Debate

Clinical ethics revisited: responses

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Editorial note

This series of responses was commissioned to accompany the article by Singer *et al*, which can be found at [http://www.biomedcentral.com/1472-6939/2/1] . If you would like to comment on the article by Singer *et al* or any of the responses, please email us on editorial@biomedcentral.com.

Promoting national and international justice through bioethics
Let's highlight current weaknesses to facilitate progress

Solomon R Benatar

Singer *et al* [1] note that despite progress in clinical ethics: (i) most medical schools lack adequate role modelling by a sustainable community of clinicians focussed on the ethical concerns of patients and their families; (ii) mechanisms for encouraging and monitoring institutional ethics are inadequate, (iii) improved patient care and outcomes do not seem to have resulted; and (iv) the doctor patient relationship has deteriorated . While the achievements mentioned by Singer *et al* should be praised, the weaknesses noted by the authors should be highlighted to facilitate further progress.

Surprisingly no explanation is offered for these serious shortcomings. Several possibilities are evident to those who both admire and are critical of North American medicine and bioethics. First, the growth of bioethics has taken place in an era when medicine, particularly in the USA, has been transformed into a business, and health care has been commodified and bureaucratised [2, 3, 4, 5]. Second, there has been loss of trust in health care professionals and their work has been devalued [6, 7]. Third, bioethicists may have become co-opted into the change, and critical attitudes to the commercialisation of health have been muted [8, 9, 10]. Fourth, the excessive focus on autonomy in highly individualistic and self-centred societies has deflected attention away from the important principle of justice in health care and from considerations of social justice in general [11]. Fifth, medical research, increasingly driven by commercial interests, has become more exploitative [12]. Finally these, and other serious deficiencies eloquently described by Rene

Fox [13], are also being replicated under the guise of 'development' in economically deprived countries.

What can be done? First, the legitimacy of the USA's heavily market-oriented health care system, which accounts for 50% of total annual global health care expenditure on 5% of the world's population and yet excludes many of its citizens (while claiming to be a standard to which others should aspire), needs to be questioned and contested [8, 9, 10, 13, 14, 15]. Second, the growing interest in linking human rights and medical ethics should be developed and extended beyond concern for civil and political rights, to include the social and economic rights essential for re-promoting the eroded concept of civic citizenship [16, 17]. Third, attention should be focussed on the injustice of the global economic milieu within which health care is being transformed [18, 19, 20], and how this adversely affects the health of entire populations. Fourth, attempts should be made to temper excessive public and professional feelings of entitlement to every possible expensive medical intervention. Fifth, renewed interest is needed in professionalism, as societies cannot flourish without professionals [21]. Finally, instead of recruiting/extracting physicians from developing countries at great cost to the latter [22], the recent example set by the Fogarty International Centre to build capacity in research in developing countries could be emulated [23]. However, the process here should include rebuilding the capacity of privileged physicians and bioethicists to function with high ethical ideals by sending large cohorts of them to developing countries for a year or two. There they could rediscover professional commitment through delivering health care to deprived people under difficult circumstances. On returning home their mandate could be to educate their own health care institutions and governments about the economic policies of wealthy nations that blight the lives and health of millions of 'unseen' people [18, 19, 20, 24].

Ambitious programs are required to make real progress in improving the ethics of the local, regional, and global environments in which health care is delivered. Without these I anticipate that a review in 2010 will identify even greater lack of success in bringing ethics to bear meaningfully and more universally on medical practice.

Will the yawning divide widen?
Miniscule and mundane ethical issues occupy media attention, rather than truly global issues

Zulfiqar A Bhutta

The paper by Singer *et al* [1] is a timely review of the field of clinical ethics, labelled by some as bioethics. Although there has been considerable movement in this field in general over the past decade, the slow progress on many specific fronts is somewhat disappointing. Singer *et al* highlight key advances and remaining challenges. However, much of their discourse pertains to developments in the field of clinical ethics in Western academic circles, and it is only in the closing section of the review that we catch a glimpse of the global context of the ethics debate. This relegation of the ethics debate to the pristine luxury of Western academics and armchair philosophers is a classic mistake, and makes many of the arguments irrelevant to much of the developing world.

The vital links between clinical and research ethics and human rights are perhaps of even greater significance in developing countries, where human rights are frequently ignored and violated. Much too often the health debate blithely accepts economic, health and gender inequity, and attempts to impose an artificial code of practice on the way health is delivered and researched in disadvantaged circumstances. To do so under the guise of pragmatism and expedience is to promote the status quo and growing inequity. I feel that much of the heat and rancour generated by the debate on research into perinatal transmission of HIV in sub-Saharan Africa also arose because of a failure to recognize the close links between human rights, gender equity, and the challenge of practicing ethical and 'just' health care in an unjust world. The miniscule and mundane ethical issues that occupy media attention pale in comparison with the global ethics of turning a blind eye to the systematic starvation of a whole generation of women and children in Iraq and Afghanistan through economic sanctions. The silence on these issues by the academic community, which defines the ground rules of clinical ethics, is incomprehensible. Some of us do not see these issues as divorced from those that pertain to 'end-of-life decisions' or 'clinical equipoise', problems that generate far more attention in the West. It is in this area of 'global or international ethics' that there has been almost no real movement over the past decade, and many of us are concerned that this yawning divide will become even wider over the next decade.

Notwithstanding the above, I am frequently struck by the relative ease and collective wisdom with which many communal and 'underdeveloped' societies handle ethical dilemmas, often in a manner that is worth emulating by others. A sharing of burden among extended closely-knit families and communities, with faith providing the important binding force and solace, is often the key. Thus, while the world waits for a sufficiently large pool of truly international ethicists to develop, there is much to be gained by increasing communication and interaction between health care providers and researchers who work in diverse and disparate circumstances.

It is unrealistic to imagine that the world will change dramatically by the time this subject is revisited again. I do hope, however, that the enormous challenge of increasing communication between disparate economies and health systems will be accepted and addressed. We need a better understanding of the factors that determine global inequalities, poverty and inequities, and the way in which ethical practice and understanding of health is closely intertwined with these issues. It is in these circumstances of deprivation that the teaching and practice of clinical ethics become key to the assurance of justice and equitable sharing of the burdens and fruits of development. In the current climate of globalisation, if trade and tariffs are global issues then surely human rights and ethical standards are as well.

Failure of clinical ethics to deliver on its promise
An unevaluated ethics 'industry' in North America does not constitute a success to be emulated

Abdallah S Daar

Singer *et al* [1] look back at their assessment of, and predictions for, clinical ethics from 10 years ago. Historical overviews such as these help us to navigate our way through the high noise to signal ratio that is so characteristic of modern ethics literature.

What is the take-home message from their revisitation? It is that the clinical ethics project has failed to deliver on its promise. In their assessment, Singer *et al* state, "if the goal of clinical ethics is to improve patient care and outcomes, there is scant evidence this has been achieved." Much of the US 'ethics industry' remains unevaluated. The role of clinical ethics consultation, which is a model that could spread out of the USA, is particularly in need of evaluation. Singer *et al* mention that the report from the American Society for Bioethics and Humanities was an important development, but would we have had more data if, having identified core competences for ethics consultations, it went on to recommend accreditation of programmes and certification of practitioners? Very likely, yes.

About 3 years ago I was asked by Stuart Youngner, a professor in biomedical ethics, to join a group studying how to develop and introduce clinical ethics beyond the USA. We made a start, but were plagued by the same question that persists today - where is the evidence that clinical ethics as practiced in the USA improves patient care and outcomes? The peculiar history and milieu of modern bioethics in the USA has provided the momentum for spreading and developing the clinical ethics consultation model. However it is difficult to see, even in Canada, how this could be adopted on a larger scale without more sub-

stantial evidence of effectiveness. Singer *et al* identified ten years ago three key dangers of ethics consultations and committees, namely: (1) an abrogation of moral decision making by the referring physician; (2) usurpation of moral decision making by the ethics consultant and; (3) diffusion of responsibility within the ethics committee.

Today it is still difficult to see how these three key dangers can be avoided. An additional point that Singer and his colleagues could have addressed is the role of bioethics centres in furthering the aim of better patient care and outcomes. This would have been of real value in this whole important discourse.

Singer *et al* comment that clinical ethics has primarily been a phenomenon of developed countries. What they probably mean is that the conscious and professional development of an ethics industry, as opposed to good clinical ethical patient care, is primarily a US phenomenon. For the same reasons identified by Singer *et al*, I am not sure that this represents a step forward for patients. Mark Siegler and I recently took part in an expert panel at the American College Surgeons Congress in San Francisco, and were presented with a case that I viewed as clearly pitting the interests of the surgeon against those of the patient. Coming from a UK background and having worked in developing countries, it was clear to me that tortured ethical analysis was not called for - there was a real conflict of interest which was not identified as such by the surgeons involved and which was not declared to the patient. When I pointed this out, the reaction from the audience indicated to me that there was a serious gap in the USA between ethical discourse, the traditional understanding of good patient care, and routine clinical practice. It appeared to me that attempting good, ethical patient care in a health care system whose reimbursement method encouraged such a conflict of interest between patient and physician was like cycling uphill with a strong wind in your face. The reaction to the (what we now recognize as) unethical behaviour of researchers in studies involving human subjects that was publicized by Beecher (see Rothman) [25] may have done a lot of theoretical good for human research subjects, and resulted in strict research regulations on paper, but in real life the system has worked against the interests of research subjects and against good, ethical medical care generally. This was clearly demonstrated by the Gelsinger case, in which a teenager died while undergoing gene therapy in the hands of researchers who allegedly had conflicts of interest and failed to report to the authorities important previous research data that may have contributed to the fatal outcome.

These problems may not be as intractable in other countries, even in European countries. We could benefit from looking at other systems and cultures. For example, does the developed world have much to learn from the developing world? I would identify this as a major remaining challenge for clinical ethics. As I have recently pointed out [26], much of the ethical discourse is carried out in the developed world. As more people in the developing world become involved in the discourse, which is often championed and led by Western practitioners, there is a danger that we might impose value interpretations, inappropriate emphases, and confusion on the developing world. The added challenge then is to develop the humility (mercifully identified by Singer *et al* as an important virtue) that would allow us to listen and learn.

Singer *et al* correctly observe that, although public education has grown tremendously, meaningful public engagement has not. In this context, I fail to see how a dominant media ethics voice that they identify can be perceived as a 'major contribution to the field'? Although some good has come from the involvement of bioethicists with the media, we should be careful in praising at least one particular characteristic of such engagement, namely the tendency to provide an instant expert ethics opinion. As we have learned from the 2001 presidential election in the USA, the public is quite capable of remaining patient until important matters are resolved. There is no need to have an instant opinion for the media only a few hours after the breaking of complex scientific news, other than perhaps to clarify the issues for the public. There is also a danger of having a unitary and narrow approach toward important questions when one or only a few ethicists dominate opinion making. There is the added danger that such dominance, and its presumed wisdom, can cause patients to be harmed, practitioners to be sued, and the ethics project itself to be set back.

I end by returning to patient care. It is unfortunate that as we enter the new millennium we still need to relearn ancient lessons [27]. Singer *et al* identified the need to listen to our patients, to be better role models and to pay more attention to developing character. It is stunning and demoralizing to discover that the doctor-patient relationship, after 20 years of clinical ethics, is 'in worse shape than it was when the field began'. Another remaining challenge is to determine whether this is true for other countries also, and not just for the USA and perhaps Canada.

The greatest value of the contribution of Singer *et al* is its demonstration that it is possible, amid all the noise, to see these failings so clearly. We look forward to another assessment in 2010.

Clinical ethics in the UK
The next 10 years may see a relaxing of boundaries between clinical ethics and other disciplines

Tony Hope

The past 10 years have seen major developments in clinical medical ethics in the UK. A decade ago I was struggling to introduce at least a minimum of ethics teaching into one UK medical school. Now I have difficulty in meeting the demands for such teaching. Singer *et al* [1] have provided an excellent overview of the recent history, the current position and possible future developments in clinical medical ethics. Although their experience is from the USA, much of what they say is relevant to the UK. I comment on what I see as some salient points in UK clinical medical ethics.

Teaching
By 1990 there were two major developments in medical ethics teaching: a number of thriving student groups that discussed issues in medical ethics; and a rapidly growing number of master's level courses that catered for those doctors and nurses with an interest in the subject. What was lacking was ethics in mainstream medical education, both at undergraduate and postgraduate levels.

The UK General Medical Council gave an enormously significant boost to medical ethics in 1993, as mentioned by Singer *et al*, by requiring all medical schools to teach a core of ethics. The next 10 years will see considerable development of such teaching, and an increasing focus on evaluation, both of students and of the teaching itself.

Continuing education in medical ethics, after qualification, has developed much less substantially. I predict that this will be the major new development in medical ethics teaching over the next decade within the UK.

Clinical ethics consultation
A second major development in UK medical ethics over the past 10 years has been the start of clinical ethics committees. [28, 29]

The first wave has developed mainly as a bottom-up response from practising clinicians. There are signs that a second wave may result partly from political imperatives for mechanisms to scrutinize the ethical aspects of good medical care.

Some of the UK committees set up by health authorities, rather than hospitals, focus on resource allocation, because such authorities have a requirement to make the best use of limited resources. A major restructuring of primary care, with the formation of primary care trusts,

will provide an opportunity for clinical ethics committees to develop a focus on community care rather than hospital care.

Research

Singer *et al* emphasized that empirical medical ethics will be an increasingly important area over the next 10 years. The same developments are taking place in the UK and other countries in Europe. I predict that there will be an increasing collaboration in medical ethics research between the USA, Europe and Australasia.

Conclusion

Over the past 1 or 2 years there has been a developing interest in the medical humanities and social sciences, including the launch in 2000 of a new UK journal - *Medical Humanities*. I believe that over the next 10 years there will be a relaxing of boundaries between medical ethics and other disciplines. The primary goal is to solve ethical problems, such as the huge inequities in global health. Solutions are most likely to be found if the relevant research makes use of whatever tools are helpful, rather than being bound by a single discipline.

Getting back in line
Clinical ethics needs to address the day-to-day needs of patients and families

Sue MacRae RN

Singer *et al* [1] commented that the goal of clinical ethics is to improve patient care. In their review of clinical ethics, however, they lament that the full impact of clinical ethics on improving quality of care is yet to be realized. Why is this?

The clinical professions have long recognized the need to take patient values, preferences and life experiences into account in clinical decision making and practice. To a thoughtful clinician, good clinical practice has always meant both good technical and ethical care [30]. Clinicians commonly see themselves as the patient's protector or pride themselves as being the patient's strongest advocate. However, many clinicians are beginning to realize that health care is not meeting the basic needs of those who seek care [31–34]. For example, patients often leave the hospital not knowing their diagnoses, or what medications they are taking [34]. Patients' expressed levels of pain are still high, especially at the end of life [35]. The amount of time patients wait for appointments and test results is unreasonable and increasing [36]. Also, an alarming number of patients feel like they have not been treated with basic respect and humanity, have not been provided with adequate emotional support, or did not

have their family involved to the extent that they wished [37, 38].

These important patient-centered measures of quality have been validated and widely discussed in both quality improvement and medical literature [39, 40]. The value of improving patient care by building systems of care around basic human needs (as patients themselves define them) has been shown [41–44] to improve the quality of care at both the clinical and institutional levels. Surprisingly, this approach has not made its way widely into the clinical ethics literature. In the field of clinical ethics, much has been written over the past 30 years regarding values and ethical issues from the perspectives of health care professionals and organizations, whereas only a few studies have systematically gathered and described the views of patients and family members [45–47].

Because studies have found that clinicians and others - even family members - inaccurately judge what patients value [48–50], understanding how patients define 'good' or ethical care is essential if clinical ethics is to represent a model of care that respects patients' actual values and preferences. Clinical ethicists have a unique opportunity to engage clinicians, organizations, patients and families in a dialogue regarding the meaning of high quality ethical care that respects the organizational ethos and the clinician's moral agency, and also accurately represents and respects the patient's experience.

There are many ways that clinical ethicists could begin to promote this dialogue. They could:

• conduct research to explore how patients define good or ethical health care;

• collaborate in hospitals with clinical departments and other departments with similar interests (such as quality control or patient relations) to explore patient needs, values and beliefs in more depth;

• explore how definitions of high-quality ethical care given by patients and their families intersect with the definitions given by clinicians and organizations;

• investigate the barriers that face clinicians and organizations in providing high-quality ethical care;

• help clinicians and organizations translate the values and beliefs of patients and family members into their processes and philosophy of care;

• work directly with clinicians to support their ability to provide high-quality ethical care;

• conduct research to explore how ethics consultation services can be understood by patients and their families, and directly benefit them;

• investigate the views and beliefs of patients on common ethical issues that impact on them directly, such as competency, end of life care and resource allocation; and

• conduct research to discover whether ethics policies and guidelines, such as those surrounding informed consent and end of life care, include the patient's voice, and actually represent the values and needs of patients they are intended to benefit.

Few would argue that meeting the basic human needs of the people we serve should be an important ethical priority in health care. However, when we reflect on what clinical ethics means today, we are likely to think more in terms of issues that are highly controversial (eg euthanasia, genetic technology) or well-publicized (eg the recent case of the conjoined twins in the UK). However, clinical ethics today has an important opportunity to realign itself more directly with the original goal of clinical ethics - to improve patient care by promoting an ethical health care system that ensures that we meet the day-to-day human needs of our patients and their families.

Clinical ethics as a parent discipline
Attention to psychiatric clinical ethics as a subdiscipline may alleviate one of the main causes of human suffering and socioeconomic burden

Laura Weiss Roberts

Clinical ethics is a discipline that seeks to translate scholarship into meaningful ways of understanding and alleviating human suffering. The most basic goal of clinical ethics is to improve patient care [51, 52], and the methods and knowledge harnessed by this discipline derive from the fields of clinical medicine and bioethics, biomedical and social sciences, health policy, philosophy, humanities, law, theology, and, more recently, population and information sciences. Through its focus on interactions and effects - between clinicians and patients, between social policies and systems of care delivery, between scientific discoveries and society - clinical ethics values differing perspectives and is inherently relational. Informed by clinical experience, conceptual analysis, and empirical evidence, clinical ethics is about beneficent, practical wisdom in a world knotted with suffering.

In characterizing the 'future directions in clinical ethics' 10 years ago, Singer and his colleagues [53] defined three requirements for the maturation of the field: strengthening of the field's conceptual and research base; pursuing

the 'professionalisation' and standardization of clinical ethics expertise and training; and enriching the interpersonal communication skill set of clinical ethicists. In their update [1], those authors define a much broader array of challenges for the future.

They identify research issues, including improved funding opportunities for clinical ethics studies, greater integration of ethics data into 'mainstream' scientific and clinical knowledge, and more rigorous and more diverse inquiry. In teaching, they articulate insights echoed throughout the education literature, such as the need for Internet-based and adult-centred learning methods, greater focus on the 'informal curriculum' and character development in medicine, and augmenting our capacity to teach and evaluate ethics knowledge and skill. With respect to ethics consultation and committees, they argue for greater representation of clinical ethics within the fundamental processes of health care organizations and for more systematic study of clinical ethics interventions and clinical outcomes within systems. Finally, they suggest that the principal task ahead is to address the profound bioethics issues, primarily health care inequities, which we now face on a global level. However, they do not emphasize the challenges that face subdisciplines. Psychiatric clinical ethics as a subdiscipline has an entire universe of difficult questions that are yet to receive attention.

Psychiatric clinical ethics is a small field that is evolving in parallel with its parent discipline. As in clinical ethics, psychiatric clinical ethics seeks to help patients, specifically people with mental illness or combined physical and mental disorders. Psychiatric clinical ethics work is multidisciplinary, respectful of diverse perspectives, and focused on understanding the relations between people, systems, and phenomena. It is enriched by theory, substantiated in data, and revealed through experience.

With only a handful of established scholars, our capacity for research and education in psychiatric clinical ethics has been modest in comparison with the development of clinical ethics in internal medicine. Nevertheless, using the criteria outlined by Singer *et al*, indications for progress within the area of psychiatric clinical ethics are good. The US National Institute of Mental Health [54] identified studying the ethics of research involving people with mental illness as a priority area for funding. Similarly, the Ethical, Legal, and Social Implications Program of the National Human Genome Research Institute [55] has defined psychiatric genetic issues as a critical domain for study. The number of psychiatrists who are engaged in ethics inquiry has grown in recent years, as have the number of publications in mainstream psychiatric journals on ethics topics [56, 57]. Systematic,

rigorous work by psychiatrists, such as Appelbaum and co-workers [58–60], from related disciplines over the past 2 decades has made a profound contribution to our understanding of informed consent and decisional capacity. Psychiatric educators have been engaged in developing innovative ethics training and in addressing professionalism issues in medical curricula at several institutions in the USA [61–64]. Furthermore, psychiatric ethicists and practicing psychiatrists have been long recognized for their contributions in ethics committees and organizational leadership, and in providing expertise in ethics and clinical decision-making through consultation-liaison services [65–69].

Despite these encouraging signs, the challenges encountered in psychiatric clinical ethics are considerable. As has been noted by the World Health Organization, the Surgeon General in the USA, and psychiatry leaders internationally, mental illnesses are among the top diseases in the world in terms of human suffering and socioeconomic burden [70–72]. These prevalent and severe illnesses are poorly understood, however, and people with mental illness and their families are often gravely stigmatised and prejudicially treated [73–75]. Mentally ill populations of all ages and ethnic backgrounds are underserved within current systems of care in rural and urban settings, both in developed and developing countries [76–78]. Medical education gives insufficient attention to psychiatric topics, particularly across intersecting age, sex, and cultural spectra, especially given their prevalence in clinical practice [79,80]. Public policy related to mental illness treatment and research has been a curious mixture of valuable insight and misapprehension [81, 82]. Interestingly, despite these regressive pressures, research into neurobiological, clinical, genetic, and epidemiological aspects of mental illness has generated extraordinary advances and new moral dilemmas in recent years [83, 84]. Consequently, psychiatric clinical ethics as a subdiscipline has an entire universe of important, difficult questions that are yet to receive systematic study [83, 85]. There are few areas so replete with human anguish and so worthy of our attention.

Over the past decade we have witnessed the substantive development of the field of clinical ethics. In canvassing this extraordinary scholarly discipline, based primarily in internal medicine, Singer *et al* may have omitted one of the most important contributions clinical ethics has made: it serves as a well-spring for sustained ethics scholarship that seeks, in parallel with its parent discipline, to enhance the care and well-being of people with serious illnesses across diverse fields of medicine.

Broadening the foundation
Dealing with current blind spots will help to create a more complete vision for the future

Virginia A Sharpe

Clinical ethics - the field that Singer *et al* [1] have been instrumental in establishing - importantly emphasizes ethical concerns that are indigenous to the practice setting. Unlike the current canonical approaches to medical ethics, which are grounded in utilitarian or deontological philosophy, clinical ethics seeks to explore medicine from the inside, as something more than simply a fruitful opportunity for the application of ethical theory. As Singer *et al* state, "clinical ethics is not founded in philosophy, law, or theology but, instead, is a subdiscipline of medicine, centering upon the doctor-patient relationship."

I have written sympathetically about this 'bottom-up' approach, but I take this opportunity to push the authors and the rest of us to seek a broader foundation, one that is still grounded in healing as a particular type of relational practice but that recognizes the following: the moral significance of relationships beyond that of the doctor with the patient; locations other than the 'bedside' as key for moral learning; and the value of a plurality of theoretical approaches. My aim is to highlight some blind spots that should be guarded against as we look toward the future of clinical ethics.

Relationships beyond that of the doctor with the patient
It is particularly frustrating at this late date that Singer *et al* and many of us who write in this field continue to overlook the moral work of other healing relationships. Are there really good theoretical reasons to privilege the doctor-patient relationship over the nurse-patient relationship when describing the indigenous norms of healing? True, the authors urge more 'interprofessional' research, but the rationale that they offer is revealing. "Interprofessional research", they say, "enriches our grasp of the moral complexities of different professional views." By contrast, I would argue that interprofessional research, and interdisciplinary and transdisciplinary research play a more fundamental role; they provide the necessary basis for sound, broadly informed research in clinical ethics. If, as the authors say, it "is increasingly recognized that the content of clinical ethics teaching needs to be customized to the learner", then it seems equally true that clinical ethics research should not have a default lo-

cation for its raw material. In their discussion of the importance of qualitative research methods, Singer *et al* rightly note the value of ethnography. I have every expectation that ethnography [86] will usefully expand our assumptions regarding the normative content of clinical ethics.

Locations other than the bedside

I entirely agree when the authors state that the goal of clinical ethics is "to improve the quality of patient care", and that organizational ethics entails collective responsibility. It is for precisely these reasons that we must move beyond the authors' language of ethics 'at the bedside'. I do not disagree with the authors when they state that "we need to develop effective methods for teaching clinical ethics at the bedside." However, the moral quality of patient care is reflected in the patient-centred nature of institutional policies and practices, from resource allocation to health disparities, from admission to billing, and from clinical consultation to the continuity of care. Hence, using 'at the bedside' as shorthand is misleading and potentially counterproductive. Moral skill building in clinical ethics is required not only of those health care providers 'at the bedside', but also of those in policy, managerial, and support positions. To say, "clinical ethics is best learned at the bedside" fosters an overly narrow view of the location of both moral responsibility and moral challenges in health care.

A plurality of theoretical approaches

In their account of the offerings in the conceptual foundations of clinical ethics over the past decade, Singer *et al* note the developments in casuistry, narrative ethics, and feminist theory, among others. They conclude, "Somehow, all these will need to be reconciled and put into some rational order and relationship with each other." I would argue, by contrast, that reconciliation of theoretical approaches might not be a desirable goal. Diverse theoretical offerings bring particular insights and tell a particular story. Narrative ethics, for example, reflect a commitment to the ways in which patients in particular give voice to the meaning and experience of illness. Feminist ethics directs our attention to the ways in which the distribution of power shows up in the context of health care. The way in which these theories relate may be oppositional, and so reconciliation may obscure important and ongoing tensions that characterize moral life. This is especially important as clinical ethics takes on a life beyond its formal origins in the Anglo-American world.

Conclusion

The account of clinical ethics offered by Singer *et al* is forward looking in important respects. The authors affirm the increasing importance of electronic media in clinical ethics. They rightly regard ethics as a dimension of quality that must be subject to evaluation. They call for increased attention to the relationship between ethics and clinical outcomes. They anticipate the further globalisation of bioethics. In the present commentary, I have pointed to some blind spots that will need to be addressed if we are to achieve a more complete vision of that future.

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