Bioethics in Chile: Present and Future Status

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Chile's health system has been evolving rapidly in recent years. Among other things, profit-making enterprises have assumed a growing role, medical care has become increasingly technical, and the importance of less highly trained health workers has grown. Also, the assigned role of the Chilean Medical Association in deciding matters of medical misconduct has diminished, while that of the courts has grown; the nature of the doctor-patient relationship has changed; and clear divergences between medical ethics codes, laws, and prevailing social practices have emerged.

Within this context, bioethics has come to be regarded as a necessary element in the teaching and practice of medicine. So while this discipline has not yet become fully institutionalized in Chile, it seems likely to play a growing role in dealing with the aforementioned changes and could make a substantial contribution toward solution of associated problems in the future.

Although bioethics extends beyond the field of biomedical ethics, this brief account will be limited to the latter area, and more specifically to certain issues that are currently being examined.

As in other Latin American countries, the institutionalization and application of bioethical studies in Chile is still fragmentary. The inclusion of bioethics is uneven, both on the agendas of hospital ethic committees and in the curricula of university medical schools. And despite administrative instructions and requests by physicians, the discipline has not yet become well established.

THE CHILEAN HEALTH SYSTEM

The Chilean medical profession enjoys a high degree of prestige, which Roa (*1*) attributes to its spirit of service and to a professional conscience in continuous evolution since establishment of the first medical school in 1833, a successor to the schools that first began providing similar instruction at the Royal University of San Felipe in 1756.

As of August 1988, Chile's National Medical Register listed 16,373 physicians—of whom 13,451 were residing in the country, 1,343 were abroad, 1,579 had died, and 68 had resigned (2).

At present, as a result of reforms made in 1979, the Chilean health system consists of essentially three components. One is the National Health Services System (*Sistema Nacional de Servicios de Salud*, SNSS), with 27 regional services, which provides free preventive care to the entire population and curative services to workers and indigents. Another is the National Health Fund (*Fondo Nacional de Salud*, FONASA), which administers the "free selection or preferred provider" system and reimburses expenditures by the SNSS. And the third consists of the Institutes of Health Security (*Institutos de Salud Previsional*, ISAPRES), which are enterprises that sell health insurance—with closed group, free election, and mixed plans—that were established in 1981. To these various services are added

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a private sector that varies in size depending on the geographic region of the country involved.

Changes the system has experienced in recent years, especially with regard to its financing, are pertinent to our discussion of ethics (3, 4).

Most public discussions of ethical issues in health have involved the Chilean Medical Association (*Colegio Médico de Chile*). This professional association, through its department of ethics, disseminates documents and standards, organizes sessions for reflection and analysis, awards annual prizes, oversees the actions of its members, and carries out research on conditions affecting the practice of medicine. Established in 1948 by Decree Law No. 9263, the society functioned as a public corporation until 1981. In that year Decree Law No. 3261 changed it to a professional association, and it was subjected to the new provisions of Decree Law No. 2757, which, among other things, provided for voluntary membership.

This measure, criticized by the association, meant the loss of its professional-ethical control over all physicians, and also loss of its authority to set standards for fees and honoraria. The Chilean Medical Association has nevertheless maintained a certain moral position and has continued to carry out important activities in the field of ethics. To a certain extent it still regulates the relationships of physicians with other physicians, the public, and the State (2, 5–9).

CURRENT ISSUES IN BIOMEDICAL ETHICS

The practice of medicine in Chile in recent years has been characterized by the following features pertinent to this discussion of ethics: the increasingly private and technical nature of health care on the one hand, and the increasingly proletarian nature of medical work on the other. These changes, evident in practically every developing country but very significant in Chile because of the situation prevailing since 1973, have shaped the medical community's principal ethical concerns.

This presentation will address two broad subjects: aspects of professional ethics (including interrelationships between physicians and their relations with the public and the State) and ethics of medical care (including the teaching and practice of biomedical ethics).

Aspects of Professional Ethics

Interrelationships between physicians. In recent years the ethical control of physicians by their peers has been an important issue. As already indicated, in 1981 Decree Law No. 3621 took jurisdiction over physicians away from the Medical Association and passed the power to settle disputes to the ordinary courts of justice. It thus removed the distinction between ethical misconduct and criminal misconduct.

Nevertheless, in its role as a professional association, the Medical Association retains the prerogative of investigating accusations made about its members, holding internal summary proceedings, and applying sanctions. The most important matters dealt with in recent times have included participation of physicians in torture, abuse of publicity, and establishment of parallel associations. Both the Medical Association Code of Ethics and other current regulations contain specific provisions concerning the relationships of physicians among themselves. Expulsion or temporary suspension from the association are provided for in the case of some violations; however, differences over the application of such provisions, regarding issues relating to freedom of association, have arisen between the

Medical Association and the Supreme Court of Justice.

Although the institutional health structure has traditionally been "doctorcratic" in Chile, reserving managerial positions for professional physicians, the political and economic changes mentioned above have led to new problems. Participation of nonmedical economic entities (such as ISAPRES) in health activities has taken authority and autonomy away from the physicians' association and has resulted in censurable actions by some professionals. Likewise, the participation of physicians in government activities has led to disagreements on such matters as allocation of resources by the State and salary claims, and has prompted ethics-oriented legal proceedings, sometimes against high-ranking members of the profession.

The Medical Association Code of Ethics sets standards for those professionals who, as part of their functions, are involved in appointments or dismissals, and it prohibits them from replacing physicians who have been unjustly removed from their posts (Articles 38 and 39). In recent years there has been occasion to discuss and apply these principles.

The code also regulates remuneration or compensation for services rendered and expressly condemns charging commissions to fellow doctors (Article 41); in addition, it establishes the conditions under which professional advertising is permitted (Title VI). All of this needs to be understood within the context of an increasingly private and technical health system, one with growing participation by private profit-seeking nonmedical organizations in health activities.

An absence of legislation on medical specialties has led to creation of an Autonomous Commission on the Certification of Medical Specialties (*Comisión Autónoma de Certificación de Especialidades Médicas*—CONACEM), whose authority at this time is moral only. It should be noted that the preparation of specialists in Chile is supervised by the universities; however, there is active debate about the proper role and the obligations of the State in its interaction with the universities and with the Medical Association. From the standpoint of ethics in professional relations, treatment of this subject demands consideration of the association's actions in order to protect its hegemony over health care matters (*10, 11*).

In 1985, Article 25 of the Code of Ethics was supplemented by a set of standards regarding the medical care of prisoners and the participation of physicians in torture and interrogation. The Medical Association has investigated specific cases and has publicly denounced and censured some of its members. The degree to which ethics were violated in such cases has been hard to estimate (*12*).

Relations with the public and the State. Discussion of relationships between physicians, the State, and the public has tended to favor individualism in Chile and to hark back to the ideal "doctor-patient relationship." Ethical problems raised by medical secrets and confidentiality, *in vitro* fertilization, and cases of "difficult patients" (especially in psychiatry) are customarily dealt with from this standpoint.

At the same time, the heterogeneous nature of the current health system and the coexistence of various subsystems create discrepancies among a doctor's various functions that are not sufficiently explicit. For example, a physician might establish a "paternalistic" type of relationship with SNSS patients, a "contractual" type of relationship with private patients, and an "engineering" type of relationship as an adviser to an ISAPRES entity.

Title II of the Medical Association Code of Ethics, which deals with the physi-

cian's obligations toward his patients, reserves the "diagnosis, prognosis, and treatment of patients" exclusively to the physician and obligates the physician to treat any person who needs it. It stipulates that medical confidentiality (including confidentiality of the patient's name) is a natural right, requiring neither promise nor contract, and one which must be respected absolutely. Issues surrounding this matter of confidentiality exemplify recent ethical problems and show how ethical decisions need to be taken within a revised context of the doctor-patient relationship. Among other things, introduction of the State and profit-making business entities into the picture makes ethical review imperative. Along this line, the existence of automated data systems (including data banks controlled by nonmedical administrators), combined with the general public's increasing medical literacy and ability to interpret such data, means that the maintenance of medical confidentiality now depends on authorities outside the traditional doctor-patient dyad.

No less important has been the debate over the State's authority to procure confidential information relevant to criminal or terrorist acts. Although Article 19 of the Constitution of 1980 provides for respect and protection of private and public life, and Articles 246 and 247 of the Criminal Code recognize professional confidentiality, both the Code of Criminal Procedure and the Health Code regulate conditions under which these rights become relative. The issue arose recently because of conflicts—between a broadened national security doctrine (supported by the military government) and the traditional ways of interpreting medical confidentiality—in cases where the control of armed terrorism has been key. The various divergences existing between codes of ethics, the law, and political views are far from being worked out and will continue to be focal points of medical and public interest for years to come (*13–16*). In addition, new challenges are being posed by AIDS and other diseases now coming to the attention of Chilean physicians and health authorities (*17–19*).

Medical Care Ethics

Social "ethics," manifested through institutionalized practices considered legitimate and habitual components of the "medical rationale," does not necessarily coincide with legislated codes of ethics (*20*).

According to 1985 data, at that time the teaching of humanistic and psychosocial subjects accounted for no more than 6% of the total curriculum hours devoted to pursuit of a medical career (*21*). The nine medical schools existing in 1985 (the University of Chile had four independent schools that later merged into one) shared the same policy regarding length of instruction and teaching methods (*22, 23*).

Currently there is increasing interest in bioethics, and bioethics courses are being taught at the Catholic University of Chile and the University of Chile. The University of Chile's School of Medicine, the oldest in the country, established a course on medical ethics at the end of the 1960s (Armando Roa, University of Chile, personal communication, 1989). In 1988, as part of its centennial celebration, the Catholic University of Chile organized the nation's First Congress on Medical Ethics. These events, along with the ongoing work of the Medical Association, indicate that the subject of bioethics is gaining importance and will definitely be incorporated into undergraduate and graduate curricula (*24*). To date there has been no move to install a postgraduate program of medical studies devoted exclusively to bioethics.

Another development that points to the institutionalization of a bioethical rationale is the work of ethics committees. The Organic Regulations on Health Services promulgated by the Government in 1986, besides containing provisions on spiritual assistance for the sick (Title VI), established advisory committees under the director of each hospital whose members were appointed by the director. The replies to a questionnaire circulated on this subject indicated that most hospitals had no operating ethics committee, this function being assumed by the general technical committees, and that where such committees existed their functions and nature had not been well-defined (the replies either gave no information about their formation and operation or indicated that they tended to be confused with "cultural" committees). However, most of the medical schools and research institutes do have ethics advisory boards, which deal primarily with research involving human subjects. International legislation on this latter subject is widely disseminated.

Specific ethical issues relating to organ transplants (*25*), *in vitro* fertilization (*26*), AIDS (*17–19*), specific medical specialties (*27–30*), and conditions needed for the ethical practice of medicine have been dealt with repeatedly in meetings organized by the Medical Association or the universities (*31*). While the subject of bioengineering has generated great interest among both physicians and the public (*32*), to date its ethical implications have neither received comparable attention nor given rise to any specific legislation.

FUTURE OUTLOOK

Bioethics, which has displaced medical history as the basic medical discipline outside the natural sciences, is perceived in Chile as a necessary element in the teaching and practice of medicine. The most active participants in this field to date have been Chile's professional medical and university associations. Although this new discipline has not yet been fully institutionalized, the challenges posed by the political and institutional situation and changes expected soon in the medical system seem destined to promote its continued development. Within this context, it is possible that bioethics could prompt changes in the health care system and could contribute not only to a redefinition of medicine but also to less troubled and more effective relationships between medicine, law, and social practice (*33*).

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