

## Back to Basics: Re-embracing the Foundations of Clinical Ethics in Healthcare

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### Article abstract

PhD students, post-docs, and bioethics researchers are conducting nuanced research to develop advancements in the field, and this research offers valuable insights that can support the practice of bioethics. However, this research often does not address how much work is still needed to incorporate basic ethical principles into practice, from research oversight to applications within a clinic. Applying an ethical lens is often viewed as “time consuming” or “nice-to-have” in the professional field, rather than something that must be intrinsically built into every patient encounter. Much of the existing healthcare system fails to incorporate basic ethical deliberation into practice, causing avoidable conflict, tension, and mistrust. This paper cautions that there is a plethora of groundwork still needed before paving the way forward to advance the field of bioethics. The ground needs to be flat and the asphalt warm, otherwise the road we build will be cracked and unstable. To do this, new ethicists must passionately foster and promote elementary ethical deliberations across all domains of healthcare. We must strive to create spaces where all persons are comfortable sharing their concerns, values, and unique perspectives to best inform decision making. This paper synthesizes practical wisdom, emotional intelligence, and integrates surprising pragmatic lessons from the lived experience of an early career clinical ethicist.

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TÉMOIGNAGE / PERSPECTIVE

## Back to Basics: Re-embracing the Foundations of Clinical Ethics in Healthcare

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### Résumé

Les doctorants, les postdoctorants et les chercheurs en bioéthique mènent des recherches nuancées pour faire avancer le domaine, et ces recherches offrent des perspectives précieuses qui peuvent soutenir la pratique de la bioéthique. Cependant, ces recherches ne tiennent souvent pas compte du travail qu'il reste à faire pour intégrer les principes éthiques fondamentaux dans la pratique, depuis la supervision de la recherche jusqu'aux applications dans une clinique. L'application d'un point de vue éthique est souvent considérée comme « chronophage » ou « agréable à avoir » dans le domaine professionnel, plutôt que comme quelque chose qui doit être intrinsèquement intégré dans chaque rencontre avec le patient. Une grande partie du système de santé actuel ne parvient pas à intégrer la délibération éthique de base dans la pratique, ce qui provoque des conflits, des tensions et de la méfiance qui pourraient être évités. Le présent document met en garde contre la pléthore de travaux préparatoires encore nécessaires avant d'ouvrir la voie à l'avancement du domaine de la bioéthique. Le sol doit être plat et l'asphalte chaud, sinon la route que nous construisons sera fissurée et instable. Pour ce faire, les nouveaux éthiciens doivent encourager et promouvoir avec passion les délibérations éthiques élémentaires dans tous les domaines des soins de santé. Nous devons nous efforcer de créer des espaces où toutes les personnes se sentent à l'aise pour partager leurs préoccupations, leurs valeurs et leurs points de vue uniques afin d'éclairer au mieux la prise de décision. Cet article synthétise la sagesse pratique, l'intelligence émotionnelle et intègre des leçons pragmatiques surprenantes tirées de l'expérience vécue d'un éthicien clinique en début de carrière.

### Mots-clés

bioéthique, confiance, pratique fondée sur des données probantes, principisme, éthique clinique

### Abstract

PhD students, post-docs, and bioethics researchers are conducting nuanced research to develop advancements in the field, and this research offers valuable insights that can support the practice of bioethics. However, this research often does not address how much work is still needed to incorporate basic ethical principles into practice, from research oversight to applications within a clinic. Applying an ethical lens is often viewed as “time consuming” or “nice-to-have” in the professional field, rather than something that must be intrinsically built into every patient encounter. Much of the existing healthcare system fails to incorporate basic ethical deliberation into practice, causing avoidable conflict, tension, and mistrust. This paper cautions that there is a plethora of groundwork still needed before paving the way forward to advance the field of bioethics. The ground needs to be flat and the asphalt warm, otherwise the road we build will be cracked and unstable. To do this, new ethicists must passionately foster and promote elementary ethical deliberations across all domains of healthcare. We must strive to create spaces where all persons are comfortable sharing their concerns, values, and unique perspectives to best inform decision making. This paper synthesizes practical wisdom, emotional intelligence, and integrates surprising pragmatic lessons from the lived experience of an early career clinical ethicist.

### Keywords

bioethics, trust, evidence-based practice, principlism, clinical ethics

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With a desire to promote human flourishing, medical innovations are continuously under development. The boundaries of the beginning and end of life have been pushed further in recent years than ever before in human history. Through developments achieved via research and innovation, new treatment options are available to mitigate suffering, improve quality of life, and improve healing. As the field of healthcare advances, our technologies and strategies for the provision of care will continue to evolve, shifting necessarily in tandem with our system of healthcare delivery. Artificial intelligence, medical assistance in dying, equity, diversity, and inclusion, and other technological advancements demonstrate the intersection of values in healthcare, highlighting the necessity of ethics support in decision-making and impetus for new bioethics research initiatives. However, advocating for more change in healthcare comes at a difficult time; with an increasingly polarized political landscape and a system where demand is already exceeding the available resources, developing new expectations for our system to uphold would undoubtedly be taxing, yet is necessary for growth.

The expectations of working in healthcare are high, as real human lives are at stake and patients require continuous support across domains of healthcare. To provide the highest quality evidence-informed care, providers are expected to keep up to date with new research, maintain their administrative duties, participate in knowledge generation projects, and commit to continuously improving care. Healthcare providers are also expected to do this while tending to the suffering of numerous individuals with contrasting needs, core life values, and sociocultural backgrounds. Balancing these priorities between persons can be exceptionally challenging, time consuming, and rife with ethical tension. This is, of course, also occurring during a global pandemic, planetary ecological crisis, international wars, and within increasingly polarized societies. Unsurprisingly,

burnout, emotional exhaustion, compassion fatigue, and moral distress are also occurring more frequently for healthcare providers as captured by the research literature (1).

Scientific developments are also being published at such a high rate that it is often inconceivable for a healthcare provider to maintain practical awareness of the emerging evidence available while providing the best care possible for suffering persons. While new evidence is uncovered regularly, implementation of research into clinical practice is also highly variable (2). Morris, Wooding, and Grant (3) suggest there may be a seventeen-year gap for research evidence to be implemented into clinical healthcare practices. Furthermore, new research seldom speaks to how findings could or should be implemented into practice. Clinicians are often left wondering how to balance the potential benefits of leveraging new knowledge with the risks of the proposed interventions. When evidence becomes available that offers a new way to improve patient outcomes, providers are expected to radically shift their practice to offer interventions in the best interests of their patients. Yet, novel research does not provide a road map on how to ethically integrate these new findings into everyday practice. Limitations may also exist around funding or available health human resources which inhibits the implementation of positive changes to clinical practice. Unfortunately, ethics is also often perceived as yet another task to be completed, with consultations viewed as speed-bumps that slow down process.

Ethics is integral to the act of providing any form of healthcare, and serves to guide all clinical encounters (4). While new research initiatives are necessary to keep our field up to date with scientific advancements, we must also continuously focus on the basic application of ethics across all domains of healthcare. The practical application of ethics needs to remain at the forefront of healthcare delivery as we live in a time where members of the public may feel a sense of conflict, tension, and mistrust when entering healthcare settings. Promoting an environment where individuals feel comfortable accessing healthcare, and who feel they can trust their providers, will afford greater opportunities for flourishing.

The relationship between suffering persons and medical providers is the foundation for healthcare. Without trust there is no healthcare, and thus suffering persons do not always choose to become patients. Individuals who do not have trust in medicine will be less likely to seek out therapeutic relationships with those who can offer medical support. A challenge that we will and are already encountering related to trust is maintaining our humanity within healthcare. Systemic stressors and patient/provider ratios inhibit a healthcare workers' ability to sit down and learn about a person's unique values. Loss of trust can occur when patients feel like they are solely viewed as Personal Identification Numbers or are participating in a "conveyor belt" industrial healthcare complex. However, one element of care that will remain consistent through all future healthcare advancements is the human connection that exists between providers and suffering persons. The embodiment and application of bioethics is integral to facilitating trust within the social practice of medicine. By leveraging ethical principles into everyday care, ethicists can support care teams in navigating values tensions and conflicting perspectives that exist across medical settings, thus creating opportunities to restore patient trust in the healthcare system.

Ethicists have a responsibility to support front line providers, advocate for transparency, and help navigate conflict that arises across healthcare practices. Conflict frequently arises when discussing treatment plans, discharge pathways, complicated family dynamics, policy interpretations, and/or consent. Supporting the resolution of such conflicts requires the leveraging of ethical theories to facilitate values-based decision making. In falling back to the basic principles of respect for persons, beneficence, non-maleficence, and justice, we can better establish a functional foundation for the provision of care in conflictual situations. This is particularly important as such principles should be seen as the minimum standard for values-based decision making which, given pressures being experienced across the Canadian healthcare system, may not always be easy to uphold. The future of bioethics calls for an investment to promote trust in support of public health. More groundwork that focuses on facilitating transparency, confidence, and trust within everyday clinical practice is needed to ensure that the foundations on which we build upon are stable. To highlight where this work still needs to be done to promote basic ethical deliberation and practice in healthcare, I share the story of Leo.

## CASE STUDY: LEO

This story amalgamates some of the issues that I have witnessed or been consulted on while providing ethics consultations over the past two years. All names are fictitious. Additionally, the story does not depict a unique patient's experience.

Leo is a 75-year-old cis-gendered male (pronouns he/him) who has recently been admitted to hospital after experiencing a stroke. The severity of Leo's stroke was mild, and he has capacity to make decisions. Leo is able to communicate, though his speech is much slower than how he communicated prior to his stroke. He is also at an increased risk of having another stroke. Leo is single, but has two adult children, William and Melissa. After a minor health concern a few years ago, Leo updated his will and named William his Power of Attorney (PoA) for personal care, meaning that William would be able to make treatment and personal care decisions on Leo's behalf when he is no longer capable of such decisions. Both William and Melissa have been actively involved in supporting Leo during his hospital admission, however, they were often treated differently.

Melissa described finding it difficult to obtain information about her father's condition, whereas William was always provided information once he informed staff that he was the PoA. William often led the discussions pertaining to Leo's treatment plans in front of Leo, and Leo never objected to any decisions that were made. William was also invited to be a part of the discharge planning meetings by staff, whereas Melissa was told about the meeting by William. In this meeting, it was discussed that Leo had lost some of his ability to manage day to day tasks. However, it was made clear that Leo could be supported in his home,

which is also what Leo adamantly wished for. Halfway through this meeting, Leo became frustrated as he wasn't invited to participate; his family tried to calm him down and told him that they were taking care of everything for him. William and Melissa informed Leo they were looking out for his best interests, but he remained agitated and was able to indicate he wanted everyone to leave. The medical team and family left Leo's room and finished the meeting in a conference room without Leo. While he ultimately agreed to proceed with the steps that were pre-determined, he was not offered the same opportunity to participate in these discussions.

With a retrospective review of such a case, it is evident that Leo's autonomy was minimized and limited at several stages. His current wishes and self-agency became overwhelmed by the 'power' of legal documents. Leo's voice was less heard than the voice of family members, and family members were also treated unequally by healthcare providers. This reflects how the power that a PoA holds is often misunderstood, and such misuse can cause confusion and further conflict between family members and healthcare providers. In this scenario, healthcare providers allowed access to personal health information and decision-making privileges to the individual named on the PoA, while a person with capacity to make his own healthcare decisions sat in another room. This case study also reflects how ageism and biases contribute daily to the disempowerment of suffering persons within healthcare. Healthcare providers sometimes turn to a family member with whom it is easier to communicate, rather than the patient, which results in a failure to respect that person's autonomy (similar issues can arise when a patient does not speak the dominant language of healthcare providers). Leo's wishes in this scenario cannot even be entirely known, as the staff and family failed to ask Leo the questions that would help respect his values.

Ethicists continue to see straightforward ethical concerns arise and go awry in clinical care, highlighting the lack of ethical foundations in practice. To continue developing evidence-based care, the road forward must be built upon integrity, trust, and open communication. Further emphasis is required within our field for pragmatically implementing ethical values, facilitating transparency within every clinical interaction, and encouraging better interpersonal communication with suffering persons. My hope in sharing this case study is that it demonstrates the importance for ethicists to be passionately dedicated to fostering space for elementary ethical deliberation and reflections. What may seem like 'basic' practices that feel repetitive to the ethicist are often invaluable for generating institutional ethical capacity and greater ethical literacy across diverse healthcare teams. While advancing research in bioethics has implicit value, it is nevertheless important for ethicists to ensure that basic practices of communication, consent, and patient empowerment are being implemented in everyday health care.

By supporting healthcare providers in upholding and embodying ethical principles, we are more likely to have a tangible and positive impact on healthcare as a collective profession. What we often require is a form of practical wisdom. Practical professional wisdom within healthcare means cultivating deep reflection and intentionality that brings awareness to the core life values and needs of individuals within particular contexts (5). Leveraging such a way of thinking, in combination with ethically literate healthcare providers who fully appreciate the implementation of ethical practices, could allow us to mitigate harms in an unprecedented way. Suffering persons require the development of a system that fundamentally respects all persons from all backgrounds, and which can then attune itself to their unique values and lived experiences. As ethicists, we must be committed to fostering such a system where open conversations, deep listening, critical reflection, and curiosity towards patients is the standard of practice.

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