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ETHICAL DILEMMAS IN THE DOCTOR–PATIENT RELATIONSHIP IN A POST-PANDEMIC CONTEXT: A LITERATURE REVIEW

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ABSTRACT: *The COVID-19 pandemic has profoundly reconfigured the doctor–patient relationship, bringing to the fore ethical dilemmas related to informed consent in conditions of uncertainty, the balance between individual well-being and public health, resource allocation, confidentiality in telemedicine, and the risk of structural discrimination. This literature review critically examines the transformations in the role and moral responsibility of physicians after 2020 through the lens of the main bioethical frameworks (principlism, physician–patient relational models, virtue ethics, capabilities) and professional guidelines published during and after the crisis. Four areas of tension are analyzed: (1) autonomy vs. paternalism in conditions of collective risk; (2) beneficence/non-maleficence in therapies with limited evidence; (3) distributive justice in resource allocation; (4) confidentiality, privacy, and relationship quality in the virtual environment. The paper argues that, in the post-pandemic stage, medical ethics calls for an "ethics of extended responsibility," which combines traditional standards of the clinical relationship with obligations to the population, deliberative transparency, and digital skills. It proposes directions for ethical education, updating telemedicine guidelines, and participatory risk communication mechanisms.*

Keywords: *bioethics; medical ethics; doctor–patient relationship; post-pandemic; autonomy; distributive justice; telemedicine; informed consent.*

Introduction

The COVID-19 pandemic has tested the limits of ethical standards, bringing to the fore long-standing tensions in the doctor-patient relationship and generating unprecedented situations: consent under pressure, treatments with limited evidence, resource triage, large-scale virtual consultations, as well as increased reporting and isolation requirements with an impact on confidentiality. Although the classic bioethical principles of autonomy, beneficence, non-maleficence, and justice remain normative benchmarks (Beauchamp & Childress, 2019), their application in a crisis context has revealed the need for clarification regarding prioritization and the extension of responsibility to the public good.

The doctor–patient relationship has historically been conceptualized through normative models that reflect the distribution of moral authority and decision-making responsibility. Emanuel and Emanuel (1992) proposed four models-paternalistic, informative, interpretive, and deliberative that continue to structure debates about autonomy, values, and professional roles. The pandemic has highlighted the limitations of the purely informative model in conditions of uncertainty and has revitalized the call for ethical deliberation and clinical partnership, in which the physician guides the patient through evolving values and options.

At the same time, the tradition of medicine as a profession with a fiduciary duty (Pellegrino & Thomasma, 1993) has been superimposed on public health imperatives, generating tensions between the duty to the individual patient and obligations to the community (Daniels, 2008). Dilemmas regarding the allocation of scarce resources have called for transparent and ethically justified criteria, such as severity, prognosis, and likelihood of benefit, to avoid arbitrariness and discrimination (Persad, Wertheimer, & Emanuel, 2009).

The accelerated digital transformation has raised additional ethical questions. Telemedicine, while valuable for continuity of care, has affected the quality of the relationship (absence of nonverbal cues, limitations in examination), amplified risks to confidentiality and data security, and brought to light digital inequities impacting access (AMA, 2021; Greenhalgh et al., 2020). In addition, the infodemic has complicated informed consent, requiring more robust risk communication based on transparency and the correction of misinformation (WHO, 2021).

The doctor-patient relationship must now be understood in the context of the extension of professional ethics to multidisciplinary teams. Not only doctors, but also social workers, psychologists, and auxiliary staff participate in the act of caring for and protecting the dignity of patients. As Bugnariu (2021) points out, ethical challenges no longer arise exclusively in the medical setting, but throughout the patient's social support system, where decisions have an implicit moral component that requires reflection and interdisciplinary coordination.

Therefore, the post-pandemic period calls for an ethical recalibration: (a) reaffirming deliberative partnership in decision-making; (b) integrating distributive justice criteria into clinical practice and resource allocation; (c) explicit standards for confidentiality and relationship quality in telemedicine; (d) professional skills in communicating uncertainty. This paper provides a theoretical review of the relevant literature, mapping the main ethical frameworks and post-pandemic dilemmas, with the aim of formulating ethical recommendations for clinical practice and updating professional guidelines.

1. Ethical frameworks for the doctor–patient relationship

The doctor–patient relationship is at the heart of clinical practice and the field in which the normative frameworks of bioethics are applied and tested. In the post-pandemic context, these frameworks must be re-examined considering scientific uncertainty, systemic pressures, and digital transformations, without abandoning fundamental ethical requirements (Beauchamp & Childress, 2019).

Principlism, classical landmarks, and current tensions. Principlism offers four landmarks: autonomy, beneficence, non-maleficence, and justice, which are widely used in clinical deliberation (Beauchamp & Childress, 2019). Post-pandemic, it remains useful but requires nuance: (a) autonomy must be understood relationally, taking into account the social, cognitive, and informational dependencies of the patient in crisis (Mackenzie & Stoljar, 2000); (b) beneficence and non-maleficence require transparency about the uncertainty of evidence; (c) justice takes on greater weight in situations of scarcity (Persad, Wertheimer, & Emanuel, 2009). The typical tension is between respect for individual choices and obligations to public health, a tension that requires explicit argumentation and proportionality.

Models of the doctor–patient relationship. The four models-paternalistic, informative, interpretive, deliberative-describe different distributions of moral authority and the role of the physician in clarifying the patient's values (Emanuel & Emanuel, 1992). In a post-pandemic context, the deliberative model is often preferable: the physician not only conveys data but also facilitates a negotiation of values and priorities under uncertainty, integrating considerations of social justice (Emanuel & Emanuel, 1992; Daniels, 2008). However, emergency situations may temporarily require paternalistic traits justified by proportionality and necessity, with the subsequent obligation to debrief and re-establish the partnership.

The ethics of virtues: from rules to professional character. Virtue ethics shifts the focus from rules to the clinician's character, prudence, compassion, courage, and honesty as resources for prudent judgments in morally complex situations (Pellegrino & Thomasma, 1993). In crises, virtues such as sincerity in communicating risk and the moral courage to support vulnerable patients become crucial. Virtue ethics does not replace principles, but makes them applicable through practical discernment, reducing the algorithmic rigidity of decisions.

The Capabilities Model: Real Freedoms for Decision Making. The capabilities approach shifts the discussion from resources and preferences to the actual freedoms of individuals to pursue a healthy life (Sen, 2009; Nussbaum, 2011). In clinical practice, this means assessing the functional barriers (digital access, social support) that condition informed consent and adherence. In the post-pandemic era, digital capabilities are becoming part of the moral infrastructure of effective autonomy (Greenhalgh et al., 2020).

Relational autonomy and ethics of care. The theory of relational autonomy highlights that patient decisions are socially constructed and depend on networks of trust, time for deliberation, and relational support (Mackenzie & Stoljar, 2000). Complementarily, the ethics of care insists on responsibility and attention to vulnerabilities, which are essential when consultations move online or when social isolation weakens support (Tronto, 1993). Integrating these perspectives corrects excessive individualism and promotes a robust therapeutic alliance.

The frameworks analyzed converge toward an integrative vision: the post-pandemic doctor-patient relationship calls for deliberative partnership, professional virtues, support for patient capabilities, and attention to contexts. An "ethics of extended responsibility" combines duty to the individual with obligations to the community and justice in the allocation of resources (Daniels, 2008; Persad et al., 2009). In practice, this translates into: (a) clearly explaining uncertainty; (b) value-oriented deliberation; (c) attention to equity and access; (d) cultivation of clinical virtues.

The ethics of care involve recognizing vulnerabilities and interdependence between professionals and patients. Studies on collaboration between doctors and social workers reveal that moral dilemmas frequently arise in areas where professional competencies overlap and responsibility is shared (Bugnariu, 2018). This confirms that patient autonomy must be understood relationally, in the context of the support provided by interdisciplinary teams, rather than as an isolated act of individual will (Mackenzie & Stoljar, 2000).

2. Post-pandemic dilemmas in the doctor–patient relationship

The health crisis caused by the COVID-19 pandemic has brought to the fore multiple ethical dilemmas that have reshaped the doctor-patient relationship. In a context dominated by uncertainty, institutional pressure, and limited resources, traditional bioethical principles have been put to the test. The relationship of trust, an essential element of medical practice, has often been replaced by a digitally mediated relationship, subject to distancing constraints, and patient autonomy has been temporarily subordinated to public health objectives.

Autonomy versus public health: the balance between freedom and responsibility. One of the most obvious post-pandemic tensions is the conflict between individual autonomy and public health protection. During the pandemic, clinical decisions were often influenced by mandatory protocols, quarantines, and restrictions imposed to protect the community. Under these conditions, patient autonomy was limited in favor of the common good (Daniels, 2008).

Although the principle of autonomy remains a central pillar of medical ethics, health emergencies have demonstrated that decision-making freedom must be interpreted relationally as interdependence between individual rights and social responsibilities (Mackenzie & Stoljar, 2000). In addition, risk communication has become a form of moral deliberation: physicians have had to explain the rationale for restrictions and rebuild trust in a climate of anxiety and mistrust (World Health Organization [WHO], 2021).

Thus, the major ethical dilemma was finding a balance between autonomy and justified paternalism, given that individual actions had consequences for public health. This led to a reassessment of the deliberative model of the doctor–patient relationship, shifting it towards shared responsibility and moral solidarity (Prainsack & Buyx, 2017).

Informed consent in conditions of scientific uncertainty. The pandemic has put pressure on the practice of informed consent, especially in the early stages, when scientific evidence on treatments and vaccines was limited. Consent has become a complex process, based on incomplete information, but also on shared responsibility between doctor and patient (Beauchamp & Childress, 2019).

Ethically, doctors had to navigate between their duty of truthfulness and the impossibility of offering certainties. Greenhalgh et al. (2020) show that honest communication of uncertainty expressing the limits of knowledge, without authoritarianism but also without relativism, has strengthened trust. In contrast, a lack of clarity has fostered misinformation and mistrust in the medical profession.

From an ethical perspective, the pandemic has demonstrated that epistemic transparency is an integral part of the physician's moral responsibility. Post-pandemic informed consent is not limited to signing a form, but involves a deliberative dialogue based on values, context, and trust (Emanuel & Emanuel, 1992).

Distributive justice and the allocation of medical resources. One of the most difficult ethical dilemmas was the allocation of limited resources: ventilators, intensive care beds, experimental treatments. Triage situations raised questions about who should be given priority and on what criteria.

Bioethical literature has offered several models: the prognostic criterion (chances of survival), the criterion of life span saved, and the principle of "the greatest good for the greatest number" (Persad, Wertheimer, & Emanuel, 2009). However, these criteria have been criticized for the risk of discrimination against the elderly, people with disabilities, or people with chronic diseases (Daniels, 2008).

From an ethical perspective, doctors have faced a dual loyalty to the individual patient and to the healthcare system. This tension has required clear ethical guidelines, triage committees, and procedural transparency to protect professional integrity and maintain public trust (Ruger, 2010).

In the post-pandemic era, the principle of distributive justice has been expanded: it no longer refers only to material resources, but also to equitable access to innovation, vaccines, telemedicine services, and psychological support (Gostin & Meier, 2018).

Telemedicine: confidentiality, privacy, and digital equity. The expansion of telemedicine has generated undeniable benefits, but also significant ethical dilemmas. The doctor-patient relationship, mediated by technology, has been redefined by the absence of direct contact, the loss of nonverbal cues, and the limitation of clinical examinations. These changes have raised questions about the quality of the relationship, the authenticity of empathy, and the confidentiality of medical data (Greenhalgh et al., 2020).

According to the American Medical Association (AMA, 2021), ethical principles applicable to virtual consultations should include: protecting sensitive data, ensuring equitable access to digital platforms, and maintaining professional standards of communication. However, digital inequalities, lack of connectivity, and low technological literacy have excluded vulnerable groups from online services, exacerbating pre-existing injustices (Prainsack & Buyx, 2017).

Thus, telemedicine requires a new operational code of ethics, based on digital solidarity, mediated empathy, and guaranteed confidentiality, so that the doctor-patient relationship remains person-centered, not technology-centered.

Risk communication and moral responsibility in the face of misinformation. Another crucial aspect of the post-pandemic doctor–patient relationship is risk communication in an environment saturated with conflicting information. The WHO (2021) has defined an "infodemic" as an excess of information, both accurate and false, that hinders decision-making. In this context, the physician is no longer just a provider of treatment, but also an epistemic mediator, responsible for combating misinformation through clear explanations, empathy, and appeals to rationality.

From an ethical point of view, this expands the scope of professional responsibility: silence in the face of falsehoods becomes a form of moral complicity (Beauchamp & Childress, 2019). Risk communication should be understood as a moral act, based on transparency, respect, and cooperation, not as a simple transfer of information.

The dilemmas analyzed show that the post-pandemic doctor-patient relationship cannot be viewed solely through the lens of individual interaction. It becomes an expanded moral space, where clinical, collective, and technological obligations intersect. Contemporary medical ethics must integrate three dimensions:

1. Relational responsibility: negotiated autonomy and deliberative communication.
2. Social responsibility: justice in access and distribution of resources.
3. Digital responsibility: confidentiality and fairness in the virtual environment.

Only by balancing these levels can post-pandemic medical ethics respond to current moral challenges and restore trust between doctor and patient.

3. Ethical implications and recommendations for practice. The pandemic crisis has highlighted not only the vulnerabilities of healthcare systems, but also the need for a moral redefinition of the medical profession. In the post-pandemic context, the doctor-patient relationship must move beyond traditional models based on authority and evolve towards a deliberative partnership centered on trust, shared responsibility, and solidarity. From an ethical perspective, this process involves reconfiguring professional competencies and institutional norms to respond to emerging ethical demands.

Reaffirming the ethics of professional responsibility. Post-pandemic medical ethics must be based on an ethic of extended responsibility, which goes beyond individual duty to the patient and includes responsibilities to the community and the healthcare system (Ruger, 2010). The physician becomes a reflexive moral agent, capable of integrating the social dimension of clinical decisions.

This perspective involves cultivating three types of moral responsibility:

- Personal responsibility – making clinical decisions based on principles and not just protocols (Beauchamp & Childress, 2019).
- Collective responsibility – awareness of the impact of individual decisions on health equity (Daniels, 2008).
- Epistemic responsibility – transparency in communicating uncertainty and active involvement in combating misinformation (WHO, 2021).

Thus, medical ethics is no longer just a code of rules, but a form of ethical reflexivity applied to the complex context of post-crisis medicine.

Ethical education and continuing professional development. An essential aspect of strengthening the ethics of the doctor–patient relationship is the integration of bioethical education into medical training. In the post-pandemic context, ethical education must go beyond theoretical approaches and include ethical simulations, moral reflection, and exercises in communicating uncertainty (Greenhalgh et al., 2020).

Continuing education should include:

- modules on informed consent under uncertainty.
- ethical triage and resource prioritization.
- ethics of telemedicine and data protection.
- skills in risk communication and moral conflict management.

Ruger (2010) and Prainsack & Buyx (2017) emphasize that effective ethics education develops the capacity for deliberation, not just knowledge of norms, transforming medicine into a reflective and responsible profession.

In agreement with Bugnariu (2021), ethical training in the medical and social fields should include the practical dimension of moral reflection, through interdisciplinary case studies and the analysis of situations of ethical tension. These approaches contribute to the development of a "collective professional moral conscience," necessary for the ethical functioning of integrated health systems.

Digital ethics and privacy protection. The expansion of digital medical technologies requires an update of ethical codes. Telemedicine and artificial intelligence involve new risks regarding confidentiality, patient autonomy, and equity of access (AMA, 2021). Digital ethics must enshrine:

- the patient's right to digital privacy.
- algorithmic transparency in decision support systems.
- informed consent adapted to the virtual environment.
- digital equity, guaranteeing equal access to consultations and technologies (Greenhalgh et al., 2020).

Doctors must combine technological competence with moral judgment: technology is a tool, not a substitute for human relationships. Respect for patient dignity must remain unalterable, regardless of digital mediation.

Institutionalization of ethical deliberation. To prevent the recurrence of arbitrary decisions during the pandemic, medical institutions must establish permanent mechanisms for ethical deliberation. Ethics committees, interdisciplinary groups, and transparent triage protocols should become structural elements of healthcare management (Persad, Wertheimer, & Emanuel, 2009).

Daniels (2008) argues that the legitimacy of medical decisions depends on responsiveness to institutions to publicly justify prioritization criteria and allow for their review. In addition, including patient representatives on ethics committees would increase the democratization of clinical decision-making and public trust in medical institutions.

Summary recommendations for practice and policy. Based on the analysis of the literature, the following courses of action can be formulated:

1. Revision of codes of ethics to include standards on telemedicine, risk communication, and digital equity.
2. Continuing ethics training for healthcare personnel, focused on deliberation and social responsibility.
3. Procedural transparency in resource allocation and patient prioritization.
4. Strengthening ethics committees and integrating patients into decision-making.
5. Promoting a culture of solidarity and trust through empathetic and honest communication.

These recommendations can transform medical ethics into a dynamic tool capable of responding to post-pandemic social and technological changes.

In conclusion, the ethical dilemmas generated by the pandemic highlight the need for an ethical paradigm centered on solidarity, transparency, and shared responsibility. The medical ethics of the future must combine patient autonomy with social justice and genuine care for vulnerability.

As Prainsack and Buyx (2017) point out, solidarity is not only a moral virtue but also a condition for the ethical functioning of medical systems. In this sense, the post-pandemic doctor-patient relationship is no longer just a professional interaction, but a mutual moral commitment, a form of ethical cooperation aimed at ensuring not only survival, but also human dignity.

Conclusions

The doctor–patient relationship, considered by medical tradition to be the core of clinical practice, has undergone a profound transformation in the post-pandemic context, requiring a deontological and bioethical reinterpretation. The COVID-19 pandemic has served as a moral stress test for the principles of medical ethics, revealing structural vulnerabilities, but also the profession's ability to adapt and innovate morally.

An analysis of the literature shows that, in the post-pandemic era, medical ethics must move towards an ethic of extended responsibility, which integrates three dimensions: (1) responsibility towards the patient, centered on respect for autonomy and dignity; (2) responsibility towards the community, oriented towards distributive justice and the protection of public health; and (3) digital responsibility, specific to new technological environments and virtual communication.

Classical principlism (Beauchamp & Childress, 2019) remains a fundamental benchmark, but it must be complemented by relational models (Emanuel & Emanuel, 1992), virtue ethics (Pellegrino & Thomasma, 1993), and the capabilities approach (Sen, 2009; Nussbaum, 2011). Only an integrative vision can respond to contemporary ethical dilemmas: consent under uncertainty, resource allocation, telemedicine, misinformation, and digital inequalities.

Thus, post-pandemic deontological dilemmas confirm the need for an interdisciplinary ethics of care that transcends the traditional boundaries of medicine and integrates social reflection on vulnerability and justice (Bugnariu, 2018, 2021).

At the same time, rebuilding the post-pandemic doctor-patient relationship involves reaffirming trust as a moral foundation. This is achieved through transparency, empathetic communication, and deliberative participation. The doctor thus becomes not only a technical expert but also an ethical mediator, capable of balancing individual good with the common good.

For the future, the literature indicates the need to develop digital ethics, continuous ethical training, and institutional mechanisms for moral deliberation (Ruger, 2010; AMA, 2021). These directions can strengthen a professional culture based on solidarity, reflexivity, and social justice.

In conclusion, the ethical dilemmas that have arisen in the post-pandemic context are not only moral challenges but also opportunities to rehumanize medicine. An authentic medical ethic, oriented towards responsibility and solidarity, can transform the crisis into a catalyst for a new moral contract between doctors and society, one based on dignity, trust, and fairness

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