PART II
SPECIAL NATIONAL REPORTS

THE LAW AND BIOETHICS OF END-OF-LIFE DECISIONS IN ARGENTINA*

Jorge Nicolás Lafferriere

1. INTRODUCTION

This report addresses how Argentine law regulates end-of-life bioethical and legal matters. To that end, I will present the general legal framework which

* Translated by Mariano Vitetta from Spanish into English.

applies to end-of-life decisions (section 2), making a distinction between the major principles involved (section 2.1) and the rules in the general framework for medical purposes and in connection with end-of-life decision-making (section 2.2). Then I will focus on the main guidelines of the Argentine legal system in connection with end-of-life matters, to wit: euthanasia (section 3.1), assisted suicide (section 3.2), treatment withdrawal (section 3.3), and palliative care (section 3.4). The next section will cover some specific topics, such as advance directives (section 4.1), health care staff and end-of-life decision-making (section 4.2), and conscientious objection (section 4.3). The report will finish with some conclusions.

2. THE LEGAL FRAMEWORK OF END-OF-LIFE MATTERS

Argentina is part of the civil law tradition; as a republic, its Constitution dates back to 1853. The Constitution and some international human rights treaties which rank at constitutional level (Art. 75(22) Argentine Constitution) are the supreme law of the land. The Constitution breaks down federal government into three branches: the executive, the legislature, and the judiciary. Legislation is the main source of law. Decisions rendered by the courts are in principle only binding for the parties, but there is a soft obligation to follow the jurisprudence of the Argentine Supreme Court, which entails that lower courts may depart from that jurisprudence for good reasons.

Argentina adopts the federal form of government. This reality is key in analysing the legal regulation of end-of-life topics. In that regard, the Argentine Congress is empowered to regulate in a consistent manner for the entire nation the particulars of private law, such as the concept of the human person, their strictly personal rights, the beginning and end of the existence of the human person, contracts, and family law provisions. The Argentine Congress is equally empowered to enact the Criminal Code, which details which conducts are crimes, including actions connected with euthanasia and assisted suicide. In turn, provinces retain powers in connection with the exercise of police powers for health care matters, including anything in connection with the practice of medicine.

2.1. APPLICABLE LEGAL PRINCIPLES

To analyse end-of-life decisions in Argentina from a legal point of view, it is necessary to start with the constitutional legal principles: human dignity, the right to life, the right to physical integrity, and the right to freedom.

2.1.1. Dignity of the Human Person

Dignity is one of the core principles in the Argentine legal system. It has been recognised under multiple human rights treaties, such as the Universal Declaration of Human Rights (Art. 1). The concept of dignity underlying these human rights treaties is inherent in every human being, without prejudice to their current conditions or capacities. This inherent dignity takes a central role in the Civil and Commercial Code (CCC; Law No. 26994, Official Gazette 8 October 2014), when regulating both strictly personal rights (art. 51 CCC) and the object of legal acts (Art. 279 CCC). Under the Civil and Commercial Code, every human being is a person as from conception (Art. 19 CCC), which makes it possible to assert that ontological dignity is recognised, which is not conditional on any actual rational capacity, but the mere possibility of developing a rational capacity.

2.1.2. The Right to Life

The Argentine Constitution protects the right to life implicitly under Article 29 and there is agreement that this right is considered to be included under the so-called 'implicit rights' of Article 33.

The right to life has a central place in international human rights treaties ranking at the constitutional level (Art. 75(22) Argentine Constitution), including, for example, the American Declaration of the Rights and Duties of Man (1948), the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), and the American Convention on Human Rights (1969).

These provisions are clear in recognising life as a basic human good which must be protected by the different branches of government.

In 2017, Law No. 27360 (Official Gazette 31 May 2017) was enacted, which passed the Inter-American Convention on Protecting the Human Rights of Older Persons, adopted by the Organization of American States on 15 June 2015, which recognises the right to life and dignity in old age under Article 6:

> States Parties shall adopt all measures necessary to ensure older persons' effective enjoyment of the right of life and the right to live with dignity in old age until the end of their life and on an equal basis with other segments of the population. States Parties shall take steps to ensure that public and private institutions offer older persons access without discrimination to comprehensive care, including palliative care; avoid isolation; appropriately manage problems related to the fear of death of the terminally ill and pain; and prevent unnecessary suffering, and futile and useless procedures, in accordance with the right of older persons to express their informed consent.

2.1.3. Preservation of Individual Freedom

The Argentine Constitution gives individual freedom a central position. Article 19 is key, as it provides:

> Any private actions of men which in no way offend public order or morality, and do not affect a third party, are only reserved to God and exempt from the authority of the courts. No inhabitant of the Nation shall be required to do what the law does not command or deprived from doing what the law does not prohibit.

Human rights treaties include many express provisions regarding the topic of the end of life. In particular, it is important to highlight that Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD)[1] is about the capacity to make decisions. Along similar lines, it is necessary to mention the Inter-American Convention on Protecting the Human Rights of Older Persons, which addresses the autonomy of older persons as a general principle (Art. 3(c)), and enshrines the right to independence and autonomy (Art. 7), the right to give a free and informed consent regarding health care matters (Art. 11), and the right to personal freedom (Art. 13), among others.

2.2. GENERAL RULES ON END-OF-LIFE DECISION MAKING

Understanding the rules applicable to end-of-life decisions in Argentina requires resorting to the CRPD, the Inter-American Convention on Protecting the Human Rights of Older Persons, the CCC, the Criminal Code (Law No. 11179, Official Gazette 31 November 1921 and subsequent amendments) and Law No. 26529 (Official Gazette 20 November 2009) on the Rights of the Patient, amended in 2012 by Law No. 26742 (Official Gazette 24 December 2012). In this section I will cover the general provisions on the human person and the end of their existence, the rights of the patient, the decision-making capacity in terms of health care matters, and the order of precedence for proxy consent.

2.2.1. The Human Person and the End of their Existence

Under the powers granted by the Constitution, the Argentine Congress passed the Civil and Commercial Code, which is in force throughout the nation (Art. 75(12) Argentine Constitution). This Code regulates everything in connection with the human person and the beginning (Art. 19 CCC) and the end of their existence (Art. 93 CCC). The CCC does not define 'human person',

[1] Passed under Law No. 26378, Official Gazette 9 June 2008, with constitutional rank pursuant to Law No. 27044, Official Gazette 22 December 2014.

because under international human rights treaties which rank at the constitutional level, every human is a person (Art. 1.2 American Convention on Human Rights).

Under Article 93 of the CCC, 'the existence of the human person ends with their death.' In turn, Article 94 provides: 'The proof of death is subject to accepted medical standards, and special legislation applies to the ablation of organs from the corpse.' In turn, Law No. 27447 (Official Gazette 26 July 2018) regulating organ transplantation, in Articles 36 and 37, as follows:

> Article 36. Certification of death. The death of a person may be certified after confirming that circulatory or brain functions have irreversibly stopped. Both must be the result of an appropriate clinical examination after an adequate period of observation.
>
> Article 37. Clinical diagnosis criteria, observation periods, and diagnosis tests which are required depending on medical circumstances to determine the interruption of brain functions must conform to the protocol approved by the Argentine Ministry of Health, with advice from the Argentine Central Institute for the Coordination of Ablation and Implants (INCUCAI).

The Protocol referred to in Article 37 was passed by Resolution No. 716/2019 of the Office of the Secretary of Government of Health of the Ministry of Health and Social Development (Official Gazette 29 April 2019) and details the findings to be shown by the clinical and neurological examination to be compatible with a death diagnosis. These include:

> (1) Deep coma with no brain response at all after any kind of stimulus. Spinal reflexes do not invalidate the diagnosis of brain death. (2) No brainstem reflexes …. (3) Definite apnea … (4) Flaccid hypotonia with absence of spontaneous or induced movements of brain origin. (5) In neonates, check for absence of sucking and searching reflexes. (6) The presence of spontaneous or induced motor activity of spinal origin does not invalidate the diagnosis of brain death.[2]

2.2.2. Patient's Rights

The CCC includes a chapter on strictly personal rights and acts, which govern informed consent (Art. 59) and advance directives (Art. 60), excluding euthanasia practices (Art. 60). The CCC also contains general rules on legal capacity, including decision-making on health matters.

In turn, Law No. 26529 on the rights of patients in their relationship with health care professionals and facilities, as amended in 2012 by Law No. 26742, regulates the 'exercise of patients' rights, in terms of autonomy of will, clinical information and documentation' (Art. 1). As for what is interesting for the

[2] Exhibit, Resolution No. 716-2019.

present discussion, this law contains specific rules on end-of-life legal decisions. First of all, one of the features of this law is that it prioritises the principle of free will (Art. 2(e) Law No. 26529). This law regulates the rejection of treatment in situations of therapeutic cruelty (Art. 2(e)), forbids euthanasia practices (Art. 11), and covers informed consent (Art. 5), its withdrawal (Art. 10), how consent is given (Art. 7), and the scenarios in which health care professionals are exempted from obtaining consent (Art. 9). Proxy consent (Art. 6) and advance directives (Art. 11) are also regulated here.

Unlike the Civil and Commercial Code, which is a law about a power that the provinces delegated to the Argentine Congress (under Art. 75(12) Argentine Constitution), Law No. 26529 is an expression of police power in health issues, which is a province shared concurrently by the federal government and the provinces. Therefore, most provinces have adhered to Law No. 26529.[3] Other provinces have passed their own laws on patients' rights, such as Formosa (Law No. 1255, Official Gazette 21 December 1997) and Neuquén (Law No. 2611, Official Gazette 24 October 2008). Córdoba stands out among these provinces, as it enacted Law No. 10058 (Official Gazette 15 June 2012) on the 'regulation of the right to decide in advance regarding the rejection of medical means, treatments, or procedures entailing therapeutic cruelty aimed at extending life in an undignified manner', amended in 2017 by Law No. 10421 (Official Gazette 30 January 2017). In Chubut, Law No. III-34 (Official Gazette 28 March 2011) regulates advance directives. Río Negro adhered to Law No. 26529 through Law No. 4692 (Official Gazette 10 October 2011), even if it has its own patients' law (Law No. 3076, Official Gazette 21 March 1997) and the Advance Directives Act (Law No. 4263, Official Gazette 3 January 2008). In San Juan, Law No. 7746 (Official Gazette 15 November 2006) regulates patients' informed consent, especially in connection with diagnosis or therapeutic procedures affecting the person and entailing important, significant, or considerable risks. Santa Fe has its own patients' rights law (Law No. 13956, Official Gazette 3 February 2020), which in some aspects adheres to national Law No. 26529.

2.2.3. Decision-Making Capacity on Health Matters

Legal capacity is consistently regulated for the entire nation under the Civil and Commercial Code. The CCC provides that human persons have legal capacity

[3] Buenos Aires (Law No. 14464, Official Gazette 25 February 2013), Catamarca (Laws No. 5325, Official Gazette 12 July 2011 and No. 5502, Official Gazette 14 February 2017), Chaco (Law No. 6925, Official Gazette 16 January 2012), Chubut (Law No. I-436, Official Gazette 17 January 2011), Corrientes (Law No. 5971, Official Gazette 9 June 2010), Jujuy (Law No. 5645, Official Gazette 23 July 2010), La Pampa (Law No. 2990, Official Gazette 16 June 2017), La Rioja (Law No. 9585, Official Gazette 4 November 2014), Santa Cruz (Law No. 3288, Official Gazette 30 October 2012), Tierra del Fuego (Law No. 885, Official Gazette 30 July 2012) and Tucumán (Law No. 8906, Official Gazette 7 September 2016): Legisalud Argentina, 'Derechos de los/as pacientes', http://www.legisalud.gov.ar/atlas/pacientes_provincial.html#1.

(Art. 22 CCC). Unborn persons do not have capacity to exercise their rights, but they are represented by their parents (Arts 24(a) and 101(a) CCC) and minors also lack capacity to exercise their rights and are represented by their parents (Arts 26 and 101(b) CCC), except for the acts they are authorised for under the law (Art. 26 CCC). Regarding the medical acts of minors, Article 26 CCC provides that they are represented by their parents if they are not 13 years old yet. If the minor is between 13 and 16, any decisions on medical treatments will be made by the minor him- or herself, except in the case of invasive treatments or treatments which compromise his or her health or when his or her integrity or life are at risk, in which case the decision is made by the minor with the assistance of his or her parents. After turning 16, a person is considered capable of making decisions connected with the care of his or her body. In addition, under Article 2 of Law No. 26529, 'children and adolescents have the right to take part as provided under Law No. 26061 to make decisions on medical or biological therapies or procedures involving their life or health.'

Among persons of legal age, the rule is that they are capable of exercising their rights. In cases of addiction or mental affection, whether permanent or long-term, which is serious enough and which may entail a risk to the person or his or her assets if he or she exercises full capacity, a court may render a judgment restricting certain acts or functions, for which purpose one or several support persons may be appointed (Art. 32 CCC). These support persons may have assistance or, exceptionally, representation functions (Art. 101(c) CCC). The courts are tasked with determining the scope and functions of support measures, which must observe the will and preferences of the person with the disability (Art. 12 CRPD and Art. 43 CCC).

As an exception, 'when it is absolutely impossible for the person to interact with his or her environment and express his or her will in any appropriate way, means, or format and the support system proves to be insufficient, the court may declare the incapacity and appoint a curator' (Art. 32, last paragraph CCC). The curator has representation functions (Art. 101(c) CCC) and must act following the will and preferences of the person represented (Art. 12 CRPD) and his or her main function is 'to take care of the person and the property of the incapable person, and to try to make him or her recover his or her health' (Art. 138 CCC).

A person with full capacity may, via advance directives, propose persons who may represent him or her in the event that he or she is prevented from expressing his or her consent to medical acts (Art. 60 CCC) and may also propose the person to act as a curator (Art. 139 CCC).

Finally, one has to bear in mind that Article 59 CCC makes it clear that in the absence of his or her legal representative, support person, spouse, cohabiting partner, relative or acquaintance accompanying the patient, 'the physician may dispense with securing consent if the act needed is urgent and is aimed at avoiding a serious harm to the patient.' Likewise, Article 9 of Law No. 26529 sets forth that the health care professional will be exempted from requiring consent

'(b) [w]hen there is an emergency situation, with a serious danger for the health or life of the patient, and the patient is unable to give his or her consent individually or via legal representatives.'

2.2.4. The Order of Precedence for Proxy Consent

The CCC includes so-called 'proxy consent' when 'the person is absolutely unable to express his or her will at the time of the medical treatment and has not given advance directives' (Art. 59 CCC). In this scenario:

> consent may be given by the legal representative, the support person, the spouse, the cohabiting partner, the relative, or acquaintance accompanying the patient, provided that there is a situation of emergency with a certain and imminent risk of serious harm for his or her life or health. In the absence of all of them, the physician may disregard securing consent if the act needed is urgent and is aimed at avoiding a serious harm to the patient.

This article has sparked controversy, as Law No. 26529, after being amended by Law No. 26742, had already established a different order of precedence for this proxy consent. Article 6 of Law No. 26529 provides that:

> if the patient does not have the capacity or the ability to give an informed consent due to his or her physical or psychical state, consent may be given by the persons mentioned under article 21 of Law No. 24193, with the requirements and following the order of precedence established therein.

In turn, Article 21 of Law No. 24193 (Official Gazette 26 March 1993) established the following order of precedence:

(a) The non-divorced spouse who lived with the decedent or the person who was not a spouse but had a spouse-like relationship with the decedent of at least three (3) consecutive and uninterrupted years;
(b) any of the children older than 18;
(c) any of the parents;
(d) any of the siblings older than 18;
(e) any of the grandchildren older than 18;
(f) any of the grandparents;
(g) any blood relative up to and including the third degree;
(h) any relative by affinity up to and including the second degree;
(i) the legal representative, tutor, or curator.

Likewise, it must be considered that Decree No. 1089/2012 (Official Gazette 6 July 2012) clarified some additional points to prove the bond and in the event of discrepancies among relatives at the same order. Under Article 5 of Decree

No. 1089/2012, in that case 'the relevant institutional ethics committee shall take part, with the purpose of deciding whether or not it is appropriate to resort to the courts, only when there are difficulties to ascertain the situation which is most favourable to the patient.'

As noted, while under Article 59 CCC the legal representative and support person are in the first order of precedence, under Law No. 26529 priority is given to the spouse, the cohabiting partner and relatives, and representatives are last. Article 59 CCC also includes support persons, consistent with the capacity restriction system, as it is presumed that such support persons have been appointed by a court to perform health-related duties for the receiver of support. Finally, Article 59 CCC includes an 'acquaintance' as a potential provider of proxy consent, a decision which may be criticised based on how indeterminate such a figure is.

This normative overlapping regarding the order of precedence for health-related decision-making has since become even more complicated, because in 2018 Law No. 27447 (Official Gazette 26 July 2018) repealed Law No. 24193 and in doing so modified the order of precedence set by the Patient's Rights Act. Now, Article 6 of Law No. 26529 refers to a law which has been repealed.

Therefore, nowadays, when the patient is absolutely unable to express his or her will and has not appointed a person to make decisions for him or her via advance directives, the order of precedence established under Article 59 CCC applies: the legal representative, the support person, the spouse, the cohabiting partner, the relative, or the acquaintance accompanying the patient.

Of course, as established under Article 6 of Law No. 26529, in cases of proxy consent, 'it must be secured that the patient participates in decision making throughout the health care process, to the extent of his or her abilities.'

Finally, Article 10 of Decree No. 1089/2012 provides:

> In the case of doubt regarding the prevalence of an authorisation or a revocation, when there has been proxy consent, the decision which favours the patient must be applied, with the intervention of the relevant institutional ethics committee, based on reasonable, and not paternalistic, criteria. For that purpose, pre-eminence will be given to the will expressed by the patient in connection with a therapeutic indication, even when that entails the rejection of treatment.

3. PRINCIPLES OF THE ARGENTINE LEGAL SYSTEM IN CONNECTION WITH END-OF-LIFE MATTERS

3.1. EUTHANASIA

In Argentina, euthanasia is a type of homicide from the legal point of view, whether by action or by omission directly aimed at causing death. In terms of

homicide, Articles 79 and 80 of the Criminal Code shall apply, and there might be aggravating or mitigating circumstances. There is no article in the Criminal Code including any type of mitigating circumstances given the terminal situation of the patient or if the death has been caused by another person at the patient's request.[4]

Article 11 of Law No. 26529 and Article 60 CCC regulate 'advance directives' and expressly exclude 'euthanasia practices'. Under Article 11 of Decree No. 1089/2012 the health care professional is responsible for determining whether an advance directive 'entails carrying out euthanasia practices, after consulting with the relevant ethics committee of the facility and, if there were no such a committee, with a committee from another facility' and in that case shall 'invoke the statutory impossibility of complying with such advance directives.'

In connection with euthanasia and assisted suicide, in a position which I do not share, some Argentine legal scholars believe that while the conduct is defined as a crime and is against the law, it may not be subject to punishment 'due to the impossibility of requiring another conduct, due to a prohibition error, or due to the defence of necessity.'[5]

Since October 2021 five bills proposing the legalisation of euthanasia and assisted suicide have been introduced in the Argentine Congress.[6] These bills substantially reflect the content of Spanish Law No. 3/2021 regulating euthanasia (Spanish Official Gazette 25 March 2021) and allow euthanasia or assisted suicide only in cases of serious and incurable disease or a serious, chronic and disabling

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4 Authors in favour of the legalisation of euthanasia include M.D. Farrell, *La ética del aborto y la eutanasia*, Abeledo-Perrot, Buenos Aires 1985; M.D. Farrell, 'Eutanasia' in J.C. Rivera et al. (eds), *Tratado de Derechos Constitucionales*, Abeledo-Perrot, Buenos Aires 2014, pp. 871–900; L.F. Niño, *Eutanasia. Morir con dignidad. Consecuencias jurídico-penales*, Editorial Universidad, Buenos Aires 1994. Academics opposing euthanasia include E.A. Sambrizzi, *Derecho y Eutanasia*, 1st ed., La Ley, Buenos Aires 2005; J.N. Lafferriere, 'La eutanasia y la justicia en el final de la Vida' in J.C. Rivera et al. (eds), *Tratado de Derechos Constitucionales*, Abeledo-Perrot, Buenos Aires 2014, pp. 822–62.

5 M. Ciruzzi et al., 'Estudio descriptivo de la opinión de miembros de la Justicia Nacional en lo Penal y Civil (Familia), en situaciones de limitación de soporte vital en pediatría', *Revista de Derecho Penal*, 2013-9, p. 1817, TR LALEY AR/DOC/6175/2013.

6 File no. 4597-D-2021, Bill on the Good Death Act and regulation of euthanasia by Representatives Cornejo, Latorre and Cacace, filed on 25 November 2021; file no. 4734-D-2021, Bill 'Alfonso' on the Right to Receive Help to Die with Dignity Act by Representatives Estévez, Brawer, Carrizo, Gaillard, Macha, Moreau, Lampreabe and López, filed on 6 December 2021; file no. 3956-D-2022, Bill on the Voluntary Interruption of Life Act by Representatives Cobos and Verasay, filed on 8 August 2022; file no. 4092-D-2022, Bill on the Right to Receive Help to Die with Dignity Act by Representative Moises, filed on 11 August 2022; and file no. 4855-D-2022, Bill on the Medical Assisted Voluntary Death Act by Representatives Brawer, Gollan, Carro, Yasky, Ormachea, Gaillard, Martinez, Landriscini, Hagman and Bormioli, filed on 13 September 2022. See J.N. Lafferriere, 'Análisis de los proyectos de legalización de la eutanasia y el suicidio asistido en Argentina', Centro de Bioética, Persona y Familia, 22 August 2022, https://centrodebioetica.org/analisis-de-los-proyectos-de-legalizacion-de-la-eutanasia-y-el-suicidio-asistido-en-argentina/.

condition. The bills regulate the procedure to request euthanasia or assisted suicide, consent and the supervision of a euthanasia commission, among other provisions. The bills introduced by Representatives Cobos and Verasay and Brawer and others proposed amending the Criminal Code and Law No. 26529 on patient's rights.

3.2. ASSISTED SUICIDE

In Argentina, there is no specific provision regulating or legalising assisted suicide. Under the Criminal Code, '[a] person who instigates or helps another to commit suicide shall be punished with one to four years in prison if the suicide has been attempted or consummated' (Art. 83, Criminal Code).

As for the distinction between euthanasia and assisted suicide we may cite Fontán Balestra, who states:

> The interest protected by the law is human life. In taking part in the suicide of another, the perpetrator shows disregard for another's life; the perpetrator does not kill by him- or herself, but induces or helps another one to kill him- or herself … The suicide's activity, who, whether or not induced, whether or not assisted, executes the act willingly is what makes the act not to be considered homicide.[7]

He points that out again that '[t]he acts of the one who assists cannot be acts of execution of the crime of injury or that of homicide.'[8]

In 2015, the Argentine Congress enacted Law No. 27130 (Official Gazette 8 April 2015) with the purpose of declaring the national interest in 'biopsychosocial care, scientific and epidemiological research, professional training in the detection of and care for persons under a risk of suicide, and the assistance of families who were victims of suicide' (Art. 1). The purposes of this law include:

(a) The coordinated, interdisciplinary, and interinstitutional approach of the suicide problem;
(b) The development of actions and strategies to raise public awareness;
(c) The development of assistance services and training of human resources;
(d) The promotion of the creation of support networks in the civil society for the purposes of the prevention, detection of persons at risk, treatment, and training.

This law was regulated under Decree No. 603/2021 (Official Gazette 10 September 2021), which promotes multiple actions to prevent suicide.

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7 C. Fontán Balestra, *Derecho Penal. Parte Especial*, 16th ed., updated by G. Ledesma, Abeledo-Perrot, Buenos Aires 2002, p. 64.

8 Ibid., p. 68.

Likewise, under Resolution No. 357/2016 (Official Gazette 5 April 2016), the 'persistent demand for euthanasia and/or assisted suicide' is considered a medical or psychosocial emergency situation in palliative care (section 5.4.3.2).

3.3. TREATMENT WITHDRAWAL

In 2012, Law No. 26742, known as the Dignified Death Act, amended Law No. 26529 to allow for the rejection of disproportionate treatments which amount to therapeutic cruelty. As already explained, this law did not legalise euthanasia or assisted suicide.

The right to reject 'certain medical or biological therapies or procedures, with or without cause' is generally recognised under Article 2(2) of Law No. 26629.

If the patient is suffering from 'an irreversible or incurable illness or is in a terminal state, or has suffered injuries placing him or her in that situation' (Art. 2(e) Law No. 26529), the patient 'has the right to express his or her will regarding the rejection of surgical procedures, artificial reanimation, or withdrawal of life support measures when they are extraordinary or disproportionate as compared to the prospects of improvement or which cause excessive suffering.' This right was also recognised under Article 59 CCC. In this regard, when Law No. 26529 was regulated by Decree No. 1089/2012, it was clarified that this right could be exercised if the patient is suffering from 'an irreversible or incurable illness or is in a terminal state, or has suffered injuries placing him or her in that situation.' In my view, the accuracy in the regulatory decree removes the possibility of any confusion regarding this scenario, as there might be people with an irreversible or incurable illness who are not necessarily in a terminal state.[9]

The patient may also 'reject hydration or nutrition procedures when they have the only effect of extending that irreversible or incurable state.' The possibility of relinquishing hydration and nutrition was the subject of controversy and criticism by some authors, with whom I agree, in the understanding that it is a type of passive euthanasia and the above are ordinary means of care which are due to every patient.[10]

In the event of rejection of treatments, the law provides that actions for 'the adequate control and relief of the patient's suffering' shall not be discontinued (Art. 2(e) Law No. 26529).

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9 U.C. Basset, 'La ley que regula decisiones sobre la muerte: la paradoja de restringir la autonomía personal del paciente bajo pretexto de ampliarla', *Revista de Derecho de Familia y de las Personas*, August 2012, p. 161.

10 J.N. Lafferriere, 'Entre el derecho a la vida y la autonomía de la voluntad. Comentario a la ley 26.742' in A. Gil Domínguez (ed.), *Muerte digna*, La Ley, Buenos Aires 2013, pp. 329–48.

Under Article 2 of Decree No. 1089/2012:

> in the event of discrepancy in the decisions, a bioethics committee may be consulted. The medical history shall include an express record of the diagnosis, including any of the relevant patient's physical and psychical parameters, as the effective exercise of free will, with the signature of the physician involved, the second professional if appropriate, and the patient or, upon his or her incapacity or impossibility, of a relative, representative, or an authorized person.

Regarding treatment withdrawal, it is unavoidable to refer to the decision rendered by the Argentine Supreme Court in 'D., M.A., on Declaration of Incapacity' of 7 July 2015, in which authorisation was given to withdraw nutrition and hydration from a patient who had been in a state of 'minimum consciousness' for 20 years. The Supreme Court considered that the requirements were met under Article 2(e) of Law No. 26529, as amended by Law No. 26742, which provides that the patient 'may reject hydration or nutrition procedures when they result in the only effect of extending that irreversible or incurable terminal state.' As the patient had not given advance directives, the Court considered that the patient's will to withdraw these life-support measures was proven by affidavits of the patient's sisters, who were authorised to testify on the will of M.A.D. under Article 6 of Law No. 26529, as amended by Law No. 26742.

The decision reads: 'It must be clarified and highlighted that as life and health are strictly personal rights, in no way may it be considered that the lawmaker has transferred to these persons an unconditional power to decide on the destiny of a patient of legal age who is in a total and permanent state of unconsciousness' (grounds paragraph 22). The Court makes it clear that 'the lawmaker did not intend to authorise euthanasia practices, which are expressly prohibited under article 11 of the law; instead, in some specific situations the therapeutic "abstention" was admitted upon the request of the patient' (grounds paragraph 13). This decision was justifiably criticised, especially because how weak a piece of evidence it is that a mere affidavit has led to a decision as complex as the withdrawal of nutrition.

3.4. PALLIATIVE CARE

Article 2 of the Inter-American Convention on Protecting the Human Rights of Older Persons defines palliative care as follows:

> Active, comprehensive, and interdisciplinary care and treatment of patients whose illness is not responding to curative treatment or who are suffering avoidable pain, in order to improve their quality of life until the last day of their lives. Central to palliative care is control of pain, of other symptoms, and of the social, psychological, and spiritual problems of the older person. It includes the patient, their environment,

> and their family. It affirms life and considers death a normal process, neither hastening nor delaying it.

Article 6 of this Convention requires State Parties to adopt measures so that 'public and private institutions offer older persons access without discrimination to comprehensive care, including palliative care.' Under Article 12(e), the states also undertake to 'ensure that older persons receiving long-term care also have palliative care available to them that encompasses the patient, their environment, and their family.' In turn, Article 19 provides that it is a duty of the states to 'design and implement comprehensive-care oriented intersectoral public health policies that include health promotion, prevention and care of disease at all stages, and rehabilitation and palliative care for older persons, in order to promote enjoyment of the highest level of physical, mental and social well-being.' This article also provides that States Parties must 'promote the necessary measures to ensure that palliative care services are available and accessible for older persons, as well as to support their families' (Art. 19(l)) and 'ensure that medicines recognized as essential by the World Health Organization, including controlled medicines needed for palliative care, are available and accessible for older persons' (Art. 19(m)).

Law No. 26529 and the CCC provide that when giving consent, the patient must be informed of his or her right 'to receive comprehensive palliative care in connection with the treatment of his or her illness or disease' (Art. 5(h) Law No. 26529 and Art. 59(e) CCC). Under Decree No. 1089/2012 regulating Law No. 26529, 'palliative care means the multidisciplinary care of a terminally ill person aimed at securing hygiene and comfort, including any pharmacological or other procedures to control pain and suffering' (Art. 11). It is relevant to point out that there are no specific provisions in Law No. 26529 or in the CCC regarding palliative sedation.

In 2022, the Argentine Congress enacted Law No. 27678 (Official Gazette 21 July 2022) with the purpose of ensuring patients have access to comprehensive palliative care benefits in their various forms, in the public, private and social security spheres, and support for their families. The purposes of this law include:

(a) The development of a person-centered interdisciplinary care strategy that addresses the physical, mental, social and spiritual needs of patients suffering from life-threatening and/or limiting illnesses;
(b) The promotion of access to available pharmacological and non-pharmacological therapies, based on scientific evidence and approved in the country for palliative care;
(c) The promotion of undergraduate and postgraduate professional training, continuing education and research in palliative care.

In 2016, Resolution No. 357/2016 (Official Gazette 5 April 2016) of the Argentine Ministry of Health approved the Guidelines on Palliative Care

Organization and Operation. That year, the Argentine Programme for Palliative Care (Resolution No. 1253/2016, Official Gazette 2 September 2016) was established within the Argentine Cancer Institute, 'with the purpose of implementing quality palliative care as a strategy during the evolution of the disease for cancer patients and their families throughout the Argentine territory, in accordance with the grounds, general and specific purposes, development, and execution' (Art. 1).

This account shows that there are multiple regulations recognising the right to access palliative care. But this does not mean that this right is guaranteed for the patients who are in a situation to receive such care, because access depends on each sector of the health care system, and there is a deficit in this regard. According to the Argentine Council of Scientific and Technical Research's (CONICET) End-of-Life Care, Rights, and Decisions Network, only 14% of persons who need palliative care have access to it.[11]

On this issue, there are provincial laws, including Law No. 6424 (Official Gazette 19 December 2017) establishing the Palliative Care Provincial Programme in Corrientes, Law No. 5488 regulating the Palliative Care System in the Province of Catamarca (Official Gazette 11 November 2016), Law No. 9627 (Official Gazette 2 October 2015) of La Rioja on the Palliative Care Provincial Programme, Law No. 7129 (Official Gazette 7 December 2012) establishing the Chaco Palliative Care Provincial System, Law No. 8312 (Official Gazette 21 July 2011) establishing the Palliative Care Provincial Programme in Mendoza, Law No. 13166 (Official Gazette 5 January 2011) on Palliative Care in Santa Fe, Law No. 9977 (Official Gazette 2 August 2010) creating the Entre Ríos Palliative Care Provincial Programme, Law No. 3759 (Official Gazette 16 October 2003) amended by Law No. 4266 (Official Gazette 3 January 2008) on Palliative Care in Río Negro, and Law No. 2566 (Official Gazette 7 December 2007) on Palliative Care in Neuquén, among others.

4. SOME SPECIFIC MATTERS

4.1. ADVANCE DIRECTIVES

As for human rights treaties, Article 11 of the Inter-American Convention on Protecting the Human Rights of Older Persons provides:

> States Parties shall also establish a procedure that enables older persons to expressly indicate in advance their will and instructions with regard to health care interventions,

[11] Red de Cuidados, Derechos y Decisiones en el final de la Vida de CONICET, 'Datos Relevantes sobre Cuidados Paliativos', 2021, https://redcuidados.conicet.gov.ar/datos-relevantes-sobre-cuidados-paliativos/.

> including palliative care. In such cases, that advance will may be expressed, amended, or expanded at any time by the older person only through legally binding instruments in accordance with domestic law.

Likewise, within the framework of General Comment No. 1 (2014), the UN Committee on the Rights of Persons with Disabilities, commenting on Article 12(3) CPRD, stated that 'for many persons with disabilities, the ability to plan in advance is an important form of support, whereby they can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others' and 'States parties can provide various forms of advance planning mechanisms to accommodate various preferences.'[12]

The concept of 'advance directives' has been recently included under Article 11 of Law No. 26529 on Patients' Rights.[13] This text was in turn amended in 2012 when Law No. 26742 was discussed, clarifying the way in which 'directives' had to be implemented:

> Advance Directives. Any person of age may give advance directives on his or her health, with the possibility of consenting to or rejecting certain medical, preventive, or palliative treatments, as well as decisions concerning his or her health. Any directives must be accepted by the physician responsible for the patient, except if those directives entail euthanasia practices, which shall be considered as non-existent.

This article was regulated by Decree No. 1089/2012 of the Argentine Executive.

In turn, Article 60 CCC provides:

> Medical Advance Directives. A fully capable person may give advance directives and confer a mandate (agency) regarding his or her health and in anticipation of his or her own incapacity. That person may also appoint the person or persons who shall give consent for medical acts and exercise a curatorship. Directives entailing the development of euthanasia practices are considered as not written.

Similarities and differences are noted between these provisions. First of all, it must be taken into account that the CCC is substantive law, which is consistent

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12 Committee on the Rights of Persons with Disabilities, Eleventh Session, 31 March–11 April 2014, General Comment No. 1 (2014) (CRPD/C/GC/1), no. 17.

13 See A.S. Andruet (ed.), *Directivas anticipadas en Argentina (Muerte Digna)*, Universidad Nacional de Villa María, Villa María 2015; J.N. Lafferriere and C. Muñiz, 'Directivas anticipadas en materia de capacidad en el nuevo Código Civil y Comercial Unificado', *Revista de Derecho de la Familia y las Personas*, June 2015, p. 147, AR/DOC/1411/2015; R. Rabinovich-Berkman, *Actos jurídicos y documentos biomédicos*, La Ley, Buenos Aires 2004; N.A. Taiana de Brandi and L.R. Llorens, 'El consentimiento informado y la declaración previa del paciente' in L.G. Blanco (ed.), *Bioética y bioderecho. Cuestiones actuales*, Editorial Universidad, Buenos Aires 2002, pp. 117–34; E.A. Sambrizzi, 'Voluntades anticipadas, su valor legal' (2010) 11(2) *Vida y Ética* 145, https://repositorio.uca.edu.ar/handle/123456789/1597.

for the entire country. Instead, Law No. 26529 is about the police power on health matters, and provinces may enact their own laws in this area. The relevant laws on the matter are listed in section 2.2.2 above.

Advance directives must be executed when the patient is absolutely unable to give his or her consent, as established under Articles 59 and 60 CCC. Regarding the determination of the absolute impossibility to express one's will under Article 59, the regulation of the Patient's Rights Act refers to medical criterion, while the new CCC is silent on the issue.

The act of giving an advance directive requires full capacity (Art. 60 CCC). Regarding minors, it seems that the scope of Article 26 CCC should be considered. However, Article 11 of Decree No. 1089/2012 provides:

> Any advance directives given by minors or persons without capacity at the moment they were given shall not be considered valid, and the same shall apply to any directives which are contrary to the legal system or which do not conform to the scenario the patient has foreseen when giving the directives.

Regarding persons of legal age with restricted capacity, the court judgment restricting capacity must be observed and an analysis must be made of whether the person's capacity for medical acts has been restricted and whether a support person has been appointed (Arts 32, 43, 102 CCC). Persons of legal age who are 'incapable' under Article 32, last paragraph, cannot give advance directives.

Under Article 11 of Law No. 26529, 'the statement of will must be made in writing before a notary or a trial court, for which the presence of two (2) witnesses will be required.' In turn, Article 11 of Decree No. 1089/2012 provides: 'Notaries, through their representative entities and judicial authorities through the relevant stages may agree on modalities to record such directives, in the event that there is no record system at the local level.'

Article 11 of Decree No. 1089/2012 provides that:

> witnesses, whatever the means used, in the text of the advance directives must express their knowledge on the capacity, competence, and discernment of the patient when giving the directives, and execute them, without prejudice to the patient's duty to also state that circumstance, in addition to his or her condition as a person of legal age with capacity.

Article 60 of the Civil and Commercial Code removed the phrase from Article 11 of Law No. 26529 establishing that 'directives had to be accepted by the physician responsible for the patient' and, in that regard, the jurisprudence of the Supreme Court must be followed, as well as any general rules on medical acts, especially considering that any directives entailing euthanasia practices are considered as not written.

None of these regulations provide for a term of duration for directives nor do they establish the duty to renew the directives periodically.

The Argentine Supreme Court decided on advance directives in the case 'Albarracini Nieves, Jorge Washington on precautionary measures' on 1 June 2012 (*Fallos* 335:799).

4.2. HEALTH CARE STAFF AND END-OF-LIFE DECISION MAKING

As euthanasia and assisted suicide have not been legalised in Argentina, there are no rules regarding potential situations of pressure or lack of comfort which may be caused on health care professionals taking part in these decisions.

The state has a duty to 'promote and strengthen research and academic training for specialised health professionals in geriatrics, gerontology, and palliative care' (Art. 19(j) Inter-American Convention on Protecting the Human Rights of Older Persons). In that regard, Resolution No. 508/2011 of the Argentine Ministry of Health (Official Gazette 10 May 2011) created the Cancer Human Resources Training Programme within the Argentine Cancer Institute, which offers scholarships to train health care professionals in multiple areas, including palliative care. In turn, the Argentine Palliative Care Programme is aimed at '[t]raining the first level of care on the general purposes of the programme to provide specific tools for the care of these patients, guaranteeing an appropriate coverage, ensuring equity, quality, effectiveness, efficiency, and thereby attaining the satisfaction of patients, families, and professionals.'

4.3. CONSCIENTIOUS OBJECTION

The right to conscientious objection is based on the provisions of international human rights treaties relating to freedom of worship, conscience and religion (Art. 14 Argentine Constitution, Art. 18 Universal Declaration of Human Rights, Art. 12 American Convention on Human Rights, Art. 18 International Covenant on Civil and Political Rights, and Art. 5 International Convention on the Elimination of All Forms of Racial Discrimination). In that regard, the Human Rights Committee has interpreted Article 18 of the International Covenant on Civil and Political Rights as follows: 'The Covenant does not explicitly refer to a right of conscientious objection, but the Committee believes that such a right can be derived from article 18.'[14]

In connection with end-of-life decisions, it is important to mention that in the 'D., M.A.' case decided by the Argentine Supreme Court on 7 July 2015, the

[14] Human Rights Committee, 'General Comment No. 22: The right to freedom of thought, conscience and religion (Article 18)', 48th Period of Sessions, 30 July 1993.

right to conscientious objection was expressly considered. For the Court, health care staff must be able to exercise their right to conscientious objection 'but that shall not translate into referrals or delays which compromise the patient's care' and 'the objection must be required to be made at the moment when the protocol is implemented or when the activities start at the relevant medical facility, so that any facility dealing with the situations examined here has enough human resources to permanently secure the exercise of the rights given under the law to patients in the situation provided for under Law No. 26529' (grounds paragraph 33).

5. CONCLUSION

In Argentina, end-of-life legal and bioethical matters were subject to intense debate in 2012, when Law No. 26742 was discussed. This law was known as the Dignified Death Act and amended Law No. 26529, known as the Patient's Rights Act. This amendment was marked by heightened principles of autonomy and the recognition of a person's right to reject some disproportionate treatments. The main source of controversy was the possibility of rejecting nutrition and hydration. The Dignified Death Act, however, ratified the decision that had been adopted under Law No. 26529 by virtue of which the legalisation of euthanasia was excluded.

A new debate took place in 2015, when the Argentine Supreme Court rendered a decision in 'D., M.A.' and authorised the withdrawal of nutrition and hydration of a patient in a state of minimum consciousness. The patient died on the same day the judgment was rendered, so the judgment was not enforced. This decision is the landmark case on the matter in recent years. It is appropriate to mention that Argentina is not facing any claims before the Inter-American Court of Human Rights for any end-of-life issues.

When the new Civil and Commercial Code was enacted, the Congress ratified the prohibition of euthanasia (Art. 60 CCC).

In 2021 and 2022, public campaigns were launched to legalise euthanasia and assisted suicide, and five bills along those lines were introduced in the Argentine Congress.

As has happened in other places, the debate focuses on the scope of human dignity. In general, tendencies to favour the possibility of rejecting nutrition and hydration were promoted as a result of the exaltation of dignity understood as mere individual autonomy. In this regard, Argentina shows a strong legal tradition of respect for the ontological dignity of the person, and the inviolability of human life plays an important role in this debate, rejecting any attempts to legalise euthanasia and reasserting the importance of promoting palliative care and other ways of supporting persons in a terminal situation.