Legal repercussions of the Resolution CFM 1.995/12

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Abstract

This research article aims to verify the juridical consequences of Resolution 1.995/12 of the Conselho Federal de Medicina (Federal Council of Medicine). In order to understand the institute, an analysis of advance directives in the world is done, later, analyze how this resolution reflects in the legal world, concluding, by the necessity to legislate about the theme in Brazil.

Key words: Advance directives. Legislation as a topic. Regulations.

Resumo

Reflexos jurídicos da Resolução CFM 1.995/12

O presente artigo de pesquisa tem como objetivo verificar os reflexos jurídicos da Resolução 1.995/12 do Conselho Federal de Medicina. Para tanto, faz uma análise das diretivas antecipadas no mundo, intentando entender o instituto e, posteriormente, analisar como esta resolução reflete na área jurídica, concluindo, por fim, pela necessidade de legislação específica sobre o tema no Brasil.

Palavras-chave: Diretivas antecipadas. Legislação como assunto. Regulamentos.

Resumen

Reflejos jurídicos de la Resolución CFM 1.995/12

Este artículo de investigación tiene por objeto comprobar las consecuencias jurídicas de la Resolución 1.995/12 del Conselho Federal de Medicina (Consejo Federal de Medicina). Para tanto, hace un análisis de las instrucciones previas en el mundo, con el fin de comprender el instituto y, más adelante, analizar cómo esta resolución refleja en el ámbito jurídico, concluyendo, por fin, por la necesidad de una legislación específica acerca del tema en Brasil.

Palabras-chave: Directivas anticipadas. Legislación como asunto. Reglamentos.

Research article

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This article proceeds from research realized by a literature review on regulation of advance directives in countries that have already legislated on such institute, and as legal literature and specific boethic about subjects related to the advance directives like capacity, suspension of nutrition and hydration, and formalization of wish´s manifestation.

Traditionally, the advance directives (advanced care documents) have been understood as genre from which species the *living will* are and the durable power attorney. Both documents will be used when the patient could not express himself in a free and conscious manner - even by a transitory situation -, in other words, the advance directives as genre do not refer exclusively to terminality situations. While the living will refers to instructions on the future medical care of a person who might be unable of expressing his will front a life terminality diagnosis, the durable power attorney refers to a simple nomination of a third person to take decisions when the patient is unable - permanent or temporarily - to manifest his wish[1].

The advance directives are based on the principles of autonomy, respect to people and loyalty and as benefit they improve doctor-patient relationship, and the patient's self-esteem. It also helps to reduce the feelings of guilt and indecision within relatives[2].

The durable power attorney is a document on which the patient nominates one or more attorneys who must be consulted by physicians in case of temporary or definitive inability to take decisions related to the treatment or proceeding, when there is no previous will manifestation or, if there are, if any gaps could prevent the full comprehension by who handles the patient. It is important to notice that the healthcare attorney will decide based on patient´s wish[1].

According to the autonomy models suggested by Beuchamp and Childress[3] it is possible to infer that the durable power attorney is suitable on the substituted judgment model, in which is necessary that the intimacy of the subtitled decision-maker with the patient has to be deep and relevant enough for that the patient's purpose and opinions are reflected on the judgment. In contrast, the living will is a document in *which an able person can indicate his will to stop applying a treatment in case of a terminal disease*[4]. This document suits a model named by Beuchamp and Childress[5] as pure autonomy since it is expressed the will´s manifestation of the patient while the person is able to do it.

The coexistence of the durable power attorney and the living will in the same document is possible and efficient for the patient but the applicability of the durable power attorney does not restrict to end-of-life situations. It would be interesting for the attorney to make a living will containing the nomination of an attorney and concurrently a durable power nominating the same attorney – to evitate conflicts within the documents - for him to be able to act in situations that do not include terminality.

Global context

At the 60s, the advance directives emerged in USA. In fact, firstly the specie most used, the living will, proposed for the first time in 1967 by American Society for Euthanasia *as an anticipated care through which a person could register his wish choose to stop medical interventions of life-affirming* [6].

In 1969, the lawyer Louis Kutner proposed a living will model of the terminal patient that according to Urionabarrenetxea[7] it was used as a solution of conflicts between physicians, end-of-life patients and their families about the decision on what the treatments terminal patients should have been submitted to. In 1976, California State approved the Natural Deah Act created by Yale Law School. It is a law which has become the first legal certificate to textuality recognize the living will.

After approval of the Californian law, many other North American States also approved laws regulating the living will, but in the Nancy Cruzan´s case whose parents decided to remove the devices that kept her alive because she was in permanent and irreversible vegetative state after she got into a car accident, alleging she had manifested once, when she talked to a friend before the accident she would not want to keep herself alive in case she had less than a half of her normal capabilities was decisive to create a law about this subject. This case reached Supreme Court in 1990, and upheld the request ordering the hospital to fulfill the wish of the patient´s family. In 1991 with a strong publish clamor, it was approved the Patient Self-Determination Act (PSDA)[8], the first federal law to recognize the right to self-determination of the patient and the right of the patient to make an advance directive in its two modalities: living will and durable power.

Actually, the state legislation has already made a clear the confusion between the two species and such fact has contributed to this imbroglio to prevail until nowadays – and it will be debated in this ar-

ticle. Spain was the first European country to legalize the advance directives, in 2002 decreed the law number 41[9]. Nevertheless the spanish legislation contested the american terminology "advance directives" because it was considered by them out of bioethic´s world and the sanitary law, thus in Spain this institute is termed *instrucciones previas*.

Despite the Spanish legislation has been decreed more than ten years after the American legislation, the debates in that country has started in 1986 with a *Associación Pro Derecho a Morir Dignamente* and in the same year developed a living will model, but the first spanish province to legislate the topic was Catalan, in its law 21/00[10], in December 19th, Article 8º. After this publication, autonomous community as Galicia, Extremadura, Madrid, Aragón, La Rioja, Navarra e Cantabria also regulated the theme[11-17]. Following this tendency, Spain approved the law in *intrucciones previas in* 2002.

In general, the advance directives in Spain must contain guidance to the medical team about the wish of not extending life artificially; not using extraordinary treatment;, the suspension of the therapeutic effort and, among others, the use of medicines to reduce de pain. The law 41/02[9] allows that in the advance directives´ document grantor appoints a representative for cases when the person is unable of expressing his wish, and this third would be able to on behalf of the document subscriber. In other words, the Spanish law presents a real advance directive, with the possibility to contain in one document the living will and the durable power of attorney.

In February 2nd, 2007, it was published a Royal Decree 124/07[18] , instrument which regulates the point 5 of this article, since it creates the National Register of *Instrucciones Previas* and the correspondent automated file of personal data. According to the decree, the access to this National Registration is restrict to the people who made the advance directives to the legal representatives of these people or who the grantor has designated in the document, the responsable people to autonomous registers and the people designated by sanitary authorities of autonomous community or by the Ministry of Health.

The discussion in Portugal has started in 2006, with a law project from the Portuguese Association of Bioethics, but only in July 2012 the law which regulates the advance directives of wish [19] was created, with some amendments from the original text. This law contains a clear terminology confusion, due to equals the living will to the advance directives and treats the durable power attorney named *procurador para cuidados em saúde*, as another legal institute - but it predicts the creation of a nacional register meaning a wide advance on the operation of this institute.

In Argentina the first legislation related to advance directives was the Law 4.263 from province of Rio Negro, promulgated in December 19th, 2007. In 2009, was created the federal law 26.529 [20] for the right of the patient, which in article 11 recognizes their right about stating their wishes through advance directives, however this law does not bring large details about the theme.

Resolution CFM 1.995/12

On August 31st, 2012, the Federal Council of Medicine (CFM) approved the resolution 1.995[21], disposing of will advance directives. This is the first regulation on the subject in the country which the CFM proceeds the tradition of positioning itself about bioethics themes before the Legislative Power. In a technical compliance to the historicity of the institute, CFM chose to recognize in the same document the living will and the durable power of attorney, a fact not understood by Brazilian press that has often referred to the approval of living will by the council.

It is interesting to notice that the resolution refers to the terminal patient and its exposure of reasons to the end-of-life patients. However these two expressions are not synonyms and can generate conflicts in the advance directives' application. It is because a terminal patient is who has an irreversible condition, independent of being treated or not, and also who presents a high possibility to die in a short period of time [22]. The end-of-life patients could be understood as the terminal ones and also that ones who are in an irreversible and deep coma or persistent vegetative state.

As expressed in a clarifying note by CFM, the Resolution 1.995 respects the patients´ wish as the orthotanasia´s concept and does not relate itself with euthanasia´s practice. Actually this clarification just reaffirmed the main concept of advance directives: it cannot include contradict statements towards the legal system proposed in the country. The euthanasia is forbidden in Brazil and the orthotanasia is allowed according to the judicial in the judgment of civil and public action 2.007.34.00.014809-3[23]. Logically, the resolution accepts this determination. The resolution effectively recognized the right of the patient to refuse useless treatments, also known as

extraordinary treatments, which are understood as *treatments that do not offer a real benefit to the patient, because death is inevitable*[3]. In other words, they are those treatments that will just extend the biological life of the patient, without a guarantee of life quality.

Legal Practice Implication

The effects of Resolution Law CFM 1.995/12 are questionable. Firstly it is necessary to highlight that this resolution as the others from CFM, has a power of law within the medical class, meaning that if advance directives are not legalized in Brazil, it is necessary to recognize it as wide theme to debate in the country. Just over one year ago these debates were incipient, there were only scientific articles in bioethics journals that would discuss the theme in a broad manner[24-27] and a specific book relationed with the topic[28]. The information of registers about advance directives in the Brazilian registry offices was not extensive, but this number has grown exponetially [29].

It is nowadays made necessary to regulate the advance directives because CFM does not have legal competence to regulate important and necessary points, presented below.

Who can make advance directives?

The press released that only people over 18 years old or the emancipated ones could appeal to the advance directives; however it is possible that a specific legislation could establish that incapable ones (over 16 years old) might make it as well.

The important issue in advance directives is the discernment of the grantor because capacity is genre of which are species the capacity of right and the capacity itself. The first refers to the acquisition of rights and obligations; the second to the practice of them, considering that the capacity of right is inherent to the human being, according to Civil Code art 1º 2002[30], and the capacity itself depends on discernment. Thus the incapacity scheme was designed as a system that protects the ones who do not have enough discernment to make or express a valid wish[31].

In legal situations which involve doctors and patients, capacity is not always a synonym of discernment because it is possible that a patient is civilly able to, but the doctor detects that the patient is using medicines that could affect their mental faculty or that the disease is affecting their possibility of making autonomous choices. What has been questioned then is the patient's capacity of making a decision and understand the information provided by the doctor, not the capacity described in the Civil Code of 2002 [30].

Thus is essential the capacity understood as discernment is an essential requirement to validate the rendered consent. However the civil capacity is mere formality, not so important to confer the rendered consent informed by the patient because it should be checked if in the manifestation period of the patient´s consent the person had his cognitive functions and not only if he would fit the concept of a person civilly able. It means that the main limits of fixing age used by the Civil Code should be softened, since *the declaration of incapacity can not, in a supposition manner, to compromise completely the private autonomy confered by legal system to the human being, even if a infirmity, physical or mental disability affects his discernment*[31]. Therefore in case of an under age be willing to elaborate an advance directive, he should first require a judicial authorization, and it would only be denied if it is proved a lack of discernment for this act.

Specification of the treatments that can be accepted or not

The mere information that a patient can refuse to an extraordinary treatment is not satisfactory under the institute's practicality. There is controversy points about the classification of some treatments or procedures as palliative care or extraordinary treatments, specifically the suspension of hydration and nutrition.

There are four points that orientate the palliative cares. The first point is the therapeutic proportionality, in that there is a moral obligation of implementing all the therapeutic measures in proportion to the environments applied and a predictable result; the second point is the double effect, verifying the proportional reason between double effect treatments; the third point is the prevention that should predict possible complications and symptoms that are often presented to carriers of a determined disease; the fourth and last point, is about not abandoning and the treatment of the pain, since the physician cannot abandon a patient, except in consciousness objection cases and must control the pain.

Thereby, any treatment or procedure which are not be oriented by these principles could be consider extraordinary and therefore liable to be

refused by the patient even the hydratation and nutrition, since it has occurred in many studies [32,33], in extreme cases the patient´s organism do not absorb nutrients anymore and the nutrition and hydratation can even cause a discomfort. It is imperative that the new CFM ´s resolution or even the federal legislation clarify this situation.

Comparative law presents in the content of advance directives it has been accepted the disposal about organ donations. In Brazil, however, it is already regulated by the law 9.437/97[34] and updated by the law 10.211/01 [31] and for the donations to be realized, this law needs to be followed through. One of the paragraphs, the authorization of a partner or relative of majority age is valid if the line of succession is respected. This would not be acceptable in the advance directives since it expresses the autonomous wish of the patient.

Obligation of a registry in public register and the creation of a National Registry

CFM as a body organ does not have competence to determinate the advance directives to be obligatory registered in a public register. However this formality is imperative to guarantee to the declarant their wish to be made. In other words, the term of the public scripture of the advanced directives ensures legal certainty.

The creation of a National Register of Advance Directives is also recommended to enable a higher effectiveness in the fulfillment of the patient´s wish in such a way that there is no risk of the declaration to become innocuous. Considering these formal dispositions, the register office should refer the advance directives to the National Register in a short-term, to ensure its effectiveness. This procedure will follow the recommendations of Testaments Register Center from the Brazilian Notorial College in Brazil, São Paulo´s section in the provision CG 6/94 (Annex G) [36], with the main objective of implanting a single register of testaments in São Paulo, a model which had been extended for other Brazilian states as Minas Gerais, where the single one register is in a fase of implantation.

Accompaniment of a doctor during the procedure of the advance directives

The CFM´s resolution 1.995/12 establishes in its second paragraph of articles II that *the doctor will register in the medical charts the advance directives that were directly communicated by the patient*[21]. In other words the CFM regulated that the doctor´s role is to register in the medical chart the patient´s wish, and only that.

However the professional´s role goes beyond the patient´s wish. His function is not only to transcribe the advance directives but, as a technical, to assist the declarer about the treatments and procedures which may or may not be refused. So it is essential the orientation of a declarant's family´s doctor for the realization of the advance directives. This orientation guarantees that the content of the advance directives really expresses a real wish of the patient, as the rules on the Medical Ethics Code. Finally the doctor´s posture must be active for the advance direction´s realization.

Final considerations

The CFM resolution 1.995/12 certainly represents a large progress in the debates related to advance directives in Brazil. Thus this progress occurs in a punctual perspective, being into the medical scope and other health scholar professionals of the theme. It is necessary to understand that the resolution does not drain the theme, but the opposite, it expresses the need of a specific legislation on advance directives that would regulate questions about the grantor´s discernment, to an example of treatments and cares which can or can not be refused, to the norms for acceptance or refuse of them, to the register of advance directives and to the extension of the physician's participation in a directive ´s realization.

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