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ADVANCE DIRECTIVES: A DOCUMENTARY ANALYSIS IN THE GLOBAL CONTEXT

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ABSTRACT

Objective: to know the laws regarding living wills in different countries, establishing a parallel with established in Brazil.

Method: there was documentary analysis of domestic and foreign governmental laws, adopting the content analysis of Bardin in the material identified until 2013.

Results: approximately fifteen countries have regulatory laws of the living will, whereas in Brazil there is only one resolution of the Federal Council of Medicine. Advance directives will or living will, nomenclature adopted in Brazil, operates in the preservation of patient autonomy.

Conclusion: know the laws in different countries contributes, to support discussions and legal developments in Brazil, so that health professionals who work with patients, may consider the wishes of the beneficiaries.

DESCRIPTORS: Advance directives. Living will. Legislation as topic. Terminally ill.

DIRETIVAS ANTECIPADAS: UMA ANÁLISE DOCUMENTAL NO CONTEXTO MUNDIAL

RESUMO

Objetivo: conhecer as legislações referentes ao testamento vital em diferentes países, estabelecendo um paralelo com a instituída no Brasil.

Método: realizou-se análise documental de legislações governamentais nacionais e estrangeiras, adotando a análise de conteúdo de Bardin nos materiais localizados até 2013.

Resultados: aproximadamente quinze países possuem legislações regulamentadoras do testamento vital, enquanto que, no Brasil, há apenas uma resolução do Conselho Federal de Medicina. As diretivas antecipadas da vontade ou o testamento vital, nomenclatura adotada no Brasil, atua na preservação da autonomia do paciente.

Conclusão: conhecer as legislações em diferentes países contribui no sentido de subsidiar discussões e avanços legais, no Brasil, para que os profissionais da saúde, que atuam com pacientes, possam considerar os desejos dos assistidos.

DESCRIPTORIOS: Diretivas antecipadas. Testamentos quanto à vida. Legislação como assunto. Doente terminal.

DIRECTIVAS ANTICIPADAS: UN ANÁLISIS DOCUMENTAL EN CONTEXTO GLOBAL

RESUMEN

Objetivo: conocer las leyes relativas a los testamentos vitales en diferentes países, estableciendo un paralelismo con lo establecido en Brasil.

Método: se realizó análisis documental de las leyes gubernamentales nacionales y extranjeras, adoptando el análisis de contenido de Bardin en los materiales localizados até 2013.

Resultados: aproximadamente quince países tienen leyes reguladoras del testamento en vida, mientras que en Brasil sólo hay una resolución del Consejo Federal de Medicina. Las directivas anticipadas serán o testamento vital, nomenclatura adoptada en Brasil, opera en la preservación de la autonomía del paciente.

Conclusión: conozca las leyes de los distintos países contribuye, para apoyar los debates y desarrollos legales en Brasil, por lo que los profesionales de la salud que trabajan con los pacientes, pueden considerar los deseos de los beneficiarios.

DESCRIPTORIOS: Directivas anticipadas. Voluntad en vida. Legislación como asunto. Enfermo terminal.

INTRODUCTION

The development of the biomedical technological sciences has caused significant changes in the care provided to the patient, considering the resources available for the treatment of previously incurable diseases. However, at certain times, the technological apparatus is not enough to maintain life, when it comes to the terminally ill patients. The attempt to heal can lead to the artificial prolongation of life, the loss of personal autonomy and human dignity, raising discussions regarding the supposed rights of the patient to manifest their will in situations of incapacity.

In this direction, given the possibility of building an instrument for the manifestation of interests¹ the Advance Directives of Will (ADW) come out, usually known in Brazil as Living Will (LW), which are linked to the possibility of the patient to express previously their will about the medical treatments (dialysis, artificial respirators, cardiorespiratory resuscitation - CPR, feeding tube) to which or not undergo if in the future the patient is in a state of incapacity.²

The ADW have emerged in recent decades as one of the main discussions of global bioethics and as guarantors of the preservation of the personal autonomy. Countries such as Germany, Argentina, Austria, Belgium, United States of America (USA), France, Holland, Hungary, England, Mexico, Puerto Rico, Portugal, European Union and Uruguay already have specific legislation on the subject. In Brazil, there is no jurisprudential legislation on the subject, however, the Federal Medical Council (FMC) issued the Resolution 1995/12, which treats and authorizes the practice of the ADW.³

Based on this assumption, the ADW is anchored on the idea that it is a process that includes the notion of an active patient who participates in making decisions about their health.⁴ In a research carried out in Brazil, in order to identify the perception of cancer patients and their companions in relation to the LW, it was identified that both groups are unaware of the meaning of this term. From the presentation of its meaning, it was found that patients who have been in treatment for a longer time have a greater desire to decide on their dying process, and younger patients are less likely to be prepared. However, the decisions of family members, doctors, patients and patients along with their doctors are well accepted by both groups surveyed. Thus, based on this research, the implantation of the LW in Brazil seems to be welcomed, both by cancer patients and by their companions.⁵

Thus, from this study and from the belief that there are many obstacles and dilemmas related to the exercise of autonomy by the patient, there is a need to foment the discussion about the LW in Brazil, in order to contribute to patients' compliance with their wishes and that the professionals who work with terminal patients have their actions supported, since the actions in terminal situations are, at different moments, permeated by ethical conflicts. The ADW are a way of determining not only the type, but also the intensity of the medical treatment that the person wants.⁶

Considering the relevance of the topic and the possibility of the patient to previously decide and register how they want to receive care at the end of life, helping health professionals as well as family members to make decisions, and the need to strive for better guidance defined on the LW, it was outlined as a research question: What are the guidelines present in the legislation of different countries about the LW and ADW? Thus, the objective of this study is to know the legislation regarding the ADW and LW in different countries, establishing a parallel with the one in force in Brazil.

METHOD

It is a research that adopts procedures of documentary analysis, as a delineation that allows to explain and clarify the question/problem in agreement with the objective of the researcher. A document is an important means of access for the understanding of the social context, of the concepts and for favoring the observation of a recent past, besides favoring the observation of the process of maturation or evolution of individuals, groups, concepts, knowledge, behaviors, mentalities and practices.⁷

In the documentary analysis, first, it is necessary to find the relevant documents and assess their credibility; thus, this stage consisted in finding the LW legislation of different countries.⁷ The website specialized in divulging the LW in Brazil, which makes available the legislation was the source of research. After the first selection carried out in the period from September to October 2013 and in the possession of the laws, it was decided to confirm the documents in the addresses referenced on the website of the following countries: USA, Spain, Portugal, Argentina, Uruguay, Belgium, Holland, England, Mexico, European Union and Brazil.⁸

The foreign documents were selected according to the following criteria: relevance of the

content to the study objective; reliability, since they are official documents prepared by governments; and documents in English, Spanish and Portuguese language. The public files containing governmental documents, civil documents, as well as documents of a notarial or legal nature, are public documents that can be searched through the documentary analysis.⁷ Thus, the laws of Austria, France, Germany and Hungary, as well as the laws of the Netherlands, Puerto Rico and the European Union that were not located, were disregarded due to the language. In Brazil, due to the absence of legislation on LW and in order to subsidize justifications to support the practice of the ADW, a recourse was made to the Federal Constitution,⁹ to the Civil Code,¹⁰ to the Code of Medical Ethics (CME)¹¹ and to the Resolution 1.995/12.³

Thus, from these documents, a preliminary document analysis was carried out according to the five dimensions: context analysis, authors, authenticity and reliability of the text, nature of the text, key concepts and internal logic of the text.⁷ Regarding the context of the LW, it occurred, incipiently in the USA, in 1967, by the American Society for Euthanasia, as a document of advance care in which the individual could register their interests regarding the interruption of medical treatments that maintained their life in situations of terminality, in addition to contributing to the possibility of mitigating conflicts between professionals, terminal patients and family members related to treatment decisions to which the terminally ill patient should be submitted.¹²

From what has been shown, cases such as Karen Ann Quinlan, Terri Schiavo and Nancy Cruzan, who remained in a persistent vegetative state, whose representatives requested the withdrawal of the supports that prolonged their lives, imposed decisive value for the creation of a law on the subject in the USA, in 1990, triggering the need for legislation in other countries.¹ In Brazil, after many years of discussion, in 2012, the Resolution on the ADW by the FMC was approved.³

As for the authenticity and reliability of the material analyzed, the documents consist of legislation, that is, they are authentic and reliable legal documents, analyzed in full, with instructions regarding the implementation of the ADW and LW in the countries. The documents analyzed exclusively illustrate the right of patients to exercise their autonomy regarding a terminal situation, based on the expositions on the procedures adopted to organize a LW. The legislation and the only resolution

analyzed portray in very similar ways the actions on the LW, not getting lost in the broad sense of guaranteeing the dignity and personal autonomy for the incapable patient.

Then, in the last stage, the documents were analyzed regarding their internal logic, content analysis¹³ belonging to the documentary analysis.⁷ The content analysis is a set of verbal and non-verbal communication analysis techniques that aims, through systematic and objective procedures, to describe the content of the messages, to obtain indicators, qualitative or not, that allow the inference of knowledge about the conditions of production of these messages.¹³

Thus, the pre-analysis, the exploitation of the material and the treatment of the results were carried out.¹³ The pre-analysis was the data organization phase and comprised: reading in full, respecting the validity norms that refer to: completeness, representativeness, homogeneity and pertinence. In order to organize the material for the analysis and performance of the floating reading, information was extracted from the texts referring to the country, year, what establishes the legislation, patients' rights and the dynamics of applicability of the ADW.

In the exploration of the material, which consisted of the codification operation, the theme was used as the unit of record, which originated the categories by bringing together a group of elements, under a generic title, because of the common characters.¹³ And finally, the last stage of the content analysis proposed to make the inference of the predicted interpretations around the theoretical dimensions suggested by the reading of the material; in order to do so, the reference used was the bioethics and the Brazilian legislation, which made it possible to reflect on the legislation.

It is also complemented that this research exempts from the Free and Informed Consent Term (FICT) due to its documentary nature. As the documents analyzed in this research were extracted from governmental and departmental websites of public domain, the ethical aspects were respected, considering that the information presented reflects what the legislation deals with. It should be emphasized that this research is free of external financing and it is responsibility of the authors.

RESULTS AND DISCUSSION

Currently, the discussions about the LW and ADW are relevant because they enable patients to exercise autonomy, and health professionals and

family members can have information about the patient's desires in difficult situations, exempting them from the responsibility to decide on behaviors that, perhaps, were repudiated by the patients. Thus,

table 1 shows the countries, legislation, the year of its creation, and what the laws that were considered in this research deal with, in order to raise a discussion parallel to what has been established in Brazil.

Table 1 - Legislation on advance directives and living will in different countries

Country	Year	Legislation	What it establishes
EUA ¹⁴	1991	Patient Self Determination Act of 1990	The patient's right to self-determination and to make an advance directive, in its two forms: a living will and a lasting mandate
Spain ¹⁵	2002	Law 41 of November 14, 2002	Rights and obligations of patients, users and professionals, as well as public and private schools and health services, on patient autonomy, clinical information and documentation
Belgium ¹⁶	2002	Law of August 22, 2002	Law on the rights of Belgian patients
England ¹⁷	2005	Law on mental capacity of 2005	Law on mental capacity
Mexico ¹⁸	2008	Law 247 of January 7, 2008	Law of advance will for the Federal District
Uruguay ¹⁹	2009	Law 18,473 of April 3, 2009	Advance will
Argentina ²⁰	2009 2012	Law 26,529 of October 21, 2009 repealed by the law 26742 of May 24, 2012	It establishes the rights of the patient and their relationship with health professionals and institutions
Portugal ²¹	2012	Law 25 of June 16, 2012	It regulates the DWA, namely in the form of LW, and the appointment of a health care procurator, creating the National Registry of Living Will
Brazil ³	2012	FMC Resolution 1995 of August 31, 2012	Provides for patients' ADW

It should be highlighted that there is a vocabulary proliferation of terms referring to the ADW and LW, distinct in the different countries surveyed. The advance declaration of will is designated in the US by "living testament" or "advance directive"; in Belgium,¹⁶ by "testament biologique"; in Spain,¹⁵ "Instrucciones previas"; in Uruguay¹⁹ and in Mexico, "Voluntad anticipada"; in Portugal²¹ and in Brazil,³ "Diretivas antecipadas de vontade" and, in Argentina,²⁰ "Directivas anticipadas".

By reading and analyzing the content of the laws of the different countries, it was possible to perceive similarities of the conducts guidelines in the application of the advance directives, emerging and constituting two categories: advance directives and the right to respect the autonomy of the patient.

Advance directives

The ADW, found on the world scenario for years, were introduced on the national scenario in

2012. The resolution 1,995/12 guides the medical conduct in situations of termination, guaranteeing the patient's autonomy and maintaining the human dignity.³ According to the resolution, the ADW constitute a set of wishes, previously expressed by the patient, that will be considered, regarding the care and treatments, whether or not they want to receive at the moment when they are unable to express, free and autonomously, their will. In addition, the resolution in Brazil considers the possibility of the patient designating a prosecutor so that their wishes are respected when they can no longer manifest it.³

In the United States, the first country to present legislation on the subject, the advance directive is a written instruction, such as a living will or long-term mandate of the health lawyer, recognized by the State legislation and related to the provision of such care when the individual is unable, and it should be documented in the individual's chart; in addition, employees and the community should be clarified on issues related to the advance directives.¹⁴

Spain, the first European country to legislate on the advance directives, treats in general terms that they should contain guidelines to the medical team about the desire not to prolong life artificially, not to use extraordinary treatments, to suspend the therapeutic effort and the use of medicines to reduce pain, among others.¹⁵ It also complements that the advance directives can be revoked at any time regardless of whether the patient leaves a written record. In order to ensure the effectiveness of the instructions given by the patients, a National Registry of instructions has been set up in the Ministry of Health so that patients can be cared for in accordance with the rules established by an agreement governed by the Interterritorial Health Council.¹⁵

In Argentina, in 2009, a law that recognized the right of the patient to dispose of their wills by means of advance directives was approved; however, the law did not mention details on the subject. Thus, in 2012 this legislation was changed, addressing the issue in a directed manner. The legislation in Argentina determines that the advance directives can be carried out by any able adult, being able to consent or to refuse certain medical, preventive or palliative treatments, as well as the decisions that involve their health. The directives must be accepted by the attending physician, except those involving the development of euthanasia practices, which will be considered as non-existent. The declaration shall be made in writing and may be revoked at any time.²⁰

In Brazil, the resolution of the directives foresees that the physician registers, in the medical record, the ADW that are directly communicated to him by the patient. If the prior guidelines are not known, and if there is no designated representative, available relatives or a consensus among them, the physician will refer to the Bioethics Committee of the institution, if any, or, failing that, to the Hospital Ethics Committee or to the Regional and Federal Office of Medicine to base their decision on ethical conflicts when they understand this as a necessary and convenient measure.³

In Portugal, the discussion began in 2006 with the presentation of the law project authored by the Portuguese Bioethics Association. However, only in July 2012 was the law regulating the ADW approved, namely in the form of a LW, with the appointment of a health care attorney. In addition, the National Register of Living Will (RENTEV - Registro Nacional do Testamento Vital) was created to register, organize and keep up to date, as regards to national, foreigner and stateless people residing in Portugal, the information and documentation

related to the ADW document and the power of the health care attorney.²¹

In Portugal, the advance directives are effective for five years and represent a unilateral document that is freely revocable and modifiable at any time, in which a person who is of legal age and who is not deprived or disabled due to any psychic anomaly, expresses in advance their conscious, free and enlightened will, regarding the health care that they wish to receive, or do not wish to receive, in case, for any reason, the person is unable to express their will personally and autonomously.²¹ In Brazil, the delimitation of time does not exist, being understood that once performed, if not suspended by the individual, it will be valid indefinitely.³

In Uruguay, the legislation provides the right to express their will to oppose the future application of medical treatments and procedures to prolong life to the detriment of its quality, if it the person has a terminal illness, which is incurable and irreversible. The diagnosis of the terminal condition of an incurable and irreversible disease must be certified by the attending physician and confirmed by a second physician in the patient's medical history chart.¹⁹ In addition, the advance directive may be revoked orally or in writing at any time, and in all cases, the physician shall record this statement in the medical record. The document must always include the nomination of a person as representative, of legal age, to ensure the compliance with this will, in the event that the holder becomes unable to make decisions for themselves.¹⁹

If the terminal patient of an incurable and irreversible disease has not expressed their will and is unable to express it, the suspension of the treatments or procedures will be a decision of the spouse or companion of common law or, in the absence of this person, of a family member in its first degree of consanguinity.¹⁹ Thus, public and private health services must ensure the compliance with the patient's advance directive, incorporate it into their medical history chart, provide educational programs for employees and users on the rights of the patients prescribed in this law, and the Ministry of Health must implement a wide distribution of the educational process.¹⁹

In England, the Mental Capacity Law includes, in one of its chapters, the decisions regarding the advance directives that must be carried out by a person with the capacity to consent with the accomplishment or continuation of the treatment, being able to withdraw or change the decision at any moment, while able to do so.¹⁷

In Mexico, the law of advance directives is of public order and social interest. It allows the refusal to submitting to medical means, treatments and/or procedures that intend to prolong life unnecessarily, protecting the human dignity when it is impossible to maintain life naturally. The application of the provisions of this law is related to orthotanasia, not allowing abbreviating life intentionally.¹⁸

In this perspective, in Brazil, the advance directives, in practice, mean the performance of orthotanasia that is recognized as a right by the FMC² and by the sentence of the judicial process number 2007.34.00.014.809-3, that is, it allows the patient to die naturally, since there are no more resources coming from medicine that can reverse the scenario; in short, nothing can be done with the intention of healing the patient.²³

It is important to highlight that the legislations researched include in their structures mentions on: the right to conscientious objection by health professionals and the lack of discrimination in access to health care due to having or not an ADW document. In addition, all the legislations mention the possibility of naming a representative to act on decisions when individuals become incapable.

Directing the look to what is predicted in Brazil, it is noticed that the Resolution of the FMC³ also mentions that the doctor, if the terminal patient's previous declaration of will complies with the dictates of their conscience, may refuse to implement it, as long as another doctor is ready, able and willing to take his place. However, in any way, the physician may not act in accordance with their conscience alone, and the patient's will over the physician's will prevails.

Right to respect the patient's autonomy

The right of the patient to decide on the future intentions of the treatments to which he or she wishes or not to be submitted in situations of incapacities is ensured in all the legislations researched. The advance directives became a federal law in 1991 in the USA through the publication of the Patient Self-Determination Act (PSDA) and provide for the patient's right to participate in decisions that involve their health care and determine that providers policies and procedures to provide written information to each individual on: their right to decide about the medical care, including the right to accept or refuse medical or surgical treatment and to formulate advance directives.¹⁴ In this way, the ADW are within the scope of the patient's autonomy, besides being

considered as one of the main motivations of the patients to complete them with the fact of assuring their autonomy and affirming it, above all, to the possible therapeutic obstinacy.²⁴

The word autonomy means "self-government, right to freedom, privacy, individual choice, freedom of will, being the engine of one's own behavior and belonging to oneself."^{25:137} Respecting the autonomous patient is, at the very least, recognizing their right to have their opinions, make their choices and act based on their personal values and beliefs. In this sense, the advancement of human autonomy, in the last decades, has given the patient the right to be informed, to make the choice of treatment among those available, and to consent or refuse a proposed procedure or therapy.⁵ Thus, the respect for the patient's autonomy takes into account the patient's own way of apprehending the world, making choices based on self-values, acting in accordance with their principles, beliefs, and worldview. Thus, health professionals must walk side by side with the patient, helping them in their decisions, never judging or deciding for them.²⁶

In Brazil, the will of the patient is sovereign, since the FMC¹¹ establishes that it is forbidden for the professional to fail to guarantee the patient the exercise of their right to freely decide on their own person or their own well-being, and to exercise their authority to limit it, besides the right of the patient or their legal representative to decide on the execution of diagnostic or therapeutic practices, except in case of imminent risk of death. In accordance with the Resolution 1995/12, the physician responsible for the treatment, aware of the patient's stated intention, should record it in the medical records, so that the previously expressed will can be used.³ Indeed, medical professionals must comply with the regulations of the resolutions, as established by the FMC, stating that it is prohibited to disobey the judgments and resolutions of the Federal and Regional Councils of Medicine or disrespect them, thus being subject to penalties provided by law.¹¹

In Belgium, the patient has not only the right but also the responsibility to cooperate with the health professional, that from this relationship between the patient and the health professionals, it is possible to improve the quality of health, summarizing the basic rights and the qualifications to maintain health records and access to those records. It is also possible to determine the person(s) who can represent patients who are unable to exercise their own rights. The services are provided respecting the dignity of the human being and the autonomy

of the patient, in addition to the fact that the patient has the right to give their informed, prior and voluntary consent to any intervention made by the health professional. If the patient does not want to receive the information, the healthcare professional must respect their desire by notifying the health records.¹⁶

In Spain, the dignity of the human person, respect for the autonomy of their will and privacy, serve as a guideline for all activities. The patient decides freely, after receiving the appropriate information, in a comprehensible and accessible language to their needs, and to obtain help to make decisions according to their own will, among the clinical options available. Any professional involved in the care activity needs not only to perform adequate procedures, but also to perform the duties of information and clinical documentation, in addition to respecting the patient's free and voluntary decisions.¹⁵ However, there is also the right to respect not to be informed. That is, the right to information on the health of patients can be limited by the existence of a state of therapeutic need, that is, when the knowledge of their situation could put their health at risk. In that case, the doctor will record the circumstances and communicate their decision to the people related to the patient or family.¹⁵ In Uruguay, any person in a legal age and who is mentally capable, on a voluntary, conscientious and free basis, has the right to oppose the application of medical treatments and procedures, unless this affects their health or the health of others.¹⁹

In Argentina, it must be ensured that the patient, as far as they can, participates in the decision-making throughout their health process, and the legislation emphasizes the right to freedom of choice, that is, the patient has the right to accept or to reject certain medical or biological therapies or processes, with or without just cause, as well as to later revoke their manifestation of will. The professional performance must respect the patient's decision and must proceed the records.²⁰ The safely informed terminal patient has the right to express their will regarding the rejection of surgical procedures, artificial resuscitation or withdrawal of life support, when they are extraordinary or disproportionate in relation to the prospect of improvement or when they produce excessive suffering. They may also refuse nutrition procedures and hydration when they occur as the sole effect of prolongation of the final stage time.²⁰

Regarding the artificial hydration and nutrition restrictions, many characterize this decision as euthanasia, a practice prohibited by the Brazilian legal system.¹ In this sense, the suspension has a

predominantly symbolic meaning, that is, family and professional often suffer in the face of the suspension of these vital resources because they think that the patient died of hunger and thirst, although studies prove that in certain clinical settings, the patient does not satisfactorily absorb hydration and nutrition.²⁷

Although there is no explicit Brazilian legislation on LW, there are in addition to the support of the Resolution 1995/12,³ mentions in the Brazilian Constitution⁹ on the constitutional principles of the Dignity of the Human Person (Article 1, III), Private Autonomy (principle implicit in Article 5) and the constitutional prohibition of inhuman treatment (Article 5, III), which imply in the affirmation that the maintenance of human dignity, the autonomy of the human being, and the right not to be subjected to a treatment that one does not wish to be carried out are recognized. Thus, professional medical decisions, respecting their conscientious decisions and legal predictions, will accept the choices of their patients regarding the diagnostic and therapeutic procedures by them expressed, as long as they are appropriate to the case and scientifically recognized.¹¹

Based on the foregoing, it is confirmed the need to respect the patient's autonomy, when the Resolution 1.995/12 states that the patient's ADW prevail over any other non-medical opinion, including the wishes of the family members. However, the physician will no longer consider the ADW of the patient or their representative who, in their analysis, are in disagreement with the precepts dictated by the FMC.³ In addition, the physician is prohibited from obtaining consent from the patient or their legal representative after clarifying the procedure to be performed, except in case of imminent risk of death.

However, corroborating the provisions of the Spanish legislation, the FMC in Brazil provides that it must be disclosed to the patient the diagnosis, prognosis, risks and treatment objectives, except when the direct communication can cause harm, in which case the communication must be made to the patient's legal representative.¹¹

Based on the idea that the advance directives in Brazil allow the individual to dispose of their acceptance or refusal of extraordinary treatments, in case of termination of life, the fundamental right to freedom set forth in the Federal Constitution confirms the right of autonomy of the patient.⁹ In this way, the terminal patient's previous declaration of will corresponds to the possibility of exercising

the fundamental right to freedom in a genuine way, since this document is nothing more than a space that the individual has to make personal decisions that are - and must continue to be - immune to external interference, whether they come from doctors, families, or any person and/or institution wishing to impose their own will.¹

In addition to the Federal Constitution, the Civil Code prescribes that no one can be constrained to undergo life-threatening medical treatment or surgical intervention.¹⁰ Thus, the ADW of the terminal patient is a guarantee of this legal device, since it avoids the embarrassment of the patient being subjected to futile medical treatments that only increase the risk of life, since the medical and hospital procedures always represent a risk.

CONCLUSION

The acceptance of death is not an easy task; talking about one's own death being healthy is different from the situation of being diagnosed as having only a few months to live. In this sense, if death is inevitable, treating it as an irreversible process would help the inclusion of dying well, since death often happens in inhuman situations. New technological resources allow the adoption of disproportionate measures that can prolong the suffering of the terminally ill patient without benefits, and these measures may have been rejected by them in advance. Thus, cases of refusal or rejection of procedures mean the interruption of measures and actions for adequate control and relief of the patient's suffering.

Knowing the legislation in force in different countries corroborates the discussion that it is imperative to adhere to this tool, in order to avoid that people who cannot even think about the subject, in the future may suffer unnecessarily because they have not left their wills registered. It also contributes to subsidize discussions in Brazil, so that not only the doctors, who have the prerogative of the diagnosis, but also health professionals who act directly and intensively with the patients considered terminal can act considering the wishes of the patients assisted.

The recommendations proposed in the Resolution on directives in Brazil seem generalizable without considering the operational details of conduct, as is the case of other countries' legislation. For this reason, there is a need to legalize the practice, in order to disassociate from actions that may become illegal, due to the deficient protection provided by

the Brazilian Resolution. Undoubtedly, it is a great advance and, in addition to the current resolution, it is possible to consider that other determinations already exist, such as the constitutional, civil, among others; however, it is necessary to focus on its operation, in order to protect professionals, family members and, above all, the patient so that they have their will fulfilled when they are no longer able to actively participate in the decisions that involve their own lives.

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