

# Trajectory of an ethics committee in primary health care

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## Abstract

Primary health care is an essential health strategy and represents the basis of the Chilean health system. The comprehensive health care model transitions from an entrenched paternalistic clinical relationship to respect for autonomy and a rights-based approach. This transition entails ethical conflicts in any provider network; however, these have been little addressed at the first level of care. This study investigated the case of a Health Care Ethics Committee in the O'Higgins region of Chile. For this purpose, reports and opinions from a seven-year period were analyzed. The main results show the use of Diego Gracia's deliberative method and the approach to conflicts related to autonomy and confidentiality. The institutionalization of health care ethics committees is considered relevant since they intersect with quality and person-centered care.

**Keywords:** Primary health care. Ethics committees, clinical. Bioethics. Ethical analysis.

## Resumo

### Trajetória de um comitê de ética na atenção básica

A atenção primária é uma estratégia de saúde global essencial e representa a base do sistema de saúde chileno. O modelo de atenção integral à saúde passa de uma relação clínica paternalista enraizada para o respeito à autonomia e uma abordagem baseada em direitos. Essa transição gera conflitos éticos em toda a rede de prestadores, porém eles têm sido pouco abordados no primeiro nível de atenção. Este estudo investigou o caso de um comitê de ética em saúde na região de O'Higgins, no Chile. Para isso, foram analisados relatórios e pareceres por um período de sete anos. Os principais resultados dão conta da utilização do método deliberativo de Diego Gracia e abordagem de conflitos relacionados à autonomia e confidencialidade. Considera-se relevante a institucionalização de comitês de ética em saúde, uma vez que eles se relacionam com o cuidado de qualidade e centrado na pessoa.

**Palavras-chave:** Atenção primária à saúde. Comitês de ética clínica. Bioética. Análise ética.

## Resumen

### Trajectory of an ethics committee in primary health care

La atención primaria es una estrategia sanitaria esencial y representa la base del sistema de salud chileno. El modelo de atención integral en salud transita de una relación clínica paternalista arraigada hacia el respeto por la autonomía y el enfoque de derechos. Esta transición conlleva conflictos éticos en toda red de prestadores, no obstante, estos han sido poco abordados en el primer nivel de atención. Este estudio indagó el caso de un Comité de Ética Asistencial de la región de O'Higgins en Chile. Para ello, se analizaron memorias y dictámenes de un periodo de siete años. Los principales resultados dan cuenta del uso del método deliberativo de Diego Gracia y del abordaje de conflictos relacionados a la autonomía y confidencialidad. Se considera relevante la institucionalización de los comités de ética asistencial, ya que se intersectan con la calidad y la atención centrada en la persona.

**Palabras clave:** Atención primaria de salud. Comitês de ética clínica. Bioética. Análisis ético.

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## Universal and equitable primary care New service model

Primary health care (PHC) in Chile is structured in the International Declaration of Alma-Ata of 1978 as an essential health care strategy of universal reach to all, with their full participation and at an affordable cost for the country, in addition to being the main focus of the health system and an integral part of the overall socioeconomic development of the community. In this context, PHC functions as a “gateway to the health system,” as it represents the first contact of the enrolled population with the health system, promoting health protection, disease prevention, cure, rehabilitation, and palliative care<sup>1</sup>.

In Chile, PHC covers a network of more than two thousand outpatient clinics, 90.5% of which are managed by the municipalities of each commune<sup>1</sup>. Among the beneficiaries are citizens who have less geographic, economic, or social security conditions to access private health services. Therefore, the benefits do not involve a direct economic cost for beneficiaries of the public health plan Fondo Nacional de Salud (FONASA) or those who have no income or cannot contribute as long as they are formally registered at a network health center. Service coverage reaches 70.6% of the population<sup>1</sup>.

When planning care networks, the aim is for PHC to become the primary strategy for care for the entire population, with a view to its universalization to meet health needs with justice and equity<sup>2</sup>.

### People-centered

#### Comprehensive Health Care Model (MAIS)

Since 2005, the Comprehensive Health Care Model (MAIS) for Family and Community has been included in PHC. This model places individuals at the center of decision-making, recognizing them as members of a complex sociocultural system. Individuals as active healthcare agents lead the organization according to their needs to achieve the best possible well-being through comprehensive, timely, decisive, and high-quality care. This model establishes three principles: person-centered care, comprehensiveness, and continuity of care through the network of providers<sup>2</sup>.

#### Ethical conflicts

The national guidelines for implementing MAIS establish an ethical basis associated with an updated PHC for the country<sup>3</sup>, which correlates with health network planning approaches such as safe and quality care (non-maleficence); citizens' rights, life course, self-determination and community participation (autonomy); social determinants of health (equity) and cultural and gender relevance (beneficence)<sup>2</sup>.

Primary health care teams develop activities both at the institutional level, where they offer direct assistance and work together with the hospital network (intrasectoral), and in the territory where home and community assistance facilitates knowledge of the social context and its determinants, in addition to working with other institutions in the intersectoral network. Based on this comprehensive care model, all stages of the individual's life course advance, intervening in the family and environment, which leads to frequent ethical conflicts that have been little addressed<sup>4,5</sup>.

This lack of attention affects the quality of care<sup>6,5</sup>, generating feelings of anxiety, paralysis, and indecision in healthcare teams and even authoritarian attitudes toward patients. According to the reviewed literature, these issues are resolved differently using intuition, scientific evidence, or professional experience<sup>5</sup>. Specifically, both international<sup>4,7-11</sup> and national<sup>12-16</sup> evidence identifies ethical conflicts in the context of PHC, including difficulty in handling confidential data, questioning of patients' autonomy in the face of refusing treatments or failing to comply with instructions, discrepancies within the healthcare team, limitation of home treatments, among other issues of profound social sensitivity and risk of moral distress in the healthcare team.

Gracia explains the neologism “bioethics” from the union of two Greek roots, *bios* and *ethos*, as a “responsible vision” to combine “science” and “life,” respecting the values related to conflicts that arise between both<sup>17</sup>. While the area of bioethics in clinical practice has developed mainly at the hospital level, it has not been alien to practice at the primary level.

Thus, the proposal is for bioethics to seek its own path in PHC through the Care Ethics Committees (CEA) <sup>12,18,19</sup>. However, in Chile, the legislation that regulates these committees <sup>20</sup> highlights that their formation is not mandatory in primary care units and can even opt for the affiliation of an external CEA. Despite the ethical conflicts that arise in hospital care, where it is mandatory to have a CEA, at the primary level, the way of facing them can be identified as notably different <sup>21</sup>. Gracia describes that the peculiarities added to the ethics of the primary level itself can be reduced mainly to the greater importance of the context <sup>17</sup>.

## PHC Care Ethics Committee

### The experience

CEAs are *collegial bodies of a consultative and interdisciplinary nature created to analyze and advise on ethical conflicts that arise due to health care, aiming to contribute to a better quality of care and protecting people's rights concerning it* <sup>17</sup>. Furthermore, they perform a normative function of proposing institutional protocols of a preventive nature and training the healthcare team on ethics issues <sup>20</sup>. According to data from the Department of Bioethics of the Ministry of Health, of the 135 CEAs at the national level, only 13% belong to PHC <sup>22</sup>. This explains the scarce literature published in Chile on how these CEAs identify and resolve ethical conflicts in PHC <sup>13,16</sup>.

This study conducts a qualitative documentary analysis based on annual CEA reports on primary health in a municipality in the O'Higgins region. From this review, the proposal aims to identify the main activities in its trajectory, the areas of ethical conflicts addressed, and their relationship with the comprehensive healthcare model. The study is expected to contribute to expanding knowledge about the processes of confronting ethical conflicts in care in PHC and mitigate the implementation of CEAs due to the valuable support they can provide to care teams.

### Method

This study used the interpretative paradigm, qualitative methodology, and case study. According

to Yin, a case study *is an empirical method that investigates a contemporary phenomenon (the case) in depth, within its actual context, especially when the phenomenon and the context are unclear* <sup>23</sup>. The case study was unique and descriptive and addressed the phenomenon of the functioning of PHC CEAs in the national context where there are few functioning committees, establishing the following question: how are PHC ethical conflicts resolved in a CEA in the O'Higgins region?

This study followed the following steps: a) a description of the CEA context; b) an in-depth description of the case, including the ethical conflicts addressed; and c) conflict resolution processes. Therefore, public documents, annual reports, and opinions from a CEA in the O'Higgins region were searched over a seven-year registry period between June 2015 and December 2022.

Data analysis considered two rounds of readings of the selected documents: one performed by the principal investigator, a specialist in bioethics with extensive experience in CEA and PHC, and another by a collaborating researcher, a bioethics specialist with no experience in CEA but with extensive experience in PHC, thus managing the principal investigator's bias. This made it possible to identify the context of the study, describe the CEA concerning its legal, normative, consultative, and training functions, and identify the central consultations carried out with the committee to identify how ethical conflicts are addressed.

Subsequently, a thematic categorization was carried out following these purposes, using an Excel® table to facilitate data analysis. The reliability criteria were triangulation between researchers, dense and varied documents corresponding to the CEA over the seven years, and information saturation when reviewing the documents several times. Replicability is possible, considering the documents are public and easily accessible following public transparency protocols.

### Results

The documents analyzed were 36 opinions (documents with analysis of cases or consultations

and their recommendations) and seven reports (annual reports of activities carried out) from the CEA of PHC in a municipality in the O'Higgins region, registered from June 2015 to December 2022. During this period, 70 consultations were received, which were resolved according to the CEA's competencies, with the consultative function being distributed first, secondly, the training function, and, thirdly, the normative function. Regarding the method used to resolve consultations involving ethical conflicts in PHC clinical practice, the deliberative method of Diego Gracia<sup>24</sup> was the most used, with eight traditional steps identified:

1. sending the consultation to the CEA;
2. discussion of clinical, social, normative, and legal aspects;
3. identification of the moral issues and bioethical principles involved;
4. choice of ethical conflict to be discussed;
5. identification of possible courses of action;

6. deliberation of ideal courses of action;
7. final recommendations;
8. arguments with the willingness to defend publicly.

According to the data analyzed, the following activities were identified that refer to the functions of the CEA:

### Consultative function

The consultations carried out by the CEA are related to ethical conflicts in clinical practice, which, once identified by the healthcare providers, were entered as consultations with the purpose of preventing the infringement of patient rights, as detailed in Table 1. In addition, the main queries and conflicts are related to the principle of autonomy (Table 2), and the right to confidentiality of patient data (Table 3).

**Table 1.** Main ethical conflicts and associated rights that the CEA addressed in the period 2015-2022

Case consultations on:	Ethical principles involved and the role of the CEA
<b>Patient's right to privacy</b>	Confidentiality. Ensure the protection and use of data present in medical records and concerning the clinical practice.
<b>Right to decide about their own health</b>	Autonomy. Ensure the patient's freedom of decision based on information, willingness, and capacity.
<b>Right to complete and objective information and, in no case, intended to influence women</b>	Justice and vulnerability. Ensure the timely, accurate, and understandable provision of information on the characteristics and alternatives of medical provision for termination of pregnancy based on what is established by Law No. 21,030 in Chile.
<b>Sexual and reproductive rights of women with cognitive impairments</b>	Justice and vulnerability. Ensure equal opportunities and respect for people's opinions and decisions, considering their individual characteristics.
<b>Rights of the older adults</b>	Vulnerability. Ensure a dignified death at home.
	Principle of proportionality. Ensure adequacy of the therapeutic effort provided for patients with severe dependence cared for at home.  Justice. Ensure access to health services related to quality of life and individual projects.
<b>Rights of children and adolescents (NNA)</b>	Vulnerability and other interests. Ensure access to health services related to the individual development of NNA.
<b>Rights of migrants</b>	Justice, equity, and vulnerability. Ensure access to health protection.

**Table 2.** Type of consultations associated with confidentiality and the comprehensive healthcare model, 2015 and 2022

Handling confidential data for charitable campaigns at CESFAM	
Confidentiality	<p><b>People-centered approach</b></p> <p>Data privacy when using WhatsApp-Telegram-other applications.</p> <p>Use of audiovisual recordings within a CESFAM.</p> <p>Access to electronic medical records by employees outside of working hours.</p> <p>What should be recorded or not recorded in the medical record?</p> <p>Protection of privacy in the care of immigrant patients with the participation of interpreters due to the language barrier.</p>
	<p><b>Family approach (Integrity)</b></p> <p>Disclosing diagnoses to family members of patients or partners of patients with HIV who refuse to do so on their own.</p> <p>Disclosing diagnoses to some HIV patients who refuse to do so on their own.</p> <p>Protection of data present in the records of adolescents with their guardians or parents.</p> <p>Stigmatization of deceased people due to third-party access to data recorded on the death certificate.</p> <p>Delivery of medical records to the heirs of a deceased patient.</p>
	<p><b>Community and territorial approach (Continuity of care)</b></p> <p>Data protection of people infected with coronavirus during the contact tracing process.</p> <p>Using a list of patient names in daily records when unsuccessfully contacting them by other means.</p> <p>Intrasectoral approach. Psychiatry consultancy strategy for primary care teams with the participation of patients and professionals not involved in the case to teach and solve problems.</p> <p>Data protection within the healthcare network for managing shared patients.</p> <p>Data protection within the territory's social services network for intervention in common cases.</p>

\*CESFAM: Family Health Center

**Table 3.** Type of consultations associated with autonomy and the comprehensive healthcare model between 2015 and 2022

Questioning the level of capacity of the vulnerable population to consent	
Autonomy	<p><b>People-centered approach</b></p> <p>Informed consent process (Importance of dialogue or signature?).</p> <p>Choice of contraceptive method in adolescents with cognitive impairment.</p> <p>Is informed consent required to perform the PCR test? (During the pandemic.)</p> <p>Refusal of insulin therapy in patients with moderate mental retardation.</p> <p>Refusal of treatment in an HIV-positive patient.</p>
	<p><b>Family approach (Integrity)</b></p> <p>Indirect autonomy in 14-year-old adolescents (parents or significant adults?).</p> <p>Performing the IFI test at sentinel CESFAM to identify the virus's circulation without informed consent for the procedure.</p> <p>Vaccination refusal in patients with autism spectrum disorder. Caregiver asks for physical restraint from the team to carry out the procedure.</p>
	<p><b>Community and territorial approach (Continuity of care)</b></p> <p>Epidemiology Unit: What should one do in case of refusal to take a PCR test for a suspected case? (During the pandemic.)</p> <p>Refusal of hospitalization by an older patient. Family requests home treatment from the PHC team.</p> <p>Performing the IFI test at sentinel CESFAM to identify the virus's circulation without informed consent for the procedure.</p>

Research

## Training function

Three annual training sessions were held for the healthcare team and the community interested in bioethics. The activities aimed to delve deeper into issues related to the functioning of the committees and the main ethical conflicts identified in the CEA deliberations that generated debate between the healthcare team and public opinion, such as humanization of care, confidentiality and data management, human rights of older people, end-of-life decisions, organ donation, progressive autonomy of children and adolescents, stigmatization of patients with mental health pathologies and problems in healthcare for migrants.

## Normative function

Regarding CEA's participation in the organization's internal policy advisory services, it is worth highlighting that, over seven years, a community protocol called "Attention to immigrants in an irregular migration situation" was developed. This stems from a case treated in the emergency service of a CESFAM, in which the migrant was denied care due to lack of health insurance. Furthermore, an "informed assent" form was created to deliver confidential data to guardians or parents of adolescents to promote progressive autonomy in this age group.

## Discussion

According to Cortina, all organizations make value-oriented decisions described in their mission<sup>25</sup>. However, the big problem for institutions is that they inform too many values in theory, and people do not realize that decisions are made based on these values. Therefore, the process of organizational ethics consists of trying to implement steps so that decisions are made based on articulating these values. In this sense, the Spanish philosopher proposes that the ethics of healthcare organizations must include:

1. clinical ethics (interdisciplinary);
2. management ethics (providing good for society);

3. the ethics of health professions (acting in the patient's interests)<sup>25</sup>.

In Chile, the ethical component is incorporated into the criteria to evaluate the quality and accreditation of institutional providers through the existence of a CEA as a mechanism to protect medical, professional, and institutional ethics<sup>26</sup>. As mentioned by Callahan and Jennings in Pérez Ayala<sup>27</sup>, historically, CEAs were promoted in the biomedical field and in hospital centers, where the first level of care was relegated to the background.

However, advances in health rights and their direct relationship with the quality of care have allowed the ethical dimension to be a fundamental area in people-centered services. The Chilean experience is similar to that of countries such as Spain<sup>28</sup> and Norway<sup>29</sup>, whose national regulations aimed mainly at the hospital level were adapted to the primary health level with the main objective of finding a way to incorporate and institutionalize bioethics in the organization of health through the Care Ethics Committees<sup>12</sup>.

The findings of this study show that the development and operation of a PHC's CEA in the O'Higgins region is a concrete and permanent instance for resolving cases, both clinical and institutional ethics. The level of demand in consultations confirms this, and the generation of opinions to address the ethical problems at this level of care and the promotion of training spaces in bioethics and its scope in the law applied to basic care<sup>12</sup>.

As Diego Gracia points out, improving the quality of care requires promoting a permanent reflection on health practices in a dialogic and transdisciplinary way because if the difficulty lies in the discrepancy between the courses of action from one person to another, in addition to facts and consequences, it seems necessary to consider the different values involved that influence user satisfaction, considering the particularity of the contexts<sup>17</sup>.

## Development of CEA functions

The analysis of the documents showed that the functions of the CEA are distributed mainly in the consultative function, followed by the

training function and, finally, the normative function (Figure 1). According to Art. 8 of Decree No. 62, the consultative function aims to *advise users or providers in the decision-making process related to those ethical-clinical conflicts that arise as a result of healthcare*<sup>20</sup>, the training function seeks to contribute to *the promotion of training in bioethics for individual providers and its dissemination to users of the institution, as well as members of the committee itself and the management team of the institution to which they belong*<sup>20</sup>, and the normative function allows *the institution to propose protocols and guidelines for preventive action to face situations in which ethical-political conflicts may frequently arise*<sup>20</sup>.

This major concern of the CEA with consultative issues is related to the importance given to respecting the dignity, autonomy, and privacy of people involved in clinical practice<sup>20</sup>. According to Atienza<sup>30</sup>, *dignity is a common characteristic of all declarations at the international or national level*. This is why UNESCO's Declaration of Human Rights and Universal Declaration on Bioethics and Human Rights are based on human dignity. According to the author, dignity is a complex and imprecise concept whose properties apply to every human being without distinction, which does not admit classifications and applies universally.

In Chile, Law No. 20,584/2012<sup>31</sup>, which regulates the rights and duties that people have concerning actions related to their health care, includes in Paragraph 2 the *right to dignified treatment*<sup>31</sup>, while in its Article 5 it states that, *in healthcare, people have the right to receive dignified and respectful treatment at all times and under any circumstances*<sup>31</sup>. This legislation makes "patient dignity" mandatory for institutional and individual providers and is a significant step forward for monitoring quality indicators associated with patient dignity and treatment.

Likewise, the Health Superintendence operationalizes, in scope 1, *respect for the dignity of patient treatment*<sup>31</sup> through compliance with a series of institutional requirements to guarantee the treatment granted, establishing that the Care Ethics Committee is responsible for resolving ethical issues that are consequences of care activities<sup>32</sup>. Based on this standard, the training and qualification of professionals

who work in primary care and who also make up a CEA is an essential requirement to have the minimum skills in bioethics and apply deliberation methods when receiving consultations.

In this sense, the exploratory study carried out by León in 2010 on committees from three municipalities in the Chilean metropolitan region coincides with the need for training their members since, despite their professional experience, some never took bioethics subjects in their undergraduate training or those who declared having had it considered that it did not cover the problems of primary health care. Although the moral conflicts discussed in PHC's CEAs may be expected at the hospital level, sociocultural contexts will always exist in territories with particular characteristics<sup>17</sup>.

The reviewed literature coincides with the idea that CEAs' functions are progressive and evolutionary. Once the permanent committee members acquire bioethical deliberative skills, they advance their formative and normative functions<sup>12</sup>.

## Ethical conflicts in primary health care

The review carried out establishes that the central ethical conflicts resolved by the CEA are related to the principle of confidentiality and autonomy, both rights contemplated in Law No. 20,584, which regulates people's rights and duties concerning actions related to healthcare<sup>31</sup>. Other issues addressed by the committee concern the rights of older people, children and adolescents, people with mental health pathologies, women's reproductive rights, and the rights of migrants.

Compared with the study conducted by Contreras<sup>14</sup> in a municipality in the metropolitan region, there is a coincidence with the ethical conflicts addressed by the CEA and differentiated by life course associated with the life cycle approach present in MAIS, in addition to problems related to confidentiality and autonomy. However, the ethical conflicts associated with the right to health of the migrant population are not mentioned, possibly related to the greater flow of immigrants in recent years in

Chile, who frequently require health services. In this sense, legislation reinforced the National Migration Policy in the last decade based on international conventions signed by the country to guarantee human rights to migrants<sup>33</sup>.

Concerning consultations associated with the principle of autonomy (Table 3), ethical-clinical conflicts arise from complexities in healthcare between the provider and the system's user<sup>20</sup>. In this case, it is noteworthy that the majority refers to users' refusals of treatments, hospitalizations, vaccinations, and exams.

At this point, tensions related to the right to exercise autonomy, competence, and the legal capacity of patients not to consent are intertwined with professional responsibility, especially when there is a conviction on the part of the team that what is offered to the patient is essential. Respect in the face of a patient's refusal or abandonment of treatment is a conflict that generates great concern among the medical team<sup>34</sup> and exposes the difficulty for physicians and healthcare teams in abolishing the paternalistic model and moving towards informative, interpretative, and deliberative models, characterized by the right of patients to be adequately informed to participate and make decisions related to their health<sup>35</sup>.

While there are no in-depth studies in Chile on medical paternalism, it is possible to associate these findings with the biomedical model and the nature of the provision of medical services, which are related to the "professional duty" explicit in the code of ethics. Furthermore, there is a legal determination in the Civil Code, in which the physician signs a contract with the patient, assigning them an "enforceable" responsibility in delivering "information, protection, and security." In this sense, non-compliance with "unjustified" medical services will affect the physician, the team, and the health center.

The duty to adequately inform the patient fulfills the principle of self-determination, repairs the asymmetry between physician and patient, and allows, to a certain extent, the patient to control their own health decisions<sup>36</sup>.

The long-term nature of relationships in primary care provides a different perspective on respect for autonomy, which is often linked

to obtaining informed consent in the hospital setting, although differing in primary care given the closer relationship between the healthcare team and the patient<sup>9</sup>. On the other hand, the treatment is less urgent, and the patient is an expert in their own reality and less "obedient" to comply with instructions.

Therefore, the ethical rationale for consent or refusal of treatments needs a new look at its application to encompass situations in which the primary healthcare team has the responsibility to explore the social and biomedical causes of illness and in which the preferences and priorities of the patient or their family do not necessarily fit the available evidence<sup>37</sup>.

According to Gracia<sup>17</sup>, this ethical current with a community approach allows for a deeper understanding of traditional issues in medical ethics (assessment of patients' capacity, determination of the patient's most significant benefit, identification of proportional and disproportionate treatments, etc.), as it increasingly contextualizes the reality of the specific case and, unlike the hospital level, intervention in primary health is not only or mainly about the fact under analysis or the patient, but also about the community and the sociocultural structure. The language of principles and consequences is straightforward at the primary health level because it is abstract, generic, and decontextualized; the *ad hoc* moral language at this level is that of life habits (virtues and vices). At the hospital level, actions can represent serious moral problems, but they can hardly become habits due to the short hospital stay.

On the contrary, at the primary level, the actual ethical problems are not actions nor habits, further justifying value education procedures with specific methodologies, as not only do different facts occur than those that occur in the hospital, but also a world of values of greater breadth and complexity<sup>17</sup>.

Concerning the consultations carried out on data processing (Table 2), it is worth highlighting that confidentiality refers to the protection the healthcare team must maintain over patient data to which they have access to guarantee the patient the right to privacy<sup>38</sup>. The increased risk



of exposing confidential information and violating confidentiality is inevitable when considering the number of providers involved in patient care (professionals, technicians, and administrative staff)<sup>14,39</sup>. Biopsychosocial data are necessary to obtain a comprehensive intervention of the care model, and confidentiality is interpreted differently by the patient, depending on the hospital or primary level<sup>40</sup>.

### Deliberative method used by the CEA

The CEA cases consulted used Diego Gracia's deliberative method, which corresponds to a process of moral deliberation for decision-making based on carefully analyzing the circumstances and consequences that attend a specific situation to identify the best course of action among those available<sup>41</sup>.

Deliberation involves an interdisciplinary, plural, and sequential dialogue in which relevant facts, values, and reasonable and prudent courses of action are identified. This fulfills the objectives of recognizing the distinctive cases of PHC and, in the long term, offering continuing education to its members and the healthcare team, as well as developing institutional guidance policies regarding the routine work of the healthcare team<sup>13</sup>. The path of deliberation has been widely considered to resolve this type of conflict in a plural society, as it facilitates the finding of ideal courses of action between the extremes of a decision, respecting human dignity.

This review of the annual reports shows that the resources invested (professional hours) translate into care with an ethical dimension essential to improving care quality. However, this is insufficient to justify the existence of the CEA at PHC. To this end, more empirical research is needed to demonstrate results<sup>42</sup>. Therefore, it is necessary to focus on improving the management of CESFAM by including CEA recommendations, which are drawn up based on case analysis or scientific literature available on the topics covered in its sessions to apply bioethics to specific health problems and prevent violations of rights in the population served.

### Final considerations

From the case of PHC's CEA in the O'Higgins region, Chile, in conclusion, although ethical and clinical conflicts are shared at the hospital level, the sociocultural context where they occur makes the relationship between provider and patient unique and complex. This implies challenges in having healthcare teams with high bioethics skills and legislation favoring health committee institutionalization. In this sense, the relationship between CEAs and the quality of person-centered care favors their institutionalization and highlights the scope of human dignity.

The processes identified to address the consultations included in the CEA respond to Diego Gracia's deliberative method, whose contribution not only allows systematizing the process of approaching consultations but also facilitates the identification of ethical conflicts and installs a form of a pluralistic and interdisciplinary argumentation to solve these problems. This opens a window of opportunities to better respond to ethical conflicts and develop guidelines to prevent their occurrence and/or improve how to resolve them. In this sense, the challenge of advancing the universalization of PHC makes it more necessary to support teams in ethical aspects, given that ethical conflicts will arise more frequently that will be beyond their competencies.

The central consultations and ethical conflicts reviewed were organized according to the life cycle related to the comprehensive care model approach. Other issues, such as the right to health of the migrant population, are also addressed, which shows that the CEA is adapting to the country's new sociodemographic and epidemiological scenarios.

Finally, the authors highlight the contribution of CEAs to training in bioethics, human rights, social justice, patients' rights and duties, and, above all, patient autonomy, which is why they encourage other studies to strengthen this line of research.

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Carmen Nadal Agost performed the study conception and design, data collection, analysis, and interpretation, manuscript writing, critical review of the article with essential contributions to its intellectual content, and approval of the final version to be published. Maggie Campillay Campillay performed the study conception and design, manuscript writing, critical review of the article with essential contributions to its intellectual content, and approval of the final version to be published.

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