

# European Journal of Health Law

## To Act or Not to Act, That is the Question: Informed Consent in a Criminal Perspective --Manuscript Draft--

<b>Manuscript Number:</b>	EJHL109R1
<b>Full Title:</b>	To Act or Not to Act, That is the Question: Informed Consent in a Criminal Perspective
<b>Article Type:</b>	Article
<b>Keywords:</b>	informed consent, advance directive, euthanasia, dysthanasia
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## **To Act or Not to Act, That is the Question: Informed Consent in a Criminal Perspective**

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### **Abstract:**

Some years ago the doctor was seen as the one who “knows better”, and was absolutely unconceivable that the patient could refuse the suggested treatment or even ask any question about it. Differently, nowadays doctors are demanded to keep their patients informed and can even be sued when they act without the patient knowledge and consent.

On the patient’s side this new paradigm does not necessarily legitimate euthanasia - still criminally forbidden in most parts of the world – but allows some kind of personal power over body, health and life, materialized in advance directives. On the doctor’s side it entails a change in the list of good medical practices, imposing the doctrine of informed consent and the prohibition of dysthanasia.

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## 1. Introduction

Litigation surrounding the medical profession increased dangerously and the relevance of the patient's autonomy has become the *punctum crucis* of medical malpractice. Therefore, currently, the discussion about informed consent is indispensable to medical lawyers and health professionals.

In fact, patient's consent has become a keystone of medical acts in the Portuguese legal order. It is required in almost every legal text concerning the medical activity, as for instance on the law that provides the basic principles for health care (principle IV of law n. 48/90, from 24 August), on the Deontological Code of the Medical Association (Articles 44 and following) and on numerous laws regarding specific medical acts, such as the law on medically assisted reproduction (Article 14, n. 2 of law n. 32/2006, from 26 July), the law on clinical trials (Article 2/o of law n. 46/2004, from 19 August), or the law on voluntary sterilization (Article 10, n. 1, of law n. 3/84, from 24 March), just to name a few.

However, in concrete situations of everyday life it is not always clear if information was correctly given or provided by the person legally bound to do so. Some doubts also arise regarding the manifestation of consent, namely, if that particular expression of consent is juridically relevant in order to exclude the doctor's criminal responsibility.

The present discussion becomes more complex when concatenated with refusals to blood transfusions by Jehovah's Witnesses; requests for euthanasia presented by patients submitted to severe pain and to whom medicine is still unable to provide a cure, not even an improvement in their health conditions; and unconscious patients showing up in the emergency room with living wills and health care proxies.

## 2. Interventions Without the Patient's Consent (Article 156 of the Criminal Code)

The Portuguese Criminal Code expressly demands that every medical act must be performed with the patient's consent (Article 156), furthermore, with enlightened consent (Article 157 of the Criminal Code).

Hence, if the doctor acts without the proper consent he will be committing a criminal offence, denominated arbitrary medical interventions, sanctioned with up to 3 years imprisonment or a fine.<sup>1</sup> By virtue of Article 157 the referred consent presupposes a previous clarification about the diagnosis and nature of the person's health, scope, scale and possible consequences of the intended intervention.

The legal interest protected by this criminal law norm is neither human life nor physical integrity, but self-determination on issues related to body and health. Medical interventions performed without the patient's consent embody a violation of his liberty and dignity,<sup>2</sup> even if the medical act was intended to prevent the patient's death.

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<sup>1</sup> About this norm, Manuel da Costa Andrade, "Art. 156.º", in: Jorge de Figueiredo Dias (ed.) *Comentário Conimbricense do Código Penal, Parte Especial, Tomo I* (Coimbra: Coimbra Editora, 1999) pp. 393-395; Paulo Pinto de Albuquerque, *Comentário do Código Penal - À Luz da Constituição da República e da Convenção Europeia dos Direitos do Homem* (Lisboa: Universidade Católica Editora, 2008), pp. 421-422.

<sup>2</sup> ERS, Entidade Reguladora da Saúde, 2009. "Consentimento Informado (Relatório Final)." ERS, Entidade Reguladora da Saúde, May 2009. Retrieved 15 March 2010, <http://www.ers.pt/3590BDB6-5EFE-4B47-B05F-2B5CD0E1095E/FinalDownload/DownloadId-1048468E9FF63ABE047053CBEB23A30/3590BDB6-5EFE-4B47-B05F-2B5CD0E1095E/actividades/pareceres-e-recomendacoes/Estudo-CI.pdf>; Guilherme de Oliveira, André

If, besides the absence of consent, the patient suffered an injury on his body or health the crime committed will not be this one, but corporal injuries (as long as the medical act involved a violation of *leges artis*). If in a particular case the doctor acted without the required consent, and, in addition, damaged the patient's body or health, only this last occurrence will be punished, as if it had consumed the first one, since Article 156 of the Criminal Code is only called into question when the damage is confined to the violation of the patient's autonomy (decision of the Lisbon Court of Appeal, from 18 December 2007).

### **2.1.Presumed Consent**

When the patient is unable to provide the required consent the doctor must apply for presumed consent, foreseen in number 2 of Article 156 of the Criminal Code.

According to this norm, the doctor is allowed to perform the intervention provided that he respects the will presumably manifested by the patient if he were able to do so. Consequently, he is not demanded to act in view of the best interest of the patient from an objective perspective (what a lay man would consider to be the best decision in that particular situation, which commonly coincides with the acceptance of the lifesaving medical act or with the one that would improve his clinical state), but to behave according to the subjective analysis that the patient would make in that case, bearing in mind his knowledge about the patient's beliefs and lifestyle.

If the doctor is in contact with the patient on a regular basis probably he has some acquaintance with him and therefore he is in possession of some factual information to guide his medical decision. However, the doctor may face an unconscious patient in the emergency room, with whom he has no relationship at all. In that case, and unless additional and reliable information is brought to him (by relatives, friends or especially advance directives), the doctor must treat the patient as if he has given the necessary consent, since this is the most reliable option from an objective perspective.

Presumed consent is specially raised in two circumstances: first, if the consent cannot be obtained at that moment and the adjournment of the intervention involves a threat to the patient's life or serious danger for the patient's body or health; secondly, if the consent was expressly supplied for a particular act, during which some other medical intervention became necessary in order to prevent danger to the life, body or health of the patient.

Whenever the actual consent is possible to obtain there is no need, nor justification, to apply to presumed consent. It is especially forbidden to apply to presumed consent in order to overrule an express decision of the patient which contradicts the doctor's opinion. Actually, there is no juridical figure able to exclude the

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Dias Pereira, 2006. "Consentimento Informado". Retrieved 2 September 2010 <http://www.centrodedireitobiomedico.org/files/ConsInfLivroPratico.pdf>; Guilherme de Oliveira, "Estrutura Jurídica do Acto Médico, Consentimento Informado e Responsabilidade Médica", in: Guilherme de Oliveira (ed.) *Temas de Direito da Medicina* (Coimbra: Coimbra Editora/Centro de Direito Biomédico, 2005) pp. 59-60; André Dias Pereira, *O Consentimento Informado na Relação Médico-Paciente* (Coimbra, Coimbra Editora: 2004); J. Martins Nunes, "Da Responsabilidade dos Médicos Anestesiologistas. Dos Diversos Tipos de Responsabilidade, Formas de Apuramento e Instâncias Decisórias. Consentimento Informado." Retrieved 25 January 2011, [http://www.huc.min-saude.pt/anestesiologia/docs/Responsabilidade\\_med\\_Anestes\\_Dr\\_JMNunes.pdf](http://www.huc.min-saude.pt/anestesiologia/docs/Responsabilidade_med_Anestes_Dr_JMNunes.pdf); Vera Lúcia Raposo, "Directivas Antecipadas de Vontade: Em Busca da Lei Perdida", *Revista do Ministério Público*, 125 (2011) p. 200.

criminal responsibility of the doctor in case he decides to intervene against the patient's unequivocal will, nor even when he acts to protect his health or to save his life.

The judicial prosecution of this crime requires a previous complaint by the offended - or by his closest family, in case he dies - to the police authorities or to the Public Defendant (because it is not a crime which occurrence is automatically investigated). If the doctor is actually accused and the proceeding is presented to a court of law the judge will be asked to analyse whether the doctor had, in light of the circumstances, reasonable grounds to presume that the patient would consent to a certain medical act or that he would not consent. In case of doubt, and in the name of the *in dubio pro vita* principle,<sup>3</sup> the judicial decision shall support human life, therefore, shall conclude that the doctor did not act in an illicit way by treating the patient. This solution, besides being grounded on the *favor vitae* doctrine, also respects the *in dubio pro reu* principle. Therefore, in order to obtain the doctor's judicial condemnation it is not sufficient to demonstrate that the patient would most likely have refused the consent if he had been able to express his will, but instead it is imperative to display that he would in effect have declined the treatment. The figure of presumed consent is established in general terms in Article 39, number 2, but in a less demanding way than in Article 156, number 2, because according to the first mentioned norm the doctor will not be punished when it is safe to conclude that the consent will not be refused, while in light of the second norm - the one that effectively rules this situation since it is a special provision for medical interventions - the doctor will not be punished unless it is safe to assume that the consent would be refused, a solution based in the core principle of *favor vitae*.<sup>4</sup>

Presumed consent is different from hypothetical consent, which is used when the explanation provided by the patient is insufficient, thus, ineffective, however, it is possible to assume that the patient would have consented if he were in possession of all necessary information. When this situation occurs the doctor must be acquitted. He will not be punished because of the theory of objective imputation and its solution to exclude a condemnation when things would have occurred in the exact same way as they actually happened if the offender had behaved in licit terms (in our case, if the doctor had provided the required clarification).

Note that while presumed consent operates when the effective consent cannot take place, the hypothetical consent comes into play in situations where effective consent existed and where it could have been obtained for the particular situation for which we are hypothesizing the consent if information had been clearly communicated.<sup>5</sup>

Special problems may be raised by patients that lost definitively their conscience. Presumed consent aims to achieve the will that the patient would manifest if he were in position to express it, for the purpose of respecting his autonomy. Nonetheless, these particular patients are not autonomous anymore, neither practically neither juridically. In consequence, we cannot apply to a supposed consent since the patient is effectively unable to consent.

Very controversial - and an easy target for criticism - is the decision from the Portuguese Supreme Court from 18 March 2010. Though issued in a civil law perspective, the remarks made about informed consent can be translated also for the

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<sup>3</sup> On the *in dubio pro vita* principle, Manuel da Costa Andrade, "Consentimento em Direito Penal Médico: O Consentimento Presumido", *Revista Portuguesa de Ciência Criminal*, 14 (2004), p. 145; Jorge de Figueiredo Dias, "Art. 131.º", in: Jorge de Figueiredo Dias (ed.) *Comentário Conimbricense do Código Penal, Parte Especial, Tomo I* (Coimbra: Coimbra Editora, 1999), p. 369.

<sup>4</sup> Andrade ("Art. 156.º", 1999) *supra* note 1, p. 38; Andrade (2004) *ibid.*, p.129.

<sup>5</sup> Andrade (2004) *ibid.*, p. 133.

criminal field. Basically, the Court sustained that in the domain of private medical practice the requirements for informed consent should not be so demanding for the reason that when the patient chooses a certain clinic and a certain doctor he is simultaneously accepting in advance the several procedures the doctor will find necessary. This decision authorizes the doctor to presume the patient's consent for medical care when any serious risk is at stake, based on the initial reliance on the doctor when he was firstly approached by the patient. But this thesis forgets that it is illegitimate to presume the patient's consent whenever he is actually able to express his will. Taken to its ultimate consequences this proposal would abandon the patient into the hands of the private practitioner without recognizing his personal decision-making.

## ***2.2.The Level of Guilt***

Criminal acts can be committed with negligence or malice, both configuring different levels of guilt, being the latter more severe in its consequences than the mere negligence.

All criminal offences are punished when it is demonstrated that the defendant acted with malice, but only some of them are punished in case of neglect.

Arbitrary medical acts are sanctioned when committed with malice or with gross negligence (Article 156, numbers 1 and 3). The demand of malice implies for the agent the knowledge that he is acting without consent or that the consent is ineffective, for instance, because the patient proceeded under mistake. But number 3 of this norm also sanctions the doctor who, because of an inexcusable misconduct, is not aware that the patient did not consent or that he is not in presence of an accurate consent, in other words, when the doctor demonstrates a particularly objectionable attitude of carelessness or sloppiness. Instead, if the doctor is not aware of the absence of consent, and doesn't reveal a gross negligence in his misrepresentation, there can be no condemnation (decision from the Lisbon Court of Appeal, from 18 December 2007).

## **3. The Patient's Consent**

The patient's consent must fulfill certain requisites in order to operate as a cause of justification:<sup>6</sup> it must be given at the current moment (though, we have to consider the problem of advance directives), and it must be personal and informed.

### ***3.1.Personal Consent***

The personal nature of consent excludes decisions taken by relatives.

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<sup>6</sup> Strictly speaking this consent is an agreement, taking into account the distinction between both figures, according to which the agreement operates whenever the protection of the offended self-determination is the only legal interest protected by that norm (for instance in sex crimes, nowadays directed to protect sexual self-determination) and the violation of the person's will configures an element of the criminal prohibition (as it happens in the crime of arbitrary medical interventions). The remaining situations are cases of consent. The practical distinction is that the agreement excludes the criminal nature of the conduct in a more anticipated stage than consent. For all, Manuel da Costa Andrade, *Consentimento e Acordo em Direito Penal - Contributo para a Fundamentação de um Paradigma Dualista* (Coimbra: Coimbra Editora, 1991); Andrade, (2004) *supra* note 3, pp. 122-124.

However, the requisites demanded for consent also apply to the agreement.

But in certain situations the patient cannot provide the necessary consent for reasons of temporary or permanent incapacity. Temporary incapacity refers to unconscious patients, for whom we make use of presumed consent as discussed above. Permanent incapacity refers to children and adults with mental limitations which prevent understanding of the situation.<sup>7</sup> For children, decisions will be taken by parents, unless they act against the best interest of the minor, a situation in which the decision will be remitted to a judge. Very much the same goes for mentally ill adult patients, but instead of parental powers we have a guardian who must act within the same limits.

### **3.2. Informed Consent**

An informed consent is the one that takes into account sufficient data in order to make a decision.

Exceptionally the doctor is not required to inform. This may happen either because the patient already possesses the necessary information (suppose he is also a physician), or because the communication of some data may disturb the patient and undermine the chances of recovery.<sup>8</sup> This last hypothesis – designated therapeutic privilege – is provided by Article 10, number 2, of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine), and also by the last sentence of Article 157 of the Portuguese Criminal Code.

Note that the duty to inform is also evaluated by civil courts in order to assign a compensation for moral damages. However, civil courts tend to be more demanding regarding these criteria – what is understandable since a condemnation by a criminal court involves the most severe penalty of the juridical system, ultimately a jail sentence – so, its reasoning cannot be totally accepted for criminal purposes.<sup>9</sup>

The scope of the duty to inform cannot be determined in abstract because it depends on several factors,<sup>10</sup> namely the level of understanding of the patient, the expectations he has for his life and the urgency and relevance of the intervention:

- i) The amount and specificity of data communicated to a patient possessing more knowledge, mainly in the particular medical domain, is obviously higher than the information communicated to an illiterate patient (unless the knowledge of the patient is so complete that it does not need any additional information, situation which can occur with physicians of that same specialty);
- ii) Some information is only significant to people with particular professions or hobbies (for instance, subtle changes in the tone of voice are trivial to the regular person but extremely relevant to a singer);
- iii) In case of imperative and lifesaving treatments the level of elucidation can be reduced in comparison with measures which do not need any medical indication, are merely aesthetic or that can be postponed without threatening the patient's well-being.

### **3.3. Actual Consent**

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<sup>7</sup> Wolfgang Frisch, "Consentimento e Consentimento Presumido nas Intervenções Médico-Cirúrgicas", *Revista Portuguesa de Ciência Criminal*, 14 (2004), p. 90.

<sup>8</sup> Frisch, *ibid.*, pp. 78-80.

<sup>9</sup> Frisch, *ibid.*, pp. 77-78.

<sup>10</sup> Frisch, *ibid.*, p. 80.

We will refer the problem of actual consent when discussing advance directives.

#### 4. Euthanasia - The Old Problem

We usually distinguish three modalities of euthanasia:<sup>11</sup> active direct euthanasia consists of causing the death of a person through a direct action in response to a request from that person; however, in active indirect euthanasia death is caused by substances supplied to provide the patient with some comfort, but that have as a collateral effect a diminution of his life; passive euthanasia, on the other hand, is characterized by removing (or not starting at all) mechanisms of life support, thus letting nature take its course (examples include such things as turning off respirators or discontinuing food and water).

Active direct euthanasia is qualified as a criminal offense in the Portuguese Criminal Code. It can assume different modalities of manslaughter: manslaughter at the victim's request (Article 134) and physician-assisted suicide (Article 135), punished in a less severe way than the regular manslaughter.

Conversely, the criminalization of active indirect euthanasia and passive euthanasia is not so consensual and linear. Indeed, in some circumstances they are not criminal acts and are even in compliance with good medical practices.

Passive euthanasia deserves special consideration. This practice can be defined as the medical omission of adequate means to maintain or prolong the patient's life (medicines, surgical interventions, oxygenation, reanimation), anticipating a death that, in any case, is already a certainty because we are referring to terminally ill patients.<sup>12</sup>

The juridical configuration (and the subsequent legitimacy of criminalization) of passive euthanasia is very controversial, since it may qualify either as a manslaughter committed by a negative behaviour (by omission<sup>13</sup>), or as a medical practice in accordance with *leges artis*.

A small part of the doctrine defends that the doctor is obliged to intervene anyway, for the reason that his duty of protecting the patient's life and health does not cease, otherwise we would have to accept the self-disposition of the legal interest "life"<sup>14</sup>. However, it is unconceivable that the doctor's duties remain against the will of the patient. The juridical system even recognises in some measure juridical power over

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<sup>11</sup> Cfr. Susana Sanz Caballero, "El Comienzo y el Fin de la Vida Humana ante el TEDH: El Aborto y la Eutanasia a Debate", *Cuadernos Europeos de Deusto*, 31 (2004), pp. 168-169.; Maria Elisa Villas-Bôas, "A Ortotanásia e o Direito Penal Brasileiro", *Revista Bioética*, 16(1) (2008), pp. 62-64.

<sup>12</sup> Helena Morão, "Eutanásia Passiva e Dever Médico de Agir ou Omitir em Face ou Omitir em Face do Exercício da Autonomia Ética do Paciente – Resposta Jurídico-Penal a uma Colisão de Valores Constitucionais", *Revista Portuguesa de Ciência Criminal*, 15 (2005), p. 36. The author notes that terminally ill patients cannot be mistaken by those in a vegetative persistent state.

<sup>13</sup> This omission can actually be committed by means of an action, i.e., through an active behaviour. This happens when the medical treatment has already been initiated and the doctor interrupts it. According to the criminal doctrine, following the German criminalist Claus Roxin, the act of turning off a machine must be evaluated from a normative perspective as an omission, though physically materialised in an action. Cfr. Claus Roxin, 1999. "Tratamiento Jurídico-Penal de la Eutanasia", *Revista Electrónica de Ciencia Penal y Criminología*, 01(10) (1999). Retrieved 2 January 2012, [http://criminet.ugr.es/recpc/recpc\\_01-10.html](http://criminet.ugr.es/recpc/recpc_01-10.html); Manuel da Costa Andrade, "Art. 134.º", in: Jorge de Figueiredo Dias (ed.) *Comentário Conimbricense do Código Penal, Parte Especial, Tomo I* (Coimbra: Coimbra Editora, 1999) p. 68; Dias, *supra* note 3, p. 13.

<sup>14</sup> Teresa Quintela de Brito, "Crimes Contra a Vida: Questões Preliminares", in: Teresa Quintela de Brito (ed) *Direito Penal – Parte Especial: Lições, Estudos e Casos* (Coimbra: Coimbra Editora, 2007) p. 58.



this legal interest by not sanctioning suicide and by demanding consent to any medical intervention, even if aimed to save the patient's life.

It is a fact that the Criminal Code expressly states that the patient can freely dispose of his physical integrity by consent (Article 149), but that it does not include a similar norm in reference to life. We are also aware that the Criminal Code punishes acts that conduct to the person's death, even with his consent or at his request. Based on these evidences some argue that the refusal of treatment admitted on Article 156 can only operate when the patient is not in risk of dying. In other words, they sustain that the norm tolerates disposition of the body and health, but not of life.<sup>15</sup>

Nevertheless, we must always bear in mind that within criminal law the principle of legality is very strict, absolutely incompatible with extensive lectures of the norms. The fact is that Article 156 admits the rejection of medical care without excluding the cases of undoubtful and inevitable death caused by the refusal. But even detaching from a textual reading of the norm (though in criminal law interpretation must always be strictly textual) let us not forget that legislature decriminalised suicide years ago, therefore, life is not totally excluded from our decision-making.

Professor Figueiredo Dias, one of the leading Portuguese scholars, distinguishes between two different scenarios in passive euthanasia: if the patient expressly refuses treatment, the doctor should not act or shall interrupt the intervention, otherwise he will be committing the crime of arbitrary surgical interventions (Article 156); on the other hand, if it is not possible to obtain the patient's consent and the doctor does not take any measure he will not be punished for manslaughter, for the reason that his conduct is criminally atypical, except if he has good enough reason to believe that the patient would authorize the treatment.<sup>16</sup>

A very similar position to this one is that of professor Costa Andrade, another leading scholar in the subject, who also claims that the absence of medical intervention as far as the doctor is concerned in these circumstances configures a homicide by omission.<sup>17</sup>

This thesis has been criticised with the argument that those authors invert the *dubio pro vita* presumption<sup>18</sup> regarding unconscious patients, preferring not to treat than to treat<sup>19</sup>. However, this is a wrong interpretation of Figueiredo Dias's words. In reality the author is not encouraging the doctor not to act, much less forbidding him to act, but simply letting the evaluation about the proper behaviour to his professional judgment, based on *legis artis* and scientific knowledge, with the guarantee that he will not be criminally condemned if he decides not to intervene. Actually the doctor should decide not to act if the hypothetical intervention will disturb and hurt the patient without any perspective of cure or improvement to his health.<sup>20</sup> Good medical practices condemn therapeutic obstination<sup>21</sup> - the so called dysthanasia – for violation of *leges artis*, as it is

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<sup>15</sup> Morão, *supra* note 12, pp. 54-62. Morão refers a dualistic system regarding the protection of life, dependent on whether the lesion is committed by the person itself (legally accepted) or by someone else (legally forbidden).

<sup>16</sup> Dias, *supra* note 3, pp. 13-14.

<sup>17</sup> Andrade (1991) *supra* note 6, pp. 400, 449; Andrade ("Art. 134.", 1999), *supra* note 13, p. 71; Andrade ("Art. 156.", 1999), *supra* note 1, p. 385.

<sup>18</sup> Underlining this principle, Andrade ("Art. 156.", 1999), *supra* note 1, p. 382.

<sup>19</sup> Morão, *supra* note 12, p. 52, 53.

<sup>20</sup> Sustaining this position Dias, *supra* note 3, p. 13.

In the opposite sense, Brito, *supra* note 14, p. 58 and following.

<sup>21</sup> Laetitia Stefani, "Problèmes Éthiques Soulevés par la Prise en Charge Thérapeutique des Patients Âgés Démonts Atteints de Cancer", *Revue Internationale Francophone de Soins Palliatifs*, 23(3) (2008), pp. 83-90.

corroborated by Article 57, number 2, of the Deontological Code of the Medical Association that forbids euthanasia, dysthanasia and physician-assisted suicide (number 1 of this norm imposes that the physician's conduct should be guided by the respect of the patient's dignity, which also strengthens this assumption), and by number 1 of Article 58, that discourages futile means of diagnosis and therapy. This orientation shall prevail even if the patient is unable to give his consent whenever the best medical practices advice the withdrawal of medical interventions.

Whenever the patient consents – or even requires – that the doctor does not intervene, the juridical doctrine is consensual in classifying this conduct as criminally atypical. The difference between scholars is that some always consider a hypothetical intervention from the doctor as a criminal offense, while others do not qualify this intervention as a crime if the patient's life is at danger, just as it was underlined *supra*.

## 5. Advance Directives – The New Problem

Advance directives are juridical mechanisms that allow a person to convey his/her decisions about end-of-life health-care ahead of time. In other words, they are instruments provided by the legal order to competent adults as their right to decide (to accept or refuse) any medical treatment.<sup>22</sup>

Advance directives may be used for two opposite purposes: either to refuse a certain treatment or every kind of treatment in a specific condition; or to expressly ask for a treatment in case the doctor is in doubt about the patient's consent regarding it. Note that this last possibility does not force the doctor to provide that treatment since it may not be suitable for the clinical condition of the patient.<sup>23</sup>

Advance directives may assume the form of a living will or of a document nominating a health care proxy.<sup>24</sup> Living wills are documents signed by a competent person conferring directions to health care providers about treatment choices in certain circumstances. The health care proxy is a surrogate decision-maker in the event that the person becomes unable to make medical decisions on her or his own behalf.

The comparison between these mechanisms reveals that each one of them presents its own weaknesses and benefits.

The decision outlined in the living will is a more personal act because it is taken by the person itself, while the decision of the health care proxy will come from a third party, even though not a stranger but someone designated by the patient and close to his wishes (it is not mandatory to be a relative, and sometimes it is even better not to be one, because of the close emotional connection they have with the sick person).

Although more personal, the consent expressed in the living will is not as up-to-date as the decision taken by the health care proxy. This may make it difficult to use as a justification cause to exclude the wrongfulness of the practitioner's behaviour, since legal dispositions about consent require a current (taken at that exact same moment) expression of will. Nonetheless, this obstacle can be overturned by the determination of an expiry date for the living will and the consequent imposition of reasserting the decision expressed in the document.

The conformity of the written document with the present situation of the patient may raise other difficulties. In effect, the prior and written prediction of a scenario can

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<sup>22</sup> Vera Lúcia Raposo, *supra* note 2, pp. 171-183.

<sup>23</sup> Helena Pereira de Melo, "Directivas Antecipadas de Vontade", p. 5. Retrieved 2 September 2010 [www.fd.unl.pt/docentes\\_docs/ma/hpm\\_MA\\_7777](http://www.fd.unl.pt/docentes_docs/ma/hpm_MA_7777).

<sup>24</sup> Helena Pereira de MELO, *ibid.*, pp. 3-11.

never embrace all the multiple dimension of real life dramas. Therefore, lawyers must be very cautious in the redaction of the document: descriptions should not be too detailed, otherwise the picture described in the living will may never occur in real life, but on the other hand language cannot be so vague that the desire of the patient becomes ambiguous.<sup>25</sup> The most common statement in a living will is similar to this one: if the person suffers an incurable and irreversible illness, disease or condition, and the attending physician determines that such a condition is terminal, life-sustaining measures that would serve only to prolong the dying process should be withheld or discontinued. More precise living wills may include information regarding an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, cardiopulmonary resuscitation and the use of life-support equipment, including ventilators.

Currently advance directives do not yet have an express regulation among us conferring them binding power. However, some norms do recognize their role as an important element to be weighted when deciding how do act in case of unconscious patients. Article 46, number 2, of the Deontological Code of the Medical Association, recommends that directives should be taken into consideration by the health care provider, though this is a very ambiguous formula. On the other hand, they may play a decisive role in presumed consent. Even if not expressly mentioned in Article 156, number 2, of the Criminal Code, they will certainly be a key factor in order to presume consent or to presume the absence of it. Nevertheless, and until the lawmaker does not impose the mandatory force of anticipated directives, it would be quite simple for a doctor to reject its content, basically arguing that he took the directive into consideration but concluded that its content was not clear and uncontroversial enough to prevent him from acting.

## **6. A final remark**

Doctors want to save lives. They promised to act guided by the principle of beneficence. Nonetheless, from the perspective of an innovative paradigm in doctor/patient relationship, nowadays the most beneficial for the patient is not always to be treated or even to be kept alive.

Doctors must be aware that any medical act performed without the patient's free and informed consent is considered a criminal offense and may involve a criminal sanction, even if the final result is to save the patient's life.

On account of these new circumstances health care professionals face new challenges and if not properly advised they may ultimately be condemned in a criminal penalty.

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<sup>25</sup> Vera Lúcia Raposo, *supra* note 2, p. 176.