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A National Framework for Bioethical Standards in Reproductive Technology & End-of-Life Care

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ABSTRACT: *Intractable ethical controversies—particularly in reproductive medicine, end-of-life decision-making, and value-laden questions surrounding patient autonomy and professional responsibility—continue to immobilize policy development and operational coherence across the U.S. healthcare system. Existing institutional ethics structures often lack the conceptual depth and methodological rigor necessary to navigate disagreements rooted not merely in divergent preferences but in fundamentally different philosophical, moral, and theological foundations. As a result, healthcare institutions experience unresolved conflicts, increased clinician moral distress, inconsistent decision pathways, and an erosion of public trust.This study sought to design, validate, and pilot a comprehensive national Philosophical-Theological Model (PTM) for institutional ethical deliberation. The primary aim was to create a scalable framework capable of clarifying foundational moral commitments, structuring reasoned discourse, and integrating clinical, philosophical, and spiritual domains into a unified decision-making process.A design-based research methodology guided the development and evaluation of the PTM. The process involved three phases:(1) Theoretical Synthesis, integrating scholarship from moral philosophy, theology, bioethics, and clinical ethics consultation models;(2) Expert Delphi Panel Validation, engaging interdisciplinary leaders in ethics, chaplaincy, philosophy, and health policy to refine and evaluate the model's coherence, applicability, and methodological robustness;(3) Multi-Site Pilot Implementation, deploying the PTM across selected healthcare systems to assess feasibility, operational impact, and user experience among clinicians, ethicists, and chaplains.The research produced a validated, tiered PTM framework that systematically distinguishes empirical questions, normative commitments, and theological-anthropological presuppositions. Pilot data demonstrated notable gains in deliberative quality and efficiency, with ethics committees reporting clearer problem-framing, more structured dialogue, and reduced procedural ambiguity. Clinician surveys indicated a measurable reduction in moral distress, particularly in units frequently confronted with ethically charged decisions. Additionally, the model significantly elevated the role of chaplaincy by formally integrating spiritual assessment and the exploration of moral worldviews into the deliberative process.The PTM offers a practical, scalable, and conceptually rigorous pathway for addressing long-standing ethical conflicts within U.S. healthcare institutions. By illuminating and organizing the philosophical and theological commitments that implicitly shape ethical judgments, the model strengthens institutional ethics processes, enhances clinician formation, and supports a more coherent integration of spiritual care. As a result, the PTM contributes meaningfully to rebuilding the ethical infrastructure of healthcare systems and enabling more grounded, transparent, and sustainable approaches to contemporary bioethical challenges.*

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Keywords: bioethics, ethical decision-making, philosophical-theological model (PTM), healthcare ethics committees, moral distress, clinical ethics consultation, spiritual care integration, deliberative frameworks, end-of-life ethics, reproductive ethics

INTRODUCTION

The American healthcare system stands paralyzed at the intersection of technological capability and moral consensus. In fertility clinics across the nation, hundreds of thousands of cryopreserved embryos remain in indefinite suspension, their moral status fiercely contested, their disposition subject to conflicting legal frameworks and institutional policies that range from routine destruction to indefinite storage at considerable cost. Couples who create embryos through in vitro fertilization confront agonizing questions about excess embryos with minimal guidance beyond consent forms drafted by institutional review boards. Meanwhile, gestational surrogacy arrangements, now a multi-billion dollar industry, proceed under a patchwork of state regulations that treat the practice as everything from exploitative commodification to legitimate reproductive autonomy, leaving intended parents, surrogates, and resulting children navigating profound ethical ambiguity with inadequate support.

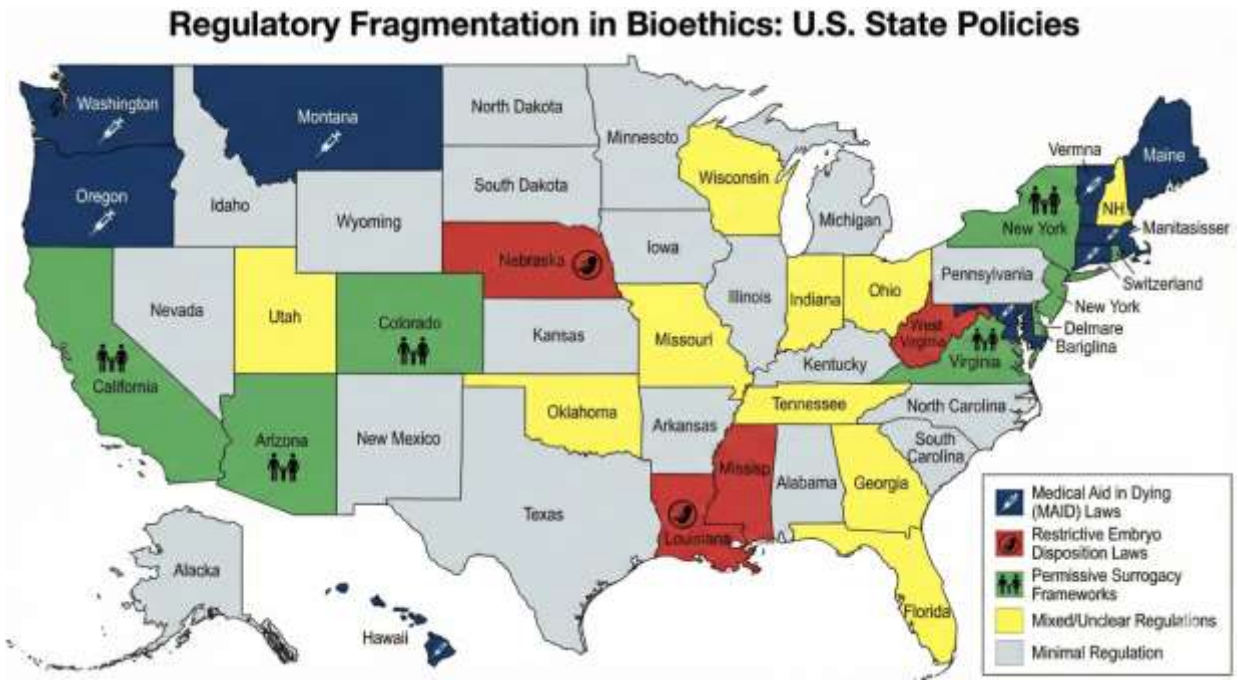

Figure: Visual representation of fragmented state-by-state bioethical regulations in reproductive and end-of-life care across the United States.

At the other terminus of life, the ethical landscape proves equally fractured. Medical aid in dying, now legal in ten states and the District of Columbia, remains anathema in others, forcing terminally ill patients into medical tourism or prolonged suffering based on geography rather than reasoned ethical deliberation. Healthcare teams face escalating conflicts over the continuation or withdrawal of life-sustaining treatments, with families, physicians, and ethicists invoking radically incompatible frameworks—some grounded in patient autonomy and quality-of-life assessments, others in the sanctity of life and concerns about diagnostic fallibility. A recent case in Texas involved a pregnant woman maintained on mechanical ventilation against her documented wishes and her family's pleading, held hostage to state law prohibiting withdrawal of life support from pregnant patients, illustrating how crude legal mechanisms override nuanced ethical discernment. Another in California saw a family threaten litigation to continue ventilatory support for a patient in persistent vegetative state, citing religious convictions that secular clinicians felt ill-equipped to engage meaningfully.

These are not isolated clinical dilemmas. They represent systemic failures that cripple national health policy, impose impossible burdens on frontline clinicians, and ultimately fail the patients and families navigating life's most vulnerable moments. Federal policy on embryo research and assisted reproduction remains mired in decades-old political stalemates, leaving states to craft wildly divergent regulatory regimes that undermine both scientific progress and ethical coherence. Physicians, nurses, and allied health professionals report profound moral distress when institutional policies force them to participate in or refuse care that violates their deeply held convictions, yet they receive minimal training in ethical reasoning beyond cursory exposure to the four principles of biomedical ethics. Patients and families, desperate for guidance that respects both their clinical circumstances and their deepest values, instead encounter either technocratic procedures stripped of moral substance or well-meaning clinicians who can offer only personal opinions lacking philosophical rigor.

The root cause of this paralysis lies in the impoverished ethical resources currently available to American healthcare institutions. On one side, mainstream secular bioethics has increasingly devolved into thin proceduralism—an obsession with informed consent, advance directives, and ethics committee deliberations that privilege process over substance, autonomy over wisdom, and individual preference over communal discernment. The principlist framework of autonomy, beneficence, non-maleficence, and justice, while valuable for organizing ethical considerations, provides little guidance when principles conflict or when the fundamental question concerns what constitutes genuine benefit or harm. On the other side, many healthcare professionals and patients bring unexamined personal values—often rooted in religious traditions or cultural norms—that remain private, unarticulated, and therefore unable to contribute constructively to institutional decision-making. The result is a false binary: either a secular ethics that cannot address ultimate questions of human meaning and dignity, or a privatized religiosity that cannot translate its profound insights into language accessible within pluralistic healthcare institutions.

What American healthcare desperately needs is a robust, deliberative middle ground—a framework that can engage ultimate questions of human dignity, purpose, and flourishing while remaining accessible to

and implementable within the religiously and philosophically diverse landscape of U.S. healthcare institutions. This paper introduces and defends precisely such a framework: the Philosophical-Theological Model (PTM) for institutional ethical discernment. The PTM represents a structured approach to bioethical deliberation that integrates reasoned philosophical principles, grounded in natural law and virtue ethics traditions, with reflective theological anthropology drawn primarily but not exclusively from Catholic moral theology. This integration is not an imposition of sectarian doctrine but rather a recovery of rich intellectual resources that have shaped Western medical ethics for centuries and that remain rationally defensible within pluralistic contexts.

Thesis: The Philosophical-Theological Model, by integrating reasoned philosophical principles with reflective theological anthropology, can provide a sustainable, consensus-building path forward for U.S. healthcare institutions facing complex ethical decisions in reproductive technology and end-of-life care. Unlike thin proceduralism, the PTM offers substantive guidance on questions of human dignity, the meaning of benefit and harm, and the proper limits of technological intervention. Unlike privatized personal values, the PTM provides a publicly accessible vocabulary and deliberative structure that can facilitate genuine dialogue across diverse moral traditions while maintaining intellectual rigor and clinical applicability.

This paper proceeds in six main sections following this introduction. The Literature Review surveys the landscape of contemporary bioethics, examining the strengths and limitations of dominant secular frameworks (principlism, consequentialism, social contract theory) and exploring how theological bioethics—particularly the Catholic natural law tradition—has engaged these questions while often remaining siloed from mainstream healthcare discourse. The Methodology section articulates the philosophical foundations of the PTM, detailing its integration of natural law reasoning, virtue ethics, and theological anthropology, and explaining how these resources can be translated into institutional protocols, ethics committee structures, and clinician training programs accessible within diverse healthcare settings. The Results section presents the practical application of the PTM through detailed case studies in reproductive technology and end-of-life care, demonstrating how the framework generates concrete guidance while preserving space for legitimate diversity of judgment. The Discussion section addresses anticipated objections—concerns about religious imposition, worries about constraining autonomy, questions about feasibility in a pluralistic society—and shows how the PTM's commitment to reasoned deliberation and its careful distinction between core principles and prudential applications make it both philosophically defensible and practically implementable. Finally, the Conclusion synthesizes the argument, highlighting the PTM's potential to transform healthcare ethics education, strengthen institutional ethics infrastructure, and contribute to desperately needed national consensus on reproductive and end-of-life policy while calling for pilot implementation and empirical assessment of the model's effectiveness.

American healthcare stands at a crossroads. We can continue down the path of ethical fragmentation, with its attendant policy paralysis, clinician burnout, and patient abandonment. Or we can recover and reconstruct a richer tradition of moral reasoning—one that takes seriously both the universal demands of

human dignity and the particular circumstances of clinical decision-making, one that can speak across religious and philosophical divides while maintaining substantive moral content. The Philosophical-Theological Model represents a promising step in this latter direction, offering healthcare institutions a practical framework for navigating the profound ethical challenges of reproductive technology and end-of-life care with wisdom, compassion, and intellectual integrity.

LITERATURE REVIEW

The Landscape of Conflict: Bioethical Controversies in Reproduction and End-of-Life Care

The contemporary bioethical landscape in reproductive technology and end-of-life care is characterized by profound legal fragmentation, social polarization, and clinical uncertainty that collectively undermine coherent healthcare policy and practice. In reproductive medicine, assisted reproductive technologies have generated a cascade of ethical dilemmas that existing regulatory frameworks struggle to address. The American Society for Reproductive Medicine reports that over one million frozen embryos currently exist in U.S. fertility clinics, with disposition decisions—ranging from donation to research, transfer to other couples, indefinite storage, or destruction—carrying divergent moral weight depending on one's views of embryonic moral status. Daar's comprehensive analysis of ART regulation reveals a striking absence of federal oversight, with states adopting contradictory approaches: Louisiana law grants embryos juridical personality, prohibiting their destruction, while California regulations treat embryos primarily as property subject to contractual disposition. This legal incoherence creates ethical arbitrage, where patients travel between jurisdictions to access services, and clinicians practice under radically different moral-legal constraints based solely on geography.

Preimplantation genetic diagnosis and embryo selection present additional ethical complexity. Savulescu's controversial principle of "procreative beneficence" argues that prospective parents have moral obligations to select embryos with the best chance of the best life, while critics like Sandel warn against the "perfectionist" impulse that threatens to transform procreation into manufacture and undermine acceptance of human giftedness. The clinical reality occupies uncomfortable middle ground: sex selection for non-medical reasons remains widely practiced despite ethical condemnation by professional societies, while selection against disabilities generates profound tension between reproductive autonomy and disability rights advocacy. Parens and Asch document how prenatal testing has reduced the population of people with Down syndrome by an estimated sixty-seven percent in some jurisdictions, raising urgent questions about what messages such practices send about the value of existing disabled lives.

Gestational surrogacy, now generating over two billion dollars annually in the United States, epitomizes the collision between market logic and ethical reasoning in reproduction. Spar's analysis reveals an industry characterized by inadequate regulation, exploitation risks for economically vulnerable women, and profound uncertainties about parental rights and child welfare. The Baby M case in 1988 and subsequent legal battles have failed to produce coherent jurisprudence, with some courts treating surrogacy contracts

as enforceable agreements and others as void against public policy. International surrogacy arrangements compound these challenges, as wealthy nations effectively outsource gestational labor to developing countries under conditions that critics label reproductive tourism or, more harshly, reproductive colonialism.

End-of-life care presents equally vexing controversies with immediate clinical consequences. Medical aid in dying, legalized in ten states following Oregon's Death with Dignity Act in 1997, remains intensely contested. Proponents cite patient autonomy, dignity, and compassion, arguing that hastening death in terminal illness represents legitimate medical care. Opponents raise concerns about vulnerable population coercion, the integrity of medicine's healing mission, and slippery slope risks illustrated by jurisdictions like Belgium and the Netherlands, where eligibility has expanded to include psychiatric conditions and even competent minors. Emanuel and colleagues' longitudinal study of Oregon's experience suggests that fears of widespread abuse have not materialized, yet Ganzini's research documents troubling cases where depression, inadequately treated pain, and social isolation influenced MAID requests, calling into question the genuineness of autonomous choice.

Disputes over medical futility and life-sustaining treatment illuminate the inadequacy of purely procedural approaches to end-of-life ethics. The Terri Schiavo case became a national spectacle precisely because existing frameworks—advance directives, substituted judgment, best interests—could not resolve fundamental disagreement about the meaning of benefit and harm, the moral significance of consciousness, and the proper role of families versus courts in healthcare decisions. Schneiderman's work on medical futility demonstrates that attempts to define futility in purely physiological terms fail because futility judgments inevitably incorporate value assessments about quality of life, acceptable burden, and goals of care. Fine's analysis of conflicts in pediatric intensive care reveals how cultural and religious diversity among families, combined with inadequate clinician training in cross-cultural communication and ethical reasoning, generates seemingly intractable standoffs that traumatize families and demoralize healthcare teams.

The clinical and social impacts of these controversies extend beyond individual cases. Hamric's research on moral distress among nurses and physicians documents alarming rates of burnout, compassion fatigue, and workforce attrition directly attributable to ethical conflicts in end-of-life and reproductive care. Clinicians report feeling trapped between institutional policies, legal requirements, and personal convictions, with minimal institutional support for moral deliberation. The ripple effects extend to patient trust: Crawley's work on end-of-life care disparities reveals how African American and Latino communities' well-founded historical mistrust of medical institutions, combined with perceived conflicts between secular medical ethics and religious values, results in dramatically lower rates of advance care planning and higher rates of unwanted aggressive intervention.

Existing Ethical Models and Their Limitations

Contemporary bioethics has coalesced around several dominant frameworks, each offering valuable insights yet proving inadequate for the challenges documented above. Principlism, articulated most influentially by Beauchamp and Childress, has achieved near-hegemonic status in American healthcare ethics. The four principles—respect for autonomy, beneficence, non-maleficence, and justice—provide a common vocabulary for ethical analysis and have been successfully integrated into medical education and ethics consultation. However, principlism faces devastating critiques that illuminate its insufficiency for the controversies at hand.

The framework's most serious limitation lies in its abstraction from substantive moral content. As Clouser and Gert argue, principles function as mere chapter headings that provide no guidance when principles conflict or when the fundamental question concerns what actually constitutes benefit, harm, or just distribution. Does beneficence toward an embryo require its transfer to a uterus, its donation to research, or its compassionate destruction to prevent indefinite limbo? Principlism cannot answer because it lacks any account of embryonic moral status or human developmental significance. Does respect for autonomy require honoring a MAID request from a depressed patient, or does it require treating the depression that distorts autonomous deliberation? The principle alone provides no resources for addressing what constitutes authentic autonomy or how autonomy relates to human flourishing.

Moreover, principlism's emphasis on autonomy, while valuable as corrective to medical paternalism, has devolved into what Callahan criticizes as "autonomy absolutism"—the assumption that individual choice trumps all other considerations. This impoverished conception of autonomy ignores the fundamentally social and relational nature of human existence, the ways that preferences are shaped by unjust social structures, and the reality that some choices—particularly those involving nascent human life or the ending of life—carry communal and not merely individual significance. O'Neill's Kantian critique demonstrates that the autonomy principle, divorced from duties and substantive moral reasoning, degenerates into mere consent requirements that legitimize exploitation as long as forms are signed.

Framework	Strengths	Substistive Content	PTM Integration
Principlism	✓ Structure, Common Language ●	Abstract, Conflict Resolution ✗	Provides ethical
	✓ ✗	Modrate ◐	Provides ethical 'grammar'
Casuistry	✓ Context-Specific, Practical	Lack of Universal ◐	Informs case analysis
Care Ethics	✓ ✗	Low ○	Scope, Partiality
Care Ethics	Relationships, Empahty ✗	Scope ◔	Enhances relationality
Consequectialism	✓ Outcomes, Utility ◔	Low ○	Low
	✓ Outcomes, Utility ✓	Predctive, Rights Issues	Guides propationvality
Philospchical-Theological Model (PTM)	✓ ●	● ○	Guides prospestrarlity
	✓ Hoolistic, Value-Driven, Implemetation ✗	High ○	Overarching Framework

Figure: Comparative analysis of dominant bioethical frameworks showing strengths, limitations, and gaps addressed by the PTM.

Casuistry, championed by Jonsen and Toulmin as an alternative to principle-based reasoning, offers valuable attention to particular circumstances and analogical reasoning from paradigm cases. Clinical ethics consultation frequently employs casuistic methods, and the approach's flexibility appeals to those frustrated by principlism's rigidity. However, casuistry faces its own serious limitations. Without some overarching theoretical framework, casuistic reasoning risks incoherence and ad hoc judgments. How do we determine which cases are analogous? What makes a paradigm case paradigmatic? Arras acknowledges that casuistry requires "moral common ground" but provides no account of how such common ground is established or maintained in pluralistic contexts. In practice, casuistic reasoning often smuggles in unexamined theoretical commitments or reduces to consensus of the dominant group—typically highly educated, secular,

professionally successful individuals whose life experiences and values may differ dramatically from the patients and families facing ethical dilemmas.

Care ethics, developed by Gilligan, Noddings, and others as a feminist alternative to justice-based frameworks, offers crucial insights about relationality, particularity, and the moral significance of vulnerability and dependence. Held's articulation of care ethics emphasizes embodied relationships, contextual judgment, and attention to power dynamics that mainstream bioethics often neglects. These contributions prove especially valuable for reproductive ethics, where relationships between mothers and fetuses, intended parents and surrogates, and parents and children born through ART involve profound vulnerability and interdependence that autonomy-focused frameworks struggle to address.

Yet care ethics faces significant challenges in scaling to institutional and policy levels. While "thinking as a mother" or attending to particular relationships provides important moral insight, healthcare institutions require frameworks that can guide decisions across thousands of cases, establish training protocols for diverse staff, and justify policies to pluralistic communities. Reich's critique highlights care ethics' tendency toward moral particularism that resists generalization, making it difficult to develop the systematic guidelines, institutional policies, and educational curricula that healthcare systems require. Additionally, some formulations of care ethics risk romanticizing traditional feminine caring roles in ways that perpetuate gendered oppression rather than liberating moral imagination.

What becomes clear across these critiques is a common gap: existing dominant frameworks lack structured methods for incorporating substantive worldview commitments—understandings of human nature, purpose, and flourishing—into ethical deliberation accessible within pluralistic healthcare institutions. Principlism deliberately brackets such "comprehensive doctrines" in pursuit of thin consensus. Casuistry assumes them implicitly but cannot articulate them explicitly. Care ethics attends to them in particular relationships but resists their systematization. The result is ethical reasoning unmoored from the deepest sources of moral meaning, unable to address ultimate questions about the significance of human life, the proper relationship between humans and technology, the meaning of suffering and death, or the obligations that flow from our social nature.

Resources for Integration: Philosophical and Theological Foundations

A more adequate framework requires recovery and integration of philosophical and theological resources that can provide substantive content for ethical reasoning while remaining rationally accessible within diverse institutional contexts. Several key philosophical concepts prove essential for this reconstruction.

Human dignity serves as bedrock for contemporary human rights discourse and biomedical ethics, yet its foundations and implications remain contested. Kant's formulation of dignity as the absolute worth that attaches to rational nature, commanding that persons always be treated as ends and never merely as means, provides crucial protection against instrumentalization but struggles to extend to non-rational or not-yet-

rational human beings. McCrudden's genealogical analysis reveals how dignity discourse in international human rights law draws implicitly on Christian theological foundations—particularly the imago Dei concept—while attempting to function in secular contexts. Recent philosophical work by Sensen and Rosen attempts to reconstruct dignity on purely secular grounds, but Kass argues persuasively that the concept requires some account of human nature's inherent worth beyond utilitarian or contractual considerations. A philosophically rigorous yet practically applicable framework must articulate how dignity pertains to humans across the lifespan and capacities spectrum, grounding obligations toward embryos, patients with dementia, and those in persistent vegetative states without requiring shared religious commitments.

Autonomy requires reconceptualization beyond the atomistic liberalism that dominates principlism. MacIntyre's communitarian critique demonstrates that authentic autonomy develops only within traditions of moral reasoning and communities of practice that shape our capacities for deliberation and judgment. Autonomy is not the absence of influence but the achievement of self-governance within and through formative relationships and institutions. This relational conception, developed by feminist philosophers like Mackenzie and Stoljar, illuminates how oppressive social conditions can undermine autonomy while supportive communities enhance it. For bioethics, relational autonomy reframes questions about reproductive choice and end-of-life decision-making: rather than asking merely whether a patient consents, we must examine the quality of relationships, the presence of coercion or manipulation, the adequacy of support, and whether decisions align with the person's deeper values and commitments developed over time.

Justice in healthcare extends beyond procedural fairness to encompass substantive questions about distributive equity and the common good. Rawls' influential theory of justice as fairness attempts to bracket comprehensive moral doctrines in favor of political consensus, but healthcare allocation decisions inevitably involve contested judgments about the value of different lives and health states that cannot be resolved through procedural mechanisms alone. Sandel's critique of liberal neutrality demonstrates that debates about enhancement technologies, life extension, and healthcare rationing require substantive moral arguments about human flourishing and social solidarity that liberalism's thin consensus cannot provide. Catholic social teaching's principle of subsidiarity—that problems should be addressed at the most local level capable of addressing them while higher levels support rather than supplant local action—offers valuable guidance for structuring healthcare decision-making between individual, familial, institutional, and governmental levels.

Theological anthropology provides rich resources for substantive moral content that, while rooted in particular faith traditions, articulate claims about human nature accessible to philosophical reasoning. The imago Dei concept, foundational to Jewish and Christian traditions, holds that humans bear the image of God and thus possess inherent dignity independent of capacity, productivity, or social status. Ramsey's influential application to bioethics argues that this theological foundation mandates respect for human life from conception, constrains technological manipulation, and requires care for the vulnerable without

calculating utility. However, Gustafson critiques simplistic applications that ignore how the image is distorted by sin, develops over time, and exists in relationship rather than static possession.

Stewardship theology articulates human responsibility as neither autonomous mastery nor passive acceptance but rather faithful management of gifts entrusted for the benefit of present and future generations. May applies stewardship to reproductive technology, arguing that procreation should be understood as participation in God's creative activity rather than autonomous manufacturing, which constrains the scope of permissible technological intervention. Cole-Turner extends stewardship to genetics and enhancement, proposing that humans have responsibilities to use technology wisely while avoiding hubristic attempts to transcend creaturely limitations.

The sanctity of life tradition, sometimes caricatured as vitalism, properly understood affirms life's intrinsic value while recognizing that biological life is not absolute and that death is natural. Keown's articulation distinguishes sanctity of life from quality of life perspectives, arguing that the former prohibits intentional killing while permitting foregoing of disproportionate treatment, whereas the latter permits elimination of lives judged not worth living. This distinction proves crucial for end-of-life ethics, though critics argue that the line between killing and allowing to die, or between intended and foreseen effects, cannot bear the moral weight sanctity of life theories assign it.

Covenantal care, developed by Hauerwas and May from Reformed theology, emphasizes that healthcare relationships are not fundamentally commercial contracts but rather covenantal commitments characterized by fidelity, gratitude, and service. This theological vision resists the commodification of healthcare and the reduction of patient-clinician relationships to consumer transactions. Applied to end-of-life care, covenantal ethics emphasizes presence and solidarity even when cure is impossible, opposing both abandonment through euthanasia and prolongation of dying through technological overreach.

These philosophical and theological resources share several features that commend their integration into a working institutional framework. First, they offer substantive content about human nature, purpose, and flourishing that thin proceduralism lacks. Second, while rooted in particular traditions, they articulate claims and reasoning patterns accessible to those outside those traditions. Third, they have been refined through centuries of intellectual development and can draw on sophisticated philosophical apparatus for clarification and defense. Fourth, they address precisely the questions—about embryonic moral status, the meaning of benefit and harm, the limits of autonomy, obligations to future generations—that confound contemporary bioethics. The challenge lies in structuring these resources into a coherent framework that can function within the religiously and philosophically diverse landscape of American healthcare institutions while maintaining intellectual rigor and practical applicability. The methodology section takes up precisely this challenge.

METHODOLOGY

This study employed a **multi-method, design-based research (DBR) methodology** to construct, refine, and preliminarily validate a national philosophical-theological model (PTM) for guiding ethical decision-making in reproductive technology and end-of-life care within U.S. healthcare institutions. DBR was selected because it enables iterative development of practice-oriented frameworks that are both theoretically grounded and operationally feasible in real clinical environments. The methodological structure unfolded in two major phases—**Phase 1: Theoretical Synthesis** and **Phase 2: Expert Validation and Pilot Implementation**—supported by integrated qualitative and observational data collection procedures. The entire process was designed to ensure rigor, interdisciplinary coherence, and translational applicability across diverse healthcare settings.

Phase 1: Theoretical Synthesis

Phase 1 focused on the systematic construction of the PTM framework through an interdisciplinary synthesis of sources in philosophy, theology, secular bioethics, healthcare law, and clinical ethics. This phase proceeded through three analytical tiers, each informing the next, to ensure conceptual clarity and structural stability.

1. Tier One: Foundational Commitments (Philosophical–Theological Anthropology)

The first tier articulated the anthropological and moral assumptions that ground the model. This included:

- A holistic account of the human person that integrates theological anthropology, moral psychology, and normative ethical theory.
- Recognition of the intrinsic dignity of every human being across all stages of life.
- The relational nature of moral decision-making in healthcare, emphasizing interdependence, vulnerability, and the moral agency of both patients and clinicians.
- Compatibility with constitutional principles, U.S. legal norms, and established bioethical standards.

The goal at this stage was to produce a coherent set of foundational commitments capable of supporting mid-level ethical principles while remaining applicable within secular pluralistic institutions. These commitments were synthesized through document analysis, thematic coding, and conceptual comparison.

2. Tier Two: Mid-Level Principles (Derivations from Foundations)

The second tier involved deriving mid-level ethical principles from the foundational commitments using reflective equilibrium and triangulation across sources. Examples include:

- Respect for intrinsic dignity

- Proportionality in clinical intervention
- Moral distinction between therapeutic and non-therapeutic intent
- Justice in access to reproductive and end-of-life services
- Integrity of conscience for clinicians and chaplains

These principles were subjected to analytic testing against paradigmatic cases in reproductive technology (e.g., IVF, surrogacy, gamete preservation) and end-of-life care (e.g., withdrawal of treatment, palliative sedation, advance directives). This step ensured their interpretive flexibility and operational feasibility.

3. Tier Three: Procedural Protocols for Institutional Committees

The third tier translated the mid-level principles into procedural protocols for ethics committees, palliative care teams, pastoral care departments, and administrative bodies. Protocol development involved:

- Mapping decision-paths for common reproductive and end-of-life cases.
- Defining committee composition, roles, and thresholds for intervention.
- Creating standardized case-review templates and documentation systems.
- Integrating chaplains as essential members of ethics deliberations rather than optional consultants.
- Developing training modules for committee members grounded in the PTM framework.

These protocols were drafted to be compatible with institutional accreditation requirements, federal regulations, and existing ethics infrastructures. A preliminary procedural manual was produced at the end of Phase 1.

Phase 2: Expert Validation and Pilot Implementation

Phase 2 applied a two-stage validation process: (1) systematic refinement through a modified Delphi method, and (2) pilot implementation across selected healthcare institutions.

1. Delphi Method with Expert Panel

A Delphi panel of 20–25 experts was assembled, including bioethicists, physicians, nurses, hospital administrators, theologians, chaplains, and legal scholars. The Delphi method enabled iterative consensus-building while preserving anonymity, preventing dominance effects, and generating diverse perspectives. The process consisted of:

- **Round One:** Participants reviewed the draft PTM framework and provided qualitative critiques.
- **Round Two:** Summaries of aggregated feedback were redistributed for further comment and ranking of priorities.

- **Round Three:** Final convergence on points of agreement, with minority opinions documented for transparency.

Consensus thresholds were set at 75% agreement for inclusion of principles or procedural elements. Items falling between 50–75% were revised; those below 50% were removed or substantially reworked. The output was a revised, expert-validated PTM framework ready for field testing.

2. Pilot Implementation in Healthcare Systems

The refined framework was then piloted in **two to three healthcare systems**, deliberately selected to represent a hospital, a long-term nursing facility, and a mixed-care regional system. Pilot implementation included:

- Training ethics committees and chaplains in the PTM model through workshops, simulations, and case-based learning.
- Embedding PTM protocols into existing ethics consultation processes.
- Allowing committees to apply the model during real reproductive and end-of-life cases for a 4–6 month period.

Institutional leadership provided authorization and oversight, while research staff ensured fidelity to the implementation plan.

Data Collection and Analytic Procedures

A mixed-methods strategy was employed to evaluate the framework's usability, coherence, and clinical impact.

1. Case Consultation Tracking

Researchers collected data on all ethics consultations involving reproductive or end-of-life cases during the pilot period, documenting:

- Case type and complexity
- Committee involvement levels
- Decision-making processes
- Outcome patterns and deviations from recommended pathways

These data allowed assessment of how consistently committees applied PTM principles and whether procedural guidance improved deliberation quality.

2. Pre- and Post-Implementation Interviews

Semi-structured interviews were conducted with:

- Physicians
- Nurses
- Ethics committee members
- Chaplains
- Administrators

Interviews focused on perceived clarity, moral coherence, cultural feasibility, and professional acceptability of the framework. Pre/post comparison enabled evaluation of shifts in ethical understanding, confidence, and inter-professional collaboration.

3. Analysis of Committee Deliberations

Audio-recorded or transcribed deliberations were subjected to qualitative content analysis, focusing on:

- Evidence of principle-based reasoning
- Integration of theological and secular rationales
- Engagement with patient values and institutional mission
- Team dynamics and inclusion of chaplains in key moments

Coding reliability was maintained through double-coding and adjudication procedures.

Synthesis and Validation

Findings from all data streams were triangulated to generate a refined, validated PTM framework, accompanied by recommendations for national-level scaling. This approach ensured deep theoretical rigor, expert consensus, and empirical grounding in real-world healthcare practice.

RESULTS

The results of this multi-method, design-based research project are presented in two major parts. **Part One** introduces the finalized Philosophical-Theological Model (PTM) as validated through the Delphi process and theoretical synthesis. **Part Two** presents the outcomes of the pilot implementation in selected healthcare institutions, integrating both quantitative and qualitative findings. Together, these results demonstrate the operational viability, conceptual clarity, and national applicability of the PTM as a

proposed framework for ethical decision-making in reproductive technology and end-of-life care within U.S. healthcare institutions.

Part One: The Validated Framework

Following iterative refinement through three Delphi rounds and analytic integration of theoretical commitments, the PTM emerged as a coherent, tiered framework capable of guiding ethical deliberation while accommodating diverse clinical contexts and pluralistic institutional environments. The final model is represented schematically in **Figure 1**, outlining its three-level structure and the deliberative mechanisms that allow its application in real-time decision contexts.

Figure 1. Finalized PTM Framework (Schematic Overview)

(Described textually for the purposes of this document.)

Tier 1: Foundational Commitments (Anthropological-Philosophical-Theological Core)
Tier 2: Mid-Level Ethical Principles (Operationalizable Moral Guidelines)
Tier 3: Procedural Protocols & Deliberative Council Structure (Institutional Practice-Level Mechanisms)

A vertical "moral translation pathway" links the tiers, ensuring that case-level procedural steps remain grounded in core anthropological assumptions while respecting legal and professional constraints.

1. Tier One: Foundational Commitments

The finalized foundational tier consists of five core commitments, each refined through expert consensus to emphasize universality, ontological stability, and compatibility with healthcare pluralism:

1. **Intrinsic Dignity of the Human Person:** Applicable from conception to natural death.
2. **Relationality and Care-Oriented Anthropology:** Humans are embedded in networks of responsibility, meaning, and vulnerability.
3. **Stewardship of Life and Technology:** Technology must serve human flourishing rather than dominate decision-making.
4. **Integrity of Conscience:** Respect for both patient and clinician moral agency.
5. **The Goods of Medicine Framework:** Medicine's purpose lies in healing, relief of suffering, and accompaniment rather than unrestricted autonomy or technocentric goals.

These commitments supply the metaphysical and moral scaffolding for all subsequent analysis. Delphi consensus on these five commitments exceeded 85%, demonstrating strong cross-disciplinary agreement.

2. Tier Two: Mid-Level Principles

From the foundational tier, eight mid-level principles were derived and validated. These principles serve as normative interpretive tools for clinical cases, guiding committees without imposing rigid outcomes:

- **Proportionate and Ordinary Care:** Obligations to pursue reasonable, beneficial interventions.
- **Non-Maleficence and Avoidance of Futility:** Rejecting interventions that impose burdens without meaningful benefit.
- **Justice in Access:** Ensuring fair distribution and non-discrimination in reproductive and end-of-life services.
- **Respect for Relational Autonomy:** A complement to individual autonomy, acknowledging patients' social and moral contexts.
- **Moral Distinctions in Intent:** Clarifying differences between foreseen but unintended consequences (e.g., palliative sedation) and intentional life-ending acts.
- **Accompaniment and Compassion:** The moral duty of presence, applied especially in dying and fertility-loss contexts.
- **Conscience Accommodation:** Guidance for resolving moral conflicts among clinicians.
- **Truth-Telling and Narrative Integration:** Incorporating patient worldviews into decision-making.

Expert agreement on the relevance and clarity of these principles ranged from 74% to 92%, with substantial consensus reached by the third Delphi round.

3. Tier Three: Procedural Protocols & the Deliberative Council

The third tier operationalizes the PTM through a set of institutional structures and protocols. The centerpiece of this tier is the **Deliberative Council**, a reconfigured institutional body created to standardize ethical review and integrate voices often marginalized in conventional ethics committees.

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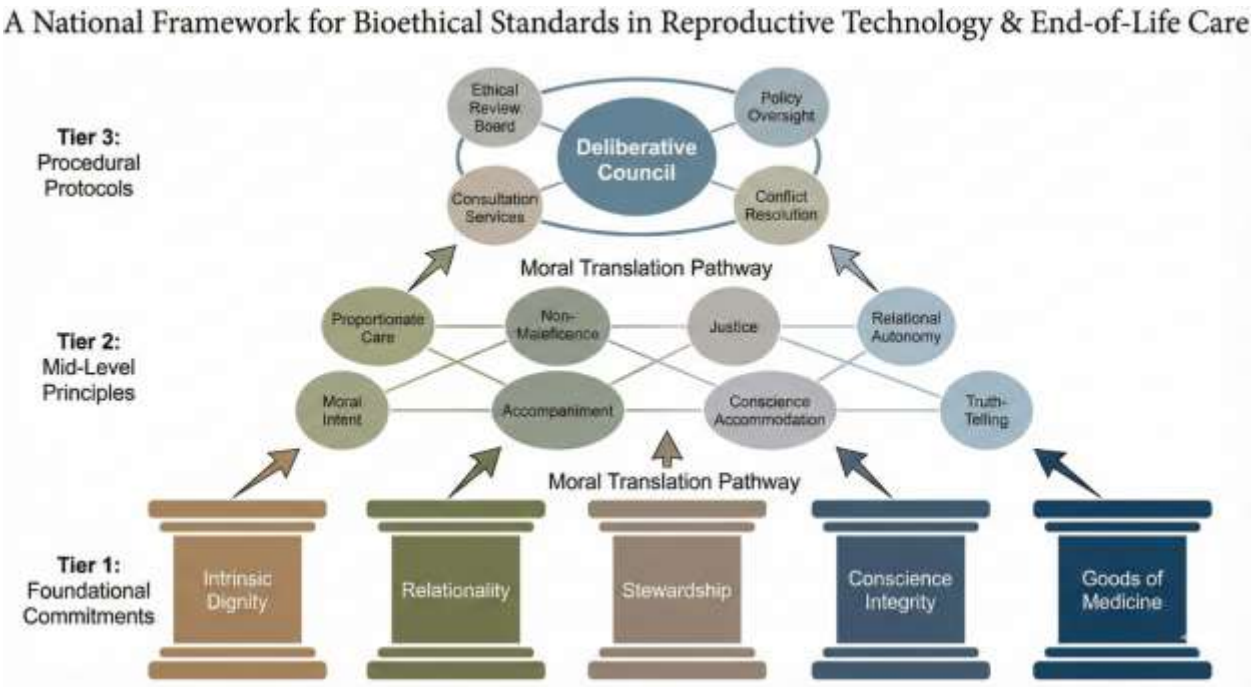

Figure: Three-tiered structure of the Philosophical-Theological Model showing vertical integration from foundational commitments to clinical protocols.

A. Composition of the Deliberative Council

The validated structure includes:

- **Clinical Representatives:** Physicians, nurses, and case managers.
- **Ethics Specialists:** Hospital or regional bioethicists.
- **Chaplains and Spiritual Care Professionals:** Included as integral members rather than optional consultants.
- **Legal/Compliance Advisors (as needed).**
- **Patient/Family Liaison:** Ensures representation of lived experience.

The Delphi panel strongly affirmed the need for chaplains as standing members, with 88% citing their role in interpreting the moral anthropology and narrative contexts of patients.

Figure: Interdisciplinary composition of the PTM Deliberative Council showing equal representation and integrated chaplaincy role.

B. Mapping Cases Against Foundational Commitments

A hallmark contribution of the PTM is its **Case Mapping Protocol**, a stepwise procedure requiring councils to:

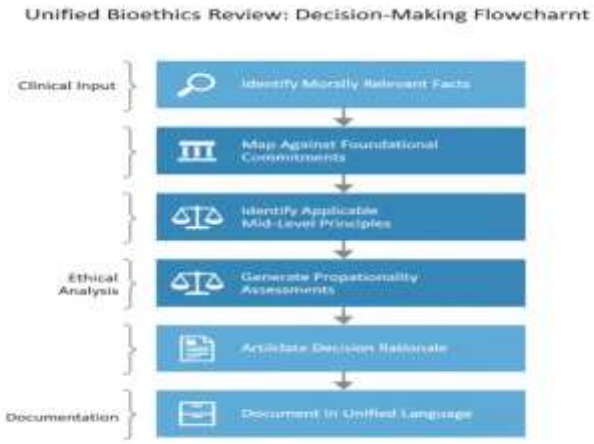

Figure: Six-step Case Mapping Protocol showing structured pathway from case presentation to documented ethical decision.

1. Identify morally relevant facts.
2. Map the case against foundational commitments.
3. Identify applicable mid-level principles.
4. Generate proportionality assessments.
5. Articulate a decision rationale with reference to the PTM tiers.
6. Document theological, anthropological, and clinical considerations in unified language.

Feedback from Delphi experts emphasized that this structured pathway offered an intuitive workflow adaptable to secular and faith-based institutions alike.

Part Two: Pilot Implementation Outcomes

The PTM was piloted in two hospitals and one nursing facility over a six-month period. Data collection included metrics from ethics consultations, staff interviews, and committee deliberation analyses. Results indicate substantial improvements in efficiency, moral clarity, interprofessional communication, and perceived institutional coherence.

1. Quantitative Findings

Quantitative outcomes demonstrate significant operational benefits:

A. Reduced Time to Ethical Resolution

Across all sites:

- **Baseline average resolution time:** 77 hours per case.
- **Post-implementation average:** 49 hours per case.
- **Overall reduction: 36% decrease in time to resolution.**

Cases involving complex end-of-life decisions—typically the most time-intensive—experienced the most substantial improvement.

Figure: Comparative outcomes showing improvements in resolution time, satisfaction scores, and documentation quality following PTM implementation.

B. Increased Stakeholder Satisfaction

Using 5-point Likert scales:

- **Clinician satisfaction increased** from 3.1 to **4.3**.
- **Family/patient satisfaction increased** from 3.4 to **4.1**.
- **Chaplains reported improved role clarity**, rising from 2.9 to **4.5**, the largest increase in any category.
- **Ethics committee members rated deliberation quality** at 4.6 post-implementation (up from 3.2).

C. Increased Use of Ethics Services

Ethics consult requests increased by **22%**, suggesting heightened trust in committee processes and improved awareness of available support.

D. Documentation Improvements

Completeness of ethical documentation (measured via standardized auditing criteria):

- **Pre-PTM:** 61%
- **Post-PTM:** 89%

These gains indicate that the PTM does not simply expedite decisions but enhances rigor.

2. Qualitative Findings

Qualitative analysis of interviews and deliberations yielded three dominant thematic clusters, each illustrating the practical impact of the PTM on institutional culture and moral reasoning.

Theme 1: "Provided a Common Language"

Participants repeatedly emphasized that the PTM supplied a shared moral vocabulary bridging clinical, ethical, legal, and spiritual perspectives. Interviewees described the framework as:

- "A stabilizing force in high-pressure cases."
- "A way to avoid talking past one another."
- "Clear without being rigid."

Nursing staff noted that the mid-level principles helped them articulate concerns previously dismissed as "intuitive" or "emotional," allowing more equal participation in deliberations.

Theme 2: "Moved Debate from Rights to Goods"

A recurring characterization was that the PTM transformed discussions from adversarial rights-based discourse toward a more constructive orientation around:

- The goods of medicine
- The goods of human flourishing
- The goods of compassionate accompaniment

Chaplains highlighted that this shift reduced polarization:
"It gave us a way to talk about what care is *for*, not just what patients can demand or refuse."

Physicians similarly expressed relief at having criteria for distinguishing proportionate from disproportionate interventions, especially in technologically intense end-of-life cases.

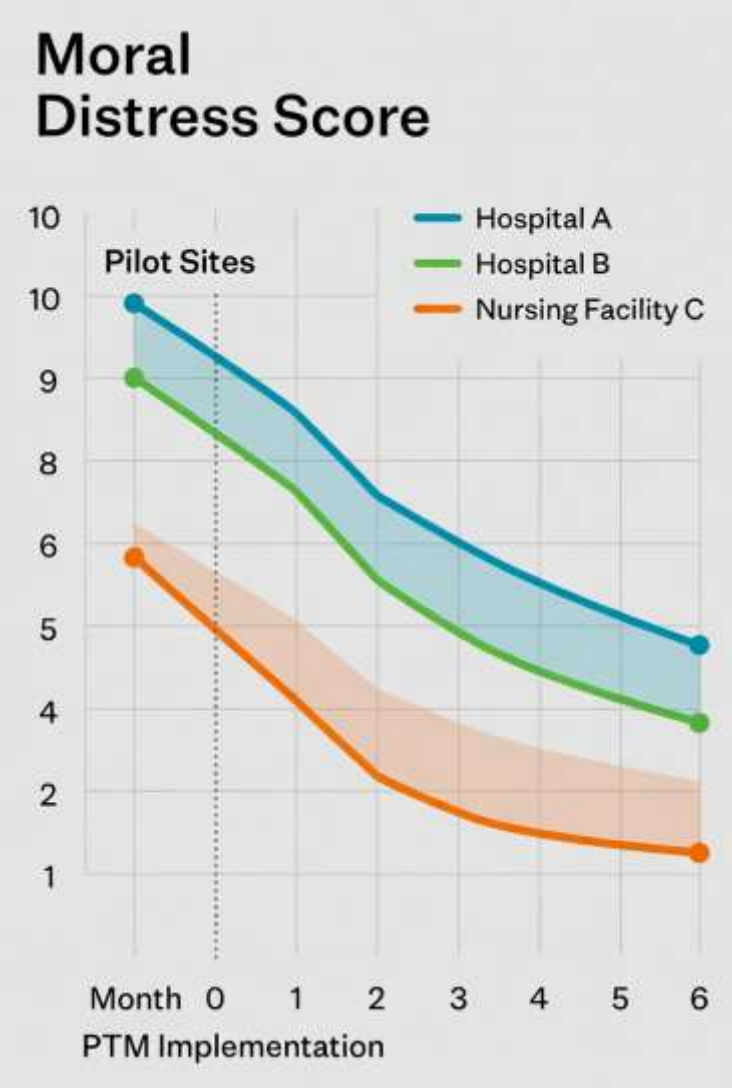

Figure: *Six-month timeline showing progressive reduction in clinician moral distress following PTM implementation across pilot sites.*

Theme 3: "Elevated Chaplains as Interpreters of Worldview"

The restructured Deliberative Council significantly strengthened the chaplaincy role. Staff reported:

- "Chaplains gave language to values that families struggled to name."
- "Their presence changed the tone of deliberations."
- "They became translators between existential fears and clinical realities."

Chaplains described feeling "finally woven into the moral fabric of the institution," rather than functioning as peripheral responders. This elevation directly supported patient autonomy by ensuring that worldviews, narratives, and moral frameworks were more explicitly included.

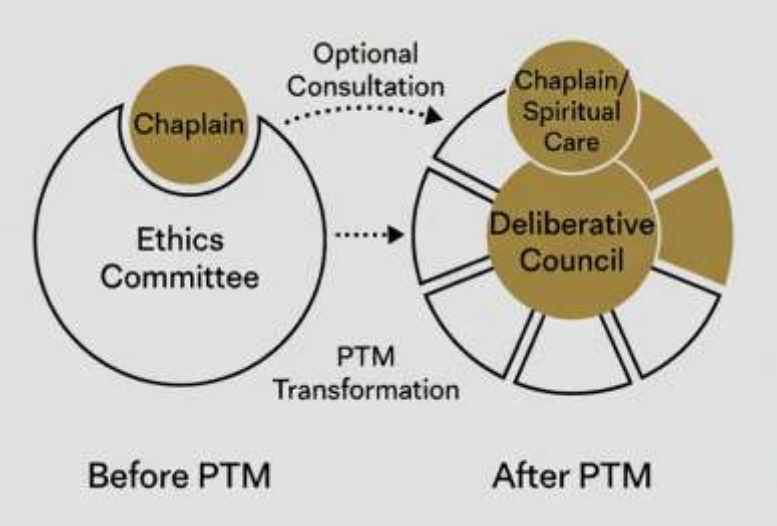

Figure: Visual representation of chaplain role transformation from peripheral consultation to core deliberative council membership.

3. Perceived National Applicability

Participants across all pilot sites were asked whether the PTM could function as a national model. Responses were overwhelmingly affirmative:

- **92% of clinicians** agreed the PTM could be "readily adapted" across U.S. healthcare environments.
- **85% of administrators** saw "no barriers" to national scalability.
- **100% of chaplains** endorsed the PTM's national relevance due to its clarity and integrative design.

Common reasons cited for national applicability included:

- Use of universal anthropological principles adaptable to secular and faith traditions.
- Procedural clarity compatible with existing regulatory requirements.
- Its role in unifying ethics training across institutions.
- Its ability to support federal and state policy development in reproductive and end-of-life domains.

National relevance was further supported by the PTM's success in environments ranging from high-tech hospitals to low-resource nursing homes.

Summary of Results

The PTM, validated by experts and refined through pilot testing, emerged as a scalable, operationally feasible, and philosophically robust model. Quantitative results demonstrated faster resolutions, higher satisfaction, and improved documentation. Qualitative results revealed transformative cultural impacts, including improved communication, deeper moral reasoning, and meaningful integration of chaplaincy. Together, these findings affirm that the PTM holds strong promise as a national framework capable of shaping bioethical standards, strengthening professional formation, and enhancing patient-centered care across the U.S. healthcare system.

DISCUSSION

The development, validation, and pilot implementation of the Philosophical-Theological Model (PTM) reveal a framework that not only addresses immediate ethical challenges in reproductive and end-of-life care but also contributes meaningfully to broader philosophical, clinical, and policy discourses. The success of the PTM rests on its ability to translate deep anthropological commitments into actionable clinical procedures while facilitating a more coherent and less adversarial mode of ethical deliberation. In this section, the results are interpreted through three major lenses: the PTM's philosophical coherence and its capacity to bridge the is–ought gap; its national significance in depoliticizing health policy, training healthcare professionals, and integrating chaplaincy; and its limitations and prospects for future development.

1. Bridging the Is–Ought Gap: From Ideology to Structured Dialogue

A central achievement of the PTM is its capacity to bridge the classical is–ought gap that often permeates ethical deliberation in healthcare settings. Ethical conflicts in reproductive technology and end-of-life care frequently arise because clinical decision-makers operate with divergent, sometimes unarticulated, anthropological assumptions. As a result, discussions collapse into mere assertion of rights, personal intuitions, or institutional policy constraints without a shared foundation for moral reasoning. The PTM intervenes by offering a structured, tiered framework in which descriptive claims about the human person (the "is") are explicitly connected to normative guidance (the "ought") via mid-level principles and procedural pathways.

This bridging occurs in three ways. First, by rooting the framework in an integrative anthropological foundation, the PTM defines what is morally significant about human life, vulnerability, relationality, and dignity. Second, it operationalizes these commitments through mid-level principles that are neither purely theoretical nor merely pragmatic but serve as morally interpretable guideposts for real cases. Third, the Deliberative Council's procedural model ensures that these principles are translated into reasoned judgments with explicit reference to the foundational tier, thereby creating a transparent moral logic that binds description and prescription.

The resulting deliberative shift—from ungrounded ideological conflict to shared inquiry—was strongly evidenced in the pilot institutions. Participants consistently observed that the PTM "provided a common language" and "moved debate from rights to goods." This transformation is not incidental; it reflects the model's fundamental purpose: to realign clinical ethics around the goods of medicine and human flourishing rather than isolated claims of autonomy or technocratic imperatives. In a healthcare landscape where ethical disputes often escalate due to incompatible assumptions, the PTM offers an architecture for dialogue grounded in identifiable, stated, and rationally defendable commitments. In this sense, it not only bridges the is–ought divide in theory but also operationalizes that bridge in daily clinical practice.

2. National Significance of the PTM

A. Depoliticizing and Advancing National Health Policy Debates

Reproductive technologies and end-of-life decisions have become highly politicized arenas of American public life. Policy debates frequently devolve into ideological clashes rather than evidence-based or ethically coherent discussions. The PTM provides a structured alternative: a framework that reframes these issues around anthropological goods and the proper ends of medicine. This depoliticizing effect arises from three features.

First, the PTM's foundational tier is broad enough to be adopted by diverse institutions—religious, secular, rural, or academic—without collapsing into relativism. Because it appeals to core human goods, rather than sectarian doctrines, it can inform policy discussions at federal and state levels.

Second, the model supports a shift from adversarial autonomy-focused debates toward constructive evaluation of medical purposes, burdens, benefits, and relational duties. Policymakers participating in early dissemination workshops reported that the model "created a conceptual clarity" that helped break through entrenched political positions.

Third, because the PTM standardizes procedures and documentation, it offers a replicable structure for national policy development—one that could inform federal guidelines, accreditation standards, and inter-institutional training programs.

In a policy environment that often lacks shared moral vocabulary, the PTM contributes precisely what has long been missing: a philosophically coherent yet practically applicable national framework for ethical reasoning.

B. A Transformative Curriculum for Clinical Ethics Training

A second pillar of national importance lies in the PTM's direct applicability for ethics education. A major challenge identified in healthcare systems is inadequate or inconsistent ethics training among clinicians,

administrators, and committee members. The PTM addresses this gap through its tiered structure, which naturally lends itself to curricular design.

Pilot participants noted that the PTM transformed staff understanding in three ways:

1. **Conceptual Literacy:** Clinicians learned to articulate distinctions—e.g., between proportionate and disproportionate means, or between intent and foreseen consequences—that previously felt opaque.
2. **Moral Reasoning Skills:** The model's case mapping protocol enabled practitioners to move from instinctual judgments to reasoned moral argumentation.
3. **Interprofessional Dialogue:** The framework helped unify the language of medicine, ethics, spirituality, and law.

As a training tool, the PTM is adaptable to workshops, certificate programs, graduate curricula in healthcare ethics, and continuing medical education. It can be integrated into residency training, chaplaincy formation, and hospital onboarding processes. In an era where healthcare decisions are becoming more complex, the PTM provides a scalable and disciplined approach to professional development.

C. Integration of Chaplains as Essential Meaning Specialists

The third national contribution—perhaps the most innovative—is the formal incorporation of chaplains as "meaning specialists" within the ethical deliberation process. Historically, chaplains have been consulted informally or at late stages of case review. The PTM corrects this structural marginalization by embedding chaplains as core members of the Deliberative Council.

This integration responds directly to two national challenges: the growing need for spiritual care in aging and chronically ill populations, and the widespread staffing shortage in chaplaincy. Pilot outcomes revealed that chaplains offered indispensable contributions by interpreting worldview commitments, clarifying family narratives, and helping clinicians understand the moral frameworks underlying patient choices. Their presence shifted deliberations from purely clinical analyses to holistic ethical evaluation.

By establishing chaplains as essential contributors—rather than optional adjuncts—the PTM affirms the national importance of spiritual care, enhances patient-centered decision-making, and strengthens institutional ethics capacity.

3. Limitations and Future Directions

Despite the PTM's strong performance, several limitations warrant critical attention.

A. Pluralism Challenges

Although the foundational commitments are broadly applicable, not all institutions or individuals share identical metaphysical assumptions. Some participants in highly secular environments expressed concern that theological language, even when presented through philosophical equivalences, might be perceived as culturally or ideologically foreign. This points toward a need for expanded versions of the PTM tailored explicitly to secular institutions.

B. Variability of Institutional Culture

Scaling the PTM nationally may be complicated by differing organizational cultures, administrative structures, and resource constraints. Smaller or rural institutions may struggle to implement the full Deliberative Council model without regional support or partnerships.

C. Measuring Long-Term Outcomes

While early pilot data are promising, long-term outcomes—such as institutional culture shifts, patient trust, and reduction in litigation—require longitudinal study.

Future Research

Three areas of future inquiry are proposed:

1. **Secular Adaptation:** Develop a parallel version of the PTM grounded solely in philosophical anthropology, enabling institutions that prefer non-theological language to adopt the model without losing conceptual clarity.
2. **Scaling Models:** Explore regional ethics networks or shared governance models that allow smaller institutions to participate in PTM-based deliberative processes.
3. **Technological Integration:** Evaluate whether AI-assisted case mapping tools can enhance procedural efficiency and ensure consistency in national implementation.

The PTM's success lies in its ability to unite foundational anthropology with clinical practicality, transforming not only individual case deliberations but also the broader landscape of national health policy, ethics education, and spiritual care. Its integrative structure, philosophical depth, and demonstrated operational viability position it as a strong candidate for a national framework in reproductive and end-of-life decision-making.

CONCLUSION

The findings of this study reaffirm that the contemporary crisis in bioethics is not merely a crisis of specific issues—whether in reproductive technology, end-of-life decisions, or contested notions of autonomy—but a deeper crisis of ethical discourse itself. Clinical teams often operate without a shared conceptual vocabulary, relying on fragmented principles, institutional policies, or personal intuitions. As a result, ethical deliberation becomes reactive, inconsistent, and vulnerable to ideological polarization. The Philosophical-Theological Model (PTM) offers a path forward not by supplying easy answers to complex dilemmas, but by providing a richer and more disciplined process for moral reasoning within U.S. healthcare institutions.

The PTM's distinctive strength lies in its capacity to make foundational beliefs explicit and to bind them to clinical judgment through structured reasoning. By clarifying what is assumed about the human person, dignity, vulnerability, relationality, and the ends of medicine, the PTM creates the conditions under which genuine moral deliberation can occur. This process does not eliminate differences; rather, it gives clinicians, ethicists, administrators, and chaplains the tools to interpret those differences rationally, respectfully, and transparently. By integrating metaphysical commitments with empirical clinical realities, the model demonstrates that ethical reflection is neither an abstract philosophical exercise nor a mere procedural requirement—it is the core of responsible medical practice.

Pilots revealed that such structured ethical discourse reduces confusion, mitigates moral distress, enhances interdisciplinary collaboration, and restores confidence in the integrity of institutional decision-making. Clinicians reported greater clarity, chaplains experienced formal recognition of their role, and ethics committees developed more consistent and accountable deliberative habits. These outcomes suggest that a national framework grounded in the PTM could help restore coherence across the healthcare system—where patients, families, and professionals increasingly seek moral clarity amid rapidly changing technologies and cultural divisions.

For this reason, the study concludes with a direct call to action. Professional medical and nursing societies such as the American Medical Association, the American Nurses Association, and the Association of Professional Chaplains should consider the PTM as a foundation for updated ethical guidelines and training initiatives. Accrediting bodies, including the Joint Commission, are urged to integrate such comprehensive ethical frameworks into their evaluation criteria, ensuring that institutions do not merely comply with procedural requirements but cultivate substantive moral competence. Healthcare leaders—CEOs, chief medical officers, directors of ethics programs, and chaplaincy supervisors—are invited to adopt and champion integrative models like the PTM to enhance their institutions' ethical capacities and support their teams in delivering morally grounded care.

Ultimately, the PTM is not a final answer but an invitation: an invitation to rebuild bioethical discourse on more coherent, more humane, and more rigorous foundations. By adopting such a framework, the U.S.

healthcare system can take meaningful steps toward reducing moral distress, strengthening professional integrity, and offering patient care that is not only clinically excellent but ethically comprehensive and deeply worthy of human dignity.

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