Bioética sin Más: The Past, Present, and Future of a Latin American Bioethics

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The most casual conversation about Latin American life, politics, or culture can turn into a shouting match just by innocently asking the table to define what Latin America is. Some will dismiss the term as an American (or French or Jesuit) construct that fails to capture the geographic and cultural complexities of the former Spanish colonies. Others will fervently argue that despite its imprecision—or perhaps because of it—this lexical wild card connotes an aspiration of brotherhood against colonialist threats past and present. When the dust settles, both sides will likely concede that the question is a beguiling one indeed.

Three hundred million people from Mexico to Cape Horn speak Spanish. But Spanish-speaking peoples share more than language. Roman law and the Catholic tradition are as homogeneous inheritances from Spain as the common tongue.[1] These nations have parallel histories as well. The common revolts against Spanish colonial rule in the early 19th century were propelled by new ideas centered on the principles of emancipation, people's sovereignty, individual rights, and republican institutions that gave birth to young democracies throughout the continent.

The countries also shared a past of spotty and disorganized democracy until roughly the turn of the 19th century, when they consolidated their democratic institutions, only to be overthrown—with the exceptions of Mexico, Colombia, and Costa Rica—in the mid-1900s by predominantly, although not exclusively, right-wing dictatorial experiments, occasionally interrupted by weak democracies. The most recent of Latin America's common history is the stable return to the rule of law in the last decades of the 20th century, when, despite the longevity of some die-hard *comandantes* and the rise of occasional new authoritarian *caudillos*, most of the region aspired to emulate Spain's transition from dictatorship to democracy 30 years ago.

This highly simplified account represents for us a good editorial proxy for the existence of large social and cultural commonalities across Latin America, without ignoring the fact that a closer look would show vast ethnic, cultural, historical, and political diversity. Against this backdrop, we try here to trace the roots and current features of bioethics in the Spanish-speaking countries of Latin America. (We are consciously excluding here Brazil and other non-Hispanic countries, which have a different historical and cultural heritage, even though, as we will see, Brazilian bioethics has recently been gaining influence around the rest of the continent.)

Latin American bioethics registers two other regional commonalities: the temporal power of the Church and the traditionalist role of medical associations. Traditionally, the Catholic Church held sway over visible medical ethics in Latin

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America. The Church has influenced most—if not all—public and civic institutions across Latin America and, until the 1980s, had a de facto monopoly on bioethics, monitoring strict adherence to Catholic orthodoxy, particularly on matters of reproductive ethics. The Church enjoyed a real or perceived editorial veto power, which led to significant self-censorship among academics on these matters. Needless to say, this conditioned the medical ethics curricula in the region's universities. Curiously, though, on issues such as end-of-life care, with its doctrine of ordinary versus extraordinary care, and the ethics of organ transplant, the Church's positions have sometimes been more progressive than those of doctors and societies at large. Medical associations, not immune to the Church's influence, had their codes of ethics dealing with the duty of confidentiality and prohibiting the abuse of patients either sexually or economically. The bulk of these codes were, however, dedicated to regulating relationships among colleagues. Rather than medical ethics, they dealt with questions of medical etiquette. In these codes, information given to and decisionmaking by patients belonged in the paternalistic tradition.

Given this context of shared bioethics traditions, in this article we start by analyzing the changing paradigms in medical thinking, shifting from the classical positivist model to an anthropological one, thanks in large part to the influence of the late Spanish scholar, physician, and humanist Pedro Laín Entralgo and his disciples on both sides of the Atlantic. We explore the meaning of this anthropological paradigm and its long-lasting influence on subcontinental bioethics. Later, we analyze the role of the doctrine of human rights, also heavily influenced by Spanish thinkers, on the evolution of Latin American bioethics. Finally, we look at the views of a movement of political bioethics that is shaping regional bioethics.

Through this examination, we will see that Latin American bioethics is a highly diverse branch of the discipline, and one that is still seeking to articulate a full-fledged identity as it emerges out of its North American roots after a long process of reception, assimilation, and re-creation.[2]

Might and Perplexity

In his seminal work on the history of medicine, which would define the parameters of Spanish medical ethics, Laín Entralgo called attention to the effects of medical positivism that had evolved over the preceding 150 years. Since the 19th century, science had flourished at an exceptional pace in both Europe and the United States. The old methods of observation were replaced by the scientific method in most areas of knowledge, with knowledge growing exponentially as a result. Medicine, reflecting these broader trends in the history of science, very rapidly embraced this new *positivist paradigm*, giving rise to the century's crowded hall of luminaries. From Virchow to Ramón y Cajal, from Laennec to Billroth and Osler, the 19th and early 20th centuries were marked by an evolving scientific basis of disease. Thanks to this positivism, medicine achieved, for the first time in history, real effectiveness.

But this positivism also had some unintended consequences: It started to depersonalize the doctor–patient relationship.[3] The Edwardians were already aware of this positivist trend, by which the patient as person was increasingly replaced by the patient as object of science in the physician's eyes. George

Bernard Shaw exposed this in the first act of his *Doctor's Dilemma*,[4] where he creates a closed-door conversation among a clique of doctors who are more infatuated with their bogus science than concerned about their patients' fate.

This objectification of the patient became even more prevalent after World War II, when doctors could master only a small part of the new and vast mass of medical knowledge and practices, which fragmented medicine and patient care into myriad specialties and subspecialties. Technology did the rest to consolidate medicine's effectiveness and fragmentation, which became the trademarks of the modern doctor–patient relationship.

Feeding on each other, medical positivism and technological development produced a radical transformation of the doctor–patient relationship, which was progressively reduced—in Laín's language—to an ''objectivant-operational'' one, amputating its interpersonal dimension and risking its ethical direction. For Laín, writing in Spain throughout the 1950s and 1960s, contemporary medicine became *technologically mighty and morally perplexed*.[5]

Drawing on philosophy and anthropology to overcome this crisis of medical reason,[6] Laín proposed a doctor–patient relationship modeled around an asymmetric, *quasi-dyadic* form of *friendship*.[7] The virtuous doctor would cultivate this ethically and therapeutically superior form of relationship.[8] Laín's teachings, which set some of the foundations for Spanish and Latin American bioethics, remained a dominating theme in academic circles until the late 1970s in both Spain and Latin America.

A New Paradigm

As brilliant as Laín's formulation was, it was too theoretical for the growing needs of medical practice in Latin America in the last third of the 20th century. It was too distant from the needs of the bedside clinician and was relegated to some extent to the margins, replaced by a nascent North American bioethics that started to seep into the Latin American context by the mid-1970s. This movement of bioethics into Latin America was helped by highly publicized cases such as the right-to-die case of Nancy Cruzan[9] and revelations about the Tuskegee syphilis study, both of which opened a whole new perspective centered on the idea of the patient as a moral subject whose self-determined, autonomous decisions were central to the integrity of the doctor–patient relationship.

The new North American doctrines of those years focused on informed consent[10] in research and practice, and the Belmont Report's focus on principles (which later became the ''Georgetown mantra''[11]) were forces that energized Spanish and Latin American scholars. For Spanish-speaking bioethics, the Americans had come up with the missing link between the theoretical heights of Laín's anthropology and the concrete possibility of applying his thinking at the bedside in a more pragmatic fashion.

Meanwhile, the retreat of dictatorial regimes and the restoration of democracy throughout Latin America created a new, free environment marked by personal and collective empowerment. Power relationships became more leveled than in previous decades, and—as a natural consequence—patients rebelled against the passive role assigned them by the old, objectivant positivism. In addition, the rapid expansion of new medical technology posed a number of new ethical

questions for which neither classical medical ethics nor the omnipresent but increasingly questioned teachings of the Catholic Church provided acceptable responses.

In this context, the new bioethical paradigm was rapidly embraced by Latin America during the 1980s. Taking the path of least resistance, countries *assimilated*, to a large extent, North American bioethics. At a fast pace, ethics committees, informed consent procedures, and legislation dealing with biomedical issues from organ transplantation to assisted reproduction flourished in the region.

The process was fueled by the creation of academic institutes and programs dedicated to bioethics in different countries. In 1972, one of us (J.A.M.) founded a privately funded bioethics training program for doctors in Argentina, which, in close cooperation with many American scholars,[12] expanded into a regional program in bioethics.

At the university level, the Universidad Javeriana in Bogotá opened its Instituto Colombiano de Estudios Bioéticos in 1985; in 1988, the Universidad Católica de Chile started a bioethics unit, the same year the Pontificia Universidad Católica de Rio Grande do Sul established in Brazil its own bioethics program. In 1992, the Universidad de Guanajuato, in central Mexico, created a center for bioethics. Catholic scholars heartily endorsed the core of the anthropologic paradigm, although on reproductive issues they have stayed rather monolithically faithful to the Holy See.

By the mid-1990s, bioethics had gained momentum and critical mass, to the point that the Pan-American Health Organization (PAHO) commissioned Edinboro University bioethicist James Drane—an American disciple of Laín—to visit the region and produce a report. International experts also met in Washington, D.C., at the headquarters of PAHO to assess priorities and respond to the draft proposal written by Drane and Hernán Fuenzalida, then PAHO's chief of legal affairs.[13] This effort culminated in the creation, in 1994, of PAHO's Regional Program on Bioethics, in Santiago, in cooperation with the Chilean government and the University of Chile. The program's goal was to contribute to the academic and applied development of bioethics, emphasizing the ethics of biomedical research, healthcare, and professional and public education, besides developing links with international agencies in order to highlight the specificity of the contents and policies in the field of bioethics.[14]

Contrary to the American model, Latin American bioethics was never seen as a *rebellion*, but rather as a *revolution*, in the way Spanish philosopher José Ortega y Gasset understood that distinction: For Ortega, rebellion is aimed at correcting abuses, whereas revolution is aimed at changing uses.[15] Latin American bioethics was born to replace the positivist paradigm with a new, anthropologic paradigm. Medicine had to be centered on the human being if it wanted to overcome the moral perplexity raised by its technological might, which was itself the prodigal child of positivism.

For those who came of age in the 1970s, though, the dictatorial regimes of those years left some scars that neither Laín's anthropology nor the American bioethical model could cure per se. Bioethics was meant to go deeper into the structure of *power* of microrelationships, extending to biomedicine the paradigms of the newly recovered classical liberal democracy, best represented—in this case—by the doctrine of human rights.

Human Rights

Medicine has traditionally been paternalistic, with James Childress's definition of paternalism as refusing to accept or consent to the wishes, options, or actions of another person, invoking that person's benefit.[16] Medical practice has historically been centered on the patient's physical benefit, making the patient's wishes and preferences an inadmissible interference with its interventions.[17] This prevalent approach sinks its roots in the traditional Hippocratic ethics, stressed in *Decorum.*[18] Classical medical ethics codes and treatises invariably reflected these teachings, with small nuances, and Latin America was no exception.[19]

Laín's anthropological medical doctrine, in addition to making inroads into the field of medical positivism, could be read as a warning against paternalism. After all, Laín postulated that the morality of the virtuous doctor required him or her to abide by the principle of the "authenticity of the good," which meant that the doctor should respect the patient's intimate beliefs about what he or she understands as his or her good.[20] For some of us, this doctrine relied too much on the doctor's benevolence and intellectual enlightenment.

If entering the doctor's office was in many ways a leap back to the times of the absolute state, what medicine needed was not only good intentions but also its own French Revolution and Declaration of the Rights of Man. If the doctor's office could at times resemble a resilient pocket of dictatorship, then liberal democracy, empowerment, and human rights were the answer. Bioethics was—in this view—all about *human rights*, and American bioethics, together with the global postwar doctrine of human rights, provided the best possible foundation for progress. Additionally, the doctrine of human rights was able to go beyond self-determination in the doctor–patient context to expand into a communitarian claim for a right to healthcare.

Human rights are, in the doctrine of Gregorio Peces-Barba, the most influential of contemporary Spanish authors on the topic, the hierarchically superior, universal set of guarantees and institutions recognized by the law. They make concrete the founding moral demands of human dignity, freedom, and equality.[21] In this framework, the first expressions of contemporary American bioethics, represented by early 20th century court decisions, provided legal status in the common law system to the notion that the patient's lack of information and consent to medical procedures—even to successful ones—violated one's right to physical integrity.

This was clear in the now famous cases *Mohr v. Williams*[22] and *Schloendorff v. Society of New York Hospitals*,[23] which provided what has been called the *jurisprudential root* of the human rights-centered Latin American bioethics.[24] On the other hand, the Nuremberg Code was, for this branch of Latin American bioethics, seen as a declaration of human rights aimed at specifically protecting the participants in research on human subjects. Nuremberg would provide the *experimental root*[25] for this bioethical model.

This human rights-based bioethical doctrine promotes a somewhat more legalistic approach to bioethics. Drawing on Italian scholar Norberto Bobbio, this position holds that patients' intrinsic vulnerability requires a statutory *ius singulare* (specific right) to specify the *ius comune* of general human rights.[26] In this model, it is not enough for doctors to be virtuous. Rather, patients have moral claims to freedom and physical integrity that must be protected by the law. This

is, in turn, consistent with the tradition of codified law typical of the Roman law informing Latin American culture. This model assigns the state a relevant role and can make incursions into issues of healthcare allocation, something outside the anthropologic tradition.

The doctrine of human rights classically focused on individual freedom, which had to be protected against the abuses of the absolute state. In that context, what today are called *first-generation human rights* were basically a set of freedoms over which the power of the state was excluded, such as the right of movement and speech or—in general—the right to carry out without limitations all actions that are not expressly forbidden by the law. These rights are satisfied by the state's abstention, and thus are called *negative rights.* After Hans Nipperday and his doctrine of the applicability of human rights bills between particulars, these rights also require the abstention of individuals from interfering with fellow individuals' rights.[27]

But there is a more recent line of human rights, called *economic and social rights*, such as the right to education or the right to healthcare. These require an action from the state to be satisfied and are thus called *positive rights*. These rights, which were first established in Latin America by the Mexican constitution of 1917[28] and later universally adopted by the United Nations in 1966, may look on the surface like rights aimed at guaranteeing a decent level of equality. Delving deeper, though, these are no less *freedom rights* than the classical negative ones. As Peces-Barba characterizes them, "the end of *all* fundamental rights is a single one, without exception: to deepen and to potentiate individual freedom.... There are no freedom rights and equality rights. All rights are freedom rights, including those that contribute an egalitarian component, such as economic, social and cultural rights, because that component strengthens and reinforces freedom for all."[29]

Latin American bioethics has not yet fully explored the problem of justice in healthcare, perhaps because the inequalities in health and access represent the manifestation of wider social inequalities that pervade our continent. The prevalent approach to these problems has tended, for better or worse, to be political. This brings us to the politics of bioethics in Latin America.

Politics

The profound socioeconomic inequalities prevalent in Latin America, together with the failure of recovered democracies (too frequently infected by populism, political clientelism, and corruption) to solve them, have recently pushed bioethics from its liberal bent toward a more communitarian one. Should bioethics pursue this incarnation, it would become a political movement of social reform more than just a discipline circumscribed to health and healthcare. If this were to happen, the principle of justice would represent to the Latin context what the principle of autonomy has been for North American bioethics, except that in this view, the emphasis on distributive justice would extend beyond questions of health. In this epistemic diversion, bioethics would be seen by some as a revolutionary political movement with the intention of radically transforming society.

This approach is still developing among bioethicists in Spanish-speaking Latin America, and is strongly influenced by Brazilian colleagues.[30] Pursuing originality and suspicious of ideological imperialism, it opposes the classic

American bioethics and proposes a "hard" or "interventional" bioethics as an appropriate approach to the regional reality. Hard bioethics maintains that there is a de facto unjust global order that only benefits industrialized nations. This is at the expense of developing ones, whose resources are looted by international trade.

In this context, authors who are partisan to this line of thinking maintain that classical ethics—and therefore bioethics—centered on respect for the individual and the promotion of individual freedom are mere devices to perpetuate predatory practices. They propose, instead, "the political analysis of moral conflicts."[31] These authors advocate analyzing the sociopolitical structures that generate asymmetries, inequalities, and exclusion, calling for a structural transformation in defense of the excluded and vulnerable members of society, demanding justice and equity.[32] As Brazilian scholars Volnei Garrafa and Dora Porto, the main representatives of this movement, explain, hard bioethics is "a proposal that breaks the enforced paradigms and *re-inaugurates a utilitarianism oriented toward the search for equity* among segments of society, capable of dissolving this centre-peripheral structural division of the world and of assuming a *consequentialism based on solidarity,* on the overcoming of inequality."[33]

This inflammatory language may appeal to many. Regrettably, it also says more about social sensitivity than about hard evidence. Nations that prosper are not those that are insulated from foreign investment and trade, but rather those that protect property rights and integrate themselves with the rest of the world. If not, Argentina—the authors' native country—would have been among the poorest nations of the world until the 1940s and would now be an industrialized country. But exactly the opposite has happened, after 70 years of protectionist experiments.[34] If isolationism were the road to prosperity and equality, post-Franco Spain would not now be the wealthy, socially fair place that inspires the rest of the Spanish-speaking world. As the famines provoked by the English Corn Laws proved more than a century ago and as an ongoing rice crisis in the Philippines proves today, protectionism only protects local elites, who benefit from the newly induced scarcity and monopolistic power. It does not protect the poor.

Hard bioethics correctly sounds the alarm on the region's social situation, though the treatment proposed may not fit the diagnosis.[35] Latin America is permeated by injustice and inequality, and this reality should produce a bioethics different from that in more stable developed countries if it is to be relevant. However, many of the movement's diagnoses and prescriptions are contentious. It tends to place blame outside our borders while overlooking the region's internal insensitivity, political corruption, and indifference to the rule of law. Hard bioethics aspires to transform all biomedical interactions through political interventions on the social structure,[36] putting its focus on pursuing *collective freedom*. But, in our view, collectivist experiences show that collective freedom is rarely *freedom* and never *collective*.

This trend, which pursues an *authentic* Latin American model, runs the risk of becoming the mere proclamation of moral ideals, lacking intellectual substance. As noteworthy Chilean scholar Fernando Lolas puts it, "[R]egrettably, sometimes the pursuit of originality and authenticity is reduced to picturesque 'anti-isms': anti-imperialism, anti-Europeism, anti-intellectualism.... This attitude is frequently not paired with contributions that merit entering with their own identity

the patrimony of global intellectuality… [and] contributes no arguments for dialogue but rather slogans for [political] strife."[37]

Concluding Remarks

Though richly diverse, the countries of Latin America share a common heritage of language, culture, religion, and philosophy. These are nations whose past and recent vicissitudes, along with their endemic social and political problems, have notable parallels and whose mainstream biomedical models are largely similar. Latin American bioethics can be seen as another commonality, and not just the sum of focal bioethics around the region.

By virtue of cultural links and personal connections, Spanish bioethics has had a strong influence in Latin America, in two different currents. The first, with Laín Entralgo's anthropological model, called for overcoming the limitations of the positivist paradigm to conceive and practice a human-centered medicine. The second proposed extending the doctrine—and language—of human rights to the biomedical field. The sick deserve, in this framework, specific protection by means of a right to access healthcare and by having their rights of autonomy specifically safeguarded, as a way to overcome traditional medical paternalism. Both waves—themselves heavily influenced by American bioethics—found in the historical conditions of their time the right soil to develop and flourish on their own.

The anthropologic and human rights traditions complement each other. The former provides the moral foundations; the latter provides specific foundations to pursue the enactment of morality by legal means. One is reflective and relies on virtue and education; the other invites a more pragmatic response. One does not deny the need for distributive justice; the other emphasizes the moral demand for equality and equal freedom. It can be said that both, in their own way, assert the rights and freedom of the sick.

Political bioethics, or hard bioethics, is aggressively claiming the space left empty by past approaches and is certainly right in its description of a wanting reality. For us, however, this movement is not necessarily correct, but rather counterproductive, in its response to the causes and the remedies to overcome the region's social ills. It may contribute arguments for political struggle, which is perfectly valid. But in our view, it also represents an epistemic jump beyond bioethics. Nevertheless, it is an important call to attention on how responsive bioethics has been to the priorities of the region's peoples. Latin American bioethics has sometimes insulated itself from the most urgent problems of the region while public and reproductive health are in dire conditions and access to healthcare has not yet been solved.

Perhaps, in the end, these different currents of bioethics have been so busy proposing universal solutions to change universal paradigms that we have overlooked the real, concrete—though modest—contributions that could be made to our patients' and peoples' well-being. Mexican intellectual Leopoldo Zea noted that Latin American philosophers would do well to focus on creating *filosofía "sin más"* (simply philosophy),[38] just as the Greeks developed philosophy without asking themselves whether they were creating something Greek or Egyptian or Babylonic.[39]

This is, perhaps, the great challenge facing Latin American bioethics: forging a *bioetica sin más.*

Notes

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