Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.34 Brasília 2026

# Advance directives in Brazil: applicability in psychiatry

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## Abstract

This study aimed to analyze the perception of psychiatrists working in Brazil regarding the actual applicability of advance directives in their work and their presumed consequences, considering that there is still no specific law regulating the use of this tool in Brazil. A qualitative study was conducted, involving a population of 40 psychiatrists in the city of Rio de Janeiro. Data were collected via interviews with two open-ended questions, and the results were treated according to Bardin's content analysis principles to analyze reflections of the professionals on the topic. The findings show that most physicians tend to support the use of directives, with few arguments against them. The possibility of sharing decisions with patients tended to be well received. It can be said that directives in advance lack dissemination among psychiatrists. Actions to improve this scenario are already being implemented, reaching medical school graduates.

**Keywords:** Personal autonomy. Patient preference. Critical illness. Paternalism. Psychiatry.

## Resumo

### Diretivas antecipadas de vontade no Brasil: sua aplicabilidade em psiquiatria

O objetivo deste estudo foi analisar a percepção de psiquiatras que atuam no Brasil sobre a real aplicabilidade das diretivas antecipadas de vontade em seu trabalho e suas consequências presumíveis, levando em conta que ainda não há uma lei específica para regulamentar o uso dessa ferramenta no Brasil. Foi realizado estudo qualitativo, que abordou uma população de 40 psiquiatras da cidade do Rio de Janeiro. A coleta de dados se deu por meio de entrevista com duas perguntas abertas, e os resultados foram tratados conforme os preceitos da análise de conteúdo de Bardin a fim de analisar as reflexões dos profissionais sobre o tema. Os achados mostram a tendência da expressiva maioria dos médicos a apoiar o uso das diretivas, com poucos argumentos contrários. A possibilidade de compartilhar as decisões com pacientes teve tendência a ser bem recebida. Pode-se afirmar que as diretivas antecipadas de vontade carecem de divulgação entre psiquiatras. Ações para melhorar tal cenário já estão sendo aplicadas, atingindo a graduação em medicina.

**Palavras-chave:** Autonomia pessoal. Preferência do paciente. Estado terminal. Paternalismo. Psiquiatria.

## Resumen

### Directivas anticipadas en Brasil: su aplicabilidad en psiquiatría

El objetivo de este estudio fue analizar la percepción de los psiquiatras que trabajan en Brasil sobre la aplicabilidad real de las directivas anticipadas de voluntad en su trabajo y sus posibles consecuencias, teniendo en cuenta que aún no existe una ley específica que regule el uso de esta herramienta en Brasil. Se realizó un estudio cualitativo, que abarcó una población de 40 psiquiatras de la ciudad de Río de Janeiro. La recopilación de datos se realizó mediante una entrevista con dos preguntas abiertas, y los resultados se trataron de acuerdo con los preceptos del análisis de contenido de Bardin con el fin de analizar las reflexiones de los profesionales sobre el tema. Los resultados muestran la tendencia de la gran mayoría de los médicos a apoyar el uso de las directivas, con pocos argumentos en contra. La posibilidad de compartir las decisiones con los pacientes tendió a ser bien recibida. Se puede afirmar que las directivas anticipadas de voluntad carecen de difusión entre los psiquiatras. Ya se están aplicando medidas para mejorar esta situación, que llegan hasta la licenciatura en medicina.

**Palabras clave:** Autonomía personal. Prioridad del paciente. Enfermedad crítica. Paternalismo. Psiquiatría.

Research

The authors declare no conflict of interest.
**Approval CEP-FIMCA 3.730.018**

http://dx.doi.org/10.1590/1983-803420264058EN

Humanity shares a common destiny: finitude. Finitude appears as something distant. However, it becomes the focus of all concern when, in the final period of existence, reflection on the subject is inescapable[1].

According to reports, the perception and experience of the death of a family member have undergone many changes in society, occurring, up until the 18th century, within the family environment in the community the person inhabited[2]. Gradual changes occurred and, thus, death began to occur in the hospital environment, in which sick persons are often unaccompanied by people from their family circle or by those to whom they are emotionally connected. In turn, farewell rituals between family and friends became ever shorter[2].

Technological procedures, which permeate end-of-life care and are often authorized by family members, began to occur without considering the opinion of the sick person[2]. After all, is the use of technologies providing the prolongation of life or death? This fundamental issue has been brought up for discussion[3]. In this sense, advance directives (AD) can represent an important resource that values the autonomy of each person[3] as it enables them to express themselves about their treatment in times and situations in which they can no longer do so.

Advance directives are the reason for the Resolution 1,995/2012[4] of the Federal Council of Medicine (CFM). They aim to protect the autonomy of sick people if they are unable to express themselves about what they accept or reject for themselves in terms of treatment. There is the possibility of a substitute judgment when a person is designated by the patient or their legal guardian[4].

The terrain of AD is not peaceful. The Brazilian Code of Medical Ethics brings in its core the need for an integrated interpretation of its articles because, if each of these is taken separately, guidance can be considered conflicting; for example, the text of articles 32 and 41, sole paragraph, which read, respectively, that it is forbidden

> (...) *to fail to use all available scientifically recognized means of health promotion and prevention and disease diagnosis and treatment within their reach in favor of the patient and, in cases of incurable and terminal disease, physicians must offer all available palliative care without undertaking useless or obstinate diagnostic or therapeutic actions, always considering the express will of the patient or, if this is impossible, that of their legal representative*[5].

There are also limitations to the wishes expressed via AD according to national legislation. An example is that of ancient Rome, in which citizens could refuse to undergo treatment and even opt for death. Refusing treatment is possible in Brazil, but euthanasia is not (even if it is included in the AD established by the person) if it is done without the help of adequate guidance[6].

Still regarding conflicts, medical training, with mainly curative practice, proposes reflection: evidently the objective of healing is an ideal, but this ideal is often unachievable. Welcoming, support, and acceptance of the life cycle must be encouraged[7]. Approaches such as palliative care are also a goal[7]. The knowledge of AD is still unsatisfactory: in research directed to the command of the content of CFM Resolution 1,995/2012[4], the application of a questionnaire on the subject among psychiatrists showed that only 45% of them were aware of the subject, leading to a gap in its applicability[8]. Elisabeth Kübler-Ross, a psychiatrist and scholar of end-of-life care in the context of technological development since the mid-20th century, questions the evolution of medicine: *medicine is to remain a humanitarian and respected profession or a new but depersonalized science in the service of prolonging life rather than diminishing human suffering?*[9]. In this sense, AD seek to reinforce the humanitarian sense of the medical profession[4].

In reality, the reinforcement of the humanistic sense in the sciences related to biology and medicine is a worldwide movement to which the resolution on AD is linked in search of valuing the sick person and their understanding of what is the life they want for themselves until its end[10]. Studies and research point to the importance of respecting the autonomy of the sick person and raise questions about persistent medical paternalism. They state that the possibility of having early manifestations of will welcomed/respected by the medical community is already widespread but that its use in the context of mental health care, including dementia, is scarce.

Zaragoza-Martí, Julià-Sanchis, and García-Sanjuán[11] question the reasons for this situation

http://dx.doi.org/10.1590/1983-803420264058EN

and the use of "living will" for AD, a term used for documents of deceased people. Dadalto[12] proposes another interesting approach by making a comparative analysis of the way in which several countries have standardized AD and trying to bring the issue to the Brazilian reality. The author criticizes the use of the term "living will" with the same arguments as the previous authors[11] and affirms the importance of the ability to understand and determine the validity of AD[12].

Continuing with the problems and conflicts related to the autonomy of the sick person, Martinez states that, if there were quality communication between the sick person and their physician, it would possibly be better than AD, making the following observation: *perhaps the greatest danger to health in the 21st century is no longer the autocratic paternalism of physicians but the respectful abandonment of patients*[13].

The principles of medical ethics, considered by the principlist strand of bioethics, emphasize respect for the autonomy of the person, justice in the distribution of resources, beneficence, and non-maleficence in decision-making about health care[14]. The management of resources in society is not always simple, especially in the face of the scarcity of health inputs[14]. It is found that the use of AD and their knowledge is greater among professionals who work with palliative care[15]. Even in the South American countries that have structured legislation on the subject, such as Mexico, Argentina, Puerto Rico, Colombia, and Uruguay[16], knowledge is restricted.

As can be seen, AD are still little known, something also pointed out by a recent survey in Brazil[17]. The Brazilian Ministry of Education has placed as a requirement the inclusion of bioethics in medical training, following a proposal by the United Nations Educational, Scientific and Cultural Organization[18], which illustrates an evolving process.

The general objective of this study is to analyze the perception of psychiatrists working in Brazil about the use of AD in their professional activity and their real applicability and probable consequences. Its specific objective is to analyze the themes that arise during the process of the research itself. This study aims to further the findings previously described/presented to the academic-scientific community[8] with the aim of understanding how psychiatrists think and feel about the use of AD in their practices. The chosen method was qualitative, based on content analysis, according to Bardin[19].

## Method

This study is part of a more extensive project on AD in psychiatry in Brazil. Its intention is to further the results obtained in Domingues and collaborators[8] via a qualitative analysis of the collected data[19]. To answer the general objective, two open questions were applied, formulated at the end of a questionnaire about AD[8], namely: 1) do you believe that AD value patients' autonomy? and 2) do you believe that AD will bring what influences in your work with patients? With the answers, the specific objectives and their respective analysis were carried out according to the collected material.

The estimated population included 212 psychiatrists from the list of professionals of the Brazilian Association of Psychiatry (which is available to the public). There were 40 interviews in the convenience sample of this study.

The analysis of the demographic data can be found in a published article[8]. The analysis of the open questions followed a qualitative method, namely content analysis[19]. The interviews, as required by the Research Ethics Committee (CEP), had to be face-to-face, which is why this research was restricted to the municipality of Rio de Janeiro.

The two researchers practiced the presentation of Resolution 1,995/2012[4] and of advance directives and the reading of the free and informed consent form among themselves to obtain an estimate of the minimum time to be invested by each physician throughout the interview[8].

Contact attempts were made by phone. Professionals who neither answered such calls nor accepted to participate were excluded. The location of the interview was defined according to the availability of each research participant[8]. At the beginning of each interview, the informed consent form was read. Once the existence of doubt was verified, it was clarified and the term was then signed, with one copy filed by the researchers and the other delivered to the participant. Resolution 1,995/2012[4], which provides for AD, was read, with the explanation that the questions would be linked to that document.

The open questions were presented after the clarifications and after the answers to the sociodemographic questionnaire and the questionnaire on AD had been validated [8]. The content of the answers to the open questions was free, according to the understanding of each participant, and the researchers avoided any intervention. The interviews were transcribed by the researchers to prevent any possibility of identifying the physicians.

After the third month of 2020, the methodology became unfeasible due to the COVID-19 pandemic, and the research was halted for four months. After this period, CEP granted permission for adaptations in the methodology. This research was mainly done remotely, and the sending of the material took place electronically. Much was lost with this change; the loss in terms of participant withdrawal is evident [8]. The interruption of data collection was, therefore, due to exhaustion of sources [20].

## Results

The answers to questions 1 and 2 were arranged in two main groups, one with a valued theme and the other with ambivalent or rejected theme. The participants are symbolized by the letter R followed by a corresponding number in the order of application of the questions.

### *Answers to question 1*

**Table 1.** Group A: valued theme

| Heading or category* | Component** | Examples*** | Frequency**** | |
|---|---|---|---|---|
| | | | Absolute | Relative |
| Fair | R1 | *"Artificially maintaining life would not be fair"* | 1 | 2.5% |
| Yes | R2<br>R6<br>R7<br>R8<br>R9<br>R10<br>R11<br>R12<br>R13<br>R15<br>R18<br>R19<br>R20<br>R21<br>R22<br>R23<br>R24<br>R26<br>R27<br>R28<br>R29<br>R31<br>R32<br>R33<br>R34<br>R35<br>R36<br>R37<br>R38<br>R40 | *"Yes (...) respect autonomy"*<br>*"Yes (...) step forward"*<br>*"Yes (...) fit for the acts of life"*<br>*"Yes"*<br>*"Yes (...) choose how to close"*<br>*"Yes"*<br>*"Yes, I believe in it"*<br>*"Yes (...) capacity"*<br>*"It is made for that"*<br>*"Yes"*<br>*"Yes"*<br>*"I think so"*<br>*"Yes"*<br>*"Yes, organize their ideas"*<br>*"Yes, main guide"*<br>*"Yes, when one realizes it"*<br>*"Yes, Latin affectivity"*<br>*"Yes (...) unprotected physician..."*<br>*"Yes"*<br>*"Yes, to have autonomy"*<br>*"Yes, little knowledge"*<br>*"Yes, it gives the patient a voice"*<br>*"Yes (...) exercise their will"*<br>*"Yes, super important"*<br>*"Yes (...) I thought the idea was fantastic"*<br>*"Yes (...) it would help the family"*<br>*"Yes (...) on their own obviously"*<br>*"Yes (...) more tolerable"*<br>*"Yes. They exist for that"*<br>*"Yes (...) right that should exist"* | 30 | 75.0% |

continues...

**Table 1.** Continuation

| Heading or category* | Component** | Examples*** | Frequency**** | |
|---|---|---|---|---|
| | | | Absolute | Relative |
| Autonomy | R3 | *"Protecting the autonomy of the patient and physicians"* | 1 | 2.5% |
| I believe so | R16<br>R25<br>R30 | *"I believe so..."*<br>*"I believe in it. An important step"*<br>*"I believe it is (...) important"* | 3 | 7.5% |

**: addressed topic; **: people who answered the questions; ***examples of answers; ****number of responses in absolute and relative terms within the universe of 40 respondents*

Group B and its ambivalent or rejected theme will be described textually. Its first category was "autonomy," mentioned by R4, who pointed out that "*it revolves around critical capacity*," absolute frequency was 1 and relative frequency 2.5%; the second category was "yes," mentioned by R5, who stated "*Yes (...) questionable, especially in psychiatric patients*," absolute frequency was 1 and relative frequency 2.5%; the third category was "partially," mentioned by R14, absolute frequency was 1 and relative frequency 2.5%; the fourth category was "family," mentioned by R17, who brought up the question "*Prepare the family*," absolute frequency was 1 and relative frequency 2.5%; and the fifth and last category of this group was "*no*," mentioned by R39, who justified "*they suffer*," absolute frequency was 1 and relative frequency 2.5%.

## *Answers to question 2*

**Table 2.** Group A: valued theme

| Heading or category* | Component** | Examples*** | Frequency**** | |
|---|---|---|---|---|
| | | | Absolute | Relative |
| Dignity | R1 | *"Dying with dignity"* | 1 | 2.5% |
| Autonomy | R2<br>R11<br>R13<br>R15<br>R31 | *"They are free"*<br>*"It strengthens their autonomy"* *"Legal provision reduces clashes"*<br>*"It makes it a lot easier"* *"Desires"*<br>*"Respect the interest of the other"*<br>*"Autonomy"* *"They have a voice"* | 5 | 12.5% |

continues...

**Table 2.** Continuation

| Heading or category* | Component** | Examples*** | Frequency**** | |
|---|---|---|---|---|
| | | | Absolute | Relative |
| Clarifications | R3 | *"Reduces the degree of uncertainty"* | 11 | 27.5% |
| | R6 | *"People are unaware of AD"*<br>*"Knowledge of AD can ease grief"* | | |
| | R7 | *"I'm already guided by them"* | | |
| | R8 | *"It will improve guidelines"* | | |
| | R14 | *"I've already thought about it"* | | |
| | R15 | *"Respect the interest of the other"* | | |
| | R18 | *"In the title of the thesis, they realized its applicability"* | | |
| | R25 | *"Ideally, the person should disclose the AD to all their close family members"* | | |
| | R30 | *"People hardly have this culture"*<br>*"Giving clarity"* | | |
| | R36 | *"I feel it is my duty to bring this information"* | | |
| | R40 | *"My job is to ensure that people's rights are respected"*<br>*"Positive influence"* | | |
| Conflicts | R35 | *"Denial process"*<br>*"An agenda to really discuss it before a terminal process"* | 2 | 5.0% |
| | R38 | *"Very religious family"*<br>*"Prolonging life for a long time"*<br>*"Uselessly prolonging suffering"* | | |
| Collaboration | R9 | *"To get out of the paternalistic posture that is culturally demanded"*<br>*"Patients for a collaborative posture"* | 5 | 12.5% |
| | R20 | *"It helps to think about health and death"* | | |
| | R32 | *"It brings us even closer to our patients"* | | |
| | R33 | *"It will bring a greater relationship of trust"* | | |
| | R34 | *"It will make it easier to work on finitude"* | | |
| Limitation | R10 | *"More influence on hospitals that work with terminally ill patients"* | 1 | 2.5% |
| Capacity | R12 | *"They will help"*<br>*"Moments of patient incapacity"* | 2 | 5.0% |
| | R23 | *"As long as the person is lucid it would make a big difference"* | | |
| Validity | R16 | *"Directives are valid"* | 1 | 2.5% |
| Positive | R17 | *"It will have a positive influence"* | 3 | 7.5% |
| | R22 | *"It makes the medical decision less painful"* | | |
| | R37 | *"If they did this for me, I would like it and I would appreciate it"* | | |
| Legislation | R3 | *"Reduces the degree of uncertainty"* | 3 | 7.5% |
| | R11 | *"It strengthens their autonomy"*<br>*"Legal provision reduces clashes"* | | |
| | R13 | *"It makes it a lot easier"*<br>*"Desires"* | | |

**: addressed topic; **: people who answered the questions; ***examples of answers; ****number of responses in absolute and relative terms within the universe of 40 respondents (R3, R11, R13, and R15 are in more than one heading)*

**Table 3.** Group B: ambivalent or rejected theme

| Heading or category* | Component** | Examples*** | Frequency**** | |
|---|---|---|---|---|
| | | | Absolute | Relative |
| Autonomy | R28 | *"Patients have no autonomy"*<br>*"Threatening patients"* | 1 | 2.5% |
| Clarifications | R21 | *"Patients complained of lack of information"* | 1 | 2.5% |
| Conflicts | R5 | *"Conflicts"*<br>*"They are not in a position to decide"* | 1 | 2.5% |
| Limitation | R19 | *"I don't work with terminally ill patients"* | 5 | 12.5% |
| | R24 | *"In the lucid interval it may be time to prepare the AD"*<br>*"A family can have economic and financial interests"* | | |
| | R26 | *"It is important, but it lacks detail and modernization in addition to serious registration"* | | |
| | R29 | *"Maybe in dementia"* | | |
| | R39 | *"There will end up being laws that prevent physicians from using extraordinary resources"* | | |
| Capacity | R4 | *"Critical capacity"*<br>*"Alteration"* | 2 | 5.0% |
| | R5 | *"Conflicts"*<br>*"They are not in a position to decide"* | | |
| Legislation | R27 | *"There is no legislation that definitively clarifies the issue"* | 1 | 2.5% |

**: addressed topic; **: people who answered the questions; ***examples of answers; ****number of responses in absolute and relative terms within the universe of 40 interviewees (R5 is found in more than one heading, namely, conflicts and capacity)*

## Discussion

After the reading and overall appreciation of the obtained material, we began to search for the meaning that would give an answer or answers to the objective by thematic enumeration, its contextualization and analysis. According to Marshall, "*the aims of the qualitative approach, where improved understanding of complex human issues is more important than generalizability of results*" [21]; AD encompass complex human issues, and, according to the same author, the ideal size of a qualitative sample is the one that can answer the asked questions, that is, the search for answers is our main objective.

To understand the collected material with the aim of answering the raised questions, suggestions were found in Minayo [22]: quantitative research and qualitative research complement each other to the extent that the former seeks the size of the phenomenon and the latter, how intense the phenomenon is; the search for the type of population that should be directly involved with the investigated phenomenon (a characteristic found in the activity of psychiatrists) fulfill the criteria of this research.

Searching for a result or results is important for researchers, although it is known that the idea of provisionality in this search is fundamental [23] and that its main criterion is not numerical in the case of qualitative research, referring to the meeting of the internal logic of its object of study [22]. According to content analysis, the option revolved around thematic analysis because, according to Minayo [23], it is more appropriate to issues related to qualitative research in health. Since the AD are linked to health care, this was the option, so the search followed Minayo's [23] and Bardin's [19] guidelines to maintain the validity of the process and follow the rules that must comply with the categories of communication fragmentation whenever possible: it must be homogeneous, exhaustive, exclusive, objective, and appropriate or pertinent [19].

According to Bardin, *theme is the unit of meaning that is naturally freed from a text analyzed according to criteria related to the theory that serves as a guide to the reading* [19]. For this reason, context units were prioritized over coding units, which are usually used in content analysis in view of the ambivalent meanings found in the obtained material [19].

In the answers to the first question (Group A), it was very evident how much the participants consider that AD value the autonomy of patients since 35 were in favor of their use and four were ambivalent, with R4 and R12 bringing the importance of the ability to understand and determine to validate AD [12]; only one participant was unfavorable, emphasizing the compassionate aspect, considering that the ability to evaluate the situation would be impaired in the sufferer. Thus, a clear trend toward support and acceptance of AD was observed, considering the total number of participants, predominantly in favor of the use of AD.

Regarding the second question, in R1, there is the meaning of dying with dignity, which refers to a relevant item in the relationships in health care: *human dignity—of all human persons—must be considered as the foundation of ethics in a plural and secular society* [24], being highlighted by a participant as important. In the next heading, “autonomy,” five participants brought the theme (R2, R11, R13, R15, and R31), three of whom were included in more than one heading. R31 says, referring to patients, “*They have a voice*,” an important observation as the resolution [4] “considers” strengthening patients’ autonomy. It is then considered a positive result [7].

The theme “clarifications” was the most mentioned by participants, confirming the findings of the literature regarding the need for dissemination and clarification both among professionals and the general population [7,11,13,16]. Conflicts with a positive meaning in the context units mean the tendency to help, whether in R35 or R38, to find a solution that privileges patients’ desires.

In the item “collaboration,” the cultural demand for medical paternalism [11] is put on the agenda in R9, as is the position of the professional who, in reality, wants a collaborative posture, replacing paternalism, mentioned as a burden. In R20 and R34, the aspect of facilitating the approach to the sensitive theme of finitude [1] appears as somewhat a social taboo removed from everyone’s experience [1]. Valorization, in R32 and R33, mainly involves the approximation and improvement of the doctor-patient relationship, mentioned as fundamental in some authors [13].

In the “limitation” theme, although with a positive aspect of use, R10 limits the scope of AD to hospitals that work with patients in the terminal phase of illness, and no other use has been identified. The question of capacity, in R12 and R23, is posed with the meaning of “capacity for understanding and determination” and is brought up by its importance for AD to be considered valid [12]. R16 also evaluates AD as valid, in the sense of positivity; R17, R22, and R37 use the term “positive;” and R22 emphasizes: “*It makes the medical decision less painful*.” The influence on the doctor-patient relationship is taken as a positive, a facilitator. The theme “legislation,” as expected, appears in more than one heading because it permeates medical and legal relations in the issue of the validity of AD in R3, R11 and R13.

In the answers to the second question, in the ambivalent or rejected themes (Group B), there is a smaller number of participants: only 11 out of 40. In “autonomy,” participant R28 states that patients are threatening and have no autonomy, highlighting the period in which criticism is lost [11,13]. In the theme “clarifications,” R21 mentions the absence of information for patients, which makes it impossible to prepare AD [11]. In a sense, it reinforces the finding in “clarifications” of group A, but here in the sense of making the use of AD unfeasible without valuing the possibility of dissemination actions.

In “conflicts,” R5 highlights the period of absence of understanding and determination, associated with conflicts with family members, which, for R24, in addition to conflicts due to the loss of critical capacity, are worsened by the family’s attitude, which is always partial. R24 values the use of the lucid interval [11,13].

In the “limitations” theme, R19 sees the use of AD only for patients in the terminal phase of the disease, not bringing other possibilities of use, as well as R29. Still in “limitations,” R26 brings the lack of detail and modernization in the resolution [4], whereas R39 sees a stronger limitation, even referring to "*laws that prevent physicians from using extraordinary resources*." In this item, several situations of conflict with family members, professionals, or patients are listed. The item "loss of the capacity for understanding and determination" returns specifically in R4 and R5 given its importance for the validity of AD. Periods of critical loss are placed as persistent.

Under the heading "legislation," R27 states that "*There is no legislation that definitively clarifies the issue*." Much has been written about this gap[25]; and the disclosure may generate pressure and a propitious moment for the creation of a bill that remedies part of the difficulties in applying AD. This aspect, here, is not considered as a possible result of studies and publications.

Convenience samples bring the limitation inherent to their characteristic. In principle, their results are not generalizable but concern professionals who may be closely linked in their activities to the theme of this research.

## Final considerations

Regarding the first question, it is possible to state that the AD fulfill the proposed objective of valuing the autonomy of patients in the studied population, being, in principle, widely accepted by the physicians in the sample. Those who were ambivalent mentioned themes that were also brought up in the answers to the second question but with a sense of greater impossibility since R39 sees suffering as totally disabling.

Regarding the answers to the second question, in Group A, the question of clarification is the most valued, including psychiatrists, patients, and family members, according to the obtained answers. Dissemination to the population would be an important facilitator. Among physicians, compliance with the recommendations of the Ministry of Education, the new National Curriculum Guidelines[18], will bring progressive clarification and dissemination with the following acquisition of knowledge of themes related to bioethics in medical courses, such as AD. It would be interesting if other healthcare providers could also benefit from such guidance.

Soon after, in the answers to the second question, autonomy is seen as an important attribute and, along with it, the possibility of collaboration in the doctor-patient relationship, which can make decision-making less difficult for all the involved people—an encouragement. AD are perceived as positive; and the resolution is, so far, one of the supports in terms of ethical and deontological guidance as something specific is non-existent in the country. Valuing periods of capacity and taking advantage of them are understood as a solution, and AD are seen as a possibility for better resolution of conflicts between patients, physicians, and family members.

Dignity emerges as a pillar of bioethics; and the possibility of dying with dignity, one of the objectives of AD, is valued here. Regarding the question of validity, the vision seems to correspond to the importance for life and for the end-of-life choices one desires. In Group B, the item considered most relevant (with five participants out of 40) is "limitations," and the mentioned problems are similar to those in Group A, but with less flexibility for the possibility of using AD.

The next item was the issue of "capacity," with R4 being more flexible than R5, who even appears in two headings. The situation is considered almost unfeasible in psychiatric patients without considering the periods between crises and other possible solutions. The other headings were "autonomy," "clarifications," "conflicts," and "legislation," with one participant for each of the 40 items. It is interesting to note that no themes appear here other than those already mentioned in the valued themes.

In an era in which there is still no specific law in Brazil for the use of AD, their dissemination to healthcare providers and society in general takes great relevance as it enables greater adherence to them, as well as the perception of death as a fundamental fact for the valorization of life as an ephemeral good to be experienced responsibly in its fullness while available. It is suggested that more studies be carried out as they may would bring further evidence of the difficulties in the use of AD and its applicability, with the subsequent search for solutions to provide a life well lived until its end.

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**Contribution of the authors**

Vania Novelli Domingues participated in the conception of the study, elaboration of the method, data collection and analysis and writing of the manuscript. Mônica Monteiro participated in the elaboration of the method, data collection and analysis and writing of the manuscript. Anderson de Almeida Rocha participated in the analysis and interpretation of the results and critical review of the content. Daniel Domingues Monteiro participated in data analysis, analysis and interpretation of results and critical review of the content. Natalia Oliva Teles participated in the analysis and interpretation of the results and critical review of the content. Francisca Rego participated in the analysis and interpretation of the results, and critical review of the content. Guilhermina Rego participated in the analysis and interpretation of the results and critical review of the content. All authors participated in the approval of the final version and have responsibility for the integrity of the content.

**Data availability:** The data are available upon request to the corresponding author due to ethical restrictions.

**Editor in charge:** Dilza Teresinha Ambrós Ribeiro

**Received:** 6.11.2025
**Revised:** 10.22.2025
**Approved:** 11.11.2025