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ETHICAL DILEMMAS IN BIOETHICS A Diagnostic Tool and the Limits of Its Implementation with Artificial Intelligence¹

Classical ethics aims to guide human conduct toward its natural end and perfection, entailing virtuous living. Once the inherent finality of reality is denied—reduced to the purview of science, concerned solely with material and efficient causes—ethics loses its ground. There is no inherent human good. Only personal freedom of choice remains—a freedom devoid of objective grounding. The available options become nihilism, the will to power, or existential nausea.

THE GENESIS OF BIOETHICS

Bibliographical summaries commonly trace the origins of bioethical principles to the censurable medical research uncovered in the United States during the 1960s and 70s (the Tuskegee Syphilis Study being particularly resonant), prompting Congressional inquiry. That investigation culminated in the development of ethical principles governing such research, articulated by the Belmont Commission and published in 1979.² The principles emphasized the autonomy of research subjects to participate, the requirement of potential benefit to the subject, and the prohibition of discrimination based on the research's

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² See The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, “The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, April 18, 1979,” U.S. Department of Health and Human Services, Office of Human Research Protections, <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html>.

perceived promise. The terms *autonomy*, *beneficence*, and *justice* were thus established.

Subsequently (in 1979), Tom L. Beauchamp and James R. Childress published their seminal work, *Principles of Biomedical Ethics*,³ which has had numerous expanded and revised editions and is considered the cornerstone of modern bioethics. While developed independently of the Belmont Report, this work adopted the same terms (autonomy, beneficence, and justice) to apply them to medical activity in general but assigned them distinct meanings.

In the Belmont Report, autonomy denoted the subject's voluntary participation in research. In the nascent field of bioethics, however, autonomy came to signify the patient's inherent authority, their judgment superseding that of the physician. While superficially similar, a deeper examination reveals that bioethical autonomy effectively diminishes the depth of the physician–patient dialogue, reducing it to a technical explanation followed by the patient's selection from a presented menu of options; the patient commands, the physician obeys. Similarly, beneficence within this bioethical context does not equate to acting in the patient's best interest, but rather to fulfilling the patient's wishes.

The foregoing summary presents a highly simplified version of these concepts, necessarily employing stark contrasts between the two perspectives. However, this simplification does not negate the fundamental differences between the two approaches. Bioethical texts often present a less binary perspective; nuanced discussions may integrate elements reminiscent of the classical approach embodied in the Belmont Report (primarily emphasizing duties) with those of later bioethics (primarily emphasizing rights). Frequently, these discussions blend classical ethical concepts with those of American bioethics, thereby complicating the identification of underlying philosophical positions within various texts. This necessitates the development of tools to facilitate the identification of these fundamental, often unexpressed, positions.

The discrepancies between these two ethical approaches remain largely unknown to many clinicians and even bioethicists. The prevalent understanding of bioethics often entails a rather uncritical and simplistic application of Beauchamp and Childress's principles, typically prioritizing autonomy: Is the patient's request fulfilled? If so, everything appears to be in order, as the good is defined by the patient's own assessment, thereby simultaneously satisfying the principle of beneficence. Justice is relegated to a secondary concern, usually pertaining to equitable resource allocation—a factor often outside the purview of individual clinicians grappling with immediate patient care decisions.

³ See Tom L. Beauchamp and James R. Childress, *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 1979).

The profound disparities in meaning stem, in our view, from fundamental shifts in conceptions of ethics, the good, and nature of society, which we will now outline.

CLASSICAL ETHICS

The Western tradition of ethical inquiry can be traced back to Aristotle's work, representing a mature reflection on human action in terms of good and evil. Subsequent thinkers (notably Thomas Aquinas) provided significant refinements and additions, but Aristotle's framework provides a foundational starting point. We will refer to his analysis and its subsequent developments as classical ethics.

A cornerstone of classical ethics, and indeed of Aristotelian philosophy, is the concept of *final causality*: things, in their dynamic essence, inherently strive toward a natural end, a purpose that attracts their activity. This applies to all changeable beings, even those merely passively changing location or state. This assertion, firmly grounded in Aristotelian reasoning, gives rise to a conception of nature encompassing remarkable insights—insights that, while challenging contemporary science, continue to inspire researchers. In essence, all natural finality points toward a good; things in motion act to realize their full potential and perfection. This end, or good, is what nature seeks; not in the sense that it is equally desirable to all beings, but rather in the sense that each being has a natural end, a good toward which its nature strives. A cat's good differs from a human's, reflecting their differing natures. But each pursues its own proper end, its good, according to its inherent nature.

For the study of human behavior and ethics, the concept of natural finality is indispensable. The fundamental premise is that the nature of every human being is directed toward happiness, understood as a complex state of human fulfillment and perfection. This perfection requires the cultivation of virtues, guiding conduct toward the good.⁴ While the paths to happiness are diverse, achieving this end requires proper orientation of actions.

As seen, the philosophical thesis of finality oriented toward the good is linked to the concept of nature. Every entity possesses an inherent mode of being, directing it toward specific ends. Consequently, human beings are inher-

⁴ Aristotle posits that human acts are directed toward ends, and that the person must pursue one of these ends for themselves; otherwise, the pursuit would extend indefinitely. See Aristotle, *Nicomachean Ethics*, trans. Roger Crisp (Cambridge: Cambridge University Press, 2004), bk. I, ch. 1 and 2, 4. Moreover, he clarifies that this ultimate end, happiness, manifests as an activity (see *ibidem*, bk. X, ch. 6, 7–13), which unfolds according to virtue and wisdom (see *ibidem*, ch. 7 and 8, 10–15).

ently driven to seek happiness; while we may often pursue goals that do not lead to happiness, this inherent orientation remains.

ENLIGHTENED ETHICS

The Enlightenment worldview rejects this concept of inherent nature. It posits that human nature is characterized by the absence of predetermined ends; humans are inherently indeterminate, free to choose without constraint.⁵

This conclusion necessitates a new understanding of reality: the world is composed of interacting material entities, lacking inherent purpose or natural finality (Aristotle's *final cause*). This reductionist perspective, emerging in the seventeenth century, remains incomplete; even contemporary science cannot entirely dispense with elements implying natural ends, although these may be subtly embedded within scientific explanations. While it might superficially appear that science can function without invoking natural finalities, this is ultimately not the case.

The paradigm shift, paradoxically often labeled “naturalist,” fundamentally alters our understanding of ethics, even if the terminology suggests a continuous lineage.⁶ Classical ethics aims to guide human conduct toward its natural end and perfection, entailing virtuous living. Once the inherent finality of reality is denied—reduced to the purview of science, concerned solely with material and efficient causes⁷—ethics loses its ground. There is no inherent human good. Only personal freedom of choice remains—a freedom devoid of objective grounding. The available options become nihilism, the will to power, or existential nausea.

Classical ethics rightly recognizes that communal life is an extension of ethics; we are inherently social beings, not for mere utility, but to achieve the good life,⁸ a life of human fulfillment requiring virtue. Virtue is cultivated

⁵ Although the notion of unrestricted freedom is explicitly articulated later in the history of ideas, its origins can be traced back to Hobbes. See Leo Strauss, *Natural Right and History* (Chicago: University of Chicago Press, 1953), 166–202. For a discussion of the transformation of natural law into its modern version, see *ibidem*, 167. Hobbes holds that rights exist by nature and argues for the right to defend one's life based on one's knowledge and understanding, thus establishing himself as a founding figure of political liberalism. See *ibidem* 180–82.

⁶ See Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* (London: Duckworth, 1985), 286. MacIntyre makes clear this lack of continuity; concepts such as virtue have been largely absent from the marketplace of ideas for approximately three centuries.

⁷ Nowadays, this assumption, while valid as a description of the initial ideas of the new science, does not appear very accurate, as more elements, such as formality, tendentiality, systems theory, and complexity, are increasingly entering it, which cannot be encompassed by that simplified mechanistic view.

⁸ “Though it [the state] owed its origin to the bare necessities of life, it continues to exist for the sake of a *good* life.” Aristotle, “Politics,” trans. John Warrington, in *Aristotle, “Politics.” The*

through interactions with others.⁹ Without an inherent natural purpose for human existence, the rationale for society is diminished; it ceases to promote virtue and righteous conduct, functioning instead as a means to more easily meet human needs.¹⁰

The question then arises: If there is no inherent natural purpose to human conduct, what does society offer beyond mere utility? There must be some inherent social dimension, given that even within a society rooted in individualistic perspectives, there exist conflicting views on shared goals. (The very concept of “shared” assumes a substantive commonality, which the radical individualistic perspective undermines.) The major Enlightenment thinkers offer contrasting answers: Hobbes prioritizes individual security, Locke emphasizes property, and Rousseau prioritizes well-being (or the agreeable experience of existence).¹¹

In each case, the modern approach cannot escape individual preference; it is a matter of individual choice, and the problem of coordinating conflicting views arises. This gives rise to modern individualism—a situation where no common vision of the good life is acceptable. Rousseau already posed this problem in the eighteenth century, and concluded that no solution is possible: if everyone does, without further ado, what they personally propose, without any other consideration, coordinating the whole becomes impossible. The only way out is to limit freedom so that there can be coincidence in the basics,¹² and leave it unimpeded for everything else, peripheral to that nucleus.

Federalist Papers. Adam Smith, “*The Wealth of Nations*” (Chicago: The Great Book Foundation, 1966), bk I: “The Household,” 3.

⁹ See Andrés J a l i f f Z e l i g u e t a, “La amistad como comunicación personal y consenso político en Aristóteles” (doctoral thesis, University of Navarra, 1996). For a summary of the dissertation, see Andrés J a l i f f Z e l i g u e t a, “La amistad como comunicación personal y consenso político en Aristóteles,” *Cuadernos de Filosofía: Excerpta e dissertationibus in philosophia* 9 (1999): 179–267 (also available at dadun, <https://dadun.unav.edu/handle/10171/9704>).

¹⁰ Reflecting on Adam Smith’s description of pin-making in *The Wealth of Nations* is enlightening. See Adam S m i t h, *An Inquiry into the Nature and Causes of the Wealth of Nations*, ed. Edwin Cannan (Chicago: University of Chicago Press, 1977), 18. This analysis fully aligns with the new social paradigm: efficiency to satisfy needs. Consequently, today, many view the economy as fundamental to societal functioning. This perspective, however, is essentially a modern degeneration.

¹¹ In this regard, see S t r a u s s, *Natural Right and History*, 166–294.

¹² This “basic,” unassailable notion does not correspond with natural law or human nature. It merely guarantees a social exchange that maximizes benefits for everyone, that is, satisfying individual desires—a utilitarian foundation. Of course, regardless of what is chosen as basic, it always generates less favored groups. This leads to the emergence of oppressed minorities in society; accounting for them to avoid injustices (which are not a lack of justice but of equity—treating everyone the same) creates privileges that others perceive as unfair. Once again, this presents an unsolvable dilemma. These minorities, however, do not include many Christians groups who maintain that this absolute freedom is a mistake, and that society must have common basic rules that are not subject to consensus.

The way to determine what constitutes that which is basic in society is consensus. This is not a result of the dialogue constituted by an interpersonal exchange of ideas, with the presentation of reasons and the convincing of some by others. It is an mere opinion count, and the winner is the one with the most votes.¹³ In this view, the possibility of convincing an adversary through the exchange of ideas does not properly exist: while it survives, it does not belong to the new framework of ideas. The problem of life in common is reduced to achieving practical consensus for collective action.

All these enlightened approaches to the new science, the new ethics and the new society were, in their beginnings, the prerogative of the upper classes, and, as such, a subject of discussion in the salons of the *femmes savantes*. In the nineteenth century, the advance of techniques applied to everyday life helped the new ideas to become generalized and permeate the social masses: it is no longer a life of perpetual scarcity that requires mettle and virtue to live, but everything is given, it is the right to live as one wishes¹⁴—the absolute freedom of the Enlightenment. It can be said that, at present, this is the dominant vision.

THE ENLIGHTENED VISION AND BIOETHICS

We now turn to the connection between the American principles-based bioethics and the Enlightenment ethical and political philosophy. The connection becomes clearer when examining its simplified, popularized version—a version less ambiguous than Beauchamp and Childress’s work, yet still grappling with ambiguities despite the eight editions of their book. Regardless, this perspective is currently undergoing a crisis, having been challenged for over a quarter-century. While the principles remain frequently cited, their application in medical practice is far removed from their original intentions.¹⁵

Without aiming for exhaustiveness, we will enumerate several key shifts in the terminology, arguments, and attitudes within medical ethics since the principles-based bioethics emerged. These shifts reflect the broader changes in the philosophical landscape.

¹³ This foundational premise of modern liberal democracy claims: each person gets one vote, leaving it to new rhetoricians, the publicists, to secure that vote, without any genuine exchange of ideas for a common social action.

¹⁴ See José O r t e g a y G a s e t, *The Revolt of the Masses* (London and New York: Routledge, 2022). While the content of *The Revolt of the Masses* is much broader, it confirms this dissemination, observable in an intensified form today, with its key aspects connecting directly to Enlightenment ideas.

¹⁵ See Edmund D. P e l l e g r i n o, “The Metamorphosis of Medical Ethics: A 30-Year Retrospective,” *JAMA*, no. 9 (269) (1993): 1158–62.

THE EMPHASIS ON AUTONOMY

The most prominent principle within modern bioethics is respect for autonomy. A proper medical intervention must consider and respect the patient's autonomous decisions. Exploring the precise definition of an "autonomous decision" proves complex, yielding varied interpretations. One might consider the Kantian ideal of autonomy. However, bioethical autonomy differs significantly from the Kantian model; Kantian autonomy necessitates profound reflection to reach a decision, ensuring it is both internally consistent and universally applicable as the highest good. Conversely, contemporary bioethics equates autonomy with the freedom to do as one chooses, without coercion¹⁶—an approach reflecting the Enlightenment emphasis on individual independence.

The repeated invocation of patient autonomy strongly suggests an underlying model of the physician–patient relationship derived from Enlightenment ideals.

PATIENTS AND CLIENTS

In the classical anthropological perspective, respect transcends mere non-interference; it involves positive engagement with others. The classical understanding of humanity recognizes individuals as beings who grow and develop through intimate connection with others. This is evident in Aristotle's assertion that friendship underpins the polis.¹⁷ Though not invariably the case, such interactions enrich all involved. The expression "respect for autonomy" within this classical framework implies a positive influence, guiding the other toward a shared understanding of the good.

The Enlightenment perspective, however, views society as an artificial construct, designed to optimize the production of goods and services to increase individual well-being. "Respect" in this context simply denotes non-interference. It does not involve encouragement or guidance but rather the provision of services, typically with economic compensation.

This perspective leads to a purely economic or service-oriented view of medical practice, reflecting a change in how patients are regarded, shifting from "patient" to "client."

¹⁶ See Enrique H. Prats, "El principio de autonomía: Una nueva perspectiva," a closing lecture of the Master in Bioethics, University of Navarra, Pamplona, May 23, 2009, Universidad de Navarra, Unidad de Humanidades y Ética Médica, <https://www.unav.edu/web/unidad-de-humanidades-y-etica-medica/material-de-bioetica/el-principio-de-autonomia-una-nueva-perspectiva>.

¹⁷ See Aristotle, *Nicomachean Ethics*, bk. VIII, ch. 1, 143.

THE NEW DIGNITY OF THE PATIENT

If absolute patient autonomy reigns supreme in the physician–patient relationship, then the classical ethical framework becomes an obstacle to its implementation. Classical medical ethics acknowledges the inherent limitation of freedom due to the moral obligation to act for the good of others (a deeply ingrained human inclination). Therefore, bioethics has presented absolute autonomy as recognition of the patient’s dignity, portraying them as rational beings whose opinions must be considered.¹⁸

The rise of the issue of autonomy coincided with arguments suggesting that it masked the increasingly commercialized nature of American healthcare. This commercialization emphasized the provision of services, rather than a commitment to the patient’s overall well-being.

The emphasis on inviolable autonomy has led to the disparagement of the supposedly paternalistic medicine of the past. Bioethical discussions promoting the overcoming of paternalism reflect the embrace of absolute Enlightenment freedom.

However, the view of paternalism is oversimplified. Patients always retain the freedom to disregard their physician’s advice; compliance implies consent. A truly paternalistic approach to medicine is impossible. While criticism of overbearing physicians lacking patient dialogue is valid, the theoretical shift has not significantly altered the situation.

The classical ethical approach emphasizes concern for others and acting in their best interests, according to one’s knowledge and understanding. Physicians practicing this approach always strived for dialogue. Respect for absolute patient autonomy, however, is not true dialogue; it often manifests as mere indifference. Physicians who engage in genuine dialogue do so not simply from deference to the ideal of absolute autonomy but out of commitment to their conscience and a genuine desire to assist their patients.

¹⁸ The view of the rise of autonomy as a greater consideration for the patient is indeed grounded in reality, and seems justified to a certain extent; however, it appears to have been persistently discredited by actual circumstances. This positive view can be seen, for example, in Gonzalo Herranz lecture on the ethical aspects of the patient–physician–public health institutions relationship. See Gonzalo Herranz, “Aspectos éticos de la relación paciente–médico–instituciones públicas de salud,” Ferrara, 2002, Universidad de Navarra, Unidad de Humanidades y Ética Médica, <https://www.unav.edu/web/unidad-de-humanidades-y-etica-medica/material-de-bioetica/conferencias-sobre-etica-medica-de-gonzalo-herranz/aspectos-eticos-de-la-relacion-paciente-medico-instituciones-publicas-de-salud>. This idea is frequently reiterated in Herranz’s lectures and writings. See “Conferencias sobre ética médica de Gonzalo Herranz,” Universidad de Navarra, Unidad de Humanidades y Ética Médica, <https://www.unav.edu/web/unidad-de-humanidades-y-etica-medica/material-de-bioetica/conferencias-sobre-etica-medica-de-gonzalo-herranz>.

THE DISAPPEARANCE
OF THE LIBERAL NATURE OF THE PROFESSION

Traditionally, concern for those with whom one interacts professionally was ethically mandated. This gave rise to professional duties—the specific obligations inherent to the healthcare professions, namely, the pursuit of the patient’s health. Health, understood as the capacity for a fulfilling human life, is inherently diverse. Healthcare professions, therefore, belong to the category of liberal professions—those shaping the modes of human life. Their rules are not fixed or mechanistic, unlike those of agriculture, for example. Administering an analgesic or performing surgery fundamentally alters a patient’s life, aiming to improve their human flourishing. This gives rise to specific professional duties, which must be defended by professional associations,¹⁹ which are neither optional nor changeable, but constitutional to the profession.

The enlightened approach, by recognizing patient autonomy as a basic rule, does not accept that the physician can think for himself what is in the patient’s best interest. The life of each person, in this modern view, is a matter for each individual alone, and the physician should not interfere. He only provides paid services.²⁰ Therefore, the demands of deontology are inadmissible. Moreover, the laws defending the nature of the colleges are nothing more than an obsolete privilege. From this follows the contemporary discussion on whether to convert the colleges into professional unions: what matters is the interests of the members, not those of the profession.²¹

THE JURIDIFICATION OF BIOETHICS

In the American social context, legal recourse is the ultimate arbiter. This legalistic bias equates ethical correctness with legal compliance.²² This cor-

¹⁹ Although professional associations are referred to in the Anglo-Saxon context as associations, their nature is quite similar to that of the medical colleges in Spain, l’Ordre des médecins in France, or the Ordini Medici Chirurghi e Odontoiatri in Italy. In Spain, the Constitution considers them as entities that are not merely private associations.

²⁰ These services can vary without issue: the profession may shift from seeking health to any other activity. Medicine would not possess intrinsic ends; it all depends on what is actually done or permitted (by consensus). Thus, if a physician practices euthanasia, it would merely be a change in activity, and the only concern would be the slippery slope. See Mary W a r n o c k and Elisabeth M a c D o n a l d, *Easeful Death: Is There a Case for Assisted Dying?* (Oxford: Oxford University Press, 2008), 75 ff.

²¹ See Antonio P a r d o, “Los intereses de la clase médica,” *Revista de Medicina Universidad de Navarra* 53, no. 3 (2009): 17–19 (also available at Academia, https://www.academia.edu/36217205/Los_intereses_de_la_clase_m%C3%A9dica).

²² While merely anecdotal, during a series of disturbances and looting in California a few years ago, a case emerged of a woman exiting a store with a television; she was approached by a journalist

relation is logical given the Enlightenment view of society as a framework where individuals pursue their desires, regulated solely by laws designed to mitigate conflict.

This leads to a juridified bias within bioethics. If there are no inherent goods, and society merely facilitates co-existence, a purely external framework suffices—the framework established by law and judicial rulings. From a classical perspective, law and judgments guide ethical conduct, taking into account human nature and the good. However, within the Enlightenment framework, laws and rulings define conduct—an external imposition. H. Tristram Engelhardt's work,²³ advocating radically liberal bioethics, exemplifies this, particularly its strong reliance on jurisprudence.

The persistent emphasis on legislation and case law, without reference to the good or conscience, strongly suggests that the underlying framework of this bioethics is rooted in Enlightenment ideals.

INFORMED CONSENT

Nearly universally, contemporary legislation has enshrined the concept of informed consent, requiring it prior to significant medical interventions. It is now a cornerstone of the physician–patient relationship.

Considering the earlier discussion of paternalism, its purported overcoming through the implementation of informed consent initially appeared as progress. However, experience reveals its limitations; it is primarily a legal requirement, creating significant bureaucratic hurdles in medical practice.²⁴ In many instances, patients sign documents without a thorough explanation, and legal precedent repeatedly confirms that such signatures do not guarantee genuine informed consent. The process has become a mere formality, failing to reflect genuine communication.²⁵

True informed consent necessitates a genuine dialogue, impossible to guarantee through mere bureaucratic procedures. The persistence of paternalism, despite the theoretical acceptance of autonomy, is undeniable. This is evident

who asked her if she thought what she was doing was wrong, to which she responded by pointing to the police present who were not moving a muscle. For that mindset, only illegal acts are deemed incorrect.

²³ See H. Tristram Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986).

²⁴ Informed consent also fosters very unprofessional attitudes, such as defensive medicine; this important issue exceeds the objectives of this work.

²⁵ See Daniel K. Sokol, "Let's Stop Consenting Patients," *BMJ*, no. 348 (2014): g2192 (also available at the *bmj*, <https://www.bmj.com/content/348/bmj.g2192>).

in the pressure (often driven by a scientific view of medicine) patients face to undergo treatments²⁶ or to accept abortion or euthanasia.

RECONCILING VALUES

Starting with the premise of radical autonomy, further challenges emerge for bioethics. These challenges stem from the subjectivity of values.

Values are defined by what individuals subjectively appreciate. This appreciation can be derived from the nature of things (subjective appreciation of the good) or simply from personal preference (autonomous decision).

Given the imperfect nature of good's apprehension, classical ethics, which emphasizes the alignment of values with reality, does not guarantee mutual understanding; dialogue is necessary to reach consensus, and this dialogue includes persuading others of the correctness of one's values.

Within the Enlightenment framework, however, this is impossible. Value appreciation within a framework of simple autonomy is emotivism—a surrendering to immediate feelings. Persuasion is unacceptable, as it would constitute manipulation²⁷.

This is another clue that guides us to the basic ideas in bioethics: if the attempt to convince by way of argument disappears,²⁸ we are faced with ideas derived from an enlightened ethics.

THE PURSUIT OF CONSENSUS

This emphasis on autonomy creates practical problems in achieving consensus. The pursuit of consensus reveals characteristics distinct from conflicts between values, yet ones rooted in the inherent subjectivity of values and in the impossibility of genuine dialogue.

The Enlightenment perspective underpins this approach. It views reality as purely material, analyzable through the hypothetical-deductive method of sci-

²⁶ See Antonio P a r d o, "El diálogo en la amistad terapéutica: estadística, riesgo y felicidad," *Cuadernos de Bioética* 36, no. 116 (2025): 29–46.

²⁷ The transformation of the attempt to rationally convince into manipulation is discussed in Chapter 3 of MacIntyre's *After Virtue*. See M a c I n t y r e, *After Virtue*, 23–35.

²⁸ See "Is Dying Better than Dialysis for a Woman with Down Syndrome?" *Cambridge Quarterly of Healthcare Ethics*, no. 3 (1994): 270–71. The article, whose author has not been mentioned by name, recounts the case of a mother who refused treatment for her twenty-two-year-old daughter with Down syndrome, despite the daughter being self-sufficient and capable of living many years with appropriate treatment. The daughter passed away, and no effort was made to convince the mother that treatment would be the best option for her daughter.

ence. Values, reduced to mere subjectivity, cannot be scientifically addressed; hence, there is no scientific resolution to value conflicts. Since values do not reflect an objective good but only personal preference, the goal is to identify these preferences to reach a consensus.²⁹

This approach is fundamentally flawed. It attempts to create rules that, based on expressed values, lead to a negotiated outcome—an attempt to theoretically resolve practical interpersonal issues.³⁰ This can be done through bioethical principles or more complex systems.³¹

The assertion that bioethics is a pursuit of consensus is therefore a product of the Enlightenment worldview. Consensus is achievable only if the points of disagreement do not involve fundamental ethical principles, as we will see later.

ETHICAL DILEMMAS

Having examined the extremes of contemporary bioethics, revealing its Enlightenment origins, we now turn to the central topic—the classical and modern understanding of ethical dilemmas. We will explore this concept within its historical context.

THE CLASSICAL VIEW

Classical ethics, as previously noted, is founded on natural finality; every being strives towards its natural end, or fulfillment. For a being without deliberative capacity, this movement toward its end is governed by instincts and learning, either through interaction with conspecifics or through experience.

Humans, however, possess a unique intellectual capacity enabling free choices, although these choices are influenced by pre-rational factors (sensible

²⁹ Diego Gracia, who introduced American principles-based bioethics in Spain, highlights this point: the new science leaves room only for subjective values, and bioethics aims to seek consensus. The issue of bioethics and the problem of life was addressed by Diego Gracia in his acceptance speech at the ceremony of awarding him an honorary doctorate by the University of Burgos on October 17, 2024. See Diego Gracia, “La bioética y el problema de la vida,” Universidad de Burgos https://www.ubu.es/sites/default/files/news/files/discurso_diego_gracia_la_bioetica_y_el_problema_de_la_vida.pdf.

³⁰ See Antonio Pardo, “Filosofía y Medicina,” *Revista de Medicina de la Universidad de Navarra* 35, no. 2 (1991): 43–44 (also available at Academia, https://www.academia.edu/5706209/Filosof%C3%ADa_y_Medicina).

³¹ See Diego Gracia, *Procedimientos de decisión en ética clínica?* (Madrid: EUEMA Universidad, 1991).

impulses, moods, character, and personality), which do not negate, but rather modulate, the intellectual capacity.

Setting aside the potentially complex terminology of Thomas Aquinas,³² this intellectual capacity encompasses understanding the implications of a proposed action, its moral goodness or badness (its suitability for achieving human fulfillment), and considering various aspects linked to the agent's freedom³³: reasonable foresight, correct intention, and a right decision, maintaining a balance between intended and tolerated effects. Let's examine these in turn.

First, knowledge is voluntary. To consider an action, its technical aspects or moral implications, requires a voluntary act which can, itself, be judged as correct or incorrect. Therefore, reasonable foresight is crucial in ethical evaluation.

Second, every voluntary action is goal-directed. The voluntary pursuit of a goal (intention) is a key component of ethical evaluation.³⁴

A given goal rarely dictates specific means to its attainment; various paths exist. Therefore, decisions regarding which means to employ are also ethically significant, independent of the intention itself. These decisions gain ethical weight upon their execution.³⁵

Finally, beyond intended effects, actions produce unintended consequences. If reasonable foresight has been exercised, these consequences are known beforehand and accepted³⁶; they are tolerated, though not intended.

Moral goodness requires reasonable foresight, good intentions, correct decisions, and a will uncorrupted by the acceptance of consequences worse than the intention itself. This last point was highlighted by Pius XII's discussion of ordinary and extraordinary means in medical care,³⁷ later termed as

³² The historical vicissitudes following Thomas Aquinas have greatly obscured the understanding of his ideas across various eras. For a reconstruction of the core of the Thomistic view, adapting its terminology to ordinary language to avoid technicalities that hinder understanding, see Antonio P a r d o, "Sobre el acto humano: Aproximación y propuesta," *Persona y Bioética* 12, no. 2 (2008): 78–107 (also available at *Persona y Bioética*, <https://personaybioetica.unisabana.edu.co/index.php/personaybioetica/article/view/962>).

³³ See J o h n P a u l I I, Encyclical Letter *Veritatis Splendor* (1993), The Holy See, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html. One of its key points is the insistence that ethics must always be approached from a first-person perspective, focusing on the acts of the acting person.

³⁴ It is common to confuse this voluntary aiming with the objective itself. This is a mistake, as only a voluntary act can be morally evaluated, in this case, the intention of the person aiming at that objective.

³⁵ They would correspond to the moral object in Thomistic terminology. See P a r d o, "Sobre el acto humano: Aproximación y propuesta."

³⁶ Exceptions may be considered, such as in drug research, where the intent is to determine, among other things, whether the trialed product causes undesirable effects.

³⁷ Pius XII made that statement in his address to the members of the Italian Institute of Genetics "Gregor Mendel" on resuscitation and artificial respiration. See "Address to an International

proportionate and disproportionate means. The core element here is the balance between tolerated effects and intention.

This classical view aligns with subjective experience. Within this framework, ethical dilemmas can arise in two ways.

First, dilemmas can result from insufficient knowledge of good and evil, causing uncertainty about the appropriate course of action. While ignorance can generate doubt, it is rarely the primary source of doubt in ordinary life, whether professional or personal. In professional contexts, some complexity may exist for observers, but seldom for those well-versed in the field.

Second, dilemmas can emerge when it is difficult to ascertain the proportionality between intended and tolerated effects. This often involves a “grey area,” with some consequences clearly disproportionate, others clearly proportionate, and others ambiguous.

It is crucial to remember that ethics is not engineering; it cannot provide absolute certainty. Moral certainty—sufficient for action—is attainable, but mistakes will inevitably be made. Those with perfectionist tendencies often find it harder to navigate the “grey area.”

The resolution to these situations lies in seeking detailed information to clarify both material and ethical aspects, consulting experts, and acting according to one’s conscience. Life proceeds, and decisions cannot be indefinitely postponed. We have to trust that, thanks to decisions and time, experience will make us know more about the subject. Our attitude of always seeking the best action will end up increasing the virtue of prudence, which, ultimately, will allow us to judge easily and intuitively in matters in which, in the first instance, the unsolvable ethical dilemma seemed to be the rule.

Not all this detracts from the fact that there are situations in which the ethical dilemma and the ensuing perplexity are insoluble. We have a good example in the problem of “surplus” embryos from in vitro fertilization: none of the solutions that are being considered is clearly preferable, since they all have serious drawbacks.³⁸

Congress of Anesthesiologists,” Vatican, November 24, 1957, Lifeissues.net, https://www.lifeissues.net/writers/doc/doc_31resuscitation.html.

³⁸ See Congregation for the Doctrine of the Faith, Instruction *Dignitas Personæ* on Certain Questions of Bioethics (2008), Section 19, The Holy See, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html. The section in question refers to John Paul II’s call to halt the production of surplus embryos. See also John Paul II, “Address to those attending a Symposium on ‘Evangelium vitae and Law,’ and the 11th International Colloquium on Roman and Canon Law,” Vatican, May 24, 1996, EWTN, <https://www.ewtn.com/catholicism/library/i-appeal-to-worlds-scientific-authorities-halt-the-production-of-human-embryos-8784>.

THE MODERN VIEW

The approach derived from the Enlightenment perspective is arguably simpler, avoiding the intricacies of internal deliberation. Its fundamental premise is that humans are autonomous beings with absolute freedom, primarily seeking self-interest. Those who disagree might consider this unrealistic, especially as a universal description of human behavior. However, even partial adherence to this perspective is evident within society. It represents a distortion of sociability. This premise underpins the American version of bioethics.

For utilitarian reasons, individuals (in their natural state, as described by Rousseau³⁹) associate for mutual benefit. Collaborative action often yields superior results compared to isolated efforts.⁴⁰ Therefore, the challenge lies in enabling individuals to maintain their unfettered freedom while engaging in practical cooperation.

Within this context of collaboration, individuals may autonomously desire mutually incompatible outcomes. Some conflicts are resolvable through convention (e.g., the use of various currencies, traffic signals); mutual agreement is sufficient. However, other conflicts are non-conventional, involving fundamental incompatibility (e.g., respecting human life versus taking a life). While adding qualifiers like “under certain circumstances” might seem to bridge the gap, the fundamental incompatibility remains.

This type of irresolvable conflict prompted classical thinkers to invoke the concept of nature: certain principles apply universally to all humanity, remaining unaffected by dialogue⁴¹ or societal convention. Adherence to these principles brings fulfillment; disregard leads to degradation.

However, within the Enlightenment framework, differing preferences create conflicts, which, within a scientific worldview, seem to manifest as disagreements over material issues. (In practice, this is not the case, as the realm of values intrudes.) Such conflicts can be addressed through equity, though only in limited circumstances (e.g., dividing a cake fairly). In bioethics, equity relates to the principle of justice, which in itself provides no solution; inequities are unavoidable.

These conflicts of interest, or what bioethics terms “ethical dilemmas,” differ significantly from the classical understanding. The modern solution proposed is (Enlightenment-style) dialogue among stakeholders: physicians,

³⁹ See Strauss, *Natural Right and History*, 252–94. Strauss shows there that Rousseau himself considers that this “natural” state is a fiction.

⁴⁰ The prisoner’s dilemma is a typical issue that can only be explained if this context is accepted.

⁴¹ As mentioned earlier, this dialogacy should not be confused with the classical meaning of the term, which implies mutual intimacy with the possibility of changing one’s opinion as a result of that conversation. It merely serves to clarify autonomous and immovable positions, allowing for understanding how they can fit together.

patients, institutions, and insurance companies. This approach is fraught with problems; it lacks a clear endpoint, and the continual emergence of new details means no solution incorporates all relevant factors. This approach attempts to provide a theoretical, rational resolution to practical problems of human interaction, an objective demonstrably impossible to achieve.

Despite its superficial limitations, clearly articulating each party's perspective can prove useful. An initially unacceptable stance, when fully explained, might become acceptable.⁴² Given bioethics' focus on achieving consensus, AI tools have been suggested to improve conceptual precision during dialogue,⁴³ aiding in the resolution of what might be apparent rather than actual conflicts. This approach, rooted in the principles-based bioethics, can resolve seeming conflicts that arise merely from misunderstandings.

However, in contemporary medical practice, with its technological advancements, little space remains for such dialogue. While dialogue is necessary for understanding, it cannot reconcile fundamentally incompatible standpoints. Classical thinkers explored deeper principles rather than mere dialogue to address practical issues of cooperation. This enlightened "dialogue" serves only to ascertain the other party's position or to resolve conventional conflicts (ones lacking inherently irreconcilable positions). In cases with fundamentally opposing positions, one must be judged correct and the other incorrect; this is beyond the capabilities of an algorithm, however sophisticated.

Principles-based bioethics, therefore, represents a secondary step, building upon prior ethical analysis. It performs tasks algorithms can execute but falls short where human judgment is needed. A program cannot prioritize the fundamental imperative of pursuing the good; it can only subsequently consider ways to facilitate coexistence among people holding differing viewpoints.⁴⁴ Prioritizing the latter without the former leaves bioethics adrift, incapable of providing genuine moral guidance. While AI might reduce friction, it cannot determine the proper course of action. This is why the belief that AI can make truly ethical decisions is erroneous.

Principles-based bioethics, by focusing on dialogue to achieve pragmatic consensus, displays two key characteristics. First, it addresses external, prima-

⁴² Thus, an article, discussing the utility of chaplains in hospital care, shows how dialogue with the chaplain clarified something initially unacceptable: prolonging a patient's life without hope becomes meaningful because the objective was to celebrate a birthday. See Robert Klitzman, "How Chaplains Can Help the Fractured U.S. Health Care System," *STAT 10*, November 14, 2024, *STAT 10*, <https://www.statnews.com/2024/11/14/chaplains-hospitals-health-care-burn-out-religion-mortality/>.

⁴³ See Helena Kudibor, "AI Tool Helps People with Opposing Views Find Common Ground," *Nature*, October 17, 2024, *Nature*, <https://www.nature.com/articles/d41586-024-03424-z>.

⁴⁴ Clarifying this would require a more detailed discussion which exceeds the objective of this work.

rily material aspects (what can physically be done) rather than intentions or the decisions analyzed in classical ethics. Within this framework, proportionality of tolerated effects becomes mere acceptability. The voluntary acceptance of undesirable consequences disappears, as only their material nature is considered. Second, it emphasizes ethical dilemmas, essentially reducing all conflicts to this type of problem—a problem seldom reflecting true moral perplexity. These features characterize the approach of those working to apply AI to resolve ethical dilemmas, as illustrated by UNESCO’s work on Artificial Intelligence and ethical dilemmas.⁴⁵

The abundance of the term “ethical dilemmas” and a consequentialist approach (weighing consequences) reveal the underlying framework (classical or enlightened). The first characteristic points to a lack of emphasis on genuine moral dilemmas (ones stemming from conflicting obligations of conscience). The second, the consequentialist approach, suffers from the limitations which spring from the fact that pure consequences, without further interpretation, cannot determine which outcomes should be preferred; only expressed preferences remain. When AI is applied, those preferences are those of the programmers. This is the paradox or deception: tools intended to provide objectivity, when misused (within the framework of enlightened bioethics), merely reflect subjectivity.

The tools used within the context of enlightened bioethics offer only subjectivity. Future developments will determine whether we learn to utilize this technology appropriately.

This analysis pushes the enlightened approach to its extreme. However, many authors and texts blend classical and enlightened elements. Some advocate a dialogical approach to reconcile opposing perspectives, yet maintain certain moral absolutes. Others acknowledge the existence of moral absolutes but suggest that circumstances might justify exceptions; essentially, these absolutes are not truly absolute. Unfortunately, many works lack coherence, mixing different viewpoints without reconciliation. This is particularly common in analyses of specific clinical cases. This situation necessitates paying attention to the interests of those driving technological advancements.

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Readers may have noticed that we have not delved into terminological details, such as distinguishing between Aristotelian ethics, Thomistic ethics, Christian Hippocratic medical ethics, or, more recently, issues like utilitarian-

⁴⁵ See UNESCO, “*Artificial Intelligence: Examples of Ethical Dilemmas*,” *UNESCO: Artificial Intelligence and Emerging Technologies*, <https://www.unesco.org/en/artificial-intelligence/recommendation-ethics/cases>.

ism or pragmatic consensus, nor have we explored other aspects of classical or contemporary ethical doctrines in order to establish their specific content or relationships. This approach is common among those who regard bioethics as a clear and well-defined body of knowledge, a complete science to which clarifications and refinements are added over time through research.

However, in our paper, we have attempted something quite different: it starts from a philosophical analysis that allows us to identify two distinct ways of understanding ethics. The first can be traced back to Aristotle and has continued through the centuries, passing through various schools, including Thomism and the Christian Hippocratic ethical perspective. Despite their apparent differences, these schools share a common foundation: the idea that ethics pertains to voluntary actions that aim toward perceived good, made possible because conscience allows us to discover that good and recognize the imperative to pursue it. The second, which dates back to Enlightenment ideas, is what the classics called political philosophy. In this framework, the purpose of actions is to ensure that social life proceeds harmoniously—not through dialogue that facilitates the exchange of ideas and the voluntary movement of individuals toward a good end, but solely through consensus among differing views on what should be done. Such consensus becomes impossible in cases of irreconcilable ideas, such as whether all human life must be respected or whether it can be sacrificed in certain circumstances. The principles of bioethics—whether in their original form or the simplified versions used by clinicians—are good examples of this second approach. In real life, individuals must consciously confront their actions before engaging in political dialogue about what can be done collectively. The enlightened view of ethics omits this initial step: what matters most is reaching agreement; objective good and conscience are regarded as irrelevant.

The challenge of this division, as revealed by philosophical analysis, is that both approaches employ similar terminology, including the phrase “ethical dilemmas.” In the first view, this refers to an internal conflict within conscience, which struggles to clearly identify what good should be sought, especially in complex situations. In the second, it refers to a social conflict: disagreement about what should be done, making consensus difficult or impossible.

Therefore, our aim here has been to clarify the use of the term “ethical dilemmas” in research that approaches it with sufficient depth. We have argued that there are two distinct bioethical frameworks—the classic and the enlightened. To do so, we analyze not only this expression but also other consequences of the modern approach to bioethics. This approach justifies our decision not to address minor issues or tangential points, or to treat some details superficially, as they are not essential to differentiating the underlying ideas.

This also explains why we have not defined the ethical dilemma: the reason is that its definition depends on the ethical basis adopted. Nor have we sought

to illustrate specific cases, because such examples would also depend on the ethical foundation, whether it involves a conflict of conscience or a problem of reaching consensus. Finally, the use of AI in clinical ethics faces the same issue: it would only be applicable to facilitate consensus, which is impossible when disagreements are fundamental—such as whether life deserves respect—since we are dealing with a true ethical problem, namely, a voluntary approach to the good.

Finally, our analysis of the expression “ethical dilemmas” has led us to the following summarized conclusions:

(1) The classical ethical approach precedes any discussion amongst those involved in healthcare. Human action begins with internal, personal acts, possessing their own prior evaluation. Subsequently, it is rational to exchange perspectives and concerns to arrive at a shared course of action, thereby reflecting the essence of social life. This is where AI can be truly useful.

(2) Principles-based bioethics emphasizes the latter stage, which is often done superficially. While consensus is important, individual conscience cannot be ignored. Not everything is acceptable in the bioethical dialogue. Both physicians and patients can legitimately reject proposals. Failure to reach consensus is not catastrophic; respectful coexistence of people who hold differing opinions is possible.⁴⁶ It is doubtful that AI can grasp this subtle point of ethical discernment.

(3) The decisions to be negotiated are not arbitrary or idealistic; dialogue is necessary to understand the motivations of others. However, this dialogue is open to change, except for core, fundamental principles held by individuals. This underscores the necessity of dialogue for comprehending opposing perspectives. However, dialogue cannot force reconciliation where irreconcilable differences exist. In Asimov’s terms, AI will always require inherent laws or principles.⁴⁷

(4) Achieving ethically correct decisions and mutual understanding requires moral habits, particularly prudence. This cannot be achieved through rules or algorithms. The success of American bioethics stems from the ease of applying its rules—far simpler than reflecting on the specifics of a situation to reach an optimal decision.⁴⁸ Our future hinges on overcoming this ease, on doing what machines cannot—however much it might seem otherwise.

⁴⁶ This must be done while maintaining the basic ethical principles on which social life is founded. In certain circumstances, achieving this can be very difficult and is a typical origin of civil violence: We do not want to live in a way that seems inhumane to us.

⁴⁷ Isaac Asimov proposed his three famous laws for robots. See Isaac Asimov, “Runaround,” in Isaac Asimov, *I, Robot* (New York: Bantam Dell, 2004), 25–45. For three additional, supplementary rules, see Luis Enrique Echarte Alonso, “Inteligencia artificial emocional en el reverso del test de Turing: Al borde de la singularidad tecnológica son precisas cuatro nuevas leyes para la robótica,” *Revista Iberoamericana de Bioética* 25 (2024): 1–22 (also available at <https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/21351>).

⁴⁸ See Sokol, “Let’s Stop Consenting Patients.”

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ABSTRACT / ABSTRAKT

Luis ECHARTE and Antonio PARDO, Ethical Dilemmas in Bioethics: A Diagnostic Tool and the Limits of Its Implementation with Artificial Intelligence

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The adoption of the American model of bioethics in medical practice was a remarkable swift following its introduction roughly half a century ago. This rapid dissemination can largely be attributed to its structure around readily applicable practical principles. These principles employ easily understood terminology that, however, diverges significantly from the meaning of those same terms within the context of classical Hippocratic-Christian medical ethics. This terminological convergence, devoid of semantic equivalence, can lead to misinterpretations of bioethical texts and undesirable technological drifts. To address these interpretive ambiguities, we analyze fundamental elements of both classical and bioethical ethical approaches, identifying key differences. These differences, particularly regarding the terminology of ethical dilemmas or conflicts, can help illuminate the underlying assumptions of various texts and guide the optimal ways in which AI can assist in medical decision-making.

Keywords: classical ethics, enlightened ethics, ethical dilemmas, artificial intelligence, machine ethics, bioethics, principlism, principles of ethics

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Luis ECHARTE, Antonio PARDO – Dylematy etyczne w bioetyce. Narzędzie diagnostyczne oraz granice jego wdrażania za pomocą sztucznej inteligencji

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Od czasu pojawienia się około pięćdziesięciu lat temu amerykańskiego modelu bioetyki jego powszechne przyjęcie w praktyce medycznej dokonało się w niezwykłym tempie. Błyskawiczne rozprzestrzenienie się tego modelu można w znacznym stopniu przypisać faktowi, że wpisuje się on w praktykę aplikowania istniejących już, gotowych zasad postępowania medycznego. Zasady te wykorzystują łatwą do zrozumienia terminologię, która znacznie jednak odbiega od jej interpretacji w kontekście klasycznej hipokratejsko-chrześcijańskiej etyki medycznej. Owa terminologiczna konwergencja, której nie towarzyszy

równoważność semantyczna, może prowadzić do błędnych interpretacji tekstów z zakresu bioetyki oraz do niepożądanych skutków łączących się z wykorzystaniem technologii. Odnosząc się, do wszystkich tych niejednoznaczności interpretacyjnych, przedstawiamy analizę elementów podstawowych podejścia zarówno klasycznego, jak i bioetycznego, wskazując na zarysowujące się między nimi kluczowe różnice. Różnice te, dotyczące w szczególności terminologii przyjętej w debacie nad etycznymi dylematami bądź konfliktami, pozwalają rzucić światło na podstawowe założenia obecne w poszczególnych tekstach oraz wskazać na optymalne sposoby wykorzystania sztucznej inteligencji w podejmowaniu decyzji w praktyce medycznej.

Tłumaczenie *Dorota Chabrajska*

Słowa kluczowe: etyka klasyczna, etyka postępową, dylematy etyczne, sztuczna inteligencja, etyka maszynowa, bioetyka, principializm, zasady etyki

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