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RESEARCH ARTICLE

Clinical Empathy as a Cornerstone of Healthcare Bioethics

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Abstract

Clinical empathy is one of the cornerstones of Healthcare Bioethics, a novel theoretical-normative framework within Clinical Bioethics proposed as an alternative to Principlism. Methodologically, this paper consists of theoretical research aimed at examining the foundational role of clinical empathy on Healthcare Bioethics and its implications on care. In the first part of the paper, we present the theoretical-normative foundations of Healthcare Bioethics, arguing that clinical empathy's moral role derives from its epistemic and motivational functions. Its epistemic function enables professionals to understand the mental and emotional states of patients, ultimately promoting care aligned with Patient-Centered Care and Shared Decision-Making models. We also argue that the very concept of care is deeply intertwined with clinical empathy, as it fosters a partnership between professionals and patients that promotes meeting patients' needs in a responsible and respectful manner. Regarding its motivational function, we propose that, through empathic concern's intrinsically-induced altruistic motivation, clinical empathy promotes the effective delivery of care while also strengthening the patient's trust in the professional. In the second part of the paper, we examine clinical empathy's contributions to the ethical deliberation process regarding moral conflicts that arises from clinical practice. Aligned with a restorative just culture in healthcare, clinical empathy facilitates understanding the individuals involved in the moral conflict and contributes to perspective shifts, ultimately reducing the likelihood of future conflicts and promoting the reconstruction of fractured relationships.

Keywords: Bioethics, Medical Ethics, Empathy, Ethical Deliberation.

1. Introduction

Clinical Bioethics is a branch of Bioethics that seeks to detect, understand, analyze, and resolve moral conflicts that arise in healthcare [1]. The theoretical frameworks constituting this branch of Bioethics can offer different solutions to moral problems and controversies in this context [1,2]. They also distinctly define the characteristics that render professional-patient relationships and decision-making in healthcare ethically appropriate.

Following Beauchamp and Childress's 1979 publication of Principles of Biomedical Ethics, Principlism has been widely adopted in Brazil as the standard ethical guideline for healthcare practice [1,3]. This framework is based on the principles of respect for patient autonomy, beneficence, non-maleficence, and justice [4]. Although an extensive analysis of Principlism lies beyond the scope of this paper, a brief overview of criticisms articulated by Albuquerque [5] is provided to illustrate its influence on healthcare practice.

Beauchamp and Childress's publication was developed concurrently with the Belmont Report [6], published in 1978, addressing human research ethics. Beauchamp [7] said the Belmont Report significantly influenced their work. Consequently, Albuquerque

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[5] critiques Principlism for treating patients and research participants equivalently, neglecting the particular vulnerability of patients. Additionally, she argues that Principlism does not acknowledge that decision-making in healthcare should prioritize meeting patients' needs, will, and preferences – an aspect not central to clinical research contexts. Thus, Albuquerque challenges Principlism as an ethical framework initially designed for clinical research rather than healthcare. As a result, this framework overlooks patient centrality, undervalues the inherent importance of the professional-patient relationship, and disregards patients' experiential knowledge of their health condition. Furthermore, Albuquerque [5] critiques Principlism for conceptualizing patient rights as a derivative of healthcare professionals' moral obligations, thereby positioning healthcare professionals – rather than patients – as the primary moral agents in this relationship.

In response to these critiques, the Postgraduate Program in Bioethics at University of Brasilia has been developing a novel Clinical Bioethics framework, referred to as Healthcare Bioethics, as an alternative to the current hegemonic model in the field [2]. Thus, this paper has a dual objective: first, to introduce the foundational theoretical principles of this new framework; second, to present clinical empathy as one of its core structural elements. To this end, the article is divided into two primary sections. The first section presents the substantive and procedural dimensions of Healthcare Bioethics, while the second examines the relationship between clinical empathy and each of these dimensions. This paper draws extensively from the previous theoretical contributions of Aline Albuquerque, one of the authors of this article and a leading scholar in the development of Healthcare Bioethics. The subsequent section begins with an exposition of the foundational principles of this framework.

2. Foundational Principles of Healthcare Bioethics

The guiding principle of Healthcare Bioethics is the recognition of the patient as an active participant and agent in their care, challenging the entrenched paternalistic model that regards patients as passive recipients of care [2,3]. It also dismisses the consumerist perspective that assigns responsibility for decisions related to healthcare almost exclusively to the patient. Thus, this framework is built upon a mutualist perspective, which emphasizes the significance of the relationship between healthcare professionals and patients in achieving Shared Decision-Making, a model that requires fostering patient autonomy and ensuring that decisions align with the patient's needs, will, and preferences for its effective implementation [3,8,9].

Ribas [10] asserts that medicine is both a practice and a moral activity; consequently, actions undertaken in clinical practice must be both good – or virtuous – and correct. His critique of Principlism describes it as an essentially procedural theory with a paucity of moral content, suggesting that it fosters a professional-patient relationship based on a legal contract that promotes a consumerist model of healthcare, ultimately eroding the trust that could – and should – be established between the participants of this relationship.

According to Ribas [10], Clinical Bioethics frameworks must encompass moral content that can guide morally good or virtuous professional actions and procedures that operationalize the proper form of deliberation in moral conflicts. From this perspective, Healthcare Bioethics is structured in two dimensions: the substantive, which contains its moral foundation, and the procedural, which guides the process of ethical deliberation in moral conflicts that arise in clinical practice [2,3]. The substantive dimension of this framework will be presented below.

The substantive dimension of Healthcare Bioethics is structured around four axes: i) clinical empathy, ii) the relationship of partnership between professionals and patients, iii) the centrality of the patient, and iv) Patients' Rights. This section will briefly introduce the last three axes (ii to iv) so that the framework can be generally understood. The relationship between clinical empathy and healthcare bioethics, the main focus of this paper, will be examined in a subsequent section due to the need for a more comprehensive analysis.

This framework's second axis is the partnership relationship between professionals and patients. This relationship is understood to be intrinsically valuable in the context of healthcare, and its preservation is considered an ethical command [11,12, 51, 52]. Herring suggests that this relationship embodies the very essence of care since "caring" for another person without establishing a partnership with them would result in reducing care to the mere performance of a sequence of tasks or contractual obligations [13] that would be embedded in the consumerist model that Healthcare Bioethics strives to dismiss. The establishment and maintenance of this partnership necessitates that both the professional and the

patient mutually acknowledge the inherent humanity and universal vulnerability of one another – i.e., the inherent risk that any individual faces of being physically, emotionally, or socially harmed by the other -, being aware that not only the professional influences the patient, but also that the patient affects the professional [11,13]. According to Herring [13], this awareness is fundamental to enable the actors involved in this relationship to manifest empathy and trust in each other.

The centrality of care for the patient, the third axis that grounds Healthcare Bioethics, signifies that the focus of the relationship is on the patient. Therapeutic actions should be directed towards meeting their needs and aligning with their will and preferences, representing a shift from the paternalistic model that prioritized professionals' decisions over those of the patients themselves [2,3,5]. Healthcare Bioethics adopted Patient-Centered Care approach as an ethical imperative, which holds that its implementation is inherently justified since therapeutic actions are patient-centered [14]. According to this model, the practical implementation of care necessitates establishing and maintaining a partnership relationship in which both participants acknowledge their roles and actively fulfill them based on open dialogue and mutual trust [14].

Adopting Patient-Centered Care as the guiding model of care entails a shift from the prevailing professional-centered model to one that focuses on the patient. This paradigm shift also implies a novel perspective through which Healthcare Bioethics examines the moral conflicts that emerge in clinical practice. While in Principlism these conflicts are approached primarily from the perspective of the duties and obligations held by professionals, Healthcare Bioethics proposes that these conflicts should be evaluated from the primary perspective of the Patient's Rights, from which those duties and obligations emerge secondarily [2,3,14].

The Patient's Rights, the fourth axis of Healthcare Bioethics, define the entitlements of all persons receiving healthcare [2]. These rights, in turn, are derived from human rights, which, from the perspective of this bioethical framework, represent a globally shared secular ethic that pragmatically expresses, through the language of rights, the moral commitments adopted by humanity that establish moral minimums to be upheld [2,15,16]. In light of this, Healthcare Bioethics supports the idea that the analysis of moral conflicts and the prescription of ethical conduct in clinical practice should primarily stem from the patient's rights, which are, therefore, hierarchically superior to duties, rules, or principles derived from theories - such as Principlism or Utilitarianism - that are not grounded on the firm moral commitments embodied by these rights [2].

In addition to its substantive dimension, which contains the theoretical-normative elements of this framework, Healthcare Bioethics also has a procedural dimension, which will be presented below.

The procedural dimension of Healthcare Bioethics consists of a formal method for analyzing and resolving moral conflicts that arise in clinical practice, guiding a process of ethical deliberation that culminates in prescriptions for moral conduct based on the theoretical-normative elements that constitute the substantive dimension of this framework [2,3,16]. This ethical deliberation process necessitates classifying moral conflicts arising in clinical practice into one of two categories: moral problem or moral controversy [3].

According to Greene [15], humanity's moral progress is reflected in the moral commitments made by individuals, expressed through the language of rights. From this perspective, Albuquerque [3] asserts that the theories of Clinical Bioethics have not kept pace with this moral progress, as they have failed to incorporate firm moral commitments regarding healthcare, such as Patient-Centered Care and patients' rights derived from human rights, such as the right to participate in decision-making; the right to informed consent; the right to a second opinion; the right to refuse treatments and procedures; the right to access information; the right to access patient's records; the right to data confidentiality; the right to quality and safe care; the right not to be discriminated against; the right to lodge complaints; and the right to redress [3,14].

Within this framework, moral conflicts that arise from the infringement of widely accepted moral norms, particularly those articulated through patients' rights, are classified as moral problems. These moral problems stem from non-compliance with previously resolved moral issues [2,3]. In such cases, the ethical deliberation process aims to establish a dialogue with the professional, thereby facilitating their understanding that their actions breached the established moral commitments that have previously resolved the issue [3]. Peer support is an approach in which the professional involved in the ethical deliberation process receives support from another professional with similar experience [17,18]. Their shared experiences foster the development of a

relationship, allowing the supporter to offer empathic listening, assessment, and assistance, thereby validating the emotions and perspectives of the other person, facilitating their understanding that they have violated a moral commitment, which may prevent similar occurrences in the future [17,18].

In healthcare, moral conflicts may arise from clashes of divergent moral perspectives between patients – or their family members – and healthcare professionals in scenarios where no firm moral commitments have been established to address the issue. In such cases, classified as moral dilemmas, Healthcare Bioethics proposes establishing a dialogue between the parties involved in the conflict through a restorative process, which involves both parties working together to resolve the issue and rebuild the fractured relationships resulting from the moral disagreement. This conflict resolution model prioritizes the needs of the affected individuals and the meeting of those needs, emphasizing the rebuilding of trust and the redress of the harm suffered [19]. Furthermore, deliberation in moral controversies involves weighing rights, principles, and rules as guiding standards. This collaborative effort enables the involved parties to formulate an ethically appropriate solution for the specific case collectively. It is imperative to note that such solutions are inherently casuistic, implying their validity is confined to the particular scenario for which they were developed [2,3].

In addition to differentiating between moral problems and moral controversies, Healthcare Bioethics posits that the process of moral deliberation should be guided by the precept of the primacy of patient care [3]. According to Herring [20], care is a practice defined by four markers: i) meeting the needs of the other – which can be biological, emotional, or relational; ii) respect for the other – which involves recognizing the humanity and dignity of the other person; iii) responsibility for the other – which entails assuming, to a certain extent, the duty to meet the needs of the other, regardless of whether or not it is convenient for the caregiver; and iv) care as an interpersonal relationship – which occurs within a dynamic interaction between the caregiver and the person being cared for, who influence each other. In light of these characteristics, Albuquerque [3] defines healthcare as a relational activity aimed at responsibly meeting patients' needs, respecting them as individuals with unique mental states who, therefore, hold a singular will, preferences, morality, and experiential knowledge. Consequently, the author argues that since moral conflicts emerge from clinical practice, ethical deliberation in such cases must be guided by the fundamental characteristics of care, which constitute the essence of clinical practice [3,9,11].

Based on these considerations, the ethical deliberation process in Healthcare Bioethics can be structured into four stages [2,3]. Stage 1 involves assessing the case, wherein information regarding the event is gathered from all relevant individuals, including the patient, family members, and professionals whose accounts are equally pertinent. Stage 2 involves delineating the scope of the case, that is, determining the fundamental moral issue at the core of the ethical deliberation. Once identified, this issue is classified as either a moral controversy or a moral problem. Stage 3 consists of the ethical analysis of the case. If it is a moral controversy, it involves identifying and analyzing the principles, rights, and decision-making criteria guiding the involved parties; if it is a moral problem, it entails identifying and analyzing both the firm moral commitment that was violated and the perspective adopted by the professional to justify non-compliance with this commitment. Stage 4, in cases of moral controversy, involves facilitating a dialogue between the parties, if they express such a desire, guided by a restorative process. In cases of moral problems, Stage 4 entails promoting a dialogue with the professional, if they express such a desire, supported by a peer support process.

Having outlined the foundational principles of Healthcare Bioethics and its substantive and procedural dimensions, the subsequent analysis will examine the relationship between clinical empathy and this theoretical-normative framework.

3. Clinical Empathy and the Substantive Dimension of Healthcare Bioethics

Clinical empathy is one of the four structuring axes of the substantive dimension of Healthcare Bioethics [3], and, according to Albuquerque [11], it is deeply intertwined with the very concept of healthcare. This analysis examines the relationship between clinical empathy and Herring's [20] four markers of care: (a) meeting the patient's needs, (b) respect for the patient, (c) responsibility for care, and (d) care as an interpersonal relationship.

(a) Meeting the patient's needs: Clinical empathy contributes to meeting the patient's needs in two ways. First, it facilitates the identification of these needs through its epistemic function; second, it motivates professionals to address them. The cognitive and

emotional components of clinical empathy serve as instruments that enable professionals to understand patients' mental and emotional states by mediating the acquisition of both non-phenomenal information– about the recognition of what the patient feels – and phenomenal information – of the understanding of how the patient feels [21–23]. Integrating both types of information allows healthcare professionals to identify patients' needs and hierarchy of values [21], promoting shared decision-making by facilitating the understanding of the patient's will and preferences [9].

Clinical empathy also contributes to meeting the patient's needs through empathic concern. As Herring [20] notes, caring is not limited to emotions or feelings; it involves actions to effectively meet those needs [20,24]. According to Batson's model [25], two conditions are necessary and sufficient for the emergence of empathic concern in healthcare: intrinsically valuing the patient's welfare and perceiving them as in need. Thus, when healthcare professionals value the patient's welfare and recognize their needs, they are inherently motivated to act to meet those needs. Therefore, clinical empathy contributes to fulfilling care by facilitating the identification of the patient's needs through its epistemic function and by inducing, through empathic concern, a motivational state in the professional that drives them to promote the patient's welfare [24].

(b) Respect for the patient: The second marker of caring, respect for the patient, requires empathy, according to Herring [20]. Respectful care entails acknowledging each person's uniqueness and recognizing that their mental and emotional states reflect their needs, will, and preferences, which should guide care practice [9,11,20]. Additionally, Albuquerque [11] argues that respectful care involves recognizing the patient's humanity, actively listening to their needs, obtaining their consent for treatment, treating them with dignity, and being mindful of their care experience.

In addition to the aforementioned characteristics, Albuquerque [11] and Herring [20] posit that one of the most critical qualities of respectful care is meeting the patient's needs without objectifying them. The principle of non-objectification – or non-instrumentalization – of others stems from the recognition of human dignity, regarded as an intrinsic value of the person and the foundation of human rights, from which patients' rights are derived [3,14,26–29]. Consequently, respectful care is defined as care guided by recognizing the patient's dignity, countering their instrumentalization [11,12,27].

Within the healthcare context, the instrumentalization of patients manifests by reducing them to mere bodies, as seen in the devaluation of their experiential knowledge of their illness, in the implementation of interventions or diagnostic tests without adequately informing the patient, in the performance of gynecological exams without informing the patient or obtaining their consent; and in paternalistic attitudes that override or disregard the patient's needs, will, and preferences by prioritizing what professionals consider most relevant, thereby minimizing the patient's participation in their treatment [14,26]. It can be inferred based on Albuquerque [9] and Kaufmann [27] that the instrumentalization of patients occurs when the practice of caring is primarily driven by the professional's objectives – i.e., those that they consider most appropriate – disregarding the patient's own needs, will, and preferences.

Tan et al. [30] posit that the capacity to execute tasks competently and efficiently has been central to professional training in medicine and nursing. However, task-oriented practice is regarded by patients as antithetical to empathic care. That model prioritizes the completion of tasks in a mechanistic manner, often failing to adapt to each patient's unique needs [31]. Despite critiques of this approach, Bourgault [32] underscores that in certain circumstances – particularly in critical care and emergency settings –timely and coordinated task fulfillment can be considered hallmarks of quality care. For task-oriented practice to align with Patient-Centered Care, Bourgault [32] argues that it should serve as a complementary approach to clinical practice, applied in specific situations where it benefits the patient while ensuring that the fundamental guiding principles remain the patient's needs, will, and preferences.

Clinical empathy can minimize patient instrumentalization through its epistemic function by promoting understanding of the patient's mental and emotional states and, according to Herring [20], by enabling professionals to anticipate those needs through an other-oriented perspective. Therefore, the author argues that empathy is a prerequisite for respectful care. However, the relationship between clinical empathy and respect for the patient extends beyond its epistemic function, as empathic concern further fosters respectful care. The following analysis introduces Batson's [33] concept of different types of motivation for action, which is particularly relevant to this discussion.

Batson [33] posits that humans are driven by various motivations to engage in moral actions. This study

focuses specifically on altruistic, selfish, and moral motivations. Altruistic motivation refers to actions primarily aimed at enhancing others' welfare. In contrast, selfish motivation refers to actions primarily intended to advance the welfare of the individual performing them, regardless of whether these actions or their outcomes conform to prevailing moral standards [33]. Thus, even actions or outcomes deemed morally correct may have been selfishly motivated, meaning that such actions were primarily driven by the pursuit of benefits or the avoidance of material or social harm to the individual carrying them out. Conversely, Batson [33] argues that moral motivation refers to actions primarily aimed at upholding moral principles or obligations, such as justice or the duty of care.

From this perspective, a link can be observed between selfish motivation and the instrumentalization of others. Objectification occurs when an interaction is established primarily to generate benefits – or avoid harm – for the individual acting while disregarding the other party's interests. Through its epistemic function and the altruistic motivation induced by empathic concern, clinical empathy acts as a safeguard against patient instrumentalization. Thus, the practice of care extends beyond merely addressing the patient's specific needs since, if motivated by selfishness or carried out with disregard for the patient's other needs, will, or preferences – as understood by the patient rather than the professional – it fails to uphold respect for human dignity [26,27]. Therefore, through its epistemic functions and the altruistic motivation fostered by empathic concern, clinical empathy has the potential to promote respect in healthcare.

(c) Responsibility: The third marker of care is responsibility, which, according to Herring [20], stems from the very relationship between individuals, where, to some extent, the caregiver assumes the duty to care for the other. The responsibility implies that meeting the other person's needs becomes, to some extent, an obligation rather than a voluntary or optional task [20]. This obligation of care, as suggested by Ludewigs et al. [34] and Herring [35], arises from the particular vulnerability of the person receiving care, who becomes reliant on the caregiver for meeting their needs, and from the trust placed in the caregiver's commitment to fulfilling their duty of care. Rhodes [36] corroborates these authors' perspectives by proposing that establishing a tacit relationship of trust between the patient and the healthcare professional occurs simply due to their social role. In this relationship, the patient confers discretionary powers to the professional, who, as posited by Rhodes [36], by accepting these powers, binds themselves indissociably to the responsibility of using them to address the patient's needs, guided by their will and preferences.

According to Albuquerque, responsibility in care implies that professionals should assume it voluntarily, irrespective of their preferences. In this sense, caring is regarded as an intrinsic obligation within the health professions (37); therefore, Albuquerque, Herring [20], and Rhodes [36,37] emphasize that professionals should, at the very least, fulfill this duty motivated by their ethical obligation to care. This assertion is associated with Batson's [33] concept of moral motivation, which, within the context of healthcare, pertains to professionals performing care primarily motivated by the fulfillment of their responsibility – or duty – to care. However, Batson [33] argues that this type of motivation, perceived as an "I should" impulse, is weak, implying limited motivational strength. In light of this, Batson [33] proposes that moral motivation, or acting out of duty, can be associated with altruistic motivation to connect the "I should" impulse to an "I want" desire stemming from the motivation induced by empathic concern. In a similar vein, Rhodes [36] posits that acting by the moral ideals of the health professions entails internalizing the duty of care, thereby becoming an integral component of an individual's personality, who, from that point, fulfills their duty not just out of obligation but also out of a genuine appreciation for the practice of care [33]. Empathic concern, therefore, contributes to the practice of care by motivating the professional to act not only out of professional duty but also on a more substantial emotional basis, that of altruistic motivation. According to Rhodes [37], this increases the likelihood of professionals adhering to their responsibility of care.

The association of altruistic and moral motivations may also yield additional benefits. Since empathy can result in biased behaviour towards specific individuals or groups, it can also give rise to discriminatory attitudes towards certain groups of patients while favoring others [38–42]. Consequently, integrating altruistic and moral motivations can counter favoritism and discrimination in healthcare settings [33,38], fostering an environment of respectful care.

(d) Care as an interpersonal relationship: The fact that Healthcare Bioethics considers the patient the center of care does not imply that they are passive recipients of care. The relational nature of care, the fourth marker of this practice, is based, according

to Herring [13], on recognizing the universal vulnerability of human beings, which refers to the risk inherent in the human condition of suffering physical, emotional, psychological, and social harm as a result of their interaction with the world and with other people. Consequently, while there is a component of particular vulnerability in patients stemming from their dependence on professionals to meet their needs and the conferring of discretionary powers to these professionals, there is a form of vulnerability – a universal one – that is shared by all individuals, irrespective of their social role. Consequently, when a patient and a professional establish a relationship, the very same emotional openness that facilitates the epistemic function of clinical empathy by enabling the professional to understand the patient's mental and emotional states can also render the professional vulnerable to being influenced by these same states and by the other person's behavior [12,20,43]. Professionals can experience positive or negative outcomes from patient interactions and family interactions. While this relationship can predispose professionals to greater personal fulfillment and protect them from emotional exhaustion, it can also lead to indirect trauma and higher rates of burnout [44–47].

Herring [13] suggests that emotional openness and vulnerability are pivotal in fostering intimacy and trust, which are fundamental to a patient-centered care relationship, enabling healthcare professionals to meet patients' genuine needs respectfully and responsibly. In addition, another potential outcome of the professional's emotional openness towards the patient is the elicitation of empathic concern, which fosters altruistic motivation. The patient's perception of the professional's empathic concern strengthens the belief in the professional's trustworthiness, as the professional primarily acts to promote the patient's welfare. This finding, when associated with Halpern's [48] assertion that patients appreciate the mere fact that the professional is committed to understanding them, reinforces clinical empathy's contribution to building and deepening the relationship between professionals and patients.

Having examined the relationship between clinical empathy and the substantive dimension of Healthcare Bioethics, the next objective is to explore its relationship with this framework's procedural dimension.

4. Clinical Empathy and the Procedural Dimension of Healthcare Bioethics

Clinical empathy plays an important role in the substantive dimension of Healthcare Bioethics and its procedural dimension, which involves a formal process of analyzing and deliberating moral conflicts arising from clinical practice. The subsequent analysis will examine the relationship between clinical empathy and the four phases of ethical deliberation.

Stage 1 of moral deliberation entails the assessment of the case, which involves gathering relevant information from all involved parties. This stage allows for delimiting moral issues, which pertains to Stage 2. As Albuquerque [3] emphasizes, this specification should be made from the perspective of those involved in the case – rather than based on the conclusions of the deliberation participants –as those are best suited to express the reasons that render the case morally challenging. In Stage 1, deliberation, participants must apply clinical empathy resources, such as perspective-taking (cognitive empathy) and emotional sharing (emotional empathy), to understand how each party perceives the situation that led to the moral conflict. As Albuquerque and Eler [2] emphasize, it is crucial to consider the perspectives of all individuals involved in the case, ensuring that the viewpoints of professionals are not prioritized over those of patients or family members. To this end, deliberation participants should aim to understand the patient's clinical history and social, cultural, religious, and economic context. These elements shape their worldview and influence how the patient – or their family member – interprets the moral conflict [2].

The ethical analysis is conducted after defining the moral issue and determining whether the case involves a controversy or a moral problem. At this stage, a key question arises: Could the use of clinical empathy resources in moral deliberation compromise the impartiality of the analysis due to empathy-induced biases?

Albuquerque [12] asserts that empathy alone is insufficient to guide moral behavior. Consequently, drawing from Albuquerque [12], Hoffman [38], and Oxley [21], it is essential to highlight that while clinical empathy is part of the ethical deliberation process in Healthcare Bioethics, the foundation of this process is rooted in rights, principles, and decision-making criteria, whose impartiality must counterbalance empathy's inherent partiality.

In this sense, Oxley [21] proposes a combined perspective-taking approach in empathic moral deliberation, alternating between a self-oriented perspective – imagining oneself in another's situation– and an other-oriented perspective – imagining how another person feels in their situation.

This proposition is based on Batson's [33] findings, which are endorsed by Oxley [21], who argues that these forms of perspective-taking can yield different outcomes.

On the one hand, other-oriented perspective-taking provides information about the parties involved in the moral conflict, thereby being related to the epistemic function of clinical empathy, which facilitates the identification of values and the understanding of the reasons behind each party's thoughts and actions, ultimately leading to the conflict. Conversely, self-oriented perspective-taking helps ethical deliberation participants identify rights, principles, and decision-making criteria that may have been violated in the case at hand, which will be relevant in Stage 3 of the ethical deliberation process. The role of self-oriented perspective-taking in this context is supported by Batson [33] and Verplanken [49,50], who argue that imagining oneself in another's situation (self-oriented perspective) helps individuals recognize discrepancies between valued states and the actual situation of the other person. This process triggers a negatively valenced emotional state, which, in turn, induces moral motivation – the desire to act in support of the violated right, principle, or decision-making criterion.

Both forms of perspective-taking are pertinent in Stage 4 of the moral deliberation process. In the context of a moral controversy, this stage proposes a dialogue between the parties involved in the conflict as part of a restorative process. In this context, patient-oriented perspective-taking, combined with emotional empathy as part of clinical empathy's epistemic function, can help professionals identify the patient's values that have been compromised by their decisions, allowing professionals to understand what and how the patient felt – and maybe still felling – in that particular situation. This understanding enables the professional to recognize the patient's needs. When complemented by the primacy of care and the intrinsic valuing of the patient's welfare – principles that should guide therapeutic action – it fulfills the two sufficient conditions for manifesting empathic concern, as outlined in Batson's model [25]. The perception that the professional expresses empathic concern, which is associated with altruistic motivation, can help the patient partially restore trust in the professional. This perception occurs when the patient recognizes that, even in a morally controversial situation, the professional still expresses concern for their well-being and understands their needs. Consequently, this contributes to restoring the fractured relationship and resolving the moral conflict.

In cases where Stage 4 involves moral problems, clinical empathy also plays a relevant role in the peer support process. As Carbone et al. [18] suggest, the similarity of experiences between the professional involved in the moral conflict and their peer providing support facilitates emotional sharing between them and the latter's understanding of the former's perspective. The peer support process, embedded within a restorative organizational culture, facilitates the professional's understanding that a violation of patients' rights or a firm moral commitment has occurred, allowing for this professional to acknowledge their share of responsibility for that breach while being assisted their coping process and being supported to be reintegrated into clinical practice [18,19].

5. Final Considerations

This article outlined the foundational principles of Healthcare Bioethics and examined clinical empathy's structuring role within this framework. In its substantive dimension, clinical empathy is closely linked to four markers of care. Therefore, cognitive empathy, emotional empathy, and empathic concern—components of clinical empathy—contribute to meeting patients' needs responsibly and respectfully, guided by patients' will and preferences. Furthermore, clinical empathy fosters a partnership between patients and professionals and strengthens the former's trust in the latter.

In the procedural dimension of Healthcare Bioethics, clinical empathy, through its epistemic function, facilitates understanding the mental and emotional states of those involved in the moral conflict, allowing the acquisition of information about their unique perspectives. Empathic concern, combined with self-oriented perspective-taking, induces altruistic and moral motivations, potentially leading to shifts in perspectives and promoting actions that resolve moral conflicts and restore fractured relationships.

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