

Medical prudence or practical reasoning applied to the clinical care in Thomas Aquinas

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Abstract

This article offers a philosophical reconstruction of medical prudence based on the thought of Thomas Aquinas to provide an adequate category for understanding the rationality of the medical procedure. Facing approaches that reduce good medical practice to the technical application of protocols or to the professional's subjective intuition, this article advocates that medicine requires a specific form of practical prudence. To this end, it examines the notion of virtue and addresses prudence as a virtue that is formally intellectual and materially moral, attending to its subject, its acts, and its relationship with the moral virtues. The study also translates prudence integral parts into the clinical sphere, highlighting memory, intelligence, docility, foresight, and caution. Finally, the article defines medical prudence as a straight practical reason applied to the care of a concrete patient, oriented toward the patient's well-being through the proportionate integration of evidence, experience, patient values, safety, justice, and institutional context.

Keywords: Medical ethics. Virtues. Clinical decision-making. Clinical reasoning. Bioethics. Physician-patient relations.

Resumen

Prudencia médica o razón práctica aplicada al acto médico em Tomás de Aquino

Este artículo reconstruye filosóficamente la prudencia médica desde el pensamiento de Tomás de Aquino, con el fin de ofrecer una categoría adecuada para comprender la racionalidad del acto médico. Frente a visiones que reducen la buena práctica médica a la aplicación técnica de protocolos o a la intuición subjetiva del profesional, se sostiene que la medicina exige una forma específica de prudencia práctica. Este artículo examina la noción de virtud y estudia la prudencia como virtud formalmente intelectual y materialmente moral, atendiendo a su sujeto, sus actos y su relación con las virtudes morales. Asimismo, traduce sus partes integrales al ámbito clínico, destacando la memoria, la inteligencia, la docilidad, la previsión y la precaución. Finalmente, define la prudencia médica como recta razón práctica aplicada al cuidado de un paciente concreto, orientada a su bien integral mediante la integración proporcionada de evidencia, experiencia, valores del paciente, seguridad, justicia y contexto institucional.

Palabras clave: Ética médica. Virtudes. Toma de decisiones clínicas. Juicio clínico. Bioética. Relaciones médico-paciente.

Resumo

Prudência médica ou razão prática aplicada ao cuidado clínico em Tomás de Aquino

Este artigo reconstrói filosoficamente a prudência médica a partir do pensamento de Tomás de Aquino, com o objetivo de oferecer categoria adequada para compreender a racionalidade do ato médico. Diante de perspectivas que reduzem a boa prática médica à aplicação técnica de protocolos ou à intuição subjetiva do profissional, sustenta-se que a medicina exige uma forma específica de prudência prática. Para isso, o artigo examina a noção de virtude e estuda a prudência como uma virtude formalmente intelectual e materialmente moral, considerando seu sujeito, seus atos e sua relação com as virtudes morais. Além disso, traduz suas partes integrais para o âmbito clínico, destacando memória, inteligência, docilidade, previsão e precaução. Por fim, define prudência médica como reta razão prática aplicada ao cuidado de um paciente concreto, orientada ao seu bem integral mediante a integração proporcionada de evidência, experiência, valores do paciente, segurança, justiça e contexto institucional.

Palavras-chave: Ética médica. Virtudes. Tomada de decisão clínica. Raciocínio clínico. Bioética. Relações médico-paciente.

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Contemporary medical practice is crossed by a hard-to-resolve tension. On the one hand, evidence-based medicine seeks to reduce clinical variability through guidelines, protocols, algorithms, and quality standards. On the other hand, the daily care practice shows that good clinical judgment is not limited by the application of general rules, because each patient bears their own biographical, pathophysiological, ethical and social singularity that resists simplification¹. When poorly resolved, such conflict gives rise to two reductionist approaches: the first absolutizes the protocol and equates good medicine with formal adherence to standardized procedures; the second approach absolutizes the professional's intuition and leads to clinical subjectivism, paternalism, or arbitrariness^{2,3}. Between the two extremes, a category must be delineated to allow us to think of medical rationality as a situated, justifiable, and morally oriented practical judgment.

In this context, the prudence elaborated by St. Thomas Aquinas, based on the Aristotelian tradition, offers a specially fruitful theoretical framework. It is a formally intellectual and materially moral virtue, as it resides in practical reason, but it deals with contingent human acts, concrete choices and passions that must be ordered to the good. Its function is not to create ends or to calculate means for any purpose, but to recognize the relevant human goods and to ordain a proportionate action in particular circumstances towards them. For this reason, prudence is not opposed to scientific evidence, but rather integrates it, creates an hierarchy on it and translates it into practical decision.

In view of this, the central hypothesis of this article is that medical prudence can be formulated as an analogous class of practical prudence and that this category enables a better understanding of the specific rationality of the medical act. Medical prudence is the practical reason applied to the clinical care of a patient, aimed at their integral good as a vulnerable person, by the proportionate integration of scientific evidence, clinical experience, patient values, safety, justice, and institutional context. Thus, the good physician is not only the one who knows better or applies a protocol precisely, but also the one who has perfected their practical

judgment to properly deliberate, judge correctly and act proportionately in favor of the patient.

Virtue from the Thomistic tradition

Virtue is often defined as “good habit” or “golden mean.” Although both expressions are legitimate, they are incomplete when addressed separated from their supporting pillars, the metaphysics and moral anthropology. St. Thomas Aquinas, following Aristotle, picks up several decisive formulations: virtue is *the ultimate power*⁴; *the virtue of man also will be the state of character which makes a man good and which makes him do his own work well*⁵; and it is *an arrangement of that which is perfect (...) by comparison to the excellence*⁶. The classical definition of virtue according to Aristotle is *a state of character concerned with choice (...) determined by a rational principle, and by that principle by which the man of practical wisdom would determine it*⁵.

These expressions show that virtue is not an extrinsic addition or a simple behavioral repetition. It is the excellence of a faculty in order to its perfected operation. It not only excels what the subject does, but also the very way in which they are certainly inclined to do well. Virtue inwardly configures the agent to act in a connatural manner^{7,8}.

Virtue is defined by Peter Lombard and taken up by Thomas Aquinas as *a good quality of mind whereby we live rightly, which no one misuses and that God works in us without*⁹, which concentrates three characteristics: it is quality, because it is a certain disposition; it is good, because it perfects the subject and orders them to an end; and it belongs to the mind, that is, to that which is proper to the human being as rational. Virtue should not be understood, therefore, as a simple affective inclination or as an external discipline, but as a established perfection of faculties ordered to the good.

Thomas responds to the objection that virtues would be unnecessary if the human being already possesses reason, will, and operational capacities⁹ affirming that virtue is a complement to power. Precisely because human power is not determined

in a single way to a single operative end, it requires habits that stably dispose it to act well.

Virtue fulfills three decisive functions: it gives uniformity to action, avoiding constant oscillation; it makes it possible for the good operation to be carried out easily, without clumsy improvisation; and it leads to fruition, that is, to joy in the good done, since the perfection of the habit generates connaturality between subject and act^{7,9}.

Thus, the good physician is not only the one who knows biomedical information or correctly follows a clinical guide, but also the one who has perfected their cognitive, deliberative, affective and volitional faculties to act uprightly in front of the patient. Clinical excellence is not merely technical, but a form of rationality embodied in the agent. Hence, medical ethics cannot be reduced to external codes or abstract principles, even if these are necessary. A protocol can indicate a general conduct; and it cannot become, by itself, the clinical approach capable of discerning when it should be applied, adapted or integrated with the integral good of the patient.

Thomas Aquinas maintains that the virtues are not naturally found in us in a perfected manner⁹. Rather, the powers and certain initial inclinations or “seeds” of virtue are naturally placed within individuals; virtue, on the other hand, demands a process of realization and consolidation through repeated acts guided by reason⁹. Knowledge can be acquired by one’s own activity and also by external doctrine⁹. This point allows the theory of virtue to be extended beyond modern individualism.

Taking inspiration from Buber¹⁰, Levinas¹¹ and Pinsent^{12,13}, it can be argued that certain forms of human excellence are not adequately understood if they are abstracted from the link between an “I” and a “you.” In this key, virtue does not appear only as a established disposition acquired by repetition of acts, but as a capacity that matures in contexts of shared presence, joint attention and interpersonal openness. The appropriate experience to understand the ethics of virtues in Thomas Aquinas thought is not only found in Aristotelian habituation, but also in I-you relationships such as the game between father and son, friendship,

or harmonious work between people. In these relationships, the subject performs good acts and learns to be moved by another in a specifically personal manner¹³.

The notion of joint attention is especially fruitful. Pinsent¹³ describes it as a shared awareness of shared focus: two people attend to an object together and know that they are doing it together. This triadic structure (person₁, person₂ and object) shows that the development of virtue involves more than just the repetition of correct actions: it involves learning to look at, value, and interpret the world along with others. For this reason, the second-person perspective is a condition of possibility for certain modes of understanding and formation of character.

The Thomistic category of docility and the importance given to teaching, correction and friendship allow the theory of virtue to be extended to this interpersonal horizon. To understand this, Gutiérrez-González proposes the metaphor of resonance or harmony in a symphonic concert: just as two musicians can play in consonance, during life, moral and intellectual dispositions are refined by dealing with another until a more lucid and more perfect joint action occurs¹⁴. Observed through this lens, virtue is not only habituation, but also an openness to be shaped by the presence of the other.

This has direct consequences for medicine, considering that a physician who did not acquire virtues based on a second-person perspective, may degrade clinical practice by reducing the patient to an object of observation, a statistical case or a technical problem. Clinical practice may also be deformed when professionals close themselves in an epistemic self-sufficiency that refuses the help of colleagues, nurses, family or interdisciplinary teams. Medicine is not only learned by reading scientific literature or repeating procedures, but also by guidance, followups, observation of models, discussion of cases, prudential correction, and vertical community. Some aspect of prudence are learned by observation, that is, when the student or resident observes how an experienced physician organize priorities, interprets ambiguous signs or symptoms, listens to the patient, consults the team and decides. Virtue is passed on, at least in part, through examples.

The virtue of prudence

Thomas Aquinas defines prudence as the right reason for what should be done (*recta ratio agibilium*)^{15,16}. The expression condenses a double belonging. By its essence and subject, prudence is an intellectual virtue, since it formally resides in practical reason; by its matter, it is counted among the moral virtues, as it deals with contingent human acts, concrete choices, and passions that must be ordered to the good⁸. This double condition explains why it is not one virtue among others, but the highest form of mover of human action.

Prudence does not establish ultimate ends; in fact, Thomas Aquinas reserves this level for synderesis¹⁵, to the natural law⁷ and to the moral virtues in so far as they rectify the appetite with respect to the good⁸. The end is not constituted by prudence, but presupposed by it. Its task is to discern and choose proportionate means to realize those ends in the singularity of the action. Prudence, therefore, belongs eminently to practical reason; it does not simply contemplate what it is, nor does it draw speculative conclusions, it only knows in order to act. However, this practical knowledge is not a neutral instrumental rationality^{9,17}.

Therefore, it can only be called prudence when it directs the means to a good end. Hence the intrinsic connection between prudence and moral virtue, for there can be no true prudence in which the will and appetites are disordered with respect to the good⁸. Prudence needs the moral virtues because they rectify the subject's inclination towards the proper end; without this rectification, practical reason is easily captured by desire, fear, ambition or disordered pleasures, and instead of prudence cunning arises⁸. At the same time, the moral virtues need prudence, because moral virtue consists in a rationally determined means, and this means cannot be fixed without the judgment of practical reason⁹. In this sense, prudence is the governor of virtues, since fortitude without prudence becomes fear or daring; temperance, concupiscences; justice, rigid legalism or blind application of the norm⁸.

Its relevance is best understood by attending to its proper object, for unlike wisdom or

science—which deal with the necessary and universal—prudence deals with the contingent, singular, and operable. The field of human action is not composed of geometrically deducible invariant objects, but of concrete, historical situations open to different courses of action. Therefore, a prudent individual cannot be limited to universal principles: they must also know the singular principles¹⁴. The practical decision does not take place at the abstract level of what is generally convenient, but at the level of what is convenient here and now for this person, in this situation, with these risks, limits and foreseeable consequences.

Thomas Aquinas articulates prudence in three fundamental acts: to take counsel, to judge, and to command⁸. To take counsel is the act of inquiry or search for suitable means to achieve a good end, therefore, inquiring means investigating, comparing, consulting, weighing possibilities⁸. This presupposes epistemological humility, because those who inquire admit not possessing the complete answer from the outset. For this reason, Thomas Aquinas links to this act the *eubulia*, an annexed virtue that perfects good advice; in this way, the prudent does not improvise or react impulsively⁸.

Once the means have been considered, reason must move on to judgment, that is, to the evaluation of the rectitude of what is deliberated⁸. Here practical reason deliberates and judges which of the means discovered is the most appropriate. Such process can be perfected by specific annexed virtues, such as *synesis*, which makes it possible to judge well according to common law⁸, and the *gnome*, which allows to judge well when the common law does not suffice and the physicians must resort to higher principles of justice or equity⁸. This process shows the finesse with which Thomas Aquinas understands practical reasoning, because moral action is not reduced to the uniform application of general rules.

To command is the principal act of reason, because it is possible to deliberate and judge correctly what should be done, and yet not to execute it through fear, negligence, inconstancy, or lack of solicitude⁸. Hence, to command is superior to judge from the practical point of view, for while to judge still remains on the cognitive plane, to command puts in practice what has

been deliberated and pondered. It is the act by which reason effectively commands the inferior powers to act. Since the end of practical reason is the operation itself, to command constitutes the product act of prudence.

The distinction between to judge and to command allows us to better understand the seriousness of prudential flaws, because to err in deliberation or judgment may come from ignorance, haste or lack of experience; to err in the command means to fail in the act closest to the end of the act. Hence, Thomas Aquinas considers the sins of inconstancy and negligence especially serious, which is not a mere accidental forgetfulness, but a lack of readiness of reason to command what must be done⁸.

The complexity of the prudential act explains why Thomas Aquinas distinguishes integral, subjective and potential parts⁸; here the first two are of particular interest. The integral parts are elements that must concur for the prudential act to be perfect, since on the cognitive side are memory, understanding, docility, shrewdness, and reasoning⁸; and on the operative side, foresight, circumspection and caution⁸.

Among these integral parts, the relationship between memory and foresight deserves special attention. Prudence cannot deliberate well exclusively based on universal deductions; it must include experience, and experience is formed from multiple memories. Memory provides the material from which the subject learns which courses of action usually lead to good and which to failure, but all the cognitive elements of prudence are ordered to a higher function; namely, foresight, that is, the ability to see from afar, to anticipate what is to come. Foresight thus constitutes the principal and complementary part of prudence, because only the past is remembered and the present is understood to order action correctly towards the future; in this way, prudence integrates past, present, and future in a single rational dynamism.

The subjective parts show that prudence adopts different modulations according to the type of subject or multitude that must be governed. Thomas Aquinas mentions that there are personal or monastic prudence, economic, political and military prudence⁸. These species do not destroy the formal unity of prudence,

but actualize it according to different matters and responsibilities. Note that Aquinas does not conceive of prudence as a virtue confined to the moral intimacy of the individual. In a scenario in which there is orderly human action, responsibility for others, and need for adequate means for right ends, prudence is required.

Finally, Thomas Aquinas recognizes that even the best formed human prudence remains limited in the face of the uncertainty of singular and contingent events; therefore, in the supernatural economy, prudence receives help and perfection through the gift of counsel⁸. This gift does not replace prudence, but elevates and assists it from a higher principle: while prudence is the rectitude of practical reason as the lower human mover, the gift of counsel expresses the motion of the Holy Spirit, who guides the mind in which created reason does not attain sufficient clarity⁸. Hence the explanation why it is called counsel and to judge or to command, since in the order of gifts, the human mind does not act as the main mover that commands, but as a receptive faculty that is moved and taught by God⁸.

The formulation of medical prudence

Based on this framework, it is legitimate to propose medical prudence as an analogous species of practical prudence. The medical practice has its own subject, that is, the care of the health and bodily life of a vulnerable person, in conditions of uncertainty, dependence, epistemic asymmetry, risk and complex institutionalization. Therefore, medicine requires a specific form of prudence. One can speak of internal modulations according to specialties and contexts: surgical, pediatric, geriatric, palliative, psychiatric, prudence in emergencies, among others. They all share the general structure of prudence, but adapt it according to their subject, temporal decision-making, risk profile and type of vulnerability of the patient.

Medical prudence can be defined as “the right practical reason applied to the clinical care of a specific patient,” aimed at their integral good as a vulnerable person, through the proportionate integration of scientific evidence, clinical experience, patient values, safety, justice and

institutional context. This definition allows us to highlight some features. First, medical prudence is pure practical reason, that is, it is not a naked intuition or mechanical application of protocols, but rationally based judgment. Second, it can be applied to clinical care, since its subject is decisions that affect diagnosis, treatment, follow-up, withdrawal or intensification of therapeutic efforts, communication and care coordination. Third, it is oriented towards the patient's good and not only to an isolated biological marker or variable. Fourth, it integrates various levels of normativity, such as evidence, experience, patient preferences, safety, proportionality, and distributive justice. Fifth, it recognizes that the medical act always occurs in a specific institutional context.

The Thomistic tripartition of to take counsel, to judge, and to command is particularly fruitful in describing the medical act. In medicine, to take counsel corresponds to the collection and initial interpretation of information: anamnesis, physical examination, reading of signs, review of medical record, formulation of diagnostic hypotheses, comparison of therapeutic alternatives, risk assessment, and consultation with colleagues or written guides.

To judge is the moment in which reason deliberate what is appropriate for the case and by integrating scientific evidence, clinical experience, pathophysiological singularity, patient values and justice in the use of resources: which diagnosis is most plausible; which exam has real value; which intervention is proportionate; what risk is acceptable, and what good should be prioritized. To command, on the other hand, means prescribing, intervening, referring, hospitalizing, communicating prognosis, indicating palliatives, withdrawing disproportionate resources, coordinating the team and ensuring continuity of care. Medicine does not end with understanding the case, it culminates in decisions that effectively influence a vulnerable person.

If medical prudence is to be understood as an analogous species of practical prudence, it can also be analyzed in the light of the integral parts of Thomistic prudence. These are not distinct virtues, but parts that must concur for the prudential act to be complete, upright, and effective. Translated into the clinical field, they offer a normative and operational map of medical excellence.

Memory is not a mere psychological storage of data, but a truthful conservation of what has been experienced; thus allowing us to integrate previous cases, complications, diagnostic errors, adverse events, morbidity and mortality knowledge and successful or failed therapeutic trajectories¹⁸. Without prudential memory, the physician might repeat previous mistakes or select—under bias—only what confirms their self-perception of competence.

Understanding refers to the correct apprehension of principles and, clinically, to the ability to grasp the essence of the case under analysis. It is not about accumulating signs or following algorithms, but recognizing what is really happening and which elements have decisive relevance. Therefore, by means of understanding, the physician avoids correct reasoning built on a mistaken understanding of the case^{19,20}.

Docility have a particularly important role, because it is a rational openness to learn from those who have more experience. It is expressed by asking for a second opinion, accepting correction, consulting an expert colleague, listening to the nursing staff, integrating other clinical disciplines and recognizing that the patient and their family can provide decisive information about the disease and the specific purposes of care²¹⁻²³. Docility corrects professional self-sufficiency and a dangerous form of epistemic arrogance.

Shrewdness is the good sense to quickly grasp what should be done when there is no time for extensive deliberation; this part of prudence is specially relevant in emergencies, acute deterioration, uncertain diagnostics, triage decisions or incomplete clinical scenarios. Note that, shrewdness does not mean impulsive improvisation, but rather that it is a fast-thinking born of experience, a well-exercised memory and training²⁴.

Reasoning organizes the clinical plan by comparing differential diagnoses, prioritizing probabilities, justifying the request for examinations, integrating laboratory or imaging information, contrasting risks and benefits, and articulating a sequence of actions that does not depend on mere “this is how it is done”²⁵. Thanks to this rational dimension, medical practice escapes both protocol automatism and unjustified insights; however, clinical reasoning

can degenerate into defensive rationalization, excessive testing without sufficient indication, or technocratization of judgment if it loses sight of the patient's concrete good²⁶.

Foresight, the principal part of prudence, orders the present towards the due future; in medicine, it requires considering clinical trajectories, possible complications, adverse effects, probable adherence, rehabilitation needs, family impact, progressive deterioration, relapses, transition to palliative care or consequences of omitting or unduly prolonging an intervention²⁷⁻²⁹. Medical prudence not only questions what to do now, but what horizon of care the current decision may open.

Circumspection consists in attending to the concrete circumstances surrounding the action. The same treatment may be prudent or not depending on available resources, family support network, access to medication, health literacy, age, comorbidities, cultural context, socioeconomic status, or home care setting^{30,31}. Circumspection prevents the absolutization of ideal models detached from the real world of the patient³².

Caution, finally, allows us to defend the good end against foreseeable evils that may arise mixed with it. In medicine, many interventions pursue a good end, but they carry significant risks. Precaution requires preventing iatrogenesis, *iatrolalia*, drug interactions, medication errors, care-associated infections, delirium, falls, overdoses, functional sequelae, overtreatment or therapeutic obstinacy^{33,34}.

Taken together, these parts show that medical prudence can be accurately described without losing ethical density. The excellent medical act is not an instantaneous act or a subjective inspiration or a simple compliance with protocols, but a complex synthesis of truthful memory, capture of the essential pieces of information, openness to learning, proportionate speed, orderly reasoning, projection into the future, attention to circumstances and caution in the face of damage. From this perspective, medical prudence not only names a desirable professional virtue, but the very structure of a truly human medicine.

Final considerations

The Thomistic reconstruction developed in this article allows us to affirm that medical prudence is not an addition to health practice, but a central category for understanding the rationality of the medical act. Its fruitfulness lies in shedding light that is often concealed in contemporary debates: medicine cannot be reduced either to the technical application of protocols or to the professional's subjective spontaneity, because the authentic medical act requires a practical reason exceeded by habit, oriented to the good and capable of deliberate, judge, and command in conditions of contingency.

From this perspective, medical prudence is the ultimate form of guidance of clinical action, the one in which science, experience, moral discernment and responsibility of actions are articulated in favor of a given patient.

This conclusion allows us to specify the nature of medical prudence in the face of several contemporary misconceptions. It should not be confused with defensive medical prudence, whose main logic is to avoid litigation or protect the professional's job. Nor can it be identified with an administrative prudence that absolutizes efficiency, the optimization of resources or institutional governance as if they simply coincided with the good of the patient. Notably, it is not equivalent to a clinical cleverness aimed at results, prestige or technical control, but detached from the proportionality of the act and the patient's vulnerability. Medical prudence requires an honest end, proportionate judgment and operational responsibility. Therefore, its truth is not measured only by the instrumental effectiveness of the decision, but by the rectitude of the good it seeks to achieve and by the human way in which it is carried out.

This article also shows that medical prudence decisively goes beyond the technical and ethical binomial. The good medical practice is not first technical and then ethical, but is simultaneously cognitive, moral, relational and institutional.

A physician may excel in physiology, pharmacology, statistics, or guidebook reading, and yet lack prudence if their judgment is distorted

by vanity, fear, indifference, comfort, or incentives alien to the good of the patient. Hence, medical prudence must be understood as a formally intellectual virtue, because it discerns what is true in order to act, and materially moral, because its exercise is inseparably linked to the concrete good of the patient, to the proportionality of the intervention and to the justice of care. Prudence does not arbitrarily invent the good or oppose the evidence: it recognizes the good in its human complexity and orders the evidence within a defensible decision.

Likewise, the clinical translation of the integral parts of prudence confirms that medical excellence cannot rest on variable moods, conjunctural pressures or fortunate improvisations. Health practice demands stable deliberation, ease of discernment, and readiness to act well even under pressure. On this point, memory, understanding, docility, shrewdness, reasoning, foresight, circumspection, and caution are not accessory qualities, but structural conditions of prudent medicine. Thanks to them, the medical act is no longer conceived as an isolated moment of decision but rather a complex synthesis of truthful experience, grasping the

essential, openness to learning, anticipating consequences, paying attention to circumstances and caution with harmful practices. The professional who has only scattered knowledge or fragmentary technical skills can sometimes act correctly, but does not achieve consistent excellence or stable moral reliability.

Finally, one of the most relevant contributions of this article is to show that medical prudence is not only a descriptive category to better think about the clinic, but also a normative and pedagogical category to renew health education. Teaching medical prudence cannot be reduced to adding courses in normative bioethics or reinforcing diagnostic skills; it implies forming the practical reasoning of the physician in contact with real cases, tutors, teams, patients and specific institutional contexts. In this sense, the second-person perspective is decisive, because it reminds us that medical excellence is not built in isolation, but in the mediation of others who correct, refine, question and teach us to deeply examine. Medical prudence, when addressed in this manner, offers an ordering principle for medical education, bioethical deliberation and responsible clinical practice.

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Manuel Alejandro Gutiérrez González: conceptualization, data curation, methodology, supervision, validation, writing – original draft, writing – revision and editing. Samanta Carolina Vargas Malpica: validation and writing – revision and editing.

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