LIFE-AND-DEATH DECISION-MAKING: EXAMINING THE DO-NOT-RESUSCITATE (DNR) ORDER IN THE PHILIPPINE SETTING[*]

Jerland S. Casilan[**]

ABSTRACT

The lack of statutory recognition for Do-Not-Resuscitate (DNR) orders in the Philippines creates serious legal ambiguities that endanger both patients and healthcare providers. In the absence of a clear legal framework, DNR orders are implemented inconsistently across institutions, giving rise to conflicts among patient autonomy, surrogate decision-making, and medical duties. Current laws do not expressly provide for the right to refuse resuscitation, leaving unresolved questions about legal enforceability and distinctions from passive euthanasia. The absence of jurisprudence only deepens this uncertainty, potentially exposing physicians to liability whether they honor or disregard a DNR order.

This paper proposes that DNR orders be recognized not merely as ethical directives, but as revocable unilateral acts under civil law, akin to a last will and testament. Rather than treating them solely as ethical or clinical instruments, it proposes a legal framing grounded in the principles of succession and agency. By situating DNR orders within the existing Civil Code, the paper offers a doctrinal path forward that avoids the need for sweeping legislative change while affirming the legal force of patient autonomy.

---

[*] *Cite* as Jerland S. Casilan, Note, *Life-and-Death Decision-Making: Examining the Do-Not-Resuscitate (DNR) Order in the Philippine Setting*, 98 PHIL. L.J. 590, [page cited] (2025).

An earlier draft of this paper received the Dean's Special Citation for Legal Writing (2023), University of the Philippines College of Law.

[**] J.D., University of the Philippines (2023); M.S. in Nursing, major in Adult Health Nursing, with High Distinction (*magna cum laude* standing), Holy Angel University (2014); B.S. in Nursing, *cum laude*, Angeles University Foundation (2011). Registered Nurse (RN); Certified Basic Life Support (BLS) Provider. Attorney IV, Civil Service Commission.

Special thanks to my mentors from UP Law, namely Dr. Lee Edson P. Yarcia, Dr. James Dennis C. Gumpal, Associate Professor Rowena E.V. Daroy-Morales, and Dr. Joseph Emmanuel L. Angeles for their invaluable support and guidance.

INTRODUCTION

In the Philippines, the decision to refuse life-sustaining treatment—particularly cardiopulmonary resuscitation ("CPR")—remains legally undefined. No statute, regulation, or Supreme Court ruling expressly recognizes Do-Not-Resuscitate ("DNR") orders. In this legal vacuum, end-of-life decisions are often made on an *ad hoc* basis, shaped by hospital policies, family dynamics, and clinical judgment rather than clear legal standards. The result is a landscape marked by inconsistency, ethical uncertainty, and potential liability for medical practitioners. At stake are core questions of patient autonomy, surrogate authority, and professional responsibility.[1]

Consider the case of Patient A, a 75-year-old woman with terminal cancer who was brought to the emergency department following a suspected stroke.[2] While awaiting transfer to the Intensive Care Unit ("ICU"), she became unresponsive, breathless, and pulseless, prompting the initiation of CPR. Her son, already present, insisted on continuing CPR. Shortly after, her husband arrived and demanded that resuscitation be halted, claiming it was against his wife's wishes. A dispute ensued. Dr. C, the attending physician, explained that under hospital policy, CPR could only be withheld in the presence of a signed DNR order, a document which Patient A had not executed. CPR continued despite protest. She later expired, and Mr. B, her husband, exclaimed, "You went against my wife's wishes. She wanted a peaceful and dignified death."

This clinical episode encapsulates the dilemmas at the heart of this paper: Was Patient A's right to refuse treatment violated? Did her husband have legal authority to stop resuscitation in the absence of an advance directive or DNR order? Could the medical team face liability for continuing CPR despite the family's protest? And, more broadly, how should the law respond to such emotionally fraught, time-sensitive decisions?

At present, the Philippine legal system provides no comprehensive framework for resolving these questions. While constitutional principles uphold the right to autonomy and informed consent, the lack of statutory

---

[1] Marcia Celine Abando et al., *Advance Directives by Terminally Ill Patients: A Grounded Theory*, 5 ASIA PAC. J. EDUC. ARTS & SCI. 4, 5 (2018), *at https*://doi.org/10.13140/RG.2.2.10517.06880.

[2] An actual case which I personally witnessed as a nurse in one of the tertiary hospitals in Quezon City. The names of the parties involved were changed for anonymity.

guidance has led to highly variable institutional responses.[3] Some hospitals honor family or patient preferences informally; others require strict compliance with internal DNR forms; many decline recognition altogether, citing the absence of legal authorization. The result is a fragmented system where the enforceability of end-of-life decisions depends less on patient intent than on institutional policy or the assertiveness of a family member.

This uncertainty is further compounded by strong familial influence in Filipino culture, where relatives often assume *de facto* decision-making roles, regardless of legal authority. In practice, when no written directive exists, physicians often defer to the family's designated decision-maker—typically determined by cultural norms such as birth order or seniority.[4] However, in situations where no such consensus exists or multiple family members assert competing views, physicians may feel paralyzed by conflicting demands, leading to ethical uncertainty and decision-making delays. As the case of Patient A shows, this custom-driven approach often overrides patient autonomy, increases physician exposure to liability, and undermines the integrity of end-of-life care.

Faced with this legal and ethical ambiguity, many healthcare providers default to defensive medicine, administering aggressive life-saving measures even when medically futile or contrary to the patient's presumed wishes.[5] The result is unnecessary suffering, misallocated resources, and continued exposure to professional risk.

This paper addresses a legal issue that is both pressing and unresolved: Should the Philippines enact an enabling statute to formally recognize and regulate DNR orders? Or can current doctrines on autonomy and informed consent provide sufficient legal grounding for their enforcement? By examining the intersection of civil law, constitutional rights, and medical ethics, this study argues for a doctrinal reinterpretation—one that anchors DNR orders within the existing legal architecture, while paving the way for future legislative reform.

---

[3] Leonardo De Castro, Renato Manaloto, & Alexander Atrio Lopez, *Advance Directives in the Philippines: In Search of a Legal Framework*, in ADVANCE DIRECTIVES ACROSS ASIA 198–200 (Daisy Cheung & Michael Dunn eds., 2023), *at* https://doi.org/10.1017/9781009152631.013.

[4] Jennifer McAdam, The Attitudes of Critically Ill Filipino Patients and their Families Toward Advance Directives, at 8 (2003) (M.A. thesis, University of California San Francisco) (ProQuest), *at* https://escholarship.org/uc/item/9k0481j1.

[5] Rayssa Pacheco et al., *Medicolegal Problems Associated with Do Not Resuscitate Orders*, 13 MED. & L. 461, 3 (1994).

I. END-OF-LIFE DECISIONS IN THE PHILIPPINE CONTEXT

End-of-life decisions in the Philippines are shaped not only by legal and ethical principles but also by deeply rooted cultural values. Central among these is the concept of "*bahala na*"—a form of fatalism that reflects surrender to divine will, which often diminishes the perceived necessity for formal documentation of one's medical preferences.[6] Although the phrase "right to die" is commonly invoked in such discussions, the underlying issues engage multiple legal doctrines, some overlapping and others distinct.

At its core, the notion is anchored in personal autonomy, the belief that individuals possess the right to determine the manner and timing of their own death. In both comparative literature and cultural practice,[7] this right manifests in various contexts: the refusal of life-prolonging treatment, the desire for dignity in terminal illness, the loss of will to live, and, in more contested cases, assisted suicide.

In the Philippine legal context, suicide does not result in the forfeiture or escheat of property, nor is attempted suicide considered a criminal offense. Historically, those who attempt to take their own lives are seen as individuals in distress, deserving of compassion rather than punishment.[8] However, while the Philippine Revised Penal Code does not criminalize suicide itself, assisting another in taking their own life is a punishable offense:

> Article 253. *Giving Assistance to Suicide. — Any person who shall assist another to commit suicide* shall suffer the penalty of prisión mayor; if such person lends his assistance to another to the extent of doing the killing himself, he shall suffer the penalty of *reclusión temporal*.[9]

This provision explicitly penalizes aiding suicide and encompasses cases of homicide upon request. However, Philippine law is silent on whether instigating or encouraging suicide constitutes a crime, creating a legal gap that complicates enforcement.[10] It is also worthy to note that giving assistance to suicide is not the same as euthanasia in this jurisdiction. A

---

[6] De Castro et al., *supra* note 3.

[7] *See also* Andrea Rodríguez-Prat et al., *Patient Perspectives of Dignity, Autonomy and Control at the End of Life: Systematic Review and Meta-Ethnography*, 11 PLOS ONE 3 (2016), *at* https://doi.org/10.1371/journal.pone.0151435.

[8] LUIS B. REYES, II THE REVISED PENAL CODE: CRIMINAL LAW 515 (1974).

[9] REV. PEN. CODE, art. 253. (Emphasis supplied.)

[10] Jose Crisostomo Jr. et al., *The Right to Die*, 55 PHIL. L. J. 338, 381–82 (1980).

doctor who deliberately resorts to "mercy-killing" his or her patient could be held liable for murder.[11] In euthanasia on the other hand, the person who has been killed did not want to die in the first place.[12]

This distinction between assisted suicide and euthanasia highlights the broader debate on patient autonomy in end-of-life care. While Philippine law criminalizes direct participation in causing death, it does not fully address the extent to which individuals can exercise control over their medical treatment, including the right to refuse life-sustaining interventions. This legal ambiguity has profound implications for Filipino doctors, patients, and families, especially when life-prolonging measures may result in undue suffering. Thus, the discussion shifts from the legality of aiding death to the ethical and legal recognition of a patient's right to determine their own treatment, emphasizing the need for clear policies that uphold autonomy while safeguarding against potential abuse.

A. Ethical Considerations in End-of-Life Care

End-of-life care presents ethical challenges that require balancing the preservation of life, alleviation of suffering, and respect for patient wishes. Medical decision-making in this context is guided by four key ethical principles: (a) autonomy, which upholds a patient's right to make informed choices about their treatment; (b) beneficence, which obligates healthcare providers to act in the patient's best interest; (c) non-maleficence, which ensures that medical interventions do not cause unnecessary harm or suffering; and (d) justice, which emphasizes the fair allocation of medical resources and ethical decision-making.[13]

In the Philippines, the ethical debate on euthanasia remains unresolved. Euthanasia, as a complex issue, has several dimensions, as noted by Suresh Bada Math and Santosh K. Chaturvedi "from active (introducing something to cause death) to passive (withholding treatment or supportive measures); voluntary (consent) to involuntary (consent from guardian) and physician-assisted (where physicians prescribe the medicine and the patient or a third party administers it to cause death)."[14] While active euthanasia—

---

[11] REV. PEN. CODE, art. 248.

[12] REYES, *supra* note 8.

[13] Ilora Finlay, *Ethical Principles in End-of-Life Care*, 48 MED. 1, 1–2 (2020), *at* https://www.medicinejournal.co.uk/article/S1357-3039(19)30250-6/abstract.

[14] Suresh Bada Math & Santosh K. Chaturvedi, *Euthanasia: Right to life vs right to die*, 136 IND. J. MED. RES. 899 (2012), *at* https://pmc.ncbi.nlm.nih.gov/articles/PMC3612319.

often referred to as mercy killing—is illegal in the Philippines, passive euthanasia, which allows death to occur naturally by withholding or withdrawing life-sustaining treatment, has gained recognition.

In 1997, the Philippine Senate debated a bill proposing the legalization of passive euthanasia.[15] Senate Health Committee Secretary John Basa noted that the bill sought to legalize passive euthanasia, a sensitive issue at the time. He further stated that approving such legislation would make the Philippines the first country to formally authorize what some termed "compassion killing."[16] Religious institutions, particularly the Catholic Church, strongly opposed any form of euthanasia, viewing it as a violation of the sanctity of life. Monsignor Pedro Quitorio, spokesperson for the Catholic Bishops' Conference of the Philippines ("CBCP"), asserted that any act or omission that directly causes death to alleviate suffering constitutes murder and is fundamentally opposed to human dignity and divine will.[17]

However, an emerging perspective argues that withdrawing life-sustaining therapy when death is not the intended outcome (e.g., pain management) should not be classified as euthanasia.[18] This approach, known as non-voluntary passive euthanasia, involves withholding or removing life-sustaining measures from incompetent, terminally ill, or severely injured patients when continued treatment is deemed futile. Common examples include terminal sedation and high-dose morphine administration for pain relief.[19] The perception that death occurs naturally in non-voluntary passive euthanasia has contributed to its growing acceptance.[20]

---

[15] S. No. 2003, 13th Cong., 1st Sess. (2005). Natural Death Act of 2005 introduced by Senator Miriam Defensor Santiago.

[16] Claire Wallerstein, *Philippines Considers Euthanasia Bill*, 314 BMJ 1641, 1644 (1997), *at* https://www.bmj.com/content/314/7095/1641.10.

[17] *Id.*

[18] Iain Brassington, *What Passive Euthanasia Is*, 21 BMC MED. ETHICS 41 (2020), *at* https://doi.org/10.1186/s12910-020-00481-7.

[19] Ya'arit Bokek-Cohen & Mahdi Tarabeih, *Grave New World: The Conspiracy of Silence Surrounding Non-Voluntary Euthanasia*, 52 APPLIED NURSING RES. 151245 (2020), *at* https://doi.org/10.1016/j.apnr.2020.151245.

[20] Jukka Varelius, *Mental Illness, Natural Death, and Non-Voluntary Passive Euthanasia*, 19 ETHICAL THEORY MORAL PRAC. 635, 639 (2016), *at* https://doi.org/10.1007/s10677-015-9664-7.

B. Emerging Professional Recognition of Passive Euthanasia

The ethical and professional acceptance of passive euthanasia in the Philippine medical community is reinforced by medical discussions clarifying when withholding or discontinuing life support aligns with patient rights and ethical responsibilities. In a 2017 symposium,[21] then-Philippine Medical Association ("PMA") President Dr. Irineo Bernardo outlined two recognized forms of passive euthanasia: (1) *Withholding Life Support*, wherein advance directive or request by the patients are considered should they become incapacitated; and (2) *Discontinuing Life Support*, which requires the exercise of the extraordinary care principle. Dr. Bernardo presents this in this wise:

> Extra-ordinary Care:
> - If the present gadget or medicines are no longer of further use due to futility;
> - The futility of medical care must be well explained to all concern [sic] especially the family;
> - Ordinary care still deserves to be provided like nutrition for symptomatic pains, fever or infection;
> - *There is no element of killing because the natural process of dying is allowed to take its course without unnecessary outside intervention* [sic].[22]

The recognition of passive euthanasia and the ethical considerations surrounding withholding and discontinuing life support reflect a growing acknowledgment of patient autonomy in medical decision-making. While these concepts have been discussed in professional and ethical guidelines, their application remains largely dependent on institutional policies and physician discretion, rather than a well-defined legal framework.

It also appears that the concept of withholding life support has also long been recognized in the 2019 Code of Ethics of the PMA.[23] Prior to its revision in 2019, this Code has been adopted by the PMA and the Board of Medicine of the Professional Regulatory Commission ("PRC") to guide the

---

[21] Irineo Bernardo, President, Lecture delivered at the Phil. Med. Ass'n Symposium "*Palliative Care and End-of-Life Care*" (Sept. 13-15, 2015), *at* https://www.cmaao.org/wp-content/uploads/2020/09/32nd_symposium_12_SYM-Philippines.pdf.

[22] *Id.* at 7. (Emphasis supplied.)

[23] PHILIPPINE MED. ASS'N., CODE OF ETHICS OF THE MEDICAL PROFESSION (2019).

practice of medicine in the Philippines. Specifically, the Code has already acknowledged the right of the patient to refuse treatment. It has also recognized the existence of advance directives as a component of this right to refuse treatment in Article II, Section 5 thereof:

> Section 5. A physician should exercise good faith and honesty in expressing opinion/s as to the diagnosis, prognosis, and treatment of a case under his/her care. *A physician shall respect the right of the patient to refuse medical treatment.* Timely notice of the worsening of the disease should be given to the patient and/or family. A physician shall not conceal nor exaggerate the patient's condition except when it is to the latter's best interest. A physician shall obtain from the patient a voluntary informed consent. In case of unconsciousness or in a state of mental deficiency the informed consent may be given by a spouse or immediate relatives and in the absence of both, by the party authorized by an advanced directive of the patient. Informed consent in the case of minor should be given by the parents or guardian, members of the immediate family that are of legal age.[24]

With this, end-of-life care in the Philippines remains legally and ethically ambiguous, particularly in matters of passive euthanasia, advance directives, and patient autonomy. While professional guidelines acknowledge a patient's right to refuse treatment, the absence of clear legal policies creates uncertainty and potential conflicts among families and healthcare providers.

C. Legislative Efforts and Policy Gaps

Recognizing the various challenges posed by prolonged and aggressive medical interventions, efforts have been made to introduce legal mechanisms that empower individuals to make informed end-of-life decisions. One such initiative was the proposed Advance Directives Education Act, a bill filed in 2016 by then-Senator Miriam Defensor-Santiago to establish a legal framework for advance care planning by defining key concepts such as advance directives, health care proxies, and end-of-life care, and launching a nationwide public education campaign.[25] However, the bill was archived following the end of the 16th Congress and Senator Defensor-Santiago's passing.

---

[24] *Id.* at § 5 (Emphasis supplied.)

[25] S. No. 3195, 16th Congress, 1st Sess. (2016). Advance Directives Education Bill.

Another bill, the Natural Death Act, was also proposed by Senator Defensor-Santiago in 2016.[26] This bill aimed to allow terminally ill patients to refuse life-sustaining treatment, thereby enabling the natural process of dying.[27] It sought to eliminate legal uncertainties surrounding the withdrawal of life support and to protect physicians and healthcare providers from liability when following a patient's expressed wishes. The bill provided for the formal execution of advance directives, including notarized documents that would guide medical decision-making when a patient is no longer competent.[28] Unfortunately, this bill also failed to progress beyond the committee level.

A notable step forward occurred in 2018, when the Philippines enacted Republic Act No. 11036, or the Mental Health Act.[29] While primarily focused on mental healthcare, this law introduced the concept of advance directives and legal representatives, albeit limited to mental health-related decision-making.[30] Under Section 4 of this Act, a "Legal Representative" is a person authorized, either by the service user, court, or applicable law, to act on behalf of the service user, including someone named in an advance directive.[31]

A service user can formally appoint a legal representative through a notarized document, granting them the authority to support, represent, and make decisions when the service user is temporarily impaired, and to be consulted on treatments.[32] If no one is appointed, specific individuals, starting with the spouse; non-minor children; a parent (if the service user is a minor); a chief, administrator, or medical director; or a person appointed by a Court may serve as the representative.[33] Additionally, a service user can designate up to three supporters for supported decision-making, allowing them to access medical information, consult on treatment, and accompany the user during appointments.[34]

Although this is a significant development, it remains restricted in scope and does not extend to general medical care or end-of-life decisions.

---

[26] S. No. 1887, 16th Congress, 1st Sess. (2016). Natural Death Bill.
[27] § 4(A).
[28] § 4.
[29] Rep. Act No. 11036 [hereinafter, "Mental Health Act"] (2018).
[30] §§ 9–10.
[31] § 4(i).
[32] § 10.
[33] § 10(c).
[34] § 11.

Nevertheless, the Mental Health Act laid important groundwork for recognizing patient autonomy in medical decision-making, raising awareness of advance care planning, an issue that becomes even more complex when addressing end-of-life situations such as DNR orders.

D. The Role of Advance Healthcare Directives

Advance healthcare directives serve as essential tools for individuals to assert their medical preferences in situations where they can no longer communicate their wishes.[35] These directives help reduce uncertainty and prevent disputes among families and healthcare providers by offering clarity in medical decision-making.[36]

In the Philippines, institutional guidelines in many hospitals recognize three core forms of advance directives:

a. Living will — A document that specifies a patient's treatment preferences in the event of terminal illness, such as a request for comfort measures only or refusal of intensive interventions.[37]

b. Declaration to withdraw or withhold treatment — A directive indicating the patient's intent to forgo medical procedures that would merely prolong the dying process.[38]

c. DNR order — A specific medical directive, issued by a competent patient or, in some institutions, by a designated surrogate, instructing healthcare providers to withhold cardiopulmonary resuscitation in the event of arrest. This is distinct from physician-initiated do-not-attempt-resuscitation (DNAR) orders, which are based on clinical futility assessments.[39]

Research suggests that proactive discussions around advance care planning can improve patient satisfaction, reduce anxiety, and enhance communication between patients, families, and healthcare professionals.[40]

---

[35] *See* DAVID JOHN DOUKAS & WILLIAM REICHEL, PLANNING FOR UNCERTAINTY: LIVING WILLS AND ADVANCE DIRECTIVES FOR YOU 6 (2007).

[36] *Id.*

[37] De Castro et al., *supra* note 3, at 200–01.

[38] *Id.*

[39] *Id.* at 201–02.

[40] *See* William Smucker et al., *Elderly Outpatients Respond Favorably to a Physician-Initiated Advance Directive Discussion*, 6 J. AM. BD. FAM. PRACT. 473, 481 (1993).

Patients who express their end-of-life preferences in advance often report a greater sense of control, while physicians are better positioned to respect and implement those wishes.[41]

Despite these benefits, advance directives remain largely underutilized in the Philippines. As De Castro et al. explained, Filipino cultural norms favor collective family-based decision-making over individual autonomy, and there is an expectation that the family would take care of a critically ill patient.[42] Compounding this is the lack of public awareness and the absence of clear legal framework, both of which leave patients vulnerable to unwanted medical interventions and healthcare providers unsure of their legal obligations.[43] Many healthcare providers remain hesitant to fully honor DNR directives due to fears of liability and cultural sensitivities surrounding death and decision-making.[44] Standardizing DNR protocols and promoting informed dialogue among stakeholders are essential steps toward ensuring ethical, compassionate, and legally sound end-of-life care.

II. UNDERSTANDING DNR ORDERS

A DNR order is a formal medical directive issued upon a patient's informed decision, instructing healthcare professionals to withhold CPR in the event of cardiac or respiratory arrest.[45] The principal aim of a DNR order is to prevent unnecessary suffering by foregoing invasive and potentially futile life-prolonging interventions.[46]

A. Development of DNR Orders

DNR policies emerged in the early 1970s as part of the medical community's evolving recognition of the ethical complexities surrounding

---

[41] *Id.* at 479.

[42] De Castro et al., *supra* note 3, at 194–95.

[43] *Id.* at 203–04.

[44] *Id.*

[45] Leo Olarte, Lecture delivered at the Philippine Medical Association's "Do Not Resuscitate: Legal and Ethical Issues" Webinar (Feb. 22, 2022), *at* https://web.facebook.com/pma1903/videos/1027370041184732.

[46] Thaddeus Mason Pope, *Do-Not-Resuscitate (DNR) Orders,* MSD MANUAL WEBSITE, Oct. 2023, *at* https://www.msdmanuals.com/home/fundamentals/legal-and-ethical-issues/do-not-resuscitate-dnr-orders. *See also* Joseph Breault, *DNR, DNAR, or AND? Is Language Important?*, 11 OCHSNER J. 4, 302 (2011), *at* https://pubmed.ncbi.nlm.nih.gov/22190879/.

end-of-life care. The American Medical Association ("AMA") formally recommended in 1974 that DNR decisions be documented in patient records and communicated to all involved healthcare professionals.[47] This was later reinforced by institutional studies advocating for proactive DNR discussions to prevent the repeated resuscitation of terminally ill patients, efforts that were often physically traumatic and medically futile.[48] By the 1990s, many jurisdictions had adopted legislative measures to codify DNR practices and protect patient autonomy.[49]

Today, the American Heart Association ("AHA") advises that all patients in cardiac arrest be given CPR unless a valid DNR order is in place or irreversible death has occurred.[50] In select jurisdictions, CPR may be lawfully withheld if it is deemed medically inappropriate, notwithstanding family objections.[51] However, in the Philippines, such discretion remains limited, and physicians typically must secure consent from the family before withholding resuscitation, even in clearly futile cases.

B. Clinical Indication for DNR Orders

When CPR is unlikely to be effective, the physician may order a DNR, even if the patient or their representatives object. Evidence-based standards by the National Association of EMS Physicians ("NAEMSP") guide terminating CPR efforts in cases where (1) spontaneous circulation does not resume outside a hospital, (2) emergency personnel were not present when the incident occurred, or (3) no shockable rhythm is detected.[52]

Prolonged CPR, especially in terminal cases, can result in complications such as rib fractures and neurological impairment. Physicians

---

[47] Michael E. Shapiro & Eric A. Singer, *Perioperative Advance Directives: Do Not Resuscitate in the Operating Room*, 99 SURG. CLIN. NORTH AM. 859, 860 (2019), *at* https://pmc.ncbi.nlm.nih.gov/articles/PMC6729135. (Author manuscript.)

[48] Fareed Mohd Hassan, *Do Not Resuscitate Order by Competent Adults: The Legal Position in the United States and Canada Perspectives*, 8 INT'L. J. HUMAN. & SOC. SCI. 53, 58 (2018).

[49] Charles P. Sabatino, *Advance Directives and Advance Care Planning: Legal and Policy Issues* 10 (U.S. Dept. of Health & Human Servs., Off. Of the Asst. Sec'y for Planning and Evaluation Report, 2007), *at* https://aspe.hhs.gov/reports/advance-directives-advance-care-planning-legal-policy-issues.

[50] American Heart Association, *Part 2: Ethical Aspects of CPR and ECC,* 102 CIRCULATION 12 (2000), *at* https://doi.org/10.1161/circ.102.suppl_1.I-12Circulation.

[51] *Id.*

[52] Christopher Libby, Robert B. Skinner, & Amit R. Rawal, *EMS Termination of Resuscitation and Pronouncement of Death*, *in* STATPEARLS (2022), *at* https://www.ncbi.nlm.nih.gov/books/NBK541113/.

often explain these risks to the family and, with their agreement, initiate the DNR process. The DNR form is typically signed by the patient, or if incapacitated, by a surrogate decision-maker. However, these practices vary across hospitals and are not uniformly regulated.[53]

Clinical indications for DNR orders in the Philippines include conditions in which CPR is unlikely to restore cardiac or pulmonary function, the presence of multiple comorbidities with high risk of severe neurological damage, or when continued intervention offers no meaningful benefit to the patient's quality or duration of life. DNR status is also often appropriate for patients with terminal, untreatable illnesses where further invasive procedures would merely prolong the dying process. The goal remains to provide proportionate and patient-centered care that honors the individual's wishes while minimizing harm.[54]

C. Variety and Forms of DNR Orders

In Philippine hospitals, DNR orders are typically implemented through institutional forms, signed either by the patient[55] or, in cases of incapacity, by an authorized family member or legal representative. The author has observed that, based on apparent institutional practices, these forms are reviewed periodically to ensure continued validity, with some institutions requiring reauthorization as frequently as every 24 hours. Hospital-provided DNR forms remain the most prevalent mechanism for documenting such directives in the local setting (see *Annex* for example).

In addition to a DNR designation, advance care forms often include related medical directives such as Do Not Intubate ("DNI"), Do Not Defibrillate, and Limited Emergency Care.[56] But to date, no comprehensive

---

[53] PAM MOULE & JOHN ALBARRAN, PRACTICAL RESUSCITATION FOR HEALTHCARE PROFESSIONALS 9 (2nd ed. 2009).

[54] Olarte, *supra* note 45.

[55] *Advance Directives and Do Not Resuscitate Orders*, MED. CITY WEBSITE, *at* https://www.themedicalcity.com/news/advance-directives-and-do-not-resuscitate-orders.

[56] *See Do-Not-Resuscitate (DNR),* CLEVELAND CLINIC WEBSITE, Mar. 24, 2025, *at* https://my.clevelandclinic.org/health/articles/8866-do-not-resuscitate-orders.

empirical study has been conducted to formally enumerate or standardize DNR practices in the Philippine.[57]

Unfortunately, while DNR orders have become standard practice in many developed healthcare systems, their application in the Philippines remains limited. This infrequency can be attributed to a combination of legal uncertainty, cultural reluctance, and the absence of a standardized framework. The lack of enabling legislation has resulted in a highly inconsistent approach, wherein some hospitals allow patient-initiated DNR orders while others rely solely on familial decision-making.

III. IMPLEMENTING DNR ORDERS IN THE PHILIPPINES

The fragmented and inconsistent approach to DNR orders in the Philippines exposes both patients and healthcare providers to legal, ethical, and logistical dilemmas. Without a statutory framework, hospital practices remain *ad hoc*, resulting in significant legal ambiguities, undue burdens on families and physicians, and inefficient resource allocation.

A. Legal and Ethical Barriers for Patients and Families

Under established legal principles, a competent individual retains the right to refuse medical treatment, including resuscitation. The presumption of capacity requires that a person be regarded as capable of making medical decisions unless proven otherwise. Legal incapacity is not determined by poor judgment or memory alone; rather, it arises only when an individual, despite reasonable assistance, is unable to comprehend and communicate informed choices.[58] However, as De Castro et al. observe, while advance directives are available in the Philippines, individual autonomy is often mediated by family decision-making, reflecting the strong cultural and legal recognition of kinship roles in healthcare decision-making. [59]

---

[57] This observation is based on the author's personal clinical experience and review of institutional protocols encountered in multiple hospital settings, including both private and government facilities.

[58] Alec Samuels, *Do-Not-Resuscitate: Lawful or Unlawful?*, 62 MED. SCI. & L. 144, 146 (2021), *at* https://doi.org/10.1177/00258024211032799.

[59] De Castro et al., *supra* note 3, at 194–95. *See also* Karlos Pio Alampay et al., *Measuring the Levels of Knowledge and Attitudes Regarding Advance Directives of Families of Patients Admitted in UERMMMCI: A Descriptive Cross-Sectional Study*, 7 HEALTH SCI. J. 51, 52 (2018).

This lack of legal clarity extends to surrogate authority. Although the Mental Health Act recognizes advance directives and surrogate decision-making in the mental health context,[60] no corresponding legislation exists for general medical care. As a result, decisions made by surrogates, often in crisis settings, lack clear legal authority, leaving families and physicians exposed to legal risk.

In local hospital practice, a DNR order may be written by a physician if the patient has executed an advance directive that clearly expresses a desire to forego resuscitation. This structure, expressed explicitly in Section 5(c) of the Mental Health Act,[61] reflects the principle of substituted judgment, which aims to preserve the patient's known or presumed values.[62] In jurisdictions without statutory surrogate laws, such as the Philippines, this hierarchy often exists only in hospital policy or ethical convention. As such, disputes may arise, and surrogate authority may be challenged in emergency settings. Physicians face particular vulnerability, as Philippine law does not currently authorize them to withhold or terminate resuscitative efforts unilaterally, even when CPR is deemed futile.[63]

B. Challenges Faced by Physicians and Healthcare Providers

In emergency settings, the existence of a DNR order is not always immediately recognized, particularly when healthcare teams, acting under urgency, initiate life-saving measures without verification. The failure to immediately communicate DNR status between medical personnel may result in unintended resuscitative efforts, exposing physicians to liability for either performing unwanted CPR or failing to act.[64]

Moreover, some healthcare providers mistakenly interpret DNR orders as directives for palliative or comfort care only, leading to withholding of non-resuscitative interventions such as antibiotic therapy, intravenous

---

[60] Mental Health Act, §§ 2, 9.

[61] § 10(c).

[62] Olarte, *supra* note 45.

[63] *Id.*

[64] Nicole Marie Saitta & Samuel Hodge, Jr., *What Are the Consequences of Disregarding a "Do Not Resuscitate Directive" in the United States?*, 32 MED. & L. 441, 446 (2013).

fluids, or symptomatic treatments. This misinterpretation undermines patient rights and the proper implementation of DNR protocols.[65]

Healthcare professionals are often reluctant to engage in DNR discussions due to fear of malpractice claims, bureaucratic hurdles, and cultural sensitivities surrounding end-of-life decisions.[66] These challenges are compounded by an absence of a clear legal framework, leaving physicians vulnerable to potential legal and ethical repercussions.[67]

Instances involving the use and expansion of unilateral DNR policies also lead to a dilemma regarding the ethics of such policies. This is seen in the controversial practice during the height of the pandemic, wherein all COVID-19 patients would have a DNR order signed for them (regardless of their intentions) and any patient who suffered a cardiac arrest would be permitted to die naturally.[68] Reports also indicate that patients at residential care homes were apparently pushed or pressured to sign DNR forms.[69] Convincing vulnerable patients to sign these documents is a clear indication of a shift to excessive paternalism that fails to respect patient autonomy.

Apparently, encouraging people with incurable illnesses and senior care home residents to sign DNR forms appeared to be motivated by a desire to avoid overburdening precious healthcare resources.[70] The broad application of unilateral DNR policies under the guise of medical futility creates a dilemma between clinical judgment and patient rights. While intended to guide end-of-life care, such policies risk overriding informed consent and disproportionately affecting vulnerable groups. When used without proper consultation, they blur the line between medical necessity and discriminatory triage, raising serious ethical and human rights concerns.

---

[65] Amal Al Farhan et al., *Patient Reluctance to Accept Do Not Resuscitate Order: Impact on Clinical Care*, 26 EAST. MEDITERR. HEALTH J. 933, 936 (2020), *at* https://doi.org/10.26719/emhj.20.009.

[66] Geoffrey Phillips, *Do Not Resuscitate Orders: A Reappraisal*, 2 HEC F. 101, 103 (1990), *at* https://link.springer.com/article/10.1007/BF00115868.

[67] *Id.*

[68] Jay Ciaffa, *The Ethics of Unilateral Do-Not-Resuscitate Orders for COVID-19 Patients*, 49 J. L. MED. & ETHICS 633, 634-35 (2021), *at* https://doi.org/10.1017/jme.2021.87.

[69] Robert Booth, *UK healthcare regulator brands resuscitation strategy unacceptable,* THE GUARDIAN, Apr. 1, 2020, *at* https://www.theguardian.com/world/2020/apr/O1/uk-healthcare-regulator-brands-resuscitation-strategy-unacceptable.

[70] Stephen Thomson & Eric Ip, *COVID-19 Emergency Measures and the Impending Authoritarian Pandemic*, 7 J. L. & BIOSCI. 1, 13 (2020)*, at* https://doi.org/10.1093/jlb/lsaa064.

At the same time, however, medical ethics in the Philippines continue to emphasize the physician's duty to preserve life. The 2019 Code of Ethics of Medical Professionals underscores this principle, stating that:[71]

> Sec. 1 The fundamental principles to guide the physicians in the practice of their profession.
>
> 1.1 *Principle of Respect for Life*. The right to life is inviolable. Life is a necessary condition for all other human goods. *It must be protected and fostered at all its stages beginning from conception to its natural end.*
>
> 1.2 Principle of Respect for Person. Every person has an intrinsic worth and dignity. Trust shall be central to the physician-patient relationship. Physicians shall respect patient autonomy.
>
> * * *
>
> 1.5 *Primum Non Nocere. The foremost responsibility of the physician is to do no harm to the patient.*[72]

Despite this declaration of principles, it has been observed that the revised Code omits any explicit recognition of a patient's right to refuse treatment or issue advance directives, which were previously included in the 2009 Code of Ethics. The deletion of these provisions further weakens the legal standing of DNR orders in the Philippines.

While medical ethics provides guidance on best practices, the Code of Ethics does not have the force of law.[73] Thus, the absence of a statutory right to refuse treatment exposes the ethical tension between a physician's duty to preserve life and the patient's right to autonomy. While the Code affirms both principles, it offers no clear guidance on how to reconcile them in end-of-life situations like DNR orders, leaving physicians to navigate this balance without firm ethical or legal footing.

---

[71] PHILIPPINE MED. ASS'N., CODE OF ETHICS OF THE MEDICAL PROFESSION, §§ 1.1, 1.2 (2019).

[72] *Id.* at § 1.5. (Emphasis supplied.)

[73] *See* Angela Campbell & Kathleen Cranley Glass, *The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research*, 46 MCGILL L.J. 473, 475, 488 (2001). While ethical codes offer important normative guidance, they do not have the force of law unless incorporated into legislation or regulations.

C. Systemic Barriers to Effective DNR Implementation

A primary obstacle to DNR enforcement is the absence of legal protections for healthcare institutions and providers through standardized protocols in the law. In the absence of clear statutory guidelines, physicians may be reluctant to honor or issue DNR orders for fear of liability, often defaulting to resuscitation over patient autonomy to mitigate legal risks.[74] While some hospitals have developed internal DNR policies, the absence of nationally uniform DNR protocol results in inconsistency, including who may authorize a DNR order—sometimes requiring multiple physician approvals or family consent despite a competent patient's clear wishes.[75] Compounding this is the lack of a centralized registry for advance directives, creating logistical challenges for emergency responders and leading to overlooked DNR orders—an issue seen not only in the Philippines but globally.[76]

The absence of a specific legal provision governing DNR orders forces physicians to operate in a legal gray area, where both honoring and disregarding a DNR request can lead to potential liability. While Article III, Section 1 of the 1987 Constitution affirms the right to life and liberty,[77] the prerogative to refuse medical treatment also finds support in the constitutional right to privacy[78] and the State's declared policy to uphold human dignity and fully respect human rights.[79] These provisions reflect a broader constitutional commitment to individual autonomy, particularly in matters involving personal health, bodily integrity, and end-of-life decision-making.

However, without clear statutory recognition, physicians who comply with a patient's verbal request to withhold resuscitation risk accusations of medical negligence, as there is no legal precedent explicitly allowing them to do so. Conversely, administering resuscitation against a patient's wishes could also constitute a violation of patient autonomy, raising

---

[74] Daniel Sulmasy et al., *Beliefs and Attitudes of Nurses and Physicians About Do Not Resuscitate Orders and Who Should Speak to Patients and Families About Them,* 36 CRITICAL CARE MED. 1817, 1821 (2008), *at* https://doi.org/10.1097/ccm.0b013e31817c79fe.

[75] De Castro et al., *supra* note 3, at 205.

[76] Ghania Haddad et al., *A Descriptive Analysis of Obstacles to Fulfilling the End of Life Care Goals Among Cardiac Arrest Patients,* 8 RESUSCITATION PLUS 100160 (2021), *at* https://doi.org/10.1016/j.resplu.2021.100160.

[77] CONST. art. III, § 1.

[78] Art. III, § 3.

[79] Art. II, § 11.

concerns about potential civil and criminal liabilities. This legal uncertainty places an unreasonable burden on healthcare providers, compelling them to act defensively rather than in the best interests of the patient.

D. Broader Implications of the Limited Use of DNR Orders

The absence of a clear DNR framework leads to inefficiencies in healthcare, particularly in critical care settings where ICU beds, ventilators, and emergency services are limited. In hospitals with overwhelmed emergency departments, patients with terminal illnesses or DNR status may often occupy ICU beds for extended periods, delaying access to care for other critically ill patients who may have higher chances of recovery.[80]

In lieu of formal DNR protocols, many Philippine healthcare institutions rely on informal mechanisms such as Discharge Against Medical Advice ("DAMA"), Home Against Medical Advice ("HAMA"), or signed waivers and patients who invoke these mechanisms are often presumed to be exercising their right to refuse treatment.[81] However, these instruments primarily serve as institutional acknowledgments that the patient is departing from care despite medical advice; they do not function as definitive non-resuscitation directives. While some hospitals allow patient discharge if the patient is informed of the risks,[82] releases medical personnel from liability, and poses no public health or safety risk, this is based on administrative practice, not law.

DAMA, HAMA, and waivers lack clear legal standing and fail to provide substantive protection for either patients or healthcare providers in cases involving the withholding of resuscitative efforts. While no existing jurisprudence or academic study in the Philippines addresses their authority in this context, this reflects the author's scholarly assessment of a significant legal gap informed by clinical practice. In the absence of a formally

---

[80] An-Yi Wang et al., *Characteristics and Outcomes of "Do Not Resuscitate" Patients Admitted to the Emergency Department–Intensive Care Unit,* 118 J. FORMOSAN MED. ASS'N 223, 227 (2019).

[81] *See* Maria Aleth Ramirez-Anog & Erwin M. Faller, *In-Depth Analysis of Discharges against Medical Advice: Reconciling Patient Autonomy, Ethical Obligation and Professional Accountability in an Infirmary Hospital in Apayao Province, Philippines,* 5(9) INT'L J. RES. PUBLICATION & REV. 1595, 1595–96 (2024).

[82] *See e.g., Know Your Rights to Getting Quality Patient Care*, MAKATI MED. CTR WEBSITE, *at* https://www.makatimed.net.ph/blogs/know-your-rights-to-getting-quality-patient-care.

recognized DNR framework, physicians remain exposed to liability whether they honor or override a patient's informal refusal of CPR. The informal workarounds highlight the urgent need for a standardized, legally binding approach to end-of-life decisions in the Philippines.

Moreover, DAMA and HAMA offer no substantive legal protection for healthcare providers as they do not absolve a physician of responsibility, as Philippine law does not recognize these documents as substitutes for formal advance directives. Under the Philippine Medical Act and the Revised Penal Code, physicians may still be held liable for negligence[83] or malpractice[84] if they withhold resuscitation without a legally binding DNR order. Additionally, family members who initially agree to DAMA or HAMA may later contest the decision, exposing healthcare providers to potential litigation.

These mechanisms also raise concerns regarding patient rights and informed consent. Many families opt for DAMA or HAMA due to financial constraints rather than genuine agreement with the withdrawal of care, calling into question the voluntariness of such decisions.[85] Moreover, patients discharged under these mechanisms may lack the mental capacity to fully comprehend the consequences of refusing further treatment, further undermining the legal and ethical validity of DAMA and HAMA as stand-ins for formal DNR orders.

Ultimately, the informal nature of DAMA and HAMA, combined with the absence of explicit legal recognition, leaves both patients and healthcare providers in a precarious position. Without a legally established DNR framework, these mechanisms remain unreliable, unenforceable, and insufficient to safeguard either party from legal repercussions.

---

[83] *See* REV. PEN. CODE, art. 365.

[84] Rep. Act No. 2382 [hereinafter, "Medical Act"] (1959), § 24.

[85] *See* Anog & Faller, *supra* note 81, at 1598.

IV. ANALYZING THE LANDSCAPE OF DNR ORDERS

A. Establishing the Legal Basis of DNR Orders in the Philippines

1. A Person's Right to Life and Right to Health

The right to life holds transcendental importance in Philippine constitutional law. Article III, Section 1 of the 1987 Constitution explicitly provides that "[n]o person shall be deprived of life, liberty, or property without due process of law."[86] Constitutional framer Fr. Joaquin Bernas, S.J., emphasized that this guarantee extends beyond mere survival to encompass the *right to a good and dignified life*, underscoring the importance of quality of life as a constitutional ideal.[87] In this context, the use of advance directives, including DNR orders, may serve to preserve a person's dignity by allowing for a peaceful and humane death.

According to Jose P. Crisostomo, Jr., although the "sanctity of life" is often invoked in religious and ethical debates to assert that only God should decide when life ends—raising concerns that allowing medical non-intervention may devalue life—patients with terminal illnesses are often left to choose between between a "protracted death" and a "rapid death."[88] The former may involve prolonged suffering, loss of bodily control, and intractable pain, while the latter, in the form of allowing natural death through the refusal of futile resuscitative efforts, preserves patient dignity.[89]

Although certain religious institutions may oppose the refusal of life-saving interventions, the Constitution expressly prohibits the State from enforcing religious beliefs on individuals. The freedom of religion under Article III, Section 5 of the 1987 Constitution guarantees that no person shall be compelled to adhere to religious doctrines that conflict with their personal convictions.[90] Thus, while some may view the rejection of resuscitative efforts as incompatible with religious values, the State cannot impose such beliefs on individuals who exercise their legal right to refuse treatment.

---

[86] CONST. art. III, § 1.

[87] JOAQUIN BERNAS, THE 1987 CONSTITUTION OF THE REPUBLIC OF THE PHILIPPINES: A COMMENTARY 110 (2009 ed.).

[88] Crisostomo Jr. et al, *supra* note 10, at 373.

[89] *Id.*

[90] CONST. art. III, § 5; *see* Reynolds v. United States, 98 U.S. 145, 165 (1878).

Catholic doctrine itself has long recognized the right to refuse extraordinary or disproportionate medical treatment.[91] In 1957, Pope Pius XII, addressing medical professionals, affirmed that Christian principles do not require futile medical interventions for patients in hopeless conditions.[92] He clarified that this applies to both refusing treatments that have not yet begun and discontinuing those already initiated.[93]

The National Catholic Bioethics Center has similarly stated that patients should be free to pursue experimental treatments if there is reasonable hope of benefit but may also refuse treatment when its benefit is dubious.[94] This principle resonates with constitutional values that emphasize respect for human dignity and bodily integrity. While the 1987 Constitution does not expressly provide a right to determine one's own course of medical treatment, it affirms the right to life under Article II, Section 15, which mandates that "[t]he State shall protect and promote the right to health of the people and instill health consciousness among them."[95] This provision highlights the State's duty to adopt an integrated and comprehensive approach to healthcare—one that includes respecting patient rights, such as informed consent, medical choice, and refusal of treatment. Bernas has interpreted this obligation to encompass not only access to humane and appropriate care but also health promotion and disease prevention.[96] The recognition of DNR orders aligns with these principles by empowering patients to make informed end-of-life decisions consistent with their medical, ethical, and personal beliefs.[97]

2. Principle of Autonomy and Patient's Right to Refuse Treatment

The principle of autonomy affirms that competent individuals have the right to refuse medical interventions, including CPR. While Article II,

---

[91] NAT'L CATH. BIOETHICS CTR., A CATHOLIC GUIDE TO END-OF-LIFE DECISIONS: AN EXPLANATION OF CHURCH TEACHING ON ADVANCE DIRECTIVES, EUTHANASIA, AND PHYSICIAN-ASSISTED SUICIDE 2 (2005), *at* https://www.stpatricks.org/documents/end-of-life-decisions.

[92] Pope Pius XII, *The Prolongation of Life: An Address to an International Congress of Anesthesiologists*, Nov. 24, 1957, *in* THE POPE SPEAKS 365 (1958).

[93] *See* William Baughman & John Bruha, *Euthanasia: Criminal, Tort, Constitutional, and Legislative Considerations*, 48 NOTRE DAME L. REV. 1203, 1209 (1973), *at* https://scholarship.law.nd.edu/ndlr/vol48/iss5/6.

[94] NAT'L CATH. BIOETHICS CTR., *supra* note 91.

[95] CONST. art. II, § 15.

[96] BERNAS, *supra* note 87.

[97] S. No. 1402, 17th Cong. 1st Sess. (2017). An Act Proclaiming the Rights and Obligations of Patients, Providing a Grievance Mechanism Thereof and for other Purposes.

Section 5 of the 1987 Constitution declares that the State shall protect the right to life,[98] this constitutional duty must be balanced with Article III, Section 1 which protects not only life but also liberty.[99] Although the Constitution does not explicitly recognize a right to refuse medical treatment, this right has been inferred from the broader constitutional protections of the right to privacy.[100]

The State's *parens patriae* authority—its duty to protect those unable to protect themselves—is often invoked to justify overriding DNR orders for incapacitated individuals. In *Sama v. People,*[101] the Supreme Court reiterated the State's duty to safeguard the welfare of vulnerable individuals. However, this power is not absolute.

While the State has a constitutional duty to preserve life, this must be balanced against the equally important constitutional protection of individual rights, including the principle that patients have the right to refuse unwanted medical treatment—even life-sustaining interventions such as resuscitation.

The Supreme Court affirmed this right to refuse medical treatment in the case of *Li v. Spouses Soliman,*[102] where it upheld a patient's right to informed consent and the refusal of medical procedures. The Court emphasized:

> The doctrine of informed consent within the context of physician-patient relationships goes far back into English common law. As early as 1767, doctors were charged with the tort of "battery" (i.e., an unauthorized physical contact with a patient) if they had not gained the consent of their patients prior to performing a surgery or procedure. In the United States, the seminal case was *Schoendorff v. Society of New York Hospital* which involved unwanted treatment performed by a doctor. Justice Benjamin Cardozo's oft-quoted opinion upheld the basic right of a patient to give consent to any medical procedure or treatment: "*Every human being of adult years and sound mind has a right to determine what shall be done with his own body*;

---

[98] CONST. art. II, § 5.

[99] Art. III, § 1.

[100] *See also* Integ. Bar of Phil. v. Purisima, 940 Phil. 589, 631 (2023) (recognizing decisional privacy as the right "to make certain kinds of fundamental choices with respect to their personal and reproductive autonomy").

[101] G.R. No. 224469, 967 SCRA 55, 185, Jan. 5, 2021.

[102] [Hereinafter, "*Li*"], G.R. No. 165279, 651 SCRA 32, June 07, 2011.

> and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." From a purely ethical norm, informed consent evolved into a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, *may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.*[103]

In this case, the Court reinforced that informed consent is not merely an ethical duty but a legal obligation, requiring physicians to fully disclose all material risks and treatment alternatives so that patients can intelligently weigh the probable risks against the probable benefits.[104] Similarly, in *In Ruñez v. Jurado,*[105] the Supreme Court ruled that a competent patient has the right to accept or refuse medical advice and that a physician's duty to provide care ends when the patient voluntarily refuses treatment:

> It has been held that *a patient cannot attribute to a physician damages resulting from his own failure to follow his advice, even though he was ignorant of the consequences which would result from his failure.* If a patient leaves the hospital contrary to instructions, the physician is not liable for subsequent events. There is no expectation from doctors that they track down each patient who apparently missed their appointments or force them to comply with their directives. *After all, a person is still the master of his own body.*[106]

These rulings affirm that the right to refuse treatment extends to all medical procedures, including resuscitation, and that healthcare providers must honor a patient's informed decision. Failure to respect this right may expose medical practitioners to legal liability for unauthorized medical interventions.

---

[103] *Id.* at 56–57. (Emphasis supplied, citations omitted.)
[104] *Id.*
[105] [Hereinafter, "*Ruñez*"], A.M. No. 2005-08-SC, 477 SCRA 1, Dec. 9, 2005.
[106] *Id.* at 7. (Emphasis supplied, citations omitted.)

Where a patient has previously expressed a clear and informed refusal of resuscitative measures, such expression should carry ethical and legal weight. The absence of a statutory framework for surrogate decision-making in DNR contexts does not preclude the recognition of patient preferences when such preferences are consistent with existing legal principles.

3. Patient's Right to Privacy and the Doctrine of Informed Consent

The right to privacy, recognized as the source of all other liberties,[107] is enshrined in the provisions of the 1987 Constitution[108] and protects individuals from unwarranted state interference, which may include medical decisions.

American jurisprudence interpreted the right of terminally ill patients to refuse medical treatment as an exercise of constitutional right to privacy. Although the US Constitution does not explicitly enumerate a right to privacy, the US Supreme Court has consistently recognized it as a fundamental right derived from the Bill of Rights, as established in *Griswold v. Connecticut*[109] and *Doe v. Bolton.*[110] The right to privacy, as extended to healthcare, is not absolute. US courts have held that state intervention may be justified when compelling interests, such as protecting dependent children, ensuring medical ethics, or preserving life, are at stake.[111] Nonetheless, in cases where a competent individual refuses life-sustaining treatment, the balance of interests generally favors individual autonomy over state intervention.[112]

This principle is closely tied to the doctrine of informed consent, which dictates that no medical procedure may be performed without a patient's voluntary and informed approval, after being informed of "what was to be done, the risk involved, and the alternatives to the contemplated

---

[107] *See* Samuel Warren & Louis Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

[108] CONST. art. III, §3.

[109] Griswold v. Connecticut, 381 U.S. 479 (1965).

[110] Doe v. Bolton, 410 U.S. 179 (1973).

[111] *See In re* Application of Pres. and Dir. of Geo. C., 331 F. 2d 1000, 1008-09 (1964); U.S. v. George, 239 F. supp. 752, 754 (1965); Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488, 504 (1967), *cited in* Crisostomo et al, *supra* note 10.

[112] *See* Bouvia v. Superior Ct., 179 Cal. App. 3d 1128, 1141 (1986).

treatment."[113] English common law has long recognized that physicians who perform medical treatment without patient consent may be held liable for battery.[114] The seminal case of *Cobbs v. Grant*[115] further refined the doctrine of informed consent, establishing that the adequacy of disclosure must be measured by the patient's need for information—not the physician's discretion. The test for determining whether a particular risk must be disclosed is its materiality in the patient's decision-making process.[116]

While the Philippine Supreme Court has recognized the doctrine of informed consent in the aforementioned case of *Li*, Philippine jurisprudence has yet to fully evolve this doctrine to encompass refusals of life-sustaining treatment or contemplate the legality or validity of CPR orders. There is no definitive case law establishing the right to refuse life-sustaining treatment as an exercise of bodily autonomy or constitutional privacy.

B. Ethical and Institutional Barriers

As previously discussed, the Revised Code of Ethics upholds the principle that the patient has the right to self-determination, to make free decisions. The said right is balanced with the correlative duty of the physician to inform the patients of the consequences of their decisions.[117]

This reinforces the idea that individuals have the right to make informed decisions about their medical treatment. However, the said Code does not explicitly recognize DNR orders, leaving medical practitioners uncertain about their legal and ethical obligations when confronted with end-of-life decisions.

Nurses and allied healthcare professionals also play a critical role in DNR implementation and patient advocacy. The Philippine Nurses Association ("PNA") and the Board of Nursing ("BON") under the Professional Regulation Commission (PRC) follow ethical guidelines that emphasize patient dignity, holistic care, and the right to refuse medical

---

[113] Wilkinson v. Vesey, 295 A.2d 676 (1972), *cited in Li,* 651 SCRA, at 64 (Carpio, *J.*, *dissenting*).

[114] Graham McBain, *Modernising the Common Law Offences of Assault and Battery*, 4 INTL L. RES. 39, 127 (2015), *at* http://dx.doi.org/10.5539/ilr.v4n1p39.

[115] Cobbs v. Grant, 8 Cal. 3d 229, 245 (1972), *cited in Li*, 651 SCRA, at 58.

[116] *Id.*

[117] CODE OF ETHICS, *supra* note 71.

interventions.[118] However, just like the Medical Code of Ethics, these guidelines do not explicitly address DNR orders, placing nurses in an ambiguous position when assisting in emergency resuscitations.

As mentioned earlier, the growing recognition of passive euthanasia within the Philippine medical community supports the legitimacy of DNR orders. Withholding life support is a form of passive euthanasia, distinguishing it from active euthanasia or assisted suicide, both of which remain illegal under Article 253 of the Revised Penal Code. Unlike active euthanasia, which involves a deliberate act to cause death, a DNR order simply allows the natural dying process to take its course without medical intervention.

In this context, DNR orders should not be misconstrued as euthanasia or assisted suicide but rather as a legitimate expression of an individual's right to decline medical intervention. The principle of passive euthanasia, already acknowledged in Philippine medical ethics, further distinguishes DNR orders from prohibited acts that actively end life. Therefore, despite the absence of a comprehensive legal framework, DNR orders remain valid and enforceable under existing ethical, professional, and legal principles, ensuring that patients receive dignity and compassion in their final moments.

Finally, the enforceability of advance directives in the Philippines is severely hampered by the absence of any centralized legal registry or state-endorsed framework. Without formal mechanisms for recording and verifying such directives, healthcare providers often err on the side of overtreatment out of fear of liability, and patient wishes are easily overridden or ignored. This lack of administrative infrastructure leads to inconsistent enforcement and systemic disregard for patient autonomy, an outcome that mirrors the challenges encountered with informal mechanisms like DAMA or HAMA.

---

[118] PROF'L REG. COMM' BD. OF NURSING, CODE OF ETHICS FOR REGISTERED NURSES, art. 2, §§ 4–5 (2004), *at* https://prc.gov.ph/sites/default/files/NURSING-CodeEthics-2004-220.pdf.

C. Legislative Reform and Global Best Practices

1. U.S. Approach: Life Support and State Interests

The legal recognition of the right to refuse life-sustaining treatment has been firmly established in various jurisdictions, particularly in the United States, where judicial precedents have shaped the evolving discourse on DNR orders. The development of case law surrounding DNR orders reflects an emerging consensus within the broader right-to-die and right-to-refuse-treatment movements. The landmark rulings in *In re Quinlan* (1976)[119] and *Cruzan v. Director, Missouri Department of Health* (1990)[120] illustrate the judiciary's approach to balancing patient autonomy against the state's interest in preserving life.

In re Quinlan marked the first judicial recognition that life-sustaining treatment may be withdrawn even when the patient is incapable of making the decision. The case arose when the parents of Karen Quinlan, a young woman in a persistent vegetative state, sought judicial authorization to remove her from artificial ventilation. The hospital, fearing criminal liability, refused to comply without a court order. The court, ruling in favor of the Quinlans, recognized that the right to privacy encompassed the right to refuse medical treatment. In its landmark decision, the Court declared: "The evidence in this case convinces us that the focal point of decision should be the prognosis as to the *reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence* to which Karen seems to be doomed."[121]

By prioritizing the patient's quality of life over mere biological survival, the *Quinlan* ruling set a precedent that allowed surrogate decision-makers, such as family members, to make end-of-life choices on behalf of incompetent patients. The case was instrumental in shifting the debate from the preservation of life at all costs to a more nuanced consideration of patient dignity and medical futility.

While *Quinlan* advanced the principle of patient autonomy, *Cruzan* reinforced the state's authority to regulate the conditions under which life support may be withdrawn. The case involved Nancy Cruzan, a woman in a persistent vegetative state whose parents sought to discontinue her artificial

---

[119] *See In re* Quinlan [hereinafter, "*Quinlan*"], 355 A.2d 647 (1976).
[120] *See* Cruzan v. Dir. Mo. Dept. Health [hereinafter, "*Cruzan*"], 497 U.S. 261 (1990).
[121] *Quinlan*, 355 A.2d, at 669.(Emphasis supplied.)

nutrition and hydration. The Missouri Supreme Court ruled against the parents, holding that no one could refuse treatment on behalf of an incompetent patient without clear and convincing evidence of the patient's prior wishes. On appeal, the U.S. Supreme Court upheld *Missouri*'s stringent evidentiary standard, ruling:

> It is permissible for Missouri, in its proceedings, to *apply a clear and convincing evidence standard*, which is an appropriate standard when the individual interests at stake are both particularly important and more substantial than mere loss of money [...] Here, Missouri has a general interest in the protection and preservation of human life, as well as other, more particular interests, at stake. *It may legitimately seek to safeguard the personal element of an individual's choice between life and death*. The State is also entitled to guard against potential abuses by surrogates who may not act to protect the patient."[122]

This decision marked a shift in judicial reasoning, requiring a higher standard of proof before life-sustaining treatment could be withdrawn from an incompetent patient. The ruling underscored the state's role in preventing potential abuses and ensuring that decisions to withhold or withdraw treatment are based on reliable and documented expressions of a patient's wishes.

The interplay between *Quinlan* and *Cruzan* reflects the continuing struggle to balance individual rights with state interests. Over time, courts have generally upheld a competent patient's right to refuse medical treatment, including resuscitation. Following *Cruzan*, physicians in the United States typically do not incur liability for entering a DNR order with the patient's informed consent. However, when dealing with incompetent patients, the legal standards vary by state.

Moreover, the once-stringent requirements concerning the irreversible and terminal nature of a patient's condition have become less rigid over time. Earlier rulings insisted on imminent death as a prerequisite for discontinuing life-sustaining treatment, whereas later jurisprudence acknowledges that treatment decisions should consider broader factors such as prolonged suffering, medical futility, and the patient's dignity.[123]

---

[122] *Cruzan*, 497 U.S., at 262, *citing* Santosky v. Kramer 455 U.S. 745 (1982). (Emphasis supplied.)

[123] *See In re* C.A., 603 N.E. 2d 1171 (1992).

2. Asian Perspectives: Family-Centered Decision-Making

Like the Philippines, family-centered decision-making often takes precedence over individual autonomy in many Asian countries, making it difficult for patients to independently sign their own DNR orders.[124] For instance, in Taiwan, although legal frameworks exist, such as the Patient Right to Autonomy Act ("PRAA") which mandates advance care planning ("ACP") consultations with the patient, family members, and healthcare professionals, studies show that family members often influence DNR decisions—reflecting Confucian cultural norms—which may lead to conflict or compromise patient autonomy.[125]

Similarly, in Singapore, legal provisions allow for advance directives, yet medical professionals face challenges in reconciling family expectations with patient rights.[126] The emphasis on decision-making complicates the standardization of DNR policies, leading to inconsistencies in their implementation across different healthcare institutions.

Japan does not have a comprehensive legal framework governing DNR orders, but the Ministry of Health, Labour and Welfare ("MHLW") has issued guidelines promoting physician-patient-family discussions regarding end-of-life care. Unlike in Western nations, where patient autonomy is prioritized, Japan's approach is more family-centered, meaning that family members often make decisions when the patient's wishes are unclear.[127]

In contrast, South Korea's Act on Hospice and Palliative Care of 2018 provides a legal framework for DNR orders, granting formal recognition to advance directives.[128] This law protects physicians from

---

[124] Yufang Tu et al., *Implications for End-of-Life Care: Comparative Analysis of Advance Directives Laws in Taiwan and the United States*, AM. J. HOSP. PALLIATIVE CARE 9, *online ahead of print* (2025), *at* https://doi.org/10.1177/10499091251328.

[125] Chun-Ta Huang et al., *High Mortality in Severe Sepsis and Septic Shock Patients with Do-Not-Resuscitate Orders in East Asia*, 11 PLOS ONE 1, 9 (2016), *at* https://doi.org/10.1371/journal.pone.0159501.

[126] Grace Yang, Ann Kwee, & Lalit Krishna, *Should Patients and Family be Involved in "Do Not Resuscitate" Decisions? Views of Oncology and Palliative Care Doctors and Nurses*, 18 INDIAN J. PALLIATIVE CARE 52, 53 (2012), *at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3401735/.

[127] Y. Tokuda, N. Nakazato, & K. Tamaki, *Evaluation of End-of-Life Care in Cancer Patients at a Teaching Hospital in Japan*, 30 J. MED. ETHICS 264, 264 (2004).

[128] Act No. 15912 (2018), art. 2 (S. Kor.). Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life.

liability when honoring a patient's documented DNR, ensuring both legal clarity and respect for patient autonomy. Furthermore, South Korea has developed a national registry for advance directives, ensuring that DNR orders are standardized and accessible across healthcare institutions.[129]

Thailand's National Health Act of 2007 explicitly recognizes a patient's right to refuse medical treatment, including resuscitation, through advance directives.[130] Healthcare providers are legally mandated to respect such directives, with structured protocols ensuring that DNR orders are ethically implemented while safeguarding patient autonomy.[131]

DNR in Malaysia policies vary due to its multicultural, multi-religious landscape. The Ministry of Health permits DNR orders based on medical futility, requiring patient or proxy consent. Islamic bioethics supports withholding futile treatment if legally and ethically justified. However, without standardized legislation, hospitals face inconsistent interpretations, creating ethical and medical dilemmas.[132]

4. International Human Rights and Medical Ethics Principles

The right to refuse medical treatment has been widely recognized under international legal instruments, reinforcing the principle that individuals cannot be subjected to unwanted medical interventions. The International Covenant on Civil and Political Rights ("ICCPR") establishes that forcing medical treatment on a person against their will constitutes a violation of their physical integrity and fundamental rights.[133]

This principle is echoed in the World Medical Association ("WMA") Declaration on the Rights of the Patient, which mandates that patients

---

[129] Ha Yeon Lee et al., *The Situation of Life-Sustaining Treatment One Year After Enforcement of the Act on Decisions on Life-Sustaining Treatment for Patients at the End-of-Life in Korea: Data of National Agency for Management of Life-Sustaining Treatment,* 53 CANCER RES. & TREATMENT 897, 898 (2021), *at* https://synapse.koreamed.org/articles/1154800.

[130] National Health Act, B.E. 2550 (2007), § 8 (Thai.).

[131] Srivieng Pairojkul et al., *Thailand's Experience in Advance Care Planning,* 180 ZEITSCHRIFT FÜR EVIDENZ, FORTILDUNG UND QUALITÄT IM GESUNDHEITSWESEN 85, 87–88 (2023), *at* https://doi.org/10.1016/j.zefq.2023.05.010.

[132] Keng Sheng Chew et al., *Navigating Do-Not-Attempt-Resuscitation Decisions in Emergency Department in Malaysia: A Retrospective Study*, 79 MED. J. MALAY. 591, 591 (2024), *at* https://www.e-mjm.org/2024/v79n5/do-not-attempt-resuscitation.pdf.

[133] International Covenant on Civil and Political Rights [hereinafter "ICCPR"] art. 17, Dec. 19, 1966, *at* https://www.ohchr.org/sites/default/files/ccpr.pdf.

actively participate in medical decision-making, including the right to reject resuscitative measures. These provisions collectively affirm that individual autonomy must be protected in end-of-life care, including decisions regarding DNR orders.[134]

In the Philippine context, a local hospital has referenced the World Medical Association's Lisbon Declaration on the Rights of the Patient as a basis for recognizing a patient's right to refuse treatment, including resuscitation.[135] However, there is no official record that the Philippine government has formally acceded to this declaration through legislative or executive action. It is only through the PMA, which is a member of the World Medical Association, that the Declaration of Lisbon on the Rights of the Patient was adopted by the country in 1981.[136] The Philippine Health Insurance Corporation ("PhilHealth") mandates all hospitals to publish a set of Patients' Rights and Responsibilities. However, the absence of a standardized version from the Department of Health (DOH) has resulted in hospitals developing their own versions independently.[137]

5. The Necessity for Legislative Action

While constitutional and jurisprudential principles uphold patient autonomy and the right to refuse treatment, the absence of clear legislation creates inconsistent application, potential conflicts with the state's duty to preserve life, and liability concerns for medical practitioners. Legal developments in various jurisdictions demonstrate that a well-defined legal framework for DNR orders not only safeguards patient rights but also provides essential guidance for the medical community in balancing ethical and legal responsibilities. In the absence of clear legislation, the enforceability of DNR orders remains vulnerable to judicial and institutional interpretation, potentially undermining the patient's right to self-determination.

Aligning the Philippine legal system with international human rights principles and ethical medical standards will promote respect for patient dignity while addressing the legal uncertainties that currently hinder the implementation of DNR orders. By enacting and formalizing a legal

---

[134] WORLD MED. ASS'N, WMA DECLARATION OF LISBON ON THE RIGHTS OF THE PATIENT (1981), *at* https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/.

[135] Patient Rights & Obligations, MAKATI MED. CTR. WEBSITE, *at* https://www.makatimed.net.ph/patient-and-visitor-guide/patient-reference/.

[136] PASCUAL, *supra* note **Error! Bookmark not defined.**.

[137] *Id.*

framework, the government can provide a coherent policy that reconciles individual autonomy with the state's legitimate interest in life preservation, ensuring a humane and legally sound approach to end-of-life decision-making.

V. FORMALIZING THE LEGAL FRAMEWORK OF DNR ORDERS IN THE PHILIPPINES

Legal scholars have begun to acknowledge the potential for the Civil Code's testamentary provisions to serve as a framework for understanding and formalizing advance directives.[138] Academics have suggested that the autonomy inherent in testamentary instruments may serve as a basis for legally recognizing end-of-life medical preferences.[139] These insights support the doctrinal viability of analogizing DNR orders to revocable wills, particularly as a transitional legal construct pending comprehensive legislation on advance directives.

A. Reconceptualizing DNR Orders as a Revocable Unilateral Act under the Civil Code

DNR orders may be doctrinally anchored on Philippine law as a form of revocable will. Under Article 783 of the Civil Code, a will is defined as "an act whereby a person is permitted, with the formalities prescribed by law, to control to a certain degree the disposition of his estate, to take effect after his death."[140] This provision highlights three essential attributes of a will: it is a unilateral and personal declaration of intent;[141] it becomes operative only upon a future contingency, namely, death; [142]and it is revocable at any time before that event.[143] These features bear a striking resemblance to the legal character of DNR orders.

When understood not merely as clinical directives but as juridical acts, DNR orders emerge as functionally analogous to other recognized

---

[138] Clyne Michael Jude Alvar et al., *The Right to Die: Establishing a Legal Framework for Living Wills and Healthcare Proxies in the Philippines* (Apr. 2021) (Law Master's Thesis, De La Salle University College of Law, *at* https://animorepository.dlsu.edu.ph/etdm_law/4/).

[139] Leido, *supra* note 96.

[140] CIVIL CODE, art. 783.

[141] Art. 784.

[142] Art. 783.

[143] Art. 828.

unilateral declarations under the Civil Code. Their defining elements—unilateral declaration of intent, future contingency, and revocability—are similar to testamentary instruments like wills and other declarations like a grant of agency.

At its core, a DNR order reflects the patient's autonomous will. It is issued without the need for acceptance or concurrence from any other party, be it a physician, relative, or healthcare institution. Like a testamentary disposition, the DNR order is a preemptive, personal declaration that articulates the patient's refusal to undergo CPR or other life-saving interventions in specific, foreseeable medical circumstances.

In juridical terms, it constitutes an exercise of the right to bodily integrity and informed refusal, grounded in the broader constitutional principle of autonomy. Its character as a unilateral act distinguishes it from bilateral arrangements or contractual protocols requiring mutual consent.

Similar to a will, which takes effect only upon the testator's death, a DNR order is operative only upon the occurrence of a future, medically defined contingency—typically cardiopulmonary arrest, clinical death, or a state of irreversible incapacity. Until such a condition materializes, the directive has no binding legal effect. Its essential juridical nature is thus prospective. This future-oriented structure aligns with how the law treats other instruments of anticipatory intent, including testamentary provisions and living wills.

Revocability is another fundamental attribute of both wills and DNR orders. So long as the declarant retains decisional capacity, they may unilaterally withdraw or modify the directive at any time. This revocability reflects the continuing dominance of the patient's will during their lifetime and reinforces the non-contractual, personal character of the instrument. Unlike binding agreements or third-party directives, a DNR order does not impose fixed obligations but remains subject to the evolving preferences of the patient. This feature further differentiates DNR orders from physician-initiated protocols, which may be governed by institutional standards rather than patient-driven revocation.

The legal significance of a DNR order emerges precisely at the point when the declarant can no longer participate in decision-making. It is intended to govern the moment of decisional incapacity, when the patient is unable to express consent due to unconsciousness, terminal decline, or imminent death. In this sense, a DNR order parallels the legal function of a

will: it takes effect when the subject is no longer capable of affirming or changing their decision. This aspect highlights the role of anticipatory declarations in preserving individual intent beyond the point of communication or consciousness.

Notably, the Civil Code recognizes a range of juridical acts that derive legal effect from unilateral declarations of will. These include wills,[144] the revocation of donations,[145] and the grant of authority under agency law.[146] A DNR order, while *sui generis*, shares structural features with each.

Where it involves the designation of a surrogate decision-maker, such as a spouse or child empowered to enforce the patient's wishes—the framework of special agency applies. Such authority, revocable at any time, operates within the limits of the grant and becomes relevant only upon the incapacity of the principal. The analogy to agency further supports the enforceability of DNR directives within the contours of existing civil law principles.

A DNR order, therefore, is a unilateral, anticipatory expression of a patient's intent to refuse resuscitative efforts upon a defined medical contingency. Like a will, it is prospective, revocable, and personal. Both are rooted in the legal principle of autonomy and reflect a structured exercise of self-determination.

Article 828 of the Civil Code affirms that a will is revocable at any time before death.[147] This principle has a clear analog in medical practice, where consent to treatment may be withdrawn at any point. DNR orders operate under this same logic: they remain subject to the declarant's evolving preferences and may be rescinded unilaterally.

Moreover, Philippine law already recognizes unilateral medical declarations with posthumous or incapacitative effect. In fact, Republic Act No. 7170 permits individuals to authorize the donation of their organs through a written instrument, without requiring the consent of another party.[148] These declarations, like DNR orders, gain effect only upon death or incapacity and are grounded solely in the declarant's autonomous will.

---

[144] Art. 783.
[145] Art. 760.
[146] Art. 1868.
[147] Art. 828.
[148] Rep. Act No. 7170 (1991), § 4(a). Organ Donation Act of 1991.

Though DNR orders are not yet subject to the same formalities as notarial or holographic wills, current hospital practice in the Philippines often requires written documentation, patient or surrogate signature, and physician acknowledgment. These procedural safeguards functionally mirror the evidentiary standards applied to testamentary instruments and reinforce the authenticity of the patient's intent.

In sum, the doctrinal similarities between DNR orders and revocable wills, both grounded in autonomy, revocability, and prospective effect, warrant a reclassification of DNR orders as unilateral declarations of will. Recognizing them as such not only aligns with existing Philippine legal principles but also provides a coherent, ethically sound, and legally defensible foundation for future regulatory frameworks. This approach affirms the dignity of patients facing end-of-life decisions and clarifies the legal obligations of healthcare providers who are often left navigating the moral and procedural uncertainties surrounding resuscitation.

B. Family and Surrogate Roles in DNR Decisions for Incapacitated Adults

While living wills provide clear guidance for patients who have expressed their wishes in advance, many situations arise where a patient is incapacitated and unable to communicate their preferences. In these cases, the roles of surrogates, family members, and the attending physician become critical in ensuring that decisions about DNR orders remain aligned with the patient's best interests, legal rights, and ethical standards of care. The authority to make medical decisions for an incapacitated individual is traditionally grounded in either parental authority (for minors), legal guardianship (for incapacitated adults), or legal representation (under the Mental Health Act).

1. Legal Representatives under the Mental Health Act

Under the Mental Health Act, a service user may appoint a legal representative or, if none is designated, the role defaults to specified family members, with up to three supporters also allowed for access to medical information and treatment discussions. These principles are further detailed in the Mental Health Act, particularly in Sections 10 and 11, which outline the designation, functions, and hierarchy of a legal representative, as well as the framework for supported decision-making:

Section 10. Legal Representative. - A service user may designate a person of legal; age to act as his or her legal representative through a notarized document executed for that purpose.

(a) Functions. A service use's legal representative shall:

(1) Provide the service user with support and help: represent his or her interests; and receive medical information about the service user in accordance with this Act;

(2) Act as substitute decision maker when the service user has been assessed by a mental health professional to have temporary impairment of decision-making capacity;

(3) Assist the service user vis-a-vis the exercise of any right provided under this Act; and

(4) Be consulted with respect to any treatment or therapy received by the service user. The appointment of a legal representative may be revoked by the appointment of a new legal representative or by a notarized revocation.

* * *

(c) Failure to Appoint. - If the service user fails to appoint a legal representative, the following persons shall act as the service user's representative, in the order provided below:

(1) The spouse, if any, unless permanently separated from the service user by a decree issued by a court of competent jurisdiction, or unless such spouse has abandoned or been abandoned by the service user for any period which has not yet come to an end:

(2) Non-minor children;

(3) Either parent by mutual consent, if the service user is a minor;

(4) Chief, administrator, or medical director of a mental health care facility; or

(5) A person appointed by a Court.

Section 11. Supported Decision Making. - A service user may designate up to three (3) persons or "supporters", including the service user's legal representative, for the purposes of supported decision making. These supporters shall have the authority to: access the service user's medical information; consult with the service user vis-a-vis any proposed treatment or therapy; and be present during service user's appointments and consultations with

> mental health professionals, workers and other service providers during the course of treatment or therapy.[149]

Applying these provisions, a duly appointed legal representative acts as the substitute decision-maker during periods of temporary incapacity, with the authority to consent to or refuse life-sustaining treatments, including resuscitation. If no representative is appointed, decision-making defaults to the next of kin in the order specified by the Act. In all cases, decisions regarding a DNR order must give utmost consideration to the service user's previously expressed wishes, values, and best interests, upholding their autonomy and dignity. Additionally, mental health professionals are expected to consult any designated supporters to ensure decisions reflect the service user's preferences and maintain transparency in such critical matters.

2. Provisions on Support under the Family Code

On the other hand, Article 194 of the Family Code defines support as encompassing sustenance, dwelling, clothing, education, and notably, *medical attendance*.[150] It also provides an order of priority among those obliged to give support, as outlined in Article 195 of the same Code:

> Article 194. Support compromises everything indispensable for sustenance, dwelling, clothing, *medical attendance*, education and transportation, in keeping with the *financial capacity* of the family.
>
> The education of the person entitled to be supported referred to in the preceding paragraph shall include his schooling or training for some profession, trade or vocation, even beyond the age of majority. Transportation shall include expenses in going to and from school, or to and from place of work. (290a)
>
> Article 195. Subject to the provisions of the succeeding articles, the following are *obliged to support each other to the whole extent* set forth in the preceding article:
>
> (1) The spouses;
>
> (2) Legitimate ascendants and descendants;
>
> (3) Parents and their legitimate children and the legitimate and illegitimate children of the latter;
>
> (4) Parents and their illegitimate children and the legitimate and illegitimate children of the latter; and
>
> (5) Legitimate brothers and sisters, whether of full or half-blood.[151]

---

[149] Mental Health Act, §§ 10–11.

[150] FAM. CODE, art. 194.

[151] Arts. 194–95. (Emphasis supplied.)

However, it seems that this provision primarily addresses the financial obligation to ensure such needs are met, rather than explicitly granting decision-making authority in medical treatment. Though the Supreme Court has not had any occasion to define what encompasses *medical attendance*, it may refer to the provision of necessary healthcare services such as consultations, treatments, medications, and other interventions essential to preserving the recipient's health and well-being. The extent of support is qualified only by Article 201 of the Family Code which states that "The amount of support… shall be in proportion to the resources or means of the giver and to the necessities of the recipient."[152] For example, in *Lim-Lua v. Lua*,[153] the Supreme Court affirmed that support encompasses essential needs, including medical expenses, as part of familial sustenance, citing Article 194 of the Family Code.[154]

Nevertheless, beyond its practical application, this concept also carries legal, cultural, and ethical implications, particularly regarding decision-making authority in medical care. In this context, the duty to provide medical attendance reflects a broader expectation of care, which may support a family member's role in consenting to necessary or appropriate medical interventions, or withholding them, when the patient is unable to do so. This is especially relevant in life-and-death situations where medical consent must be given promptly, such as signing a DNR order.

For spouses, the Family Code imposes mutual obligations that may strengthen this argument. Articles 68 to 71 enumerate the essential marital duties, including mutual love, respect, fidelity, and support.[155] Articles 70 and 71 further require spouses to render mutual support and jointly manage the household.[156] Importantly, Article 195 reinforces that spouses are legally bound to support each other, which, consistent with Article 194, extends to medical attendance.[157] These obligations go beyond mere financial support and reflect an expectation of active involvement in the spouse's welfare, including health-related matters.

---

[152] Art. 201.
[153] G.R. No. 175279, 697 SCRA 237, 250, June 5, 2013.
[154] FAM. CODE, art. 194.
[155] Arts. 68–71.
[156] Arts. 70–71.
[157] Arts. 194–95.

While the Family Code may not explicitly grant decision-making power for medical treatments, jurisprudence provides interpretative support. In *Azcueta v. Republic*,[158] the Supreme Court underscored the significance of marital obligations, which is ultimately based on the constitutional principle that family law is based on the policy that marriage, being more than a mere contract, is a social institution which the State protects. Although the case did not directly rule on medical decision-making authority, the Court recognized that the changing societal milieu does not change the ideal that the family ought to be an autonomous social institution, "wherein the spouses cooperate and are *equally* responsible for the support and well-being of the family."[159] This suggests an implied authority for a spouse to make such decisions, especially where the incapacitated partner's best interest and dignity are at stake.

Taken together, these legal provisions may reasonably be interpreted to support the authority of close family members to make critical medical decisions, such as signing a DNR order, when the incapacitated individual can no longer express their will. In the absence of clear hospital guidelines, these familial duties, combined with the necessity to protect the patient's dignity and welfare, provide a compelling basis for recognizing such authority in urgent medical situations.

This interpretation aligns with the practical realities of medical care, where immediate decisions are often necessary to uphold the patient's best interests. In such cases, family members naturally step into the role of surrogate decision-makers, acting out of love, duty, and necessity. By legal extension, a recognized surrogate's consent to a DNR order is valid and enforceable even without a formal Special Power of Attorney ("SPA"). Acting under the principles of implied agency or necessity, the surrogate's decision binds healthcare providers, who are obligated to respect and honor the patient's expressed wishes conveyed through the surrogate.

3. Civil Code Provisions on Agency

Under the Civil Code's provisions on agency, individuals may designate a healthcare proxy to act on their behalf when they are no longer capable of making medical decisions.[160] The requisites of agency, as

---

[158] G.R. No. 180668, 588 SCRA 196, 205, May 26, 2009.

[159] *Id.* at 217.

[160] CIVIL CODE, art. 1868. "By the contract of agency a person binds himself to render some service or to do something in representation or on behalf of another, with the consent or authority of the latter."

established in jurisprudence, are as follows: (1) Consent between the parties; (2) execution of a juridical act concerning third persons; (3) representation by the agent; and (4) the agent acting within the scope of the authority granted.[161] A special agent is limited to performing specific acts authorized by the principal, in this case, the patient.[162] For DNR decisions, the healthcare proxy's authority should be explicitly defined in a legally binding advance directive or power of attorney.[163] Any action taken outside this authority constitutes a breach, making the proxy legally accountable.

Jurisprudence establishes that powers of attorney are construed strictly, meaning that a proxy cannot make medical decisions beyond the scope of what is explicitly authorized.[164] Courts will not infer or presume additional powers beyond those expressly conferred. This principle ensures that the agent's actions remain within the bounds of the principal's intent. Additionally, agency relationships are subject to extinguishment, which is particularly relevant in addressing concerns about the perceived irrevocability of DNR orders. Under Article 1919 of the Civil Code, an agency terminates upon the accomplishment of its purpose, the expiration of the period for which it was constituted, or the death of the principal or agent.[165]

Thus, DNR orders must provide a mechanism for revocation, allowing a competent patient to modify or withdraw their directive at any time. Likewise, if a surrogate exceeds their legal authority, their decisions may be challenged as unauthorized or invalid. By formally recognizing DNR orders within the framework of wills and agency law, the Philippine legal system can establish procedural safeguards while ensuring patient autonomy is preserved.

---

[161] *See* Rallos v. Felix Go Chan & Sons Realty Corp., G.R. No. 24332, 81 SCRA 251, 259, Jan. 31, 1978; Tuazon v. Heirs of Ramos, G.R. No. 156262, 463 SCRA 408, July 14, 2005.

[162] CIVIL CODE, art. 1876. "An agency is either general or special. The former comprises all the business of the principal. The latter, one or more specific transactions."

[163] Loreto Laragan, *Do Not Resuscitate Order with Termination of Life Support Directive*, 43 FILIPINO FAM. PHYSICIAN 115 (2005), *at* https://www.herdin.ph/index.php?view=research&cid=24.

[164] *See* Woodchild Holdings, Inc. v. Roxas Electric & Constr. Co., Inc., G.R. No. 140667, 436 SCRA 235, 249, Aug. 12, 2004.

[165] CIVIL CODE, art. 1919.

C. Execution and Institutionalization of DNR Orders

Recent studies have underscored how the formal requirements imposed on advance directives, such as notarization or physician attestation, raise significant concerns regarding their evidentiary value and practical accessibility. While such formalities may enhance the legal robustness of a directive in probate or litigation settings, their more urgent function lies elsewhere: ensuring that a patient's wishes are clearly documented and readily retrievable by healthcare providers in emergency contexts, particularly when the patient is incapacitated. In this regard, the core legal challenge is not merely the authenticity of the directive, but its timely institutional availability. Legislative reforms must therefore prioritize systemic integration and accessibility within hospitals and emergency medical systems over rigid procedural formality.[166]

This broader inquiry into advance directives invites closer scrutiny of one specific type of directive that presents unique legal and clinical challenges: the DNR order. Unlike general living wills or healthcare proxies, DNR orders usually pertain to a highly specific medical intervention—CPR—and must often be acted upon in urgent, high-stakes clinical scenarios. The formal and substantive requirements governing DNR orders must therefore be attuned to both legal and medical exigencies: they must be simple enough to be executed and understood by laypersons, yet sufficiently clear to provide enforceable guidance to medical practitioners operating under time pressure.

International models offer valuable insights. The US developed "*Five Wishes Document*," for instance, provides an accessible, plain-language format through which individuals can articulate their values regarding surrogate decision-makers, comfort care, and the scope of life-sustaining treatment.[167] Its success stems from its ability to bridge legal enforceability and clinical practicality, qualities that DNR orders in the Philippines currently lack. Adapting similarly structured, patient-centered templates would enhance the operational clarity of DNR directives, ensuring both legal validity under the Civil Code and responsiveness to the realities of end-of-life care.

To institutionalize these reforms, the DOH should establish a centralized, state-maintained registry for DNR orders, accessible to hospitals and emergency medical services nationwide. At present, no law mandates

---

[166] Leido, *supra* note 96.

[167] *Id.*

such a system, leaving the implementation of DNR directives fragmented and dependent on individual hospital policies. A formal statutory framework is urgently needed—one that codifies written and witnessed DNR orders, provides clear rules on revocation, and offers legal protections for healthcare providers who act in good faith. Such a framework would bring the Philippines in line with international standards while reaffirming core constitutional principles of patient dignity, autonomy, and due process.

D. Legal Protections and Accountability for Healthcare Workers

The enforcement of DNR orders has been complicated by the increasing number of malpractice lawsuits for "wrongful prolongation of life." Courts have begun recognizing claims against healthcare providers who disregard a patient's documented refusal of treatment, shifting the legal landscape and raising fundamental questions regarding the enforceability of DNR orders.

1. Civil Liabilities of Healthcare Workers

In the United States, malpractice claims based on "wrongful prolongation of life" have been filed against physicians and hospitals that resuscitate patients despite documented DNR orders. These lawsuits assert that the patient's right to refuse medical intervention has been violated by medical professionals who either negligently or deliberately disregarded DNR directives. The core issue in these cases is whether a physician may be held liable for failing to honor a legally binding directive to withhold life-sustaining treatment.[168]

In the Philippines, medical malpractice litigation remains a complex and challenging area of law, as no special statute currently governs medical negligence. Unlike in other jurisdictions where specific laws define the legal parameters of medical liability, the Philippines relies primarily on jurisprudence to establish standards for medical malpractice and professional accountability.[169] The Supreme Court, in *Reyes v. Sisters of Mercy Hospital*,[170] defined medical malpractice in the following manner:

---

[168] Hassan, *supra* note 48, at 54.

[169] Lee Edson Yarcia, *Redefining "Duty" Towards an Objective Standard: An Interdisciplinary Appraisal of Medical Negligence Jurisprudence in the Philippines*, 91 PHIL. L. J. 416, 419 (2018).

[170] G.R. No. 130547, 341 SCRA 760, Oct. 3, 2000.

> Petitioner's action is for medical malpractice. This is a *particular form of negligence* which consists in the failure of a physician or surgeon to apply to his practice of medicine that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions, and in like surrounding circumstances. In order to successfully pursue such a claim, a patient must prove that the physician or surgeon either failed to do something which a reasonably prudent physician or surgeon would have done, or that he or she did something that a reasonably prudent physician or surgeon would not have done, and that the failure or action caused injury to the patient. *There are thus four elements involved in medical negligence cases, namely: duty, breach, injury, and proximate causation.*[171]

In this case, the Supreme Court further emphasized that medical negligence requires proof of four elements: duty, breach, injury, and proximate causation.[172] To clarify, there is a difference between medical negligence and medical malpractice, the latter being broader in scope. For violation of DNR orders, it is submitted that the broader concept of medical malpractice will be more applicable.

As will be discussed below, lawsuits involving DNR violations do not only arise based on negligence, but also on breach of contract. Medical malpractice suits are primarily governed by the Civil Law concept of damages.[173] For such actions to prosper, we should view this in terms of the legal recourse that a victim of medical malpractice has.

Under our present laws and jurisprudence, there are three main civil remedies available to patients:

a. Civil Action Based on Quasi-Delict

When a physician is at fault for an injury, a civil action like this is typically based on tort or quasi-delict.[174] A patient who has been the victim of medical negligence may bring a civil lawsuit to seek compensation for his

---

[171] *Id.* at 769. (Emphasis supplied.)
[172] *Id.*
[173] *See* Casumpang v. Cortejo, 755 Phil. 466, 484 (2015).
[174] *See* Lucas v. Tuailo, G.R. No. 178763, 586 SCRA 174, 199, Apr. 21, 2009.

injuries based on Article 2176 of the Civil Code.[175] The Supreme Court, in the case of *Cruz v. Court of Appeals*,[176] held that even where a contractual relationship such as a physician-patient relationship exists, Article 2176 may still be applied as a legal foundation for medical malpractice claims.

To establish liability for quasi-delict, the following elements must concur: (1) an unlawful act or omission amounting to fault or negligence, imputable to the defendant; (2) damage or injury to the plaintiff; (3) such damage or injury to the plaintiff was the natural and probable; or direct and immediate consequence of the defendant's wrongful act; and (4) there are no prior contractual relations between the plaintiff and the defendant,[177] although the fourth element may yield in medical negligence cases. Thus, to be held liable for malpractice**,** the elements of duty, breach, injury, and proximate causation must be established with substantial evidence, rendering a hospital, doctor, or other medical professionals liable for malpractice.[178]

Violation of DNR orders may constitute such breach. Although our jurisprudence has not directly tackled DNR-related negligence, the ruling in the U.S. case of *Anderson v. St Francis-St. George Hospital*[179] elaborates this concept in this wise: "*Whether intentional or negligent, interference with a person's legal right to die would constitute a breach of that duty to honor the wishes of the patient*."[180] Where a breach of duty has occurred, liability will not attach unless there is a causal connection between the conduct of the medical professional and the loss suffered by the patient.[181]

Additionally, under the Doctrine of Informed Consent, failure to adequately inform the patient of the nature and consequences of a treatment may amount to negligence. Based on the doctrine, the plaintiff must establish four key elements: "(1) the physician had a duty to disclose material risks; (2) he failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment

---

[175] CIVIL CODE, art. 2176. "Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called quasi-delict."

[176] G.R. No. 122445, 282 SCRA 188, 192, Nov. 18, 1997.

[177] CEZAR SANGCO, PHILIPPINE LAW ON TORTS AND DAMAGES (1993).

[178] *See* Gore v. Bd. Med. Quality, 110 Cal. App. 3d 184, 196 (1980)**.**

[179] Anderson v. St. Francis-St. George Hosp., 671 N.E. 2d 225 (Ohio 1996).

[180] *Id.* (Emphasis supplied.)

[181] *Id.*

[she] otherwise would not have consented to; and (4) plaintiff was injured by the proposed treatment."[182]

For DNR cases, this doctrine may be logically applied to mean the reverse situation—before the patient and/or legal representative consents to the proposed withdrawal of life support. In this situation, it is vital for the physician to disclose material information on DNR protocols.

b. Civil Action Based on Intentional Tort

Intentional tort applies where a physician deliberately disregards a patient's will, such as by performing CPR despite an active DNR order. Under common law, such acts may amount to battery, defined as the intentional infliction of physical contact without consent.[183] Battery is legally defined as "[a]ny unlawful beating, or other wrongful physical violence or constraint, inflicted on a human being without his consent"[184] In this context, the issue is not the standard of care but the deliberate, unauthorized physical interference. Apart from demonstrating an unauthorized examination or treatment, there must be evidence that the physician's "touching" was deliberate, such as when there is deliberate disregard on the active DNR order.[185]

As explained in the case of *Allore v. Flower Hospital*,[186] recovery may be limited to damages directly resulting from the act of resuscitation, excluding broader claims like medical expenses or pain and suffering. In *Wright v. Johns Hopkins Health Systems,*[187] the court expressly deferred to the legislature the question of whether wrongful prolongation of life constituted a separate tort.

---

[182] *See Li*, 651 SCRA at 59, n.64 Davis v. Kraff, 937 N.E. 2d 306 (2010), *citing* Coryell v. Smith, 653 N.E. 2d 1317 (1995).

[183] JOSEPH KING, THE LAW ON MEDICAL MALPRACTICE 179 (2nd ed. 1986).

[184] HENRY CAMPBELL BLACK, BLACK'S LAW DICTIONARY 123 (2nd ed. 1910).

[185] Leonard Berlin, *Do Not Resuscitate*, 175 AM. J. ROENTGENOLOGY 1513, 1515 (2000), *at* https://www.ajronline.org/doi/epdf/10.2214/ajr.175.6.1751513

[186] Carol Wessels, *Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives*, 2 MARQUETTE ELDER'S ADVISOR 217, 231 (2012), *citing* Allore v. Flower Hospital, 699 N.E. 2d 560 (1997).

[187] *Id., citing* Wright v. Johns Hopkins Health, 728 A.2d 166 (1999).

c. Civil Action Based on Breach of Contract

While rare, medical malpractice liability may also arise from breach of contract, particularly where care plans incorporate advance directives.[188] In the United States, certain lawsuits for wrongful prolongation of life were filed for breach of contract. In *Scheible v. Joseph L. Morse Geriatric Center, Inc,*[189] a jury awarded damages upon finding that the nursing home violated its contractual obligation to honor the patient's living will, despite rejecting the claims for battery and negligence.

However, on appeal, the court found no sufficient basis for wrongful prolongation of life under a contractual theory, underscoring the uncertainty surrounding such claims in the absence of clear statutory or jurisprudential guidance.

2. Legal Protections for Healthcare Providers

Protection against litigation for withholding resuscitation is another crucial area for legal reform. Currently, medical malpractice laws focus on wrongful prolongation of life, but there is also a risk of lawsuits from families contesting the withholding of resuscitative measures. To mitigate this risk, legal reforms should clarify that a provider cannot be sued for withholding CPR if a valid DNR order is in place. Additionally, legal presumptions should favor healthcare providers who document their decision-making process, and professional discretion should be recognized in ambiguous cases while safeguarding against liability.

Legal protections must also consider ethical and religious beliefs of healthcare providers. Some professionals may object to DNR orders on moral grounds. Laws should allow conscientious objection, provided the provider ensures continuity of care by transferring the patient to a willing provider. Healthcare institutions should develop policies that accommodate diverse beliefs while prioritizing patient autonomy.

3. Integration into the Broader Healthcare and Legal Framework

For DNR orders to be effective, they must be standardized, legally recognized, and integrated into healthcare systems. Inconsistent hospital

[188] *See* Christ v. Lipsitz, 160 Cal. Rptr. 498 (1979).
[189] Scheible v. Joseph L. Morse Geriatric Ctr., Inc., 988 So. 2d 1130 (2008).

policies create confusion, highlighting the need for uniform guidelines, a national registry, and recognition across jurisdictions to ensure seamless enforcement, especially during patient transfers.

Incorporating DNR orders into electronic health records ("EHR") enables real-time access, reduces errors, and ensures immediate medical staff alerts. Legal frameworks should require advance directives to specify resuscitation preferences, establish clear surrogate hierarchies, and mandate legal counseling for enforceability.

DNR recognition must extend to emergency medical personnel. Emergency Medical Services (EMS) teams should be trained to verify and honor pre-hospital DNRs, with legal protections ensuring compliance without liability risks. Institutionalizing DNR orders within Philippine law will safeguard patient rights, provide legal clarity for healthcare providers, and align medical practice with global standards while respecting cultural and religious values.

VI. CONCLUSION AND RECOMMENDATIONS

While Philippine law does not criminalize suicide, it likewise does not affirmatively recognize a right to die or a right to refuse medical treatment. As *parens patriae*, the State has a legitimate interest in preserving life. Yet this interest cannot be exercised in a vacuum—it must be balanced against the constitutional right to autonomy and the ethical imperative to preserve dignity at the end of life. The forced administration of life-sustaining interventions, when no meaningful therapeutic benefit exists, can prolong suffering, violate bodily integrity, and erode the patient's humanity. In this context, the right to refuse treatment must be understood not as an abstract constitutional guarantee, but as a concrete juridical expression grounded in existing civil law principles, particularly those governing wills and special agency.

In the case of Patient A, as narrated in the Introduction, no legal rights were violated when the medical team initiated resuscitative measures, as there was no pre-existing DNR order. Under existing medical and legal principles, Dr. C was duty-bound to initiate life-saving interventions upon the deterioration of the patient's condition.

The physician-patient relationship obligates physicians to act in the best interests of their patients. In the absence of a documented refusal of

resuscitation, Dr. C had the legal and professional authority to administer CPR until such efforts were deemed medically futile or no longer in the patient's best interest. Faced with conflicting views among family members and the urgency of the situation, Dr. C was compelled to intervene and proceed with life-saving measures. At no point did he have the unilateral authority to withhold resuscitation without legal documentation explicitly supporting such a decision.

While Mr. B, as the spouse of Patient A, naturally stood as her closest family member, his authority to make surrogate medical decisions would have been recognized in the absence of specific hospital guidelines requiring formal legal documentation, such as an SPA or a healthcare proxy. Without such hospital guidelines in place, Mr. B could have reasonably been allowed to speak on behalf of Patient A. However, in this case, as the hospital did require formal documentation, his capacity to intervene was limited, leaving him without a legal basis to challenge Dr. C's decision to continue CPR.

Nevertheless, when viewed alongside relevant legal provisions and jurisprudence, a reasonable interpretation supports the authority of close family members to make critical medical decisions, such as signing a DNR order, when the patient is incapacitated and unable to express their will. In situations where hospital protocols are unclear or absent, the familial role, grounded in the duty to safeguard the patient's dignity and welfare, provides a compelling basis to recognize such authority, particularly in urgent medical circumstances.

Discontinuing life support in cases where extraordinary care is still being administered allows the natural process of dying to take its course. This aligns with the principles of non-voluntary passive euthanasia, wherein medical professionals cease interventions that prolong life without actively hastening death. However, Philippine law does not explicitly recognize passive euthanasia as a legal practice, and the lack of statutory clarity on DNR orders has resulted in uncertainty in end-of-life decision-making.

The implementation of DNR orders must be explicitly sanctioned by legislation to provide legal safeguards for physicians, protect patient autonomy, and clarify the rights and responsibilities of families. Without a formal legal framework, medical professionals will continue to face legal and ethical dilemmas in withholding resuscitative efforts, while patients and families will lack clear guidance on their rights in making end-of-life decisions.

This article examined the legal and ethical challenges of DNR orders in the Philippines, emphasizing the lack of national legislation and standardized guidelines, which has led to inconsistent hospital policies and conflicts among patients, families, and healthcare providers, especially during COVID-19. Without statutory support, DNR orders risk being misinterpreted as passive euthanasia. Allowing families to authorize DNR decisions without prior consent exposes healthcare providers to legal risks, including allegations of negligence or liability. Physicians, lacking clear authority, struggle with critical care decisions in the absence of institutional guidelines.

To address this, the paper advocates the recognition of DNR orders as unilateral, revocable declarations of will, analogous to testamentary acts under the Civil Code. This doctrinal grounding offers a viable legal basis for enforceability while preserving the patient's autonomy and shielding medical professionals from liability. In pursuing legislative reform, the following considerations must be taken into account: an enabling statute should codify the legal effect of DNR orders, set standards for surrogate decision-making, and promote public awareness on advance care planning. While the then-proposed Magna Carta of Patients' Rights gestures toward this goal by recognizing a patient's right to make an advance written directive for terminal care,[190] it remains insufficient without specific statutory language governing the legal effect, scope, and procedural implementation of end-of-life decisions.

In the short term, the DOH should establish standardized DNR policies across all healthcare facilities. These policies must define eligibility criteria, set documentation requirements, and clarify the legal standing of healthcare proxies. Additionally, public awareness campaigns and education programs for medical professionals are essential to ensure informed decision-making and consistent implementation of DNR orders.

In the medium term, legal recognition of advance directives is necessary to safeguard patient autonomy. Enacting a law on advance directives should be a priority, establishing the legal validity of living wills and medical power of attorney under Philippine law. DNR orders should also be classified as legally enforceable wills under the Civil Code, ensuring compliance with legal standards. A centralized electronic registry for DNR

---

[190] S. No. 812, 14th Cong., 1st Sess., § 4 (2007). Magna Carta of Patient's Rights and Obligations introduced by Senator Ramon Bong Revilla, Jr.

orders would further enhance accessibility and prevent misinterpretation or disputes over medical decisions.

In the long term, a law on natural deaths should be introduced to provide legal protections for patients who refuse resuscitation, clearly outlining the responsibilities of healthcare providers in implementing DNR orders. This law should differentiate passive euthanasia from assisted suicide, preventing legal ambiguities in end-of-life care. Physicians and nurses who comply with valid DNR orders should be shielded from civil and criminal liability, ensuring that honoring a patient's directive is not mischaracterized as medical negligence. Establishing judicial precedents would further clarify legal interpretations of DNR compliance, affirming that withholding resuscitation per a patient's wishes does not constitute malpractice.

Integrating DNR protocols into medical education is also essential. Medical and nursing curricula should include training on end-of-life ethics, palliative care, and advance directives to prepare future healthcare professionals for the complexities of DNR implementation. Continuing education should also be mandated for practicing physicians and healthcare workers to ensure the consistent application of DNR policies. Ultimately, the legal and ethical uncertainties surrounding DNR orders in the Philippines highlight the urgent need for legislative, institutional, and procedural reforms. By implementing a structured, phased strategy, the country can establish a clear, comprehensive, and ethically sound legal framework for end-of-life decision-making.

- o0o -

ANNEX: SAMPLE DNR ORDER FORM[191]

DO NOT RESUSCITATE (DNR) ORDER/
ORDER TO WITHHOLD/ WITHDRAW LIFE SUSTAINING TREATMENT

(This form shall always accompany a DNR written order in the Patient's Chart)

Date / Time	☐ In patient ☐ Outpatient	Room/Bed no.	PIN
Last Name	First Name	Middle Name	
Attending Physician			

In case of cardiopulmonary (CP) arrest: Call the Code Team ☐ YES ☐ NO
Indicate treatment/s to be withheld / withdrawn:

[redacted]	☐ Withhold	☐ Withdraw
Defibrillation	☐ Withhold	☐ Withdraw
[redacted]	☐ Withhold	☐ Withdraw
Dialysis	☐ Withhold	☐ Withdraw
[redacted]	☐ Withhold	☐ Withdraw
Other(s):		
Nutrition	☐ Withhold	☐ Withdraw
_____	☐ Withhold	☐ Withdraw
_____	☐ Withhold	☐ Withdraw

Rationale (check all that apply):
☐ Patient is terminally ill
☐ Resuscitation would be medically futile
☐ Patient is permanently unconscious
☐ Patient (or legal surrogate/relative) has determined that burdens outweigh benefits
☐ Others: _____

Other Instructions / Specific orders:
_____

Medical Facts: _____

Evidence of patient's wishes (if any): _____

Patient's mental competency (check one): ☐ CAPABLE ☐ INCAPABLE

[191] Actual DNR order form used in a tertiary hospital in Quezon City.