DRAFT

WHO Guidance on Clinical Ethics

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For Public Consultation

Not for citation or dissemination

Working Group on Developing WHO Guidance on Clinical Ethics

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Background and goals of the Public Consultation:

Over the past decade, clinical ethics has gained increasing prominence within the broader field of global health ethics. The COVID-19 pandemic, in particular, has highlighted numerous clinical ethics challenges, ranging from resource allocation at the bedside to the provision of unproven therapies. Although the World Health Organization (WHO) has occasionally addressed specific clinical ethics issues through its ethics guidance, there remains a lack of comprehensive, general WHO guidance on clinical ethics and its governance. The need for such a document has been repeatedly expressed by WHO Member States, technical departments, and the Global Network of WHO Collaborating Centers for Bioethics.

This initiative is intended to provide comprehensive, context-sensitive ethical guidance to support healthcare decision-making globally and to assist a wide range of stakeholders. These include Member States and health policymakers, WHO technical departments, healthcare workers (including both medical professionals and non-professional health personnel), health facility administrators, international and national professional medical organizations (such as medical councils and professional associations), healthcare workers' unions, ethics oversight agencies, related UN agencies, the medical education sector, non-governmental and civil society organizations (including patients' rights advocacy groups), and other relevant entities.

To develop this draft guidance, WHO has consulted with an internal steering committee, the Global Network of WHO Collaborating Centers for Bioethics, and participants of several relevant events, including the International Conference on Clinical Ethics and Consultation (ICCEC-2023), the World Congress of Bioethics (WCB-2024), and the Australian Association of Bioethics and Health Law Conference (AABHL-2024). An international expert group was formed in 2023, with members representing all WHO regions. In addition to the independent experts on the committee, representatives from observer organizations—including the World Medical Association, the International Council of Nurses, and the World Patient Alliance—have been invited to participate in the working group. The group has convened regularly on a monthly basis to discuss the development of the work, under the coordination of the Health Ethics and Governance Unit at WHO headquarters in Geneva.

To ensure transparency, inclusiveness, and relevance across diverse global contexts, WHO is launching this public consultation on the draft guidance to gather feedback from a wide range of stakeholders. This public consultation aims to make the development of the WHO Clinical Ethics Guidance a participatory and inclusive process. By leveraging digital tools for structured input, WHO seeks to refine the draft into a robust, context-sensitive, and globally applicable resource to support ethical decision-making in healthcare.

The online public consultation will remain open until 11:59 PM on Monday, 30 June 2025 (Central European Time, GMT/UTC +1). Please note that this is an unedited and unformatted draft, shared solely for consultation purposes and not for citation. The final version will undergo full language editing prior to publication. Respondents are kindly requested not to comment on language unless

a term is perceived to carry substantive ethical, technical, or cultural significance. All feedback will be reviewed with care and held in strict confidence by WHO; it will not be shared with third parties and will be used exclusively to inform the development of this guidance on Clinical Ethics and related outputs. A summary of the key themes and feedback, along with anonymized demographic and stakeholder group representation, may be published on the WHO website. Finally, please note that the final version of the guidance will be completed and become more applicable by adding an executive summary and a recommendations section.

WHO Health Ethics and Governance Unit

Geneva

Chapter 1: Introduction and background

1.1. Introduction

A wide range of ethical challenges arise in clinical practice globally on a daily basis. Healthcare professionals and healthcare teams must make difficult decisions regularly:

- How should limited resources like intensive care beds or renal dialysis machines be fairly distributed?
- How could we achieve quality and cultural sensitivity for "breaking bad news"?
- When could ventilation of patients with a poor prognosis be discontinued?
- What should be done when a patient declines life-saving treatment?
- How much coercion can be used to treat patients with severe mental illness?
- How should we balance women's reproductive rights with concern for fetal wellbeing?

In addition to these challenges that typically arise in hospitals, many other ethical challenges in health care practice and are referred to as "microethics". These microethical issues might include therapeutic privilege to withhold a diagnosis in specific cases due to patient fragility or dealing with adverse events from the use of specific medication (Truog et al., 2015). How can we use (medical) language sensitively so that terminology and explanations for patients are understandable, non-discriminatory and empathetic as well as helpful and trustworthy? What are ethically appropriate ways to manage conflicts arising among family members, within the treatment team, or between healthcare professionals and institutional policies? Who looks after the best interests of a patient who has compromised decision-making capacity? How do we confront the ethical challenges generated by the aging population? How can we respect the patient's hierarchy of values when the healthcare team does not share them?

These and other challenging questions that arise in healthcare need to be deliberated to reach the best outcomes for patients. In most parts of the world, healthcare professionals (HCPs) make these difficult decisions on their own or together with their healthcare teams. In other regions, clinical ethics committees, teams or consultants can assist in the decision-making process. While many diverse factors are taken into account in such decision-making, the practice of moral deliberation uses principles, virtues and a wide range of theories in bioethics.

Bioethics has variously been defined as a branch of applied Ethics that explores the intersections between philosophical, legal and social issues that arise in medicine and the biological sciences. Medical Ethics provides a broad set of moral notions, such as principles and virtues to guide medical practice. Use of these notions in decision-making in patient care occurs in the context of clinical ethics. Consequently, clinical ethics is regarded as a practical, sub-discipline of bioethics that provides a structured approach to assist HCPs and healthcare teams in identifying, analyzing, and potentially resolving ethical issues that arise in clinical practice (Singer et al., 2001). The goals include improving the quality of patient care, respecting patient dignity and responding to moral distress amongst HCPs. These are important goals if we wish to retain HCPs, improve health outcomes and reduce challenges in clinical environment and medical litigation.

In the last decade, clinical ethics has gained substantial prominence within the field of health care from a global perspective. In particular, the COVID-19 pandemic has raised many clinical ethics challenges, ranging from triage, rationing at the bedside and at all levels of care and caused moral distress amongst HCPs. While there is general WHO guidance on challenges in bioethics, there is no specific guidance on clinical ethics, clinical ethics consultation and support services. The need for such a document has been repeatedly expressed by various WHO Member States and technical departments and the Global Network of WHO Collaborating Centers for Bioethics. This WHO "Guidance on Clinical Ethics" is intended to fill this gap.

Clinical ethics challenges appear in different healthcare settings at primary, secondary and tertiary levels of care and impact on multiple stakeholders – interdisciplinary medical and clinical teams, policymakers, healthcare funders, patients, families and communities. Furthermore, given the complexity of healthcare, medicine and ethics in diverse settings, values may conflict in multicultural settings in different countries and across urban and rural contexts.

Conflict resolution strategies vary from informal or formal ethics consultation services to structured clinical ethics committees (CECs), hospital ethics committees or other types of healthcare ethics committees. The terminology associated with these committees varies from one country to the next. In many settings, in the absence of formal committees, healthcare practitioners and teams are required to make difficult decisions themselves. Even where formal committees exist, they may only have an advisory role, requiring healthcare teams to make final decisions and to implement such decisions. Consequently, and to promote prudent and reasonable decision-making, ethics education in healthcare is necessary at undergraduate and postgraduate health sciences institutions everywhere in the world. Because every decision in medicine and healthcare has an ethical component, the best outcome for each patient should be sought.

Although research ethics committees (RECs) or institutional review boards (IRBs) are well established globally, clinical ethics consultation services, clinical ethics committees tend to be less well established. The great techno-scientific development of medicine brings new questions. Moral pluralism requires that healthcare providers consider the different values and preferences of patients.

The over-specialization of medicine has the risk of generating fragmented patient care, sometimes forgetting that the patient is a person who suffers and experiences a disease or health condition. These problems are questions of healthcare ethics in every society, all hospitals, primary care and everyday practice.

This guidance of the World Health Organization is intended to raise awareness around clinical ethics, and it is hoped that it will be of value to all stakeholders involved in conflicts of clinical and healthcare ethics. National sovereignty is respected and there is a great deal of flexibility with which guidance could be implemented in different contexts taking local values, resource constraints and different healthcare systems into account.

1.2. Scope and target audience

The Seventy-seventh World Health Assembly resolution that promotes inclusive and sustained social participation in health decision-making processes, empowering people, communities, and civil society at all levels, is an example that underlines the significance of endorsing these new and important

role players (World Health Organization, 2024). Consequently, clinical ethics is required to consider interests, commitments, obligations, and rights of an increasing list of potential stakeholders and their complex relationships.

Considering the crucial role of governance in shaping systems for the implementation of ethical standards in the clinical environment and during the clinical encounter at the point of healthcare delivery, and the direction of recent ethics documents provided by WHO, governance has a central place in this document. It is discussed at institutional, national and international levels. Clinical ethics includes a wide range of specific – and often controversial – issues, such as abortion and euthanasia. Different countries will develop their own ethics and legal frameworks with respect to these important issues. Rather than offering substantive guidance on these specific topics, this document focuses on implementation and governance aspects of clinical ethics. Figure 1.1 shows the main target audience of this Guidance.

1.3. Background

The 'clinical relationship' or 'clinical encounter' which endorses a patient-professional direct interaction as the core element, distinguishes clinical ethics from public health ethics or research ethics. While in health-related research the main outcome is usually a contribution to generalizable knowledge to answer questions to promote health of other and future patients, in clinical practice the focus is treating individual patients to improve their health and well-being. Similarly, the distinction between clinical ethics and public health ethics as another domain of contemporary bioethics, is rooted in the individualistic orientation of clinical ethics versus the mostly community-oriented nature of public health ethics. Although it is challenging to define these domains clearly and distinctly, in a broad sense clinical ethics refers to the ethical issues related to providing health services to individual patients by HCPs in various clinical settings.

Such an objective and "face-to-face" approach to clinical ethics does not mean that such clinical relations happen in an isolated atmosphere in clinics or hospitals without being related to a broader

context and higher-level programs, plans, and policies. So, some writers define clinical ethics as a field between patients, HCPs, and health facility administrators (Lanoix, 2009). While, as some writers argue, the desired end of clinical ethics is "to improve the quality of patient care", by addressing ethical challenges (Singer et al., 2001), Fletcher and Brody's description of clinical ethics focuses on this field's concern about the "ethics of clinical practice" and with ethical questions while "caring for the patients" (Fletcher and Brody, 1995). Jonsen, Siegler, and Winslade explain that clinical ethics tries to identify, analyze, and resolve ethical issues around the "care of a particular patient", which are inseparable from the medical aspects of a patient's care (Jonsen et al., 2015).

WHO, based on expert consultation, defines clinical ethics as "a discipline that focuses on addressing value-based questions, challenges and disagreements that arise in patient care".

Box 1.1. WHO definition of clinical ethics

Ethical challenges in clinical encounters occur in a context of cultural, religious and geographic diversity across different tiers of healthcare systems, requiring nuanced communication skills and patient and family engagement. This process of decision-making and reflection, in which the best decision for each patient is sought, is influenced by several contextual factors and is shaped by many stakeholders inside and outside health systems. For example, while patients who need ICU beds have a direct relationship with their attending physicians, the decision of the physician depends on the availability of ICU beds, which in turn is a result of prior investment in health infrastructure, e.g., building and equipping such facilities. Another example is an organ transplantation surgeon whose relationship with patients who need transplantable organs is related to the laws and public policies that regulate organ procurement and allocation in society. Therefore, while deliberating about clinical ethics, it is not possible to limit ourselves to clinical face-to-face settings only where health services are provided for the recipients, but appropriate attention also needs to be paid to thinking about crucial underpinnings and infrastructures at the policymaking levels.

Clinical ethics has been evolving and changing in parallel with the development of medical care and services. Clinical settings have become increasingly complex. Extraordinary progressive development of medical science and related technologies, the right to healthcare, increasing specialization in medicine, dynamically changing disease patterns, global health threats such as global warming, antibiotic resistance, pandemics, global health inequity and infodemics have made medical practice challenging. These changes as well as changes in the socio-political domain have led to the transition from paternalism to patient-centered healthcare in many contexts. Such evolution in healthcare has magnified the importance of clinical ethics (Shamsi-Gooshki et al., 2020).

While other fields of bioethics are more recent, the history of research ethics dates to the 19th and 20th centuries, especially after the Second World War. Public health ethics started in the late 20th century while the history of clinical ethics could potentially be as old as the history of medicine. Concerns about the ethico-legal issues in medical practice can be traced to ancient texts such as the "Code of Hammurabi" from the 18th century B.C. (Laney, 2007). However, the most famous and influential document is the "Hippocratic Oath" of the 5th century B.C (Edelstein, 1943). By 1948, the World Medical Association published the Declaration of Geneva which builds on the principles of the Hippocratic Oath(World Medical Association, 1948).

Box 1.2. Examples of historical document related to clinical ethics

Despite the claims that limit the history of clinical ethics mostly to the second half of the 20th century, when a separate service for providing ethics consultation to health professionals was start-

ed(Siegler, 2019), such an approach does not provide a fairly inclusive picture of a discipline rooted deeply in the history of medicine. This may dismiss the role of historical medical ethics documents and philosophical deliberation in establishing a modern version of medical ethics since the 18th century to date (Veatch, 2000). Early in the 1920s the term "bioethics" was first used and then resurfaced in the 1970s(Frewer, 2000; Muzur and Sass, 2012; Reich, 1994), While some scholars consider the birth of bioethics as a "replacement" for the "old thinking in medical ethics" (Koch, 2014), it seems that using or inventing a new term to cover the expanded field for bioethics was inevitable.

The clinical ethics discourse could be discussed around the concept of relationship since most ethical standards of clinical practice are a set of guiding norms and values that provide the necessary ground to facilitate establishing efficient, respectful, ethical and professional relations among different stakeholders, mainly HCPs on one hand and patients or health care recipients on the other hand. Issues such as confidentiality, respect for patients, their choices, and their privacy are among the most important and widely debated issues of clinical relationships. In such relations, each side has responsibilities, obligations as well as rights that should be respected.

Culture is a generic, dynamic, and complex concept that is informed by multiple and diverse factors. Healthcare delivery in any context requires familiarity with important cultural aspects of the community, which is sometimes known as cultural competency(Erkkilä et al., 2023; Paasche-Orlow, 2004). Usually, those HCPs who have been trained or who have practised in a particular cultural context, are familiar with different aspects of that community culture. However, those HCPs who start working in a new society or community with different cultural indicators, need to familiarise themselves with essential aspects of that culture, especially cultural sensitivities. Situations such as the migration of medical professionals to other countries or areas with different cultural contexts in the same country or mobilisation of HCPs during a health emergency are among situations that should receive special notice in this regard.

1.4. Guidance structure

This guidance, in its first chapter, provides a background for clinical ethics and its evolution to give the audience a better understanding of the context and scope of clinical ethics. Given that all member states may not have formal clinical ethics consultation services, ethics education for health science students and practitioners is a core requirement. However, where possible, clinical ethics consultation and support services at all levels of healthcare provision are encouraged. Such services have three core functions that are elaborated in chapters two to five– capacity development and education, clinical ethics consultation and policy development. In the second chapter, key issues of clinical ethics education, patient engagement and capacity-building are discussed. In the third chapter, the work of clinical ethics consultation services including CECs and clinical ethics consultants will be explored. Chapter four's main theme is policy development and review for clinical ethics in healthcare institutions. Chapter five is more focused on national/state-level governance and policy development for clinical ethics aiming at promoting ethical practice in healthcare delivery. In chapter six, international aspects and possibilities for coordination and co-operation concerning clinical ethics and its governance are discussed. Chapter seven [will be added to this draft version after the public consultation) provides recommendations for various stakeholders, including Ministries of Health in WHO Member States, to guide better governance and implementation of ethical standards

in the clinical environment and point of healthcare delivery. It is hoped that this guideline will be of value to all stakeholders who are committed to improving the quality of healthcare offered to the public. Responding to moral distress of healthcare teams, patients and families by improving access to support and consultation services is an important goal of healthcare provision.

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Chapter 2: Education and strengthening competence in clinical ethics

Clinical ethics is essential to high-quality, patient-centered care. Strengthening competence in this field benefits both professionals and the health system as a whole. This chapter offers practical guidance for organizing ethics education and lifelong learning in clinical settings. It includes recommendations for defining learning objectives, selecting effective teaching methods, and developing scalable training programs suited to various contexts. A special section focuses on the preparation and accreditation of clinical ethicists and CEC members. Real-world examples from around the globe highlight how clinical ethics education can be meaningfully integrated and sustained.

2.1. The importance of teaching and strengthening competence in clinical ethics

Both everyday- and complex ethical challenges can arise in patient treatment and care. How these challenges are addressed impacts the quality of care, patient and family experiences, staff job satisfaction, and trust in the healthcare system. Clinical ethics involves applying and interpreting ethical values and principles, a skill that can be taught and refined throughout a healthcare worker's career. Addressing healthcare ethical issues is not the sole responsibility of clinical ethicists or others with formal education and academic degrees; these challenges affect everyone in the healthcare field, making it essential to provide a strong foundation in ethics education. Building capacity and prioritizing education in clinical ethics is crucial for ensuring that healthcare professionals are equipped with the knowledge, skills, and ethical awareness needed to navigate complex challenges and deliver care that aligns with core values and other contextual factors.

Ethical challenges, such as weighing benefits against potential harm, resolving disagreements, or allocating scarce resources, can cause significant stress and moral distress for health care professionals (Amos and Epstein, 2022a). In many countries, staff recruitment and retention remain persistent issues. High turnover and intention to leave are linked to elevated moral distress and work environments that do not support ethical practice. Investing in context-adjusted and well-structured learning opportunities can better equip students and staff to navigate these challenges, potentially strengthening resilience and well-being in clinical settings (Amos and Epstein, 2022b; Rushton, 2024).

Clinical ethics and its education are interrelated with other professional concerns such as medical law, patient safety, and systems understanding of healthcare. While courses, programs and modules can be explicitly assigned to clinical ethics, the other learning arenas can be more implicit – integrated in other teaching, in practical training, in reflection groups, when ethical support services are involved in solving an ongoing dilemma and in the hidden curriculum when students and staff learn from their role models (Bennett et al., 2004). This makes clinical ethics a complex, yet vital discipline.

Unlike the global and national efforts to standardize the curricula and training in research ethics,

clinical ethics has received comparatively less attention. It often competes with other subjects in crowded curricula, and teaching resources, especially context-specific materials, are often limited. In many countries there is a need for a broader discussion on what should be taught, to explore and implement effective teaching methods, and to understand more about how life-long learning in clinical ethics can be fostered in daily clinical work (Bukusi, 2022). The approach to teaching clinical ethics varies widely across the globe, with differing levels of integration into healthcare education and daily clinical practice(Wong et al., 2022). In some countries, teaching and capacity building in clinical ethics are virtually non-existent, while in others, education programs, continuous training initiatives, and explicit funding and evaluation mechanisms are well established (Okoye et al., 2017; Tavares et al., 2021). A few countries even offer master's or fellowship programs to train clinical ethicists, supported by accreditation systems and dedicated professional roles Fox and (Wasserman, n.d.; Nicoli et al., 2017). Where clinical ethics services are provided, participating in the education of health care professionals is one of the main functions of the services (See chapters 3 &4).

The need for learning and competence in clinical ethics varies according to roles, responsibilities and clinical contexts. While all health care professionals require a foundational understanding, core skills and essential virtues and attitudes, others - depending on their specific roles - will require more advanced, detailed or specialized competencies. These diverse needs call for a stepwise and targeted approach to strengthening clinical ethics education and enhancing ethical competence within the healthcare systems. This chapter outlines educational needs across three levels: undergraduate education, postgraduate training and continuous professional development. Separate sections are dedicated to the training for members in clinical ethics committees, and advanced specialization as clinical ethics consultants and their potential role in education and strengthening ethical competence among health care professionals.

2.2. What should be taught? Learning objectives in clinical ethics

The content of a program or module is shaped by its intended learning outcomes, which specify what students are expected to achieve by the end of the learning process. A stepwise plan for learning objectives and activities is recommended. Courses should be designed with clear, measurable learning outcomes. Learning objectives are used to structure specific topics or activities that contribute to these outcomes. These objectives should be concise, clear, and specific, outlining what students will be able to do after a lesson based on the activities, teaching, and learning that took place. Well-crafted learning objectives should be Specific, Measurable, Achievable, Result-oriented, and Time-bound (SMART), providing students with a clear understanding of their learning goals. The learning objectives in clinical ethics teaching depend on several factors. See Box 2.1 for tips on what to clarify when developing or adjusting learning objectives.

The content and mandate

- Separate course or integrated with other subjects?
- How much time is available for the learning to take place? Including preparation, assignments?
- What resources are available for teaching activities (staff, time and localization)?
- What teaching material could be available (online, textbooks, local cases...)?
- Credited or not credited? Assignments? Exams?
- What is the context where the teaching will take place? Ongoing challenges, culture, religion, resources, local laws, ethical guidelines?

The educators

- Who are the teachers or the facilitators of continuous training, what are their skills and support?
- What can be done to support and ensure that they are prepared and skilled?
- What can be done to ensure a safe space for learning?

The participants

- What are the level participants' clinical experience?
- Do participants have former training in clinical ethics?
- What is the size of the group?
- What is motivation of participants – mandatory or voluntary?
- If session is for a group of healthcare staff: Is the group a mix of professions and specialties or not? What resources do you have in the group?

Box 2.1. Clarifying questions when planning learning objectives for courses or teaching sessions in clinical ethics.

Learning objectives are often categorized into three main areas: Knowledge, Skills, and Attitudes (KSA), as outlined in Bloom's Taxonomy. After completing a learning episode, students should have gained new knowledge, developed skills, or shifted /strengthened attitudes. In the following section, this taxonomy is used to propose learning objectives for clinical ethics education. "Attitudes" here also includes character, virtues and moral integrity. The suggestions below (See Table 2.1) build on discussions among clinical ethics experts, students and staff from different parts of the world. The suggestions are not comprehensive and must be adjusted according to the context, profession, experience of the student, staff and teacher and the resources available.

In addition to the learning objectives presented in Table 2.1, there are special requirements for those who should teach. They should know how to apply validated teaching methods to facilitate learning in clinical ethics. Clinical ethics consultants and in many settings, committee members as well, have special responsibilities for capacity building and supporting healthcare staff, including leading ethical reflections and facilitating discussions (See chapter 3).

The overarching goal for teaching and capacity building in clinical ethics is to have healthcare students, professionals and clinical ethics consultants with attitudes and virtues that enable ethical practice. Therefore, structures, responsibilities and engagement are important in strengthening attitudes through role modelling, etc. from early on to lifetime practical work together. See APPENDIX table 2.2. that demonstrates questions which teachers, leaders, CEC-members and others who are involved in planning and implementation of education can ask to frame the guide their initiative in the wanted direction.

Category	Knowledge	Skills	Moral sensitivity, attitudes and virtues
Ethical challenges	Ethical challenges Understanding the nature of ethical challenges, including how they arise from value conflicts, uncertainty, and contextual complexities in clinical practice. Core themes and examples might include: • • Uncertainty or disagreement about what constitutes the best course of action for the patient(s) • • Determining who should be involved in decision-making and clarifying roles and responsibilities • • Navigating competing values in situations involving: o Withholding or withdrawing life-sustaining treatment o Use of coercion or pressure in patient care o Allocation and priority setting of limited healthcare resources o Managing confidentiality and information-sharing dilemmas o Implementation and ethical use of new technologies o Addressing cultural, religious, or personal values that may influence care o Balancing students' educational needs with patients' dignity, comfort, and consent	Ability to identify ethical challenges in practice, articulate the core issues, and recognize the values at stake. Ability to explore ethical challenges in own practice.	Demonstrates a commitment to addressing ethical challenges with integrity, empathy, and a focus on patient and colleague well-being as well as societal concerns.
Analytic methods	Knowledge of background for, use and evaluation of systematic and structured methods for analyzing ethical challenges.	Ability to conduct ethical analysis, clarifying value trade-offs, propose solutions on general and self-experienced challenges.	Strive for finding and supporting the ethically best solutions in clinical practice.
Theories and concepts	Overview of theories, principles, sources of knowledge, classical cases, and the development of the clinical ethics field, tailored to other learning objectives. Relevant legal regulations and guidelines.	Ability to use knowledge of ethical theories to analyze cases and justify decisions in a structured manner.	Shows openness to the insights offered by diverse ethical frameworks and a willingness to critically reflect on them.

Processes	Knowledge of strategies and frameworks for fair and legitimate decision-making.	Ability to apply procedural frameworks and tools to ensure fair processes.	Values transparency, equity, and inclusivity in decision-making
Reflection and debrief methods	Knowledge of the structure, purpose and benefits of structured ethical reflection in groups.	Ability to participate in (and facilitate) non-judgmental and respectful ethical reflection sessions.	Maintains openness and respect for other viewpoints during ethical dialogues.
Support mechanisms	Knowledge of available resources for ethical guidance and support (like CEC) and ethical guidelines	Ability to identify and engage appropriate support systems for addressing ethical challenges	Demonstrates a proactive attitude toward seeking and providing support when needed.
Communication	Knowledge of effective communication strategies to address ethical issues.	Ability to communicate respectfully with patients, next of kin, colleagues and others, creating safe space for dialogue and decision-making processes	Prioritize empathy, active listening, and the dignity of all stakeholders.
Moral distress and moral resilience	Understand the nature of human reactions of being involved in ethical challenges and the core pillars of moral resilience. Knowledge of the concepts, theories and individual, team and organizational strategies for reducing the negative effects of moral distress and strengthening resilience	Ability to recognize signs of moral distress in oneself and others, apply coping and resilience-building strategies, and engage in constructive dialogue about ethically challenging experiences	Demonstrates self-awareness, emotional insight, and a commitment to personal and collective well-being. Cultivates moral courage, humility, and a supportive attitude toward colleagues facing ethical adversity.

Table 2.1. Suggested overarching learning objectives divided in knowledge, skills and attitudes. The objectives must be tailored to study length, profession, previous experience, roles, time and resources available etc. See box 2.1 for guiding questions for tailoring the learning objectives.

2.3. Who should be taught, and when?

2.3.1. Undergraduate teaching

Ethics education is a fundamental component of healthcare training and should begin early, continuing throughout clinical placements. Integrating ethics into clinical courses enhances learning by linking theoretical understanding with real-life ethical challenges. While dedicated time for ethics in the curriculum is important—not only to ensure foundational competence but also to make students aware of what they must learn to become responsible healthcare professionals—curricula are often dense, and only limited time and credit hours can typically be allocated to explicit ethics courses.

Given these constraints, ethics teaching at the undergraduate level cannot be exhaustive. Clear priorities must therefore be set regarding content and learning outcomes. Where possible, more dia-

logical and reflective formats—such as facilitated group discussions and integrated ethics teaching during clinical rotations—would enrich students' learning. However, such improvements must be balanced with contextual and resource considerations.

Tailored ethics education should reflect the structure of different programs. For example, medical schools with integrated pre-clinical and clinical phases may include patient contact early, implying early skilled based ethics teaching. In other curricula, introductory courses come first and then more integrated teaching when the students are in clinical terms. See boxes 2.2, 2.3 and 2.4 for examples. Shorter programs, like for example for dental assistants, should scale learning objectives and time dedicated to ethics teaching to fit their scope.

Limited teaching resources often necessitate delivering ethics education to large student groups, which may limit opportunities for interaction and reflection. Nevertheless, the use of digital tools and thoughtfully designed assignments can help improve the quality and effectiveness of teaching in these settings.

For guidance on teaching methods at this level, see section 2.4 and illustrations of how they are implemented, see the examples in the boxes.

Medical Ethics and Law I and II (4 ECTS) for Medical Students at Addis Ababa University, Ethiopia.

At Addis Ababa University, School of Medicine, two courses in medical ethics are integrated into the competency-based medical curriculum, which was introduced in 2020.

Course Structure:

3rd Year: Medical Ethics and Law I (32-hours course) and

4th Year: Medical Ethics and Law II (32-hours course)

Course format:

Students are expected to complete preparatory readings accompanied by quizzes and/or assignments during ten thematic sessions which are delivered over ten days by a team of six professors. The curriculum covers the following topics:

- Introduction to Medical Ethics
- Clinical Ethics
- Ethical Theories
- Ethical Communication
- Ethics and Law
- Ethical Challenges in Emergency Medicine
- Ethical Dilemmas in Minors
- Decision Making and the Concept of Autonomy
- Reproductive Health Ethics
- Priority Setting- Bedside Dilemmas.

Assessment: Group written assignment, group presentations, and examinations, including, multiple-choice questions (MCQs).

Comment: the courses are attended by approximately 120-160 students in a large auditorium, with some sessions held in group rooms. Teaching is often delivered by teams of two professors, supported by student representatives.

Box 2.2. Course in medical ethics and law for medical students at Addis Ababa University, Ethiopia (4 ECTs).

Undergraduate Clinical Ethics Education in nursing at UNICAMP (Brazil)

At the State University of Campinas (UNICAMP), ethics is integrated into the nursing program through the course *Professional Practice II*, offered in the fourth year. Ethics and moral reasoning are taught using **Problem-Based Learning (PBL)** in small groups, guided by tutors. Weekly sessions run over one semester (August–November), totally 30 hours.

Themes: Ethics and bioethics, nursing codes of ethics, patient rights, confidentiality, end-of-life care, public policy, and contemporary dilemmas.

Learning Methods: Case-based discussions, group reflections, and Cognitive Assessment Exercises (EACs) where students present on topics such as:

- Ethics and religion
- End-of-life decisions
- Equity and public policy (race, gender, class)
- Climate change and health ethics

Assessment: Based on participation, attendance (≥75%), group presentations, and exams.

Box 2.3 Example of how the explicit curriculum in clinical ethics is organized in undergraduate teaching of nurses in Brazil. The teachers describe to have chosen this model as it encourages active engagement with real-world ethical challenges, fostering critical thinking and professional reflection among future nurses.

Clinical Ethics Curriculum for Medical Students at the University of Bergen, Norway (5 ECTS)

1st Year: Introduction to Clinical Ethics (36-hours course)

Structure: Students complete preparatory readings or videos with an accompanying quiz or assignment before attending six thematic days with

- A 1-hour introductory lecture.
- An "Ethics Conversation" where clinicians, patients, next of kin, and others discuss real-life ethical challenges, serving as a basis for group work and assignments.
- Group work: case discussion and practice on ethical analysis.
- Participation in online discussion forums

Assessment: Written group assignment. Multiple-choice questions (MCQs) in exam.

Comment: 200 students, large auditorium and group rooms available. Two teachers, some assistance by older students/PhD-students in assessments and online facilitation.

Comment: Group of 100 students x 2. One teacher responsible.

Themes for the six days:

- **What is clinical ethics?** Identifying challenges, learn and practice on ethical analysis. Student dilemmas.
- **Where are our limits?** End-of-life challenges, values, culture, ethical theories.
- **Who decides?** Autonomy, decision-making capacity, laws, coercion, decision-making.
- **Who should get?** Priority setting and distributive justice. Procedural concerns.
- **Why is it so challenging?** Reproductive ethics, genetics, uncertainty, religion, virtues.
- **What to do when we disagree?** Procedural justice, moral deliberation, moral distress, clinical ethics support, communication and conflict resolution.

2nd Year: Public health ethics (12- hours course) with assignment and written essay exam

3rd Year: Research ethics (integrated in course on thesis writing)

4th Year: Integrated teaching in OBS/GYN and psychiatry

5th Year: Ethical challenges in clinical practice and organizational ethics

Structure: a) 4 hours of ethics reflection groups. b) course including teaching in resource allocation, ethical leadership and ethical practice

Assignment: Reflection note on a self-experienced ethical challenge.

Comment: Groups of 25 students x 8. Two teachers facilitating the groups and giving feedback on assignment.

6th Year: Advanced Ethics Teaching

Structure: Integrated sessions led by a clinician, legal advisor, and hospital chaplain focusing on practicing on making ethical decisions individually and as part of a team.

Assessment: Clinical ethics questions may be included in the final exam.

Box 2.4. Example of how the explicit curriculum in clinical ethics is organized with 5 ECTS dedicated in a 360 ECTS-curriculum for medical students. One ECTS credit points at 25-30 working hours. Professionalism, communication training and legal regulations are taught elsewhere.

2.3.2 Continuous professional development

Lifelong clinical ethics education is critical for healthcare professionals to address evolving challenges in care delivery. Continuous capacity building enhances knowledge, resilience, and job satisfaction while fostering ethical workplace cultures. Healthcare professionals serve as role models for students and colleagues, playing an indirect yet significant role in teaching and reinforcing ethical principles within their teams. Additionally, HCPs must be equipped to identify, articulate, and communicate systemic ethical challenges to policymakers and other stakeholders, advocating for necessary attention and change to improve healthcare systems. Capacity building in clinical ethics can be part of the quality improvement work in organizations, patient safety or initiative to improve health care services and work satisfaction. Leaders have key roles in initiating, supporting and speaking up for clinical ethics education. Taking part in or having a leading role in clinical ethics education is one of the main objectives for many clinical ethicists or clinical ethics committees.

- **Organize and Lead Educational Sessions**
  - Arrange seminars or lectures on relevant ethical challenges in healthcare.
  - Tailor content to general audiences or specific professional groups based on identified needs.
  - Engage in thorough preparation of seminars/lectures to understand current dilemmas and differing viewpoints among staff.
- **Promote External Learning Opportunities**
  - Share information about relevant conferences, webinars, and seminars organized by external institutions.
  - Monitor free or accessible online resources and disseminate them through internal communication channels.
- **Facilitate Informal Ethical Dialogues**
  - Host recurring events such as "Ethics Cafés," "Ethics Salons," or "Brown Bag Lunches" where staff can discuss everyday ethical questions in a relaxed setting.
  - Encourage open, respectful exchange of perspectives across professions and hierarchies.
- **Develop and Maintain an Online Ethics Resource Hub**
  - Create a webpage or intranet section with curated materials, including guidelines, case examples, videos, and links to relevant sites.
  - Regularly update content to keep it relevant and practical for clinical staff.
- **Engage with Existing Clinical Forums**
  - Attend departmental meetings, clinical rounds, or multidisciplinary forums to answer general ethics-related questions.
  - Use these opportunities to build trust and increase visibility of the CEC.
- **Facilitate Moral Case Deliberation (MCD)**
  - Offer structured case discussions using MCD or similar methodologies to support ethical reflection in complex or uncertain situations.
  - Encourage participation across disciplines to promote shared learning.
- **Be Present and Participate Actively**
  - Join ethics-related seminars or events arranged by others and contribute to discussions to model ethical reasoning and reflection in practice.

Box 2.5. Ways Clinical Ethics Committee (CEC) Members Can Support Ethical Competence Among Healthcare Professionals

Learning opportunities include courses, lectures, and clinical ethics reflection groups. See box 2.5. for ideas for what clinical ethics committees or clinical ethicists can initiate to facilitate continuous professional development among health care professionals. These activities not only improve skills but also contribute to team efficiency and high-quality care. Regular, structured ethics training in clinical settings should be prioritized. Bottom-up initiatives should be encouraged and supported. See example in box 2.6.

In 2005, due to the lack of formal bioethics education programs in Pakistan, clinicians from public and private institutions established the Karachi Bioethics Group (KBG) to address ethical issues in daily practice.

KBG meets bi-monthly, hosted by a different institution each year, and includes clinicians, medical students, residents, nurses, researchers, sociologists, and hospital administrators. From 2011 onwards, several graduates from the Postgraduate Diploma in Biomedical Ethics and Master in Bioethics programs from the Karachi Center of Biomedical Ethics and Culture, SIUT also participate in the discussions.

Meetings focus on morally challenging cases, fostering the ability to navigate conflicting values and develop ethical resolutions tailored to local contexts. Common themes include decision-making conflicts influenced by interdependent and often patriarchal family structures, as well as ethical challenges in delivering tertiary care without public health insurance.
KBG members also contribute to ethics education through workshops and publications. They have authored two handbooks: Institutional Ethical Guidelines for Physician and Pharma Industry Interactions and Understanding Medical Error.

See more here: https://www.karachibioethicsgroup.org

Box 2.6. Example of how healthcare professionals themselves initiated a self-education model of capacity building in clinical ethics in Pakistan.

Several structured ethics support instruments exist—such as Moral Case Deliberation, the Nijmegen Method of Ethical Case Deliberation, and METAP—and are further described in Chapter 3. These approaches have been shown to enhance healthcare professionals' moral competence and reduce moral distress. Regular reflection sessions with colleagues, especially in interprofessional settings, offer important learning opportunities and can serve as safe spaces for sharing ethical challenges—provided they are thoughtfully facilitated (Metselaar et al., 2015). However, one common barrier to implementing such methods is their time intensity and the need for skilled facilitators, which can be difficult to integrate into busy clinical environments.

To address this, a group of researchers in the Netherlands, working with healthcare professionals in palliative care, developed CURA—a simplified, structured method for ethical reflection (Metselaar et al., 2022). CURA is designed to be easily integrated into daily routines and does not require extensive facilitator training.

Engaging in reflective dialogue on moral issues supports moral learning by broadening perspectives and highlighting considerations that may not have been previously recognized. It encourages shared understanding and prepares professionals for future ethical challenges. Learning to express ethical concerns, applying structured reflection methods, listening non-judgmentally, and evaluating decision-making processes are all essential skills for ethical clinical practice (Rushton et al., 2023). See box 2.7 for example.

MEPRA is a six-session experiential program designed to strengthen acute care nurses' ethical competence, mindfulness, and resilience.

The curriculum includes:

- Facilitated discussions
- Role-play and case-based learning
- Guided mindfulness and reflective practices
- High-fidelity simulation training

A longitudinal study with 245 nurses across two academic hospitals assessed outcomes at baseline, post-intervention, and at 3 and 6 months. Key findings:

Sustained improvements in:

- Ethical confidence and moral competence
- Resilience and work engagement
- Mindfulness
- Emotional exhaustion, depression, and anger

Delayed improvements (seen at 3 months):

- Anxiety reduction
- Increased empathy

Temporary gains (not sustained at 6 months):

- Reduced depersonalization
- Lower turnover intentions

Takeaway: Well-designed, experiential ethics education can significantly boost nurses' ethical readiness and well-being—but follow-up and sustained support may be needed to maintain all benefits over time.

See more here: https://www.aacn.org/education/ce-activities/a233233/the-mindful-ethical-practice-and-resilience-academy-sustainability-of-impact

Box 2.7. Mindful Ethical Practice and Resilience Academy (MEPRA) Continuous education program by American Association of Critical-Care Nurses (AACN), USA.

Many experience that conducting training sessions or reflection groups in multi-disciplinary teams is beneficial, also beyond the increased competence in clinical ethics. When tailored to own challenges and needs, educational initiatives can lead to improved and changed practices and increased psychological safety in the teams. See box 2.8 for example.

Deakin Bioethics in Australia has developed a 2-part clinical ethics short course on perioperative care.

The course was designed in collaboration with clinicians involved in perioperative care, starting off with an introduction to ethical decision making, and utilizing case studies and facilitated small group discussions. Participants of this course have included critical care consultants, surgical registrars, perioperative nurses, obstetricians and anaesthesiologists.

Box 2.8. An example of how a targeted short cross professional clinical ethics course can be developed and organized in Australia.

2.3.3. Postgraduate teaching

The integration of clinical ethics education in postgraduate training can take two main forms: a) as a component within broader healthcare programs—such as master's degrees in nursing or clinical specializations and residencies, orb) as stand-alone postgraduate programs focused specifically on ethics, including master's and doctoral degrees in the field.

Integrated in postgraduate programs: Postgraduate ethics training is organized differently worldwide, with responsibilities shared among professional organizations, universities, and healthcare institutions (Deonandan and Khan, 2015). Regular updates and stakeholder collaboration on content and implementation are essential.

Specialization or postgraduate training often serves as a first encounter with clinical ethics in regions where undergraduate teaching is limited. Training at this stage should focus on the ethical challenges specific to a practitioner's specialty, such as end-of-life care in oncology or coercion in mental health.

Undergraduate and postgraduate nursing program, Kyoto University, Japan

- Undergraduate Level:Hours & Themes: Typically covered within nursing ethics or professional ethics courses is approximately 15 hours. Themes may include ethical principles and guidelines, decision-making models, patient autonomy, informed consent, and end-of-life care.
- Learning Activities: Case-based discussions, role-playing, group work, and sometimes simulations (e.g., ethical dilemmas in palliative care).
- Assessment: Written reflections, case analysis assignments, and exams.

Postgraduate & Continuing Education:

- Specialized courses for clinical ethics consultation training and bioethics seminars for nursing professionals.Some institutions offer advanced ethics workshops focusing on shared decision-making, palliative care ethics, and interprofessional collaboration.
- The unique aspect of clinical ethics education in Japan is its emphasis on collective decision-making and family involvement, reflecting cultural values around patient care. Also, integrating spiritual and humanistic perspectives, including discussions on dignity and personhood, is increasingly recognized as essential.

Box 2.9. Example from Japan on undergraduate and postgraduate nursing.

Postgraduate Training in Clinical Ethics for Medical Doctors (Norway)

In Norway, postgraduate medical training for all specialties includes mandatory common learning objectives across ten thematic areas—one of which is clinical ethics. These objectives are structured in a stepwise progression, beginning with general competencies for interns and advancing to more specialized expectations for experienced physicians.

Learning activities may include:

- Participation in ethics courses and lectures
- Case presentations and discussions with colleagues
- Engagement with hospital-based Clinical Ethics Committees (CECs)
- Attendance in supervised reflection groups
- One advanced objective is the ability to lead ethical reflection in interprofessional groups.

The program is regulated by a governmental oversight body, which ensures that physicians meet the learning objectives before advancing. Hospital trusts are responsible for organizing and delivering the required training.

A challenge is that it looks great on paper, but hard to ensure in practice and evaluate.

Box 2.10. Postgraduate Training in Clinical Ethics for Medical Doctors in Norway

Postgraduate programs focused specifically on ethics, including master's and doctoral degrees in the field: Graduate-level education in clinical ethics encompasses a broad range of programs tailored to diverse professional backgrounds—including healthcare providers (such as physicians and nurses), healthcare administrators, and scholars in philosophy, law, and related fields. Some programs integrate ethics modules into master's degrees in clinical specialties or nursing, while others offer dedicated master's or doctoral degrees in clinical or bioethics. This diversity reflects the need to strengthen ethical capacity in alignment with local healthcare needs and professional roles.

The Doctorate in Bioethics (DBe) programme offered at Loyola University Chicago is a professional doctorate by coursework. Students enrolled in this programme can pursue a concentration in clinical bioethics by ensuring they are enrolled in specific modules during their time int he programme. These include modules on clinical ethics simulation, paediatric ethics, etc.

The Interdisciplinary Course in Health Law and Ethics (MPH, LLM, MA and PhD) at Yonsei University Graduate School in Seoul offers both master's and doctoral degrees in medical law and bioethics. Structured as a joint degree program across public health, law, and philosophy, it enables students to explore the perspectives and approaches of each discipline to issues in medical ethics and health law. Traditionally, the program has focused on developing clinical ethics at the policy level and disseminating it across healthcare institutions.

Box 2.11. An example of a postgraduate clinical ethics programme

Such education aims to prepare future leaders who will assume key roles in healthcare institutions, professional bodies, and health policymaking. Graduates may serve as ethics consultants, chairs of clinical ethics committees, advisors to national health authorities, or coordinators of institutional policy development. Their capacity to guide ethical deliberation and influence systems-level decisions is essential to embedding ethical values and practices throughout healthcare systems.

Leadership in clinical ethics requires more than moral commitment; it demands advanced communication skills, conflict mediation abilities, interprofessional coordination, and strategic thinking for policy influence. Graduate programs should therefore include dedicated training in leadership, stakeholder engagement, and systems analysis. These competencies enable clinical ethicists to serve as effective liaisons among healthcare teams, patients and families, administrators, and regulators—facilitating ethically grounded decision-making in complex, value-laden environments.

The curriculum should include in-depth study of ethical theory, legal reasoning, and their application in clinical settings. Students must develop strong skills in ethical analysis, case-based reasoning, and procedural fairness. Through simulation exercises, supervised case consultations, and structured reflection, learners should be equipped to support clinical decision-making, advise on moral dilemmas, and articulate ethically justified options tailored to particular contexts.

Finally, advanced training in clinical ethics should incorporate interdisciplinary research experience. Participation in cross-sectoral studies involving medicine, law, philosophy, and the social sciences helps students develop the integrative thinking needed to address complex ethical issues. Such research fosters skills in ethical reasoning, guidance in shared decision-making, conflict mediation, and a systemic understanding of healthcare institutions. Ultimately, graduate-level education must prepare ethicists not only to resolve ethical dilemmas, but to build ethical cultures within institutions and contribute to policy at local, national, and international levels.

2.3.4. Clinical ethics committee (CEC) members

CEC members come from diverse backgrounds and may not necessarily have completed a specific postgraduate course in ethics. Hence, they require foundational and ongoing education in clinical ethics to remain effective. For those without prior training in clinical ethics, an introduction to the field is essential (Udagawa and Takimoto, 2022). See example in box 2.12. Training should be flexible, accessible and tailored to their roles, balancing efficiency with depth.

In Singapore, every hospital is required to set up a CEC. In order to provide adequate clinical ethics capacity for this, the Centre for Biomedical Ethics at the National University of Singapore organizes an intermediate-level short course called the Essential Topics in Clinical Ethics (ETCE).

The course is primarily aimed at healthcare professionals and CEC members and consists of four units that are conducted using short online video lectures and synchronous facilitated case discussions online via Zoom.

Unit 1. Ethical reasoning, ethical guidance and relationship with professionals

Unit 2: Autonomy, informed consent, truth telling, decision-making capacity and best interests

Unit 3: Shared decision-making, end of life decision-making, advance care planning and nonbeneficial treatment**.**

Unit 4: Health law, defensive medicine and therapeutic innovations.

Box 2.12. Example of a course provided for CEC-members can be developed and organized and what the learning objectives can be in such a course.

As part of a research ethics collaboration, setting up a hospital clinical ethics committee was initiated in Mbeya region in Tanzania. Two workshops were held to train committee members. The training was developed through a collaboration between University of Oslo - Centre for Medical Ethics, University of Dar es Salaam, and Mbeya Zonal Referral Hospital via ETHIMED project (Enhancing Ethics in Medical Research and Clinical Practice). (Kuhumba et al., 2025)

Box 2.13. Example of collaborative initiative to train clinical ethics committee members in Tanzania.

National conferences and cross-institution collaborations can enhance learning and networking for CEC members. See example in box 2.16.

There have been initiatives to increase clinical ethics education in Kenya with the aim of equipping healthcare professionals with knowledge skills and attitudes for handling ethical dilemmas, value conflicts and uncertainties. Due to the lack of a defined infrastructure, the Kenya National Commission for UNESCO (KNATCOM) in collaboration with the Ministry of Health, research ethicists and bioethicists have been at the forefront in championing setting up of CECs.

The efforts began in 2018 with health professionals and hospital quality assurance units being sensitized on the importance and need for CECs. By then there was only one CEC- Aga Khan Hospital which was set up because of the need for hospital accreditation by the Joint Commission.

In the last 5 years, four CECs have been set up and members trained. After the initial training, these committees are responsible for continuous training. To provide guidance on capacity building, a curriculum is being developed.

Box 2.13. Kenyan initiatives to enhance setting up of CECs and capacity building among healthcare professionals and hospital administrators.

2.3.5. Clinical ethicists

Clinical ethicists currently have varying levels of training, but no global standardized pathway for becoming a clinical ethicist exists. Most clinical ethicists will have obtained a postgraduate qualification in bioethics /medical ethics/ clinical ethics that may include a post-graduate certificate, post-graduate diploma, master's or a doctoral level award (Ph.D. or Doctorate). As the field grows, two initiatives are currently underway as part of professionalizing the field of clinical ethics. Firstly, certification programs, like the HEC-C credential in the U.S., offer structured qualifications, requiring continuing education to maintain certification. See box 2.14. Secondly, there are an increasing number of clinical ethics (clinical ethics related) fellowships that are gaining traction- however, the majority of these fellowships remain confined to the USA (Fox and and Wasserman, n.d.; Nicoli et al., 2017)Insubria University in Varese, "Federico II" University in Naples, Lanza Foundation in Padua and the Local Health and Social Care Unit n.7 (ULSS.

The Healthcare Ethics Consultant-Certified (HEC-C) program identifies and assesses a national standard for the professional practice of clinical healthcare ethics consulting. The HCEC Certification Commission which credentials healthcare ethics consultants, is an autonomous body created by the American Society for Bioethics and Humanities (ASBH) for this purpose.

October 8, 2024, the Council on Program Accreditation for Clinical Ethicist Training (COPACET) was officially approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) in the USA. COPACET was set up to develop and manage an accreditation process for education programs, such as Clinical Ethics Fellowships, that prepare trainees for jobs as professional clinical ethicists. With this approval, accreditation standards can be introduced to shape clinical ethics training and education. https://www.caahep.org

One example of such a fellowship is offered at the Cleveland Clinic, providing is a two-year, full-time in-person program designed to prepare graduates to become leaders in clinical ethics.

https://my.clevelandclinic.org/departments/bioethics/fellowships

Box. 2.14. Example of certification program for the professional practice of clinical healthcare ethics consulting in USA.

2.3.6. Teachers in clinical ethics

In many teaching institutions worldwide, those responsible for clinical ethics education often lack formal academic training in the field, such as a master's degree in clinical ethics, and may not work full-time as clinical ethicists. Some are clinicians with expertise in a specific specialty and a personal interest in the ethical issues encountered in their practice. Others may have backgrounds in research ethics or general philosophy but are also tasked with teaching clinical ethics.

Clinicians or educators with limited training in clinical ethics should be provided with guidance, support, and opportunities to enhance their knowledge in the field, along with training in effective teaching strategies. These efforts are crucial for fostering attitudes, virtues, and ethical decision-making skills in students. For clinicians who should take part in teaching clinical ethics, gaining an understanding of basic ethical frameworks is particularly valuable, as it enables them to integrate these principles with their clinical expertise. This foundational knowledge should ideally be acquired before they take on teaching responsibilities in clinical ethics. See box 2.15 and 2.16. for examples.

A 6-week "Training the Teacher" program in medical ethics education was recently established in South Korea to enhance teaching capacity. The program is structured into six thematic weeks: Week 1 focused on Theories, Week 2 on Professionalism, Week 3 on End-of-Life Care and vulnerable groups, Week 4 on Technology and Research, Week 5 on Developing Medical Ethics Curriculum, and Week 6 concluded with a Workshop on learning and teaching medical ethics courses.

Box 2.15. Training the Teacher program in South Korea.

In Ethiopia, the Ministry of Health recognized the previously limited emphasis on clinical ethics within medical curricula and the scarcity of teaching resources necessary to strengthen this area. As the number of medical schools expanded from 10 to 28 to address the critical shortage of medical doctors, the need for trained educators in clinical ethics became increasingly evident. To address this gap, a training-of-trainers (ToT) program was developed and implemented through a collaboration involving Addis Ababa University, the Bergen Centre for Ethics and Priority Setting (Norway), the Ministry of Health, and the Ethiopian Medical Association. The collaboration led to the establishment of the Addis Centre for Ethics and Priority Setting (ACEPS).

Between 2011 and 2019, data were collected to ensure the curriculum was contextually relevant, key individuals were engaged, and teaching strategies and materials were developed. The ToT program was rolled out to participants from 23 medical schools, equipping them with the skills and resources to teach clinical ethics effectively.

The insights and lessons learned from this initiative are detailed here: TOT-ME-Ethiopia

Box 2.16. Example of an initiative to increase clinical ethics and teaching skills among potential teachers and responsible lecturers in clinical ethics in medical schools in Ethiopia(Miljeteig et al., 2017).

2.3.7 International medical education, clinical electives and specialized training abroad

Ethical considerations in international medical education include the moral responsibility of high-income countries (HICs) to support capacity building in low- and middle-income countries (LMICs), as well as the international accreditation of medical education programs. In recent decades, clinical electives in LMICs have become increasingly common for students from HIC universities. These electives are valued for promoting intercultural competence, enhancing understanding of global health systems and tropical diseases, and expanding clinical experience.

However, these benefits come with ethical challenges. Students may perform tasks beyond their competence, risking patient safety (Aldulaimi and McCurry, 2017). Limited understanding of local cultural, socio-economic, and healthcare contexts may hinder effective engagement, damage relationships with local professionals, and again compromise care (Bauer, 2017).

These concerns are well-recognized, and ethical guidance for both students and institutions has been consistently recommended. Various ethical frameworks have emerged in response. More recently, debates have expanded to critique the unidirectional nature of these electives—from HICs to LMICs—within broader discussions on equity in global health education and the decolonization of medical curricula (Garba et al., 2021). See box 2.17 with key ethical principles for international clinical electives.

The same challenges should be discussed when healthcare professionals go on "missions" or similar to train and practice in resource deprived settings.

Key Ethical Principles for International Clinical Electives

To ensure safe, respectful, and equitable experiences, institutions and students should be guided by the following principles:

- Humility – Acknowledge limitations and avoid acting beyond competence
- Cultural Sensitivity – Respect local values, practices, and health systems
- Critical Reflection – Encourage ongoing reflection before, during, and after electives
- Local Embeddedness – Align activities with local needs and guidance
- Equitable Partnerships – Promote mutual benefit and long-term collaboration
- Student Well-being – Prepare and support students for safe, ethical engagement

Aligned with guidance from the WMA and emerging global health education frameworks (World Medical Association, 2016)

Box 2.17. Key ethical principles for international clinical electives.

2.4. How can the teaching be done?

2.4.1. Pedagogical considerations

Teaching clinical ethics requires pedagogical approaches that reflect its complexity, focusing on values, dilemmas, and decision-making processes that often lack clear answers. The goal is not just to impart knowledge but also to build virtues and skills in identifying and addressing ethical challenges individually and in teams. Effective methods should encourage integrity, dialogue, cultural sensitivity, and critical reflection, enabling learners to navigate conflicting values. Active learning strategies, like case discussions, role-playing, and reflection groups, allow learners to practice analyzing complex situations and developing solutions. Articulating values and reasoning while respecting differing viewpoints fosters confidence and ethical competence (Metselaar et al., 2015).

This places specific demands on teachers, who must go beyond delivering knowledge to help students recognize and analyze ethical challenges, fostering virtues like integrity, fairness, and respect. Teachers must create a safe environment where students feel supported in exploring their values, even amidst uncertainty. Teachers unaware of their facilitative role risk acting as moral authorities, undermining the goal of ethics education: encouraging students to explore perspectives and collaboratively find solutions. Instead, teachers should guide discussions and help students critically engage with ethical challenges.

Importantly, educators need not be ethics experts. This is important as in many teaching institutions worldwide where those responsible for clinical ethics education often lack formal academic training in the field, such as a master's degree in clinical ethics, and may not work full-time as clinical ethicists. Online resources, teaching materials such as videos, online lectures, textbooks, and papers, can provide valuable background knowledge and serve as input for discussions. These resources can support both students and teachers by offering diverse perspectives and a foundation for engaging in meaningful and informed dialogue. By creating a safe learning space and embracing their role as facilitators, teachers can effectively support students, even with limited backgrounds in ethics.

2.4.2. Teaching methods and materials

Effective clinical ethics teaching requires a variety of methods and materials, carefully adapted to the needs of the target audience, available time, and contextual resources. While much of the training should be planned, it is equally valuable to seize opportunities for ad hoc learning through re-

sponsive discussions when ethical dilemmas arise in real time.

Box 2.18. shows various approaches in interactive teaching. By combining methods and materials, educators can create a dynamic and adaptable approach to clinical ethics education that resonates with diverse learners and contexts.

Team Based Learning:

- Example: Students working on the consequences of changing the abortion laws, assisted suicide or mandatory vaccination
- Structured group learning format where participants work in teams to solve complex ethical scenarios.
- Fosters collaboration, critical thinking, and shared ethical reasoning in a realistic decision-making context.
- Student-student teaching
- Example: Medical students creating "EthicTok", short videos as learning activities in the theme "Ethical challenges you can experience as a student" (Norway)
- Final year students being responsible for teaching first year students
- Benefits both groups of students and increase engagement in teaching
- Role Play
- Example: Group of staff playing the scenario where a family member asks the medical team to not tell the patient that he has cancer. (Ethiopia)
- Enables participants to explore ethical dilemmas from multiple perspectives.
- Useful for building empathy and practicing communication skills.
- Video-Based Learning, podcasts, films
- Short clips or full scenarios that illustrate ethical challenges.
- Can prompt discussion and reflection on real-life situations.
- Reflection Groups
- Example: CURA (Netherland)
- Small group settings to discuss ethical dilemmas and personal experiences.
- Promotes shared learning and deeper ethical insight.
- Case Discussions
- Example: Group of students discussing ethical challenging cases during their rotation in pediatrics and psychiatry (Zanzibar).
- Analyzing real or hypothetical cases to practice ethical reasoning.
- Particularly effective when cases are relevant to the local context.
- Clinical Rounds or Patient Stories
- Example:
- Using real-time or retrospective patient cases to highlight ethical issues.
- Engages staff directly in applied ethical reflection.

- Reflection Notes
- Written reflections by learners on ethical challenges they've encountered.
- Encourages individual critical thinking and self-awareness.
- Mentoring and Peer Discussions
- Facilitated or informal exchanges with colleagues or mentors.
- Builds ethical competence through shared experience and dialogue.
- Online Tools
- Webinars, online discussions, and e-learning modules.
- Accessible and scalable options for diverse groups.

Other specific methods as Debate- versus- Dialogue techniques, interviews of decision-makers, priority setting games,

Box. 2.18. Examples of interactive teaching methods to encourage skill-based learning in clinical ethics and development of wanted attitudes and behavior.

Compared to research ethics, clinical ethics has fewer standardized teaching materials like manuals and standards like in research ethics. There is a clear need to develop practical resources for educators – especially those with limited formal training in clinical ethics – who often work in demanding environments with large student cohorts and restricted teaching time.

Online Resources

- UNESCO core curriculum: Bioethics core curriculum, section 1: Syllabus Ethics Education Programme - UNESCO Digital Library
- WMA – Medical ethics.
- WHO: Module for teaching medical ethics for undergraduates
- UiB: Introduction to priority setting in health (5ECT, free admission)

Textbooks

- Numerous resources are available, but their relevance varies based on context.
- Textbooks reflect dilemmas, laws, and values specific to that context where it is written. Might not be beneficial in other contexts.

Local and Real Cases

- Using real, contextually relevant cases is essential to enhance engagement and applicability.

Customizable Tools

- Worksheets, structured reflection guides, and ethical analysis frameworks.
- Multimedia Resources
- Videos, podcasts, and articles can complement traditional teaching.
- AI-tools, VR-teaching

Box 2.19. Suggested teaching material.

For more concrete tips and strategies for how to plan curriculum, plan learning sessions etc. see tips in appendix.

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APPENDIX

Will our teaching foster and facilitate:	Attitudes, behavior and virtues
Commitment to ethical practice?	Demonstrates a genuine commitment to integrating ethical principles into daily clinical work and decision-making.
Openness to diverse perspectives?	Values and seeks to understand different cultural, social, and personal viewpoints, recognizing their impact on ethical challenges.
Empathy and compassion?	Approaches ethical issues with empathy, understanding the emotions and needs of patients, families, and colleagues.
Respect for the patient and dignity?	Shows respect for individuals' autonomy and dignity, even in complex or morally ambiguous situations.
Non-judgmental attitude?	Maintains a non-judgmental approach when discussing or reflecting on ethical dilemmas, fostering an open and respectful environment.
Reflection on biases?	Regularly reflects on personal biases and how they may influence ethical decisions, striving for fairness and impartiality.
Commitment to lifelong learning?	Embraces ongoing learning and development in clinical ethics, recognizing its dynamic and evolving nature.
Advocacy for ethical culture?	Actively promotes an ethical culture in the workplace, supporting fair processes and fostering a supportive environment for colleagues.
Strategies to handle moral distress, strengthen moral resilience and ethical practice?	Identifies situations triggering moral distress and uses practical tools such as peer support, ethical reflection, and supervision; takes active steps to maintain moral resilience and uphold ethical standards in challenging clinical settings.

Appendix table 2.2. Inspiration question when planning for or evaluating curriculums or capacity building initiatives in clinical ethics. The list of wanted attitudes is not comprehensive.

Actors	Oversight	Clinical ethics capacity for HCPs	Capacity building	Education
International bodies	- Developing recommendations and disseminating good clinical ethics education policies		-Setting standards for increasing clinical ethics education capacity -Promoting sharing of the resources	-Promoting train-the-trainer programs
Government	- Ensuring ongoing capacity building within the jurisdiction - Establish a national-level clinical ethics education board - Engaging key stakeholders	- Setting standards for clinical ethics capacity among general practicing healthcare professionals	- Identifying and narrowing the gaps - Organizing and support professional bodies in developing clinical ethics materials and curriculum	- Setting nation-wide clinical ethics education standards
Professional bodies	-Collaborating with institutions in capacity building and educating clinical ethics	- Setting clinical ethics capacity standards for the members	- Gathering evidence for the effectiveness of clinical ethics education - Tailoring and updating ethics guidelines	- Providing education sessions for the members and promoting by specifying credits etc. - Developing and refining the learning objectives
Institutions (hospitals, academic institutes)	- Ensuring the clinical ethics being integrated into the curriculum - Appointing dedicated personnel to oversee clinical ethics education - Ensuring alignment with national and institutional learning objectives.	- Engaging all faculty, to emphasize ethical considerations - Developing the mission statement that incorporate the clinical ethics considerations	- Providing training opportunities for clinical ethics educators - Identifying the needs of resources for assessments, exams, group facilitators, group rooms, and other teaching needs.	- Developing and warranting clinical ethics education program for its employees.
Clinical Ethics Committees	- Collaborating with the institutions in developing, providing and evaluating the clinical ethics education	- Developing SOP's that specifies clinical ethics standards and education requirements.	- Collaborating and suggesting real-life cases and scenarios for teaching purposes.	- Offering mentorship and guidance for healthcare professionals and students engaging with clinical ethics issues. - Organizing training and capacity-building initiatives for committee members to ensure their skills remain up-to-date.

Appendix Table 2.3. Clinical Ethics Education Authority Matrix

Chapter 3: Clinical ethics consultation services

Clinical ethics consultation services are an essential and integral component of modern healthcare, particularly when ethical dilemmas arise in patient care. An influential article published in 1993, argued that clinical ethics establishes a "moral" space to address ethical concerns (Walker 1993). Such a consultative space is established by design and structure with the goal of promoting a "deliberative" process. Various methods or approaches have been promoted as the way to establish open and reflective dialogue that is the core of clinical ethics. These services address differences in beliefs or values that often contribute to conflicts, confusion, or disagreements in patient care. The differences are exacerbated by miscommunication and misunderstandings among those involved.

In general, the aim of clinical ethics consultation is not to make decisions for the parties involved, but rather to facilitate clear communication, identify ethical dimensions of the case, clarify values, explore alternatives, and help guide ethically appropriate actions. Moral distress is widely reported as a serious challenge affecting healthcare professionals and healthcare workers. This phenomenon points to the need for mechanisms in which multiple perspectives can be heard and discussed respectfully. Conflicts or disagreements about patient care are emotionally charged. Even among health care teams and with patients/families where respect and trust are solid, emotions influence how the problem is expressed and ultimately handled. Ethics consultation provides a venue in which these feelings can be expressed without fear of reprisal.

Clinical ethics services have a variety of forms. The choice about which functions are provided in a particular organization is typically based on the organization's need and the resources (skills and funding) available. Also, the regulatory or legal context can determine the clinical ethics services that are feasible.

3.1. Clinical ethics consultation structures

There a several structures though which clinical ethics services have been established.

3.1.1. Clinical ethics committee

The ethics committee is a commonly used format in hospitals and other health care organizations. Ethics committees are formal bodies that have specifically delegated authority for their functions including developing ethics policies, as well as providing education and consultation. The ethics committee consists of a diverse professional membership that may include physicians, nurses, social workers, chaplains, and clinical ethicists. Some ethics committees also include community representatives that are not affiliated with the hospital or hospital system and who bring a lay perspective. In the United States and Canada, the primary goal of clinical ethics committees is to promote ethical practices within healthcare organizations. In some countries, clinical ethics committees have additional and potentially conflicting responsibilities such as reviewing research protocols or addressing administrative or disciplinary issues. Although this arrangement is understandable, it is not ideal since the competencies required for clinical ethics are different.

The ethics committee may be convened to discuss current cases or, alternatively, only in exceptional situations, such as when all other efforts have failed to resolve the ethical issues. The entire ethics committee may conduct a retrospective review of cases that have already occurred. Such retrospective review can serve an educational purpose and reveal the need for ethics policy development or refinement. Patient and family notification of and participation in ethics committee meetings varies across systems. As an example, patients in a hospital in Padua, Italy are rarely informed of an ethics committee meeting, whereas they always are at a hospital in Paris (Fournier et al., 2009). The ethics committee meeting is documented in the patient chart at a hospital in Hannover, Germany, and patients have a legal right to access the record. However, at a Paris hospital, a written record is not made available to anyone, and the record of a consultation is retained only by the ethics committee (Fournier et al., 2009). As appropriate to the issue, the patient and/or family should be included. Situations of conflict among health professionals, however, might not involve the patient or family in the process of consultation. Ideally, ethics consultations and recommendations should be documented in the patient chart. Consultation services should establish procedures to record activities and to share information among consultants. Importantly, periodic reviews of such records can suggest quality improvement opportunities for clinical ethics services.

3.1.2. Ethics consultation team

Ethics consultation teams, composed of members of ethics committees or other individuals with specialized training in clinical ethics. These teams are structured to offer timely and effective support in dealing with complex situations. To ensure effectiveness, guidelines for the membership, structure and operation of the ethics consultation team should be established. Training should be defined to ensure that all team members possess the necessary skills and knowledge. Ethics consultation teams have the advantage of greater flexibility than the full ethics committee to respond to requests. This flexibility allows teams to respond swiftly to urgent ethical concerns, often providing immediate support when it is most needed. This agility enables them to adapt to the dynamic nature of clinical environments, ensuring that ethical considerations remain at the forefront of patient care. As such, ethics consultation teams can be helpful in cultivating an ethical culture within healthcare organizations, ultimately enhancing the quality of care and support provided to patients and families.

Periodic oversight by the ethics committee is essential to ensure that ethics consultation teams' activities align with institutional ethical standards and policies. Regular reviews of the team's performance, decisions, and outcomes will help identify patterns, improve practices, and maintain accountability.

3.1.3. Individual clinical ethics consultants

Ethics consultations are also provided by individuals with relevant ethics training and skills. Individuals are granted the privilege of providing ethics consultation services within a healthcare organization, ideally, through a credentialing process. They have relevant training, and they function according to guidelines established by the institution or ethics committee. Like other healthcare consultants, ethics consultants function as independent professionals and are typically more readily available than the full committee or team to respond to requests for help in addressing problems arising in the immediate course of patient care. Individuals who provide such services are trained

to advise about and apply ethical principles, relevant laws or regulations, health profession society ethics guidelines, as well as relevant policies of the institution as appropriate to the individual case situation.

Individual ethics consultants come from a variety of home disciplines or professions, but they all possess core knowledge of healthcare ethics, and they have specialized communication and problem-solving skills. Since only one person is involved in the consultation process, interactions are simplified. An individual ethics consultant can have responsibility for addressing concerns from all components of an institution or health care system or can be focused on one setting. Such "embedded" ethics consultants have a unique interest and specialized competencies appropriate for their practice setting. An ethics consultant embedded in an organ transplantation service, for example, might serve on the organ transplantation selection committee, routinely participate in transplant team rounds, or conduct ethics liaison rounds. As such, they have greater visibility to patients and families.

3.1.4. Remote ethics consultation

The previous models function in person, a fact that makes them inefficient, without modification, for supporting health care providers and patients in remote or disseminated settings. Remote ethics consultation has emerged as a vital resource in healthcare, particularly in the wake of the COVID-19 pandemic, which has driven the adoption of telehealth and virtual communication tools. Remote consultation by video conferencing, phone, or e-mail are ways to avoid the need and cost for travel to remote sites. They make it easier to respond to practitioner needs more quickly than is otherwise possible. Training ethicists in remote engagement techniques, enhancements in virtual communication tools, and ongoing evaluations of ethical consultations practices can strengthen this service, benefiting both healthcare professionals and the patients they serve. Staff resources are required to sustain these types of access as well as other resources. Besides staff with clinical ethics competence, technologically dependent approaches require an infrastructure investment and on-going technical support. Privacy and confidentiality present a complex set of challenges that deserve special attention. Nevertheless, with appropriate infrastructure and support, remote ethics consultation can be an effective way to meet the needs of practitioners in disseminated practice settings.

3.1.5. Implicit and informal clinical ethics

In healthcare settings without structured clinical ethics support services, ethical issues are often addressed in various ways. Implicit ways of dealing with ethical issues in clinical settings arise when participants do not frame the issues explicitly as being ethical or moral in nature, and occur in settings like clinical department meetings, board meetings, management meetings, and informal "hallway" discussions. Existing mechanisms like family conferences or team meetings are also settings in which discussions are framed without specific acknowledgement of the ethical nature of the issues. Informal approaches occur when those involved recognize that ethical issues are under discussion, but there is no structured format or framework for the discussion. Informal approaches can also occur in a variety of settings, including corridor conversations, clinical team meetings, and so on. These implicit and informal modalities differ from formal clinical ethics processes in that they are not typically critical or reflective in nature and do operate in a way that clearly yields principled or ethically justified outcomes. In contrast, formal clinical ethics provides a structure for explicit ethical thinking

and discussion and is increasingly recognized as an essential support for efficient healthcare. It has been noted, however, that informal mechanisms can serve as a social foundation for establishing structured clinical ethics support and clinical ethics programs (Aboud et al., 2018; Kuhumba, 2024; Moodley et al., 2021; Moodley et al., 2020; Nanyonga et al., 2024).

3.2. Clinical ethics competence

A general widely referenced characterization by the American Society for Bioethics and Humanities (ASBH) is the so-called facilitation model. It is geared toward identifying the competencies that are essential for the practice of ethics consultation. As such, it is framed at a meta-level, which means that it sets out the core competencies for doing ethics consultation that are shared among approaches. (American Society for Bioethics and Humanities, 2024) The elements are:

- Identify, clarify, and analyze specific ethical questions, concerns, dilemmas, or conflicts pertinent to the given situation.
- Gather relevant background information by examining medical records and other documents such as professional practice guidelines and policy statements, codes of ethics, books, and journal articles.
- Facilitate discussion with involved parties to gather and clarify information and relevant values, goals, and preferences.
- Introduce and clarify relevant ethical concepts and normative guidance.
- Identify ethically acceptable options and provide an ethically grounded rationale for each option.
- Facilitate mutual understanding of relevant facts, values, and preferences.
- Support ethically appropriate decision-making while respecting differing points of view, values, cultures, religions, and moral commitments of those involved.
- Synthesize the relevant medical and values-based information into an ethical analysis and assessment.
- Make ethical recommendations as appropriate; and,
- Apply mediation or conflict resolution techniques as appropriate.

This characterization is remarkably neutral regarding how to conduct an ethics consultation. Specific methods may augment, highlight, omit, or modify these features, but they provide a useful list of the component competencies that healthcare organizations can use as a guide to vetting individuals to provide clinical ethics and consultation services. Other approaches are more accurately termed methods in that they define processes for actual doing ethics consultation or for providing clinical ethics support services (Agich 2005, 2010).

3.3. Methods of clinical consultation and support

The methods used in clinical ethics consultation share the goals to open discussion and to identify ethically justified responses to ethical questions and to assist participants to gain greater moral clarity, understanding and confidence to address ethical challenges as independent moral agents (Delany C, Feldman S, Kameniar B, et al. 2025). These approaches can be classified as either top-down or bottom-up. In top-down methods, the ethics consultant brings practical expertise to clinical situations of conflict. The hallmark of such approaches is that a cardinal framework guides decision-making, for example, principlism (Beachamp and Childress, 2021), the widely used “four-box”

method (Jonsen, Siegler, Winslade 2019) the CASES approach (Fox et al., 2022), or the Nijmegen method (Steinkamp and Gordijn 2003). In contrast, bottom-up methods focus on the health professional or patient/family's own beliefs and values with the goal of motivating them to address ethical concerns. The orientation of these methods is dialogical. It aims to create space for open discussion of ethical values and beliefs and is driven more by establishing a reflective dialogue among health professionals about ethical matters in healthcare. The actual practice of ethics consultation involves actions and communications that contain elements from various methods. Although formal statements of methods do not necessarily play out in practice of doing ethics consultation, they have a role to play in how services are constructed. For example, conflict resolution, mediation, and values clarification are skill-based methods that are useful in situations in which conflicts or disagreements obstruct communication and decision making.

3.4. Proactive approaches in clinical ethics support

While ethics consultation is paradigmatically a response to conflicts and problems arising in patient care, other approaches are designed to be more proactive or preventative in nature. Ethics liaison rounds and dialogue-based approaches are characterized by collaborative engagement, active listening, reflective practice, and a proactive focus on collaborative decision making. These elements contribute to a more holistic and inclusive method of addressing ethical dilemmas in healthcare settings by building competence. For example, moral case deliberation (MCD) is a structured, dialogue-based approach to ethical decision-making. It focuses on real-life moral dilemmas, engaging professionals in a facilitated discussion to reflect on ethical challenges and develop moral competence. While ethics consultations are often reactive, called upon during specific dilemmas, MCD is more proactive aiming to develop ethical reflection and moral learning over time. Some healthcare institutions use both approaches to provide layered, ongoing ethical support: ethics case consultations for acute issues, and proactive approaches for team development and long -term capacity building. In proactive approaches, there is no pressure to make a decision; it is enough to have reflected, considered, discussed, perhaps clarified or advanced thinking but without any final resolution.

3.5. Specialized Ethics Consultation Services

Depending upon the size and resources of a specific institution or hospital system, specialized ethics consultation services have been established. These differ from embedded consultation services in that the consultant or committee members do not round with a specific medical team. However, they develop specialized expertise in the ethical issues that frequently arise in specific care contexts. A review of the literature suggests that such specialized ethics consultation services occur most frequently in the contexts of paediatrics, psychiatry, and when patients lack both capacity and a surrogate to make care decisions for them, although they have been utilized in other subspecialities as well (Meredyth, Fins, and Melo-Martin, 2022; De Panfilis et al., 2022).

3.5.1. Paediatric ethics consultation services

Unlike ethics consultations involving adults, which ideally consist of a patient or a patient surrogate and a care provider discussing and determining which of the potential care options most closely aligns with the patient's values or best interests, paediatric consultations involve a triad: the parents or guardian, the child, and the care provider. The extent to which the child-patient is provided with

knowledge about their condition and is permitted to participate in these discussions varies with the child's age, level of maturity, parental preference, local custom, and legal framework (Buchanan et al., 2019). And, unlike consultation services provided in the case of adult patients, parents may want and need to consider the impact of their decisions on behalf of the patient-child on that child's siblings, if any.

Accordingly, individuals providing ethics consultation services in paediatrics must have a solid understanding of child development, the scope and limits of parental authority in the context in which they are working, and family dynamics (Buchanan et al., 2019; Lyren and Ford, 2007). The literature that has examined the ethics services provided in the paediatric context has found that the most frequently consulted issues include end-of-life care, the benefit versus the burdens of treatment, and staff moral distress (Weaver, Sharma, and Walter, 2023). The wide range of disciplines often included on committees that specialize in paediatric consultations—a paediatric physician (intensivist, generalist, or surgeon); a nurse; an ethicist; a clergy person; a patient care advocate; a lawyer or hospital administrator; a social worker, psychologist, or child life specialist; and a hospice representative—helps to ensure that the committee as a whole possesses the requisite skills (Lyren and Ford, 2007).

Paediatric ethics committees may also be involved in the development of institutional policy as it pertains to paediatric best practices. Their participation in policymaking enhances the likelihood that the policies developed for adults will not simply be repeated for children and adolescents and that the policies will reflect the ethical standards that apply to paediatric care.

3.5.2. Psychiatric ethics consultation services

Specialized clinical ethics consultation services may be particularly necessary and welcome in the context of psychiatric care because the ethical issues that arise often differ significantly from those arising in the non-psychiatric context (Löbbing et al., 2019). Researchers in Germany found that ethical issues in this context tend to cluster in one of three domains: the relationship between the psychiatrist and the patient; situations involving third parties in addition to the psychiatric provider and the patient; and ethical issues involving additional systems (Haltaufderheide et al., 2021). Issues between the psychiatrist and the patient often involve conflict between the ethical principles of autonomy and beneficence, e.g., whether a patient should be mechanically or pharmaceutically restrained due to a likelihood of self-endangerment, how to address a patient's refusal of treatment (Haltaufderheide et al., 2021; Löbbing et al., 2019). Questions may be raised as to whether a hospital unit should be maintained, even temporarily, as a locked ward in an effort to reduce the likelihood that a particular patient will abscond if it means that other patients in the same unit —the third parties here—are unable to come and go freely. Finally, the reliance of departing patients in an open-door psychiatric unit on emergency medical teams to transport them back to the hospital places additional financial and human resource burdens on the emergency teams and could potentially lead to teams' inability to respond to other, more emergent situations, a situation that raises issues related to distributive justice and access to resources (Haltaufderheide et al., 2021). Researchers in Japan found that the solicitation of ethical consultations in the psychiatric context were most frequent in situations involving conflict with the patient's relatives, questions relating to the treatment of individuals with cognitive impairment, the discontinuation of treatment, and suicide or attempted suicide (Soto and Takimoto, 2023).

3.5.3. Persons without Proxy (PwP) Committees

PwP committees, composed of community representatives that are not connected with the hospital or the hospital system, function together with the ethics consultant or committee and the care team. In essence, they stand in as a surrogate for the patient when the patient lacks capacity to make their own health care decisions and also lacks a family member or other surrogate who can make health care decisions for them. Members may be selected to reflect the community's demographic composition with respect to race, ethnicity, religion, and sex, with the aim of providing a range of perspectives that is reflective of the community. The PwP members rely on the health care team to define the clinical issues and on the ethics consultant or committee to define the ethical issues. The PwP members provide the ethics service and the clinical care team with diverse perspectives regarding the value-laden issues raised in the patient's situation when the patient is unable to make his or her values known and has no one who can communicate their values for them. When the patient's values are not known, PwP members strive to determine which of the medically appropriate and advisable courses of care is in the patient's best interests. In this way, the members essentially serve as the voice of the patient who otherwise may not have a voice (Loue, 2022).

Because individuals who serve on the PwP committee do so voluntarily and are not attached or affiliated with the institution, they are also not beholden to the institution and can provide their opinions without fear that it will affect their positions. Because they are volunteers, they may not be available on short notice. Depending upon the local context, the establishment of a PwP committee may require judicial approval.

3.6. Advantages and disadvantages of common clinical ethics structures

3.6.1. Clinical ethics committee

Advantages: The multidisciplinary composition of ethics committees enables the discussion of ethical dilemmas from various experiences and value perspectives. This diversity of individuals is an important strength of the committee. Because committee members often have different disciplinary training and experiences, their participation not only facilitates an assessment of each case from a variety of disciplinary stances but also brings a range of moral perspectives to their assessment of value-laden issues. As an example, whether care should be escalated for an elderly patient suffering from chronic encephalopathy raises both clinical issues: "is an escalation of care for this patient medically appropriate and advisable and, if so, what form of escalation" and ethical issues: "does the patient want care to be escalated, what are the patient's values if known and, if not, is there an appointed surrogate, what is in the best interests of the patient, and so forth." A diversity of perspectives can be advantageous in navigating such a situation. Ethics committees are best suited to apply ethics policies which they created.

Disadvantages: Although committee consultation can be advantageous, by their very nature, they can be constrained by formal procedures or operational rules. In a committee setting, open discussion may be inhibited by rules of order or processes such as recording minutes and filing reports. Conducting ethics committee consultation in settings away from patient care units can additionally limit the involvement of relevant health professionals as well as patients or families. Additionally, delays associated with scheduling meetings involving multiple participants can impede timely communication and decision-making. Procedural formalities may exist, making it challenging to respond

promptly in urgent situations. In some institutions, access to the ethics committee may be limited by policy, with only certain cases being brought forward for review. This can result in some ethical issues not receiving the attention they deserve.

Participation of a full clinical ethics committee in a consultation with a patient and/or the patient's family may be intimidating, if only because of the number of people involved. Such consultations may also seem to be more formal, and patients and family members may be reluctant to raise issues or openly disclose their ethical commitments, because of the perceived leanings of committee members. Because many or most of the committee members may be clinicians themselves, there may be a tendency to either second guess recommendations of the care team or engage in "group think" rather than engaging in critical reflection with respect to the ethical issues.

3.6.2. Ethics consultation team

Advantages: Ethics consultations provided by a team may be less threatening to patients and their families than a committee consultation, because of the reduced number of participants. Depending on how the teams are constituted, they, like committees, can bring diversity of views. They are typically able to respond to requests for assistance in a timelier fashion and are more flexible in meeting with health professionals, patients, and families at the site of patient care. Because fewer staff members are called upon to participate, team consultation is more cost effective than full committee consultation.

Disadvantages: The small team model also has several drawbacks, however. Like committees, differences in professional perspectives and values within the team may complicate how advice is given and received. However, without the constraint of formal procedural requirements of committees, ethics team members can work at cross purposes. Because fewer individuals are involved in the consultation, there is a smaller range of both disciplinary and moral perspectives brought to the discussion. Coordinating among team members can be time consuming, which may delay decision making in urgent situations. The need for consensus can also complicate and prolong the consultation process.

3.6.3. Individual ethics consultants

Advantages: Ethics consultation by individuals avoids some of the procedural challenges associated with both committees and teams. Individual ethics consultants offer greater flexibility in responding to unique or emergent aspects of a case. Individual ethics consultants may be more easily reached and their participation arranged on short notice, such as through a pager or mobile phone, as compared with either small team members or a full ethics committee. For example, whether working individually or as part of a small team, ethics consultants can more easily meet with patients, their families, and healthcare professionals when needed. In addition, ethics consultants can engage in multiple conversations with involved parties, following a case over several days if necessary. Because a critical component of ethics consultation is a thorough assessment of what is often a dynamic situation, individuals can be more flexible in gaining access to the health care team members involved as well as to patients and their families. Their involvement can be ongoing rather than a one-time event. This allows for follow-up and sequenced input as the clinical picture evolves. Also, individual case consultation by medical specialists and other health professionals is a routine feature of health care and so is less likely to be perceived as an intrusion in the routines of patient care or as a chal-

lenge to professional authority than other mechanisms.

Disadvantages: The knowledge and skills required for individuals to provide ethics consultation are not dispersed among committee or team members, so specialized training is essential to develop the requisite competence. Individual consultants might be less open to fewer perspectives than other mechanisms. Because the ethics consultant is a single individual, there is the risk that an unintentional personal or cultural bias may be injected into the ethical discussions. In some instances, the individual ethics consultant may lack the experience or discipline to fully address multifaceted issues. Additionally, if there is only one individual responsible for consultations in a situation characterized by a high volume of requested consultations, burnout can result from the intensity and frequency of the consultations. (Firn & O'Neil, 2020) Clinician familiarity may lead to "mission creep" or boundary violations whereby the clinician or other care team member may ask the ethics consultant to perform an activity that is outside of the ethics consultant role or, conversely, where the consultant assumes a level of familiarity and offers advice that is beyond the scope of the ethics consultant's role.

3.6.4. Remote ethics consultation

Advantages: One of the primary benefits of remote ethics consultation is increased accessibility. Healthcare professionals and patients can engage with ethics consultants regardless of geographical constraints, making it easier for institutions in rural or underserved areas to obtain ethical guidance. This immediacy is particularly important in urgent situations where timely ethical decision-making is crucial for patient care.

Remote consultations also promote efficiency. With the ability to utilize video conferencing or phone calls, ethics consultation teams can respond more quickly to inquiries. This rapid response capability can help resolve conflicts arising from complex clinical situations, thereby enabling healthcare teams to focus on patient care without prolonged delays. Additionally, remote consultations can facilitate interdisciplinary collaboration by allowing team members from various specialties and locations to participate seamlessly in discussions, enhancing the richness of ethical deliberations.

Furthermore, remote ethics consultations can foster a more open dialogue. The virtual setting may soften hierarchical dynamics, making it easier for frontline staff to voice concerns and engage in discussions about ethical dilemmas. This democratization of the consultation process can lead to more robust input from diverse perspectives, ultimately enriching the ethical decision-making process.

Disadvantages: One significant concern is the potential for communication barriers. Nonverbal cues, which are crucial in ethical discussions, may be diminished in virtual settings. This limitation can lead to misunderstandings, or misinterpretations of key concerns, so it is essential that ethics consultants develop strategies to mitigate these risks, such as encouraging open dialogue and verifying understanding.

Another disadvantage in virtual consultations is presented by issues relating to data security and patient confidentiality. Ethics consultation often involves sensitive information, and maintaining confidentiality is paramount. Organizations must therefore invest in secure platforms and adhere to privacy regulations to protect both patient and institutional data.

Building rapport and trust in remote settings can also be more challenging than in face-to-face in-

teractions. Establishing effective relationships with healthcare teams and patients is essential for a successful consultation, and efforts must be made to foster these connections despite the absence of physical presence. This may require additional time and intentionality on the part of ethics consultants.

3.7. Contextual challenges and impediments to establishing ethics services

Resistance to the clinical ethics services in patient care arises from a cluster of factors. These include the hierarchical structure of institutional healthcare, where open discussion of patient care decisions is not encouraged. Inadequate leadership within health care impeded the development of ethics services. Ethics consultation can be perceived as a challenge to traditional professional authority even though many professional medical societies have embraced it and, like other forms of consultation, it provides recommendations rather than binding decisions.

Access to ethics consultation is a common challenge, because some prefer to ignore problems, and resist involving or supporting the open discussion essential to ethics consultation. In many settings, it is still unsettled whether all members of the health care team and patient/families/surrogates can request help from ethics (Agich and Youngner 1991). Even when that is not a problem, communication "bottlenecks" can occur and procedures for access may be unclear or inadequate. Leadership is required to promote the cooperation of healthcare professionals in the consultative process when they do not see open discussion of value conflicts as their job. Although identifying and addressing oppositional attitudes and behaviors should be a priority for both ethics consultants as well as organization leaders, in the typical way of doing things they might be ignored. In the long run, the perceived lack of support from leaders limits the effectiveness of ethics consultation in improving the overall quality of care.

Historically, forces outside health care prompted the development of clinical ethics. Changes in the law and accreditation standards (JCAHO 1992) envisioned the need for mechanisms within healthcare institutions as the best way to resolve value conflicts, especially over end-of-life care, instead of through the courts. While there are external incentives for health care to embrace clinical ethics, resources to enable ethics support are in short supply. Resource restraints are a chronic and universal problem for health systems. Overcoming the inertia associated with traditional ways of dealing with challenges in patient care is common. However, there is growing recognition that conflicts arise in specialized care units, e.g., critical care units or involving ethically challenging situations such as termination of pregnancy or high-risk clinical interventions, and are emotionally costly, resulting in burnout among healthcare workers. More recently, the COVID-19 pandemic has created massive burnout and moral distress across the spectrum of health care as well as anxiety and stress on families. The prominence of emotionally charged and ethically challenging situations in patient care indicates that there is need for services that help to ameliorate the distress plaguing healthcare systems is pressing.

Attitudes and behaviors on the part of healthcare professionals and healthcare administrators can mirror broad cultural and social attitudes and behaviors that impede open discussion and make critical reflection on beliefs and values difficult. Community authority figures can undermine support for clinical ethics. These factors point to the need for frank discussion among community leaders about

social attitudes and values that promote or impede the best patient care.

There is general agreement about the types of knowledge and skills necessary for effective clinical ethics consultation and clinical ethics support. These include knowledge of practical patient care ethics, law, regulations, and professional guidelines. In addition, knowledge of medical terminology, clinical practice settings, as well as communication and specialized skills such as medical record interpretation, interviewing, mediation or conflict resolution are necessary. However, there is no standard approach for developing the prerequisite competences, which is understandable given the interdisciplinary character of the field (ASBH Clinical Ethics Task Force, 2009). The avenues for education and training are diverse, and include bioethics and health law courses, topical seminars or workshops, clinical health care ethics conferences, mentorships, and fellowship programs, but they may not be readily available in all settings. This is a concern not only for entry into the field of clinical ethics, but for continuing education as well.

In addition, to the knowledge and skills, a specialist in clinical ethics is also expected to act with an open, non-dogmatic, and supportive attitude towards health professionals and patients/families involved. It is essential that the clinical ethics committee, team, or consultant operate in a non-judgmental fashion. These expectations can be difficult to meet in settings in which institutional, cultural, ethnic, religious, or social attitudes allow intolerance and even stigmatize certain groups. Since the fundamental purpose of health care ethics is to provide care for patients as suffering humans, accommodating differences in ways that respect basic human rights though is essential.

The COVID pandemic and the world-wide challenges associated with caring for individuals displaced by war, climate change, or political/economic circumstances have shown that the ethical challenges arising in health care are global and not confined to or constrained by national or regional boundaries. As health professionals are increasingly forced to deal with patients from different ethnic, cultural, or religious backgrounds, systems, value conflicts that impede humane and ethical patient care are inevitable. To deal with these challenges, resources such as education in clinical ethics and training in ethics consultation as well as financial and administrative support should be a priority for health care organizations and systems. Health care organizations and systems must ensure that qualified individuals provide ethics services.

Although clinical ethics services and ethics consultation first developed in hospitals, healthcare delivery exists well beyond the hospital setting to include a wide variety of outpatient and community-based healthcare services. When these fall under the umbrella of a parent organization or as part of a health care system, the opportunity exists for ethics services to be programmed centrally to avoid duplication of effort. National or regional health care systems, for example, are a prime target for the consolidation of education and policy development and for coordination of ethics consultation across settings.

Table 3.1. Features, advantages, and disadvantages of various clinical ethics consultation models

Model	Features	Advantages	Disadvantages
Clinical ethics committee	Provides advice on policy Provides advice on patient cases involving ethical issues Required for accreditation in some jurisdictions Usually professionals from various disciplines May include community members Often use dispute resolution techniques Requires endorsement of institutional leadership to function well May provide advice as needed in the moment May review cases retroactively to assess process and outcome, like a Morbidity and Mortality (M & M) conference	Provides multiple perspectives on value-laden issues Draws on knowledge from multiple disciplines	May be difficult to meet in emergent situations Members may try to second guess decisions of clinical care team Members may be susceptible to "group think" Role confusion between individuals' usual responsibilities and role on ethics committee May be overwhelming to patient and family to meet with entire committee May be viewed as dictatorial
	Involves small number of individuals compared to full committee, but more than individual consultant	May be subset of individuals from full ethics committee Less intimidating to providers, patients, families than full committee More flexibility compared to a full committee model May include ad hoc members as needed	Fewer perspectives available for discussion
Individual ethics consultant	Usually, one person or a unit of several people, each of whom deals with specific types of cases or specific institutional sites Often use dispute resolution techniques Modeled on practice of professional consultation Requires knowledge of bioethics, some clinical knowledge, skill at moral reasoning, ability to build consensus	Facilitates communication in emergent situations May provide input into institutional policy and provide staff education Available to meet on individual as-needed basis with providers, patient, family members	Bias because one perspective Potential for burnout if inadequately staffed in relation to institutional demands "Mission creep" from care team to ethicist or boundary crossing by ethicist may be perceived as challenging physician authority Budgetary issues if paid employee Sustainability issue if ethicists are volunteers Requires greater level of expertise than individuals on committee because no additional input into recommendations

Remote clinical ethics support	**May take any of various forms, e.g., phone, email, listserv, ethicist-committee communication, direct ethicist-patient-family communication**	**Depending on specific approach:** **May be cost efficient** **May improve communication**	**Depending on specific approach:** **May require investment in technology and technical support** **Communication challenges** **Difficulty accessing medical records** **May require advance planning of meetings** **Potential confidentiality issues** **Inadequate exchange of important details due to privacy and confidentiality concerns**
System models	**Train the trainer model** **Local capacity-building** **Circuit riding** **Consolidated accountability**	**Provides satellite hospitals with mechanism for ethics consultation** **Can build local capacity, with level depending on model used**	**Depending on model adopted:** **Time and financial investments vary** **Challenges assessing level of satellite ethicists' competence** **Possible ethicist burnout** **Possible clinician frustration due to multiple demands on ethicist**

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Chapter 4: Clinical ethics policy creation and review at healthcare institutions

Professional healthcare institutions are guided by clear and easy-to-understand policies. Policies may be regarded as rules, guidelines, or articulations of best practices. (Procedures lay out steps to meet, follow, or adhere to policies.) There is no good reason for a hospital anywhere in the world not to have and use policies to guide practice and operations as regards ethical issues and challenges. To have and use ethics policies may be thought of as a component of quality assessment and improvement.

The importance of good policies cannot be overstated: "Hospital policies have the potential to influence the culture and practices of an entire institution, with significant consequences for patients, families and practitioners. Thus, the drive to ensure quality must expand to include all ethics services, including ethics policy review work" (Frolic and Drolet, 2013).

The creation and maintenance of institutional policies is a core component of the mission of clinical ethics services. Such policies serve several purposes:

- They make explicit institutional standards, and they signal how or that such standards cohere with universal or professional standards. Standards are needed to harmonize efforts to ensure clinical effort is in concert with best practices. The creation and revision of policies is also a tool to help clarify those standards and practices.
- Well-crafted policies guide and justify clinical practice. Once a standard has been identified, it is an aberration not to act in parallel with a corresponding policy. Failure to follow a policy is often cited as a sign that something has gone wrong.
- Similarly, in some jurisdictions, adherence to institutional policies is essential for public justification of actions that might be subject to litigation. Failure to follow an institutional policy is often regarded as blameworthy and can be dispositive in case of litigation.

Policy creation is one of what are widely agreed to be the three primary functions of a clinical ethics service, the others being education and case consultation. In successful institutions, these three are related: Challenging cases eliciting consultations might in the future be managed better if clinicians were guided by a good policy; policies and their goals and justifications can inform education and professional development; and such education can improve case consultations. Policy drafting itself raises ethical (Winkler, 2005). In conjunction with the pedagogic mission of the clinical ethics service, policies can stimulate and guide discussion, make clear the values that govern practice, and invite suggestions for improvement. It is for this reason that policies should be reviewed and as needed, revised regularly.

4.1. Establishing a clinical ethics committee

When establishing a Clinical Ethics Committee (CEC) it is important to create as much procedural clarity as possible. Accordingly, the authoritative bodies (e.g. hospital directors) agencies that create CECs should define the Committees' procedures and policies, if possible, before the Committees

are constituted. Each Committee should be assigned a mission statement which outlines its goals. Procedures for the recruitment/invitation of Committee members must be set out. The actual appointment of the chairperson and members must follow regulated, transparent procedures. Criteria for membership should be clear. Thus, if a committee is to represent various constituencies, these should be listed and the number of seats granted to each constituency made explicit. Typically, healthcare professionals (such as physicians, nurses and paramedics), bioethicists, clergy, health lawyers, behavioural scientists, social workers, patient advocates, administrators, laypersons and public officials are among the relevant categories represented. Gender balance and clear policies regarding management of Conflicts of Interests are essential aspects of the work of a committee.

UNESCO's "Bioethics Committees at Work: Procedures and Policies" is a useful guide (UNESCO, 2005). It must also be determined whether the members serve for as long as required by those who appointed them or, instead, for fixed terms. If the terms are not fixed, then it must be determined whether the terms should be staggered or coterminous and how long they should be. Related to this is the matter of removal. It should also be clear in what circumstances a member can be taken off the committee and for which causes (e.g. malfeasance, incompetence, incapacity, failure to be present). At the same time, it should be clearly stated that no one can be expelled from a CEC only because of providing ethical opinions that are against the institution's policies.

It must also be clear how a committee's agenda is to be set. Is the Committee assigned problems by e.g. the Board of Directors of the Hospital? Can it construct its own agenda? Is it dependent on clinicians who bring issues? Can patients or their family members bring cases? Can it pick and choose among these issues, selecting the most salient ones or those it considers ripe for decision? Or must it respond to whatever is asked of it? These considerations may be decisive in determining the nature and importance of the Committee's work.

Even if Committee meetings are private, the question remains as to how they should be conducted. One path would be to follow a particular set of rules of procedure such as those of UNESCO's International Bioethics Committee (see Appendix I). The rules of procedure should be set out clearly, before the game is played so to speak, and they should be familiar to all the participants. Particular issues should be addressed in an orderly fashion and votes would reveal exactly the extent of support and opposition on specific issues. An alternative path would be to proceed informally and seek consensus. Consensus is typically defended as friendlier and easier to follow than a set of formal rules, but sometimes less transparent.

Whatever path is taken, records must be kept in a secure fashion. The question as to who has access to these records and under what circumstances is important. Firstly, this may affect the Committee's deliberations. Fear of exposure may affect discussion and voting. A member willing to take an unpopular position behind closed doors may be dissuaded by the fear that his or her position may shortly be made public. Secondly, there are the twin issues of confidentiality of information and privacy of persons involved. Morally and legally, there are obligations to respect confidentiality and privacy. When CECs do not discuss identifiable individual cases and 'only' contribute to policy-development, meetings or minutes should be made publicly available.

In summary, there are a number of issues that need to be taken into account when establishing sound procedures (see box 4.1).

members. See example in box 2.16.

1. Appoint the chairperson and all the members
2. Appoint members with diverse specialties and expertise creating gender and professional balance
3. Determine the tenure and terms of all appointments
4. Review the Committee's form, i.e. its mandate, purpose, and functions
5. Establish an annual budget
6. Create a policy that identifies who may access the Committee, and whether certain issues must be brought before it for review
7. Establish a policy regarding the presence and participation of others, including patients and families
8. Determine the procedures for documenting, retaining custody of, and accessing the Committee's confidential files and records
9. Establish mechanisms to protect persons' privacy and to maintain and secure their confidential information
10. Review periodically the Committee's mandate and determine if it should be extended to include additional functions
11. Determine if and how the media and the public will be informed of the Committee's activities: advising, recommending or decision-making
12. Establish a bioethics self-education program for present and future chairpersons and members

Box 4.1. Establishing procedures and policies for clinical ethics committees

4.2. Preparing a policy "Census"

It is assumed here that an institution willing thus to commit to the professionalization of an ethics service will also commit resources – money, staff time, and administrative support – to the effort. If one has resources to build and operate a hospital, then one usually has resources to ensure a basic ethics service.

Those conducting such initiatives must themselves be competent or in the process of acquiring competence in clinical ethics.

An institution with no ethics policies might begin with an ethics census during which the following is learned:

- Which and what kinds of clinical cases tend to feature in uncertainty, conflict, or dissent?
- What policies do other institutions have?
- Which new technologies constitute a challenge for clinicians contemplating appropriate use of the technologies?

With that, a short list of essential policies can be generated, and individuals and/or teams can begin to draft ethics policies. An institution that already has ethics policies should consider a similar review or census periodically.

4.3. Drafting ethics policies

Policies should be thorough, transparent, and easy to read (helsedirektoratet, 2009). This can help

ensure relevance and effectiveness. Policies to guide the operation of the ethics service itself are a good place to signal the importance of addressing emerging ethical challenges. For instance, though there are many kinds of ethics policies, one could argue that the need for policies to address the use of Artificial Intelligence is urgent.

Those who draft policies must be familiar with issues and standards in bioethics; any related laws and professional standards; and likely sources of discordance. For instance, a policy on abortion must be applied, or might not be, in light of local or national laws.

Ethics policy documents need to parallel or cohere with other institutional policies regarding structure and format, length, and institutional remit or governance.

It is often appropriate for ethics policies to state prominently what values they seek to serve. For instance, a policy on valid or informed consent for clinical treatment might include statements about the importance of valid consent as a right, and the institution's commitment to protecting that right. Likewise, privacy and confidentiality.

Policy drafters should have knowledge of clinical cases that raise ethical issues. Policies offer support for managing such cases. Failure to address or resolve ethical issues in healthcare settings can lead to moral distress, which may result in prolonged psychological, relational, and professional consequences for healthcare workers (World Health Organization, Public Health England and partners, 2017)

4.4. Policy review

Facilities should establish mechanisms for the ongoing review and updating of policies. This process should be informed by feedback from clinical staff, patients, and other stakeholders, as appropriate. Policies should generally address the role of ethical deliberation, provide guidance for identifying and managing moral distress in healthcare workers, and support the integration of clinical ethics education across all levels of staff. Policies are excellent sources of and levers for interactive education.

Ethics policies should be reviewed annually, biennially, or triennially. Some institutions find it effective to have subcommittees of the full ethics committee undertake an initial review and update before review and approval by the full committee.

Some institutions include in policies citations to the nursing and medical literatures and salient laws or guidance from professional societies; some do not. At the least, those responsible for reviewing ethics policies must have basic familiarity with the applicable literature.

Policy review constitutes an opportunity to identify and include experts not regularly associated with an ethics service. For instance, though an ethics service might include no neurologists or neurosurgeons, any policy on death by neurological criteria (or "brain death"), should be scrutinized by colleagues with adequate expertise.

Good governance of clinical ethics requires engaging all levels of hospital staff, as the credibility and utility of clinical ethics standards depends on the actions of many if not all employees. For example, respecting patients' privacy and confidentiality involves not only physicians and nurses. Other staff members in security, housekeeping, administration and so on also have access to sensitive information through their employment activities or incidental exposure. All employees, no matter their role,

have a duty to safeguard personal health information. They must be educated about such responsibilities. The importance of education and capacity building is addressed in chapter 2.

4.5. Public availability and transparency

There are good reasons for an institution's ethics policies to be freely and publicly available. Such transparency signals core values and might increase and sustain trust in the institution by those who need its services. Policies might be improved by comments from laypeople who are able to review them. Some institutions' websites contain policies (England, n.d.). The Royal Wolverhampton Hospital near Manchester shares 39 detailed policies, several of which address ethical issues, including "Withdrawing or Withholding Clinically Assisted Nutrition and Hydration in Adult Patients Who Lack Capacity to Consent to Treatment" (NHS Trust, n.d.).

It is sometimes suggested that if policies are easily available to the public they will enable, facilitate, or inspire hostile lawyers to find ways to document that an institution has not followed its own guidelines, thus increasing liability. Although it is true that failure to adhere to one's own policies can affect litigation – see Section 4.6 – it is cynical to suggest the solution is to hide policies.

Once it is acknowledged that good policies improve treatment and operations, it is an obligation of institutions to follow their own policies. That is the correct stance: draft good policies and follow them. Hiding policies or making them difficult to find is a stratagem that undermines the goal of good policies in the first place.

In addition, many jurisdictions' public records laws require that tax-supported health care organizations must make all policies freely available.

4.6. Compliance and liability

In many jurisdictions, hospital accrediting and oversight organisations develop standards and require adherence to them if an institution is to enjoy accreditation. Similarly, many WHO Member States have enacted laws governing privacy and confidentiality, valid consent, access to care, and other aspects of hospital operations. Compliance with such standards and laws is generally uncontroversial. Yet the task of ensuring compliance is widely regarded as appropriate for compliance offices –not ethics services.

There are several reasons why ethics services should not have a compliance function. Chief among them is that ethics services and associated committees evolved and function best if they are not viewed as an adjunct to institutional "law enforcement." Furthermore, compliance officers have a fiduciary duty primarily to the institution, whereas ethics services are to serve patients and their caregivers. For this reason, compliance officers, risk managers, and lawyers may be observers to – but ought not serve in a regular or voting capacity on – ethics committees. To allow that role could be to put them in a professional conflict of commitment.

As above, failure to follow institutional policies can affect litigation. For instance, the California Hospital Association provides a case study in which an institution failed to follow its own policy:

An example of a hospital P&P [policy and procedure] that went awry, and resulted in a lawsuit and hospital liability, was an emergency department P&P that required every patient to be evaluated by a "triage nurse" and seen by an "emergency physician" prior to discharge. A particular patient [who]

subsequently died was seen by a physician, but he was not a specialist in emergency medicine. The court determined that the hospital was negligent because it didn't follow its own policy and was therefore liable for the patient's injuries. The lesson here is to choose the words carefully. This hospital may have avoided liability by indicating each patient would be triaged by a "qualified health care professional" and evaluated by a "licensed and credentialed member of the medical staff" (California Hospital Association, 2020).

The lesson, of course, is that if we are to take policies seriously, we must be aware of them and act as they prescribe. This can be a significant institutional challenge – there are, after all, many and sometimes complex policies in modern hospitals and clinics. The only credible and professional stance is to have good policies and adhere to them.

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Chapter 5: National/state-level policy making and governance for clinical ethics

5.1. Supervening clinical ethics standards

Clinical ethics primarily focuses on the ethical aspects of providing healthcare to individual patients by HCWs. However, these clinical relationships occur within a complex, multi-stakeholder environment, involving diverse responsibilities and interests. Policies that influence clinical ethics could originate from inside the healthcare facilities and institutions or could be from a higher-level authority for example from local or national health authorities. In any case, policies and governance arrangements at the macro (national) and meso (institutional) levels significantly influence the ethical aspects of interactions within clinical encounters at the micro (individual) level. Therefore, improving the moral atmosphere for medical practice at the point of delivery of healthcare services in healthcare facilities such as hospitals or community health centers requires effective policymaking and planning at higher levels.

In recent decades, bioethicists have worked to establish ethical standards at various levels of specificity to address the increasingly complex healthcare system. For example, general clinical ethics standards—such as the requirement for healthcare workers to obtain valid informed consent from patients or their surrogate decision-makers—can be further specified for particular cases or areas to provide more action-guiding direction. This is especially relevant in situations where, for instance, parents refuse to consent to a life-saving treatment for their child. While some well-established ethical norms, like the obligation to respect patient confidentiality, are often reinforced through criminal law, others may be upheld through different legal mechanisms, including regulations, administrative law, or even soft law instruments such as professional guidelines.

The development of binding clinical ethics standards with an acceptable level of specificity is a crucial step toward ensuring adherence to ethical values in clinical practice. For example, in countries where various assisted reproductive services are offered, clear laws, regulations, and policies are needed to address ethically complex issues—such as the right of resulting children to know their genetic parents, and the commercialization of gametes and surrogacy services. Such regulatory clarity helps create a clinical environment in which both service recipients and providers can collaborate without experiencing moral distress. A more sophisticated legal and regulatory framework can also clarify the rights of healthcare workers (HCWs), including the right to conscientiously object to certain legally permitted practices. Similarly, ethical end-of-life decision-making requires a transparent legal context. Evidence shows that an insufficient or vague legal framework—particularly in the absence of clear policies on Do-Not-Resuscitate (DNR) orders—can lead to ethically problematic practices such as “slow codes.” These practices not only impose significant moral distress on HCWs but also risk eroding public trust in the healthcare system(Chung and Zhong, 2025).

Despite the significance of having a well-developed system of medical law to support efficient clinical ethics decision-making, laws and regulations alone are often insufficient. In real-world clinical practice, more complex cases arise that require context-specific interpretation. Clinical ethics ser-

vices in healthcare facilities play a vital role in interpreting relevant laws and regulations within the particular circumstances of each case to determine the ethically appropriate course of action. Even when the morally preferable choice is evident, healthcare workers may face moral hazards that discourage them from acting accordingly—such as conflicts of interest, whether financial or non-financial, or practicing defensively due to fear of litigation. For example, empirical evidence demonstrates that physicians' fear of legal litigation, as well as unclear legal requirements regarding the necessity of obtaining informed consent, is one of the major reasons contributing to delays in administering tissue plasminogen activator (tPA) to patients presenting with acute ischemic stroke(Comer et al., 2019). This example illustrates that even laws and regulations intended to promote ethical medical practice can create challenges if they are not well-aligned with the broader policy context and clinical realities. It highlights the importance of thoughtful, context-sensitive policymaking and utilizing of effective governance tools and implementation strategies in clinical ethics.

Policymaking, governance and implementation, and are complex constructs that are closely linked to the concepts of stewardship and leadership, which take place within a specific socio-political environment(Barbazza and Tello, 2014). There are two main implications for good governance related to clinical ethics. The first implication illustrates that good governance of healthcare systems requires giving enough attention to a set of substantive ethical values such as equity, well-being and respect, as well as procedural values like transparency, accountability, inclusion and participation. The second and more specific implication requires the availability of necessary elements such as laws, regulations, and guidelines, as well as educational and institutional infrastructures to specify and balance relevant ethical standards in specific situations. Additionally, efficient implementation mechanisms, including monitoring, oversight, and accreditation tools, are essential.

The healthcare system in each country is part of its broader social services and is influenced by political, economic, and cultural factors. Consequently, the governance of the health system, including its clinical ethics dimension, is shaped by the country's overall governance structure. Key factors such as the role of social services versus the free market, societal values, literacy rates, dominant and competing belief systems, corruption levels, health financing models, and economic conditions significantly impact the health system. Therefore, the clinical ethics governance of a specific context cannot be analyzed in isolation from these high-level factors.

Whilst it is possible to consider more specific levels for the governance of the health system, this chapter focuses on the national/state level. We acknowledge that sub-levels may exist within each. For example, in many countries, mediating bodies, such as provincial or city health authorities, operate between central or federal government agencies e.g., ministries of health on the one hand and healthcare institutions on the other hand. To avoid unnecessary complexity and repetition, this guidance treats all authorities above the health institution level as supervening policies.

Maintaining ethical standards in clinical practice is a shared responsibility among healthcare providers, institutions, regulatory bodies, and society at large. Only through collective effort, vigilance, and effective monitoring can we ensure that healthcare remains true to its fundamental ethical principles. As we progress, there is a need to build ample ethical awareness, person-centric approaches, and integration of moral values in the delivery of clinical services, follow-up, and eventual translation for the public good.

5.2. High-level policymaking for clinical ethics

High-level health authorities and regulators e.g., those at the national level, primarily ministries of health or national healthcare professional licensing organizations in many courtiers, play a critical role in ensuring that specified ethical standards are available and efficiently practiced within the country's healthcare system. These standards provide general guidance for various situations encountered by stakeholders in clinical practice and should be verified and legally accepted. Ethical standards for clinical practice can be embedded at different levels of the national legal and regulatory framework. For instance, fundamental issues like confidentiality and informed consent may be upheld by federal laws, or statutes. Additionally, patients' rights and healthcare workers' moral obligations in specific clinical situations can be supported or enforced through mechanisms other than laws, such as professional organizations or associations.

Entities other than ministries of health and governments, such as professional organizations, may establish ethical standards for their members, with varying enforceability, and specificity. High-level health authorities should adopt a systematic approach to clinical ethics to ensure that these diverse bodies setting moral norms for the health system are well-coordinated. This approach would help ensure that the standards remain updated, are effectively tailored to meet the evolving needs of the medical sector, and that the general messages of various guiding documents are coherent and consistent. Achieving an acceptable level of coordination could typically be achieved by strategic planning such as development of a national plans for promoting ethics in clinical settings. Such a plan should outline specific goals, strategies, programs, and activities necessary to advance clinical ethics effectively (Parsapour et al., 2021).

The dynamic and rapidly evolving landscape of technological developments in health necessitates the establishment of resilient and adaptive ethical standards. For instance, the increased use of information technologies in healthcare—such as electronic medical records and telehealth platforms, which gained widespread adoption during the COVID-19 pandemic—underscores this need. Furthermore, the growing integration of artificial intelligence, including smart listening and documentation tools for medical consultations, as well as AI-powered diagnostic and therapeutic systems, illustrates the complexity and novelty of the ethical challenges involved. Recent advancements in genetic and biotechnologies, moving toward increasingly individualized medicine and many other technological developments call for responsive and forward-looking ethical frameworks capable of addressing emerging and multifaceted issues in a timely and robust manner.

The need for clear and efficient clinical ethics standards is not limited to addressing new technological advancements or health emergencies; the evolving nature of clinical healthcare frequently requires the development of new, context-specific moral norms and ethical guidelines for routine medical practice. For example, in a country initiating an organ transplantation program based on donation after cardiac death (DCD), it becomes essential to introduce new ethical guidelines to ensure clarity, transparency, and public trust. Similarly, even in countries where DCD is already practiced, the adoption of new techniques—such as thoracic normothermic regional perfusion (TA-NRP) for in-situ organ preservation—necessitates updated ethical frameworks to address emerging concerns (Wall et al., 2022). Health authorities and governing bodies should establish mechanisms to continuously monitor sources of moral challenges, questions, and distress among diverse stakeholders—including

healthcare workers, health facility administrators, policymakers, patients, and their families. These mechanisms should enable timely responses through the provision of general or context-specific guidance, updates to clinical protocols, revisions of ethical guidelines, or amendments to relevant regulations and laws. Moreover, since ethical challenges often arise beyond the scope of existing frameworks, health governance systems must ensure that structures are in place to address specific ethical questions in clinical settings, supporting prompt and effective ethical decision-making—as elaborated in Chapter 3 of this guidance.

The systematic promotion of clinical ethics at the national level requires multiple interdependent pillars: policymaking, standard-setting, strategic planning, implementation, evaluation, monitoring, oversight, feedback mechanisms, education, and advocacy. Operating such a system necessitates both infrastructure and adequate resources. A key step is the establishment of responsible national bodies specifically mandated to coordinate and realize these pillars. Many countries have already created national ethics committees, bioethics committees (Köhler et al., 2020), and, in some cases, specialized bodies dedicated to clinical medical ethics are established in both HICs ("The Swedish National Council on Medical Ethics," n.d.) and LMICs (Soleimani et al., 2024). However, their roles, procedures, standard operating protocols (SOPs), and actual impact can vary significantly across different contexts. While questions remain regarding the tangible influence of these bodies on clinical ethics discourse, their establishment appears to be a necessary and strategic move. Therefore, countries should consider investing in these high-level structures and ensure that they function in alignment with the principles of ethical governance (Moodley et al., 2021). Such national bodies could play either an advisory role—providing guidance to law-making or regulatory bodies such as national or state parliaments—or be granted a regulatory function that allows them to develop and approve binding guidelines.

Setting ethical standards for a country requires considering procedural ethical values (Moon et al., 2022). Therefore, national policymaking and [clinical] ethics bodies must be highly transparent. Transparency requires that the composition of bodies responsible for deciding or approving clinical ethics guidelines at the national or regional level be publicly disclosed. Another key implication of transparency is that the public should be informed about the underlying reasons, moral justifications, and any empirical evidence that guided the decision-making process. For example, if a national clinical ethics body advises the government to shift from an opt-in to an opt-out organ donation system—on the grounds that it may increase the availability of transplantable organs—then, in addition to citing relevant ethical values such as autonomy, the committee should also review and present any available empirical evidence supporting the assumption that such a policy change would lead to an increase in donations.

Transparency in this context is essential, as it lays the foundation for accountability by ensuring that all relevant parties remain answerable for the ethical and empirical bases of their recommendations. Accountability is another crucial procedural value, as it helps clarify the responsibilities of various players in clinical ethics governance. In high-stakes situations, such as allocating ICU beds or transplantable organs, accountability ensures decisions align with ethical standards and are not influenced by inappropriate interests.

Inclusion and participation are essential principles that require the engagement of diverse stakehold-

ers in the development of ethical standards and guidance. Maintaining public trust in the healthcare system is difficult—if not impossible—without ensuring meaningful participation of those most affected, especially the public. While involving NGOs is an important mechanism, it is crucial to ensure that these organizations genuinely represent the interests of affected communities. Moreover, the public and other key stakeholders should have adequate representation within NGOs and broader civil society organizations. Therefore, national health authorities should actively promote and encourage the institutionalization of groups such as patient advocacy organizations and medical professional associations to enable meaningful inclusion and participation. In parallel, public education—leveraging both mass and social media—can play a key role in raising awareness and fostering engagement by increasing literacy on basic health rights.

While vertical relationships between national clinical ethics policymakers and lower levels, such as institutional ones, are crucial, fostering horizontal relationships among active individuals and institutions, such as clinical ethics committees, is equally important. Establishing overarching mechanisms, such as a national network, platform, or association, could enhance communication, facilitate experience sharing, and promote collaboration across the clinical ethics landscape. Higher-level bodies, such as national clinical ethics committees, can play a critical role in establishing the relationships and platforms necessary to facilitate the formation of such networks.

National bodies can intervene by developing regulations, policies, and governing tools in areas such as managing conflicts of interest in healthcare, establishing accreditation and licensing mechanisms for example for clinical ethics consultation services, ensuring quality clinical ethics education, and ensuring sufficient clarity in laws dealing with medical liability systems. They can also provide ethics guidance on the use of AI tools, include ethical evaluation in health technology assessments (HTA), ensure the availability of patients' rights charters, and create clear ethics policies on end-of-life decision-making, including forgoing life-sustaining treatments, DNR orders, advance directives, voluntary assisted dying, and surrogate decision-making standards. Additionally, clear positions should be established on the role of families in clinical decision-making, priority setting and allocation of scarce resources, the rights and duties of healthcare workers, including the scope of conscientious objections for individuals and organizations and reporting child and elderly abuse.

5.3. Monitoring and oversight of clinical ethics

Clinical practice operates within a complex ecosystem where patient outcomes rely not only on the skills of individual healthcare providers but also on multiple interconnected factors, including infrastructure, facilities, staff, protocols, and procedures. These elements are further strengthened by robust systems of monitoring, oversight, and accreditation to ensure high-quality care and patient safety. While the ethical dimensions of healthcare interactions remain profound—encompassing ethical values and principles, it is the systematic implementation of oversight mechanisms that ensures these standards are consistently upheld. A monitoring and oversight mechanism helps with putting in place the right checks and balances in order to ensure better quality of the services that are provided to the patients. Monitoring and Oversight is an integral component of any clinical research involving human participants. Monitoring and oversight of ethics in clinical practice are carried out through various mechanisms that operate at different levels in the medical institutions such as appointed advisory boards or committees which are involved in reviewing hospital policies to

ensure that they are aligned with ethical standards and compliance with the regulations.

The relationship between healthcare providers and patients fundamentally relies on trust, which is reinforced through transparent oversight mechanisms. When patients know that healthcare facilities are subject to rigorous monitoring and must maintain strict accreditation standards, it enhances their confidence in the care they receive. Similarly, healthcare providers benefit from clear guidelines and standards that help them navigate complex ethical situations while ensuring their practice remains within accepted professional norms.

Monitoring and oversight are terms that are often used interchangeably. In general, they mean the same where monitoring usually refers to reviewing progress made from time to time keeping an eye and observing promptly or seeking reports and making suggestions for improvement. Close oversight may help in reviewing and identifying inconsistencies or inaccuracies that require correction. Since the margin of difference is not clear, the terms will be considered together in this document.

The significance of oversight extends far beyond individual patient encounters. Regulatory bodies and professional organizations establish and enforce standards of practice, creating accountability mechanisms that span the entire healthcare delivery system. These oversight structures help identify and address potential ethical breaches before they escalate into serious violations, from ensuring proper informed consent procedures to monitoring adherence to treatment protocols. It is important to have in place a structure and framework for guiding ethical care is provided to the patients in clinical practice. Box. 5.1. provides examples of regulatory instruments to establish and enforce standards of practice.

Acts, Rules and Regulations: There may be direct laws that govern the ethical conduct of clinical practice and therefore the clinician must be well versed with the laws of the land. Box 5.2 provides an example of a law in a HIC which mandates establishment of clinical ethics committees and services in certain hospitals(lovdata, 2021).

Inspections: There are due diligence processes in place conducted by regulatory authorities in order to ensure compliance with laws related to patient care in medical institutions. In case of any complaints or at random, they plan inspections to evaluate functioning, infrastructure and routine practices or to investigate for any malpractice, or allegations. They are also free to decide about needful restrictions and to take disciplinary actions as required to maintain the safety and rights of patients.

Audits: Regular audits and reviews of clinical practice are crucial tools in monitoring compliance with ethical standards. Audits examine whether clinical procedures are being conducted in line with ethical and legal guidelines and regulations, focusing on areas such as patient consent, data privacy, and equitable treatment. These reviews are not only useful for identifying ethical lapses but also for enhancing clinical practices through feedback and corrective actions.

Accreditation: Accreditation is one of the more sophisticated approaches that can be implemented as part of a multi-layered strategy to improve healthcare quality. It is usually carried out by external validation bodies that conduct regular assessments to ensure healthcare facilities meet predefined quality benchmarks. These accrediting bodies typically operate independently, though often with government recognition and support. Their assessments are based on a set of established standards, which can—and often do—include ethical considerations alongside clinical and operational criteria. There is a need to encourage harmonized accreditation initiatives at subnational, national, and international levels to establish clear and consistent ethical practices, while also respecting local values and cultural contexts. Box 5.3. provides an example of a hospital accreditation system that enforces establishment clinical ethics committees in a LMIC.

Box. 5.1. Examples of regulatory instruments to establish and enforce ethical standards in healthcare practice

In Norway, §2-4a of the Specialist Health Services Act requires all health trusts to establish a Clinical Ethics Committee (CEC), with other healthcare institutions also permitted to do so. These committees are tasked with supporting healthcare personnel in identifying and addressing ethical challenges in patient care and resource allocation. Upon request from healthcare professionals, patients, or—if aligned with the patient's wishes—their next of kin, the CEC must provide ethical advice on individual cases. The committees must be multidisciplinary, include a user representative, and ideally have expertise in medical ethics and health law. They are mandated to function independently and autonomously.

Box. 5.2. Overview of the Norwegian Law on Clinical Ethics Committees

Iran's Hospital Accreditation Program (HAP) was launched in 2010 as a government-mandated and publicly funded initiative. The development and revision of hospital accreditation standards are overseen by the Office for Healthcare Institutions' Accreditation within the Ministry of Health. In the fifth edition of the accreditation standards (2022), one of the three core pillars is the protection of patients' rights. The program requires all hospitals to explicitly inform healthcare recipients of their rights and mandates the display of the Iranian Patients' Rights Charter in all hospital wards, ensuring that patients and their families can easily access and understand it. Key components under this domain include informed consent, the right to file complaints, confidentiality and privacy, and the active role of clinical ethics committees in policy-making. The establishment of a Clinical Ethics Committee in every hospital is deemed essential for accreditation and is listed as one of the ten mandatory committees. These committees are expected to lead the planning and oversight of efforts to uphold patients' rights, helping to embed ethical standards into hospital governance and clinical practice(Moosavi et al., 2022) .

Box. 5.3. The status of clinical ethics in Iran hospital accreditation program

The oversight of ethical issues in clinical settings presents a range of complex challenges due to the nuanced nature of these situations. While robust oversight systems are essential, they face significant challenges that must be carefully navigated through. The interdisciplinary nature of clinical care complicates oversight, as ethical decision-making often requires input from multiple fields—such as medicine, nursing, social work, and law—each with its own ethical frameworks and priorities. Reconciling these diverse perspectives can be challenging.

Socio-economic, cultural, and religious considerations also play a significant role in the cotemporary diverse societies where different beliefs and value differences must be respected, adding further complexity to the oversight process. Healthcare ethics is not a one-size-fits-all proposition, with different cultural contexts having varying interpretations of what exactly constitutes ethical care, particularly in areas such as end-of-life decisions. Oversight bodies must be sensitive to these differences and socio-cultural contexts, poverty and other such considerations while still maintaining universal ethical principles that ensure quality care for all patients.

Evolving ethical standards, driven by advances in medical technology and shifting societal values, also make it difficult to maintain consistent oversight, as what was deemed ethical practice a decade ago may now be viewed differently. Emerging technologies pose novel ethical dilemmas that are often beyond the scope of traditional oversight mechanisms. The advent of artificial intelligence, big data analytics, and telemedicine, for instance, brings new ethical questions about data privacy, consent, and the potential dehumanization of care. These areas require updated ethical guidelines and oversight strategies to ensure that technology is used ethically in clinical practice.

Resource constraints pose another significant challenge to effective oversight. Many healthcare institutions, especially in resource-limited settings, may lack the necessary personnel or funding to implement comprehensive ethical oversight mechanisms. This can lead to underreporting of ethical violations or inadequate follow-up on ethical concerns, potentially compromising patient care quality. The capacity to undertake monitoring and oversight is limited in medical institutions. Setting up a robust framework would require adequate manpower, resources, training, cooperation, and coordination between stakeholders.

Monitoring and oversight can cause tension since in general no one would like to be observed and told what to do. This may restrict their freedom of choice and decision-making in clinical practice. There is difficulty in quantifying the quality of ethical decision-making adds to the challenge. Unlike clinical outcomes or financial metrics, there are no clear metrics for assessing ethical decisions, making it harder to develop standardized systems for monitoring and oversight.

Conflicts of interest also complicate ethical oversight. Healthcare providers and institutions may face situations where financial or other personal interests come into play, potentially influencing clinical decisions. Effective monitoring systems must be capable of identifying and managing these conflicts to avoid compromising patient care.

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Chapter 6: Global cooperation and coordination

6.1. Introduction

Clinical care traverses a multitude of areas and dimensions of life and community; this means that clinical ethics is intersectional and present in different levels - from very singular aspects of an encounter to global and international exchanges and arrangements. These 'upstream' arrangements may influence the way moral dilemmas appear in real life, clinical, situations. In this chapter we would like to highlight aspects of global cooperation and coordination in light of clinical care and the ethics it must involve and consider. There is considerable evidence that coordination and cooperation are also present and relevant at the international level among a range of stakeholders, including international professional organizations, patient organizations or bodies within the UN network.

Global bioethics standards have become a focal point in areas such as global public health ethics and global research ethics, particularly in response to challenges like pandemics and international research projects. Consequently, international organizations such as the WHO have been actively developing standards for research and public health that incorporate global perspectives.

The international/global understanding of clinical ethics, and consequently the development of international ethical instruments in this field, lags behind other areas such as research ethics and public health ethics. However, the global exchange of resources and information has also impacted clinical practice. Clinical care might rely on organ transplantation and exogenous biological components such as blood and tissues; this is an area circumscribed in significant and complex ethical issues. The ethical issues regarding the reliance on human tissues, blood, organs in clinical care get an added layer of complexity when borders are crossed. Moreover, the care of people who have migrated, work or study transiently in different places, or have been displaced should raise attention over ethical implications of clinical care in these situations. These developments can have ethical implications in clinical care on the global level with varied significance and impact.

During the 20th century, the provision of healthcare services gradually became a primary responsibility of individual states toward their citizens. As a result, issues such as equitable access to healthcare and universal health coverage are often addressed at the national level, even as concepts, like minimalist or maximalist cosmopolitan strategies and global health justice theories that try to expand moral responsibilities beyond the political geographic borders and try to provide ethical frameworks for equitable access to healthcare services at the global level, gain traction.

Broader policy frameworks that discuss ethical implications on the global level can aid and impact the delivery of care. In the previous chapter, this guidance explored how national, or state-level policies shape the implementation of ethical standards within clinical environments. This chapter will discuss potential avenues for international or global governance, cooperation, and coordination that can impact the ethical delivery of healthcare at the local level.

A range of governance tools can be employed to support the global governance of clinical ethics. These include communication platforms that link national bodies, such as national ethics, bioethics,

or CECs; strategies like international accreditation or oversight mechanisms; and the development and adoption of international standards, such as declarations, guidelines, treaties, and conventions. These tools aim to strengthen the implementation of ethical standards in clinical practice (World Health Organization, 2021a).

While this guidance provides examples of such tools in clinical ethics, it is worth noting that similar strategies have been developed and applied in other areas with some success, such as research ethics. For instance, the WHO's Global Benchmarking Tool (GBT) for evaluating national regulatory systems for medical products(World Health Organization, 2021b) demonstrates how international tools can improve global practices. In the domain of research ethics, the WHO's tool for benchmarking the oversight of health-related research involving human participants is another example of a global instrument designed to enhance ethics governance (World Health Organization, 2023).

Global health governance involves diverse organizations that can also be seen as key stakeholders in clinical ethics. United Nations agencies like WHO, UNESCO, and UNICEF and professional organizations such as the World Medical Association (WMA) and the International Council of Nurses (ICN), academic institutions and intellectual associations, international patient organizations and even private sector entities, including Artificial Intelligence (AI) and Information Technology (IT) companies, contribute to the global dialogue and actions impacting ethical dimensions. For example, the World Federation for Medical Education (WFME), as an international medical education organization which is in relation to national medical education accreditation bodies, could play a pivotal role. It could for instance advocate for the inclusion of clinical ethics content in medical education curricula ensuring that future healthcare professionals are equipped with the ethical competencies necessary to navigate complex dilemmas in clinical practice, promoting consistent and high-quality ethics education. This should be done in a way that considers and is mindful of the diversity and singularities around the globe. Organizations such as the ones just mentioned act as bridges among states by fostering collaboration and harmonizing efforts to address global and local ethical challenges.

Clinical ethics, as an applied branch of bioethics, has gradually evolved at different rates across various contexts. Despite its context dependency, the experiences of any one country can provide valuable insights to others, enhancing understanding of how multifaceted clinical ethics can be. While such information can be found in academic literature, it must be acknowledged that an epistemic imbalance in academic outputs is a prevailing reality. Hence, the importance of enabling and facilitating the construction of means for exchange and dialogue among diverse groups globally.

Epistemic injustice is evident by the underrepresentation of ethical perspectives from LMICs (low- and middle-income countries) and non-Western intellectual traditions. Addressing this imbalance is challenging due to infrastructural and fundamental socioeconomic factors, such as insufficient resources, the legacy of colonization, language barriers, and other structural oppressions. Nevertheless, collective action by various stakeholders can be important in preventing the reproduction and perpetuation of such injustice. For example, funding agencies in HICs (high income countries), international journals and publishers could create more opportunities and specific spaces to share diverse perspectives and facilitate the exchange of experiences. Encouraging publishers and journals to focus on these contexts can foster a deeper understanding of their challenges and promote a global dialogue on clinical ethics issues that better represents global diversity and singularities.

Verifying specific needs of diverse contexts so that targeted support can be developed together with the local authorities to build technical capacities in clinical ethics could be a pivotal step toward enhancing the global exchange of clinical ethics parameters and promoting its development worldwide.

6.2. Examples of areas for global cooperation and governance

6.2.1. Organ transplantation

The globalization of organ transplantation is driven by the international movement of both potential donors and recipients, as well as the cross-border transfer of transplantable organs. The legitimate transboundary transfer of transplantable organs has been practiced for decades. However, the illegal transfer of organs and organ trafficking has also been a persistent challenge in the field of organ transplantation. Legal frameworks governing organ transplantation vary significantly across countries. For example, in many nations, the purchase of organs is strictly prohibited by law and is practically impossible. In contrast, in some countries, paid organ transplantation occurs, whether legally or illegally. Furthermore, organ transplantation has significant human rights implications, particularly when it involves policies related to the use of organs from executed individuals in countries where the death penalty is legal.

Organ transplantation is one of the areas where "medical tourists" travel to other countries seeking treatment. It is also among the first areas of clinical ethics that WHO identified as a global concern (World Health Organization, 2021a). Transplantation tourism raises significant ethical concerns that require global oversight and governance. These include its impacts on the healthcare systems of both departure and destination countries, unequal access to post-operative care, the risk of exploitation, and the perpetuation of colonizing North-South dynamics.

Additionally, the growing population of migrants, including refugees, presents further challenges. Migrants are often marginalized within organ transplantation systems, which are typically designed to prioritize citizens. This can lead to insufficient attention to inter-nationality transplantation, resulting in the exclusion of migrants as organ recipients or donors. Without clear protective measures, there is also a heightened risk of exploiting migrant populations as organ donors. Addressing these issues requires ethical frameworks that ensure equitable and protective practices for all populations involved in organ transplantation, potentially through collaboration with other related organizations such as the UNHCR or the International Organization for Migration (IOM).

Transitioning from national or state-based organ donor pools to global or international-regional pools could offer a promising solution to the global organ shortage by increasing the possibility of HLA match, international paired donation and North-South exchanges in case of living related kidney transplantation(Minerva et al., 2019). This approach is now more feasible than ever, given advancements in the rapid and safe transfer of organs facilitated by increased access to air travel. However, this shift also raises environmental concerns, particularly regarding the carbon footprint associated with frequent air transport.

Developing international platforms and tools to establish an equitable and ethically justified global environment for organ transplantation requires the creation of legal and regulatory infrastructures that participating countries can agree upon. This includes the development of coherent and com-

patible regulations to address key ethical challenges such as organ trafficking, informed consent, criteria for organ allocation and prioritization, and agreements on definitions for compensation, incentivization, and commercialization, as well as criteria for death determination to uphold the "dead-donor rule."

There are few international tools available for organ transplantation governance. However, their specificity, binding capacity, potential for adoption, and level of implementation across various countries remain unclear. The Australia-New Zealand paired kidney program and the European network for kidney transplantation serve as case examples of bilateral and multilateral instruments. Probably the most well-known non-binding international document in this area is the Declaration of Istanbul on Organ Trafficking and Transplant Tourism, which was initially developed in 2008 and updated in 2019(Martin et al., 2019). In addition, the World Medical Association (WMA) has also played an important role in this context by adopting the "WMA Statement on Organ and Tissue Transplantation" in 2012 (updated in 2017) and the "Statement on Measures for the Prevention and Fight Against Transplant-Related Crimes" in 2020.

Given the significant human rights implications of organ transplantation, the United Nations General Assembly adopted Resolution 77/236 in 2022, which focuses on strengthening and promoting effective measures and international cooperation on organ donation and transplantation to prevent and combat trafficking in persons for the purpose of organ removal and trafficking in human organs.

Similarly, WHO and the World Health Assembly have adopted several resolutions to address these issues. These include WHA 40.13 (1987) on "Development of guiding principles for human organ transplants," WHA 42.5 (1989) on "Preventing the purchase and sale of human organs," WHA 44.25 (1991), WHA 57.18 (2004), and WHA 63.22 (2010) on "Human organ and tissue transplantation," as well as the Madrid Resolution on organ donation and transplantation (2011). For instance, WHA 57.18 calls on Member States to "establish effective national oversight of the procurement, processing, and transplantation of human cells, tissues, and organs, ensuring accountability and traceability of human material used for transplantation."

A more recent intervention occurred in May 2024, when WHO's Member States approved a new resolution on increasing the availability, ethical access, and oversight of the transplantation of human cells, tissues, and organs. The resolution urges WHO Member States "to establish, where appropriate, official international cooperation for the exchange of human cells, tissues and organs for transplant services, based on the principles of reciprocity and solidarity, as a means to facilitate universal access to transplantation therapies"; and encourages equitable, altruistic, voluntary and non-remunerated organ transplantation. The resolution highlights the global governance role of WHO by requesting the Director-General "to assist Member States, upon request, to strengthen their regulatory capacity to effectively oversee donation and transplantation practices".

A practical example of HIC-HIC pairing is the Trans-Tasman Australian and New Zealand Paired Kidney Exchange (ANZKX) program, which was established in 2019.A The program operates by matching donor-recipient pairs across HICs and LMICs. For instance, a recipient in a HIC who cannot find a compatible donor within their own country but has a willing donor, such as a partner with an incompatible blood type, could exchange a kidney. Simultaneously, this exchange enables a pair from an LMIC to receive a transplant along with the necessary post-operative care, which they would otherwise be unable to afford. In HICs, the primary obstacle to kidney transplantation is the shortage of organs from both living and deceased donors. In many LMICs, however, the major barrier is the inability to afford the procedure, particularly the cost of post-operative immunosuppressant drugs. While LMIC-LMIC or HIC-HIC pairings can be beneficial in finding compatible donors, LMIC-HIC pairings may offer more complementary advantages.

Box. 6.1. A proposal for expanding Paired Kidney Transplantation

6.2.2. Health emergencies in large populations

Large-scale health emergencies occur when a significant portion of the population faces a notable threat to their health. These emergencies can arise from various causes, including armed conflicts, natural disasters such as floods and earthquakes, or outbreaks of infectious diseases. Epidemics and pandemics, such as the COVID-19 pandemic, are among the most frequent examples of such emergencies. The COVID-19 pandemic highlighted the critical importance of international cooperation and governance in managing clinical responses, particularly when dealing with a newly emerging disease characterized by high levels of uncertainty. While public health responses are essential, effective international clinical responses also require coordination and governance.

International clinical ethics responses are a vital component of this coordination. For example, mechanisms to allocate scarce therapeutic and diagnostic tools, as well as personal protective equipment, have to be established. Neighbouring countries, in particular, may be called upon to assist each other by sharing resources such as ICU beds, ventilators, and oxygen tanks. International mechanisms, such as WHO guidelines, play a critical role in supporting these efforts. Some existing WHO guidelines, such as those for the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI)(World Health Organization, 2025a), include clinical ethics components. However, the development of more specific guidelines addressing micro-level clinical ethics issues could further assist countries in enhancing their pandemic responses.

In addition, ethical challenges at national, institutional, and micro levels—such as the off-label use of medicinal products, allocation of ICU facilities, and balancing healthcare workers' duty of care with their risk of harm—could be better addressed through international mechanisms for cooperation and governance on ethical issues. The issue of professional licensing also warrants attention in such situations. When the mobilization of healthcare professionals across borders is essential to support an impacted country, the availability of international mechanisms to recognize and accept medical licenses from other countries becomes crucial.

"Emergency use of unproven clinical interventions outside clinical trials – including "off-label" interventions – has surged during the COVID-19 pandemic, with unjustified, unconstrained use of unproven interventions, which raises serious ethical concerns. This document is intended to provide a reminder and an updated version of the ethical framework for emergency use of unproven clinical interventions outside clinical trials, the MEURI ethical framework, which is a collaborative project of WHO that began in 2014 and a normative product of WHO for its Member States".

Box. 6.2. WHO Guidelines for the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI)

6.2.3. Medical travel

Medical travel, also known as medical tourism, is an inherently international phenomenon with significant ethical implications, requiring international cooperation and governance to ensure its ethical practice. Medical travel "occurs when an individual travels from their home jurisdiction (for example, their country of residence) to another jurisdiction to access therapeutic interventions" (World Health Organization, 2019). The expanding medical travel market encompasses far more than organ transplantation. Increasingly, individuals travel abroad for various medical services, including assisted reproductive technologies, cosmetic procedures, and elective surgeries. Traditionally, such travel involved patients from HICs or affluent individuals from developing nations seeking care in HICs. However, a notable shift is occurring: a growing trend of health services being exported in the opposite direction, with some LMICs becoming primary destinations. While access to advanced, high-quality care remains a major driver of medical travel, other motivations include avoiding long waiting times, pursuing treatments that are legally or culturally restricted in one's home country—such as third-party gamete donation, commercial surrogacy, or voluntary assisted dying—and accessing investigational medical products not yet approved or available locally.

Despite other ethical concerns—such as the potential impact on public trust in the healthcare system of destination countries, challenges in obtaining informed consent, cultural competency requirements for healthcare workers (HCWs) in the destination country, issues with post-intervention care and follow-up, and questions of accountability and medical liability—the primary ethical issues surrounding medical tourism are related to equity. Empirical evidence highlights numerous ways in which medical tourism can restrict access to healthcare in destination countries. These include creating gaps in essential healthcare fields by diverting HCWs to areas that cater to medical travellers rather than local populations, a phenomenon known as "field migration." This shift can negatively affect the job satisfaction and technical competencies of HCWs. Additionally, medical travel often leads to resource shortages and longer waiting times for local patients, along with the possibility of discrimination against less advantaged individuals. Public health systems and primary healthcare can be weakened by redirecting investments toward expensive tertiary care facilities. This trend toward privatization can elevate healthcare costs, making services less accessible to local populations. It can also disrupt the geographical distribution of HCWs within countries, causing imbalances through "internal migration," and it may exacerbate vulnerabilities and illegal practices, such as organ trafficking.

Medical travel also presents ethical and legal challenges for patients' home countries. WMA issued a statement on the ethical aspects of medical tourism in 2018, which addresses some related ethical issues. Patients may return with altered expectations, which could strain local healthcare systems. Legal ambiguities surrounding medical errors, compensation, and litigation for treatments performed abroad add further complexity. Moreover, individuals who undergo procedures prohibited in their home countries, such as paid organ donation or commercial surrogacy, may face legal risks upon their return. Patient safety is another concern, particularly when patients seek unregulated or investigational treatments, such as stem-cell therapies, which may not be approved by their home country's regulatory agencies. These concerns underscore the need for comprehensive governance and ethical frameworks to address the multifaceted implications of medical tourism.

A range of regulatory and governance solutions could help mitigate the risks associated with med-

ical travel. These include establishing global equitable buying guidelines to ensure fair access to healthcare resources, implementing international standards and accreditation tools for monitoring and surveillance of medical travel activities, and adopting clear mechanisms for health data sharing between departure and destination countries. Medical travel destinations could consider imposing a medical tourism tax to support local healthcare systems. Additionally, regulatory frameworks could be designed to channel the expanded healthcare capacity in LMICs—resulting from increased private investment—into addressing pre-existing areas of shortage. Finally, the regulation and standardization of medical travel brokerage services could enhance transparency, fairness, and patient safety in this growing sector (Chen and Flood, 2013).

Australians often travel to countries with less restrictive regulations for commercial surrogacy due to strict domestic laws, which allow only altruistic surrogacy. A notable example of ethical and legal concerns resulting of this practice is the 2014 Baby Gammy case, where an Australian couple entered into a commercial surrogacy arrangement in Thailand. The surrogate mother gave birth to twins—one healthy baby girl and a boy, Gammy, who had Down syndrome. The couple took the healthy child back to Australia but left Gammy behind with the surrogate mother, which raised contentious ethical challenges about selective parenting based on disability, the exploitation of vulnerable women, and the rights of the child, especially concerning his future and access to his genetic history. Legal complications arose as Thailand's surrogacy laws were unclear and not well-enforced, and the Australian couple faced widespread criticism for abandoning Gammy. The case ultimately led to changes in Thailand's surrogacy laws, including a ban on foreign commercial surrogacy arrangements, highlighting the urgent need for clearer and more ethical regulation of international surrogacy.

Box. 6.3. Commercial international surrogacy: The case of Baby Gammy

In Thailand, salaries of medical doctors in private hospitals are reportedly between six and eleven times greater than what are offered by public institutions. Only from one hospital in Bangkok's 70 medical specialists, between 2005 and 2010, migrated to private hospitals that serve foreign patients. Medical practitioners who have moved from the public to the private sector tend to be those with the most experience.

Box.6.4. Internal migration of HCWs as a consequence of medical tourism: experience of Thailand (Wibulpolprasert and Pachanee, 2008)

6.3. Mechanisms for global coordination and governance

WHO has an important role in recognizing the plurality of ethical issues in clinical care that can arise in any context. The international coordination of ethical guidance for the clinical context must consider cases in relation to their contexts, building sensitivity to include different knowledge systems, understandings and practices. Ethical deliberation and action include the task of identifying the individual and the collective, with recognition of multiple and varied intersections and how interdependencies interact with what is being deliberated. The reciprocal coexistence of the individual and the collective must be at the center of the deliberations, without the negation of one or the other (Butler, 2022). Therefore, the recommendation for international coordination for clinical ethics guidance is centered in understanding, respecting and protecting the individual, without invalidating or jeopardizing the relations with the collective. It can be argued that deliberations and actions that are not centered on the singularity of the individual collective have the potential to threaten both. It is also possible that such actions may not effectively or ethically address the issues that impact health decisions. This is due to the inseparable relation between the two.

The impacts of clinical ethics reach beyond the domain of medicine. Consequently, a contextualized understanding of this matter should be reflected in how networks and guidelines are constructed and coordinated on an international scale. It is important that the health center and the medical authorities are not perceived nor created as isolated, hierarchical entities engaged in deliberations and decision-making processes, but rather collective forms. It is necessary to involve a diverse range of societal categories in order to address the relations and impacts associated with clinical ethics.

To achieve effective international coordination of clinical ethics, it is necessary to implement a contextualized approach that facilitates the co-creation of non-linear, non-hierarchical flows and the exchange of information. Contextualization encompasses the expansion and de facto inclusion of all sorts of healthcare workers and other categories involved in care. Any form of colonization in international relations related to clinical ethics consultation should be avoided. Instead, the guidance should advocate for respecting singularities and contextual nuances and fostering equitable partnerships based on respecting a people's history, so that complementary, non-universalizing relations that welcomes alterity/otherness can be created and maintained (Segato, 2021).

It is essential that representatives of a diverse range of healthcare workers, along with relevant community members, such as educators, representatives of community-led associations and patient advocacy groups, social workers, physical therapists, and psychologists be part of the processes and deliberations regarding clinical ethics. The contextualization of clinical ethics discussions would entail providing support, based on the community's assessment of necessity, in the formation of local and regional working groups for issues deemed most pertinent to them at a given time. The creation of non-linear, non-hierarchical flows and exchanges of information would facilitate the rapid and pertinent dissemination of information, thereby enabling the development of guidelines that are context-specific and responsive to the needs of those most affected by the clinical practice.

The World Health Organization can initiate the development of innovative programs based on principles for international coordination of clinical ethics, beginning with its central and regional chapters. To develop a more just, effective, timely and appropriate approach to preparing and responding to the emerging and reemerging clinical ethics issues, it is fundamental to build on local resources, technologies, and knowledge. WHO could also stimulate the creation of partnerships between CECs in different parts of the world. This could include the possibility of tele-consultations, leveraging platforms for cross-border collaboration and knowledge exchange. In spite of the contextualized approach that we favor it is also fair to say that there are a lot of commonalities in the way dilemmas appear in the delivery of health care.

Universal health coverage (UHC) is an essential target set as a Sustainable Development (SGDs). WHO's commitment to UHC was reaffirmed in 2019 and global analysis of the COVID-19 pandemic further substantiates WHO recommendation towards UHC with a reorientation towards primary health care (PHC) approach as a foundation and a mechanism to achieve it (World Health Organization, 2025b). Clinical ethics international coordination and governance should follow along UHC the pathways and frameworks. This is an important mechanism for integration of clinical ethics in multilevel, interdependent and interlinked health systems, locally, regionally and internationally. This can aid and support the progress towards UHC and create pathways for local, regional and international exchanges in clinical ethics that is inherently linked to the context and emerge from people's need.

The foundational documents that should inform the development of new treaties, binding and non-binding documents and guidelines include the Human Rights Declaration, the World Medical Association (WMA) International Code of Medical Ethics, the WMA Declaration of Geneva, the World Health Organization Constitution, the International Health Regulations (2005) (IRH) and its new amendments and other related internationally binding declarations involving member states. Country specific regulations and protocols could serve as inspiration for other countries.

It is important to see that most of the output generated by these fora for reflection are not legally binding. Declarations, recommendations, guides and resolutions are non-binding documents, and thus, cannot be enforced by court of law. What they do produce, however, are propositions about what can count as a reasonable way forward, or a reasonable response to dilemmas in the clinical encounter. Indirectly, these documents may be very influential, as per the commitment of being a member state. Governments can integrate them into existing laws or use them to create national laws. National professional organizations may use them to write guidelines on which judges (perhaps in disciplinary cases) may base their rulings. These documents are an important instrument to foment the different functions of the state to guarantee health and ethical care.

The International Alliance of Patient Organizations for example has created, with the International Council of Nurses (ICN), International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), International Pharmaceutical Federation (FIP), and the World Medical Association (WMA) a Consensus Framework for Ethical Collaboration to support partnerships that will aim to deliver greater patient benefits and support high-quality patient care. Within the bodies the UN network, we can point at UNESCO, specifically UNESCO's International Bioethics Committee (IBC) and the Global Ethics Observatory (GEObs) UNESCO has developed several key documents to guide the establishment and operation of ethics committees and build a database of global bioethics issues that is freely accessible. These resources can be used to collaborate with local and regional representations. The Universal Declaration on Bioethics and Human Rights (2005) advocates for the creation of independent, multidisciplinary, and pluralistic ethics committees at various levels to advise policymakers and encourage public debate on bioethical issues. The Assisting Bioethics Committees (ABC) Project provides practical guidance for setting up and strengthening ethics committees, particularly in countries with limited resources. Additionally, the International Bioethics Committee (IBC), comprising 36 independent experts, monitors progress in life sciences to ensure respect for human dignity and freedom. These resources collectively support the development of effective ethics committees worldwide.

As noted, several international institutions, organizations and networks that deal with issues related to clinical care, ethics and bioethics exist and can be part of a collateral/multilateral system of information exchange and collaboration. Attention must be also directed towards reframing how relations are constructed allowing for a resocialization of the understanding of "who becomes sick and why, and of who has access to health care and why" (Farmer, 2004), being aware of the complexity and history of the coloniality of power. Reframing how international organs interact with local realities is an important step towards building a future relationship that allows for co-creation, collaboration and more equitable exchange. International governance and cooperation of clinical ethics should build upon the co-creation and achievement of multilateral agreements.

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