Religious Beliefs and End-of-Life Ethical Decision-Making among Healthcare Professionals in Chile: A Mixed-Methods Study

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Abstract

This study evaluated the influence of personal religious beliefs on end-of-life clinical decision-making among healthcare professionals in Chilean public and private hospitals, identifying the socio-legal and psychological mechanisms guiding clinical choices. A convergent parallel mixed-methods design was implemented. Quantitative survey data were gathered from 412 intensive care, oncology, and palliative care clinicians across six metropolitan healthcare facilities using the Duke University Religion Index alongside standardized end-of-life clinical scenarios. Concurrently, qualitative data were collected via semi-structured depth interviews with 28 clinicians and processed using structural text analysis. Multivariate logistic regression demonstrated that high intrinsic religiosity significantly predicted clinical resistance to withdrawing mechanical ventilation (Odds Ratio = 3.42, 95% Confidence Interval [2.15, 5.44], $p < .001$) and withdrawing artificial nutrition and hydration (Odds Ratio = 4.18, 95% Confidence Interval [2.62, 6.68], $p < .001$). The qualitative analysis identified three central thematic concepts: the moral weight of divine sovereignty over life, the persistent influence of historical medical paternalism, and the cognitive dissonance experienced when navigating Chilean Law 20.584 on patient rights. Personal religious frameworks remain a primary factor shaping end-of-life clinical practice in Chile, often creating conflicts with contemporary legal mandates designed to protect patient autonomy. To bridge this gap, healthcare networks must implement standardized bioethical training and strengthen the role of institutional ethics committees to ensure objective, patient-centered care.

Keywords: *Advanced Directives; Bioethical Autonomy; Clinical Paternalism; Dysthanasia; Limitation of Therapeutic Effort; Sanctity of Life.*

A. INTRODUCTION

Modern healthcare systems frequently encounter complex ethical challenges when managing patients at the end of life. Decisions regarding the limitation of therapeutic effort, the withdrawal of mechanical ventilation, the withholding of artificial nutrition, and the application of palliative sedation require clinicians to balance technical assessments with complex ethical evaluations (Bilsen, 2016). Within these settings, healthcare professionals do not operate solely as objective technical agents. Instead, they function as moral individuals whose decisions are shaped by deeply held personal values, philosophical traditions, and religious convictions (McCormick & Conley, 2019). The intersection between a clinician's personal faith and their professional duties becomes especially apparent during end-of-life care, where differing perspectives on the sanctity of life versus patient autonomy can directly impact clinical practice.

The socio-cultural landscape of Chile offers a unique context for examining these bioethical dynamics. Historically, Chile has maintained a deeply conservative institutional framework, profoundly influenced by the moral and ethical traditions of the Roman Catholic Church (Valenzuela et al., 2014). For decades, this religious foundation shaped both public policy and medical training, fostering a traditional framework of clinical paternalism that prioritized the preservation of physical life over individual patient self-determination (Irarrázaval & Solari, 2021). However, the past two decades have seen a significant shift toward cultural secularization and institutional pluralism across the country (Aguilera & Bedregal, 2022). This cultural evolution culminated in major legislative updates, most notably the enactment of Law 20.584 in 2012, which formally established the rights and duties of patients in healthcare settings, including the explicit right to refuse unnecessary or disproportionate therapeutic interventions when facing a terminal diagnosis.

This legislative change has created a distinct tension between contemporary legal mandates and traditional clinical practices. While the legal framework now prioritizes patient autonomy and prohibits therapeutic cruelty, or dysthanasia, the actual implementation of these laws remains dependent on the clinical judgment of individual practitioners (Lolas, 2018). In Chilean intensive care units, oncology wards, and palliative care units, physicians and nurses are tasked with interpreting vague legal definitions of therapeutic futility while managing their own ethical frameworks (Salas & Umaña, 2020). When a clinician's internal religious beliefs conflict with a patient's request to limit or withdraw life-sustaining

treatment, it can lead to variations in care, institutional delays, or unwanted interventions that compromise patient dignity.

Existing studies have not sufficiently examined the specific empirical mechanisms through which personal religious beliefs influence end-of-life ethical decision-making within the evolving Chilean healthcare system. Current international bioethics literature offers insight into these relationships within secular European or highly pluralistic North American contexts (Sprung et al., 2019; Bulow et al., 2021). Yet, these foreign frameworks do not fully capture the distinct institutional challenges found in South America, where rapid secularization coexists with deeply rooted traditional religious values. Local research in Chile has focused primarily on descriptive legal commentaries or abstract philosophical analyses of Law 20.584, leaving a clear gap in empirical data regarding how these dynamics play out at the bedside. This study addresses this research gap by using a convergent parallel mixed-methods design to analyze how personal religiosity interacts with clinical decision-making among healthcare professionals in Chile.

This study contributes to the fields of clinical bioethics and the sociology of medicine in two ways. First, it provides a clear, quantitative assessment of how specific dimensions of religiosity affect a clinician's likelihood to withdraw or withhold life-sustaining interventions. Second, it uses qualitative analysis to uncover the underlying psychological and professional tensions clinicians experience when balancing personal faith, legal responsibilities, and institutional pressures. These insights are intended to assist healthcare administrators and bioethicists in developing balanced educational programs and institutional guidelines that ensure patient rights are respected within complex clinical environments.

The remainder of this article is organized as follows. Section 5 synthesizes the relevant global and regional literature regarding religiosity, paternalism, and end-of-life ethics. Section 6 describes the mixed-methods methodology, detailing participant sampling, quantitative scales, qualitative interview protocols, and integrated data analysis procedures. Section 7 presents the empirical results, including multivariate regression models and qualitative thematic maps. Section 8 discusses the findings in relation to established bioethical frameworks and identifies specific study limitations. Section 9 outlines the main conclusions and practical recommendations for healthcare policy.

B. LITERATURE REVIEW

The relationship between religious convictions and medical decision-making represents an established area of inquiry within international health ethics. Bioethical analysis generally frames end-of-life choices around the tension between two core philosophical concepts: the sanctity of life principle and the autonomy principle (Beauchamp & Childress, 2019). The sanctity of life principle, which is central to Christian, Islamic, and Orthodox Jewish traditions, holds that human life possesses an intrinsic moral worth that must be preserved from conception until natural death (Sulmasy, 2017). Conversely, the autonomy principle emphasizes the individual's right to self-determination, allowing patients to refuse medical interventions that they deem incompatible with their personal values or quality-of-life standards (Veatch & Brand, 2016).

Empirical research in Western societies shows that clinicians with high levels of religious commitment are consistently less likely to support interventions that deliberately hasten death or limit life support. In a large-scale European study involving intensive care specialists across several countries, Sprung et al. (2019) found that religious affiliation was a strong predictor of a clinician's resistance to withdrawing mechanical ventilation, even in cases of confirmed medical futility. Similarly, research within North American critical care environments indicates that highly religious physicians are more prone to order diagnostic tests and maintain invasive interventions for terminally ill patients, often driven by a belief in the potential for miraculous intervention or an aversion to moral complicity in death (Borenstein et al., 2020; Curlin et al., 2021).

In the Latin American context, this ethical landscape is heavily shaped by a long history of institutional Catholicism and a traditional model of medical paternalism. For generations, the medical profession in South America operated under a benevolent paternalistic model, where the physician was expected to make all critical treatment decisions based on the core duty of beneficence (Kottow, 2015). Under this framework, life-sustaining treatment was frequently prolonged without consulting the patient or their family, a practice commonly termed therapeutic obstinacy (Taboada & Rodriguez, 2018). While global bioethics shifted toward a patient-centered, autonomy-based model during the late twentieth century, Latin American healthcare environments have integrated these principles more slowly due to deeply embedded cultural norms regarding family involvement, protection of the sick, and respect for religious authorities (Mainetti, 2019).

In recent years, countries such as Argentina, Colombia, and Chile have introduced new legislative measures to codify patient self-determination and clarify procedures for withholding or withdrawing life support (Zúñiga-Fajuri, 2018). In Chile, the implementation of Law 20.584 was intended to modernize clinical practice by standardizing informed consent and enabling the limitation of therapeutic efforts in terminal cases. However, sociological and ethical evaluations suggest that passing legislation does not automatically transform deeply held cultural and personal beliefs (Leiva & Albornoz, 2021). Chilean physicians and nurses continue to work within an institutional environment where personal moral frameworks can conflict directly with legal expectations.

While the existing literature provides a helpful foundation, studies have not adequately integrated quantitative scales of religiosity with in-depth qualitative accounts to examine these challenges within the Chilean health system. Most regional studies rely on small, single-center surveys or purely theoretical legal analyses, which do not capture the operational realities of modern clinical practice. This gap underscores the need for an integrated, multi-center mixed-methods study to explore how personal faith shapes the ethical choices of Chilean healthcare professionals at the bedside.

C. METHOD

Research Design

This study utilized a convergent parallel mixed-methods design to investigate the influence of personal religious beliefs on end-of-life ethical decision-making among healthcare professionals in Chile (Creswell & Creswell, 2018). This approach allowed for the concurrent collection and independent analysis of quantitative and qualitative data, which were subsequently integrated during the interpretation phase. This design ensured that the statistical patterns identified within the wider quantitative sample were contextualized by the detailed personal narratives of the qualitative participants.

Data / Dataset

The study sample was drawn from six major healthcare institutions located across three administrative regions of Chile: the Metropolitan Region of Santiago, the Valparaíso Region, and the Bío Bío Region. This selection included three public tertiary-care teaching hospitals and three private clinical centers to capture a balanced representation across different institutional environments. Data collection was carried out over a twelve-month period between March 2025 and February 2026.

For the quantitative phase, a sample of 412 healthcare professionals was recruited using a stratified random sampling approach. Eligible participants included licensed physicians, registered nurses, and specialized clinical staff currently working in adult intensive care units (ICUs), oncology departments, or dedicated palliative care teams. Potential participants were excluded if they had less than one full year of continuous clinical experience in these specific specialties.

The primary qualitative dataset was constructed concurrently using a purposive sampling strategy designed to capture a diverse range of ages, medical specialties, institutional types, and self-reported religious identities. This qualitative sample consisted of 28 healthcare professionals who completed in-depth, semi-structured interviews. This group was drawn from the larger quantitative pool to ensure consistency across the study phases. Table 1 outlines the complete demographic, institutional, and religious characteristics of both participant groups.

Table 1. Socio-demographic, professional, and religious characteristics of the Chilean healthcare participant samples

Structural Variable	Analytical Category	Quantitative Sample (N=412)	Qualitative Sample (n=28)
Professional Role	Attending Physician	186	13
	Registered Nurse	226	15
Clinical Specialty	Adult Intensive Care Unit	164	10
	Oncology Department	138	9
	Palliative Care Unit	110	9
Institutional Type	Public Teaching Hospital	234	15
	Private Clinical Center	178	13
Religious Affiliation	Roman Catholic	218	14
	Evangelical / Protestant	64	5
	Secular / Agnostic / Atheist	98	6
	Other Spiritual Traditions	32	3
Clinical Experience	1–5 Years	94	5
	6–15 Years	212	14
	Greater than 15 Years	106	9

Model or System Design

The structural workflow of this mixed-methods inquiry followed a parallel path of instrument administration, narrative recording, separate data processing, and eventual data triangulation, as illustrated in the operational flowchart in Figure 1.

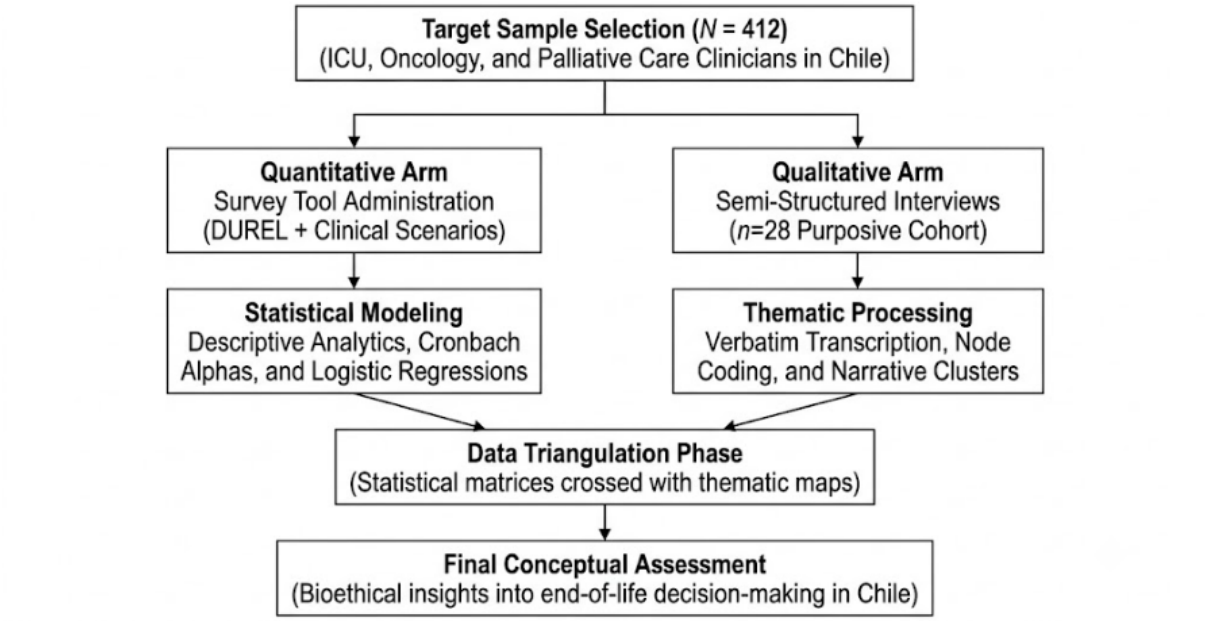

Figure 1. Methodological flowchart of the parallel mixed-methods data processing and triangulation structure

The quantitative survey instrument incorporated two standardized measurement scales:

a) *The Duke University Religion Index (DUREL):* A five-item instrument designed to assess three major dimensions of religiosity: Organizational Religious Activity (ORA), Non-Organizational Religious Activity (NORA), and Intrinsic Religiosity (IR) (Koenig & Büssing, 2010). The Intrinsic Religiosity subscale includes three distinct items evaluated on a 5-point Likert scale, providing a score range from 3 to 15.

b) *End-of-Life Scenario Tool:* A clinical case instrument featuring standardized scenarios based on Chilean end-of-life challenges. These scenarios involved a terminally ill oncology patient experiencing respiratory failure and an advanced dementia patient with complete nutritional failure. Participants were asked to evaluate specific intervention choices—such as withdrawing mechanical ventilation, withholding cardiopulmonary resuscitation, or removing artificial nutrition—on a 5-point agreement scale.

The qualitative interview guide used open-ended questions to explore clinicians' experiences when managing terminal care, focusing on how they balanced personal moral values, family dynamics, and the requirements of Law 20.584.

Experimental Setup

Quantitative data analysis was performed using R version 4.4.0 within the RStudio integrated development environment on a Linux Ubuntu workstation. Key statistical operations relied on the psych package for initial scale diagnostics and descriptive summaries, and the car and stats packages for constructing multivariate logistic regression models. Qualitative data management and thematic coding were conducted concurrently using NVivo Ultra (Version 15.25) software, which was used to organize transcript texts, create hierarchical nodes, and track code co-occurrences across participant demographics.

Evaluation Metrics

The quantitative analysis used specific statistical measures to evaluate the relationship between clinician religiosity and end-of-life decision-making. The primary dependent variables were converted into binary outcomes, indicating either a willingness or a resistance to execute an end-of-life limitation strategy. The primary metric used to evaluate these relationships was the adjusted Odds Ratio (OR), calculated using logistic regression:

$$\ln\left(\frac{P_i}{1-P_i}\right) = \beta_0 + \beta_1(IR_i) + \sum_{j=1}^{k} \gamma_j \left(X_{ji}\right)$$

where P_i represents the probability that a clinician will resist the withdrawal or withholding of a life-sustaining intervention, IR_i indicates the individual's continuous Intrinsic Religiosity score derived from the DUREL scale, and X_{ji} represents a vector of control variables, including age, professional role, years of clinical experience, and institutional setting. Statistical significance was set at a threshold of $p < .05$ with corresponding 95% Confidence Intervals (CI).

The qualitative data were assessed using thematic saturation metrics and inter-coder agreement indices. Code prevalence was tracked across the transcript segments to identify central thematic priorities within the sample.

Validation Approach

To ensure the validity and reliability of the findings across both components, this study implemented a comprehensive validation framework:

1) *Quantitative Scale Reliability:* Internal consistency for the DUREL subscales was verified using Cronbach's alpha coefficient, which yielded an alpha of $\alpha = 0.89$ for the Intrinsic Religiosity dimension within this sample, confirming strong scale reliability.
2) *Qualitative Coding Consensus:* Transcripts were coded independently by two bioethical researchers. Inter-coder agreement was evaluated using Holsti's reliability index, achieving a consensus score of 0.88, which exceeds the standard threshold for qualitative consistency.
3) *Triangulation Matrix Validation:* A convergence matrix was constructed to cross-reference quantitative regression coefficients with qualitative narrative themes. This process verified that statistical correlations were supported by matching qualitative descriptions from the participant interviews.

D. RESULT AND DISCUSSION

Quantitative Analysis and Regression Modeling

Descriptive analysis of the quantitative dataset indicated a wide range of religious commitment among the sampled Chilean healthcare professionals. The distribution of mean scores on the Intrinsic Religiosity subscale of the DUREL instrument varied significantly across professional boundaries, with attending physicians demonstrating lower average intrinsic religiosity scores (Mean = 7.42, Standard Deviation = 2.15) than registered nurses (Mean = 9.86, Standard Deviation = 2.44).

The initial analysis of responses to the clinical scenarios revealed distinct patterns regarding the willingness of practitioners to limit life-sustaining treatments. Table 2 details the descriptive responses and agreement percentages for specific end-of-life actions across the quantitative sample.

Table 2. Percentage distribution of clinical agreement regarding end-of-life interventions (N = 412)

Clinical End-of-Life Intervention Choice	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Withholding CPR in Terminal Malignancy	48.54	32.28	8.01	7.04	4.13
Withdrawing Ventilation in Brain Death	54.12	28.40	6.55	6.80	4.13
Withdrawing Ventilation in Futile Disease	26.46	31.07	12.14	18.20	12.13
Withholding Artificial Nutrition / Hydration	14.32	22.57	15.29	28.16	19.66
Administering Continuous Palliative Sedation	38.83	41.50	9.71	6.07	3.89

To evaluate the independent effect of intrinsic religiosity on clinical decisions while controlling for potential confounding variables, two distinct multivariate logistic regression models were constructed. Model 1 assessed the probability of a clinician resisting the withdrawal of mechanical ventilation in a terminally ill patient where treatment was deemed medically futile. Model 2 assessed the probability of a clinician resisting the withdrawal of artificial nutrition and hydration in a patient with advanced dementia.

The results demonstrated that intrinsic religiosity served as a strong independent predictor of clinical resistance to withdrawing life-sustaining measures. Table 3 presents the regression coefficients, adjusted odds ratios, confidence intervals, and significance values for both models.

Table 3. Multivariate logistic regression predicting clinician resistance to withdrawing life-sustaining treatments.

Explanatory Predictor Variable	Model 1: Resistance to Ventilation Withdrawal		Model 2: Resistance to Nutrition Withdrawal	
	Adjusted OR (95% CI)	p-value	Adjusted OR (95% CI)	p-value
Intrinsic Religiosity Score (Continuous)	3.42 [2.15, 5.44]	< .001	4.18 [2.62, 6.68]	< .001
Professional Role (Base: Nurse)	0.62 [0.41, 0.94]	.024	0.51 [0.33, 0.79]	< .001
Age of Practitioner (Years)	1.02 [0.99, 1.05]	.210	1.04 [1.01, 1.07]	.012
Years of Clinical Experience	0.97 [0.94, 1.01]	.154	0.95 [0.92, 0.99]	.018
Institutional Setting (Base: Public)	1.24 [0.82, 1.88]	.312	1.46 [0.95, 2.24]	.084

The quantitative results confirmed that for each one-point increase on the continuous DUREL Intrinsic Religiosity scale, the likelihood of a clinician resisting the withdrawal of mechanical ventilation increased by a factor of 3.42 ($p < .001$), independent of institutional setting or years of experience. This effect was more pronounced in Model 2, where high intrinsic religiosity increased the likelihood of resisting the withdrawal of artificial nutrition and hydration by a factor of 4.18 ($p < .001$).

Physicians generally demonstrated a lower likelihood of treatment resistance than nurses across both models, as reflected by the odds ratios of 0.62 ($p = .024$) in Model 1 and 0.51 ($p < .001$) in Model 2. Older age and fewer years of clinical experience were also significantly associated with higher resistance to withdrawing artificial nutrition in Model 2.

Qualitative Thematic Analysis

Thematic analysis of the 28 verbatim transcripts identified three primary qualitative themes that illustrated the psychological and moral processes underlying the patterns observed in the quantitative data.

The Moral Weight of Divine Sovereignty

The first theme, the moral weight of divine sovereignty, was central to the accounts of highly religious clinicians, particularly those identifying as Roman Catholic or Evangelical Protestant. These participants described human life as a sacred gift under divine ownership, which limited human authority to determine the timing of death. This perspective directly influenced how clinicians viewed the limitation of therapeutic efforts, with several expressing concern that withdrawing life support could cross an ethical line from allowing natural death into active intervention.

A primary sub-theme within this narrative was the concern over moral complicity in a patient's death. Highly religious nurses frequently noted that while they understood the concept of medical futility intellectually, the physical act of turning off a mechanical ventilator or stopping an infusion felt like a direct violation of their personal moral duties. This generated internal conflict, as clinicians struggled to balance professional responsibilities with their spiritual values.

The Persistence of Institutional Paternalism

The second theme reflected the continuous influence of traditional medical paternalism within Chilean healthcare organizations. Many clinicians, especially those with more than 15 years of clinical experience, described a medical culture that historically equated clinical success with the preservation of biological life, regardless of quality-of-life considerations. This institutional legacy often made practitioners hesitant to initiate conversations about withholding or withdrawing treatment, leading to an institutional preference for continuing active interventions.

This paternalistic approach was often reinforced by interactions with patients' families. Participants noted that family members frequently expressed strong religious expectations, including a reliance on divine intervention or miracles, which aligned with the clinician's own traditional framework. In these instances, the shared cultural and religious values between the clinical team and the family could lead to consensus around prolonged treatment, occasionally overriding previous oral or written expressions of patient autonomy.

Institutional and Legal Ambiguity of Law 20.584

The final qualitative theme concerned the operational challenges and ambiguity associated with navigating Chilean Law 20.584. While clinicians recognized that the legal framework formally protects patient autonomy and allows the refusal of disproportionate treatments, they consistently reported a lack of clear institutional guidelines on how to define or apply these concepts at the bedside. The absence of structured protocols left many clinicians concerned about potential legal liability or institutional sanctions if they withdrew life support.

This perceived ambiguity tended to exacerbate internal conflict for highly religious practitioners. Without clear, standardized definitions of therapeutic futility from institutional ethics committees, clinicians frequently defaulted to their personal moral frameworks to guide their choices. This led to variations in practice across different shifts and clinical teams, as decisions to limit treatment became highly dependent on the personal ethical perspectives of the clinicians on duty.

Discussion

The integrated findings of this mixed-methods study demonstrate that personal religious beliefs remain an important factor shaping end-of-life ethical decision-making among healthcare professionals in Chile. The quantitative regression models indicate that high intrinsic religiosity is strongly associated with clinical resistance to withdrawing mechanical ventilation ($OR = 3.42$) and artificial nutrition ($OR = 4.18$). These statistical correlations are supported by the qualitative findings, which show that clinicians' decisions are often guided by a belief in divine sovereignty over life and a desire to avoid moral complicity in death. These results align with international bioethics research showing that highly religious clinicians are consistently more inclined to maintain life-sustaining interventions in critical care environments (Sprung et al., 2019; Curlin et al., 2021).

However, these findings reveal a specific tension within the modern Chilean healthcare system that distinguishes it from more secularized North American or Western European contexts. While international studies often frame clinical challenges around a direct conflict between a secular physician and a religious family (Borenstein et al., 2020), the Chilean reality involves a complex intersection of personal faith, professional norms, and legislative mandates. The qualitative analysis shows that traditional medical paternalism remains influential within Chilean hospitals, often interacting with the personal religious frameworks of both clinicians and families. This shared cultural background can create an environment where the preservation of physical life is prioritized over patient self-determination, potentially delaying the transition to appropriate palliative care and complicating the implementation of Law 20.584 (Irarrázaval & Solari, 2021; Aguilera & Bedregal, 2022).

This study also highlights how the institutional and operational ambiguity surrounding Law 20.584 impacts bedside care. Although the law establishes a patient's right to refuse disproportionate treatment, the lack of clear institutional protocols regarding therapeutic futility often leaves clinicians to interpret these scenarios individually. For highly religious practitioners, this lack of structure frequently means personal moral values become the primary reference point for decisions, occasionally leading to variations in the care provided to terminally ill patients (Salas & Umaña, 2020). This highlights the need for clear institutional guidelines and active support from healthcare organizations to help clinicians balance legal mandates, professional duties, and personal ethical frameworks.

These dynamics point toward specific practical recommendations for healthcare management and bioethical practice in Chile. First, healthcare networks should implement clear, standardized protocols that define the criteria for therapeutic futility and the limitation of therapeutic efforts, helping reduce reliance on subjective interpretation. Second, the role and visibility of Institutional Ethics Committees (IECs) must be strengthened across both public and private hospitals. These committees should provide timely, objective consultation during ethical disagreements, serving as an independent resource to help clinical teams balance patient autonomy, family wishes, and professional responsibilities. Finally, continuous medical education programs should include comprehensive training in clinical bioethics and communication strategies, equipping clinicians with the skills needed to navigate complex end-of-life discussions while respecting diverse values and legal frameworks.

It is important to acknowledge certain limitations when interpreting the results of this study. First, while the sample included 412 professionals across six centers in three major administrative regions, the findings may not fully represent healthcare settings in more remote or rural areas of Chile, where institutional resources and cultural dynamics can vary significantly. Second, the study relied on self-reported survey responses to standardized clinical scenarios, which may introduce social desirability bias or differ from actual behavior during real-world clinical crises. Finally, the cross-sectional design of the quantitative phase captures clinician perspectives at a single point in time, omitting potential long-term shifts in ethical attitudes as the country's cultural and legal landscape continues to evolve. Future research

should consider longitudinal or observational designs to track changes in ethical decision-making over time and explore these dynamics across a broader range of regional and institutional environments in Latin America.

E. CONCLUSION

This mixed-methods study shows that personal religious beliefs continue to play an important role in shaping end-of-life ethical decisions among healthcare professionals in Chile. The quantitative models indicate that high intrinsic religiosity significantly predicts resistance to withdrawing life-sustaining measures, while the qualitative analysis highlights the complex interplay between traditional clinical paternalism, divine sovereignty frameworks, and the operational ambiguities of Law 20.584. These findings demonstrate that legislative reforms alone are not always sufficient to alter deeply rooted cultural and personal values within healthcare systems. To ensure that patient autonomy is consistently respected alongside professional standards, Chilean healthcare networks must develop clear institutional protocols for therapeutic limitation, expand the role of independent bioethics committees, and integrate comprehensive ethics education into clinical training. Future research should examine the effectiveness of specific institutional interventions, such as standardized communication training and structured ethics consultations, in reducing variations in care and supporting objective, patient-centered decisions in critical care environments.

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