

Clinical Bioethics and its practice

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Abstract

Clinical bioethics appears with Andre Hellegers related to ethical decisions in medical practice, and since bioethics principlialism concept, it is expanding due to other moral analysis alternatives. Currently there are several methodological proposals related to decision making in clinical ethics. This article aims to present the methods of David C. Thomasma, Diego Gracia, Albert R. Jons and James F. Drane, since they are the most commonly used for analysis of conflicts, problems or moral dilemmas that arise in clinical practice and care. It follows that all methods are intended to assist in the preparation of decision making rationale. Certainly, the biggest challenge is to choose one that enables a rational, systematic, and objective study of problems and that permits exploitation of facts in their particularities, because the clearer they are, the easier will be the analysis of conflicting values.

Key words: Bioethics. Ethics clinical. Decision making.



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Bioethics was, as a branch of moral philosophy, the area of knowledge that developed most, since its origin in the 1970s, from ethical questionings that scientists, humanists, and society raised on the growing scientific and technologic evolution ¹.

The Belmont Report, document prepared by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, in 1978, by determination of the United States government. It set ethical rules targeted to guide researches with human beings, and it marks the beginning of bioethical studies (from the principles: respect for people, beneficence and justice). Consequently, unfolding into the principlialist theory (funded in the principles of beneficence, non-maleficence, autonomy, and justice), proposed by Tom Beauchamp and James Childress, in 1979 ², turned it into the major references in the field of bioethics.

Medical exercise, until then, was based in the teachings of Hippocrates. The most striking character in the history of medical ethics,

based himself in the presupposition that the professional, making good use of his knowledge, acts always in his patient's well being. A huge expectation was created with the principlalist paradigm that it could respond to several ethical dilemmas arisen in the mid-20th century, resulting from the advances of science.

Some of the first public controversies that preceded, during the 50s and 60s, the emergence of bioethics were related to newly born, who are carriers of serious illness, to maintenance of medical ventilator as support to life in people in coma situation, in reanimation of patients with serious diseases or of uncertain diagnosis, in addition to the dramatic polemics emerged with the invention of venous-arterial shunt by Doctor Belding Scribner, and with the appearance of the hemodialysis machine ³⁻⁵.

At the time, it was questioned IF all resources should or should not be invested to save the newly born, if the medical ventilator should be kept in all patients, Who had to decide to reanimate or not these patients in case of heart failure, and which chronic kidney disease that would be benefited or not with the new technology. In 1962, with the establishment of the first hemodialysis program in Seattle, WA, the task of deciding who would be inserted in it generated major controversy in American society. As the number kidney illness was higher than the capacity of care, the first dilemma faced was to set criteria to

select the individuals that would get the savior of life treatment ^{4,5}.

The solution, in view of the deadlock, was to establish a committee to determine the choosing criteria ⁶. Such episode was considered a landmark between the old legacy of Hippocrates inspired ethics and that guided by bioethics, since, in medical practice, the dilemmas traditionally were solved based in the absolute principle that every life should be saved – for sacredness. Since then, physicians saw themselves in the difficult situation of deciding who would benefit from this new technology or who would get the death sentence ⁶.

Currently, there are other issues that also generate much discussion, such as, for instance, pregnancy interruption in case of anencephaly, brain death (mostly in view of transplantation of unique organs), possibility that the mother generates an immune-compatible child with *in vitro* fertilization process to become donor for brother with leukemia, possibility for parents to undertake genetic diagnosis seeking for healthy children, gender choice, use of excess embryos in stem-cells research, enabling a widow to use her deceased husband's semen to get pregnant, in addition to other single and of difficult solution ethical issues.

Additionally, there are several conflicting situation with which health professionals face in their daily care practice. For example, conflicts between the principle of beneficence and that of autonomy in face of patients who refuse blood transfusion



due to religious issues. One questions if there are situations in which the professional may oppose patient's will. If the Professional should state always the truth in all cases or if, in some situations, is it justified if he omits? One questions, among other questionings, how nurses can protect the confidentiality of patient victimized by Aids in front of his family?

If, in one hand, the legacy of traditional ethics showed insufficient to provide answers to these questioning, in the other hand, the principlialist model – moral tool extremely useful to guide decisions made in caring practice – has shown insufficient to clarify doubts in more complex clinical cases at bed side ⁷.

The appearance of several theoretical proposals shows that the problem of method in bioethics is not solved yet. For Bochaty ⁸, *this fact is very serious because the whole science and /or discipline needs its own method in order to develop itself in an universal manner.* Beauchamp and Childress' proposal, not without reason, since the beginning of the 1990s, has received serious criticism for being a mechanically applied method ⁹. One of them would be the universal pretension that its automatic application could solve several moral dilemmas in the field of life and health science ⁶.

There are, currently, several methods related to the decision making process in clinical bioethics area. They seek to develop suitable methodologies to discuss and attempt to solve conflict that appear

in caring practice ¹⁰. Due to lack of space, this paper shall not approach all similar proposals applied in medical decisions.

Therefore, one sought to expose just the moral analysis methods of David C. Thomasma, Diego Gracia, Albert R. Jonsen, and James F. Drane, as, according with Marques Filho ¹⁰, they are used mostly for a conflict analysis. One highlights, for example, Thomasma's proposal since it is relatively easy to apply in practice. This set of methodological tools applied to ethical decisions in medical area is known as *clinical bioethics*. Despite been considered as new Field of expansion associated to the principlialist bioethics since Hellegers, as one verifies in the coming section, its development only took place by end of 70s with appearance of other methods.

Clinical Bioethics

Paccine ¹¹ warns that clinical bioethics should not be understood separated from bioethics in general, as there is the risk of hiding behind analytical particularities of a clinical arguable philosophies, in as much as moral reference.. Therefore, it must be clarified that, due to its pluralist feature, bioethics (discipline that dialogues with other areas of knowledge, since knowledges, methods, and other lines of reasoning pertaining to several areas of knowledge are present in it), nourishes also from dilemmas that arise in daily routine of clinical practice.





Thus, a link between several academic areas was established, while multidisciplinary is one of its significant features. Among the many definitions, that which is closest to this conception was elaborated by Reich, in 1995, and stressed by Stephen G. Post in the introduction of the 3rd edition of the *Encyclopedia of Bioethics*, in 2003. Bioethics, for them, is defined as the *systematic study of the moral dimensions – including moral vision, decisions, behavior and policies of the sciences of life and health care, employing a variety of ethical methodologies in a multidisciplinary context*¹².

Some authors argue that its beginning was concomitant with bioethics, considered in its generality, in the beginning of the 70s, at the Georgetown University, in the United States. In Marques Filho's view¹⁰, this is due to the Dutch obstetrician Andre Hellegers, who created the Kennedy Institute of Ethics, and started to discuss aspects of medical practice that presented ethical dilemmas, using references of this new field of knowledge. These historical references show that, since that time, bioethics has been related to ethical decisions in medical practice. Certainly, the difficult dilemmas and crucial situations, both in medical area and in the other health sciences professions, gave origin to clinical bioethics¹³.

In the other hand, due to the difficulty to delimit border lines between clinical bioethics, clinical ethics, and medical ethics, in practice, sometimes these terms are used indistinctively. The word clinic, *which characterizes the core of the definition, is related to all*

*decisions, uncertainties, conflicts of values and dilemmas that physicians and medical teams face at bed side, at the surgery ward, in a private Office, and even at home*¹⁴. Thus, before any clinical deliberation, it is necessary to answer the following questions: what is the case? What is the ethical problem? What should or should not do? And why? Therefore, it is practical evaluation related to what should be done to help patient to live or die in a manner that respects his dignity¹⁴.

Durant¹⁵ clarifies specifically on the term clinical ethics that it does not refer Just to physicians, but to all other health professionals. Its domain focuses in short, immediate relationships concerning ethical requirements of these professionals with their patients. However, it does not limit itself to set what is prescribed, allowed, tolerated, forbidden/ it is based in the search for the Best, of what is preferable, or better for a determined situation.

In parallel, clinical ethics excludes almost always the relationship with the public at large, the reflection about health policies and the biomedical research field. Clinical ethics deals with desirable behavior within the scope of the relation that is set between health professionals and their patients, creating, thus, conditions for personal values of involved human beings are preserved and respect, in one hand, and in the other, so service rendering, which is the particular object of this relationship, may achieve the highest possible effectiveness¹⁶.





The term biomedical ethics, in its turn, is associated directly to modern medicine. Strictly speaking, according to Durant ¹⁵, this term *aims directly to technological medicine ethics. It excludes all acts of the daily therapeutics practice with his patient.* He warns, however, that the term is ambiguous, because despite that it seems to have been invented in order to account for modern medical practice with broad appeal to biological research field, some use it as synonym of bioethics.

Finally, the clinical bioethics term refers to one of the bioethics most complex branch, since it relates directly to analysis of moral or broader ethical issues. Clinical bioethics, for Urban, is more encompassing than clinical ethics because it aims *to set an alliance between medical scientific knowledge and humanist knowledge with broad working field. It studies from problems inherent to the beginning and end of life, to human reproduction, the individual dilemmas of health professionals facing polemic situations, researches with humans to the complex public health decisions jointly faced with legislators and citizens* ¹⁷. It has, according to Kovács ¹⁸, as core objective to discuss ethical implications applied to caring of the sick individuals, reflecting on dilemmas that involve diagnosis and treatment processes.

Despite this scope, one realizes that the concepts of clinical ethics and clinical bioethics interweave. Nevertheless, clinical bioethics differentiates itself because it regards to all situations that require decision making, either in medical

practice, in the daily routine of other health professions or in special situations in ethical committees. These features indicate that if, on one hand, bioethics encompass all fields of work, in the other hand, it shows that clinical history is also the object of ethics.

The Spanish bioethicist Diego Gracia ¹⁹, in this regard, makes two observations: 1) he warns that in medical ethics one should not begin by setting large principles, but rather by concrete case study, having, consequently, that every decision making has clinical history as its starting point; 2) he considers that *clinical ethics cannot be understood as mere application of principles set by basic ethics.* Thus, Gracia ponders that bioethics becomes a medical discipline in as much as it analyzes the moral dimensions of clinical opinion.

Method in clinical bioethics

Ethical problems consist always, for Gracia, in conflicts of values that have facts as support. Therefore, he understands that analysis procedures should depart always from detailed study of clinical facts²⁰. In his work '*Procedimiento de decisión en ética clínica*' (*Decision making procedure in clinical ethics*), he does an analogy between clinical history and the methods used to solve ethical problems. He states that *in order to solve conflicts, physicians use certain classic procedures which ultimately are those that synthesize clinical history.* From this comprehension, *one questions if does it make sense to expand clinical methods until they turn into clinical ethics' own method?* ²¹



David Thomasma, Professor of Philosophy and of Medicine at the University of Tennessee, was one of the first individuals to respond positively to this issue, who published in 1978 an article under the title of *Training in medical ethics*²¹. He designed a method that he denominated as *Ethical workup*. One stresses that this method underwent several changes, and the most recent was in 1990, becoming a broader methodological tool, comprising six stages:

1. Describe all facts of the case. Followed by the investigation of each medical fact not present in the case, possibly relevant for its solution;
2. Describe the relevant values of physician, patients, family members, the hospital itself, and of society;
3. Determine the main threatened value. For example, a case in which physician is forced to implement a treatment against patient's will;
4. Determine possible courses of action that can protect largest possible number of values de;
5. Elect one course of action;
6. Defend this course of action from the values in which it is based. For example, why did you elect, in this case, one value over the other? Why a course of action X is better than Y?

Thomasma's intention is harmonizing objective facts with involved individuals' values, especially with those of sick person. He believes that facts and values

always appear united in one context. He advocates, thus, that one should jointly analyze in a matrix that he denominates '*parrilla contextual*' (contextual grid). The purpose is to describe the whole context in the most possible objective way, in order to facilitate the fair ordainment of values, aiming at establishing the best course of action or decision making²¹.

Diego Gracia's Method

Gracia²¹ designed another proposal relying in four premises: ontological, deontological, teleological, and a moral justification, whose decision making is based in the contrast of clarified conflicts of values, in each of the propositions. Systemizing this method is based in four steps:

- I. Moral reference system (ontological)
 - Ontological Premise: man is individual, and as such has dignity and not price;
 - Ethical Premise: while individuals, all men are equals and deserve equal consideration and respect;
- II. Moral Outline (deontological)
 - Level 1: non-maleficence and justice;
 - Level 2: autonomy and beneficence;
- III. Moral experience (teleological)
 - Objective consequences or level 1;
 - Subjective consequences or level 2;



- IV. Moral verification (justification)
 Contrast the case and the rule, as set forth in step II;
 Evidencing if it is possible to justify a rule exception in a concrete case (step III);
 Contrast decision making and the reference system, as set forth in step I;
 Make the final decision.

Thus, everyone is obliged to fulfill minimal common obligations, rules, and values –such as, for example, obligation to respect people, their body, his dignity, not cause harm, treat patients without discrimination, protect the disadvantaged and treat others as he would like to be treated.

Such obligations may be defined in several ways: by rational consensus, or, at least, reasonably, among all or majority of citizens,

Step I, denominated *moral reference system*, constitutes universal moral formal landmark. Since it is based in an universally formulated anthological premise, it forces fulfill minimal moral duties, such as not kill, not to discriminate, since everyone deserves considerations and respect for his values.

or by force imposed by the State. This means that each one should seek establishing a set of common values both related to tradition and legal rules. The main areas to be covered in the minimum ethical space are: a protection of physical mental, and spiritual health (principle of non-maleficence) and protection of the interpersonal and social integrity, avoiding segregation of some individuals for others on basic companionship issues (principle of justice)²⁰.

In Step II, called *moral outline*, Gracia restructured the *prima facie* principles that base moral justification of bioethics' principlialism theory, classifying them in two levels. This hierarchy, perhaps, is associated to the fact that in European tradition one does not accept the existence of absolute principles to base moral.

The principles of *autonomy and beneficence, in their turn*, were classified as second level. As they acquire private character, that is, because they are located in private space of each individual, they represent the *ethics of maximum* or *maximum ethics*. These principles refer to relationship between health personnel and patient²². If, in one hand, they mean the individual search of maximum ethical gesture, kindness, Love, happiness, in the other hand, they force patient to exert the right over their own beliefs, values, and life ideals.

The non-maleficence and justice principles were classified as first level. Because it acquires public character, they figure as *the ethics of minimum* or minimalist ethics, that is, an obligation universally imposed for every citizen²². Therefore, it sets the duties of each individual, both in his biological life order (principle of non-maleficence) and in his social life (principle of justice).



Hierarchization of these principles, among other aspects, facilitates moral opinion analysis, because it avoids that they collide. In which case, one should seek to respect those of the first level (non-maleficence and justice) or the minimum ethical duties^{20,23}. Differently from Beauchamp and Childress' proposal²⁴, who consider the four principles as *prima facie*, that is, of the same level, in this case, due to lack of hierarchization among them in face of a conflict situation one should decide in accordance with the consequences. In other words, in a given circumstance, the principle of beneficence may be priority, and in other, that of autonomy, and in another, that of justice etc.

On this, Gracia²⁰ clarifies that *physician's function is not primarily that of beneficence, but rather that of non-maleficence*. For him, what the principle of autonomy states is that the *competent patient is the sole moral authority over his own body, and that, therefore, nobody has in principle the right to decide for him or impose limits to his decision*. Except in extreme emergence situation, the only thing that the Professional can do is to oppose patient when his wish attempts against the principles of non-maleficence or justice. If, in one hand, due to professional's moral commitment, he should avoid harm, in the other, the patient does not have the right to impose his certainties.

Gracia, in addition to *minimum ethics* and of the *maximum ethics*, relies on other argument that regards the distinction between perfect and imperfect duties. The first ones are promulgated by all, that is, by the general will, therefore they are *public*, and the State has

the obligation to enforce them, inclusively with use of force. The second ones are promulgated by each person through *individual will*, and, thus, its character is private and, then, its enforcement depends on each person. In bioethics, the principles of non-maleficence and justice would correspond to perfect duties and those of *autonomy* and *beneficence* to imperfect duties. Thus, one reaffirms that, in case of conflict, those of public level would have priority over those of private level²⁵.

For the author, hierarchization of principles is justified as, often, moral conflict arises as conceptualization of public or private result²⁰. Restalt remains to question if, in any way, he attempt to escape from the criticism made to the principlialist model of bioethics, precisely because of not attributing a hierarchy of these principles in cases of conflict of values.

In step III, a *moral experience* is linked to the experience of moral life. Considering its teleological character, decisions require the exercise of a responsibility ethics. Therefore, it should be considered both the principles and values involved and the consequences of decision making. This implies that in analysis of cases, the positive and negative effects of the act should be evaluated, both of level 1 (non-maleficence and justice) and of level 2 (autonomy and beneficence).

In step IV, *moral verification (justification)* is associated to the justification of acts. To justify is to give reason to the decision making choice.

Thus, it is necessary, before making a decision, to contrast it with steps I, II, and III: to contrast the case with the rule (II) to evidence if it is possible to justify an exception to the rule (III) and to contrast the decision with the system of reference (I). The best decision, certainly, will be that is capable to respect all principles. Exceptions to the principles can bring out the consequences and justifications for the decision making.

Gracia ²¹ recommends that before applying the methods it is necessary a detailed analysis of the clinical history, since this is the canonic procedure for decision making within clinical scope. Thus, he warns that it is necessary, in order to discuss an ethical problem, to clarify first all technical doubts (clinical opinions), and afterwards to analyze the conflicts of values (ethical opinions) and, only then, choose the best option (moral opinion). Finally, after decision making, the author²⁶ suggests to undertake a *consistence test* to evaluate it, considering the following aspects: a) *Publicity test*. One questions: what would happen if the decision becomes public? Would the physician or other team member be prepared to publicly advocate the decision?; b) *Legality test*. Does the decision have legal implication? One considers that it is not possible to accept a choice contrary to governing legal rules; c) *Time test*. After a few days, would the same decision be made?

Albert R. Jonsen's Method

Jonsen, Mark Siegler and Winslade William published ,in 1982, a small book specifically

written to facilitate clinical decisions process – in which they transformed Thomasma's six steps into four complex areas of bioethical concerns ²⁷. Afterwards, this proposal was advocated by Albert Jonsen and Stephen Toulmin in the work *The abuse of casuistry – A history of moral reasoning*, launched in 1988 ²⁸. These two authors recollect the Aristotelic tradition for deliberation on concrete case to show that, in ethics, one should start from principles, but rather from individual situations ²¹.

Moral problems are analyzed, from clinical history, based in three steps: step I regards the exposition of the clinical case, instance when all need clinical data are exposed to proceed to moral analysis. Step II refers to moral comment, departing from four categories: medical criteria, patient's preferences, quality of life, and socioeconomic factors.

Medical criteria

The principle of beneficence is their reference. They are related to all ethical implications that involve diagnosis, prognosis, and therapeutic alternatives, clinical strategy based in risk and benefit and patient's specific aspects. In addition, all technical and scientific doubts should be clarified regarding treatment alternatives, their objectives, relief of symptoms, pain, suffering, and probability of treatment success or the lack of it. The following questions should be answered: if treatment is effective, if problem is chronic, acute, critical, emergent, reversible, irreversible, palliative, and in case of

cardiopulmonary arrest, if patient will be resuscitated;

Patient's preferences

They rely in autonomy. They regard patient's values related to his preferences, beliefs, desires, and opinions. As direct consequences for the respect of autonomy, the following questions should be clarified: ethical, legal, and psychological nature of patient's preferences, treatment refusal, if patient was informed duly, and if he is competent for decision making. In case of minors or incapable, who is the legal representative, and if patient's autonomy is respected;

Quality of life

They have wellbeing as reference. How to decide when preferences are unknown and medical objectives are limited? Cases of terminal disease, unconscious, deficiencies, and the decision of not investing in cardiopulmonary resuscitation are reported. Other issues should be clarified: in order to preserve the quality of life, should one suppress non-effective therapies or treatment that cause much pain or suffering?

Socioeconomic factors

They rely in the principle of justice or equity. Usually, clinical decisions have impacts and they go beyond the physician, patient, family, and society. All factors involving diagnosis, prognosis, indicated scientific conduct standards, legality of conduct, respect for

the values of professionals, of the sick, and of society should be pondered, weighted, and their consequences should be considered before final decision. **Other** issues should be clarified: the role of stakeholder (such as family members), conflicts of interests, costs of health care, distribution of resources targeted to health, and the issues involving legal implications, research, teaching, and community wellbeing ^{19,21,29}.

Step III refers to moral advice. It is the most problematic point. To counsel about the importance of facts, opinions, and circumstances in light of ethical categories and medical indications is always a complex task. The physician is in charge to recommend to indicated treatment, however, the patient has the right to accept or reject it in accordance to his personal preferences. Therefore, in priority order, patient's preferences are ethical categories with greater weight in the physician-patient relationship. Whenever the patient refuses to accept the treatment, the professional faces a series of questions: with which end did one elect this treatment? What does the patient need? Is he/she really a competent and capable patient? Are his/her needs are big enough to replace his/her preferences? These questionings should be answered through analysis of facts. Due to their importance, the facts and opinions should be evidenced effectively in order to reach a priority order. For example, decisions base in medical urgencies indications are priority in situations of emergence, and when the patient is incompetent or incapable ¹⁹.



James F. Drane's Method

This method includes features of Thomasma and Jonsen's proposal. Although the principles of autonomy and of beneficence are also a guide for reflection, it is based in a set of moral values from description of relevant clinical factors. Systematization of this ethical methodology is structured in three phases: descriptive, rational, and volitional.

The *descriptive phase* serves as guide to identify relevant factors: 1) medical factors: diagnosis, prognosis, options of treatment, real medical objectives, treatment that produces real effect, and scientific knowledge in medical area; 2) ethical factors: who is the patient? Which are the interests, desires, feeling, intentions, and preferences both of patients, physicians, institutions, and society?; 3) socioeconomic factors: they involve cost for the patient, family, hospital, health system, insurance company, government, and society.

The *rational phase* guides toward reasoning about relevant facts. The following should be observed in this phase: 1) ethics-medical categories: free and clarified consent term, reason for treatment, confidentiality, and possibility of experimenting; 2) principles: beneficence, autonomy, respect, truthfulness, trustworthy, sacredness of life and justice are accepted as guide for reflection. The most concrete references have specific rules: they regard to prolonging dying process, relief of suffering, respect for capable patient's wishes, etc;

3) legal decisions and Professional codes: paradigmatic legal cases have as reflection guide other previous cases. The Professional organizations codes also serve as reflection guides.

The last proposed phase, *the volitional phase*, refers to facts that would serve as reflection for decision making:

1. Ordainment of goods: when there is more than one value or interest involved, they should be ordained in accordance with the priority scale. For example, capable patient's wishes have preferences over those of physician or family. It should be stressed, however, that in case of an epidemics, that is, in face a crucial situation involving collectiveness, social goods have preference over the individual goods;
2. Ordainment of principles: when principles are in conflict, they should be ordained in accordance to personal beliefs and professional commitments: beneficence (care for patients, healing them, save their lives, relieving suffering) is priority for physicians. The other principles are respected, but they do not come before those of beneficence;
3. Decision making: health professional should decide with prudence, sensibility, and according with the limits of his personal or Professional experience. Special attention is required in those decisions that may have as consequence the death of patient.



This method, as one sees, in addition to model attempts to mediate David C. Thomasma and Jonsen's methods – although the proposal is closer to the former than to the latter.

Clinical case for exercise

The proposal is to expose a case for analysis using systematization of methodological tools expressed herein. It is the plan to have a child intended to be immune-compatible with the brother carrier of serious disease. The objective is to exploit all facts of in their particularities in order to expose the values in conflict, regarding clinical interests, parents, the sick brother, and the future donor baby. Particularly, possible justifications that base physicians decision that proposes to the mother to have other child, using *in vitro* fertilization resources, aiming at to become donor for the brother who is leukemia carrier should be analyzed.

Currently, through the preimplantation genetic diagnosis (PGD) it is possible to select immune-compatible embryos – which opens, in one hand, a range of hope for the parents searching for their child cure; in the other hand, it involves multiple ethical controversies between already existing child's interests and the future child operationalization to save him.

Here is a case exposed in Jodi Pcioult's novel *For my sister*³⁰. The story in this book exemplifies how to discuss decision making. The plot develops

around the Fitzgerald family , Sara, Brian Jesse, and Kate. Kate, the youngest daughter, two years old, has promyelocitic leukemia, and it is necessary to search for a immune-compatible donor in the national bone marrow registry, since her brother Jesse is not. The oncologist, Dr. Chance, suggests an alternative to parent in order to salve Kate: to have another child using *in vitro* fertilization technique, with a posteriori resource to preimplantation genetic diagnosis for embryos HLA typing. This is how Anna is Born, whose fate is saving Kate; and it is feature of savior that seems to turn off Anna's identity.

Against all odds, Kate survives during 13 years with the sister's help, who at this age decides to resort to courts when her parents manifested the desire for her to donate one of her kidneys to save Kate from a serious renal problem. NoAt court, the mother represents the family, and the teenager is defended by Campbell, while the whole suit is supported by the *ad litem tutor*, Julia Romano. Anna's decision to cease donation to the sister seems to be na appeal to the right of been recognized at her own identity. However, nothing is exactly what it seems in this novel and the reader questions if actually Anna will not be also voicing Kate's wish of stopping medical treatment, and give life to the last days of her existence instead of giving days to her life³¹.

What does one deduce from parents' rationale? When the Fitzgerald decide to have another child to save Kate, the act based in the presupposition that they have the right to



choose between having another child or leaving Kate to die while waiting for a compatible bone marrow donor. This is the message that they transmit in the interview undertaken by a journalist of an informative program, Nadya Carter, in which they refer to community the decision of having a savior child³¹. This case exemplifies the kind of reflection that impregnates the decision making instance, pointing to be necessary to ponder on possible favorable and opposing argumentations to parents and unborn child's rights. The history illustrated the dilemma of having to choose between the hope of having another immune-compatible child or leaving their child to die waiting for donation.

The exercise bases in the search to expose the reason that lead someone to make this decision. Morally, is it justified to do anything to save the life of a son? How will the unborn be perceived? How does a human being, endowed with dignity and inherent rights become a mere repository of organs for a brother? Or does the decision only finds moral support if there is a balance between the couple's interests and those of the future child, and between parents' autonomy and the identity right of the donor child? Based in clinical bioethical tools, you, the reader, attempt to imagine which arguments could be used if you were called to give an opinion on this case or another similar.

The biotechnoscience constant progress stimulate the development to the maximum all arguments capable to defend or refute the decision to use PGD method to program the birth of a child that goes beyond the natural dimension of a parental

project. This paradigmatic example may facilitate very much the comprehension of dilemmas and conflicts experienced in clinics, allowing for sensibility enhancement in the decision making process.

Final considerations

One verifies increasingly that the theoretical trend of principlism bioethics is not enough to hold satisfactorily the more complex moral problems in the clinical practice. As well as in clinical bioethics, in addition to methods presented herein, there are currently other options capable to guide the decision making process of special clinical case, either in the assisting practice or in ethics committees.

Nevertheless, every caution is necessary to avoid establishing new discussion fields disassociated from bioethics plural view, since if in one hand it would be an error to reduce bioethics to clinical cases in the medical area, in the other hand, it would not be reasonable to imagine that certain method may be capable to provide satisfactory solution for dilemmas and/or ethical conflicts that arise in medical practice currently.

Evidently, it would be almost impossible to achieve what is absolute, much less to set general theories that may be applied to all cases. The several methods comprise a set of methodological tools that will assist in exposing facts, in analyzing argument, in identifying conflicting values and in the better possible choice.





Finally, one should warn that the application of should be above the legal order instituted by such instruments, in addition to require society, as one cannot accept an illicit proposal humbleness, prudence, technical, scientific, and or that is contrary to the legal-social order. ethical competence from involved professional, reveals that any ethical decision

Resumo

A bioética clínica surge com Andre Hellegers, relacionada às decisões éticas na prática médica, e a partir da concepção principialista da bioética vem se expandindo em virtude de outras alternativas de análise moral. Atualmente, existem várias propostas metodológicas atinentes à tomada de decisões em ética clínica. O presente trabalho tem por objetivo apresentar os métodos de David C. Thomasma, Diego Gracia, Albert R. Jonsen e James F. Drane, por serem os mais utilizados para a análise de conflitos, problemas ou dilemas morais que surgem na prática clínica e assistencial. Conclui-se que todos os métodos objetivam auxiliar na elaboração do raciocínio para a tomada de decisão. De certo, o maior desafio está em escolher aquele que possibilite o estudo racional, sistemático e objetivo dos problemas e que permita a exploração dos fatos em suas particularidades, pois quanto mais claros forem, mais fácil será a análise dos valores em conflito.

Palavras-chave: Bioética. Ética clínica. Tomada de decisões.

Resumen

Bioética clínica y su práctica

La bioética clínica surge con Andre Hellegers en las decisiones éticas relacionadas con la práctica médica, y a partir de la concepción de la bioética principialista se está expandiendo en virtud de otras alternativas de análisis moral. Actualmente, hay varias propuestas metodológicas relativas a la toma de decisiones en ética clínica. Este artículo tiene como objetivo presentar los métodos de David C. Thomasma, Diego Gracia, Albert R. Jons y James F. Drane por ser los más utilizados para el análisis de los conflictos, problemas o dilemas morales que surgen en la práctica clínica y asistencial. Se concluye que todos los métodos tienen por objeto ayudar en la preparación del raciocinio para la toma de decisiones. Seguramente, el mayor desafío es elegir aquel que haga posible un estudio racional, sistemático y objetivo de los problemas y que permita la exploración de los hechos en sus particularidades, pues cuánto más claros fueren más fácil será el análisis de los valores en conflicto.

Palabras-clave: Bioética. Ética clínica. Toma de decisiones.

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