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Evidence of bioethical discourse and behaviors in health professions

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Abstract

This study aimed to identify bioethical situations and behaviors in health professions reported in the literature. This integrative review of scientific articles indexed in the Virtual Health Library databases, published between 2014 and 2019, used the following keywords: "health personnel," "professional practice," "ethics, professional," "discourse," and "bioethics." Twenty-one studies were selected for discussion, with five categories identified in the analysis: bioethics during professional training; bioethics as a form of humanizing healthcare; interprofessional relationships, rights and duties of patients and professionals; bioethics in decisions in the beginning and end of life; and decision making in healthcare. Patient autonomy was the bioethical principle most often addressed in various clinical circumstances, especially in end-of-life dilemmas.

Keywords: Public health. Health. Bioethics. Codes of ethics. Professional competence. Professional practice. Human rights.

Resumo

Identificação de situações e condutas bioéticas na atuação profissional em saúde

O objetivo deste estudo foi identificar na literatura situações e condutas bioéticas na atuação profissional em saúde. Trata-se de revisão integrativa de artigos científicos indexados nas bases de dados da Biblioteca Virtual em Saúde e publicados entre 2014 e 2019. Utilizaram-se os descritores "pessoal de saúde", "prática profissional", "ética profissional", "discurso" e "bioética". Foram selecionados 21 estudos para a discussão, destacando-se cinco categorias de análise: bioética durante a formação profissional; bioética como forma de humanizar a saúde; relações interprofissionais, direitos e deveres de trabalhadores e pacientes; bioética nas decisões que permeiam o início e o fim da vida; e tomada de decisões na saúde. A autonomia do paciente foi o princípio bioético mais abordado em diversas circunstâncias clínicas, especialmente nos dilemas relativos ao fim da vida.

Palavras-chave: Saúde pública. Saúde. Bioética. Códigos de ética. Competência profissional. Prática profissional. Direitos humanos.

Resumen

Identificación de situaciones y conductas bioéticas en la práctica profesional en salud

El objetivo de este estudio fue identificar en la literatura situaciones y conductas bioéticas de la práctica profesional en salud. Se trata de una revisión integradora de artículos científicos indexados en las bases de datos de la Biblioteca Virtual en Salud, publicados entre 2014 y 2019. Se utilizaron los descriptores "personal de salud", "práctica profesional", "ética profesional", "discurso" y "bioética". Se seleccionaron 21 estudios para discusión y, del análisis, surgieron cinco categorías: bioética durante la formación profesional; bioética como forma de humanizar la salud; relaciones interprofesionales, derechos y deberes de los trabajadores y pacientes; bioética en las decisiones que permean el inicio y el final de la vida; y toma de decisiones en salud. La autonomía del paciente fue el principio bioético más abordado en diversas circunstancias clínicas, especialmente en los dilemas al final de la vida.

Palabras clave: Salud pública. Salud. Bioética. Códigos de ética. Competencia profesional. Práctica profesional. Derechos humanos.

Research

The authors declare no conflict of interest.

Bioethics is an interdisciplinary, pluralistic, and non-corporatist field that focuses on issues related to human life, establishing principles that support life, health, and the environment [1-3]. It was first described in the 1970s, when oncologist Van Rensselaer Potter [4] recognized that not all scientifically feasible things were always morally correct, adopting the term "bioethics." Over the years, the term has become essential for communication between different areas of knowledge, including ethical, moral, religious, technical, scientific concepts, among others, to propose, describe and assess strategies to ensure the protection of all subjects [5].

Bioethics is based on four principles: autonomy, beneficence, non-maleficence, and justice. Autonomy refers to consent, the ability to think and act, translating into the personal practice of self-government; beneficence proposes to minimize risks and maximize benefits; non-maleficence aims to avoid predictable damage; and finally justice refers to fairness in the distribution of goods and/or benefits [1,3]. Then, considering Potter's efforts in the 1970s [4], it is relevant to further examine bioethics in professional healthcare practices. In this perspective, this study aimed to identify in the literature bioethical situations and behaviors in professional healthcare practices.

Method

This is an integrative literature review, a scientific method whose purpose is to comprehensively and systematically synthesize the results of various types of studies, including empirical and theoretical data [1,6]. Six sequential and interdependent steps were adopted to systematize the methodological course: identification of study topic and selection of research question; literature search based on inclusion and exclusion criteria; definition of information to be extracted from the selected studies; evaluation of the studies included in the integrative review; interpretation of results; and synthesis of knowledge [7]. As such, this integrative review attempted to answer the following research question: according to the literature, in which contexts are bioethical situations and behaviors identified in professional healthcare practices?

The review was based on a search for scientific articles indexed in the Virtual Health Library [8] databases, adopting eight combinations of five terms from the Health Sciences Descriptors: "health personnel"; "professional practice"; "ethics, professional"; "discourse"; and "bioethics". All combinations were linked to the descriptor "health personnel" to restrict the search and avoid the inclusion of studies conducted with other professional categories (Table 1). The boolean operator *and* was used with the descriptors in each combination so only articles of similar approaches were highlighted.

The inclusion criteria included: articles available for free download published between 2014 and 2019, without language restrictions, and focusing on bioethical discourses and behaviors in health professions. After applying these criteria, the remaining articles were read to identify whether they indeed related to the study topic. Thus, 21 articles [2,5,9-27] were selected, all addressing the topic of bioethics in the practice of nurses and/or physicians.

The articles selected were then evaluated by in-depth critical-reflective reading, identifying five categories to guide the discussion: bioethics during professional training [10,15,17,19,23]; bioethics as a form of humanizing healthcare [9,15,21]; interprofessional relationships, rights and duties of patients and professionals [13-16,18,20,22,26]; bioethics in decisions in the beginning and end of life [2,5,12,14,16,17,25-27]; and decision making in healthcare [11,12,19,24].

Due to the study design, it was not necessary to submit this study to the Research Ethics Committee, according to Resolution 510/2016 of the Brazilian National Health Council [28].

Table 1. Combinations of descriptors used to search for articles in the Virtual Health Library databases.

Combinations	Descriptor 1	Descriptor 2	Descriptor 3	Descriptor 4	Descriptor 5	Total articles*	Total articles**
1	Health personnel	Professional practice	Ethics, professional	Discourse	Bioethics	3	0
2	Health personnel	Professional practice	Ethics, professional	Discourse	–	16	2 [9,10]
3	Health personnel	Professional practice	Ethics, professional	–	Bioethics	49	7 [2,11-16]
4	Health personnel	Professional practice	–	Discourse	Bioethics	7	1 [17]
5	Health personnel	Professional practice	–	–	Bioethics	74	4 [5,18-20]
6	Health personnel	–	–	Discourse	Bioethics	16	0
7	Health personnel	–	–	–	Bioethics	1.220	7 [21-27]
8	Health personnel	–	Ethics, professional	Discourse	Bioethics	5	0

**Total number of articles found before applying the inclusion criteria; **total number of articles selected after application of inclusion criteria and previous reading of remaining articles.*

Results and discussion

According to Table 2, the 21 articles identified have different main authors, and most studies were published by *Revista Bioética* (n=14). The journal with highest adherence publishes content related to research or experiences in the field of bioethics or medical ethics, covering the topic analyzed in this study.

The main segments addressed in the studies reveal a frequent association of complex issues, such as implementation of humanized care, living with the end of life and understanding bioethical principles as a work strategy in conflict situations. Bioethics is also seen in studies as a mediator in decision-making and a tool to support fundamental rights, the individuality of every person involved, and mutual respect in the relationships among the various agents in the health-disease process. But this review identified poor knowledge about the legal aspects concerning upholding patient autonomy in healthcare. Among the bioethical principles addressed in the studies, autonomy was the most recurrent in the sample, linked to the democratization of the bond between health professionals and patients, and valuation of the individual in the therapeutic process.

Table 2. Articles selected

Authors/year	Journal/article title	Main topics addressed	Bioethical principles addressed
Santos and collaborators; 2014 [2]	*Revista Bioética* "Bioethical reflections on euthanasia: analysis of a paradigmatic case"	Illegitimacy of euthanasia	Beneficence and non-maleficence
Motta and collaborators; 2016 [5]	*Revista Bioética* "Decision-making in (bio)ethics: contemporary approaches"	Complexity of professional decision making in health care	Autonomy

continues...

Table 2. Continuation

Authors/year	Journal/article title	Main topics addressed	Bioethical principles addressed
Seoane, Fortes; 2014 [9]	*Saúde e Sociedade* "Physicians and nurses' perception of the outpatient medical care regarding humanization in health services"	Diversity of meanings attributed to humanization by health professionals	Autonomy
Franco and collaborators; 2014 [10]	*Revista Brasileira de Educação Médica* "The concept of competence: an analysis of the teachers' perspective"	Applicability of knowledge and behaviors related to practices based on ethical and reflective precepts	Autonomy
Siqueira-Batista and collaborators; 2014 [11]	*Revista Bioética* "Models of decision making in clinical bioethics: notes for a computational approach"	Characterization and support of the decision-making process in clinical bioethics	Autonomy
Eich, Verdi, Martins; 2015 [12]	*Revista Bioética* "Moral deliberation in palliative sedation focusing on an oncology palliative care team"	Rational use of palliative sedation as a method to reduce suffering in the process of death and dying	Autonomy and non-maleficence
Gomes, Ramos; 2015 [13]	*Interface – Comunicação, Saúde, Educação* "Solidarity, alliance and commitment among healthcare professionals in the practices of the Brazilian Health System (SUS): a bioethical debate"	Expansion of spaces for bioethical debate aiming to intensify the dialogue and change values involving patients, professionals, society, and health services	Beneficence and autonomy
Gracindo; 2015 [14]	*Revista Bioética* "The morality of surgery for aesthetic purposes in accordance with principlist bioethics"	Rights and duties of patients and health professionals in esthetic surgical interventions	Autonomy
Saito, Zoboli; 2015 [15]	*Revista Bioética* "Palliative care and primary health care: scoping review"	Ethical issues and requirements for incorporating palliative care in primary care	Autonomy
Chehuen Neto and collaborators; 2015 [16]	*Revista Bioética* "Living will: what do healthcare professionals think about it?"	Poor knowledge of professionals about living will used in health care	Autonomy
Guimarães and collaborators; 2016 [17]	*Revista Enfermagem Uerj* "Euthanasia and dysthanasia: doctors' and nurses' perceptions in a town in southern Minas Gerais"	Lack of discussions and experiences regarding euthanasia and dysthanasia in health professional training and practice	Beneficence and non-maleficence

continues...

Table 2. Continuation

Authors/year	Journal/article title	Main topics addressed	Bioethical principles addressed
Outomuro, Mirabile; 2015 [18]	*Revista Bioética* "Confidentiality and privacy in medicine and scientific research: from bioethics to the law"	Understanding privacy as an ethical standard	Autonomy, beneficence and non-maleficence
Nora, Zoboli, Vieira; 2015 [19]	*Revista Bioética* "Ethical deliberation in health: an integrative literature review"	Deliberation as an instrument of permanent education and resolution of problems faced	Autonomy
Marques Filho, Hossne; 2015 [20]	*Revista Bioética* "The doctor-patient relationship under the influence of the bioethical reference point of autonomy"	Contributions of autonomy to developing the relationship between patients and professionals	Autonomy
Riveros Ríos; 2017 [21]	*Anales de la Facultad de Ciencias Médicas (Asunción)* "Bioethical aspects from the personalist vision of spirituality in the management of people in the health area"	Assertion of fundamental principles when relating spirituality and ethical precepts	Beneficence and non-maleficence
Santos and collaborators; 2017 [22]	*Revista Bioética* "Bioethical considerations on the doctor-indigenous patient relationship"	Divergence of perceptions in the health-disease process	Autonomy
Gomes and collaborators; 2016 [23]	*Revista Bioética* "Family Health Strategy and bioethics: focus group discussions on work and training"	Centrality of bioethics in the work in family health centers	Beneficence and non-maleficence
Fachini, Scrigni, Lima; 2017 [24]	*Revista Bioética* "Moral distress of workers from a pediatric ICU"	Ability to exercise autonomy in the workplace	Autonomy
Eidt, Bruneri, Bonamigo; 2017 [25]	*O Mundo da Saúde* "Terminally ill patients' do-not-resuscitate orders from the doctors' perspective"	Knowledge and adherence to the order of not resuscitating terminal patients	Autonomy
Pirôpo and collaborators; 2018 [26]	*Revista de Salud Pública* "Correlation of living will, bioethics, professional activity and patient autonomy"	Knowledge of health professionals about individual rights and autonomy of terminal patients	Autonomy
Brandalise and collaborators; 2018 [27]	*Revista Bioética* "Assisted suicide and euthanasia from the perspective of professionals and academics in a university hospital"	Knowledge and acceptance of euthanasia and assisted suicide by health care professionals and undergraduates	Autonomy

Research

Bioethics during professional training

Higher education institutions should promote broad discussions on ethical and moral attributes with students and society [10]. Ethical issues cannot be addressed normatively with ready-made formulas; they need to be creatively discussed to identify new solution strategies [19]. In bioethics, arguments must be analyzed considering human beings, the environment and living beings in general, from a complex and multidimensional perspective. Bioethics should also be experienced and practiced through actions that encourage practical and humanized knowledge [10].

In this perspective, a study identified that including bioethics in professional training can enhance the evaluative abilities of students, improving their professional skills in biopsychosocial, holistic perspectives, patient empowerment, accountability, and therapeutic adherence, satisfactorily increasing the quality of care provided [10]. Another study, conducted with a family health team in Viçosa, Minas Gerais, observed that professionals had trouble defining the concepts of ethics and bioethics [23], but showed desire to better understand these topics given their importance. The study also identified the need to create spaces for training and debates on bioethical issues [23].

Another context found was the deficient communication between professionals, patients and families, as observed in a study conducted in Brazil [15], with these findings being attributed to a deficient academic training. Communication is considered a strategic management tool and can empower patients and family members to exercise their autonomy while enabling exchange of knowledge between team members to ensure the best therapeutic approach, including all bioethical aspects involved. Failure to communicate make debates and conducts unfeasible according to bioethical precepts, as well as adding information for the exercise of citizenship in therapeutic and assistance procedures.

Communication was also present in behaviors to relieve the suffering of patients and family members, including when professionals must inform bad news – for instance, complex diagnosis and therapeutic limitation – and decision-making in the face of suffering and imminent death, as in the case of euthanasia. Considered a practice opposed to the ethical exercise of medicine [2], euthanasia is considered a crime according to the Brazilian legislation, categorized as homicide under article 121 of the Brazilian Penal Code [29], with imprisonment for two to four years [17].

Conflict situations in cases of terminal patients lead professionals to question the training received at college. Medical schools must thus expand the debate on the topic during professional training, as Brazil lacks valid context accepting the practice of euthanasia or dysthanasia as a supporting method. The knowledge acquired is also insufficient to eliminate patient suffering, often limited to physical care, which disrupts the integrality of care [17].

Hospital environments also lack discussions on euthanasia. For some cultures, death represents something negative, and most professionals are not prepared to face this situation. In the perception of nurses, professional training influences this aspect, as it usually focuses on saving lives, not on accepting death. As a result, professionals feel frustration, pain and distress in situations involving this topic [17].

Bioethics as a form of humanizing healthcare

The word "humanize" means "to make or become humane," that is, help people and encourage them to fulfill their desires with dignity. It is a broad concept that seeks to understand each person and their needs and peculiarities, providing conditions to exercise their desires autonomously [9]. A study observed that health professionals are concerned about issues related to patient autonomy, mainly because they recognize the importance of communication for an effective self-government and co-responsibility process [9].

Palliative care and spirituality must also be highlighted as issues involved in bioethics and humanization of health. End-of-life care aims to improve the quality of life of terminal patients or patients living with a chronic degenerative disease. These are therapeutic projects developed by a multidisciplinary team

and that must be offered at all units of the healthcare network, in all different levels of complexity. Aiming to ensure beneficence and non-maleficence, palliative care implementation is proposed as early as possible, and not only for terminal patients [15].

In a biomedical perspective, the somatic dimension is the most relevant in palliative care, and not psychosocial and spiritual aspects. Such perception explains the rare cooperation with religious agents and resistance to discuss spirituality with patients [30]. Physicians and nurses report they feel uncomfortable addressing these issues, but they recognize the relevance of spiritual and religious aspects at the end-of-life [31].

In this sense, we cite the case of an indigenous child who suffered a snakebite and was hospitalized in an emergency room in the city of Manaus, Amazonas, in 2009 [32]. The child's father requested the health center to authorize his tribe's healer in the unit to treat the child according to their cultural practices, but his request was denied. He then exercised his right to autonomy and, supported by a court decision based on human rights, had his daughter released from the hospital and transferred to an indigenous health center so she could be treated according to the tribe's traditions. Later, the hospital director contacted the child's father and proposed a joint treatment. Three days after starting a combined treatment of scientific, empirical, and spiritual therapies, the child evolved to normothermia, with an extremely significant improvement in the affected limb, without the need of amputation [32].

All aspects involved in bioethics are related to spirituality. For example, beneficence can be judged from the benefits brought to the patient through a combined view that considers the individual as a spiritual being as well. Non-maleficence minimizes risks if the spiritual context is considered. Autonomy grants religious and spiritual freedom to patients, so they can experience and evoke their beliefs spontaneously, or when suffering involves it as a therapeutic method. Finally, justice allows an individual to explore different therapeutic methods with fairness, considering all aspects permeating human life, including spirituality [21].

In the indigenous child case, the child's autonomy was disregarded in the exercise of her right to life and health. When children experience illness and hospitalization, they usually participate passively in the care process, depending on an adult figure for survival and control over various aspects related to health, which generates fear, revolt, vulnerability, dread and sadness. Children are considered capable of making decisions when they are 10.6 years old, on average, showing general self-determination [33].

Interprofessional relationships, rights and duties of patients and professionals

Regarding interprofessional relationships, a study showed failed communication between physicians and nurses of both primary care team and professionals from other services comprising the healthcare network [15]. Primary care physicians complained that specialists fail to share patient information, making comprehensive care impossible. Primary care nurses, in turn, reported that physicians hesitate to respond to requests from the nursing team, accept new initiatives, and meet patient needs [15].

Thus, we observe conflicts in the relationship between doctors and nurses due to a difference in authority of these professions. Nurses consider interpersonal relationships more important than the technical expertise and scientific knowledge of physicians [15], while the latter regard these relationships and aspects involving negotiation as less relevant [16]. One must consider, in this perspective, that medical training is based on scientific elements and biomedicine – disciplines that generally do not cover content related to health anthropology, in contrast to the ethical-humanistic training recommended by the National Education Council [34]. However, the inability of many professionals to respond to the various cultural conflicts in the practice of medicine is largely attributed to deficiencies in training [22].

In recent decades, patients have increasingly participated in therapeutic decisions, and their involvement is a target of constant changes [16,26].

Such fact may be related to the advances seen in the curricular guidelines of undergraduate courses, since in recent years professionals have understood the importance of strengthening the bond with patients [26].

Bioethics as a field of knowledge emerges as a space for debate. As Gomes and Ramos state, in *a counter-hegemonic movement against the individualizing injunctions of the contemporary model of society* (...), *expanding spaces for bioethical debate seems to reinforce the dialogicity between patient-community-professional-service and encourage changes in values with the incorporation of alliance, commitment and solidarity* [35].

The relationship between physician and patient must be based on technical, humanistic, ethical, and esthetic dimensions, and its relevance is such that only a professional action that necessarily establishes a satisfactory relationship with their patients can be named a "medical act" [20]. A study showed, however, that physicians are unlikely to discuss palliative care with patients, because they believe this is a time-consuming issue [15]. Besides, as it is a distressing discussion, physicians say it may not be beneficial for the patient [15], thereby violating the principle of non-maleficence. On the other hand, in the same study, nurses recognize the relevance of talking about death with patients with no possibility of cure, but they only address this topic when the patient is willing to or when an opportunity arises [15].

Another aspect that must be considered in bioethics is the lack of veracity when informing health status to patients and their family members [15]. Despite that, a study showed breach of confidentiality about therapy and prognosis of patients receiving palliative care [15]. The right to privacy cannot be internalized only from a legal standpoint, since bioethics has made efforts to constitute it as an ethical norm. The rules involving privacy are closely related to the principle of autonomy [18], since the right to privacy protects access to information according to the consent of the active subject in the process. Thus, violating patient privacy will seriously damage patient autonomy [18], which is considered one of the most significant bioethical achievements of the 20th century [20].

Patient autonomy is questionable in some cases, for instance, in plastic surgeries. Individuals have the right to such procedures and choose the surgeon, but their autonomy is not absolute. It is the surgeon's responsibility to inform the patient about risks and contraindications, having the right to refuse to do surgeries potentially harmful to the patient's health [14], thus respecting the principle of non-maleficence.

Bioethics in decisions in the beginning and end of life

When discussing the beginning of life, one of the issues that emerges is neonatology. Regarding neonatal intensive care units, we note that several bioethical dilemmas are also present in intensive care units for adults, including decisions about the artificial maintenance of vital functions, which newborns should be benefited and how they will benefit from the resources available, extending the pain of newborns and family members, among others [5]. Since newborns have yet to develop their self-government ability, their autonomy is shared with their family members, who are legally supported to decide with the health team about certain conducts [5,36].

The increase in life expectancy observed in recent years has pushed health professionals to reflect on whether extending life, sometimes a useless effort, is lawful, considering patient suffering. In this sense, many professionals are not prepared to identify and act in cases when the patient asks to die to relieve suffering and pain [26].

Dysthanasia is a practice that extends the life of patients with no therapeutic possibility of cure and who feels physical, psychological and/or emotional pain. Certainly, this practice does not benefit the patient and unnecessarily extends patient pain, disrespecting the principle of beneficence [2].

The fact is that the debate about life and death addresses several aspects that involve institutions, health teams, patients and family members, groups that disagree on topics related to the end of life [26]. But quantity of life does not mean quality of life, and those fears and taboos of

death as an enemy or professional incompetence must be overcome [27]. In this perspective, a new topic emerges that can create controversy: euthanasia. Coined by philosopher Francis Bacon [37] in 1623, the term means "good death" [2], but this practice is said to negate the principles of beneficence and non-maleficence [2], which mischaracterize its etymological meaning.

Euthanasia is defined as a method to end the life of an individual with an incurable disease without causing suffering, being related not only to death, but to human dignity [17]. Currently, euthanasia is a crime in Brazil [2,17], being a controversial issue that covers conflicts and values related to life and human dignity [17]. As Brazil is mostly a Christian country, the political-religious discourse has a strong influence against the acceptance of euthanasia [17].

Assisted suicide is similarly addressed. With the same purpose and indication as euthanasia, it consists in intentionally administering lethal medications, either by the patients themselves or with the help of third parties [27]. This practice is described as a crime in article 122 of the Penal Code [29], although the right to die is related to the individual's patient autonomy [2]. Thus, based on paragraph 1, article 121 of the same code [29], euthanasia can be considered privileged homicide, motivated by a relevant moral value: respect for the patient's autonomy to decide about the moment of their death, which could reduce the penalty imposed.

Another aspect to be considered is palliative sedation, whose purpose is to alleviate suffering by promoting reduced consciousness, and therefore without extending or shortening life [12]. According to Santos and collaborators, *terminal illness must be considered the most degrading state of human essence, so that each patient must be treated in a unique way, according to their physical, psychological, and spiritual needs* [38]. Increased patient suffering and lack of a perspective of improvement often generate a significant expenditure and, consequently, distress among family members, professionals and, especially, in patients [17].

Patients can express their care and therapeutic wishes in a legal document called "living will" to guide decisions when their clinical condition cannot be reverted, and they are unable to exercise self-determination and self-government [16,39]. This instrument protects patient rights and the actions of professionals in peculiar situations [16]. The literature points to duality in the goal of this instrument, which can be both a means to encourage euthanasia and to interrupt procedures that will not bring clear benefits to the patient, thus respecting the principle of patient autonomy [16].

The Federal Council of Medicine in Brazil (CFM), through Resolution 1.995/2012 [40], recognizes the living will as a valid document that protects physicians in their actions [16]. But such document is not regulated by the Brazilian Civil Code [41], which increases the insecurity of health professionals in accepting it as a form of patient care [16]. Another ethical dilemma related to living will is the stability of patient decision, since the patient may change his mind when actually experiencing a specific condition in the future [16].

Finally, another important aspect is cardiopulmonary resuscitation, which should not be performed when the patient previously signs a do-not-resuscitate (DNR) order. Its acceptance among patients is higher when they live with serious diseases and non-treatable organic effects, such as intense pain processes, nausea, and fatigue.

DNR orders are also not regulated in Brazil [25], existing only ethical guidelines, such as CFM Resolution 1.805/2006 [42] and the Code of Medical Ethics [43]. These documents are not specific, explaining the lack of knowledge of participants in a study on the topic [25]. Although the patient's wishes must be considered an essential factor for therapeutic actions, physicians do not always allow limitations to these actions, even when it is the best way to benefit the patient [25], which violates the principles of autonomy, beneficence, and non-maleficence.

Decision making in healthcare

Clinical bioethics involves several themes relevant to decision-making in healthcare. Siqueira-Batista and collaborators highlight impasses related to: *(1) beginning of life – abortion, assisted reproduction technologies; (2) end of life – euthanasia, assisted suicide, do-not resuscitate order, advance directives,*

palliative care, dysthanasia, therapeutic obstinacy, organ transplantation (criteria for death, priority for access to the procedure); (3) diagnostic, therapeutic and prophylactic decisions in case of refusal by the patient or their legal guardian; (4) secrecy, privacy and confidentiality of information; and (5) allocation and management of scarce resources (or "who will use the respirator first?") [44].

The behaviors adopted in these cases will depend on a careful analysis and implementation of bioethics theories to guide the decision-making process [11]. In addition, the main conflicts in the decision-making process between health professionals, patients and family members are closely related to values, beliefs, and culture [12]. At times, the work complexity of the health-disease process forces professionals to make choices that may be contrary to their essential values, leading to moral suffering and an impact on psychological, organic, and social dimensions [24].

Careful and reasonable decision making requires clarifying and considering the values of every individual involved in the process, given that many situations favor conflicts, such as absent or insufficient communication. As a result, the lack of information prevents patients and family members from learning about the actual health condition, the typical suffering at the end of life, and the therapeutic technologies available to minimize it [12].

In the context of clinical bioethics, however, the literature shows different decision-making models that systematically address delimitation, assessment, and submission of proposals to resolve bioethical conflicts identified in individual patient care [11]. In this regard, principlism argues that the decision-making must strictly respect its principles, without hierarchizing them [19].

Final considerations

Bioethical discourse and behaviors are fundamental to guide healthcare and services, being present in situations from birth to death of an individual. Bioethics is therefore identified as an essential tool for health management. When used in care itself, bioethics allows meeting the individual needs of every patient, guiding the therapeutic procedures to avoid or minimize risks and physical damage, as well as ethical or moral conflicts.

This review identified patient autonomy as the most frequently addressed bioethical principle in different clinical circumstances, especially in problems concerning the end of life, when self-government is not always absolute and does not always find legal support for its exercise. Further studies should be conducted on this topic, which deserves other perspectives for constant up-to-date reflections, especially for those professionals who face, daily, situations that involve the beginning and end of life.

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