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Review

Clinical Ethics–Challenges of the Past, the Present, and the Future

Ana Borovecki

Andrija Stampar School of Public Health, School of Medicine, University of Zagreb, 10000 Zagreb, Croatia; abor@mef.hr

Abstract

This contribution provides an overview of clinical ethics, examining the evolution of the field and its philosophical foundations. The evolution from the mid-1970s to the present day highlights clinical ethics as an interdisciplinary field where experts often collaborate to solve complex medical problems. Clinical ethics is embedded in medical practice, positioned at the intersection of medicine and philosophy, and grounded in various ethical and bioethical theories. Some problems in clinical ethics stem from underlying shortcomings within the healthcare system, while future challenges for the field are also underlined.

Keywords: bioethics; clinical ethics; history; background; philosophy; medicine

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1. Introduction

When giving an overview of the field of clinical ethics, one faces a discipline whose dynamic development and persistent challenges shape current and future practice. This contribution argues that understanding clinical ethics requires addressing critical, converging questions about its origins, substance, disciplinary status, expertise, and philosophical foundations. These questions—such as how clinical ethics emerged, whether it is inherently interdisciplinary, its relationship with philosophy and medicine, who counts as an expert, and the necessity of ethical theory—will structure the outline and analysis offered here.

This contribution examines how the evolving nature and foundational questions of clinical ethics frame its key challenges, past developments, and future directions. To do so, literature was sourced to emphasize the field's development, drawing on voices from its inception.

2. How Did Clinical Ethics Emerge as a Field?

Ethics is "the discipline dealing with what is good and bad, with moral duty and obligation" [1]. It concerns what is morally right or wrong, good or bad. It also examines a system of moral principles, rules, obligations, rights, virtues, and norms of practical rationality in a fundamental and ultimate sense [2,3].

Medical ethics is a term coined by Thomas Percival (1740–1804) in his code, which codified the professional ethics of physicians [4,5]. Before Percival, the essence and main principles of medical ethics appeared in the works of Greek physicians, especially Hippocrates (c. 460–c. 370 BC) and his medical school at the island of Cos [6]. The term "medical ethics" remains relevant today in texts that resonate with the legacy of the Hippocratic school and Thomas Percival [7,8].

From the 1950s until the 1970s, the concept of bioethics emerged, shaped by Joseph Francis Fletcher (1905–1991) and Paul Ramsey (1913–1988). This marked a transformation of

medical ethics under threefold pressure points. First, the medical profession faced criticism for paternalism. Second, the development of life-supporting technologies, including dialysis, transplantation, human research, and reproductive technologies, introduced complex ethical questions for everyday medical practice. Third, the physician-patient relationship shifted to emphasize patients' rights rather than only the virtues and duties of physicians. Together, these pressures were key in transforming medical ethics into bioethics [5,9,10].

The term 'bioethics' was first introduced in 1970 by Van Rensselaer Potter II (1911–2001) and, independently, by André Hellegers (1926–1979) at the Kennedy Institute. Later, it was discovered that the German pastor Fritz Jahr (1895–1953) had already introduced the German word "Bio-Ethik" in a 1927 publication. Potter's and Jahr's concepts both encompassed respect for humans and other living organisms, while the Kennedy Institute scholars used 'bioethics' to describe clinical ethics. This sequence shows the gradual emergence and broadening of the bioethics concept [5,11].

The term 'clinical ethics' appears to have emerged in the mid-1970s, following Joseph Fletcher's introduction of 'situation ethics' as a response to clinical adoption of biotechnologies that produced new ethical dilemmas for clinicians. Around the same period, Mark Siegler's scholarly work used the phrase "clinical ethics". Siegler considered clinical ethics to be an evolving part of medical, biomedical, or bioethics, reflecting changes in the field at that time [5,12,13].

3. What Constitutes the Field of Clinical Ethics? Is Interdisciplinarity a Constitutive Element of Clinical Ethics?

When examining the development of clinical ethics, three prominent authors stand out. Peter A. Singer, Edmund Daniel Pellegrino (1920–2013), and Mark Siegler have diverse interdisciplinary backgrounds and perspectives. Despite their differences, they reached the same conclusion: "ethics is an inherent and inseparable part of good clinical medicine." They also asserted, "the goal of clinical medicine was to improve the quality of patient care by identifying, analyzing, and attempting to resolve ethical problems that arise in practice." These authors divided clinical ethics into four areas: research in clinical ethics, teaching clinical ethics, ethics committees, and clinical ethics consultation [14].

Research in clinical ethics is probably its most developed area of study. A large number of articles cover different aspects of clinical practice. Singer, Pellegrino, and Siegler divided clinical ethics research into theoretical and empirical research. Theoretical research is conducted by philosophers, theologians, lawyers, and policymakers, who employ their respective methodologies to explore values, moral norms, legal frameworks, and policy development. Empirical research is conducted by social scientists, who use both qualitative and quantitative approaches. From the outset, debate has existed regarding the role of empirical research in clinical ethics and its relationship to the philosophical discipline. The main question concerns the relationship between descriptive and normative issues, or, put philosophically, the "is-ought" fallacy. The empirical side of clinical ethics research later developed into the separate field of empirical bioethics [14,15].

From the beginning of clinical ethics, the importance of education for those involved in physician–patient encounters and professional relationships was noted. Different teaching methods have since been developed and explored. These include case discussions, role-playing, moral games, and online learning platforms [14,16,17].

Ethics committees were initially developed to facilitate discussion of complex cases [14,18]. These were clinical ethics committees (CECs) or hospital ethics committees (HECs). They should be distinguished from research ethics committees (RECs) or institutional review boards (IRBs). These committees included experts in medicine, nursing, philosophy, law, theology, and lay persons. This affirmed the interdisciplinary approach.

The primary functions of clinical ethics committees include educating committee members, hospital staff, administration, and patients and their families about their role and services. Policy development and case consultation are also key roles [19]. Different methodologies for clinical case discussion emerged within their work. These discussions helped develop a new service, known as clinical ethics consultation (CEC), also referred to as clinical ethics support (CES). This service supports healthcare providers, patients, families, and other stakeholders in making informed decisions. To perform this service, a new expert was introduced: the clinical ethics consultant. Ethics consultants came from humanities disciplines such as philosophy, theology, and law. They called themselves "ethicists" [14,20,21].

4. Is Clinical Ethics a Philosophical or Medical Discipline? Who Is an Expert in Clinical Ethics?

A significant number of nonmedical academics began to specialize in clinical ethics, founding journals, institutes, departments, and teaching programs. Some, like Mark Siegler, a physician, were "disturbed by the lack of physicians involved" and wanted to focus on training physicians in the ethical analysis of cases from everyday practice. Siegler believed there is no distinction between moral and medical issues in clinical cases—they are intertwined [5,13,22].

David C. Thomasma (1939–202) held a similar view, stating, "clinical ethics is a branch of medical practice" [23]. From the beginning, clinical ethics existed at the intersection of medicine and the humanities, primarily philosophy. Some argue that ethical dilemmas in medicine opened a new field of inquiry for ethics as a philosophical discipline [24].

The debate over whether clinical ethics belongs to philosophy or medicine is closely connected to another foundational question: Who is an expert in clinical ethics? Is it the same person referred to as a bioethicist or an ethicist? Does this expert require special knowledge and skills?

Clinical ethics is rooted in clinical practice. Discussing challenging cases from daily experience or case consultations is a primary function of clinical ethics [12]. Consequently, a clinical ethics expert is someone skilled in case consultation, also known as a clinical ethics consultant. These consultants comprise a multidisciplinary group, drawing expertise from the humanities, social sciences, and healthcare professions [25,26]. The debate continues regarding the essential competencies required of ethics consultants. However, there is broad agreement on categorizing these into three types: skills, knowledge, and personal attributes. Skill-based competencies include ethical assessment and analysis, discerning relevant ethical, clinical, and psychosocial data, maintaining realistic consultation expectations, and strong interpersonal skills. Knowledge competencies require an understanding of ethical theory and reasoning, familiarity with common bioethical issues and concepts, and awareness of relevant professional codes of conduct. Attributes, attitudes, and behavior competencies include traits such as humility, leadership, and forthrightness. These and other competencies are developed through curricula designed for clinical ethics consultants [27,28].

The clinical ethics committee is an ideal setting where the core competencies of a clinical ethicist come to life. In the work of a CEC, the expertise of a clinical ethics consultant can set standards for its work [29]. The first order of business is to educate the clinical ethics committee members, patients, and the hospital about their future mission. This involves providing a healthy and ethical environment for discussing different treatment plans [30]. The core business of a clinical ethicist is clinical ethics consultation at the patient's bedside. This consultation can be done by the CEC itself, certain members of the CEC with the help of a clinical ethics consultant, or by a clinical ethicist alone [29]. Clinical ethics consultation is always performed with consideration for the relevant regulatory and institutional context.

It also takes into account different ethical viewpoints (ethical pluralism) [31]. The focus is on achieving shared decision-making. This brings together the physician's and patient's perspectives in an informed and collaborative process that integrates scientific evidence with patients' goals, preferences, and values [32]. CEC is practiced and additionally fosters a care relationship between the patient and healthcare providers. The care relationship places importance on building trust, empathy, and effective communication between caregivers and those they support [33]. Clinical ethical counseling supports the decision-making process, which does not disregard the "care relationship" between the physician and the patient, but does not replace the physician's decision regarding treatment, nor the patient's will. Different forms of clinical ethics consultation, grounded in different ethical approaches, can place clinical ethicists in various roles. These roles range from serving as a true clinical ethics consultant (as first defined in the United States of America) to facilitating a moral case deliberation [34]. In clinical ethics consultation, the focus is on shared decision-making. Here, the values of the patient, family members, and the caregiver are explored to arrive at a patient-centered decision. In moral case deliberation, the focus is on addressing ethical dilemmas and deepening understanding of situations involving moral uncertainty. Although mutual understanding and consensus might be achieved through exploring different values and perspectives, reaching a shared decision is not the primary aim of moral case deliberation. Moral case deliberation takes place not between the patient and treating physician, but among caregivers in an interprofessional context. Moral case deliberation aims to elucidate values and consider courses of action that follow from them, but a treating physician remains in charge and responsible for the decision. This contrasts with shared decision-making, in which a physician shares this responsibility with a patient [35].

5. What Are the Philosophical Foundations of Clinical Ethics, and How Do They Differ from Bioethics? Is an Ethical Theory Necessary for Clinical Ethics?

As stressed several times before in this contribution, clinical ethics is about finding solutions for complex cases in everyday practice. This is achieved with the assistance of specialized education and further research into the clinical encounter itself. The most effective way to find a solution is through a structured discussion framework. Over the years, several frameworks for discussion were developed. Upon analysis, they all share several commonalities. All authors agree that to make a sound ethical decision in a specific case, one must understand the case and the persons involved. Here, posing adequate questions and collecting all the relevant medical and social data related to the case is essential. This includes who, where what, when, why, how, and what is possible from a technical medical perspective. Interpersonal relationships between family members and patients, as well as among medical team members, must also be taken into account and considered in planning discussions. After collecting data, one must evaluate the moral problems and, finally, reach a consensus and a concluding plan of action [36,37].

These frameworks for case discussion, except for more or less standard procedures, have a philosophical background. This background informs the process itself and aids in the ethical analysis of cases. The method and the ethical theories used may vary. However, all philosophical approaches commonly cited as the basis for clinical ethics have been present throughout the history of philosophy and bioethics.

For John-Steward Gordon, a good clinical ethics consultation relies on combining different philosophical approaches. He believes that human life is too complex for a single, rigid ethical theory to address all aspects of moral decision-making. Gordon draws from Immanuel Kant's philosophy, utilitarianism, casuistry, and the principalism of Tom

Beauchamp and James Childress. He primarily emphasizes the importance of prohibiting human exploitation and universalizable action criteria. Despite this, he asserts that patients' motives, consequences, and the concept of utility cannot be ignored in clinical decisions. Decision-making should also be case sensitive and partially integrate cultural and community values. Prior decisions in similar cases should be taken into consideration. These processes always account for patient autonomy, beneficence, nonmaleficence, and justice, balancing these universal principles with both common and particular morality. For this approach to succeed, you need an expert to help those involved in the case. This expert provides ethical guidance at various levels, depending on the severity of the issues encountered in each case [36].

George Agich defines four backgrounds for case resolution, of which the first three are based on philosophical theories. The first approach is that of applied ethics, which involves applying ethical theory and concepts to real-world cases. The second approach is casuistry, and the third is the approach of principles. Finally, there is an approach that views case consultation as a form of arbitration, conflict resolution, and mediation. For Agich, using one or a combination of all four approaches will never truly encompass the whole issue at hand in a clinical ethical case. For him, philosophers are strangers at the patient's bedside when they are called to give moral advice. Ha advocates for a more hermeneutic approach, where an expert interprets and constructs an ethical reality for each case through conversation with others [38].

Guy Widdershowen, Bert Molwejnik, and Mario Picozzi also find inspiration in the hermeneutic philosophical approaches of Martin Heidegger and Hans-Georg Gadamer. For Widdershowen and Molwejnik, an expert in case consultation has many roles at once. This expert is a facilitator of moral deliberation, a trainer of health professionals to become facilitators, and a researcher examining the process. Here, the focus is not on the patient and shared decision-making as an outcome. Instead, it is on healthcare providers to help them analyze ethical issues and problems [35,39]. Picozzi also employs hermeneutical and phenomenological analysis, similar to Widdershowen and Molwejnik, but with a focus on the patient rather than the healthcare providers [40].

For authors like Uwe Fahr, clinical ethics experience is separate from theoretical discussions of foundational problems. He sees it instead as a phenomenology of "moral phenomena," inspired by the work of Jürgen Hambermans. This can only be understood through the performative attitude of participants in action [41,42].

Building on Fahr's phenomenological approach, virtue ethics provides an additional ethical framework for case discussions. Virtues in this context are understood as intellectual dispositions and sensitivity, especially among medical professionals and clinical ethicists, that guide them in realizing the patient's good in a specific case, with prudence being the most important action-guiding virtue [43]. Here, the focus is on the good of the patient, where beneficence can be understood as a moral principle that allows the physician and patient to act in each other's mutually negotiated and agreed-upon best interest [44].

In addition to virtue ethics, personalistic approaches are inspired by the works of Jean Paul Gustave Ricœur. They also have an important place in the discussion on philosophical background clinical ethics, where our encounters in specific clinical cases should aim at ethics in terms of "aiming at the 'good life' with and for others in just institutions" [45–47].

6. What Are the Future Challenges for Clinical Ethics?

Most ideas on clinical ethics and its practice come from the Anglo-Saxon world and, to a lesser extent, Europe. These ideas are often linked to medical practice using advanced modern technologies. Other parts of the world face different clinical challenges [48]. Yet, deeper issues also underlie clinical ethical problems. Years ago, Johnathan D. Moreno

described his concern with his role as a clinical ethicist: "...my greatest worry is that I am part of an elegant functional distraction from underlying shortcomings of the health care system. For at least many of the problems that present themselves as ethical in acute hospital situations are artefacts of structural arrangements that derive from political processes." [49] This highlights Ricœur's earlier notion of "just institutions." It raises the question: Can clinical ethics in the future address organizational issues in healthcare systems that were once the domain of public health?

There are still debates present in the field itself. Regarding the scope of clinical ethics, the role and provenance of experts in the field, the competencies of clinical ethics experts, the appropriateness of different methodologies for clinical ethics consultation, and the role of empirical research in clinical ethics. However, one of the recent issues raised has hit at the core of the practice of clinical ethics itself. In a recent publication, Mathew Shea has tackled the issue of the ethics of clinical ethics. He examines the two ways the ethics of clinical ethics can be understood. One way is what he calls "Real Ethics," which consists of objective moral norms and grounded truth, and "Conventional Ethics," which consists of conventional norms grounded in bioethical consensus. He thinks that for current clinical ethics practice, the latter is the case. The problem here is that conventional norms are not universal, which can bring us to ethical relativism. He is also concerned about the role of a clinical ethics expert, who is ideally seen as a facilitator of discussion with "the goal not to judge what is morally correct and do what is right but to facilitate peaceful resolutions of value conflicts," aiming to work towards consensus. He advocates for clinical ethics that involves "Real Ethics," where ethicists should engage with questions of morality as well as convention [50].

Clinical ethics and clinical ethicists have been linked to clinical ethics committees (CECs) from the beginning, which primarily address ethical dilemmas arising in patient care. At the same time, with the development of CECs, another type of ethics committee emerged: the research ethics committee (REC) or institutional review board (IRB) [51]. Unlike CECs, which focus on patient-specific clinical decisions, RECs are concerned with evaluating the ethical aspects of research projects, with a particular emphasis on methodology and the protection of research participants. RECs emphasize the risk-benefit ratio for participants, ensuring that the benefits outweigh the risks, and carefully examine the quality of the informed consent process, making sure that everything is explained clearly to research participants [52]. Although clinical ethics consultation for clinical cases was the primary focus of clinical ethicists and CECs, they have also consulted IRBs in complex research ethics cases. Some argue that CEC services are unnecessary and that the best mechanism for bioethics scholars to engage with research ethics issues is through an institutional review board (IRB), which should be the primary institutional entity to address the ethical problems in clinical research [53]. Others say that 'IRBs can be a valuable forum for researchers and IRBs to discuss ethical challenges and scientific responsibility of emerging fields and research practices' [54]. This distinction is significant in emerging situations, such as research on new diseases like COVID-19.

The COVID-19 pandemic created new challenges for clinical ethicists. Remote communication technologies were introduced, resource allocation became more pressing, and caseloads surged. Clinical ethicists expanded their role beyond consultation to other areas within healthcare institutions. This led to the development of new services, such as the middle level of ethics consultation, called Service Practice Communication Intervention (SPCI). Whether these developments will help clinical ethicists in future situations or become a permanent part of their work remains to be seen [55].

During the COVID-19 pandemic, the high volume of ethical decisions—especially those related to resource allocation—prompted interest in AI tools to support decision-

making [56]. Currently, staff shortages and financial constraints have reignited discussions about the use of AI in clinical ethics. The development of this trend remains uncertain [57]. Advances in technology will continue to shape clinical ethics challenges, not only through AI but also with new developments in medical technology, especially in neonatal care and end-of-life decisions, now with the spread of medically assisted death in the Western world [58,59].

7. Concluding Remarks

This contribution provides an overview of clinical ethics. I outline its historical development and draw the following conclusions in response to specific questions:

To begin, clinical ethics is recognized as part of the field of bioethics (a field that emerged in the 1970s with the transformation of medical ethics due to changes observed in medical practice), with which it shares some common origin and questions.

Moreover, clinical ethics is a field where experts from various disciplines often collaborate to address complex problems in medical practice.

Additionally, clinical ethics is deeply embedded in medical practice and exists at the intersection of medicine and philosophy.

Furthermore, clinical ethics is based on various ethical and bioethical theories.

Finally, clinical ethics should recognize that some problems arise from underlying shortcomings in the healthcare system; therefore, it should develop effective strategies to address them.

Future challenges for clinical ethics will be closely tied to the emergence of new roles for clinical ethicists and the development of new technologies.

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