Society of Medical Education & Research

2026, Volume 6, Issue 1, Page No: 31-41
ISSN: 3108-5059

Asian Journal of Ethics in Health and Medicine

How Clinicians Resolve Value Conflict at the Bedside: An Integrative Review of Ethical Reasoning and Decision Frameworks

Kenji Tanaka[1]*, Yui Kobayashi[1], Takeshi Nakamura[2]

[1]Department of Clinical Ethics and Bedside Decision-Making, Faculty of Medicine, University of Tokyo, Tokyo, Japan.
[2]Department of Value Conflict Resolution and Ethical Frameworks, Faculty of Medicine, Kyoto University, Kyoto, Japan.

***E-mail** ✉ tanaka.kenji@med.u-tokyo.ac.jp

Abstract

Bedside decisions become ethically difficult when clinically defensible options implicate competing patient values, professional obligations, relationships, prognostic uncertainties, or institutional constraints. Clinical ethics offers multiple reasoning traditions and decision frameworks, yet these approaches differ in what they treat as morally salient and how they organize disagreement. Their relationship to the reasoning work clinicians perform in practice remains incompletely integrated. An integrative review combined normative, conceptual, qualitative, quantitative, clinical-ethics, educational, and methodological scholarship relevant to bedside value conflict. Targeted multidisciplinary searching used PubMed/MEDLINE-indexed discovery, publisher and journal-site searching, DOI-indexed retrieval, and citation chaining. Fifty-two candidate-record manifestations were registered; four duplicates or version manifestations were removed, 48 unique records were screened, 41 reports underwent full-text assessment, and 34 sources were included. Evidence was appraised according to source type rather than through a single common quality score. The literature does not support reducing bedside ethical reasoning to one framework or decision rule. Instead, different traditions foreground principles and obligations, cases, narratives, relationships, care and practical judgment, or structured deliberative procedure. Across these traditions, the review identifies recurring but non-sequential reasoning work involving recognition, interpretation, contextualization, comparison, prioritization, negotiation, justification, action, documentation, and reconsideration. Bedside value conflict is best understood as a multidimensional deliberative problem rather than a purely informational deficit. The review develops a proposed integrative reconstruction of how heterogeneous ethical considerations become clinically actionable while preserving uncertainty, reasonable disagreement, contextual variation, and the distinction between defensible reasoning and validated clinical effectiveness.

Keywords: Clinical ethics, Ethical reasoning, Value conflict, Bedside decision-making, Moral deliberation, Relational autonomy

Introduction

Bedside ethical conflict arises when determining what should be done requires more than identifying medically available options. Clinical ethics consultation makes this additional work visible by articulating contested values, formulating the ethical question, examining alternatives, and requiring reasons for a proposed course of action [1]. The difficulty is therefore not simply that different participants prefer different outcomes. It is that clinically plausible choices may be supported by competing moral considerations whose relevance and relative importance must themselves be interpreted.

Reasoning in such situations is not uniformly principle-driven. Observation of moral case deliberation in intensive care shows clinicians using comparisons with previous or paradigm cases while also revealing how

Access this article online https://smerpub.com/

Received: 30 October 2025; **Accepted:** 07 February 2026

How to cite this article: Tanaka K, Kobayashi Y, Nakamura T. How Clinicians Resolve Value Conflict at the Bedside: An Integrative Review of Ethical Reasoning and Decision Frameworks. Asian J Ethics Health Med. 2026;6(1):31-41. https://doi.org/10.51847/fkfmaZWNFc

insufficiently scrutinized analogies can generate unwarranted moral certainty [2]. Ethical reasoning can therefore be structured without becoming mechanically reliable.

Autonomy also changes meaning when examined in actual decision relationships. Relational-autonomy evidence indicates that information, family influence, professional behaviour, interpersonal support, and power can enable or constrain a patient's ability to participate in decisions [3]. This challenges models in which preferences enter deliberation as already settled and context-free data.

Recent qualitative work further locates ethical encounters within ordinary hospital practice rather than exclusively within formal consultation services [4]. Taken together, these findings suggest that bedside value conflict is produced and managed through interactions among clinical judgment, patient values, professional commitments, relationships, institutional circumstances, and the practical conditions under which disagreement becomes speakable.

Review purpose and questions

This review examines how clinicians reason when bedside decisions involve competing values and how different ethical traditions structure that reasoning. Its purpose is not to identify a universally superior framework. The selected literature does not support such a ranking. Instead, the review asks what different frameworks make visible, what kinds of reasoning work recur across them, and which clinical, relational, emotional, professional, or institutional conditions alter how ethical deliberation proceeds.

One reason for examining reasoning processes rather than framework labels alone is that structured ethics support remains vulnerable to features of human judgment. A recent review of cognitive bias in clinical ethics support identifies multiple plausible cognitive and affective influences on assessment while also finding that their practical effects remain insufficiently characterized [5]. A procedure may therefore improve transparency without guaranteeing neutrality or correctness.

A second reason is that the outcome literature offers no single criterion for judging ethical reasoning. Reported outcomes of clinical ethics consultation differ substantially in definition, measurement, stakeholder perspective, and clinical setting [6]. Agreement, reduced conflict, satisfaction, treatment change, decisional clarity, and moral justification are related but non-equivalent endpoints.

The review consequently addresses three questions: which families of ethical reasoning are represented in contemporary bedside ethics; which reasoning activities recur across otherwise different approaches; and which contextual conditions constrain their use? The intended contribution is an integrative reconstruction of bedside deliberation, not an assertion that one sequence or framework has been clinically validated.

Integrative review methodology

An integrative-review design was selected because the review question spans scholarship that makes different kinds of claims. Empirical studies can describe what clinicians, patients, families, or teams experience and do; normative scholarship can examine what reasons should count and how competing obligations ought to be justified; conceptual work can refine the categories through which those problems are understood. Integrative review methodology is suited to connecting heterogeneous evidence while developing higher-order conceptual understanding [7].

The method therefore preserved differences among evidence types rather than translating every source into a common hierarchy. Review design, search strategy, inclusion criteria, appraisal, and synthesis were aligned with the purpose of the question, consistent with methodological guidance emphasizing coherence between review purpose and review method [8].

This produced a two-level analytic strategy. The first level retained each source's own evidential status: empirical association remained empirical association, qualitative interpretation remained contextual evidence, and normative argument remained normative argument. The second level compared what those sources contributed to the shared problem of bedside value conflict. Integration occurred only at that second level, where recurring reasoning functions, tensions, and boundaries could be examined without implying that methodologically unlike studies provided interchangeable evidence.

Eligibility criteria

Eligible sources were peer-reviewed journal articles published from 2017 through 2026 that contributed directly to understanding bedside value conflict, ethical reasoning, moral deliberation, clinical ethics consultation, patient-value interpretation, professional

obligations, relational or contextual ethics, ethics education, or methodological decisions required for heterogeneous bioethics synthesis.

Normative and conceptual papers were eligible because ethical decision-making cannot be reconstructed solely from observed behaviour. Reviews of reasons demonstrate that justificatory considerations can themselves be systematically identified and compared when the question concerns why an action should or should not be taken [9]. Qualitative, quantitative, mixed-method, educational, and review-level studies were eligible when their design supported a specific planned inference.

Eligibility was therefore based on contribution to the review question rather than conformity to one research design. Methodological guidance distinguishing review types reinforced the need to match methods to the purpose of the synthesis rather than infer a systematic-review identity from isolated procedural features [10].

Sources were excluded when they lacked direct relevance to a reasoning, framework, contextual, methodological, limitation, or synthesis claim; duplicated another publication version; required substantial extrapolation beyond the population or setting studied; or focused primarily on measurement, technological governance, or exceptional contexts without contributing a distinct transferable insight. Recency alone did not constitute eligibility.

Information sources and search strategy

Searching was completed on 9 August 2026 through complementary routes designed to capture clinical ethics, bioethics, patient decision-making, moral deliberation, ethics-support, professional reasoning, and educational scholarship. PubMed/MEDLINE-indexed discovery was supplemented by targeted publisher and journal-site searches, DOI-indexed retrieval, and backward or forward citation chaining.

Search concepts combined terms related to bedside decision-making, ethical conflict, moral deliberation, clinical ethics consultation, autonomy, relational ethics, professional responsibility, casuistry, ethical frameworks, shared decision-making, interprofessional reasoning, emotional or moral signals, and ethics education. Search strings were adapted to source interfaces rather than treated as one database-independent expression.

Transparent reporting of search routes and concepts was informed by established search-reporting guidance [11]. That guidance was used to improve inspectability of the retrieval process, not to claim exhaustive systematic-search coverage.

Selection terminology similarly distinguished identification, deduplication, screening, full-text assessment, exclusion, and inclusion in a manner consistent with contemporary review-flow reporting conventions [12]. These conventions support clear accounting of the evidence pathway but do not alter the declared integrative-review design. Candidate records entered the screening register only when bibliographic and preliminary content assessment indicated plausible relevance to a defined component of the review.

Evidence selection and critical appraisal

The search routes produced 52 candidate-record manifestations entered into the review register. Four duplicate DOI or publication-version manifestations were removed, leaving 48 unique records for title-and-abstract screening. Seven were excluded at that stage. Full texts were sought for 41 records; none was unavailable. Seven were subsequently excluded because their contribution was redundant, excessively setting-specific, primarily psychometric, AI-specific, pandemic-specific, or insufficiently concerned with how value conflict was reasoned through. Thirty-four sources were retained for integration.

Appraisal was claim-sensitive rather than reduced to one numerical quality score. Empirical studies were examined in relation to the adequacy of their design, sampling, measurement, analytic approach, and setting for the specific inference assigned to them. Mixed-method appraisal work supports such design-sensitive assessment across heterogeneous empirical evidence [13].

Normative and conceptual scholarship required a different judgment. Methodological analysis of normative-review appraisal shows that argument quality, explicit assumptions, relevance of reasons, treatment of counterarguments, and the relation between empirical premises and normative conclusions cannot be represented adequately through conventional empirical risk-of-bias criteria [14]. Accordingly, normative sources were assessed for argumentative relevance and permissible inferential scope rather than being assigned an empirical quality score.

Data extraction and integrative synthesis

Extraction was designed to preserve what made the evidence heterogeneous. For normative and conceptual sources, fields captured the focal ethical problem, operative reasons or duties, argumentative structure, assumptions, competing positions, practical implications, and stated or inferable boundaries. Reviews of normative ethics methodology demonstrate substantial variation in how arguments are searched, selected, analysed, and synthesized, supporting explicit extraction of justificatory content rather than treating normative papers as if they were empirical observations [15].

For empirical bioethics literature, extraction captured design, clinical or educational setting, population or unit of analysis, focal construct, observed reasoning process, contextual influences, reported outcomes or implications, and limitations. Meta-review evidence indicates substantial methodological heterogeneity across empirical bioethics reviews, reinforcing the need to characterize evidence before integrating it [16].

Synthesis proceeded iteratively. Sources were first read within their own methodological and normative terms. They were then compared according to the ethical work they performed: what made a conflict visible, what information required interpretation, what values or obligations were brought into competition, how disagreement was handled, what justified movement toward action, and what conditions limited transferability. Convergence across unlike sources was treated as conceptual reinforcement rather than pooled empirical effect. Divergence was retained when it reflected genuine normative disagreement, professional difference, contextual dependence, or methodological incompatibility.

Only after this methodological architecture had been established was the review-methods table generated. **Table 1** therefore represents the actual logic used to transform heterogeneous evidence into an integrative bedside-ethics synthesis rather than a predefined inventory of review procedures.

Table 1. Preserving evidential identity while constructing an integrative account of bedside ethical reasoning

Evidence stream	What entered extraction	Appraisal emphasis	Contribution to synthesis	Inference deliberately withheld
Normative and conceptual scholarship	Reasons, duties, concepts, assumptions, counterpositions, boundaries	Argument relevance, explicitness, coherence, relation between premises and conclusions	Clarifies what may count morally and why competing actions remain defensible	Normative argument was not treated as observed clinician behaviour
Qualitative empirical evidence	Experiences, interpretations, interactions, contextual influences, reasoning practices	Fit between sampling, data generation, analysis, and the assigned contextual claim	Shows how ethical problems become interpreted within real clinical relationships	Local accounts were not treated as prevalence estimates
Quantitative and mixed empirical evidence	Associations, measured outcomes, intervention findings, group or setting differences	Design-sensitive assessment of measurement and inference	Tests whether selected processes or conditions are empirically observable	Association was not converted into causation or ethical justification
Review-level bioethics evidence	Synthesized patterns, methodological heterogeneity, reported gaps	Transparency of review design and compatibility between included evidence and conclusion	Identifies convergence, disagreement, and gaps across dispersed literatures	Review conclusions were not automatically treated as primary evidence
Methodological and reporting scholarship	Review-design principles, appraisal logic, search and flow-reporting conventions	Relevance to the declared integrative purpose	Makes the evidence pathway explicit and prevents methodological flattening	Reporting conventions were not used to claim systematic-review status

Table note: The organizing distinction between "evidential identity" and "integrative contribution" is a proposed methodological synthesis developed within this review. It denotes how methodologically unlike sources were combined without treating them as epistemically interchangeable.

Characteristics of the included literature

The evidence pathway is shown before the substantive findings because the final synthesis depends on deliberate integration of unlike forms of scholarship rather than on a single empirical study type.

Figure 1 presents the manuscript-derived evidence pathway used to construct the integrative review.

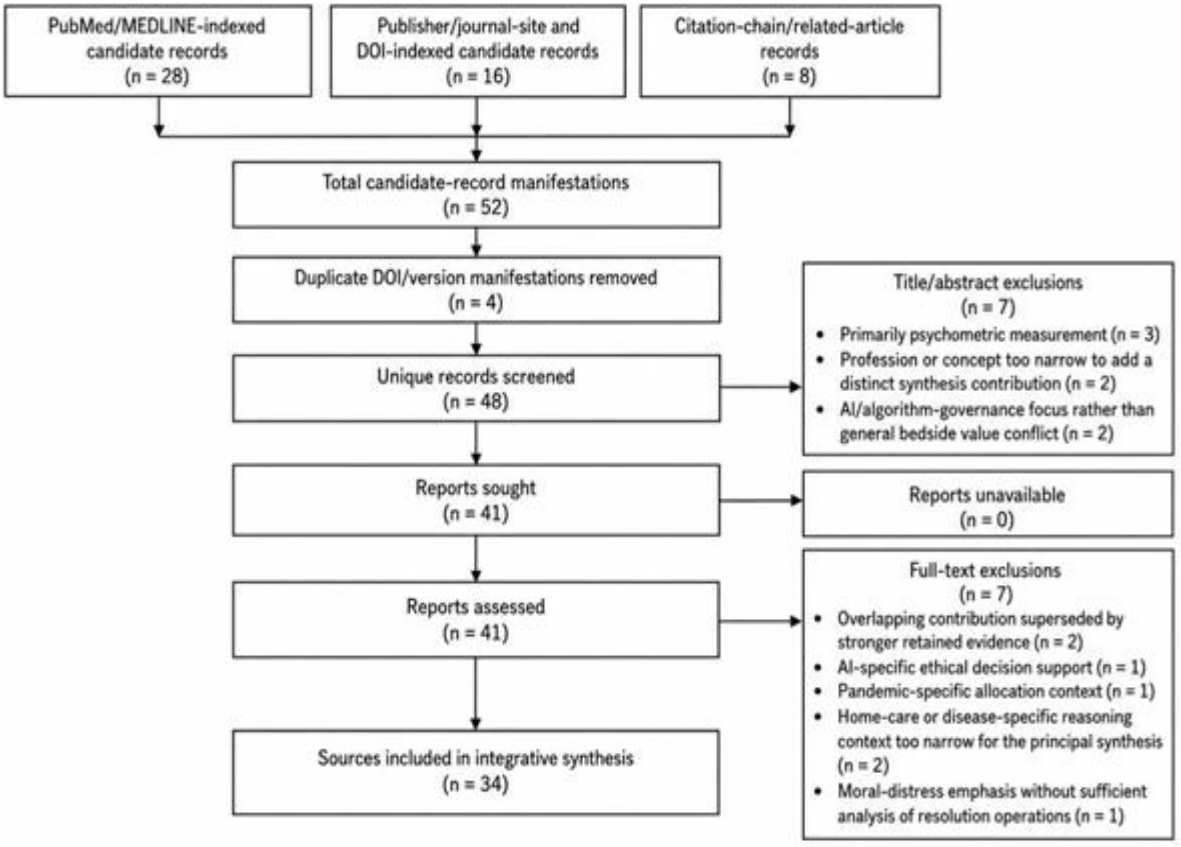

Figure 1. Evidence pathway for the integrative review of bedside value-conflict reasoning

The retained literature itself was heterogeneous in setting, unit of analysis, and type of ethical claim. Clinical ethics consultation records included conflicts involving surrogate decision-making, treatment limitation, documentation, disagreement, and multiple specialties, demonstrating that value conflict crosses conventional service boundaries [17]. Intensive-care evidence also showed that ethics-consultation patterns and associated outcomes may differ across medical and surgical environments and under particular institutional policies [18]. These findings make setting an analytic variable rather than a background descriptor.

The evidence therefore ranged from patients and clinicians to families, interprofessional teams, consultation encounters, educational groups, and institutional practices. Some studies described what occurred; others interpreted experiences, tested associations, articulated duties, or reconstructed ethical concepts. The most defensible synthesis was consequently not a tally of which framework appeared most often, but an examination of what different approaches allowed clinicians to notice, interpret, contest, and justify.

Families of ethical reasoning and decision frameworks

The framework literature differed most clearly in what each approach treats as the primary object of moral attention. Principle- and obligation-oriented reasoning begins with duties, rights, professional standards, or constraints. The revised International Code of Medical Ethics demonstrates the continuing relevance of articulated professional obligations while also illustrating why a code cannot determine every contested bedside judgment by itself [19].

Other traditions relocate the moral centre. Evidence from nurses' everyday ethics suggests that care and justice reasoning can be distinguishable yet complementary: one may foreground responsiveness to persons and relationships while another emphasizes consistency, entitlement, and fair treatment [20]. Procedural ethics-support tools take another route by structuring reflection itself. The Confidentiality Compass, for example, organizes deliberation around confidentiality conflict

without claiming to function as a universally valid decision algorithm [21].

Narrative, relational, and casuistic approaches further resist abstraction by asking how the case is told, who is situated within it, and which similarities or differences to previous cases are morally relevant. The review therefore does not treat framework families as competing brands. Their differences lie in the ethical material they privilege and the characteristic mistakes they are designed to prevent.

Table 2 presents the manuscript-derived contrast between what major framework families bring into moral focus and what each may leave unresolved.

Table 2. What bedside ethical frameworks make visible—and what remains morally unresolved

Framework family	Moral object brought into focus	Characteristic reasoning move	How disagreement is interpreted	Residual vulnerability
Principle/obligation oriented	Duties, rights, constraints	Specify and balance obligations	Conflict between legitimate normative claims	Abstract principles may underdescribe lived context
Casuistic	Morally relevant case similarities	Compare present and paradigm cases	Dispute over which analogy matters	Superficial similarity may create false certainty
Narrative	Meaning, history, voice	Interpret competing accounts	Disagreement partly concerns how the case is framed	Dominant narratives may silence less powerful voices
Relational	Dependence, power, responsibility	Interpret choice within relationships	Conflict may reflect unequal standing or support	Relationship claims still need moral limits
Care/virtue oriented	Responsiveness and practical judgment	Ask what attentive, trustworthy action requires	Disagreement may concern moral perception or character	Difficult to standardize across practitioners
Procedural	Quality of deliberative process	Structure dialogue and justification	Disagreement becomes something to examine fairly	Good process cannot guarantee a substantively justified answer
Hybrid	Multiple moral objects	Move deliberately among lenses	Persistent conflict may survive reasonable plural reasoning	**Proposed synthesis:** pluralism can become eclectic without explicit justification

Taken together, these approaches support a plural rather than monist reconstruction of bedside reasoning [19-21]. The proposed hybrid category therefore denotes deliberate movement among ethical lenses, not a claim that every framework can be combined without theoretical tension.

Reasoning operations used to resolve value conflict

Framework labels became less important when the literature was compared according to the work clinicians had to perform. Written recommendations, for example, did not function as self-executing decisions. Research on ReSPECT showed that recorded plans require interpretation in relation to current circumstances and that richer documentation of values may support later best-interests reasoning [22]. The operative task is therefore not simply retrieving a prior preference, but understanding what that preference means now.

A second recurrent task concerned moral standing. Paediatric ethics analysis showed how multiple voices can crowd the clinical space, requiring clinicians to distinguish between being heard and having decisive authority [23]. Negotiation is therefore not reducible to preference aggregation; it includes judging relevance, vulnerability, responsibility, and the legitimacy of competing claims.

A third task concerns the relationship between information and justification. In an ICU randomized trial, additional discussion of expected long-term quality of life did not improve the primary patient- and family-reported shared-decision experience, although some secondary outcomes differed [24]. More information may be clinically useful without settling how competing values should be weighed.

Across these findings, bedside reasoning appears less like movement through a fixed checklist than repeated

conversion of ethically relevant material into a defensible practical judgment.

Table 3 presents the cross-framework reasoning work that emerged only after comparing these different forms of evidence.

Table 3. Cross-framework reasoning work required to move from ethical conflict to revisable action

Reasoning work	What must be accomplished	Failure if omitted	Status in this review
Recognizing	Detect that the difficulty is normative, not merely technical	Value conflict remains hidden inside clinical language	Evidence-supported
Interpreting	Establish what facts, preferences, narratives, and recommendations mean in this case	Information is mistaken for self-interpreting evidence	Evidence-supported
Locating standing	Determine whose claims, duties, and vulnerabilities matter	Voice becomes confused with moral authority	Review-derived synthesis
Contextualizing	Identify relational, institutional, cultural, and temporal conditions	Ethical abstraction obscures constraints or dependencies	Evidence-supported
Comparing and prioritizing	Test which reasons should carry greater weight	Competing considerations remain an unranked list	Review-derived synthesis
Negotiating	Work through persistent disagreement without presuming consensus	Conflict is either suppressed or treated as procedural failure	Evidence-supported
Justifying	Give reasons why one option is more defensible than alternatives	Decision becomes preference or authority assertion	Evidence-supported
Enacting and documenting	Convert judgment into accountable clinical practice and preserve its rationale	Reasoning is lost at implementation or handover	Evidence-supported
Reopening	Reassess when facts, values, relationships, or consequences change	Earlier judgments become falsely permanent	**Proposed integrative synthesis**

The ordering in **Table 3** is analytical rather than chronological. Several forms of reasoning may occur simultaneously, recur, or become newly necessary after action has already begun.

Emotional, relational, contextual, and interprofessional dimensions

The literature also challenges the image of ethical deliberation as detached cognition. Prehospital clinicians described confidence, trust, and perceptions of safety as important to how ethical challenges were managed [25]. These findings do not establish that particular emotions improve moral accuracy. They instead suggest that emotional and moral unease may function as signals that responsibility, uncertainty, threat, or inhibited communication requires closer examination.

Ethical reasoning is also socially distributed. An international study of intensive-care clinicians identified variation in perceived ethical decision-making climate across professional and personal contexts [26]. Because the design was cross-sectional, those differences cannot establish causal effects on decision quality. They nevertheless show that clinicians reason within teams marked by different roles, hierarchies, experiences, and opportunities to challenge prevailing interpretations.

Relationships therefore matter in two ways. They may be substantively ethical, because dependence, vulnerability, trust, and caregiving responsibility can alter what autonomy or beneficence requires. They may also be epistemically formative, because relationships influence what clinicians are able to learn about patient values and whether competing perspectives can be voiced.

This distinction matters when conflict persists. Hierarchy can suppress disagreement, but disagreement itself can also reveal genuine normative plurality rather than dysfunctional teamwork. A defensible bedside process must therefore remain sensitive to relational and institutional conditions without automatically allowing those conditions to determine the morally justified outcome.

Integrated bedside deliberation model

The synthesis that emerges from the reviewed literature is not a sequence of ethical steps but a problem of translation: heterogeneous clinical and moral information

must be transformed into an action that can be justified, enacted, and reconsidered.

Symbiotic empirical-ethics work supports treating relationships as morally significant components of clinical judgment rather than merely environmental context [27]. Difficult obstetric cases show that even after autonomy, professional responsibility, and competing interests have been articulated, reasonable ethical conflict may remain [28]. Normative analysis of ecological preferences further demonstrates that the values relevant to treatment choice may extend beyond immediate biomedical interests [29]. These findings resist any model in which identifying "the patient's preference" or "the relevant principle" completes deliberation.

The review therefore proposes three deliberative crossings. A meaning crossing converts clinical facts, preferences, narratives, and moral unease into an account of what is ethically at stake. A standing crossing determines how the claims of patients, families, professionals, relationships, and institutions should count rather than merely whether they are present. An action crossing converts competing reasons into a defensible plan while retaining documentation and revisability.

These crossings are analytically separable but recursively connected [27-29]. Failure may occur at any crossing: relevant information may be misunderstood, voice may be mistaken for authority, or a plausible judgment may become unjustifiably fixed after circumstances change.

Figure 2 presents the manuscript-derived architecture of these three deliberative crossings.

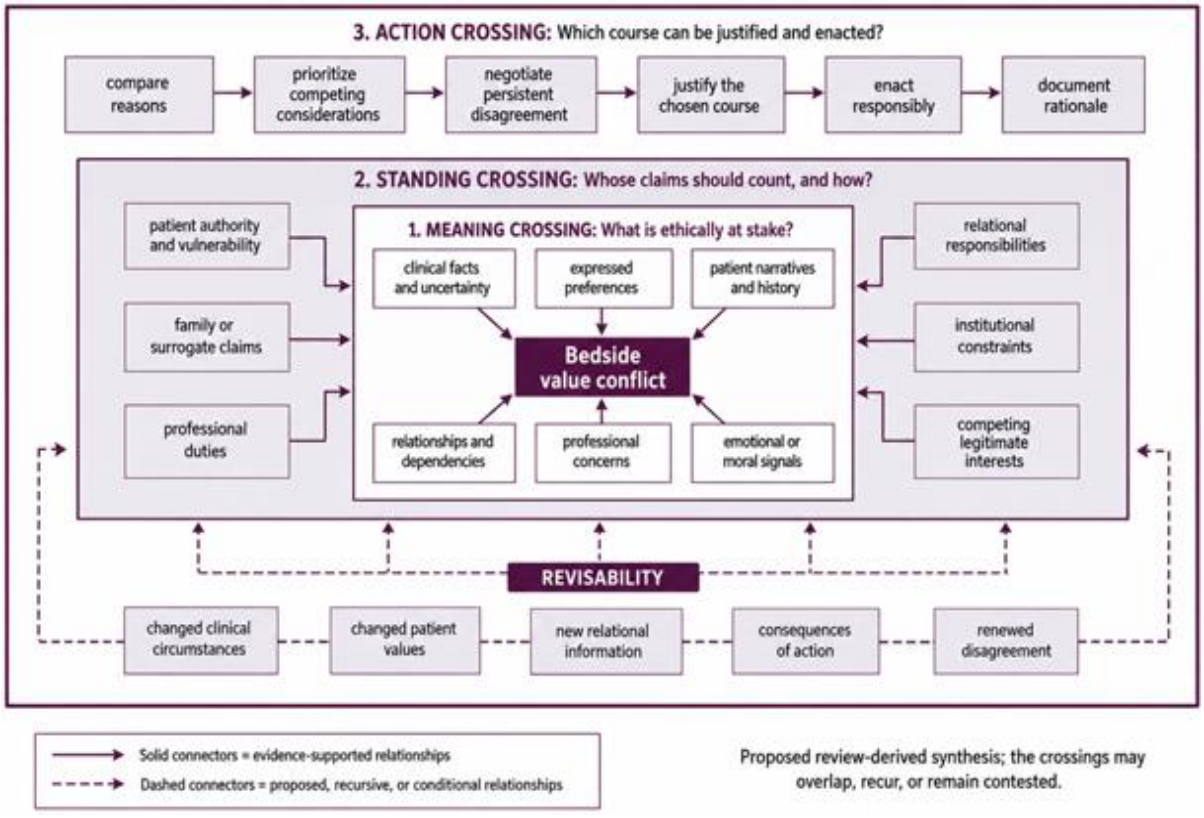

Figure 2. From morally relevant information to revisable bedside action: the three deliberative crossings

Implications for clinical practice and ethics education

For practice, the review suggests that the useful question is not simply which ethics framework should be applied? but which deliberative crossing is currently failing? A team may possess abundant clinical information yet still disagree about what it means ethically. Participants may understand the conflict yet disagree about whose claim carries legitimate authority. Alternatively, they may agree about values while remaining unable to translate them into a feasible and accountable plan.

Clinical ethics support can therefore be organized around diagnosis of the deliberative problem rather than automatic escalation to a predetermined method. Formal consultation may be particularly valuable when

disagreement persists, power differences inhibit participation, or the justification for action remains opaque. Routine difficulty, however, should not be transformed unnecessarily into specialist ethics intervention.

The educational implications are similarly process-oriented. Team-based learning in medical ethics shows promise for active ethical learning, although heterogeneous evidence does not establish uniform transfer to bedside performance [30]. Ethical competence has also been conceptualized as multidimensional rather than reducible to factual knowledge of principles [31]. Broader review evidence supports ethics education as a means of developing ethical recognition and reasoning while documenting substantial variation in educational approaches and outcomes [32].

A manuscript-derived educational implication is therefore to train learners to diagnose and work through meaning, standing, and action problems rather than simply recall frameworks [30-32]. Such training may use cases, facilitated disagreement, justification exercises, documentation tasks, and deliberate reconsideration. It should be evaluated as an educational proposal, not assumed to improve patient outcomes or eliminate moral conflict.

Review limitations

The synthesis is limited by heterogeneity in designs, settings, professions, jurisdictions, and the kinds of claims represented. Targeted searching supported conceptual breadth but was not designed to establish exhaustive systematic-review coverage. Formal ethics-support infrastructures are also unevenly distributed. Evidence from a Ugandan cancer institute illustrates how access to clinical ethics consultation and its organizational form may differ substantially from well-resourced settings [33].

Institutional and policy constraints further limit transferability. Healthcare workers caring for cross-border migrants in Botswana described tensions between professional commitments and rules or conditions outside their control [34]. Frameworks developed in settings where formal consultation, documentation systems, legal authority, and institutional resources are readily available may therefore assume capacities that are absent elsewhere.

The three-crossing model is a review-derived conceptual reconstruction. Its usefulness, observability across professions, cultural transferability, and relationship to patient, family, clinician, or organizational outcomes remain to be tested prospectively.

Conclusion

Bedside value conflict cannot be reduced to insufficient information or solved reliably by selecting one ethical framework. This integrative review instead identifies plural reasoning traditions and reconstructs their shared practical challenge as translation from morally relevant information to defensible and revisable action. The proposed meaning, standing, and action crossings distinguish three places where bedside deliberation may become difficult without assuming that disagreement itself represents failure. The model is conceptual rather than validated, and its application must remain sensitive to profession, culture, institutional capacity, clinical urgency, relationships, and persistent reasonable disagreement. Future research should test whether these crossings can be identified consistently in real clinical deliberation and whether making them explicit improves the transparency or quality of ethical reasoning.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

1. Delany C, Feldman S, Kameniar B, Gillam L. Critical dialogue method of ethics consultation: Making clinical ethics facilitation visible and accessible. J Med Ethics. 2025;51(1):10-6. doi:10.1136/jme-2024-109927
2. Kok N, Hoedemaekers C, Fuchs M, van der Hoeven H, Zegers M, van Gurp J. Evaluating the use of casuistry during moral case deliberation in the ICU: A multiple qualitative case study. Soc Sci Med. 2024;345:116662. doi:10.1016/j.socscimed.2024.116662
3. Le TD, Lin SC, Huang MC, Fan SY, Kao CY. Factors impacting the demonstration of relational autonomy in medical decision-making: A meta-synthesis. Nurs Ethics. 2024;31(5):714-38. doi:10.1177/09697330231200570

4. Durkin J, Orton S, Haydon T, Fleming D. Understanding ethical encounters in a hospital setting: A qualitative study. BMC Med Ethics. 2026;27(1):77. doi:10.1186/s12910-026-01446-y
5. Giaume L, Lamblin A, Pinol N, Gignoux-Froment F, Trousselard M. Evaluating cognitive bias in clinical ethics supports: A scoping review. BMC Med Ethics. 2025;26(1):16. doi:10.1186/s12910-025-01162-z
6. Bell JAH, Salis M, Tong E, Nekolaichuk E, Barned C, Bianchi A, et al. Clinical ethics consultations: A scoping review of reported outcomes. BMC Med Ethics. 2022;23(1):99. doi:10.1186/s12910-022-00832-6
7. Cronin MA, George E. The why and how of the integrative review. Organ Res Methods. 2023;26(1):168-92. doi:10.1177/1094428120935507
8. Snyder H. Literature review as a research methodology: An overview and guidelines. J Bus Res. 2019;104:333-9. doi:10.1016/j.jbusres.2019.07.039
9. Kuiter SG, Herrmann A, Mertz M, Quitmann C, Salloch S. Should healthcare professionals include aspects of environmental sustainability in clinical decision-making? A systematic review of reasons. BMC Med Ethics. 2025;26(1):78. doi:10.1186/s12910-025-01230-4
10. Munn Z, Stern C, Aromataris E, Lockwood C, Jordan Z. What kind of systematic review should I conduct? A proposed typology and guidance for systematic reviewers in the medical and health sciences. BMC Med Res Methodol. 2018;18(1):5. doi:10.1186/s12874-017-0468-4
11. Rethlefsen ML, Kirtley S, Waffenschmidt S, Ayala AP, Moher D, Page MJ, et al. PRISMA-S: An extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews. Syst Rev. 2021;10(1):39. doi:10.1186/s13643-020-01542-z
12. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ. 2021;372:n71. doi:10.1136/bmj.n71
13. Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, et al. Improving the content validity of the mixed methods appraisal tool: A modified e-Delphi study. J Clin Epidemiol. 2019;111:49-59.e1. doi:10.1016/j.jclinepi.2019.03.008
14. Mertz M. How to tackle the conundrum of quality appraisal in systematic reviews of normative literature/information? Analysing the problems of three possible strategies (translation of a German paper). BMC Med Ethics. 2019;20(1):81. doi:10.1186/s12910-019-0423-5
15. Mertz M, Strech D, Kahrass H. What methods do reviews of normative ethics literature use for search, selection, analysis, and synthesis? In-depth results from a systematic review of reviews. Syst Rev. 2017;6(1):261. doi:10.1186/s13643-017-0661-x
16. Mertz M, Nobile H, Kahrass H. Systematic reviews of empirical literature on bioethical topics: Results from a meta-review. Nurs Ethics. 2020;27(4):960-78. doi:10.1177/0969733020907935
17. Anderson G, Hodge J, Fox D, Jutila S, McCarty C. A review of clinical ethics consultations in a regional healthcare system over a two-year timeframe. BMC Med Ethics. 2024;25(1):127. doi:10.1186/s12910-024-01129-6
18. Lin YK, Chen CW, Yeh YS, Lin CJ, Huang YW, Lin YC, et al. Impacts of mandatory clinical ethics consultation on resource utilization and ethical conflicts in critically ill patients: A comparison between medical and surgical intensive care units. BMC Med Ethics. 2025;26(1):110. doi:10.1186/s12910-025-01268-4
19. Parsa-Parsi RW, Gillon R, Wiesing U. The revised International Code of Medical Ethics: An exercise in international professional ethical self-regulation. J Med Ethics. 2024;50(3):163-8. doi:10.1136/jme-2023-109027
20. Juujärvi SA, Tetri BH. Care and justice reasoning in nurses' everyday ethics. Nurs Ethics. 2025;32(6):1771-82. doi:10.1177/09697330241312379
21. Ligtenberg W, Stolper M, Molewijk B. Ethics support for ethics support: The development of the Confidentiality Compass for dealing with moral challenges concerning (breaching) confidentiality in moral case deliberation. BMC Med Ethics. 2024;25(1):49. doi:10.1186/s12910-024-01039-7
22. Eli K, Bernstein CJ, Harlock J, Huxley CJ, Walsh J, Blanchard H, et al. Using the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in a community setting: Does it facilitate best interests decision-making? J Med

Ethics. 2025;51(8):526-32. doi:10.1136/jme-2024-110144
23. Delany C, Moore B, Bhatia N, Burn E, Wimalasundera N, Preisz A. Responding to the 'crowd' of voices and opinions in the paediatric clinical space: An ethics perspective. Arch Dis Child. 2024;109(6):458-61. doi:10.1136/archdischild-2023-326154
24. Porter LL, Simons KS, van der Hoeven JG, van den Boogaard M, Zegers M. Discussing expected long-term quality of life in the ICU: Effect on experiences and outcomes of patients, family, and clinicians—a randomized clinical trial. Intensive Care Med. 2025;51(3):478-89. doi:10.1007/s00134-025-07812-5
25. Bruun H, Milling L, Wittrock DKW, Mikkelsen S, Huniche L. How prehospital emergency personnel manage ethical challenges: The importance of confidence, trust, and safety. BMC Med Ethics. 2024;25(1):58. doi:10.1186/s12910-024-01061-9
26. Jensen HI, Bülow HH, Dierickx L, Vansteelandt S, Vaschetto R, Élö G, et al. Perceptions of ethical decision-making climate among clinicians working in European and US ICUs: Differences between religious and non-religious healthcare professionals. BMC Med Ethics. 2025;26(1):21. doi:10.1186/s12910-025-01178-5
27. Redhead CAB, Frith L, Chiumento A, Fovargue S, Draper H. Using symbiotic empirical ethics to explore the significance of relationships to clinical ethics: Findings from the Reset Ethics research project. BMC Med Ethics. 2024;25(1):66. doi:10.1186/s12910-024-01053-9
28. Wilkinson D, Teli S, Litchfield C, Madeley A, Kelly B, Impey L, et al. Ethics round table: Choice and autonomy in obstetrics. J Med Ethics. 2025;51(9):588-92. doi:10.1136/jme-2024-110503
29. Salloch S. Ecological preferences and patient autonomy. J Med Ethics. 2025;51(9):609-13. doi:10.1136/jme-2024-110432
30. Alizadeh M, Bahrami S, Saeedi Z, Khaninezhad L. Outcomes of team based learning in teaching medical ethics: A systematic review. BMC Med Ethics. 2025;26(1):184. doi:10.1186/s12910-025-01329-8
31. Halldorsdottir S, Bryngeirsdottir HS. Ethical competence in nursing: A theoretical definition. Nurs Ethics. 2025;32(7):2134-62. doi:10.1177/09697330251346437
32. Andersson H, Svensson A, Frank C, Rantala A, Holmberg M, Bremer A. Ethics education to support ethical competence learning in healthcare: An integrative systematic review. BMC Med Ethics. 2022;23(1):29. doi:10.1186/s12910-022-00766-z
33. Nanyonga MM, Kutyabami P, Kituuka O, Sewankambo NK. Exploration of clinical ethics consultation in Uganda: A case study of Uganda Cancer Institute. BMC Med Ethics. 2024;25(1):87. doi:10.1186/s12910-024-01085-1
34. Balekang GB, Galvin T, Rakgoasi DS. "No, it is not a breach of my oath because it is beyond my control; I use the policies that are in place." Ethical challenges faced by healthcare workers in the provision of healthcare to cross-border migrants in Botswana. BMC Med Ethics. 2025;26(1):34. doi:10.1186/s12910-025-01195-4