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CLINICAL ETHICS: STATUS QUAESTIONIS

ÉTICA CLÍNICA: STATUS QUAESTIONIS

ÉTICA CLÍNICA: STATUS QUAESTIONIS

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ABSTRACT

Clinical ethics refers to an emerging field in clinical medicine that focuses on the process of ethical decision-making in a clinical setting. It has developed as a result of a growing awareness that modern medicine – characterized by technological progress, cultural diversity and social challenges – is posing a range of new “ethical dilemmas” that medical science alone cannot solve. For this reason, clinical ethics is often linked to “ethics consultation,” which consists of services provided by an individual ethicist, ethics team or committee to address the ethical issues involved in a specific clinical case. Although clinical ethics developed in the beginning mainly as a methodological analysis to arrive at a justification for clinical ethical decisions, it quickly has become clear that the difficulty in clinical decision-making is only one aspect of wider ethical problems pertaining to the doctor-patient relationship as a whole and, most likely, to the core value of the medical profession. The principles method is usually presented as the most popular methodological approach to an analysis of clinical cases. However, strong criticism of this model has been voiced, and other alternative approaches are referred to, such as the casuistry model. Recently, significant contributions have been made by narrative medicine and virtue ethics. According to these methodologies, sound anthropology and a good relationship with the sick person are key elements required of any person engaged in medical practice who aims to be genuinely appropriate from an ethical perspective.

KEYWORDS: Clinical ethics; ethics; clinical; bioethics; professional-patient relations (Source: DeCS, Bireme).

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RESUMEN

La ética clínica se refiere a un campo emergente en la medicina clínica que se centra en el proceso de toma de decisiones éticas en un entorno clínico. Se ha desarrollado como resultado de una creciente conciencia de que la medicina moderna —caracterizada por el progreso tecnológico, la diversidad cultural y los problemas sociales— está planteando una serie de nuevos “dilemas éticos” que la ciencia médica por sí sola no puede resolver. Por esta razón, la ética clínica suele estar relacionada con la “consulta ética”, que consiste en los servicios prestados por un especialista en ética, un equipo ético o un comité de ética para abordar las cuestiones éticas implicadas en un caso clínico específico. Si bien la ética clínica se desarrolló al principio esencialmente como un análisis metodológico para llegar a una justificación de las decisiones éticas clínicas, rápidamente se hizo evidente que la dificultad en la toma de decisiones clínicas es solo un aspecto de los problemas éticos más amplios relacionados con la relación médico-paciente en su totalidad y, muy probablemente, con el valor fundamental de la profesión médica. El método de principios generalmente se presenta como el enfoque metodológico más extendido para el análisis de casos clínicos. Sin embargo, una fuerte crítica de este modelo se ha manifestado, y se hace referencia a otros enfoques alternativos, como el modelo de la casuística. Recientemente, se han producido importantes contribuciones de la medicina narrativa y la ética de la virtud. De acuerdo con estas metodologías, una sana antropología y una buena relación con el enfermo son elementos clave requeridos de cualquier persona que trabaje en la práctica médica que pretende ser auténticamente apropiada desde una perspectiva ética.

PALABRAS CLAVE: ética clínica; ética; clínica; bioética; relación médico-paciente (Fuente: DeCS, Bireme).

RESUMO

A ética clínica se refere a um campo emergente na medicina clínica que se concentra no processo de tomada de decisões éticas num contexto clínico. Tem se desenvolvido como resultado de uma crescente consciência de que a medicina moderna —caracterizada pelo progresso tecnológico, pela diversidade cultural e pelos problemas sociais— está propondo uma série de novos “dilemas éticos” que a ciência médica por si só não pode resolver. Por essa razão, a ética clínica costuma estar relacionada com a “consulta ética”, que consiste nos serviços prestados por um especialista em ética, por uma equipe ética ou por um comitê de ética para abordar as questões éticas implicadas num caso clínico específico. Embora a ética clínica tenha se desenvolvido a princípio essencialmente como uma análise metodológica para chegar a uma justificativa das decisões éticas clínicas, rapidamente se tornou evidente que a dificuldade na tomada de decisões clínicas é só um aspecto dos problemas éticos mais amplos relacionados com a relação médico-paciente em sua totalidade e, bem provável, com o valor fundamental da profissão médica. O método de princípios geralmente se apresenta como o enfoque metodológico mais difundido para a análise de casos clínicos. Contudo, uma forte crítica desse modelo vem se manifestando e fazendo referência a outros enfoques alternativos, como o modelo da casuística. Recentemente, têm sido produzidas relevantes contribuições da medicina narrativa e da ética da virtude. De acordo com essas metodologias, uma antropologia saudável e uma boa relação com o paciente são elementos-chave exigidos de qualquer pessoa que trabalhe na prática médica que pretenda agir de forma apropriada segundo uma perspectiva ética.

PALAVRAS-CHAVE: ética clínica; ética; clínica; bioética; relação médico-paciente (Fonte: DeCS, Bireme).

Nowadays, the term clinical bioethics (or clinical ethics), as it is commonly accepted, refers to an emerging field in clinical medicine that focuses, in particular, on the process of ethical decision-making in a clinical setting. Not only do clinical ethics represent an area of interest for daily clinical practice, it also has evolved into a true scientific discipline, with its own specialist knowledge and academic statute.

The “novelty” of clinical ethics – namely, the special focus on the ethical decision process in a clinical setting – stems from the particular way medical practice is performed today. In fact, the profound changes that have been made in clinical medicine in the last few decades – scientific-technological changes as well as social-economic and cultural ones – have introduced new ethical dilemmas, mainly involving the moment of clinical decision-making.

Therefore, it generally can be claimed the need for clinical ethics in health care professions arises from the particular, even ethical, complexity that occurs when making ethical decisions in a clinical setting. Clinical ethics came to be as the result of a growing awareness that modern medicine – characterized by technological progress, cultural diversity, and social challenges – is posing a range of new “ethical dilemmas” that medical science alone cannot solve.

DEFINITIONS AND REFERENCE DOCUMENTS

According to *The New Dictionary of Medical Ethics*, “clinical ethics” is “a form of applied ethics practiced in the hospital or health care setting and concerned with actual clinical choices. It may involve a clinical (or hospital) ethics committee whose functions include

AS CLINICAL PRACTICE RAISES A WIDE VARIETY OF ETHICAL ISSUES THAT CAN BE DIFFICULT FOR INDIVIDUAL DOCTORS TO RESOLVE, THE PROVISION OF SUPPORT AND ADVICE TO HEALTH PROFESSIONALS AND PATIENTS ON ETHICAL ISSUES ARISING FROM CLINICAL PRACTICE OR PATIENT CARE COULD BE REQUIRED.

ethics policy making, education and case consultation, and/or a clinical ethicist who works alongside staff” (1). In *The Encyclopedia of Bioethics*, “clinical ethics” is subdivided into three entries (2-4). The examples given in the entries cover many issues: organ transplant, human experimentation, abortion, euthanasia, and others. Therefore, the *Encyclopedia of Bioethics* takes a broad view that appears to include every issue of biomedical ethics under the heading of “clinical ethics”. Likewise, in manuals dealing specifically with clinical ethics, a wide range of disparate issues is addressed. For example, issues often considered by clinical ethicists are: withholding or withdrawing treatment, “do not resuscitate” orders, advance directives, consent, capacity, refusal of treatment, genetic testing, confidentiality, emergency medicine, intensive care, and many others (5).

As clinical practice raises a wide variety of ethical issues that can be difficult for individual doctors to resolve, the provision of support and advice to health professionals and patients on ethical issues arising from clinical practice or patient care could be required. Therefore, “clinical ethics” is often linked to “ethics consultation,” which consists of “services provided by an individual ethicist

MANY INSTITUTIONS IN VARIOUS COUNTRIES HAVE ESTABLISHED CLINICAL ETHICS SERVICES OR COMMITTEES TO PROVIDE ETHICAL SUPPORT.

or an ethics team or committee to address the ethical issues involved in a specific clinical case. The central purpose is to improve the process and outcomes of patient's care by helping to identify, analyze, and resolve ethical problems" (6).

Specifically, the origins of clinical ethics committees are rooted predominantly in the United States. In 1978, the US Congress established the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission). The three key tasks of the Commission were: 1) an ethical analysis of particularly problematic clinical cases; 2) drawing up recommendations and guidelines to address recurrent ethical problems; and 3) promotion or direct management of training programs to increase ethical awareness among healthcare workers. The final report of the President's Commission was published in 1983 (7).⁴

Even if the President's Commission did not recommend the immediate establishment of an ethics committee at every hospital, it backed the formation of interdisciplinary committees to support health professionals in controversial decisions, to promote ethical education,

and to contribute to drafting and adopting guidelines and institutional policies.

CLINICAL ETHICS SERVICES AND COMMITTEES

"Ethics consultation" (considered equivalent to "health care ethics consultation" - HCEC) covers a multitude of ethically relevant issues and is oriented specifically towards the clinical setting. The American Society for Bioethics and Humanities (ASBH) defines HCEC as "a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care providers, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care" (9).

The requisites for proper clinical ethics consultations have been affirmed in studies, proposals and guidelines. Particularly relevant is "Core Competencies for Healthcare Ethics Consultation," a report published by the Society for Health and Human Values and the Society for the Bioethics Consultation Task Force on Standards for Bioethics Consultation in 1998 (10) and updated by the ASBH in 2011 (7). Meanwhile, Aulisio et al. published a position paper on the topic (11). An extensive introduction to the second edition of the report by ASBH was published in 2013 (12).

According to ASBH, there are several models for clinical consultation. Some of them involve individual experts. Others are based on a group process. There are also

4 Although the President's Commission and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (established in 1974 in response to the disclosure of unethical experiments conducted for decades) addressed different areas and had different tasks, there are similarities in their results (8).

hybrid approaches that combine elements of individual and group consultation. In this model, an expert is responsible for an initial response, and a subsequent opinion by a committee is obtained, if necessary.

Many institutions in various countries have established clinical ethics services or committees to provide ethical support. Their work falls into three main areas: providing ethics input for trust policy and guidelines on patient care, facilitating ethics education for health professionals, and giving advice to clinicians on individual cases. Several other institutions (e.g., the American Hospital Association [13] and the American Medical Association [14]) have recommended the establishment of clinical ethics committees. In some countries, ethical committees arose because clinicians were identifying difficult issues on which they felt that they needed ethics support and advice. In other countries, these committees have taken a more top down approach, with some forming in response to recommendations or requirements of regulatory authorities.

TWO "CLASSICAL" PROPOSALS FOR RESOLVING ETHICAL CONFLICTS IN CLINICAL CASES

We now turn to the methodological issue of ethics consultation. In the aforementioned entry for "clinical ethics" in the *Encyclopedia of Bioethics*, the principlism method is presented as the most popular methodological approach to the analysis of clinical cases (2). All the same, the strongest criticism of this model is mentioned as well, and other alternative approaches are referred to, such as the casuistry model, which stands out among the others.

The framework of principlism constitutes a mixed ethical theory (both deontological and utilitarian), as outlined

WHETHER IN DAILY CLINICAL PRACTICE OR IN ETHICS COMMITTEES, AN ETHICAL CONFLICT IS VERY OFTEN RESOLVED BY REFERRING TO THE PRINCIPLE OF AUTONOMY, SO AS TO UNDERSCORE THE IMPORTANCE OF THE PATIENT'S OPINION ON THE GIVEN TREATMENT, AND TO THE PRINCIPLE OF NON-MALEFICENCE, IF THE RISKS OF A SPECIFIC MEDICAL PROCEDURE OUTWEIGH THE BENEFITS A PATIENT CAN OBTAIN.

by T. L. Beauchamp and J. F. Childress at the end of the seventies and published in *Principles of Biomedical Ethics* (15). Principlism is based on four principles: autonomy, non-maleficence, beneficence and justice. The main characteristic of this model is the *prima facie* value of each principle: they are always valid and binding unless they are in conflict; it is not established which one takes priority over the others; and excluding every strict hierarchy of values, such a priority will depend on the particular situation that will change the balancing of the principles, according to those consequences connected to the decisions inspired by one principle or another. This reference relies heavily on the individual's intuition of the occurring situation.

Not only has principlism been able to dominate the debate on the ethical issues concerning single clinical cases for over twenty years, but nowadays it also has become a widely used model for clinical decisions. Whether in daily clinical practice or in ethics committees, an ethical

conflict is very often resolved by referring to the principle of autonomy, so as to underscore the importance of the patient's opinion on the given treatment, and to the principle of non-maleficence, if the risks of a specific medical procedure outweigh the benefits a patient can obtain. It is not hard to fathom the reason why those principles have spread so rapidly, becoming a touchstone for clinical bioethical discussions. Synthetically, we can point out two reasons that are important to us: the first one is philosophical and theoretical, the other is practical. The four-principles approach refers to the key elements of morality common to any ethical system (the principle of autonomy is basically a starting point for any ethical discussion, while justice is considered to be the main principle for analyzing ethical issues in interpersonal relationships), and some of them are particularly relevant in the medical field (such as *primum non nocere*, the classical principle of medical ethics). On the other hand, there is a practical reason linked to the composition of ethics committees that have to make decisions on clinical cases. In those committees, not all members have academic qualifications in ethics; therefore, to deal with clinical cases, they need clear and easily employable instruments. This is, indeed, what the "principles of bioethics" offer. On a theoretical level, the content of each principle is not hard to grasp. It does not take much to identify the relevant principle that should receive priority over the competing ones to resolve a conflict between the patient and the physician over the choice of a specific treatment. Besides, it is interesting to remember that, in the first stage of diffusion of the four principles, an important role was played by short summer courses at the Kennedy Institute of Ethics (at Georgetown University in Washington D.C.) where medical physicians from all parts of the United States were trained in the application of these principles (16).

Then, the principles spread from the USA to around the world, as proven by the bulky textbook *Principles of Health Care Ethics* by R. Gillon (17).

Nevertheless, even though the methodology has developed worldwide and now is certainly the one followed the most, mention should be made of the critical voices raised about its applicability.⁵ One of the most severe criticisms of principlism is methodological. The approach cannot resolve conflicts arising from the principles, unless they can be arranged hierarchically. Each principle, being *prima facie* (18), is not considered superior to any of the others. Thus, only the concrete circumstances of the clinical case under consideration can shed light on which principle will take priority over the others. Unfortunately, it is not always easy to come to a conclusion. An objection to the conflict between principles in a concrete situation has been put forth already by Beauchamp and Childress; they offered two instruments for coping with the problem: specification and balancing. The first tool tries to connect the fairly general principle to the situation to be judged, somehow overcoming its indeterminateness: it identifies its specific field of action, which is described by the authors with the terms "range" and "scope". It is particularly relevant to the evaluation of public health policies.⁶ Balancing is particularly effective in evaluating a single case and, therefore, in the analysis of a clinical case. It is used to determine which principle appears to be more adequate, so as to consider it as an action guide. Balancing consists of comparing the relevance of two or

5 We suggest consulting Requena's monograph (19) for an overall view of the model and the main criticism it has received. .

6 The fourth edition of *Principles of Biomedical Ethics* upholds Richardson's concept of specification (20). A "classical" criticism of specification and the Richardson model is raised by Gert, Culver and Clouser (21).

more principles in a specific case. One criticism against the balancing method is raised by Holm (22). To find a solution to many moral conflicts, we apply the balancing and specification method in one way or the other to determine the norm that must guide a specific case. Nevertheless, these tools cannot be offered by claiming they can be used without making reference to either a general moral system or to some specific anthropology. Beauchamp and Childress aim to provide a model that can be shared by different kinds of moral theories and divergent views on man, but they eventually end up needing to fill the repository of principles with the way of perceiving the specific moral agent *per*(thus, with a theory on morality). In view of this consideration, as it has often been pointed out, the solution to the conflict between two principles can come from one way rather than another, according to the standard-morality (used in its basic sense) and the concept of man.⁷

The casuistry method, particularly as put forth by Albert Jonsen along with other authors, has been offered as an alternative to the principlism model, claiming to overcome the methodological shortcomings mentioned above (23). This model is rooted in the classical casuistry that was of considerable importance in the Catholic moral tradition during the period between the XVI and XVII centuries (24). It concerns the analysis of moral cases in medicine, starting from clear-cut cases and progressing to more complex ones. The model, as explained by Jonsen, is based on an analysis of the morphology of the case, the taxonomy and prudence. In casuistical case analysis, the first step is to give a detailed presentation

on all the characteristics of the situation at hand and its circumstances. The next step is to try to compare the new case to others evaluated previously, such as the so-called “paradigm cases” with their definitive judgments. Finally, the third step is what Jonsen calls “kinetics,” where the key element is prudence; its role is to find out how and to what extent the new case is different from the paradigm case. Consequently, prudence recognizes if the same solution can be applied to the case or if a divergence from it is required.

Even though the casuistry approach has managed to overcome some of the methodological difficulties found in the principlism model, it also has received some criticism. Perhaps, as regards its use in clinical ethics, a highly controversial feature is the lack of a common moral context that was firmly upheld by the classical moral tradition, whereas it is quite absent from the context of current bioethics. Even here, the last stage of the moral analysis requires going beyond the formal level to draw on those elements that shape prudential judgment. However, they only can come from a certain view of human beings and their good. For this reason, it is possible to claim that the casuistical methodology, as well as the principlism model, can be valid, provided they have an adequate moral foundation where the virtue of prudence, together with other moral virtues, plays a key role. This issue will be the topic of the last part of this review.

PERSPECTIVES ON CLINICAL ETHICS: THE CONTRIBUTION FROM VIRTUE ETHICS AND NARRATIVE MEDICINE

Here, it is important to point out that although clinical ethics provide a solution to ethical dilemmas that arise at the moment of a clinical decision and, therefore, it deve-

⁷ The authors of the work appear to hold two different moral positions (utilitarianism and deontology), but a utilitarian drift in the study of certain concrete cases can be noted.

loped in the beginning largely as a form of methodological analysis to be able to justify a clinical ethical decision, it soon became clear the difficulty in a clinical decision is only one aspect of wider ethical problems pertaining to the doctor-patient relationship as a whole and, most likely, to the core value of the medical profession.

Nowadays, it is widely accepted that if clinical ethics restricted itself to only offering a solution in terms of decision procedures, it would not be able to come up with an adequate answer to the ethical issues in modern clinical medicine (25-26). Significant contributions in this direction have been made by narrative medicine and virtue ethics, perspectives open mainly to the ethics of relationship (27). In fact, the distinctive feature of healthcare professions is a profound, personal encounter with a sick person. Therefore, a useful tool in clinical ethics is primarily sound anthropology (28); however, considering each patient embodies and lives human values in a unique and distinct way (the same is true of each and every healthcare professional), the relationship with the sick person will become another key element of any medical practice that also aims to be genuinely appropriate from an ethical perspective (29).

Virtue Ethics

The physician's development of ethical virtues has been the main ethical approach for many centuries, focused

on dealing with the concept of a "good person" as well as "good action". The emphasis on action rather than on the person is a result of the primacy of doing (making) over being (doing as acting), a change that occurred in the context of modernity (30). The long philosophical tradition of virtues has been enhanced recently and proposed again by several contemporary philosophers, particularly Alasdair MacIntyre (31). Their work, in turn, has been taken into account by many bioethicists, following the methodological weakness that lies with the North American principlism model (32).

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Principles, norms and procedures are seen as fruitful, at times essential, and yet insufficient to fully describe the moral life that always encompasses the character of an agent. For that reason, the virtue-based ethical approach assumes that a merely deductive-formalistic approach, one limited to applying general moral principles to a specific situation without considering the specificity of a single case and

merely acting procedurally, can run the risk of reaching a harsh judgment that does not reveal the moral reality of a man. In contrast, the judgment of prudence; namely, the virtue of practical reason, which implies being able to grasp the real situation as a whole, is suitable for indicating the norms directly affecting specific moral action (33). Making the character of the agent an essential prerequisite, through the reference to prudence and to other medical moral virtues – elements entirely overlooked by the procedural approaches to clinical ethics – means

acknowledging that it is not a realistic hypothesis to deprive the decision-making process of preferences and emotions, so as to emphasize only reason (considered here, in a rationalistic sense, as a purely logical decision). So, moral decisions must be made in light of objective moral criteria and well-grounded moral reasoning. The nature of human beings has an emotional-affective dimension that tempers rational ability, thus forming an intrinsic part of how we perceive reality and how we make our judgments and our choices about single, concrete situations. Virtue-based clinical ethics, founded on the physician's virtues, has the advantage of recognizing this crucial component of any moral experience and enhancing the physician's inclination toward good, thus developing those qualities in a person who, in the long run, finds it easier and easier to carry out morally fair actions in a single concrete situation. In other words, this is a virtuous physician is who acts guided by ethically oriented reason and delves deeply into the clinical reality of a patient. Therefore, to emphasize virtue ethics as an approach to the development of clinical ethics is to speak of being a doctor who is seen as a source of his own action. More specifically, what is at the heart of virtue ethics is not so much the act that is performed, as the person who performs it. Considering this perspective, it is possible to claim that the major task of clinical ethics is to educate on prudence and, consequently, to teach not only how to assess a concrete clinical situation objectively, but also how to transform this understanding of reality into a practical course of action. In summary, the ethical virtues of a doctor come to be the final guarantee that the good of the patient will be respected.

Narrative Medicine

As part of this process to humanize clinical practice, there is a recent approach that goes by the name of

“narrative medicine” (34). The specific contribution of narrative competence within the therapeutic relationship is to offer a privileged way to recover the individuality and uniqueness of a person's life by seeking empathetic relationships with the patient. The following merits are recognized in the narrative approach: 1. implementation of diagnostic skills (the narrative approach provides relevant information, more than just an evaluation of signs and symptoms); 2. individualization of a care plan that fits the patient's personal situation (the narrative approach allows for being aware of the patient's individuality and uniqueness); 3. development of a truly collaborative relationship (fostering an affinity between doctor and patient); and 4. psychological and existential comfort for patients who, often thanks to the narrative approach, manage to make sense of their illness experience.

Therefore, with the contribution from the narrative approach, contemporary medicine again recognizes, primarily from its epistemological perspective, that medical science alone is not a sufficient basis for appropriate clinical action (35). The narration of facts is always connected to a reflection of the conscience; for this reason, the “personal” meaning of each action ideally can be found in the narrative (36). When analyzing ethical-clinical situations, it is crucial to take into account the patient's judgment of conscience; this is more than a criterion of either the patient's preferences or respect for autonomy, as suggested by the most qualified methodologies for an analysis of ethical-clinical dilemmas, at least if those criteria are perceived in a pure formal procedural sense, as most often happens (37).

It is possible to claim that narrative competence is an effective tool in contemporary clinical medicine, it also

a requisite for a moral understanding of human actions. In fact, the narrative approach to a moral experience tries to explain a moral action beginning with the agent's self-knowledge; that is, starting with an interpretation of his own life history. This is the reason why the narration has an inherently moral structure.

CONCLUSIONS

The bioethical thinking developed as of the final decades of the last century also has fostered in-depth ethical-anthropological thinking in medicine, leading to the definition of methodologies for a moral analysis of clinical cases. Nonetheless, there is still widespread practical disorientation regarding the physician's moral action and growing distrust in the ability of medicine to truly meet the patient's need. Indeed, there is no lack of scientific knowledge, nor technological instruments or ethical rules. What it seems to be lacking is "humanity" in medicine. In contrast to the procedural ethical models (principlism and casuistry), which are interested mostly in "correct" actions, virtue ethics is concerned with making the person an agent of "good," while narrative ethics strives to build a truly "personal" therapeutic relationship between physician and patient. Therefore, in addition to having knowledge of or updating theoretical notions and technological skills, medical students and trained medical professionals also must devote time and attention to the development of their character and inclinations. What we need, in order to become physicians, is to acquire not only knowledge and practical skills, but also to progressively focus our attitudes and inner resources on the good of the patient.

REFERENCES

1. Boyd KM. Clinical ethics. In: Boyd KM, Higgs R, Pinching AJ, editors. *The New Dictionary of Medical Ethics*. London: BMJ Publishing Group, London; 1997, p. 40.
2. Fletcher JC, Brody H. Clinical ethics – I. Development, role, and methodologies. In: Post EG, editor. *Encyclopedia of Bioethics*. 3rd ed. New York: Macmillan Reference – Thomson Gale; 2003, vol. 1, p. 433-9.
3. Kanoti GA, Youngner S. Clinical ethics – II. Clinical ethics consultation. In: Post EG, editor. *Encyclopedia of Bioethics*. 3rd ed. New York: Macmillan Reference – Thomson Gale; 2003, vol. 1, p. 439-44.
4. Dougherty CJ. Clinical ethics – III. Institutional ethics committees. In: Post EG, editor. *Encyclopedia of Bioethics*. 3rd ed. New York: Macmillan Reference – Thomson Gale; 2003, vol. 1, p. 444-7.
5. Ashcroft RE, Lucassen AM, Parker M, Verkert M, editors. *Case Analysis in Clinical Ethics*. Cambridge: Cambridge University Press; 2005.
6. Hurst S. Clinical ethics. In: Chadwick R, editor. *Encyclopedia of Applied Ethics*. 2nd ed. San Diego (CA): Academic Press; 2012, vol. 1, p. 476-87.
7. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Summing up. Final Report on studies on the ethical and legal problems in medicine and biomedical and behavioral research*. Washington DC, 31 March 1983.
8. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Publication OS 78-0012. Washington DC, 18 April 1979.
9. American Society for Bioethics and Humanities' Core Competencies Update Task Force. *Core Competencies for Health Care Ethics Consultation: The Report of the American Socie-*

- ty for Bioethics and Humanities 2nd ed. Glenview (IL): American Society for Bioethics and Humanities; 2011.
10. Society for Health and Human Values, Society for Bioethics Consultation. Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities. Glenview (IL): American Society for Bioethics Consultation; 1998.
 11. Aulisio MP, Arnold RM, Youngner SJ. Health Care Ethics Consultation: Nature, Goals, and Competencies: A Position Paper from the Society for Health and Human Values - Society for the Bioethics Consultation Task Force on Standards for Bioethics Consultation. *Ann Intern Med* 2000;33(1):59-69.
 12. Tarzian A. The ASBH Core Competencies Update Task Force. Health Care Ethics Consultation: An update on core competencies and emerging standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force. *Am J Bioethics* 2013;13(2):3-13.
 13. American Hospital Association. Guidelines: Hospital committees on biomedical ethics. In: Ross JW, editor. *Handbook for Hospital Ethics Committees*. Chicago, IL: American Hospital Publishing; 1986.
 14. Ethical and Judicial Council (American Medical Association). *Guidelines for Ethics Committees in Health Care Institutions*. JAMA 1985;253(18):2698-9.
 15. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press; 2013.
 16. Pellegrino ED. The Metamorphosis of Medical Ethics. JAMA 1993;269:1158-62.
 17. Gillon R. *Principles of Health Care Ethics*. Chichester: John Wiley & Sons; 1994.
 18. Ross WD. *The Right and the Good*. Oxford: Clarendon Press; 1930.
 19. Requena P. Modelos de bioética clínica: presentación crítica del principialismo y la casuística. Roma: EDUSC; 2005.
 20. Richardson H. Specifying Norms as a Way to Resolve Concrete Ethical Problems. *Philos Public Aff* 1990;19:279-310.
 21. Gert B, Culver CM, Clouser KD. Common Morality Versus Specified Principlism: Reply to Richardson. *J Med Philos* 2000;25:308-22.
 22. Holm S. Not just autonomy-the Principles of American Biomedical Ethics. *J Med Ethics* 1995; 21:332-8.
 23. Jonsen A, Siegler M, Winslade W. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 7th ed. New York: McGraw-Hill Medical; 2010.
 24. Jonsen AR, Toulmin S. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley-Los Angeles-London: University of California Press; 1988.
 25. Jonsen A. Casuistry as methodology in clinical ethics. *Theor Med* 1991;12(4):295-307.
 26. Comoretto N. Dalla natura "etica" della medicina alla natura "clinica" dell'etica medica: per uno statuto della (bio)etica clinica. In: Larghero E., Lombardi Ricci M. (eds.). *Bioetica e medicina narrativa. Nuove prospettive di cura*. Turin: Ed. Camilliane; 2012, pp. 43-57.
 27. Carrasco De Paula I, Comoretto N. Per una medicina centrata sul paziente. *Medicina e Morale* 2005;55(3):557-66.
 28. Comoretto N. Moving toward Clinical Ethics Consultation in Italy: Practical Experience and Foundational and Methodological Considerations. In: Schildmann J, Gordon JS, Vollmann J. (eds.). *Clinical Ethics Consultation. Theories and Methods, Implementation, Evaluation*. Farnham (UK): Ashgate; 2010.
 29. Comoretto N. La centralidad de la persona en la praxis médica., In Bochayey AG (ed.). *Bioética y Persona*. Escuela de Elio Sgreccia. Buenos Aires: Educa; 2008, pp. 75-92.
 30. Malo A. *Il senso antropologico dell'azione*. Rome: Armando; 2004.
 31. MacIntyre A. *Dopo la Virtù*. Rome: Armando Editore; 2007.

32. Pellegrino ED. *The Virtues in Medical Practice*. New York: Oxford University Press; 1993.
33. Comoretto N. Un'introduzione all'esercizio delle virtù etiche nella professione medica. *Medicina e Morale* 2014;3:405-447.
34. Charon R. Narrative medicine. A model for empathy, reflection, profession, and trust. *JAMA* 2001;286(15):1897-1902.
35. Solomon M. Epistemological reflections on the art of medicine and narrative medicine. *Perspect Biol Med* 2008;51(3):406-17.
36. Gahl RA. Human nature, poetic narrative, and moral agency. In <http://maritain.nd.edu/jmc/ti01/gahl.htm> (last accessed 30/04/2015).
37. Comoretto N. Le implicanze etiche della medicina narrativa. *L'arco di Giano* 2012;72:93-102.