Introduction

Clinical bioethics is a relatively new professional discipline which provides guidance for resolving ethical problems that arise in the course of patient care and professional encounters in healthcare. In general, the intent of medical care is to restore function and well-being and reduce suffering for individuals and communities. As a field, clinical bioethics strives to ensure the goals of healthcare are achieved in fair, humane, and respectful ways. Clinical bioethics as a profession combines knowledge from medicine, nursing, philosophy, law, social welfare, and other specialties forming a multidisciplinary field to address the complex dilemmas arising in modern healthcare. The clinical setting is typically defined as an arena that deals with the delivery of healthcare such as hospitals, long-term skilled care facilities, physician’s offices, outpatient clinics, and home care settings (Fletcher and Spencer, 2005). Physicians, nurses, technicains, social workers, chaplains, and researchers interacting with patients and other providers in any of these settings may face dilemmas which are ethical in nature. A clinical bioethicist may be called upon to help practitioners evaluate these value uncertainties so appropriate care can be provided to the patient.

Ethics, Morals, and Values

A brief definition of ethics is a set of moral principles which guide how actions can be understood and justified as right or wrong. In a sense, these principles can guide the decisions and conduct expected from certain groups of individuals. Physicians, nurses, and any other healthcare providers, as well as patients and families, all bring various morals and values to each clinical encounter. Ethical dilemmas occur when more than one action is perceived to be the right one. Evaluating why an action is right or wrong requires exploring the features of this action and weighing its potential to violate or uphold a commonly accepted good or benefit. With so many individuals involved in caring for a patient, differing views sometimes lead to an impasse in decision making. The perception of right and wrong is driven by morals, shared beliefs about what is right and wrong. Morals may be based on culture, religion, or any number of influences which contribute to how people define what actions are right or wrong. Values are individually held beliefs which may be based on morals, but incorporate personal beliefs about what is important, or valued, for any one individual. When faced with acting in a manner which conflicts with one’s morals, individuals can experience a form of discomfort called moral distress. Actions causing moral distress for one person may not generate any discomfort for another. Thus, two moral people may disagree on a course of action and neither one is wrong; they simply hold different views on what constitutes a morally correct act. When disagreement about a given action occurs, other resources or guidelines may be needed to determine whether an action meets broader standards of acceptability. In bioethics, there are times a single

Glossary

Advance directive Written instructions which specify an individual’s preferences for future medical care.

Autonomy The inherent right of individuals to be self-directing and make decisions consistent with one’s own beliefs and values.

Beneficence The obligation to act in a manner which confers benefit to others.

Capacity The ability of an individual to understand, evaluate, and appreciate information and express a reasoned judgment based on the information.

Clinical bioethics A professional discipline dedicated to the study and practice of providing guidance on ethical issues arising in the healthcare setting.

Distributive justice The fair distribution of goods and services.

Doctrine of double effect An ethical principle that allows for the occurrence of an anticipated harm providing the harm is not intended.

Ethics committee A group of individuals who provide guidance and education on issues related to ethics which arise in the course of institutional activities.

Ethics consultant An individual who provides guidance, resources, and education as a service to physicians, patients, and families encountering ethical dilemmas during the course of medical encounters.

Health care proxy A type of surrogate (see glossary term Surrogate) legally appointed individual designated by a patient to make medical decisions on the patient’s behalf in the event the patients are unable to do so for themselves.

Moral distress Emotional discomfort experienced when individuals are asked to perform actions which are inconsistent with their personal or professional values.

Nonmaleficence The obligation to not inflict harm upon others.

Paternalism A stance or style of action which mimics the power differential of a father and child whereby the physician maintains a paternal role and the patient holds a childlike role.

Surrogate An individual who makes medical decision on behalf of patients who are unable to make decisions for themselves.
action can have both morally right and morally wrong implications. The clinical ethicist may be called to mediate these disagreements to ensure the rights, values, and obligations of all parties are understood and respected.

**History of Clinical Ethics**

Historically, the study of ethics in healthcare can be traced to ancient Greece and the writing of the Hippocratic Oath. This oath and other writings known as the Hippocratic Corpus are often considered the origins of medical ethics, though the true purpose and authorship of the Hippocratic Oath is debated by scholars. The oath outlines a set of professed assurances and a code of conduct for medical practitioners (Veatch, 2003). As the medical practitioners continued to define their role as unique among the trades and professions throughout history, codes of ethics have been one mechanism used by physicians to distinguish themselves from others claiming to provide similar services. Today, nearly all professions connected to a healthcare setting have a code of ethics.

In striving to advance medical knowledge, there have been ethical violations which raise questions about how best to manage the need for improving the science of medicine with the interests of society. Advances in scientific knowledge and technology have given way to life-saving and life-extending treatment options. The evolution of clinical bioethics in the United States was prompted in large part by the intersection of exposed unethical research projects and two landmark cases which raised many questions about how people ought to be treated in clinical settings.

**Research**

Clinical bioethics began to emerge as a distinct field of study during the 1960s and 1970s with a convergence of multiple social, medical, and scientific advances that raised questions about how humans were being treated in the healthcare arena. During World War II, Nazi physicians performed extensive experiments on human subjects who were prisoners in concentration camps. The experimentation atrocities committed under the Nazi regime ultimately resulted in the murder, torture, and abuse of human beings and went unquestioned under policies endorsing eugenics and racial hygiene and were performed ‘in the name of medical science’ (Annas and Grodin, 1992). The horrific experiments were fully exposed during the Nuremberg Trials and resulted in the conviction of many of these doctors who were hanged (Annas and Grodin, 1992). In the Unites States, revelations of unethical research on human subjects during the Tuskegee Syphilis Study (Brandt, 1978) and Willowbrook State School Hepatitis Studies (Goldby, 1971) in the early 1970s prompted public outcry over the unchecked maltreatment of marginalized and oppressed persons who were the victims of these exposed studies. To assure protection of future human subjects, a multidisciplinary national commission was established in the late 1970s to develop guidelines which would prevent similar abuses from occurring in the future. The President’s Commission for the Protection of Human Subjects was formed and the group produced a set of recommendations. The resulting report was titled The Belmont Report, and some consider this document to the beginning of the formalizations of the field of Bioethics. The Belmont Report put forth three principles, respect for persons, beneficence, and justice, for evaluating the ethical dimensions of research using human subjects and other decision making relevant to the clinical context.

**Karen Ann Quinlan**

At about the same time, a couple of widely publicized court cases raised questions about the ethical use of medical technology to preserve life and medical decision making for others. In 1975, Karen Ann Quinlan was 21 years old when she slipped into a coma after taking barbiturates and consuming alcohol. Although she was resuscitated, she never regained consciousness and remained in a persistent vegetative state due to the brief loss of oxygen to her brain. Respirators, or ventilators, were first used in the 1960s, and Karen’s breathing was maintained using this mechanical ventilation. Liquid nutrition was provided through a tube inserted in her nose extending into her stomach. Eventually, Karen’s parents concluded that their daughter’s brain function was never going to get better and asked that she be removed from the ventilator and allowed to die. A lengthy court battle ensued and raised important ethical questions about protecting vulnerable patients, quality of life, the permissibility of withdrawing life-sustaining treatment, and who should decide. Eventually, the court consented to allow the removal of the ventilator and Karen was weaned from the machine. To everyone’s surprise, she continued to breathe on her own. She lived for another 10 years in a persistent vegetative state with a feeding tube in place (Pence, 2004).

**Nancy Cruzan**

Nancy Cruzan was 24 years old when she was injured in an automobile accident. Like Karen Ann Quinlan, she survived with a serious anoxic brain injury and remained in a persistent vegetative state. Nancy’s condition was different in that she did not require a ventilator, but she did need a feeding tube for nutrition and hydration. Nancy’s parents sought permission to stop the tube feeding to allow Nancy to die. Again, a lengthy court battle sought to answer the question of who could make the decision to withdraw life-sustaining treatment for a patient with such devastating brain injury. Eventually, Nancy’s family won the right to remove her feeding tube, but only once the court was satisfied that there was sufficient evidence, clear and convincing evidence, to support this decision would be consistent with Nancy’s own wishes. Like the Karen case, Nancy’s case prompted questions about the ethical use of medical technology to preserve life and decision making for others (Pence, 2004).

**Contemporary Clinical Bioethics**

Healthcare providers may refer to professional codes of ethics, ethics committees, ethics consultants, or any number of resources to resolve ethical dilemmas which occur in the course of their practice. Ethics committees are common in hospitals and serve as a forum for reviewing issues and problems affecting the ethical delivery of healthcare at that institution. Ethics consultants are individuals who respond to requests for ethics consultation on a specific matter that has arisen in the
institution. The consultant will typically engage in a systematic review of the case or situation and recommend a course of action to the healthcare providers. Hospitals may rely on individual clinical bioethicists to provide training for the staff members and students on bioethics topics or policies which support ethical medical practice.

Ethics Committees

One avenue to become acquainted with the practice of clinical bioethics is to serve as a member of an institutional ethics committee. Hospitals typically have an ethics committee which includes staff members and community representatives and this model is typical in other healthcare facilities with ethics committees. Committees range in size and composition, though typically include physicians, nurses, social workers, administrators, and community members. Although there are no firm regulations about how large or small a group, a balanced composition representing various healthcare professions may be required in some places. Difficult cases which present an ethical conundrum for practitioners may be brought to an ethics committee for review and advice. Ethics committees often serve multiple functions within an institution including reviewing cases which have been brought to the committee for review and educating committee members and the employees of the institution. Ethics committees may be charged with policy review and drafting new policies.

Clinical Ethics Consultation

Clinical Ethics Consultation is a specialized service provided by bioethicists in healthcare settings to clarify ethical dilemmas which occur in the course of providing medical services. Sometimes ethic consultants work in pairs or small teams, and other times the consultants work independently. Requests for input from an ethics service usually evolve from specific patient cases which have presented ethical dilemmas for the workers, family, or patient. There are no clear standards or licensure process currently established for who may be qualified to perform ethics consultations in the Unites States. Some healthcare systems have formal training requirements, and others rely on ethics committees or trusted individuals within the institution to assist with clinical cases. The American Society of Bioethics and Humanities (ASBH) Task Force has published guidelines for the skills and knowledge regarded as essential for competent ethics consultation services. These skill sets form a concise summary of core competencies for individuals actively engaged in clinical bioethics consultation (American Society for Bioethics and Humanities (ASBH), 2011). Just as a committee provides policy input, an ethics consultant may help draft new policies for an institution or serve as a reviewer for existing policies.

Clinical Bioethics Education

Healthcare institutions differ on the training required for clinical ethicists. Professional organizations offer guidelines which encourage professionalization of workers who provide clinical ethics consultation services, however, licensing and certification have not yet been standardized in the Unites States. ASBH publication, Core Competencies for Healthcare Ethics Consultation, now in its second edition, outlines the scope of healthcare ethics consultation activities, skills, and procedures relevant to the professional practice of clinical bioethics consultation (ASBH, 2011). Over the last decade, training in clinical bioethics has become more available through accredited certificate programs, graduate degrees, and fellowship training programs featuring clinical ethics topics and skills. Practicing the skills needed to serve as a Clinical Bioethicist typically involves participating in real-life consultations, learning to educate groups on ethical issues by giving lectures, and serving on ethics committees.

Guiding Principles of Clinical Bioethics

In order to understand the ethical dilemmas which arise in the healthcare setting, a set of principles is often used to distinguish competing moral claims. The four basic principles – respect for autonomy (autonomy), nonmaleficence, beneficence, and justice – used in clinical bioethics were introduced by James Childress and Thomas Beauchamp in their 1977 book Principles of Biomedical Ethics (Beauchamp and Childress, 1989). These elements are typically present in all healthcare interactions and help define the various rights and obligations of healthcare providers, patients, and society.

Autonomy

The principle of autonomy, often referred to as patient autonomy in clinical bioethics, is based on the widely accepted belief that an individual has the inherent right to act as an independent, self-directing being and make medical decisions consistent with his or her personal values. For choices to be truly autonomous, the individual must also be free from coercion or other forms of influence which alters the patient’s liberty to express preferences. Respecting the autonomous choices of an individual is one feature of ethical behavior in healthcare. However, in order to achieve the goals of medicine, there is more to consider than simply the expression of a patient’s preferences. There is an expectation that the patient understands the risks and benefits of his or her choice, and accepts these risks and benefits. There is also an expectation that the risks and benefits of the choices have been fully explained to the patient so the decision is based on factual information. The process of receiving information about a medical procedure, including the risks and benefits, and agreeing to medical treatment, or nontreatment is called informed consent. Respecting a patient’s autonomy includes obtaining that individual’s informed consent before engaging in medical intervention, enrolling a patient in a research study, or sharing private health information with others.

Capacity

Individuals who are able to understand, consider, appreciate the various healthcare treatment options, and express an informed decision that is consistent with his or her personal values is said to have capacity, sometimes called decisional capacity. However, not all people are able to understand the information offered and render an informed decision about what they do and do not want based on this information. Illness, injury, or cognitive
disability may affect an individual’s ability to participate in decisions. Patients must be able to communicate a meaningful understanding of their options and preferences. Individuals who are unable to participate in the process of receiving information and forming a decision based on the information, as well as communicating this choice are said to lack decisional capacity. If a person lacks decisional capacity, he or she may not provide informed consent, and another person may be asked to provide informed consent on behalf of the patient.

**Surrogates**

A surrogate, or substitute decision maker, may be needed to make decisions for a patient who lacks capacity. The surrogate may be a spouse, a parent, an adult sibling, other close acquaintance, or legally appointed guardian who can best represent the patient’s interests in healthcare decisions. Sometimes a patient will have specified who they would want to make medical decisions in the event the patient cannot do so by completing a legal document designating a Health Care Proxy. The role of the surrogate is to make decisions for the patient based on the patient's previously stated wishes, and this is known as substituted judgment. If the patient’s preferences are not known, the surrogate is obligated to make a decision which is in the patient’s best interests. In the absence of any surrogate at all, legal proceeding may be initiated to assign a court appointed decision maker to advise physicians (Jonsen et al., 2010). Thoughtful, informed decisions which consider the relevant facts and information related to the patients’ needs, known preferences, and best interests whether made by surrogates or patients are acceptable as an extension of the patient’s autonomy (Veatch, 2003).

**Nonmaleficence**

The principle of nonmaleficence is based on the obligation to not inflict harm, perhaps most widely recognized as the maxim ‘first do no harm’ (Beauchamp and Childress, 1989). Though this precise principle cannot be directly traced to the Hippocratic Oath, the blended concepts of acting for the benefit of those who are ill and not causing harm are noted in the ancient oath (Beauchamp and Childress, 1989). The concept of nonmaleficence is often merged with beneficence (see Section Beneficence), however, it can be useful to differentiate these two principles. Beneficence is the obligation to take action to avoid harm whereas nonmaleficence supports not initiating an action which would be harmful. For example, the obligation to not intentionally knock over another person just for fun is quite strong, and is different from the obligation to help up someone who has accidentally fallen down. The principle of nonmaleficence requires not knocking another over, however, the principle of beneficence, discussed in the next section, would obligate helping someone up who has fallen.

In healthcare, it can be tricky to determine which actions constitute harms and which do not because the outcome of some harmful actions may be beneficial to a patient. One example would be surgery. Cutting into a person’s body is an act certainly considered harmful and unwelcome in most settings, however, in the medical setting the intent of the action is to restore health or improve function. Surgical intervention offers potential benefits which are expected to outweigh the harm of having one’s body opened with a sharp tool. The process of evaluating the risks and benefits of an action is often a significant part of making decisions in healthcare settings.

The obligation to not inflict harm may also be complicated when a treatment or procedure which is intended to help a patient has a secondary effect which is foreseen and unwanted. There is wide support for undertaking interventions which have the primary intent of providing benefit even though there is an anticipated and undesired secondary outcome under the doctrine of double effect. This principle is often associated with the Roman Catholic church and serves as a mechanism for supporting otherwise prohibited actions (Beauchamp and Childress, 1989). Consider the example of a patient who has such tremendous pain that the standard doses of medication do not provide relief. The patient’s suffering is only relieved with such high doses of medication that the patient may die sooner because of the high doses. While the primary goal is to relieve the patient’s pain, the secondary effect is that the patient may die sooner. In most circumstances, it would be considered unethical to engage in actions which cause a patient’s death; however, when the intent is to relieve suffering, the anticipated hastening of the patient’s death is ethically permissible under the doctrine of double effect.

**Beneficence**

The principle of beneficence is the obligation to help others by undertaking actions which will have beneficial outcome. In healthcare, a good or beneficial outcome is one which achieves the restoration of health or improves the well-being of the patient and is assumed to underscore all actions in medical services (Beauchamp and Childress, 1989). The difference between this principle and nonmaleficence is that unlike avoiding actions which will cause harm, beneficence suggests that action must be taken for the good outcome to happen. Fulfilling this obligation to provide benefits can be complicated when there are significant risks to the patient, to other individuals, or to society.

**Benefits vs Risks**

A healthcare provider working to ensure the welfare of a patient will need to evaluate the possible benefit as well as the risks of harm to the patient when considering any action or treatment that may be performed. What are the potentially good outcomes, what are the possible bad or harmful outcomes, and do the benefits outweigh the risks? When a given action is expected to provide a large benefit with little risk, there is a tendency to prefer that action. For example, taking antibiotics for a bacterial infection generally has a low risk and high benefit. When an action has greater risks than benefits, it may be considered less desirable to provide the intervention, but can be justified if the small benefits are highly valued. When the risks and benefits are about the same, the decision about what ought to be done is most challenging. When the potential advantages and harms are equivalent, the decision-making process must consider the patient’s personal preferences and values to help determine which course of action to select.

**Paternalism**

Paternalism is defined as a fatherlike authority that anticipates obedience and respect under the father’s caring guidance. Some
medical providers may approach patient encounters with this stance and convey, either intentionally or unintentionally, the expectation that the physician’s perspective will be influential in the decision-making process. Throughout much of medical history, physicians’ advice and direction was rarely questioned. Contemporary clinical practice, however, has been dismissive of paternalism because it seems to usurp the patient’s autonomy to make informed choices based on personal values. However, there are different types of authoritative guidance and some argue that there are circumstances which warrant paternalistic interventions. Emergency care may be needed for a patient who cannot express a preference and for whom a surrogate cannot be found quickly. In these cases, physicians must make decisions for patients based on what is medically appropriate. Such actions support the principle of beneficence because the actions are initiated to help the patient.

Justice

The term justice can be defined in several ways. In healthcare, the principle of respect for justice refers to distributive justice. Under this principle, there is an obligation to respect the concerns of the society when allocating resources, such as healthcare services. How can the limited resource of healthcare services be distributed in a manner that is fair to everyone? Sometimes personal freedom and preferences must be limited in order to protect the interests of the larger community. Fair distribution of resources applies when there is a scarcity of a desired or needed resource. Some familiar methods for distributing a scarce resource include a lottery where everyone has an equal chance of being selected, a first come first served system whereby those who arrive first get what is sought or the resource can be distributed to each according to need. Consider the process of hospital admissions. Is everyone who wants to be cared for in the hospital allowed admission for treatment? Of course not, because there are a limited number of beds and caregivers. Yet, a lottery system does not seem particularly fair because those who are in dire need of medical care may not be selected. A first come first served system could be preferable, but may still cause harm when a more seriously injured or ill patient arrives but must wait behind others who arrived earlier. The scarce resource of hospital care is typically distributed according to need with the understanding that those with the most acute medical needs receive treatment first. Communities generally find this acceptable because people will have access to acute care should they themselves someday need these services urgently.

Allocating scarce resources may be decided based on serving the best interests of the community at large and not on what is best for each individual. Disaster planning requires an assessment of who will receive certain treatments in the event there is a widespread health crisis for which there are inadequate supplies to serve all who need help. Suppose a new strain of the flu is fast spreading and life threatening to human beings. Should treatment be given to people on a first come first serve basis? As noted earlier, the standard for treating each according to need is typically applied in normal circumstances, but a pandemic would not be normal. In unusual circumstances such as a disaster, the priorities for distributing scarce healthcare resources may shift from care of the sickest to preserving as many lives as possible.

Justice issues can also arise when there is a threat to the community at large. As noted, the principle of respect for autonomy supports allowing individuals to have broad freedom to make decisions about medical treatment. Yet, what if an individual has a highly contagious infectious disease transmittable by any contact and poses a serious risk to others in the community? Should this individual be permitted to refuse medical treatment based on autonomy? In this case, there is a compelling argument to restrict the activities of an individual for the safety and well-being of many. Questions about how serious the threat may be and how much restriction of individual freedom is appropriate may be addressed by balancing the relevant guiding principles and evaluating the risks and burdens of each action.

Case Analysis in Clinical Bioethics

The range of ethical dilemmas which arise in healthcare is vast. Each clinical bioethics case is as unique as the individuals involved, and resolutions must consider each person’s rights, roles, values, and the context of the given situation and setting. Analyzing the characteristics of each case is best managed using an organized format. Jonsen, Seigler, and Winslade offer one method, known as the Four Box Method, because it relies upon four categories of information for framing the various features of clinical cases (Jonsen et al., 2010). Like pieces of a puzzle, the four categories of information serve as a foundation for reviewing the facts of the case as well as the unique features and dilemmas. Information is gathered from various sources to form a cohesive and thorough assessment of each case in order to offer a recommendation that best upholds the principles of biomedical ethics.

Medical Indications

Medical decisions which respect the principles of beneficence and nonmaleficence must be grounded in a sound understanding of the patient’s medical needs and condition. Case analysis should always consider the medical facts in order to engage in a meaningful discussion of what role medicine may have in resolving an ethical dilemma (Jonsen et al., 2010). The medical indications are defined as those elements of a case which "are those facts about the patient’s physiological or psychological condition that indicate which forms of diagnostic, therapeutic, or educational interventions are appropriate." Collecting the relevant medical facts can be simplified by using a set of questions. What are the patient’s medical problems? Is this an acute, chronic, or terminal medical condition? What will treatment achieve for the patient? What are the likely outcomes with and without treatment? (Jonsen et al., 2010). Understanding the clinical situation is a key step to analyzing cases in Clinical Bioethics and is typically the first step in this process.

Patient Preferences

Respecting every patient’s inherent right to autonomy requires an assessment of the patient’s preferences for medical intervention. Engaging in a dialog with each patient is the best way
to determine what medical treatments the patient prefers. It can be tempting to presume all patients want to avail themselves of the full array of treatment options. However, this is often not the case and to act on this assumption fails to consider the patient’s rights. In cases where a patient is acutely ill or otherwise unable to communicate with medical providers, and there is no information about what medical treatments he or she would want or not want, healthcare providers typically will provide medically appropriate interventions. Sometimes patients have discussed preferences with family members and others who are able to convey these preferences to medical providers when patients themselves are unable to so do (see Section Surrogates). Written documents, called advance directives, may also be completed to indicate preferences for treatment or nontreatment.

Quality of Life Issues

Ethical dilemmas often center on whether or not a patient’s life will have a sufficient amount of pleasure, comfort, and satisfaction over time. What features of the daily living experience defines quality of life in an individual? It may seem intuitive, and perhaps morally correct, to prolong life as one of the important goals of medicine. However, some people question this claim when the quality of life for the patient will be poor. People may hold very different views about what level of treatment is desired in light of the patient’s experienced benefits and burdens. Questions about changes or lack of changes to the patient’s condition can help clarify what the current and future quality of life may be. Will the patient’s mobility or cognitive function be changed? Is the patient experiencing pain or expected to feel more or less pain in the future? Will advanced medical technology keep the patient alive but impose limits on daily life which the patient finds unacceptable or undesirable? Many people feel there is tremendous value in remaining alive regardless of any experienced burdens, and for others, there are limits to the burdens they are willing to endure in order to sustain life. Clinical Bioethicists working with patients and families often engage in discussions about quality of life issues to establish the goals of medical interventions.

Contextual Features

The unique social and situational elements that affect the medical decision-making process create the contextual features of a given case. Psychosocial features may include living arrangements, family members, financial concerns, and any conflicts that are related to the patient’s case and care would be explored and included in a summary of the context. Justice issues might be noted in an exploration of contextual features. Does the community have an interest in the medical decision making in the case? Are resources being allocated in a fair or unusual manner? Other contextual factors may include institutional regulations, legal constraints, disagreements among family members, or even conflict between medical providers.

The framework presented by Jonsen, Siegler, and Winslade is widely used; however, other formats can be used or created to summarize a clinical case. Organizing the information into a meaningful and usable structure helps all who are involved in the patient’s care understand the components of the case. Rather than simply noting a recommendation, best practices in clinical ethics include providing a concise summary and holistic view of the individual at the center of the encounter, the patient.

Summary

As a discipline, clinical bioethics continues to evolve in order to keep pace with advances in the healthcare arena. Achieving the goals of medicine in an ever-changing environment must be supported with an understanding of how ethics can be applied in healthcare encounters. Clinical cases fraught with ethical dilemmas have the potential to influence practice standards, policy, and even legislation. The significance of ethics in healthcare ought not to be minimized. The incredible scientific and technological advances in medicine have changed the landscape of healthcare; however, these same discoveries may pose unique ethical challenges at the bedside where patients and doctors make life-changing decisions each and every day. Organized approaches to resolving ethical dilemmas ensure all relevant information is considered in reaching recommendations for clinicians who are responsible for the care of patients.

See also: Ethical Issues Concerning Pregnancy and Childbirth; Ethical Issues in Behavioral Healthcare; Ethics of Issues and Stem Cell Research: The Unresolved Issues; Ethics of Placebos; Genetic Ethics; Health Care Rationing; Pharmacy Ethics; Public Health Ethics; The Ethics of End of Life; The History of Bioethics: Its Rise and Significance; The Patient–Doctor Relationship.

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