

## Understanding What Clinical Ethical Cases Are: A Review and Perspectives from a Canadian Collaborative Working Group

Gabriel Saso-Baudaux, Anna Henry, India Gaer, James Anderson, Claudia Barsed, Jennifer AH Bell, Daniel Buchman, Lee de Bie, Adélaïde Doussau, Katherine Duthie, Pierrette Fortin, Jennifer A Gibson, Gary Goldsand, Ann M. Heesters, Kim Jameson, Bashir Jiwani, Monique Lanoix, Gabrielle Lemieux, Alexandra Olmos-Perez, Élodie Petit, Amanda Porter, Andréanne Talbot, Marika Warren, Randi Zlotnik Shaul and Eric Racine

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### Article abstract

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ARTICLE (PEER-REVIEWED)

## Understanding What Clinical Ethical Cases Are: A Review and Perspectives from a Canadian Collaborative Working Group

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### Résumé

L'éthique clinique consiste en grande partie à comprendre des situations morales concrètes et à favoriser des discussions constructives à leur sujet afin d'identifier des solutions appropriées. Cependant, les concepts et les méthodes utilisés pour décrire les cas (ex. : les dilemmes, les situations, les récits) varient selon les auteurs et les méthodes d'analyse des cas. Nous avons entrepris une revue non exhaustive de la littérature — inspirée de la méthode d'analyse critique interprétative de McDougall — afin d'identifier une série d'idées influentes sur la manière de décrire les cas d'éthique clinique et les méthodes recommandées pour les comprendre. Nous avons identifié neuf familles de méthodes d'analyse de cas, qui varient considérablement en ce qui concerne la description de base des cas, les stratégies recommandées pour les comprendre et les caractéristiques supplémentaires à prendre en compte (ex. : les contextes, les dynamiques sociales et de pouvoir, les émotions). En tant que collectif d'éthicien(ne)s cliniques et d'universitaires, nous identifions cinq limites principales de ces méthodes et soulignons l'importance de développer des méthodes basées sur les connaissances pratiques des consultant(e)s en éthique clinique.

### Mots-clés

éthique clinique, cas cliniques, méthodes, recherche participative, éthique vivante, pragmatisme

### Abstract

Clinical ethics is largely about understanding concrete moral situations and supporting meaningful discussion on these to identify appropriate resolutions. However, concepts and methods used to describe cases (e.g., dilemmas, situations, stories) vary between authors and case analysis methods. We undertook a non-exhaustive literature review — inspired by McDougall's critical interpretive review method — to identify a range of influential ideas on how to describe clinical ethics cases and the methods recommended to understand these cases. We identified nine families of case analysis methods, which vary considerably with respect to the basic description of cases, the strategies recommended to understand cases, and additional features that should be considered (e.g., contexts, social and power dynamics, emotions). As a collective of clinical ethicists and academics, we identify five main limitations of these methods and underline the importance of developing methods based on the practical knowledge of clinical ethics consultants.

### Keywords

clinical ethics, clinical cases, methods, participatory research, living ethics, pragmatism

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## INTRODUCTION

Clinical ethics, as a field, is largely about understanding concrete moral situations in healthcare and supporting meaningful discussion on these to identify or suggest appropriate resolutions. For example, the third edition of the Core Competencies for Healthcare Ethics Consultation of the American Society for Bioethics and Humanities states that a chief goal of ethics consultations is “identifying and analyzing the nature of the value uncertainty or conflict that underlies the consultation” (1, p.4). This goal is seconded by the desire of “facilitating resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of all those involved” (1, p.4). In fact, these conflictual situations, which are often referred to as “cases,” can be viewed as central to clinical ethics consultation processes. Key to clinical ethics is thus the (conceptual) understanding of what clinical ethics situations or “cases” are, and what practices can be used by clinical ethicists to discern the contents and causes of these situations, notably to facilitate their management or resolution. The conceptual understanding of cases thus sits (at least) at two levels. First, a case is an ontological entity: it possesses certain defining properties and is constituted by certain features which make up its contents. Taken together, they determine what is (or is not) a case. Second, for ethicists to understand what those properties and features are for any particular case, they need an epistemological framework and a set of corresponding practices to understand a given case.

Following the literature, we call “case analysis methods” those approaches to clinical ethics consultations that contain, explicitly or implicitly, ontological and epistemological commitments as described above. In the clinical ethics literature, concepts to further describe what cases are (e.g., dilemmas, situations, stories) and which epistemological practices to use (e.g., the role of values and principles in understanding the case) vary between authors and case analysis methods. Some of these differences are grounded explicitly in concepts and ethical theories, such as “dilemmas” for principlism, “morally problematic situations” for pragmatist theory, or “stories” in the context of narrative ethics. Adding complexity, while some methods describe what cases are primarily in terms of the ethical issue or conflict at hand and the ethico-cognitive process through which a picture of what is at stake is generated and by which the issue is resolved, other methods use a broader definition which more closely equates “case” with “the clinical ethics consultation” in its entirety — where and when it happened, what happened, who was involved, etc. Likewise, proposed epistemological practices to understand the contents and causes of cases also vary, tending to align with how cases are conceptually framed by the method or author, such as interpreting and weighing principles, attending to narratives to understand stories, or adopting a situational lens. Moreover, for some methods “practices” refers to the ethico-cognitive process described above (e.g., how to reconstruct a narrative of the situation and what that may reveal about the case), whilst for others, “practices” is a more expansive concept that includes the practical steps in a consultation (e.g., who to talk to, should discussions be conducted one-on-one or in a group). In other words, methods described in the literature have different ontological and epistemological commitments, or do not state explicitly (any, or all, of) their commitments, and suggest more or less expansive understandings of what these commitments amount to. The varying terms used to describe cases (e.g., dilemmas, situations) is a *prima facie* argument for the existence of such substantially different theoretical outlooks with respect to what clinical ethicists do.

It is plausible that these different theoretical outlooks on case analysis methods affect the concrete work of clinical ethicists. For example, viewing situations as “cases”, “dilemmas” or other alternate accounts could shape a number of practices, such as which factors are deemed ethically relevant, which steps are taken to try to resolve the situation, and what constitutes a “resolved” situation. In this study, we ask: how do the main case analysis methods in the clinical ethics literature characterize the ontological features of a “case” and the epistemological practices to understand and analyze a case, and how do these characterizations relate to the day-to-day practice of clinical ethicists? Although the concept of “case” is not used by all theories and methods, given its prevalent use in the literature (e.g., “case analysis methods”) we use it in this paper as a generic term to grasp the broad spectrum of concepts used to describe clinical ethics situations. To better document the range of ideas about what cases are in clinical ethics and related case analysis practices, we undertook 1) a non-exhaustive review of various contrasting case analysis methods in the literature, and 2) embarked on a critical and interpretive analysis based on experiential knowledge rooted in case analysis practices.

This paper is part of a broader and ongoing collaborative project aiming to help bridge and enrich theory, methodology, and practice in matters of clinical ethics consultation and deliberation methods in Canada (see Box 1). The review and process reported in this paper are part of subsequent objectives to document practices to understand cases and then identify promising clinical ethics practices. The underlying pragmatist orientation of the study invokes strategies that help illuminate how practices of clinical ethicists reflect embodied and contextual knowledge about how ethics consultations are done and should be done (2,3). Making this knowledge explicit and working from the resulting insights is envisioned as a promising way to enrich theory and methodology and structure a living ethics exercise (4). Living ethics is a stance which encourages the development of participatory, dialogue-based, action-oriented ethics. Given this orientation, participating clinical ethicists formed a collaborative working group with the shared goal of generating and testing the ideas articulated in this project.

### Box 1: Collaborative improvement of moral deliberation methods: An exercise in living ethics

The five-year collaborative project, of which the current paper is part, is funded by the Social Sciences and Humanities Research Council of Canada (SSHRC). It incorporates the objective to start from 1) critical appraisals of existing literature and models in light of current Canadian practices (the focus of this paper), to then move toward 2) proposing promising practices from the repertoire of existing practices as well as creative and critical thinking, and then 3) test these practices and learn from this testing as part of an ongoing knowledge-generating and knowledge-sharing process. Practices are examined in light of three of the important tasks of clinical ethics (1): 1) describing how moral problems are understood (the subject of this paper), 2) illustrating how ethical deliberations can be structured as facilitated consultations, and 3) articulating the ways that outcomes of deliberations and consultations are assessed. The examination of activities falling under tasks 2 and 3 will be the subject of future work carried out as part of the collaborative research project.

## METHODS

This paper reports on how clinical ethicists understand cases. It includes both 1) a non-exhaustive literature review of various contrasting case analysis methods in the literature and, 2) a critical interpretive review in the form of group discussion and participatory writing about the strengths and weaknesses of these influential methods and practices, in order to offer a critical analysis. Our process is inspired by McDougall's critical interpretive review (5), in keeping with the idea of a non-exhaustive review, but with the addition that the critical analysis was conducted by a group of 25 co-authors, all of whom are clinical ethicists in Canada, except for four research staff members. This helped root the exercise in case analysis experiences and practices used by the co-authors and lay the groundwork for the participatory five-year study (see Box 1). We amended McDougall's methodology to include extensive group discussions to highlight points of agreement and disagreement and to infuse the conversations with a plurality of perspectives. To some extent this mirrors the methodology of clinical ethics committees.

### Literature review

Various exploratory search strategies were developed and piloted to scope the literature on case analysis methods. Given the goals of our group and our practical constraints, we could not review all possible literature on clinical ethics methods. In fact, initial efforts in this direction proved challenging in terms of setting rigorous and defensible search parameters (e.g., keywords, inclusion and exclusion criteria) given the lack of MeSH terms to precisely identify case analysis methods (there are no specific official keywords). Furthermore, our goal was to identify a range of influential ideas on how to describe clinical ethics cases and the practices recommended to understand these cases. Accordingly, we settled on identifying main families of methods (and representative publications) grouped according to common theoretical inspirations (e.g., casuistry, pragmatism, principlism, feminism) without claiming exhaustive or perfect representation. This then set the stage for subsequent group discussions in light of the day-to-day practices of clinical ethicists based on the existing offerings of influential methods as well as more local methods used by clinical ethicists in our Canadian group.

We began with a search for articles on the databases CINAHL, MedLine and PubMed to expand the database research process and ensure a broad reach. We chose these three databases because they cover most bioethics journals. The initial research design of the broader collaborative research project intended for three distinct literature reviews to be conducted at separate times, one for each of the important tasks of clinical ethics, and with this study focusing on the first task (see Box 1). However, we suspected, and the literature review later confirmed, that many articles would be relevant for more than one task; that some articles found through a literature review focused (i.e., by using tailored keywords) on one of the tasks might return articles relevant for one or both of the other tasks (e.g., the review for task 3 might return articles also relevant for task 1); and that given the lack of uniformity in the literature regarding the terms used to characterize what counts as the theoretical underpinning of various clinical ethics case analysis methods, both in terms of the ontology of (what are) "cases" and methods of analysis, the search might be prone to false positives (irrelevant articles selected) and false negatives (relevant articles missing). Three separate literature reviews would also be time-consuming. The initial plan was thus revised in favour of a single, exploratory, literature review conducted simultaneously for all three tasks of clinical ethics (with additional reviews to be carried out for tasks 2 and 3 in the future, if and when required to complement this initial review). For task 1, we used a combination of the keywords "moral case deliberation" OR "clinical ethics consultation" OR "ethics consultation" AND "method" OR "process". For task 2, we used a combination of the keywords "moral case deliberation" OR "clinical ethics consultation" OR "ethics consultation" AND "dialogue". For task 3, we used a combination of the keywords "moral case deliberation" OR "clinical ethics consultation" OR "ethics consultation" AND "outcome" OR "evaluation". Keywords targeted titles and abstracts.

A research assistant (AH) conducted the search in 2023 between October 3 and November 23, under the supervision of the principal investigator (ER). The search yielded a total of 495 articles: the sum of all articles found on the three databases amounted to, respectively, 255 articles for task 1, 76 articles for task 2, and 164 articles for task 3. This first set of 495 articles was reviewed by AH and ER to manually select, based on their titles and abstracts, articles relevant specifically for task 1 of clinical ethics (this paper's subject); articles in languages other than French or English and review articles were also excluded; in total, 363 articles were removed and 132 remained. Within this second set of 132 articles, ER and AH identified eight key articles most closely aligned with this study's objective, which would be later used for data-extraction piloting and testing purposes. AH took detailed content extraction notes on these eight key articles, which ER reviewed and approved.

A snowball method was then used: AH and GSB extracted from the second set of articles all references from their reference section, leading to a third set of articles. Relying on the detailed notes, AH and GSB reviewed the titles and abstracts of all

articles in this third set and eliminated review articles, articles in other languages than French or English, and articles irrelevant for the broader research project. Articles relevant for tasks 2 or 3 were set aside, and only articles relevant for task 1 were retained. At this stage of the review process, twenty-one co-researchers (clinical ethicists who are co-authors of this manuscript), were invited to send other references deemed relevant for task 1. Relevant references from the core research team's Endnote library (n=17) were also added. From this fourth set of articles, AH and GSB then created a preliminary typology of the main families of case analysis methods discussed in the literature based on a previous similar exercise by ER (2). The typology, and which articles best typified each method therein, were further revised through several rounds of refinement between ER, AH, and GSB to highlight the features and contrasts of different methods. Some methods were also excluded either because they were not case analysis methods, or because they were integrative methods which pulled from two or more families of methods, e.g., ASBH guidance and Core Competencies (1) and Jiwani's Practical Guide (6). These integrative methods were excluded to better delineate how each family of methods characterizes ethics cases. To refine the typology, the clinical ethicist co-researchers were consulted during the first set of small group meetings (see the section below) to ensure that no family of method was missed by the literature review, and that none were excluded from the final selection of methods in the typology.

The final content extraction strategy guiding the narrative synthesis was developed by the research team and adjusted based on the feedback of clinical ethicists, obtained through the group discussions described below. It was developed to extract content in ways that would reveal contrasting features of the various families of methods reviewed. The strategy ultimately included: 1) the description of cases with respect to 1.1) terminology and definitions and 1.2) the use of moral principles in understanding cases. It also considered: 2) practices to understand cases notably with respect to how 2.1) medical facts are handled; 2.2) the description of the process of understanding cases; 2.3) the consideration of issues related to interested parties, communication and social/power dynamics; 2.4) the accounting of context(s); and 2.5) the accounting and integration of emotions, values and preconceptions. Content extraction and narrative summaries were undertaken by one primary reviewer (GSB or AH), validated by a second reviewer (AH or GSB), and reviewed by the senior and lead researcher (ER). Group discussions provided further external validation by clinical ethicist co-researchers of the content extracted by the core research team. They confirmed the final narrative synthesis as accurately summarizing each method and as being faithful to their knowledge of the clinical ethics literature and their training (e.g., graduate studies, clinical ethics fellowships). In this review, we survey families of methods using representative publications for each family of method.

## Participatory group discussion and writing

The active engagement and mobilization of clinical ethicists and the academic and practical knowledge they hold is central to this project. Participating co-researcher clinical ethicists were recruited via several targeted efforts: general announcements through the Canadian Bioethics Society (e.g., at events and through its newsletter), targeted invitations to colleagues suspected of being interested in the topic, and snowball recruitment based on recommendations of recruited co-researchers. Recruitment aimed at creating one French-speaking group for Québec and francophone Canada, a second group combining the Atlantic Canadian provinces (e.g., Nova Scotia, New Brunswick, Newfoundland, Prince Edward Island) and the province of Ontario, and a third group comprised of colleagues from the Western Canadian provinces (Manitoba, Saskatchewan, Alberta, British Columbia) for time-zone issues and geographical proximity. These groups were composed of respectively six, ten, and six colleagues in addition to the research staff who support and organize group meetings. The small group meetings were organized as distinct sessions of the three groups, while the forum meetings involved the three groups meeting as a full assembly of co-researchers. All meetings took place online using Zoom, for practical reasons (e.g., accessibility, convenience, costs).

The meetings had a dual purpose. First, to amend, as needed, the literature review and narrative synthesis carried out by the core research team to ensure no important methods were missed during the literature review, and that the narrative synthesis offered sufficiently nuanced interpretations of the methods. Second, to discuss the state of the literature on clinical ethics consultation and case analysis methods, as summarized in the narrative synthesis, and to gather the reactions of clinical ethicists to prepare the critical interpretative review; the discussion section of this paper is dedicated to this critical interpretative review. To maximize the input of clinical ethicists and make best use of their expertise and practical knowledge, this research project adopted a collaborative, iterative writing process for its academic outputs (i.e., research papers). The meetings served as group discussions and as brainstorming sessions on the manuscript's contents. Three sets of meetings were planned for this portion of the project. Before each meeting, the draft manuscript was shared in advance via Google Docs for online comments prior to the meeting. The first set of small group meetings occurred in late March 2024 to engage with the initial results of the literature review shared beforehand. As a result, the literature review was amended (result section of this manuscript) and some discussion points drafted to reflect the discussions. A second collective meeting of all three groups (forum meeting) occurred in May 2024 to discuss the draft manuscript and to elaborate the discussion section (i.e., the critical interpretative review). The manuscript was again amended to revise the results and significantly extend the discussion and propose a draft introduction and conclusion. A final set of small group meetings in June 2024 sought to identify any remaining gaps or concerns with respect to the interpretation of the results and discussion. A last round of edits occurred in the summer, and a final revised manuscript was shared with and approved by all co-authors in September 2024.

## RESULTS

We identified nine families of case analysis methods (Table 1). These methods include various accounts of cases (e.g., moral dilemmas, cases, case stories, morally problematic situations) and practical orientations (principle-based inquiries, situational analyses and inquiries, dialogues).

**Table 1 Families of case analysis methods and associated practices**

Method	General account of cases	Practical orientation	Illustrative seminal publications
Principlist methods	Cases are moral dilemmas where interested parties are compelled to fulfill incompatible duties. There are many sources of moral disagreements leading to moral dilemmas, including competing views on how best to interpret relevant principles and their relative weight.	Use principles following a specification process (to substantiate the content of principles) to grasp the essence of a case.	(7)
Casuistic methods (casuistry)	Cases are made of circumstances (i.e., etymologically all that surrounds the case) and of maxims which express the nature of the moral problem.	Expose medical indications, patient preferences, quality of life and context.	(8,9)
Decision oriented methods	Cases are made of ideological intent (moral ideal) and objective context which include facts (e.g., who, when, where, how) as well as the values at stake.	Expose facts with conceptual patterns (abstraction, heuristics, proximate causation) as well as the value-structure of the situation.	(10)
Feminist methods	A case is a multidimensional situation involving (systemic) context, and the psychological and emotional aspects of the people involved.	Focus on values consensus, compromise, and a plurality of voices.	(11,12)
Pragmatist methods (clinical pragmatism)	Cases are morally problematic situations where the presumed best course of action is challenged by doubts or disagreements emanating from the particularities of that situation.	Grow a situational understanding of the case by engaging various parties to explore their assumptions and intuitions to make more transparent their implicit moral perceptions, and thus demarcate the disagreements that underline the moral problem.	(13-15)
Narrative methods	Cases are characterized and framed in terms of narratives and described as case stories.	Focus on the patient's perspective and values while understanding the overarching narrative of the case as recounted by the different stakeholders.	(16-18)
Scenario-based methods	A case is a difficult situation where a decision needs to be made.	Rely on guiding moral principles while taking into account the specificities of each case.	(19-21)
Deliberation-oriented methods	Cases are situations where conflicts of values and/or principles are exacerbated by instincts, emotions, fear and/or anxiety, leading stakeholders to uncritically take extreme and incompatible positions.	Consider values, facts, and principles, and define how minimalist (public) and maximalist (private) duties are at stake in the case. Start with deontological principles.	(22)
Hermeneutic methods	Cases as ambiguous stories where various understandings (which are interpretations of the situation based on preconceptions) collide.	Support the meeting of perspectives and interpersonal understandings, while calling for dispositions of openness and reflexivity, and methods of open communication, often in the form of dialogue.	(23,24)

### Description of cases

In this section, we review and compare key elements that underline how different case analysis methods conceptualize what cases are: 1) the terminology to describe a “case” and how these are defined; and 2) the place of moral principles in different methods and how they are used.

#### Terminology and definitions

The terminology used to refer to the object of case analysis methods, herein referred to as “cases,” varies greatly across methods, suggesting significantly different outlooks and practices.

Principlist approaches focus on “moral dilemmas.” Beauchamp and Childress define moral dilemmas as situations “in which moral obligations demand or appear to demand that a person adopt each of two (or more) alternative but incompatible actions, such that the person cannot perform all the required actions” (7, p.11). However, this view has been called into question, for instance, by feminist and care ethics approaches. The latter challenge the framing of cases as ethical problems or dilemmas because these formulations already presume that a moral dilemma is at stake. Principlism has the consequence of reducing clinical ethics to specific moral issues, which leaves aside broader considerations of human flourishing or “the good life,” and narrows the focus of ethics on decision-making (12).

In the context of casuistry, Albert Jonsen refers to “cases” (9) as “practical moral dilemmas” (8, p.1) or as “issues” (8, p.4). According to him, cases are made up of “circumstances” and “maxims.” Circumstances (i.e., all matters that surround the case) are important in the conceptualization of cases since they provide context and nuance (9). Maxims which are “brief rule-like sayings that give moral identity to the case,” (9, p.298) make up the core of the case. Casuistic methods propose to determine which maxim should direct the case (i.e., which moral direction the case should follow) and to what extent (9). “Issues” are defined by Jonsen as “the matter to be discussed in detail, the focus of attention, the knot that must be untied” (8, p.4).

Pragmatist approaches refer to “moral problems” or “morally problematic situations” which usually manifest through conflicts over, or doubts about, the best action to take in a given context (15). Clinical pragmatism brings attention to the process of “valuation” by which individuals form value judgements that are seen as reliable sources of guidance for regulating their conduct; when these value judgments prove themselves to be no longer reliable, individuals come to doubt these, which leads to moral problems where the appropriate conduct is uncertain (14).

In narrative approaches, cases are referred to as “case stories,” (16) or simply as “cases” which are seen as situations of “ethical concern” (18). Narrative approaches recognize that the process followed during a clinical ethics consultation shapes how the case is perceived (17). Cases are characterized and framed in terms of narratives: they are conceived as stories to be told and imply thus a form of linearity (i.e., they have a beginning, and an ending). Furthermore, narrative approaches recognize that the case story starts long before the beginning of the clinical ethics consultation and the healthcare encounter itself (16).

In scenario-based approaches, given the plurality of possible situations, a case can be an “ethically problematic situation” in line with pragmatist methods (19) or a “dilemma” in line with principlist methods (21). However, a distinction should be made between an ethically problematic situation (i.e., there are several moral principles at stake) and a moral dilemma (i.e., there are only two moral principles at stake) (19). Overall, an ethically problematic situation arises from a moral problem and is a situation where a decision needs to be made to resolve the problem at stake (21). Moral problems occur when interested parties are confronted with difficult choices or highly complex and often ambiguous situations (10,20). In sum, by framing “cases” as difficult choices between several moral principles, scenario-based approaches show similarities with principlism, though they differ from the latter in how cases are analyzed and what are understood to be the relevant factors therein.

Hermeneutic and deliberation-oriented methods both conceive of cases as grounded in lived experience: ethical problems stem from conflicts of values which stem from prior experiences and medical facts (22). Hermeneutic approaches, moreover, emphasize that one should use dialogue to make sense of the lived experiences of people (24). Feminist/care ethics approaches also highlight the embeddedness of cases in larger human relationships, which are themselves inscribed in power relationships and systems. Cases should be seen as “meaningful experiences and situations in general, which concern the fundamental questions of human life” (12, p.55).

Overall, some methods such as the principlist or decision-oriented methods adopt a more positivist stance and tend to view cases as situations that can be objectively described because they are made of data, facts, and values (10). These perspectives are criticized by feminist methods. Indeed, these methods advance that the presupposed “neutrality” of cases tends to erase their particular features and specificities (11). Hermeneutic methods posit that human actions are caused by a specific, embodied understanding of a situation. Each person thus has only a limited understanding of the situation, which emanates from their perspective, which is shaped by prior experiences. As such, the case is not something static nor neutral, but the sum of the stakeholder’s various and changing perspectives on the situation (24). Similarly, pragmatist methods underline the fallibility of value judgements, moral rules and principles, and the assessments of facts (14).

### *Use of moral principles in understanding cases*

Case analysis methods reflect different perspectives concerning the nature and role of moral rules and principles in the conceptualization of what cases are. According to the original interpretation of principlism, principles (or moral norms) are sourced from “common morality,” that is, a “set of norms shared by all persons committed to morality [that] is applicable to all persons in all places, and we rightly judge all human conduct by its standards” (7, p.3). Accordingly, common morality is found in all cultures, and it contains general norms that are abstract, universal and content-thin. “Particular morality”, on the other hand, contains concrete, non-universal and content-rich norms that change according to cultures, groups and individuals, as it includes their respective responsibilities, aspirations, ideals, sympathies, attitudes and sensitivities (7). For principlism, “principles do not function as precise guides to action that direct us in each circumstance in the way that more detailed rules and judgements do” (7, p.13). Casuistry refers to principles as “maxims” (9).

In contrast, for clinical pragmatism, moral principles are not fixed or immutable; rather, they function as tools or “working hypotheses” that can be tested and revised (14). For scenario-based methods, there are different substantive principles at play in different situations which inform what is right or wrong, just or unjust. These principles help formulate general rules that could be applied to particular cases (21). In hermeneutic methods, general (moral) rules and principles are created through the abstraction of certain crucial elements in the stories of participants. They help formulate the ethical problem, but they always emerge from the consultations themselves and, as such, they are always related to a concrete case and the experiences of interested parties. Because hermeneutic methods engage as many people as possible in the consultation process, moral principles and other normative considerations evolve throughout the case (24).

Deliberation-oriented methods such Gracia’s (22) rely on deontological principles. Each case involves certain principles (namely autonomy, beneficence, nonmaleficence, and justice), which must be identified and analyzed according to the circumstances of the case. Gracia classifies nonmaleficence and justice as minimalist ethical duties and part of the domain of the “public,” whilst autonomy and beneficence are maximalist ethical duties and constitute the domain of the “private.” For Gracia, the prima facie obligation is to comply with the principles, but exceptions can be made on consequentialist grounds. In Martin’s decision-oriented method, norms and principles support the decision-maker’s decisions and are created by the action of the latter’s “intellect-value complex” on the “objective context” (10). The intellect-value complex is the combination of the

decision-maker(s)' 1) ability to make sense of a situation through abstraction and the creation of concepts and, 2) their own value structure. The objective context combines 1) the facts of the case, all data (bits of information observed or that have been reported on the situation that the ethicist recognizes as somehow important to understanding the event) and, 2) the values of the interested parties (each individual's specifically "personal ideology," interests and desires, behavioral norms and role-expectations prescribed by the parties' social interrelationships, and cultural identity). The principles that will orient the actions taken in a case, born of the interaction between the intellect-value complex and the objective context, are therefore specific to that case, and they differ from the moral and philosophical principles that characterize the cultures of the decision-maker and interested parties. In sum, principles serve various functions in different clinical ethics methods. These range from more foundational roles to ground and justify recommendations, all the way to more descriptive and interpretive roles, e.g., to name and express issues at stake.

## Practices to understand cases

In this section, we review and compare the practices different case analysis methods recommended to understand the content and causes of cases, as they pertain to: 1) medical facts; 2) processes to understand situations; 3) interested parties, communication and social/power dynamics; 4) relevant contextual factors; and 5) emotions, values, and preconceptions.

### *Medical facts*

Case analysis methods generally agree that having a clear understanding of the medical facts of a case is important to be able to make sense of a case. However, how important medical facts are and what their role is in understanding a particular case will vary relative to other factors. In deliberation-oriented methods, "[e]thical problems are always connected to conflicts of values, and values are supported by fact" (22, p.230) and as such, the medical facts must first and foremost be understood in detail to be able to make sense of a case. Casuistic methods also suggest that attention should be paid to the patient's medical indications, which includes a discussion of the patient's clinical condition (e.g., diagnosis, treatment, available interventions and their goals). These methods also add that the patient's quality of life should be considered carefully. Since the goal of any medical intervention is to improve the patient's overall quality of life, it is important to ask how the latter can be improved in the specific context of the case (8). Similarly, pragmatist methods insist on understanding and critically evaluating not only the medical facts, *sensu stricto*, but also the overall life situation of the patient which can include factors such as their beliefs, values, preferences, and needs (14). This explicit focus on the patient's overall life situation is shared with feminist, hermeneutic, and scenario-based methods.

### *Description of the process of understanding cases*

The process through which cases are understood varies greatly between methods. Both pragmatist and hermeneutic methods propose an interactive and cyclical (iterative) process. The case analysis proceeds in phases within which new information is discovered and integrated into subsequent phases, leading to a progressively more detailed understanding of the case. There is continuous reanalysis and reinterpretation of the data as new information comes to light. In the hermeneutic method phases are distinct, but the iterative process can be both temporal and transversal: previous and new findings are integrated throughout the consultation process. Additionally, the design itself of the dialogue (the clinical ethics consultation) between the interested parties should not be pre-ordained by the ethicist(s) but emerge gradually from conversations to foster a sense of co-ownership. In pragmatist methods, the inquiry can be analyzed as a series of distinct steps or phases, but in reality, the process is continuous (14,24).

The hermeneutic, narrative, scenario-based, and feminist methods all appeal explicitly to narratives and stories as means to achieve understanding of a case. Hermeneutics alludes to a "narrative quest" in which the plurality of views of interested parties serve as a starting point for further exploration. Through the stories told, important patterns emerge, such as the issues that parties grapple with, their origins, and the ways parties attempt to deal with these issues (23). To adequately interpret a case, narrative methods propose paying attention to the "narrative frame" in which stories are told. This frame specifies, for instance, the protagonists of the case, the tellers of the stories, and the listeners (16). Scenario-based methods insist on the usefulness of narratives for carefully understanding a case; through stories, the complexity of a case can be reduced to its relevant components, a process known as "economizing" (20,21). Feminist methods also underline the usefulness of narrative as a tool to analyze cases, as they envision people's stories and relationships as central to ethics; resolving a case does not imply moral judgment, but the enhancement of empathy and development of these relationships (11,12).

### *Interested parties, communication and social/power dynamics*

When understanding a case, scenario-based methods such as the Doucet method take into account the perspectives of all people concerned and emphasize the importance of moral pluralism (20,21). Indeed, understanding a situation requires understanding it in all its complexity, which is not only due to the biological, psychological, and technical facts but is also the result of interactions of a complex web of actors who pursue objectives according to both individual and shared group interests (20). Paying attention to all interested parties, and making sure that their voices are heard, is thus an integral part of the case description process. Most methods agree that all interested parties should partake in the discussion equally, thereby leading to a better understanding of a case. There are, however, some differences with respect to how the role of patients and other actors is viewed.

Similarly, narrative methods favour the adoption of a pluralist stance: for instance, they allow ethicists to avoid assuming that they know what is morally best by listening to the stories of people (18). Pragmatist, hermeneutic, and feminist methods also

highlight that it is important to connect with other people, to make an effort to understand their respective points of view, and to acknowledge and take into account alternative ways of framing the moral issue or concern by asking questions from different perspectives (11-13,24). Pragmatist methods insist, moreover, on the importance of reaching a moral consensus that can withstand moral scrutiny (13). Some methods highlight that a case cannot be resolved solely by expert judgment; all people involved in the clinical ethics consultation must have space to express their opinions, and other less factual forms of knowledge should not be dismissed (13,24). Feminist methods are particularly sensitive to how power and power asymmetries prevent some from voicing their concerns and their understandings of a situation and note how others' voices can be amplified (11). Hermeneutic methods insist more specifically on the importance of taking experiential knowledge into account when framing a case because the moral knowledge of people often stems from implicit feelings and lived experiences (24).

Hermeneutic methods emphasize the importance of paying deliberate attention to "silenced voices": "those whose interests are at stake but who remain unheard and are often hard to find because, for example, they want to remain anonymous or they fear sanctions" (24, p.240). Often, patients' voices are less taken into account in case analysis methods and some methods thus insist specifically on the importance of centring the patients' experiences. Narrative methods, and the idea of a narrative frame for the situation, create opportunities to centre the patient's perspective and values when framing the case: each case story is framed "by the patient's recollections and desires rather than by the health professionals' concerns or interpretations" (16, p.10). They allow patients to be seen in their full complexity rather than as one-dimensional characters based solely on factual information (18). The views and concerns of the medical team are also important but are listened to after the patient's story has been heard. This precaution helps the clinical team to understand that they are not the protagonists of the case story and that their role is to bring pertinent information to patients and their families (16). Decision-oriented methods see the patient as a particular, historically situated individual who provides additional value-oriented information about a case (10). Casuistic methods suggest that attention should be paid to the patient's preferences by taking into account their values and their evaluation of risks and benefits. In short, one asks the question "what does the patient want?" when framing a case. In the case where the patient is not able to answer this question, someone should be identified to be responsible for articulating the patient's perspective or values (8). Finally, pragmatist and feminist methods underscore that a democratic process and deliberate efforts to understand the points of view of all relevant parties will foster the inclusion of patients' experiences (11,14).

### **Context(s)**

Context is accounted for in case analysis methods in different ways. Clinical pragmatism points to the importance of considering the social, institutional, religious, and familial contexts. Additionally, the environment where the discussions take place is important as it can make the patient and their family more or less comfortable, thereby impeding or enhancing the process of understanding the case (13). Narrative methods assert that a broad perspective on the patient's story is required, and to include this, close attention must be paid to the patient's family, community, and the social contexts that all shape the patient's story. Events that happened in the patient's remote past (e.g., childhood) may also be relevant. Similarly, Martin's decision-oriented method frames patients as historically situated individuals who create meaning and direction for their own world (life) through the combination of their value-structure and intentionality (value-intention) (10,16). In the scenario-based method, cases should be understood not only by careful description of the actual situation, but also by the repercussions that they can have for the healthcare team, and by the external factors that affect the case (21). For feminist methods, the framing of a case should include the context and the systemic conditions (e.g., socio-economic conditions) in which it has arisen (11). Casuistic methods consider the "external" impacts that can affect the patient when considering a case (e.g., legal, emotional, economic, religious) (8).

### **Emotions, values and preconceptions**

The different emotions, values, and assumptions of interested parties can, to a large degree, influence the process of understanding a case during a clinical ethics consultation and many methods explicitly touch upon these themes to make sense of cases. Hermeneutic methods emphasize that every party comes to understand a case through their individual (e.g., cultural, social) background. Interpreting a case thus is always based on prior understandings and preconceptions (23). Decision-oriented methods also acknowledge that people making decisions have a preconceived set of values that influences their analysis of a case by providing them with a set of norms and principles that informs and supports the decisions they will take. These methods not only emphasize the healthcare professional's preconceptions, but also those of the patient. Martin suggests, for example, that the patient has a complex moral (and sometimes religious) value-structure that influences the way they perceive their pain, and what should be done to respond to it. Therefore, decision-oriented methods recommend considering values, as well as empirical facts, in order to understand a case properly (10). Narrative methods similarly argue that the clinical ethicist must remain as critical of their own interpretations as they are of other interested parties' interpretations during a case. Critical reflection is needed when understanding a case, but it is also necessary throughout the consultation process (17,18).

Because cases usually arise from complex situations, ambiguity and uncertainty are often present. The hermeneutic and pragmatist methods both maintain that ambiguity and uncertainty are not only an integral part of clinical ethics consultations, but that they also can be useful when understanding a case. As explained above, hermeneutic methods argue that making sense of a case is always based on pre-understandings and preconceptions. When a variety of actors, each with different preconceptions, are trying to make sense of a case, feelings of ambiguity necessarily arise. Hermeneutics proposes that the latter should not be regarded "as a hindrance to our understanding of the situation but as its very precondition" (23, p.57). Similarly, pragmatist methods emphasize that clinical ethics cases necessarily stem from situations that arouse perplexity and doubt and that one should therefore be "open to the intrinsic ambiguity and uncertainty that inevitably attends complex clinical

cases” (15, p.142). Preconceptions and ambiguity in clinical ethics consultations are thus not seen as negative per se: they are rather constitutive of moral problems, and resolving the latter involves being reflexive about preconceptions and about their roles in the case. Finally, narrative methods emphasize that the ethicist needs to pay attention to the silences in the case story: What is the patient not mentioning? What are the gaps in their story (16)?

Methods diverge significantly on the role of emotions in understanding a case. Scenario-based methods, for instance, stipulate that having some emotional distance from the case is important when talking about a case or discussing different scenarios (21), whilst pragmatist and feminist methods both suggest that emotions are important tools for understanding the case and so adopt a charitable framework. Feminist methods stress that the understanding of a case should include the psychological and emotional responses of all persons involved (11,12). Emotions are considered part of relationships and therefore implicated in clinical ethics cases which involve tensions in human relationships. Pragmatist methods highlight more specifically that when combined with empirical facts and logical reasoning, emotions can be a valuable source of moral insight and can thus help parties to better understand a situation (14,15). Emotions are thus seen as a valuable aspect of how we relate to and understand the world.

## DISCUSSION

Understanding clinical situations is central to clinical ethics and case analysis, as evidenced by its centrality in various case analysis methods and practice guidelines. However, there are specific and variable views about what these consist of and how they should be incorporated. Our review and narrative data extraction strategy sought to analyze and contrast case analysis methods in terms of how they understand cases and recommend practices to better appreciate the nature of cases. The terminology and explicit or implicit epistemological commitments of these methods vary greatly. Principlism focuses on “dilemmas,” hermeneutic and narrative methods on “stories” and “case stories,” while pragmatist and scenario-based methods allude to “morally problematic situations.” Pragmatist, and even more so feminist, methods highlight the importance of integrating the non-clinical and social dimensions of cases and draw particular attention to power asymmetries. For this reason, they explicitly call into question the narrowing down of situations into tidy dilemmas or cases. Likewise, our review reveals that practices that are recommended to make headway in understanding cases range in nature and scope. Some methods, such as casuistry or principlism, provide rather limited detail on how or by what processes ethics consultations should construct an understanding of cases. By contrast, feminist methods, for example, offer much more detail on why and how to do so (e.g., whether, why, and when consultants should meet with the parties involved).

Although there has been extensive discussion about case analysis methods, few attempts have been made to assess these critically in light of the real-world practice of clinical ethics consultation (25). Furthermore, the academic and practical knowledge of clinical ethicists is not systematically mobilized to build and evaluate these methods, although more recent literature has seen proposals emerging from concrete practices (26-28). In the following, we reflect on some of the gaps in the literature on case analysis methods, from the perspective of a sizable co-authoring group of clinical ethicists and researchers. We formulate our comments and critical analysis below to expose some of the more striking gaps, although several issues were raised in the critical analysis of the literature which we hope to tackle in the broader process of the project in which this contribution is embedded.

### Restrictive terminology

A first critical observation is that the terminology found in the literature differs from that commonly used by the ethicists in our group in Canada. The word “case” is a common descriptor of clinical ethics situations in the literature, but in practice it can carry medical connotations and is sometimes avoided for that reason. While some routinely use the term in their practice, others do so more often in their teaching. The term “situation” is preferred by some, which can reflect a broader set of interested parties and points of view, such as patients and their circle, and professionals. Moreover, in chronic and long-term care — where the situation may be more akin to an ongoing story — the terminology of an “issue” arising within a broader narrative (personal, familial) context is a more common designation. Finally, some report that “requests” is the term that often best captures how ethicists initially become involved in a case: through a request for a meeting by one of the stakeholders (e.g., a member of the medical team).

A possible explanation for this discrepancy between practice and theory is that the term “case” and its clinical connotations were originally introduced in clinical ethics (and clinical medical ethics) through medicine and medical ethics, to confer legitimacy at a time when clinical ethics was in its infancy (29). This emphasis on cases is exemplified by Siegler, Pellegrino, and Singer’s claim that “[t]he goal of clinical ethics is to improve the quality of patient care by identifying, analyzing, and attempting to resolve the ethical problems that arise in the practice of clinical medicine” (30, p.5). At that time, there was also an eagerness in clinical ethics to take distance from principle-based bioethics — which had significantly influenced bioethics since its introduction to the field in the late 1970s — as it proved difficult to connect to clinical practice (31,32). Hence, emphasizing the medical aspects of clinical ethics, including its terminology and method, could have been a strategy to bring bioethics closer to medical practice. Medical jurisprudence might also have had an influence given its emphasis on the analysis of cases and policies (33).

When the term “case” was first introduced in clinical ethics, consultations were primarily focused on the issues that arose between patients and doctors. Yet, patients and doctors are not the only parties in a consultation; just as the ethicist’s presence

and influence on the case came to be recognized as the practice of clinical ethics consultation grew, it is now understood that a variety of individuals (e.g., family members, nurses, and other healthcare professionals) can be considered interested parties within an ethics consultation, that is, parties who often have moral standing in a situation (1). In addition, organizational ethics is also of increasing importance to the field, and it can now be difficult to differentiate between clinical and organizational ethics (34). Tellingly, the term “clinical-organizational ethics” (“éthique clinico-organisationnelle”) is used in some Canadian practice settings, sometimes to reflect their interconnections. This could be an example showing how theoretical terminology lags behind the evolution of the profession’s reality, including its institutional and organizational dimensions (35-37). Due to its foothold in medicine, the term “case” may not capture the diversity of interested parties and ethical orientations involved in clinical and organizational ethics.

## Gaps between theory and practice

A related observation is that current case analysis methods evince more theoretical sophistication (e.g., about terminology and theoretical commitments) than practice can integrate, amounting to a sizable gap between theory and practice. Ill-fitting or restrictive terminology may lead to misunderstandings and distortions with regard to understanding the issue at stake. For instance, if a situation is conceived of as a “case” in a narrower theoretical sense (e.g., following precepts of casuistry), this may leave in the shadow the informal preparatory work done to transform an issue into a case. It may lose sight of how a given situation is a narrative that started before the official case and will continue thereafter (16), or it may overlook the relationships that make up the moral situation, and which may express asymmetrical power dynamics (11). For example, when ethicists receive a request, they must assess whether the situation is one that necessitates a clinical ethics consultation; more specifically, they must assess whether there is an ethical problem at stake and ascertain what that problem may be.

This pre-consultation process will likely be iterative and intersubjective (6). Some situations may also require explorations of norms (clinical, legal, deontological) done in parallel with, or as part of, the ethics consultation process, to determine if the case is predominantly ethical, deontological (e.g., related to professional codes of conduct), or legal in nature. In contrast, the term “case” can imply — at least from the standpoint of certain methods — a relatively finite situation with a clear beginning and end. Warning against this possibility, the ASBH’s bioethics facilitation method points to “narrative reconstruction” as a means to clarify the issue at hand; it is important to recognize that when ethicists are approached with a new case, it is initially through the perspective of only one or some of the interested parties (1). Moreover, a given “issue” might span an extended period of time, and there may be changes that influence or change the nature of the situation. In fact, many ethical issues can be complex and long-lasting as is suggested by narrative ethics (16).

In the literature on case analysis methods, “cases” commonly refer to either salient or particularly illustrative ethical issues or dilemmas. Although these are useful for thinking more clearly about ethical issues, they may overshadow some aspects of daily ethics consultation practices. By focusing on these salient cases as examples, some methods may obfuscate more common and less dramatic ethical issues and therefore impede the development of conceptual tools and practical advice for resolving quotidian issues (38). In sum, the narrower theoretical understandings of moral situations (e.g., as dilemmas within principlism, or as cases as suggested in casuistry) do not squarely correspond to practices. In line with this observation about the lack of clear application or boundaries of certain theories, we note that some common theories and methods (e.g., principlism) have also been described as adapting in response to other approaches (e.g., pragmatism) (39).

## Oversight of context

Several methods suggest, from a terminological and practical standpoint, that “cases” in a narrow sense are the unit of analysis, the foundational starting point. However, in ethics consultation practice, the boundary between specific cases and organizational and contextual issues is often blurred because of the connections between organizational culture and specific situations. Some methods (e.g., feminist methods) pay heed to the ways that contexts shape the nature of cases and speak directly to how a situation’s understanding is generated within clinical ethics consultation practice, but they do not all tackle this squarely. For example, it is well documented that people can receive suboptimal care because of various important social factors, such as socio-economic marginalization, racism, sexism, ageism, and other broad economic, political or ideological forces that contribute to shaping concrete situations (40). Such factors, which can lead to discrepancies with respect to standards of care, do not only represent an aspect of the situation, but a broader organizational and social issue — one which it may be beneficial or even crucial to integrate to understand the situation at hand. Recent proposals to supplement existing methods (e.g., casuistry) with additional layers of considerations (e.g., an awareness of the effects of anti-Black racism) are important steps in expanding the understanding of clinical ethics situations (40).

## Cursory treatment of power dynamics and trust

A few methods (e.g., feminist, pragmatist) touch explicitly upon power dynamics while others tend to gloss over it (e.g., principlism, casuistry). Likewise, the ASBH explains that, when understanding a case, ethicists should be aware of power relationships between interested parties and should identify how these relationships influence how ethicists and stakeholders communicate (e.g., what information is emphasized or de-emphasized) (41). However, these methods offer limited detail to help guide efforts to identify and address power dynamics within the process of case analysis. Power dynamics can lead to the prioritization of certain relationships and voices over others. For instance, prioritizing the voice of a physician may lead to an emphasis on medical facts, whereas emphasizing the voice of a social worker may lead to a different focus (42). The

amplification of one voice over another can perpetuate negative power dynamics or result in a power imbalance which may itself be the cause of the actual ethical problem (43).

Related to the management of power dynamics is the cultivation and maintenance of trust by the clinical ethicist with regard to stakeholders. Trust ensures that stakeholders can express their uneasiness about a situation and discuss it openly. Yet the specific effects of trust and distrust between ethicists and stakeholders on case analysis and the consultation process is a topic seldom discussed directly by methods found in the literature. The topic surfaces most often when discussing the importance of communication skills. In our experience, the trust built by ethicists is central to their practices, notably because the ability to reach people and uncover salient information is vital to understanding situations fully. Trust cannot be built solely by offering high quality consultation services; training and education offered to the institution's personnel, presentations delivered during meetings, and recurring, positive, quotidian interactions with staff members, patients, and others, can greatly influence how much trust is afforded to individual ethicists within a clinical ethics consultation.

Ethicists may also need to maintain trust throughout the course of long-term relationships with the people for whom, and with whom, they are consulting if they are to remain credible agents. There may be instances in which a tension arises between, on the one hand, the desire to preserve trust, and, on the other hand, the desire to do rigorous work that may challenge existing relationships, such as when the case consultation raises disturbing questions about professional practice and attitudes. These conflicting obligations must be acknowledged, but existing methods offer little guidance on how to do so. Ideally, clinical ethicists are empowered to ask difficult questions and do rigorous work in ways that do not undermine the organization's ability to function but instead facilitate its functioning in alignment with its own fundamental values commitments. However, asking genuine ethical questions can disrupt the status quo and predetermined orientations. Trust is also often in flux — it can be built, and it can be undermined, and being aware of this ebb and flow is significant, for instance, if the ethicist is to be able to access the information needed to build a nuanced understanding of a given situation.

### Limited awareness of the positionality of ethicists and stakeholders

Several methods recognize the influence of the ethicist's values and perspectives on their practice, including how they make sense of situations and the kinds of biases that can influence their understanding of various situations (11,16). However, the treatment of this aspect of the work could be enhanced significantly with increased attention to recent literature investigating ethicists' positionality (e.g., race/ethnicity, gender, age) and background, and why it matters. The ASBH argues that ethicists must be aware of their own values and their potential influence on their practice (41). But more work on what this means and how to achieve it is needed. We recognize that, beyond the perspective of individual clinical ethicists, they are recruited into institutions which entertain reasons and provide conditions for the establishment and use of clinical ethics services.

Ethicists are not free from bias, even if their work often involves uncovering or debunking bias and stigma (44). An intersectional approach would require an ethicist to be aware of and sensitive to their own positionality as a factor shaping their understanding of situations (45). For example, cases are situated within large-scale, systemic factors and issues (e.g., social construction of categories like race, ethnicity, gender to produce systemic phenomena like racism, transphobia, and sexism within the context of healthcare). An ethicist's history, experience, and positionality may influence how they see, or fail to see, aspects of the ethical problems arising in their professional context. The positionality of the ethicist is a variable that inevitably enters the intersubjective equation that factors into how situations are framed and understood, such that the ethicist's positionality not only affects their ability to understand the case but also the lens through which the process of framing the case occurs. For example, a situation framed as one involving a difficult patient might be better (re)framed as one involving a patient who has previously been subjected to racist attitudes and behaviours (40).

Furthermore, whilst some major bioethics journals have published special issues on the pervasiveness of Indigenous-specific racism, anti-Black racism, other systemic injustices, and there is widespread acceptance of the need for anti-oppressive practices and anti-bias training, these are only starting to be incorporated in the training of ethicists. On the same note, while case analysis methods have for a long time included considerations for all relevant aspects of the case, not all offer detailed resources to situate a case within larger systemic frameworks (36). For example, it is well known that pain treatment is biased toward under-recognition and under-treatment in non-white people, and that under treatment of pain is particularly pervasive in the care of Black people (46). Likewise, there is lingering stigma and health-related discrimination toward Indigenous patients in Canadian health settings (47,48).

Given these realities, understanding cases properly requires an expanded lens and closer attention to additional considerations. Whilst many methods highlight the importance of understanding the medical facts and the patient's demographic background, they may not be explicit enough in emphasizing the nuances and implications of socio-cultural identity and systemic oppression (49). By contrast, the practices in some clinical settings may reflect a deeper understanding of these systemic factors than is reported in the literature. For example, some Canadian hospitals now have "Indigenous Navigators" as well as Indigenous health programs. The existence of these resources supports responses that are more sensitive to socio-cultural factors and merit consideration in the context of clinical ethics consultation. Addressing the positionality of ethicists and interested parties may involve further consideration of how ethicists can work with other internal institutional supports (e.g., colleagues who have expertise in law, equity and human rights, cultural safety, social work, spiritual care) and how their work fits within overall health systems.

## Limitations

Our efforts to review the literature and offer a critical perspective based on insights from clinical ethics experiences in the Canadian setting allowed us to structure a literature review in terms of practical considerations and to create a space where clinical ethicists can reflect on and share existing practices, in order to evaluate published accounts of case analysis methodology more critically. However, this exercise has several limitations. First, we could not embark on a systematic review of the literature due to methodological and practical reasons and theoretically, this did not fit the purpose of the project. Relatedly, some approaches (e.g., mediation, Indigenous knowledge generation and sharing) to resolving ethical issues may not fall under the label of case analysis methods and were therefore not included in our sample. Second, the representation of clinical ethicists in our authors' group, although broad, is certainly not exhaustive and reflects known challenges related to a lack of diversity in the field of bioethics as discussed above. Finally, this critical review is only a first step in our collaborative project; the initial critical analysis of the literature will serve to further document Canadian practices and develop more advanced and concrete practices.

## CONCLUSION

Clinical ethics is largely about understanding and surmounting specific moral situations. Our review of the literature showed that diverse case analysis methods make wide-ranging proposals for terminology (e.g., "dilemmas," "cases," "scenarios," "stories") and practices to understand these situations (e.g., continuous, cyclical, iterative). However, based on our critical analysis and by drawing on our experience, we note that certain aspects of these proposals are quite distant from actual clinical ethics practice. Accounts of clinical ethics case analysis methods may offer insights on how to conduct an ethics consultation, but they rarely draw directly and explicitly from the practical experience of ethicists. Perhaps this is the case because several methods were developed prior to ethics consultation expanding significantly and the work has not received sufficient subsequent attention to revise theory in light of current practices. It is thus necessary to bridge gaps between clinical ethics methods and actual practice in ways that draw from both the clarity and simplicity of theory, and the wisdom and experiential knowledge of practice. There is also an important gap to address relative to the ways that clinical ethicists make decisions about which method(s) to use in specific cases given that many clinical ethicists work with a variety of approaches. At this time, there is a lack of metaethical theory that would help ethicists determine which methods they should be using in specific circumstances and contexts. As a next step in our collaborative work, we plan to document practices in clinical ethics case understanding to identify promising practices therein.

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### Conflicts of Interest

None to declare

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## REFERENCES

1. ASBH. Core Competencies for Health Care Ethics Consultation. 3<sup>rd</sup> ed. Schaumburg, IL: American Society for Bioethics and Humanities; 2025.
2. Racine E. [L'éthique clinique, les émotions et le processus d'analyse de cas: Une étude qualitative et multi-site de comités d'éthique clinique québécois](#). PhD Thesis. Montréal: Université de Montréal; 2004.

3. Racine E. *The Theory of Deliberative Wisdom*. Cambridge, MA: MIT Press; 2024.
4. Racine E, Ji S, Badro V, Bogossian A, et al. [Living ethics: a stance and its implications in health ethics](#). *Medicine, Health Care and Philosophy*. 2024;27(2):137-54.
5. McDougall R. [Reviewing literature in bioethics research: Increasing rigour in non-systematic reviews](#). *Bioethics*. 2015;29(7):523-28.
6. Jiwani B. [Clinical Ethics Consultation: A Practical Guide](#). Cham: Springer; 2017.
7. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. Oxford: Oxford University Press; 2009.
8. Jonsen AR. [Case analysis in clinical ethics](#). *The Journal of Clinical Ethics*. 1990;1(1):63-65.
9. Jonsen AR. [Casuistry as methodology in clinical ethics](#). *Theoretical Medicine and Bioethics*. 1991;12(4):295-307.
10. Martin RM. [A clinical model for decision-making](#). *Journal of Medical Ethics*. 1978;4(4):200-6.
11. DeRenzo EG, Strauss M. [A feminist model for clinical ethics consultation: Increasing attention to context and narrative](#). *HEC Forum*. 1997;9(3):212-27.
12. Schuchter P, Heller A. [The care dialog: The "ethics of care" approach and its importance for clinical ethics consultation](#). *Medicine, Health Care and Philosophy*. 2018;21(1):51-62.
13. Fins JJ, Bacchetta MD, Miller FG. [Clinical pragmatism: A method of moral problem solving](#). *Kennedy Institute of Ethics Journal*. 1997;7(2):129-45.
14. Miller FG, Fins JJ, Bacchetta MD. [Clinical pragmatism: John Dewey and clinical ethics](#). *Journal of Contemporary Health Law & Policy*. 1996;13(1):27-51.
15. Miller FG, Fletcher JC, Fins JJ. Clinical pragmatism: A case method of moral problem solving. In: Fletcher JC, Lombardo PA, Marshall MF, Miller FG, editors. *Introduction to Clinical Ethics*. Hagerstown: University Publishing Group; 1997. p. 21-34.
16. Charon R, Montello M. [Framing the case: narrative approaches for healthcare ethics committees](#). *HEC Forum*. 1999;11(1):6-15.
17. Agich GJ. Narrative and method in ethics consultation. In: Finder SG, Bliton MJ, editors. *Peer Review, Peer Education, and Modeling in the Practice of Clinical Ethics Consultation: The Zadeh project*. Cham: Springer; 2018. p. 139-50.
18. Churchill L. [Narrative awareness in ethics consultations: the ethics consultant as story-maker](#). *Hastings Center Report*. 2014;44(1 Suppl):S36-39.
19. Dion-Labrie M. Présentation d'une grille d'analyse pour la résolution de situation éthiques problématiques en réadaptation physique. Association des établissements de réadaptation en déficience physique du Québec; 2009.
20. Doucet H. Éthique clinique et analyse de cas. In: Birmelé B, editor. *Des méthodes de travail pour un lieu de réflexion éthique*. CHU Tours: Espace de Réflexion Éthique Région Centre; 1995.
21. Baertschi B. Les méthodes de résolution de cas. *Bioethica Forum*. 1998;26:4-11.
22. Gracia D. [Ethical case deliberation and decision making](#). *Medicine, Health Care and Philosophy*. 2003;6(3):227-33.
23. Widdershoven G. Interpretation and dialogue in hermeneutic ethics. In: Ashcroft R, Lucassen A, Parker M, Verkerk M, Widdershoven G, editors. *Case Analysis in Clinical Ethics*. Cambridge: Cambridge University Press; 2005. p. 57-76.
24. Widdershoven G, Abma T, Molewijk B. [Empirical ethics as dialogical practice](#). *Bioethics*. 2009;23(4):236-48.
25. Bell JAH, Salis M, Tong E, et al. [Clinical ethics consultations: A scoping review of reported outcomes](#). *BMC Medical Ethics*. 2022;23:99.
26. Delany C, Feldman S, Kameniar B, Gillam L. [Critical dialogue method of ethics consultation: Making clinical ethics facilitation visible and accessible](#). *Journal of Medical Ethics*. 2025;51(1):10-16.
27. Felder RM. [Toward a new clinical pragmatism: Method in clinical ethics consultation](#). *Medicine, Health Care and Philosophy*. 2024;27(3):445-54.
28. Feldman S, Gillam L, McDougall RJ, Delaney C. [How is clinical ethics reasoning done in practice? A review of the empirical literature](#). *Journal of Medical Ethics*. 2026;52(1):32-38.
29. Jonsen AR, Siegler M, Winslade WT. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. New York: McGraw-Hill; 1998.
30. Siegler M, Pellegrino ED, Singer PA. [Clinical medical ethics](#). *Journal of Clinical Ethics*. 1990;1(1):5-9.
31. Singer PA, Pellegrino ED, Siegler M. [Clinical ethics revisited](#). *BMC Medical Ethics*. 2001;2:1.
32. Siegler M. [Clinical medical ethics: its history and contributions to American medicine](#). *Journal of Clinical Ethics*. 2019;30(1):17-26.
33. Berto M. [The influence of medical jurisprudence on healthcare policy and legislation](#). *Journal of Forensic Medicine*. 2023;8(6):229.
34. Bean S. [Navigating the murky intersection between clinical and organizational ethics: A hybrid case taxonomy](#). *Bioethics*. 2011;25(6):320-5.
35. Legault G-A. *Professionnalisme et délibération éthique: Manuel d'aide à la décision responsable*. Québec: Presses de l'Université du Québec; 1999.
36. Quintin J, Boire-Lavigne A-M. [Exercer une délibération en éthique clinique avec le souci de l'expérience des personnes](#). In: Farmer Y, Bouthillier M-È, Roigt D, editors. *La prise de décision en éthique clinique: Perspectives micro, méso et macro*. Québec: Presses de l'Université du Québec; 2013. p.43-70.
37. Legault GA. [La délibération éthique au cœur de l'éthique appliquée](#). *Revue française d'éthique appliquée*. 2016;26(1):37-44.
38. Zizzo N, Bell E, Racine E. [What is everyday ethics? A review and a proposal for an integrative concept](#). *Journal of Clinical Ethics*. 2016;27(2):117-28.

39. Schmidt-Felzman H. [Pragmatic principles--methodological pragmatism in the principle-based approach to bioethics](#). *Journal of Medicine and Philosophy*. 2003;28(5-6):581-96.
40. Vo H, Campelia GD, Olszewski AE. [Addressing racism in ethics consultation: An expansion of the Four-Box Method](#). *Journal of Clinical Ethics*. 2023;34(1):11-26.
41. Clinical Ethics Consultation Affairs Committee. *Improving Competencies in Clinical Ethics Consultation: An Education Guide*. American Society for Bioethics and Humanities; 2015.
42. Doucet H, Larouche J-M, Melchin KR. *Ethical Deliberation in Multiprofessional Health Care Teams*. Ottawa: University of Ottawa Press; 2001.
43. Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press; 2007.
44. MacDuffie KE, Patneau A, Bell S, et al. [Addressing racism in the healthcare encounter: The role of clinical ethics consultants](#). *Bioethics*. 2022;36(3):313-17.
45. Grzanka PR, Brian JD, Shim JK. [My bioethics will be intersectional or it will be \[bleep\]](#). *American Journal of Bioethics*. 2016;16(4):27-9.
46. Gillis L. [Report finds patients of colour less likely to get pain meds among racial issues plaguing health care](#). Ontario Health Coalition. 10 Jun 2020.
47. Boyer Y. [Healing racism in Canadian health care](#). *Canadian Medical Association Journal*. 2017;189(46):e1408-9.
48. Conseil des Atikamekw de Manawan, Conseil de la Nation Atikamekw. [Principe de Joyce](#). Nov 2020.
49. Linklater R. *Decolonizing Trauma Work. Indigenous Stories and Strategies*. Kijipuktuk: Fernwood Publishing; 2014.