the order of the natural world, and thus humanity was required to conform both to its own nature and, in a broader sense, to the natural order of which it was a part…Aristotle's* Ethics *and Aquinas's* Summa Theologiae *are alike efforts to delineate the limits that nature—natural law—places upon human beings. Each seeks to educate man about how best to live within those limits through the practice of virtues, to achieve a condition of human flourishing.*

Now, not only the telos of humanity but also its very physical contours have been made the targets of biomedical alteration—from Botox procedures to 'gender-affirming' (but nature-denying) healthcare. Deneen is far from the first to recognize that human liberty "necessarily stands in need of light and strength to direct its actions to good and restrain them from evil" (Leo XIII, 1888, para. 7). Critically, Leo XIII's encyclical on *Libertas* correctly identifies the relationship between choice and judgment (para. 7):

> *…he who is free can either act or not act, can do this or do that, as he pleases, because his judgment precedes his choice. And his judgment not only decides what is right or wrong of its own nature, but also what is practically good and therefore to be chosen, and what is practically evil and therefore to be avoided.*

Liberal society suggests that, because something is autonomously chosen, it is an extension of the good which resides in the 'right to choose.' Leo XIII offers a strong counterargument; the judgment of the good is a prerequisite for proper exercise of free will. This will is not entirely atomized but, instead, is governed by reason. Within this exercise of judgment and choice is "the *natural law*, which is written and engraved in the mind of every man; and this is nothing but our reason, commanding us to do right and forbidding sin" (para. 8).

Yes, Leo XIII is quoted above. Furthermore, yes, the quote stems from a papal encyclical issued from the Vatican. And yes, allowing such content to influence bioethical analysis is permitted by postliberalism, for this political philosophy recognizes the Christian foundations of the Western polis. Deneen (2023) advocates "forthright acknowledgement and renewal of the Christian roots of our civilization" (p. 182). The rigid separation between church and state has done more harm than good. The modern public sphere accepts only rational, secular arguments, to the detriment of integrated community life (Dell'Oro, 2002, p. 133):

> *A "strong," but purely procedural level of moral reasoning, free of content and essentially neutral, regulates the public sphere of society. A "soft" level of moral discourse, one taking place within each moral tradition, establishes the coherence of particular moral languages within specific moral commitments.*

This retreat to private moral corners has marked a broader retreat of the language of morality from public life. We talk about *laws*—what is *legal* or *permissible*—but not about *morals*—what is *good* or *right*. As a result, "concrete moral agents defined by a particular history and moral tradition never speak to one another" (Dell'Oro, 2002, p. 133). Defenders of this model note how it "protects the only publicly recognized faith's article of liberal societies, the autonomy

and freedom of individuals, while creating the conditions for private identification with the values and virtues each individual feels worthy of ethical pursuit" (p. 133). This sounds lovely, but one does not identify with values and virtues only *privately*. He does so in community with others. Beauchamp and Childress' principles of beneficence and non-maleficence, for example, are operable insofar as they relate to one's conduct *with respect to another*. Setting aside cases of individual (not physician-assisted or clinically-related) suicide in the present discussion, it is easy to be beneficent and non-maleficent to the self. These principles become more challenging, and derive their need to be stated and taught, from their application in a relationship to family members, neighbors, patients, physicians, and, indeed, the unborn. The perceived implausibility of pro-life maternal-fetal medicine physicians and the secular-only public abortion advocacy permitted for OB/GYNs reviewed earlier in this thesis flow directly from this commitment to the fallacy of values and virtues which can exist and govern conduct in only some private realm (Kurjak et al., 2009; Blustein & Fleischman, 1995).

There will always be elites in a society, however egalitarian its liberal commitments may seem, and postliberalism's *aristopopulism* relies on a Christian ethos to promote sacrifice, service, generosity, and a commitment to the dignity of all human life among the ruling class. The "new elite" of postliberal society is "a class of people who, through supporting and elevating the common good that undergirds human flourishing, are worthy of emulation and, in turn, elevates the lives, aspirations, and vision of ordinary people" (Deneen, 2023, p. 153). Natural law provides the roadmap to this human flourishing, for it "consists in naturally known principles held by reason, to which we have natural inclinations, and by which we are directed to actions that correspond to human flourishing" (Brugger, 2016, p. 91). While some scholars suggest that "Beauchamp and Childress have elaborated influential accounts of the moral principles of the

natural law (or common morality)," they have explicitly declined, in setting forth *Principles of Biomedical Ethics*, to offer the sort of normative judgments about goods which correspond to human flourishing (p. 98). The natural law encompasses "what is *objectively* desirable to us insofar as it will help actualize our definitive capacities" and what will lead "to perfection according to one's *nature as a human person*" (Eberl, 2020, p. 252, emphasis added). If principlism cannot converge on an objective foundational theory or an account of human nature and personhood, then it is not functioning as an extension of natural law.

Postliberalism offers the clearest path among natural law, political theory, and bioethics, for its common-good conservatism echoes the natural law mandate of Aquinas, for whom law involves "an ordinance of reason for the common good, made by him who has care of the community, and promulgated…by the very fact that God instilled it into man's mind so as to be known by him naturally" (*ST* II-I, Q[90], A[4]). Articulating the goods which are basic and common, Aquinas references "human life, procreation and education of children, knowledge of truth, religion (knowledge of God), social harmony, and practical reasonableness" (Brugger, 2016, p. 95). Humans are oriented toward pursuit of these goods by their very nature, which includes the communal nature from which duties and obligations spring (Bachiochi, 2022). Postliberalism places duties before rights, emphasizing the mutually reinforcing positions of the *aristoi* and the *populi* in the 'aristopopulist' model. Even the aforementioned school of care ethics, as applied to social work, has found a promising postliberal response to the extreme autonomy of the *Homo economicus* model of rational, self-interested human behavior. It seeks social solidarity in accordance with natural law so as to foster "personal relationships that are conducive to *eudaimonia*" (Shaw, 2019, p. 189).

Admittedly, natural law scholarship of the last century has not presented a united front. Classic natural law theory suggests that basic goods are incommensurable but comparable while, in contrast, new natural law theory holds that they are both incommensurable and incomparable (Shea, 2022). While it may be advantageous to counter principlism's specification and balancing with a notion of comparable basic goods, new natural law scholars have been particularly optimistic that their interpretation of the Augustinian-Thomistic tradition breathes new life into bioethics, especially in end-of-life cases (Tully, 2016). This thesis is not the place to wade into debates about the faithful reconstruction of natural law theory from Thomistic texts; it is enough to note that natural law theory is not a monolith but that its basic commitments hold up under the weight of bioethical applications.

Much ink has also been spilled debating whether natural law theorists—especially those of the 'new' school—have capitulated too much to secular society by learning into natural law's reliance on reason or, alternatively whether they remain too intractably linked to the Church in both the theological sources they cite and the presumed public acceptance of the common good they promote (Delkeskamp-Hayes, 2016; Thobaben, 2016). In this matter, it must be remembered that Grisez, Finnis, and other new natural law proponents were concerned, at least in large part, with questions of jurisprudence, seeking to appeal to a traditional of reasoned opinion-writing within modern liberal government structures. Postliberalism, however, introduces a new political tradition wherein civil discourse is reframed around a conception of the common good, which ought to align favorably with a natural law bioethics chiefly concerned with the common good. This bioethics is not ready for immediate implementation in full; for that, it requires a postliberal age. However, if liberalism is destined for collapse under the weight of its own individualistic commitments, then its succeeding political philosophy can cultivate an atmosphere for an

accompanying succeeding bioethical model (Deneen, 2018). Cardinal virtues bioethics which anticipates the postliberal polis is not impotent as the liberal polis declines; it stands ready to fill the ethical, epistemic, and rhetorical gaps left by liberalism's retreat into the atomized will.

Turning to the lone Biblical reference in this thesis, if "the demands of the law are written in their hearts," where the antecedent of *their* is *Gentiles*, then it ought to be possible to lean on a conception of common reason shared neither through uniform theological commitments nor through common secular conditions, but instead through fundamental human identity, to scale up natural law bioethics for widespread application (New American Bible, Romans 2:15). In other words, natural law functions sufficiently amid modern church-state separation but flourishes more fully in a postliberal age.

4.4 Postliberalism as Bioethics' Architect

Because postliberalism is natural law's companion, it is well positioned to be bioethics' architect. With its focus on the intrinsic dignity of persons—of all members of the human species, regardless of developmental stage—it permits a clear-eyed pursuit of the goods of life and health (Curlin & Tollefsen, 2021). Moreover, it reframes conversations about patient autonomy in terms of patient authority within the scope of the patient *vocation*, for natural law approaches require weighing benefits and burdens in a given scenario "in light of one's vocation" and its attendant responsibilities (George & Tollefsen, p. 60). Natural law not only comes to a coherent and internally-defensible view on abortion—namely, that "one may never directly intend to kill an innocent human being"—but also offers a rule of double effect for handy clinical reasoning (Irving, 2000, p. 46).

In the realm of bioethics, a theory based on natural law represents a return to classical forms of ethics governing the medical profession. As John Keown (2015) remarks in his preface to Alfonso Gomez-Lobo's posthumous text on natural law bioethics (para. 10):

> *Natural law is an approach that, in line with the Hippocratic tradition of medical ethics, which has shaped medical ethics for centuries and which—although increasingly challenged by utilitarian and principlist thinking—to a significant extent still does, holds that some ways of dealing with patients…are always and everywhere wrong, regardless of the good consequences that such conduct may bring about.*

As a guide for bioethicists, postliberalism directs attention toward the *common* good, not merely the individual good or the consequentialist good. In postliberal bioethics, "the strong orientation on individual rights and autonomy—which may still be quite acceptable in legal philosophy [at least until political structures more fully realize a form of postliberalism]–should be nuanced and supplemented by views in which the full dimensions of the good life and of the good society at large are elaborated" (van der Burg, 1997, p. 111). This common-good conservatism which postliberalism seeks to construct appears to be a promising avenue of remedy for a bioethical tradition most immediately handicapped by a hand-waving of considerations of the good.

Applying this approach to biomedical ethics is not only appropriate but well within the spirit of natural law scholarship, for "practical understanding of natural law precepts is often fostered in the context of *productive* social practices," of which the physician-patient relationship is certainly one (Gibbs, 2023, p. 172). Furthermore, this pursuit of excellence "entails a practical

grasp of cardinal virtues" (p. 172). Cardinal virtues bioethics, then, appears to be a faithful interpretation of applied natural law theory.

The postliberals recognize that, in principlist bioethics and liberal theory across disciplines, "the 'dignity' of every life is sacrificed on the altar of the rule of the strong…over the weak; liberty is defined not as self-government, but a liberation from constraint to do as I wish; and in the name of tearing down every vestige of an antecedent order, the liberal state and social order becomes totalizing" (Deneen, 2023, p. 229). In opposition to these trends, common-good conservatism rejects the autonomy-oriented liberal strategy in favor of care for the community. In order to care for the community, one must have a coherent view on the dignity of the life of all those who comprise the community. Without "any common understanding of what constitutes the human good, secular bioethics has little to go on to determine a patient's best interests except for the preference satisfaction of the patient herself" (Beckwith, 2014, p. 475). When this is further complicated by questions about the very identity of the patient or patients, as in cases of prenatal care, the limitations of liberal principlism are further highlighted. While various interpretations of Thomistic philosophy abound, Jason Eberl's (2020) "interpretation of the Thomistic hylomorphic view of human nature [relying on a concept of active potentiality] leads to the conclusion that a person comes into existence at conception" (p. 170). Only postliberalism, not classical liberalism or modern conservatism, is prepared to defend this view boldly in the public square.

Postliberal bioethics, and postliberalism more broadly, "begins with the primacy of the family, community, and the human goods that can only be secured through efforts of the political community—and not with the primacy of the individual" (Deneen, 2023, p. 94). The primacy of the family, coupled with a commitment to a robust definition of life and personhood, offers a sustainable position in opposition to abortion and other practices which undermine the unique

nature of family relations but in support of prenatal surgical and therapeutic approaches designed to halt the natural history of disease progression to promote healthy growth and development. The primacy of the community encourages action to care for the vulnerable within the polis—those who cannot afford healthcare or childcare, those undergoing confusion about gender identity, those experiencing suffering, those dying, and many others. In these cases, the primacy of human goods in the public sphere—not relegated to the promptings of the autonomous will—orients these actions toward the end of human flourishing. Tying this system together must be a platform of associational virtues which serve as mid-level guides to action in particular relationships and particular situations.

Until now, virtue-based bioethical approaches have failed to gain widespread traction; postliberalism contends that such methods have attempted an ethical transplant without first fully excising the tumor of liberalism. In such cases, virtue ethics is not only unsuccessful but also incoherent (Ahmari, 2023, p. 195):

> *[It is] a downright ludicrous politics centered on preaching timeless virtues while denying what political theory going back to the Greeks has taught, and what every good parent or teacher knows: that cultivating virtue requires tangible, structural supports. A child will struggle to master honesty if his parents routinely model dishonesty; a body politic will likewise spurn the virtues if subjected to merciless economic exploitation.*

However, virtue ethics in concert with natural law offers a promising foundation for bioethical analysis. Aquinas holds that, "since the rational soul is the proper form of man, there is in every man a natural inclination to act according to reason: and this is to act according to virtue" (*ST* II-I, Q[94], A[3]). The natural law is the bottom-level foundation on which the mid-level

cardinal virtues may be layered. Then, if one uses accordance with the relevant virtues as a rule of thumb for clinical decision-making, he is effectively reaching down to a Thomistic account of human flourishing in an ordered society of rational, free-will-bearing, and interdependent citizens.

The following sections present in greater detail a cardinal virtues bioethics with Thomistic-postliberal foundations. It finally unites noble attempts at accounts of virtue ethics with a coherent political philosophy removed from the influence of liberalism. To attempt to express this in the context of existing bioethics theories, one might think of it as a synthesis of care ethics' relational understanding with virtues serving as the immediate touchpoints, or 'principle analogues,' while providing a rich natural-law-based understanding of personhood. However, to think of cardinal virtues bioethics as directly reflecting any or all of these existing theoretical approaches is inaccurate, for, inasmuch as it borrows features of these frameworks, it does so in anticipation of a truly postliberal polis.

5.0 'Cardinal Virtues Bioethics': Synthesizing Medieval and Modern Accounts

It is not enough to merely synthesize the critiques of Beauchamp and Childress' principlism that have arisen in the past half-century. It is also not enough to merely diagnose the problem as one of self-scavenging liberal commitments that exalt the atomized individual over the hylomorphic understanding of human nature and the role-based duties which enrich a sense of personal identity and place within a decision-making context. It is essential to lay out a path forward which, as postliberalism gains a foothold in the structure of the polis, can accompany it as a life-affirming bioethics with bold normative commitments and reflective decision-making capabilities. The 'cardinal virtues bioethics' which follows introduces—from the philosophy of Saint Thomas Aquinas, the encyclicals of John Paul II, the jurisprudence of John Finnis, the virtue theory of Pelligrino and Thomasma, and the postliberal theory of Patrick Deneen—the roles of justice, prudence, fortitude, and temperance as a new quartet of virtuous guiding lights along the path of biomedical ethics.

Even outside of the context of the contemporary renaissance of virtue ethics approaches, Deneen's criticism of liberalism includes an appeal to the lost emphasis on the cultivation of virtues based on both participation in civic life and one's immediate status, class, or position within the polis. Early understandings of liberty recognized that "self-rule [for the individual or the state] was achieved only with difficulty—requiring an extensive habituation in virtue, particularly self-command and self-discipline over base but insistent appetites" (Deneen, 2018, Preface to the Paperback Edition). From this conception of liberty, then, a cardinal virtues bioethics is not so much a wholesale repudiation of liberalism as it is a return to the truest, classical form of liberty-oriented public philosophy. The tradition of liberty is thus recovered from the autonomy-laden

excesses of twentieth- and twenty-first-century misapplications of liberalism. This tradition is not centered on a 'live and let live' approach. On the contrary, it requires a strong virtue-oriented sense of how one ought to live, coupled with communal and political structures designed to permit, encourage, and support living according to these virtues. Snead (2020) emphasizes the nature of the healthy polis as one composed of "people who make the good of others their own good, without demand for or expectation of recompense" (p. 269). This is not merely wishful thinking; there are specific "goods and practices necessary to the creation and maintenance of these networks" and among these "are the virtues" (p. 269). Here, the virtues selected for incorporation into a new bioethical framework are more limited than those offered by Snead. They are the four cardinal, or principal, virtues on which Cicero, Ambrose, Gregory, and Aquinas converge. They are fundamental to assessing, selecting, and carrying out actions in accordance with the common good, grounded in a normative sense of right and wrong behavior which stems from the hylomorphic metaphysics of the human person. A substitute for principlism must be "well-designed to address the complex needs and wants of a community of embodied, vulnerable, and interdependent human persons" (Snead, 2020, p. 269). This cardinal virtue bioethics answers Snead's call.

This is not entirely uncharted territory. Over three decades ago, Edmund Pelligrino and David Thomasma—a pair rivaling Beauchamp and Childress for the bioethical duo of the twentieth century—outlined *The Virtues in Medical Practice* (1993), among which they count the four cardinal virtues under direct consideration in the following sections. They also pinpoint concerns about autonomy-centered models of bioethics. However, the Pelligrino and Thomasma model notably stops short of providing a specific vector for the introduction of their virtue-ethics approach into the modern clinical setting. It explicitly rejects the opportunity to do so, because "there is no agreement about which of the great moral traditional should be the source for the

principles that should guide the moral behavior of physicians" or about "what it means to have moral knowledge" (p. 183). Rather than appealing to the concept of the *imago Dei* for an account of the human person and to the concept of the common good, Pelligrino and Thomasma attempt to relate virtue theory to dominant principlist strains of bioethics without resolving the inherent conflicts between the two intellectual schools. They realize the conflict exists—for virtue theory requires "some prior theory of the right and the good and of human nature in terms of which the virtues can be defined" and "a community of values to sustain its practice"—but take few steps to meaningfully supply either of these necessary conditions which liberal bioethics has extinguished from scholarly analysis (p. 190). Postliberal philosophy and a deeper analysis of natural law provides the vector for the insertion of the present cardinal virtues bioethics model into the very nucleus of clinical decision-making. Pelligrino and Thomasma anticipate the project ahead (p. 186):

> *What is needed instead is a reconstruction of medical ethics…a critical assessment of ethical principles concerning the nature of the medical relationship, the kind of human activity it represents, the specific obligations that arise from that activity for both the physician and the patient, and the relation of the virtues of the agents to these features.*

This thesis represents one small step in this reconstruction. The following sections outline the most critical elements of the reconstructed medical ethics—cardinal virtues bioethics—to prompt the sort of inquiry that Pelligrino and Thomasma recognize as essential to achieving a cohesive framework of medicine's relationships, virtues, obligations, and appropriate ends.

5.1 Existing Appeals for a Virtue-Based Approach

In addition to the 1993 Pelligrino and Thomasma text, more modern scholars have also recognized the value of more fully integrating an account of relevant virtues into bioethical analysis. Cultivation of the virtues induces a pursuit of human excellence, and a polis of more excellent citizens is a more excellent polis in its pursuit of the common good. Among the most prominent advocates of this position is Alasdair MacIntyre, whose *After Virtue* (2007) reviews the way in which the individual, in traditional societies, "is identified and constituted in and through certain of his or her roles, those roles which bind the individual to the communities in and through which alone specifically human goods are to be attained" (p. 172). Ethics is meant to involve moral guidelines for the pursuit of perfection within human nature, but "the elimination of any notion of essential human nature and with it the abandonment of any notion of a *telos* leaves behind a moral scheme composed of two remaining elements whose relationship becomes quite unclear," namely, enumerated moral injunctions and observation of human nature (p. 55). The relational or associational virtues are unchanging, but the societal context in which they are taught and exercised determines the success of their adoption in the pursuit of basic goods. Furthermore, the practice-based application of virtues—as localized to the clinic or the biomedical research setting—is essential, for the success of action according to virtue can be observed in terms of the achievement of "those goods which are internal to practices" (p. 191). To exercise the virtues, we depend on those who surround us (p. 220-221):

> *For I am never able to seek for the good or exercise the virtues only qua individual…what is good for me has to be the good for one who inhabits [the roles that I inherit]…Notice also that the fact that the self has to find its*

moral identity in and through its membership in communities such as those of the family, the neighborhood, the city and the tribe does not entail that the self has to accept the moral limitations of the particularity of those forms of community.

A cardinal virtues bioethics will, thus, focus on the search for the good and the exercise of the cardinal virtues within the roles of healthcare provider and patient, while acknowledging the way in which increasing scientific and technological development alters the epistemic and power dynamics of the related physician-patient relationships.

MacIntyre also anticipates the postliberalism-predicted collapse of liberalism through the lens of the collapse of public obligation. Once "government does not express or represent the moral community of the citizens, but is instead a set of institutional arrangements for imposing a bureaucratized unity on a society which lacks genuine moral consensus, the nature of political obligation becomes systematically unclear" (p. 254). The moral consensus of the United States, in particular, has frayed even further since MacIntyre's first edition of *After Virtue* in 1981; one would be hard-pressed to define his relationship to the contemporary polis as one of *obligation* rather than one of mere happenstance or indifference. As a result, MacIntyre argues, "[m]odern systematic politics, whether liberal, conservative, radical or socialist, simply has to be rejected from a standpoint that owes genuine allegiance to the tradition of the virtues" (p. 255). MacIntyre sounds a great deal like a Deneenian postliberal on this rejection of all permutations of liberal political forms.

Other support for a virtues-based approach is more narrowly tailored to the bioethical context. David Misselbrook (2015), a staunch advocate of virtue ethics in medical practice, emphasizes that medicine "is a human activity rooted in human givens, human transactions, and

human relationships within the context of our wider society" (p. 227). Postliberalism reshapes this wider society such that it is more conducive to the exercise of the cardinal virtues within the activity of medicine. An account of bioethics through the lens of the virtues has support from this clinical practitioner. Snead (2020) focuses on "the practices of authentic friendship"—to include "just generosity, hospitality, misericordia," as well as "solidarity, dignity, and honesty"—in his approach to a new public bioethics but roots these practices in a deeper commitment to the cultivation of associational virtues (p. 9). The account of bioethics through the lens of the virtues has parallels in the work of this legal scholar. George and Tollefsen (2019) recognize that natural law commitments currently exist among many physicians who might be considered 'conscientious objectors' to acts such as euthanasia and abortion; the immediate response is that "better laws and professional standards need to be (re)developed that consistently respect the vocational commitment of medicine to heal and never to harm" (p. 64). The square-peg-in-a-round-hole sense that these physicians experience upon expressing their position as conscientious objectors highlights the lengths public bioethics has traveled from adherence to the natural law. Natural law is not merely on the periphery of bioethics; it is, in many cases, in contradiction to the prevailing winds of public morality claims, to the extent that such normative claims even attempt to present a cohesive moral justification. The following account of bioethics through the lens of the virtues meets a demonstrated need from within the healthcare field and from the natural law scholars who analyze it.

Public health ethics, a field which necessarily focuses on the polis and the common good rather than on the individual and his autonomous will, also recognizes the common-good implications of adopting a Thomistic account of personhood for all members of the polis. From fetal personhood to end-of-life debates, such a unified view makes possible more nuanced ethical

discussion in the public square and provides a rational underpinning for policy implementation (Blackshaw, 2021). Furthermore, considering the policy implications of cardinal virtues bioethics, there is a sector of jurisprudential and legal theory which considers law as communitarian virtue ethics. Such an approach is chiefly concerned with asking, in response to a new policy or law, "[w]hat kind of people will it help us to become" (Clark, 2005, p. 757). In contrast to "the often unspoken and essentially undefended assumption that human happiness will be advanced through the satisfaction of preferences and/or marginal increases in objective or material well-being," this legal approach—like cardinal virtues bioethics—takes the perspective that "happiness emerges instead from certain ways of being" and that the structure of government should not shy away from prescribing these ways of being (p. 758). In fact, the role of government, law, and policy is precisely to direct human activity toward these ways of being.

In a certain sense, the approach seeks to more fully realize the promise of some of the early heralds of the conservative bioethics movement, including Yuval Levin. Levin (2003) sought to "explore the character of the changes made likely by biotechnology, with an eye to their effect on our attitudes about ourselves, our dispositions toward our bodies and souls, our sense of the appropriate uses and limits of human power, and the form and function of our society." With fetal gene therapy techniques bringing us close to the 'designer babies' fears of Levin's heyday faster than he might have anticipated, it is more important than ever before to offer an accounting of the *limits* of human power as control over the natural world and even the natural biological language—DNA—appears within reach. However, Levin wanders a bit too far down the road of anti-technological sentiment—criticizing the modern biosciences and, in particular, clinical pregnancy management for scientific analysis of the *taboo* of in utero development—for which he has been criticized by Ruth Macklin and other liberal scholars (Macklin, 2006). Levin (2003) worries that

"Catholic bishops release statements making reference to arcane articles in *Nature Biochemistry*, while the scientists tell us that the embryo is no larger than the period that ends this sentence, so we should not trouble ourselves over it," such that both parties are too caught up in the science and not sufficiently focused on the moral intuitions which attend conversations about embryonic development. We need not bury our heads in the sand when faced with empirical claims from the biomedical sciences; improved clinical competencies may remarkably strengthen the pro-life cause, if only the pro-life movement harnesses the courage, power, and expertise to opine on such matters with a consistent ethic. Furthermore, in a liberal society, the sort of moral intuitions for which Levin calls has been crippled by the march of the autonomous will; in a polis with warped moral intuitions, we must supply a more rigorous response to the scientific advances of our time.

Having thus identified the philosophical port from which cardinal virtues bioethics will set sail, the following sections sketch the four cardinal virtues, in theory and in practice, as four 'new'—yet timeless—pillars of a Thomistic-postliberal approach to bioethics.

5.2 Justice

This review of the cardinal virtues, and their role in a life-affirming postliberal bioethics, begins where the novel approach coheres—at least in name—with Beauchamp and Childress' principlism. In contrast to their description of 'justice,' however, this version treats justice as a virtue borne out of commitments to respect for shared human dignity. Justice, within the intellective appetite, guides relationships of one man with other men, "first as regards his relation with individuals, secondly as regards his relations with others in general, in so far as a man who serves a community, serves all those who are included in that community" (Aquinas, *ST II-II*,

Q[58], A[5]). Already this emphasis on association draws cardinal virtues away from tendencies toward autonomy-worship. Gomez-Lobo and Keown (2015) nest autonomy within justice, moderating its excessive force such that "[r]espect for autonomy is, properly understood, more like a shield than a sword," something to be relied upon when justice is not freely rendered by another agent in the community (p. 22).

Justice "stands foremost among all the moral virtues, for as much as the common good transcends the individual good of one person," but this is not to suggest that justice is not at all concerned with individual goods (Aquinas, *ST II-II*, Q[58], A[12]). Promotion of the common good enhances the positive associational impacts of justice on all individuals within the community. Justice is not concerned with the passions, for it is measured by "the right *proportionality* between one's actions (or abstentions) and the rights of the other" (Finnis, 2015, p. 208). As "the perpetual and constant will to render to each one his right," one must have a firm conception of what one's *right* is (Aquinas, *ST II-II*, Q[58], A[1]).

Among the central tenets of this virtue is to act justly in dealings with human life, for one's life is a primary good to be protected by the polis and respected by other human beings. A survey of natural law's history reveals that, "no matter the precise natural-law theory or natural-law theorist, all agree, as a matter of self-evident objective truth, that the preservation of human life is a profound good and an inherent right of all persons" (Brief for The American Cornerstone Institute and its Founder Dr. Benjamin S. Carson as Amici Curiae Supporting Petitioners, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 28). A rich concept of the right to life is offered through the lens of justice (John Paul II, 1995, para. 2):

> *Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and the hidden*

> *action of grace, come to recognize in the natural law written in the heart (cf. Rom 2:14-15) the sacred value of human life from its very beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree. Upon the recognition of this right, every human community and the political community itself are founded.*

Justice requires fidelity to the good of the human person made in the image and likeness of God; John Paul II (1993) further instructs that "the respect due to the human person" is unjustifiably diminished by acts "'hostile to life itself, such as any kind of homicide, genocide, abortion, euthanasia and voluntary suicide…[which] contaminate those who inflict them more than those who suffer injustice, and they are a negation of the honour due to the Creator'" (para. 80). We are called to do justice to individuals not because of their individual sliding-scale value stemming from autonomous decision-making but instead because of the dignity of the human species (Bachiochi, 2022).

In cases of maternal-fetal medicine, there is a complex web of relationships which must be governed by justice. The physician must act justly toward the maternal patient and the fetal patient. The mother must act justly toward her unborn child, and she, as a patient, must act justly in her expectations of and dealings with her physician. The unborn child cannot be said to act justly or unjustly. The modern liberal perspective might suggest that this means that the child lacks rational agency, psychological capacities, or some other subjective benchmark of personhood, without which no obligations of justice are due to the fetal patient. However, by virtue of his human nature, this unborn child has a right to life in the cardinal virtues bioethics account. Justice involves avoiding that "which is hurtful to one's neighbor….to the community or in relation to God" (Aquinas, *ST II-II*, Q[79], A[1]). The unborn child is most intrinsically the neighbor of the mother,

but he is also a member of the community. Justice requires an understanding of who this individual is, and cardinal virtues bioethics relies on a robust accounting of potentiality for such a definition. It is "a fetus possessing an intrinsic potentiality to develop a brain capable of supporting self-conscious rational thought" who "is a member of the ontological kind *rational animal* or *person*" (Eberl, 2020, p. 167). We must do justice in light of the uniquely defenseless position of this *person*, both for the unborn child's individual good and for the common good which stems from the culture of medicine being one of life rather than one of death. Orientation toward primary goods, especially those most intrinsic to a vocational practice, is essential.

Furthermore, something special is *due* to the patient from the physician and something special is *due* to the child from the mother. These are roles, most often freely assumed, with specific duties of care. In these cases, justice is not merely offering some unspecified neighbor—related by human nature but, more directly, by proximity—what he is due. This would be enough to create a strong presumption against the moral claims of abortion, for justice is found only when one follows the command to "respect, protect, love and serve life, every human life" (John Paul II, 1995, para. 5). However, in these relationships the more powerful individual is freely in service to the less powerful individual; once taken on, these relationships demand more than general charity toward one's neighbors. If "[t]o claim the right to abortion, infanticide and euthanasia, and to recognize that right in law, means to attribute to human freedom a perverse and evil significance: that of an absolute power over others and against others," justice, charity, and mutual trust are impermissibly abused most especially when the absolute power of mother and physician over an unborn child is wielded not to promote its healthy development but to end its life (John Paul II, 1995, para. 5). To the patients—mother and child—is due the physician's best clinical judgment in promoting the basic goods of life and health. To the child is due the mother's respect for life but

also, more strongly, her loving care for *this* life. Justice, therefore, requires an accounting of the relevant relationships in order to discern what exactly is *due* to the various stakeholders.

5.3 Prudence

Having determined what justice demands, prudence enables one to act. Prudence, or right reason applied to action, is particularly important for biomedical ethics insofar as it constitutes the ability of one "to counsel, judge, and command concerning the means of obtaining a due end" (Aquinas, *ST II-II*, Q[47], A[9]). An account of the proper ends of the practice of medicine is essential for the development of this virtue (MacIntyre, 2007; Curlin & Tollefsen, 2021). Aquinas suggests that *prudence* is directed to the good of the self, while *domestic prudence* and *political prudence* correspond to the good of the home and the polis, respectively, even as both preside over basic civilizational units. Here, it might be said that *clinical prudence* corresponds to the good of the physician and patient, with particular emphasis on the goods of life and health which are of most immediate relevance to the medical practice. Each species of prudence is comprised of good counsel, synesis (prudence in common law or exceptional matters), and gnome (prudence in general law or exceptional matters). Gnome within clinical prudence is said to ensure "an acuteness that disposes us towards the right choice" when facing "complex medical issues" (Murphy, 2006, p. 192). Having already been assessed for a potential role in bioethics, at least in patient decision-making, prudence appears readily applicable to the clinical setting. Indeed, "if virtue theory is to have a place in a comprehensive moral philosophy of medicine, its pivot must be the virtue of prudence (Pelligrino & Thomasma, 1993, p. 90). It connects the intellectual and moral virtues so as to direct one's means toward the shared human ends.

There are eight quasi-integral parts of prudence: memory, understanding, docility, shrewdness, reason, foresight, circumspection, and caution. Thusly construed, prudence is not merely the add-on cardinal virtue to apply once the others have been employed and various courses of action have been proposed, coming in at the last minute to perform cost-benefit calculations. Prudence is, instead, essential to the moral imagination which makes possible the proposition of these various courses of action. Some quasi-integral parts of prudence are most immediately relevant to building a physician-patient relationship based on trust; "it is a mark of docility to be ready to be taught," and the physician and patient must each be prepared to listen to and learn from each other to achieve stasis on a given course of action (Aquinas, *ST II-II*, Q[49], A[3]). Other quasi-integral parts of prudence are, however, more immediately relevant to the actual decision-making process, including understanding's emphasis on deductive reasoning and caution's focus on discerning evils which may be disguised as goods.

These quasi-integral parts are critical to the exercise of prudence within a common-good framework such as postliberalism. They suggest that all humans can cultivate a virtue of prudence by which we can reason. We can discriminate between *good* and *bad*, *right* and *wrong*. We can develop a capability to evaluate situations on an account of virtuous action oriented toward the ends of medicine—namely, life and health—and the common good, in light of professional responsibility and relational duties within the moral communities of the medical profession, the family unit, and the broader polis.

Leo XIII (1888) suggests a role for prudence in the development of human law from natural law foundations (para. 9):

> *Laws come before men live together in society, and have their origin in the natural, and consequently in the eternal, law. The precepts, therefore, of*

the natural law, contained bodily in the laws of men, have not merely the force of human law, but they possess that higher and more august sanction which belongs to the law of nature and the eternal law…It is in the constitution of these particular rules of life, suggested by reason and prudence, and put forth by competent authority, that human law, properly so called, consists, binding all citizens to work together for the attainment of the common end proposed to the community, and forbidding them to depart from this end, and, in so far as human law is in conformity with the dictates of nature, leading to what is good, and deterring from evil.

Given the innate connection between bioethics and health law, prudence reminds us that we need not defer to a live-and-let-live culture of liberalism. The prudent individual has "the ability to perceive the best course of action in a particular situation, as well as the motivational and volitional inclination to put one's reasonable judgment into action" (Shea, 2020, p. 450). Just as prudence allows for comprehension of the best course of action in a particular situation, it also permits an understanding of the best legal and ethical contours to guide action within a polis and emphasizes the importance of *acting* on this understanding—in governing and in practicing medicine. Natural law theory itself does not give a clear answer on how extensive a *right* to healthcare is or ought to be (George & Tollefsen, 2016). Prudence is necessary to determine what is clinically, morally, politically, and fiscally responsible for the community. Because of the centrality of life and health as human goods, provision of healthcare must be a central role of the government overseeing the polis, and postliberalism allows for an increased role for the government in areas oriented toward basic human goods.

For the maternal-fetal medicine field, prudence is especially applicable in cases of prenatal screening. Through prudence, "the clinician must discern what means are most appropriate to the ends, how to balance the benefits and harms in clinical interventions, and how to put the moral and technical issues in a proper relationship with each other" (Pelligrino & Thomasma, 1993, p. 186). This indicates a strong presumption to act in alignment with "that which is good *for* an individual, benefits her, and is in her interest" (Shea, 2020, p. 444). For maternal-fetal medicine, this describes the physician's duties toward both patients and the mother's duties toward her unborn child. Given the increasing abilities of clinicians to diagnose and treat congenital conditions prenatally, prenatal screening is deeply in the best interests of both mother and child. Prudent prenatal care involves routine monitoring, genetic testing, and other proactive clinical assessment. Because the optimal treatment window for many congenital and inherited diseases appears to begin within the first trimester, it is critical—for the health of the unborn child, and perhaps also to reduce later complications in pregnancy for the mother—to initiate screening protocols early (Shanahan et al., 2020). The existing counterargument holds that this overmedicalizes pregnancy and should be considered only if the unborn child is viable or the mother intends wants to continue the pregnancy prior to viability (Chervenak & McCullough, 1996). This deference to the autonomous will of the mother to elect whether her unborn childhood ought to be granted patienthood or targeted for abortion is not prudential, for it is not oriented toward a due end. Early, routine, and comprehensive prenatal screening for conditions may offer an opportunity to treat these conditions before they progress uncontrollably or, at least, to prepare the parents for the needs of their child upon birth. Prudence orients the actions of prenatal care toward life and health.

5.4 Fortitude

Fortitude encompasses both "a certain firmness of mind" and firmness "in bearing and withstanding those things wherein it is most difficult to be firm" (Aquinas, *ST II-II*, Q[123], A[2]). Fortitudinous conduct involves pursuing the prudential path and acting justly toward others, despite challenges. Thus, autonomy takes a back seat to duty and obligation. The obstacles and difficulties that arise in pursuing a course of right conduct "can withdraw the will from following the reason," so fortitude is necessary for "curbing fear and moderating daring" (Aquinas, *ST II-II*, Q[123], A[3]). Fortitude is essential for dispelling the fear of advocating for a postliberal polis and a cardinal virtues bioethics in the face of modern liberal dominance. However, fortitude is far more critical in withstanding challenging clinical circumstances and maintaining commitments to human goods and human flourishing when they threaten a personal toll.

Fortitude calls for a degree of sacrifice in pursuit of the common good (John Paul II, 1993, para. 93):

> *Indeed, faced with the many difficulties which fidelity to the moral order can demand, even in the most ordinary circumstances, the Christian is called, with the grace of God invoked in prayer, to a sometimes heroic commitment. In this he or she is sustained by the virtue of fortitude, whereby — as Gregory the Great teaches — one can actually "love the difficulties of this world for the sake of eternal rewards."*

Commitment that is *heroic* is not necessarily supererogatory; a commitment to fortitude does not require all pregnant women to act as St. Gianna Beretta Molla, laying down their lives for the lives of their unborn babies (Turco, 2022). When the lives of both mother and unborn child

are at risk, there may be several factors—including, but not limited to, the existence of older children who rely on the mother's care and the absence of any other trusted caregiver or social support network for the unborn child if its birth were soon followed by its mother's death—that decide this delicate balance of two lives in favor of the mother in particular cases. This is precisely why states recognize abortion restriction exceptions for cases in which the life of the mother is in jeopardy (Donley & Kelly, 2024). Natural law offers a rule of double effect rationale to justify decision-making in favor of the life of the mother in such cases (Gomez-Lobo & Keown, 2015). However, parenthood—guiding the physical, intellectual, and spiritual development of a new human—is itself an act of heroism, and it must not be forsaken in cases where it would be simply difficult but not life-threatening.

If prudence guides one toward robust prenatal screening and provision of maternal-fetal healthcare, fortitude helps one determine the course of action and the disposition to maintain following the results of such screenings. Jérôme Lejeune, the French physician who popularized the theory of Down syndrome's genetic basis, hesitated in his work because of fear about eugenics through selective abortion that might be derived from the ability to identify, in utero, diseases that society might subjectively deem incompatible with a good life or too resource-draining for the polis (Karamanou et al., 2012). Fortitude instructs that parents ought to have the courage to parent a baby with Down syndrome or any other congenital condition. It may be claimed that the experience of watching one's child lead a difficult life, or even a life that is likely to end well before the average life expectancy, is too traumatic to impose on parents (Donley & Lens, 2022). Fortitude keeps one focused on the good of life when the will may find such focus discomforting. In the neonatal intensive care unit (NICU), fortitude is vital (Lantos, 2001, p. 117):

> *The moral claim insists that we cannot, must not, should not turn our backs on these tiny, vulnerable babies. It constructs the NICUs as the epitome of our humanity, the measure of our devotion, the test of our will…Our NICUs, then, "stand for" our moral commitment to children, our excellence in caring for them, and even our moral progress over time in recognizing that even the tiniest children have rights.*

Maternal-fetal medicine extends these rights to children even tinier than those found in the NICU—those found in utero. Although disease and "death will always be a burden we must accept if we are to live courageously and morally with life's many uncertainties," fortitudinous parenthood bears this burden with respect and dignity for all life and, especially, the life of children entrusted to one's care (Cohen, 2006, p. 48). A system of skillful and prudential prenatal screening depends on the inculcation of fortitude to respond to the results of such screening with heroic commitment to life, health, and the duties of parenthood. In such a system, physicians, too, need fortitude to "resist the temptation to diminish the patient's good through their own fears or through social and bureaucratic pressure" and instead to "use their time and training resourcefully to accomplish good in society" (Pelligrino & Thomasma, 1993, p. 114). Physicians occupy a particular role in society which gives them privileged knowledge of the biological nature of life. Those who advocate for life in today's liberal system are bluntly instructed to keep their moral opinions at arm's length while in the clinic or, increasingly, to keep out of the clinic altogether (Kurjak et al., 2009; Blustein & Fleischman, 1995). Physicians must reject these calls and remain full-throated defenders of the lives of the unborn.

5.5 Temperance

To be temperate is to have the capacity to withdraw "from things which seduce the appetite from obeying reason" (Aquinas, *ST II-II,* Q[141], A[2]). Temperance rounds out the cardinal virtues' treatment of the physician-patient relationship by instilling a confidence that the temperate physician uses his specialized knowledge within the bounds of reason and scientific knowledge (Pelligrino & Thomasma, 1993). Temperance "denotes a kind of moderation" and "is chiefly concerned with those passions that tend towards sensible goods…[and] the sorrows that arise from the absence of those pleasures" (Aquinas, *ST II-II,* Q[141], A[3]). This moderation includes both modesty regarding the exercise of the power of biomedical technology and modesty regarding the holding of reasonable and appropriate hope about the prognosis in a given case. Temperance, thus, is often colloquially defined by oxymorons such as *cautious optimism* and *humble confidence*. While perhaps not semantically accurate, these phrases capture the general spirit of temperance as an ability to recognize, evaluate, and remain within the limits of one's capabilities and one's role in decision-making.

This perspective broadens temperance beyond opposition to cases of gluttony and drunkenness. In these cases, it is argued that temperance "is not relevant to ethics, on the ground that it concerns the good of the temperate person rather than that of others" (Telfer, 1990, p. 159). Setting aside the implausibility of this objection in light of natural law's commitment to associational virtues—such that one's gluttony and drunkenness necessarily impacts the goods of other members of the polis—the temperate physician is temperate in his dealing with patients. Many clinicians refuse, except in emergent circumstances, to diagnose or treat family members or friends; the false hope or wishful thinking they might inadvertently employ risks the health and well-being of the patient. In other words, these physicians avoid circumstances in which the

appetite would be drawn to pursuing a course directed by emotion instead of reason. In these cases, temperance clearly concerns the good of others.

Returning to the maternal-fetal context, slippery-slope arguments about prenatal gene therapy abound (Fletcher & Richter, 1996; Coutelle & Rodeck, 2002). A common approach in the public sphere is to express fears of 'designer babies.' This is a legitimate concern, but temperance aids in distinguishing between goods of the present world and the more enduring goods (John Paul II, 1993). It would seem non-maleficent, and even beneficent, to engineer the healthiest possible baby, or the baby with the best chances of gaining admission to Harvard University, or the baby with an expected height sure to make him the first overall pick in the National Basketball Association draft. While it is not clear that we know *how* to genetically select for these traits—general robust health, intelligence, height, and many others—suppose that scientific knowledge advances to a point where such gene edits are not only plausible but simple. Temperance provides the buffer against inappropriate application of such biotechnology. One can tinker around the edges of the body, but he can never edit the soul of the hylomorphic being; converting nucleotide bases is not in service of the more enduring human goods.

Just because we *can* does not mean we *should*. Temperance calls for maintenance of honesty with respect to human nature and moderation with respect to humans' claimed abilities to alter nature (Pelligrino & Thomasma, 1993, p. 120):

> *Modern medical technology empowers individuals beyond their normal capacities. Because technology is, by definition, an extension of human work, it tempts us to exceed the bounds of temperance…Medical technology adds to this traditional paternalism an even greater temptation: the temptation to "play God."*

Temperance is critical to resisting this temptation. For practitioner and public acceptance of gene therapy development and implementation, there must be an underlying trust that it will be used responsibly and in pursuit of the true, basic, and enduring human goods. Vapid commitments to beneficence and non-maleficence will not do the job, especially as they have already been overridden in a plethora of other cases by the domination of autonomy. Underlying 'designer babies' trends is a concern about human pride. Temperance offers "a willful restraint on our instinctual drive to recreate and improve upon our children," a drive which stems from "the desire to attain a pleasurable state of living by perpetually 'improving' and perfecting things" (Reilly, 2020, p. 229). Temperance in gene therapy requires that such technologies are used not to *perfect* physiology but to *treat* pathophysiology. Treatment attempts to achieve restoration of typical physiological functioning, relief of symptoms, or mitigation of future pathophysiological developments. Using the capacities of reason nested with a natural law understanding of human relationships, one can discriminate between treatment and perfection. Clinical norms and medical law must conform to this standard of temperance to promote trust in potentially life-saving therapeutic strategies.

5.6 Applying the Cardinal Virtues to Cases

Application of this cardinal virtues bioethics framework starts from a bedrock rich view of personhood, from conception to natural death. This includes an acknowledgement of fetal personhood, through natural potential—rather than practical potential—and active potency—rather than passive potency (Camosy, 2008). This compares favorably to Donley's (2022) account of "subjective and relational fetal value," which, although perhaps expressed in more extreme

terms, is not far from Chervenak and McCullough's understanding of personhood as a gift bestowed by the autonomous mother onto the previable unborn child (p. 1650).

One next layers on top of this foundation the role-based duties of the decision-maker at issue, with particular attention to his or her duty to care (Shaw, 2019). This *prima facie* account of role-based duties provides a starting point for the real ethical work. Instead of assessing how a particular course of action accords with Beauchamp and Childress' four principles, focus on how each course of action displays or promotes the development of the four cardinal virtues. This allows for a detailed interrogation of intent. A physician may act *qua* caregiver or *qua* money-maker, while a pregnant woman may act *qua* mother or *qua* friend-who-hopes-to-attend-next-month's-bachelorette-party; actions might be taken in furtherance of each of these roles, but the *relevant* exercise of the cardinal virtues depends on the relationships which hold the most significant role-based duties, identified following elucidation of the most significant roles, in view of the clinical context.

This thesis has outlined the structure of cardinal virtues bioethics, but future work must elucidate its relevance and facility in clinical decision-making. It should cohere with moral intuition in easy cases but must also work for hard cases which mimic the uncertainty, risk, and limited knowledge of the clinical setting, such as those provided by Lyerly et al. (2008). It must capture the rich nuance of the maternal-fetal medicine specialty, but it is essential for cardinal virtues bioethics to hold across the lifespan and throughout the diverse clinical interactions which comprise the vocation, profession, and relationships of medicine. It should align with a postliberal vision of the polis but must be applicable in the present context to build a bridge toward the changing governmental functions and public perceptions which postliberalism anticipates.

6.0 Anticipating and Responding to Criticisms of 'Cardinal Virtues Bioethics'

In the following sections, some of the most plausible criticisms to the model presented in the foregoing discussion are briefly considered and provided with, hopefully, charitable responses in defense of cardinal virtues bioethics. Postliberalism as political theory engenders strong reactions from across the political spectrum. It has been called "proto-fascism" and an extension of the "violent, tortured bigoted history" of religion (Wright, 2023). If one stands to the political right of United States Senator Bernie Sanders on matters of the economy or climate change, he cannot possibly be concerned with the common good, these critics argue. Postliberalism has gotten the issue of autonomy all wrong, for, in our current culture, "[t]here is *too little* freedom, not *too much*" (Wright, 2023). While it is difficult to conceive of exactly what additional freedoms have not yet been but might be sanctioned by the government, such *ad hominem* or particularly partisan criticisms, which certainly abound, will not be taken up here. These criticisms tend to morph with the electoral zeitgeist of their period of authorship such that they are not instructive for a durable bioethical framework.

The following sections address, succinctly, four potential avenues of *ethical* and *practical* criticism and the most immediately fruitful rejoinder. They are not intended to be all-encompassing but, instead, to model the sort of bioethical discourse which will—and must—accompany strong advocacy for a conversion to cardinal virtues bioethics in clinical, legal, and philosophical venues.

6.1 Criticism 1: It's Natural Law Bioethics by Another Name

From the foregoing discussion, it seems that cardinal virtues bioethics draws heavily on the natural law theory of Finnis and the natural law bioethics of Gomez-Lobo and Keown. If it is founded on natural law capabilities of reasoning and articulation of human nature, the criticism might suggest, it is merely natural law bioethics by another name, a repackaged form of the same theory.

I answer that, natural law bioethics has not found the political willpower to move from a conversation piece in theological circles to a matter of practical decision-making in the clinic. Gomez-Lobo and Keown (2015) still sought to provide a "natural law interpretation of a certain number of principles," and among these principles were non-maleficence, beneficence, justice, and autonomy (p. 24). Cardinal virtues bioethics does not attempt to retrofit a suitable substructure for these mid-level principles; it begins from a new foundation rooted in the nature of the human person and uses the cardinal virtues themselves as the mid-level considerations.

However, an early work of Finnis (1970) displays a spark of such political willpower which postliberalism attempts to fan into flames. Finnis held that "if society regards something as a vice, it will generally be better to treat it as a vice and not merely as a problem of health regulation like the sale of milk" (p. 457). In the decade of *Roe* and other shifts toward greater abortion permissibility, Finnis noted that for "anyone who shares what have hitherto been the fundamental values of Western society, an abandonment of the universal respect for the value of human life must seem a harm—a change for the worse—not only to those whose lives are lost as a result, but also to those who are persuaded to commit the unjust killings" (p. 457). Those who do not share those values are far more likely to find abortion restrictions impermissible. Cardinal virtues bioethics employs natural law to justify these fundamental values of Western society but also calls

on postliberalism to foster, throughout public life and the activity of governance, a return to the fundamental values of Western society in the pursuit of human flourishing.

6.2 Criticism 2: It's Not Incompatible with Principlism

Another variant of this criticism suggests that a conception of the good could simply be added to the existing Beauchamp and Childress model of principlism. It ought to be possible to create a natural law-based approach without abandoning Beauchamp and Childress' principles (Gomez-Lobo & Keown, 2015). Shea (2020) has suggested that "a value theory is needed to specify the principles of beneficence and non-maleficence by determining what true benefits and harms are" and "to balance moral principles and decide which ones are overriding in cases where they conflict" (p. 442). Based on these claims, it might be argued that principlism as currently constructed is insufficient, but an overhaul is not necessary. The mere addition of normative guidance is enough to save principlism.

I answer that, the cardinal virtues bioethics approach does not tack on a virtue theory to an existing principlist framework that has gone off the rails. Instead, it constructs a new quartet of virtues as mid-level principles which descend from and depend on a natural law understanding of human nature and basic human goods. Shea (2020), who suggests the need for a value theory to accompany principlism, also admits that "addition of a value theory poses a threat to principlism," which demands that "its mid-level principles are…independent of a general ethical theory" (p. 442). This, of course, is an untenable position. We all might agree that a new pier must have wooden planks, railings, and dock posts. However, if we cannot agree on where this pier ought to be placed along the shoreline, anchoring it to a concrete location—in fact, the *best* location for the

functions the pier is intended to provide—these agreed-upon supplies never assume the functional form of a pier. If we cannot agree on fundamentals, such that hewing to a single ethical theory in justifying biomedical decision-making is incompatible with principlism's commitment to ethical pluralism, the resultant approach never assumes the functional form of a bioethics which is intended to provide for and defend the basic human goods of life and health. If principlism is threatened by the addition of a value theory, according to its own defenders, let it be threatened and, ultimately, replaced. As previously discussed, a live-and-let-live approach to bioethics ultimately does not often let the vulnerable—such as the unborn—live.

6.3 Criticism 3: It's *an* Approach but Not *the* Approach

Assuming cardinal virtues bioethics can be separated from existing natural law and liberal principlist bioethics frameworks, it might then be argued that, while this approach is *an* alternative to Beauchamp and Childress' principlism, it is not clear that it is *the* alternative approach which ought to be selected and promoted in the public square.

I answer that, cardinal virtues bioethics is *the* alternative approach because it starts from the very nature of the human person and anticipates the self-destruction of liberal commitments to align with a postliberal polis. Healthcare may change. Technological capacities may change. Laws may change. Social norms and taboos may change. The nature of the human person will never change. This recommends favorably the approaches which stem from the metaphysics underlying natural law.

Based on this account of the nature of the human person, the most direct precursor of the present thesis is the natural law bioethics of Gomez-Lobo and Keown (2015). Their approach

permits the elucidation of several desiderata of a postliberal bioethics which the present cardinal virtues method seeks to retain and further develop. Gomez-Lobo and Keown adopt a nonconsequentialist perspective that prevents beneficence and justice from coming into conflict. An expansive view of the common good "encompasses all of the conditions that allow members of the human community successfully to engage in the pursuit of their own goods, their own flourishing" (p. 19). Natural law bioethics further requires us "to respect fully *every real good* perfective of human persons and to refrain from intentionally choosing to damage, destroy, impede, neglect, ignore, or in any other way fail to honor these goods and the persons in whom they are meant to flourish" (May, 2013, p. 70). This analogue of non-maleficence does not concern itself with subjective perceptions or deference to autonomous wills; the command is specifically to avoid harming that which is *good* in and for persons. Gomez-Lobo and Keown's (2015) natural law bioethics also allows for a rich discussion of embryonic personhood, even if the outcomes of their specific treatment of the issue appear a bit vague. It is critical to construct a bioethical framework that functions equally well in beginning-of-life and end-of-life cases, for "[h]ow we ought to treat human embryos is a function of how we understand ourselves as adults" (p. 31). Their model explicitly tears down autonomy's reign of terror, holding that—since we "have right and wrong desires"—autonomy cannot by itself "guarantee morally right action" (p. 56). Cardinal virtues bioethics, rooted in natural law and postliberalism's common-good conservatism, satisfies *at least* all of these desiderata.

However, most modern natural law theorists still insist that "[i]n the public square, we are philosophers; at home, we are theologians; and the two disciplines are quite compatible" (Novak, 2019). The two disciplines *are* quite compatible; in fact, they are so compatible and intertwined that one cannot leave his religious hat at the door when entering the public square. Postliberalism

calls for "[p]rotecting and supporting a life of prayer, recognizing the transcendent, acknowledging the frailty and temptations of lives threatened by a madding world—all point not just to 'prayer as a political problem,' but politics as a place for prayer, since politics is how we together seek to realize the good that is common" (Deneen, 2023, p. 237). Thus, only cardinal virtues bioethics captures another critical aspect of the nature of the human person—namely, that he is a spiritual being made in the image of God. Just because public discourse shies away from this fact does not mean that our mode of bioethical analysis for the postliberal future must. Every society and every individual worships something. Currently, public square philosophy and bioethics are not located outside of theology; they lie prostrate before the altar of autonomy, a theology of the self.

Postliberals' focus on the common good relies, arguably, even more heavily on the concept of the *common* than on the concept of the *good*. Deneen (2023) suggests that "the goods that are 'common' are daily reinforced by the habits and practices of ordinary people," which form the common culture, the community, and the derivative sense of "mutual obligation" (p. 230). Pursuit of these shared goods is largely dormant today. For proof, consider the modern connotation of *commoner*. Thus, it "is not enough to ensure [ordinary people's] *freedom* to pursue such goods; rather it is the duty of the political order to positively guide them to, and provide the conditions for the enjoyment of, the goods of human life" (p. 231). Cardinal virtues bioethics offers mid-level principles which, as virtues, may be commonly held and which, as derived from natural law, may orient one *and one's associations* toward the good.

Cardinal virtues bioethics offers a superior method of bioethical inquiry because of this unique incorporation of one's associations into its analytical framework. The specific manifestations of virtue-based actions may vary depending on one's role or vocation. A pediatrician in the clinic *qua* physician, caring for young patients, will be expected to act

differently than when she returns to the clinic at another time *qua* parent, caring for her own children by presenting them to another physician for medical examination. Nevertheless, she is the same person, cultivating the same fundamental—or cardinal—virtues, in both capacities. If "the unity of a human life becomes invisible to us when a sharp separation is made either between the individual and the roles that he or she plays…or between the different role—and quasi-role—enactments of an individual life," the unity, nature, and dignity of human life may become more clearly visible—and readily bioethically defensible in the face of harmful clinical practices—through the holistic integration of cardinal virtues in all corners of the polis (MacIntyre, 2007, p. 204).

Looking beyond the individual, cardinal virtues bioethics is especially promising because both physicians and patients, in their own ways, can work toward these same basic virtues. These are not merely principles which bind the clinician's decision-making or claims to autonomy which empower the patient. Instead, both parties in the physician-patient relationship are engaged in a cooperative search for that which is good, right, and true through the mutual exercise of justice, prudence, fortitude, and temperance. This approximates the trusting relationship sought by proponents of care ethics and communitarian bioethical frameworks but conceives of this relationship not as the meeting of two autonomous wills but, instead, as the meeting of two embodied human persons converging in their attempts to act according to the cardinal virtues. Prenatal screening, with the potential to detect genetic or clinical abnormalities, is converted from a treacherous step toward recommendation of abortion to a promising precursor to life-affirming perinatal interventions when the parents trust the physician to be prudent and temperate in his proposed clinical interventions, the physician trusts the parents to exercise fortitude in the face of an unexpected and challenging fetal diagnosis, and all parties can be counted on to act justly toward

the unborn child and thereby promote the common good of all stakeholders. Because "man is a political animal, and must through the exercise and practice of virtue learned in communities achieve a form of local and communal self-limitation," a proper conception of liberty designed to promote human flourishing depends upon and continuously reinforces social interactions oriented toward the good (Deneen, 2018, p. 42).

6.4 Criticism 4: It's Incompatible With Clinical, Legal, or Societal Reality

One final, and strong, criticism suggests that, whatever the merits of a cardinal virtues bioethics may be, its normative framework and insistence on certain goods and virtues is simply incompatible with the modern age. Clinicians' decision-making is too heavily based on principlism to abandon the approach wholesale. Legal frameworks protect autonomy to such an extent that the duties-based approach would not stand. Societal reliance on liberalism—as a political structure and as a governing framework for consideration of self, others, and relationships—is simply too engrained in the human psyche and experience to be shaken. Furthermore, it is not practical, for postliberals do a lot of talking about the *post*-liberal period but not enough about how we get there.

I answer that, while postliberalism has more work to do in defining how the breakdown of liberalism necessarily or even likely leads to a postliberal polis—and what the timescale of such a radical political conversion might be, in years, decades, generations, centuries, or millennia—this cardinal virtues bioethics is useful precisely because it builds the bridge out of liberalism. It can be applied in the practice of medicine now and illustrate a favorable alternative to dominant liberal models. Then, the seeds have already been sown for cardinal virtues bioethics to bloom in a postliberal age which permits a more perfect realization of this framework in concert with a

compatible political theory. Furthermore, new natural law theorists working before the most recent wave of postliberal scholarship have expressed hope in natural law bioethics that does not directly depend on theological commitments (Tully, 2016, p. 161):

> *Our current moral milieu seems to be characterized by the belief that no moral position can be shown, in a rational and objective way, to be superior to any other sincerely held moral position. This may be due to the fact that basic moral beliefs are so often anchored to and justified by one's faith commitments and the conception of the good found therein…NNL [new natural law] can make clear the faith-independent plausibility and thoroughgoing reasonableness of its ethic of life so that the moral truth(s) relevant to beginning-of-life issues identified by this approach are not looked upon as simply one set of privately held, nonrational beliefs among other equally plausible (and equally dubious) views.*

Even though natural law is written on the human heart from God, it does not rely upon such a theological explanation for rational acceptance. Natural law-based approaches can reach skeptics from reason, without *a priori* commitments to Catholicism, Christianity, or even monotheistic faith. This is because, even though "revelation discloses that the natural law is upheld by divine sanctions," these sanctions "are not what make it law or binding" (Finnis, 2015, p. 223). In the period prior to a postliberal reintegration of religion into political life, the natural law foundations of cardinal virtues bioethics can germinate the theory while waiting for the postliberal polis to bring it into full bloom.

Existing legal scholarship and case law offer a kernel of existing jurisprudence which aligns with cardinal virtues bioethics. Over a century before scientific advances could intimately

treat the unborn human therapeutically or curatively as a patient, he was viewed as a person. It is clear that "state high courts in the years before 1868 declared that the unborn human being throughout pregnancy 'is a person' and hence, under 'civil and common law,' 'to all intents and purposes a child, as much as if born'" (Brief for Scholars of Jurisprudence John M. Finnis and Robert P. George as Amici Curiae Supporting Petitioners, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 3). Furthermore, according to neurosurgeon and former Cabinet secretary Ben Carson, "natural law simply holds that what is right and what is wrong—in other words, what advances the common good and what does not—can be determined objectively through the exercise of sound human reason alone" and, as a result, "natural law requires, at a minimum, government protection of innocent human life" (Brief for The American Cornerstone Institute and its Founder Dr. Benjamin S. Carson as Amici Curiae Supporting Petitioners, *Dobbs et al. v. Jackson Women's Health Organization et al.*, 2022, p. 12).

These opinions are not limited to amici curiae. In *LePage v. The Center for Reproductive Medicine, PC* (2024), the Supreme Court of Alabama took up the issue of embryonic personhood in relation to IVF and wrongful death liability. All parties and all jurists involved "agree an unborn child is a genetically unique human being whose life begins at fertilization and ends at death. The parties further agree that an unborn child usually qualifies as a 'human life,' 'human being,' or 'person'" (p. 8). The question of prenatal personhood—which liberal bioethics' false liberal neutrality attempts to both foreclose and answer in the negative—is resolved almost as a matter of course in the opinion written by Justice Jay Mitchell. Chief Justice Tom Parker's concurrence—which received the full force of media scrutiny—acknowledges that the *imago Dei* understanding of the human person is not restricted to the theological realm, and it is not limited to a unique political artifact in Alabama law. Alabama's "recognition that human life is an endowment from

God emphasizes a foundational principle of English common law," and human "creation in God's image is the basis of the general prohibition on the intentional taking of human life" (p. 30, 35). As a result, "even before birth, all human beings bear the image of God, and their lives cannot be destroyed without effacing his glory" (p. 38). While this concurring opinion is more theological than most jurists are currently willing to go, it helpfully lays out the existing, centuries-old foundation for religion's incorporation into the public sphere. Furthermore, the Alabama constitution is not some relic of its early days of statehood; the pro-life abortion policy amendment to the Alabama State Constitution—the mandate binding the state government and central to the ruling in *LePage*—was ratified by voters in 2018. There is recent political precedent for this anti-liberal approach to prenatal personhood protections.

It is not merely jurists in black robes who have recognized the ability to implement tenets of natural law theory and virtues-oriented pro-life sentiments in their work. Clinicians across the United States have begun healthcare programs designed to protect the smallest and most vulnerable humans. Among the most remarkable is John Bruchalski, an abortionist-turned-pro-life-OB/GYN who founded Tepeyac OB/GYN and Divine Mercy Care in northern Virginia. Bruchalski's approach to prenatal care is exactly the sort envisioned by cardinal virtues bioethics (Camosy, 2022):

> *"There is no such thing as neutral advice," I hear often. Doctors can really ignite the fear of women facing an unwanted pregnancy or a life-limiting prenatal diagnosis by offering elective abortion as the "merciful and medical" solution.*
>
> *We counter this reproductive health narrative with accompaniment. Rather than robbing our patients of an opportunity for courage, or*

underestimating their capacity to face suffering, we need to speak the medical truth and encourage them…

Mom and baby are on the same team, the same family. As a doctor, I never pit the mother against her baby. The life-affirming approach is to get both mother and baby as far along in the pregnancy as possible if it is safe. What's good for the mother is often good for the baby. If the mother's life is in danger, the baby is in danger too.

Bruchalski's treatment of both the mother and her unborn child as patients, use of the rule of double effect in cases of maternal health endangerment, and willingness to discuss caring for not only the body but also the *soul* demonstrates justice, prudence, fortitude, and temperance. This life-affirming care model has been adopted across the nation and in hostile political settings, from Bella Health + Wellness in Colorado to Elvira Parravicini's Neonatal Comfort Care Program in New York City. This sort of healthcare can be both supported by legal reasoning and implemented in modern clinical contexts.

Aside from existing legal and clinical structures which might undergird the Thomistic-postliberal approach of cardinal virtues bioethics and promote its development, existing intuition about fetal personhood, contextualized autonomy, and pursuit of the common good recommends this strategy. It seems that, at least emotionally, we ascribe some degree of meaningfully heightened status to the fetal patient. Michigan's Lunar Doula Collective (2024) is dedicated to "providing compassionate support, free of charge, to individuals experiencing pregnancy loss and termination." The collective offers bereavement support and grief care for cases of miscarriage, stillbirth, or pregnancy termination. While the Lunar Doula Collective may not admit that these are all end-of-*life* situations, its treatment addressing all three events seems to

imply at least some underlying similarity. It trains *loss* doulas to care for "people of all identities" undergoing these "reproductive health experiences"—but, reading beyond these euphemisms, what exactly has been lost? There is not a wellspring of support groups for other sorts of losses; charities have not begun to offer counseling for children who lose bicycles in the park. Perhaps an unborn child is more valuable than an easily replaceable youth bicycle. Still, there is not a booming market of support groups for families who misplace antique heirlooms, lose millions of dollars in the stock market, or drop a set of great-grandmother's imported china. It might be that there is something distinctive about biological matter, but therapy is not routinely offered for research scientists whose freezers die in the night, killing their clumps of cells in Petri dishes. However, there *are* support groups for those who lose a human family member or, in some cases, even a pet. Emotionally and sociologically, then, the entity being treated—or harmed—in utero seems phenomenologically most akin to this last class of 'lost entities,' highlighting the importance of relationships, the associational virtues, and the related duties and obligations.

Of course, this intuition-laden approach is not dispositive, and empirical, bioethical, and legal analysis of the sort conducted in this thesis is both warranted and necessary. However, the human heart offers a helpful north star, should we lose our way along the winding path of modern liberalism. Intuition is not independently defensible, but—in parallel with a natural law theory extending from the application of reason to the ordered world—it suggests one way in which contemporary, though often implicit, human reason converges along ethical lines similar to those proposed by cardinal virtues bioethics. Furthermore, these claims about intuitive approaches are supported by empirical evidence about clinical decision-making. Evaluating principlism, quantitative studies show that "people state they value these ethical principles but

they do not actually use them directly in the decision making process" (Page, 2012, p. 7). A survey of psychology students found that, "for individuals, the most important principle is, without ambiguity, 'Non-maleficence'…These results are consistent with those of Landau and Osmo. In their study 'protection of life' was the most important principle and this seems to overlap conceptually with the principle of non-maleficence" (p. 6). In addition to its philosophical underpinnings, theological consistency, legal applicability, and clinical possibility, cardinal virtues bioethics and the centrality of protecting human life is recommended by its ability to take existing intrinsic values and crystallize them in a decision-making framework that anticipates the postliberal polis.

This thesis has outlined such an approach, justified its creation, and defended it against critics. The next significant step in this work will be to apply the cardinal virtues bioethics approach to a wide variety of clinical cases, refining the framework as a tool for both decision-making and justification of the decisions made in scenarios both easy and difficult. In the meantime, cardinal virtues bioethics can enter the public square as an antidote to autonomy-laden principlism and its attendant reliance upon the falsehood of liberal neutrality, while outlining a rich view of the human person to guide interpersonal relationships within and beyond the clinical setting. This cardinal virtues bioethics thus paves the way for a postliberal polis which more fully integrates the practice of and institutional support for associational virtues, role-based duties, and duty-oriented rights in a return to a conception of liberty governed by the good, the right, and the true.

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