VII. CONCLUSION

Absolute divorce should finally be allowed in the Philippines. When the law refers to marriage as "an inviolable social institution," it should be construed as referring to marriages that actually serve as strong pillars of the family. It is futile to preserve unions when it is apparent that spouses can no longer perform the basic marital obligations to love, respect and the observance of fidelity. As upheld in *Antonio v. Reyes*, the State also has to be on guard for marriages that do not promote a healthy family life. Family members are only placed at a greater peril if they remain exposed to violence or constant conflict. These families deserve protection as well, not by constraining that they remain together, but rather, by providing them a remedy that will allow them to live free from marital discord.

Moreover, the Family Code was enacted with the avowed purpose of providing a law that is reflective of contemporary trends and conditions. The numerous petitions to dissolve marriages filed in courts, the perils of physical and emotional abuse in family relationships, the evolving power relations of husbands and wives and the inadequacy of remedies available to spouses are the realities that the law should contend with at present. The law's purpose will only be served if it will not shirk from these realities — realities that establish the need for absolute divorce in the country.

Indeed, the law should continuously strive to protect the institutions of marriage and the family because they in turn, build society in general. However, the genuineness of these relations which is determinant of whether they can actually live up to their responsibility to society does not depend solely on legal status. In cases where the latter is the only remaining tie that binds, a remedy should be available for family members to start anew.

Will to Live: A Proposal for a Philippine Law Recognizing, Governing, and Regulating Living Wills

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Cite as 52 ATENEO L.J. 463 (2007).

I. INTRODUCTION

To fear death, gentlemen, is no other than to think oneself wise when one is not, to think one knows what one does not know. No one knows whether death may not be the greatest of all blessings for a man, yet men fear it as if they knew that is the greatest of evils. And surely it is the most blameworthy ignorance to believe that one knows what one does not know.

— Plato, "The Apology, Socrates"

The acceptance of the concept of *death with dignity* has sparked an explosion of legislation about end-of-life medical decisions, one aspect of which includes living wills. A living will is a document which expresses or declares a person's choices regarding future medical treatments to be implemented in the event of incapacity.[1] It is a written instruction about medical treatment that is usually administered when a patient is terminally ill or permanently unconscious. A living will is a type of advance health care directive, and sometimes contains a specific type of power of attorney or health care proxy which designates a surrogate decision-maker. Being a legal instrument, it is usually witnessed or notarized.[2] It generally provides guidance and expresses a person's preferences for medical care, which usually deal with consent to or refusal to receive medical treatments under various circumstances.[3] It is intended to anticipate a situation wherein an individual is in an incurable or an irreversible mental or physical condition, with no reasonable expectation of recovery.[4]

A living will is based on and extends the principle of consent. Under the principle of consent, patients must agree to any medical procedure before physicians can start treatment.[5] Typically, living wills are used to direct doctors to discontinue life-sustaining treatments — such as intravenous feeding, mechanical respirators, or cardiopulmonary resuscitation — that serve only to indefinitely prolong a patient's life.[6] A living will preserves personal control and eases the decision-making burden of a family. Without

1. *Living Wills, in* THE ENCYCLOPEDIA OF SURGERY: A GUIDE FOR PATIENTS AND CAREGIVERS, (2005), *at* http://www.surgeryencyclopedia.com/La-Pa/Living-Will.html (last accessed Sep. 18, 2007).
2. *Living Wills, in* WIKIPEDIA, http://en.wikipedia.org/wiki/Living_will (last accessed Sep. 18, 2007) [hereinafter *Living Wills*].
3. *Id.*
4. Hamill & Gray, Massachusetts Living Wills, *available at* http://www.massachusetts-wills.com/living_wills.html (last accessed Sep. 18, 2007).
5. *Living Wills*, *supra* note 2.
6. *Living Will, in* THE COLUMBIA ELECTRONIC ENCYCLOPEDIA, http://www.bartleby.com/65/li/livingwill.html (last accessed Sep. 18, 2007).

one, the decision of whether or not to discontinue treatment usually becomes the responsibility and burden of spouses and family members, sometimes necessitating court intervention.[7] Instructions in living wills are usually intended to apply only if the person is in a terminal condition, is permanently unconsciousness, is in a Persistent Vegetative State (PVS), or is conscious but has irreversible brain damage and will never regain the ability or legal capacity to make an informed decision.[8] Living wills can also be used to provide for any expression whatsoever of a testator's wishes as to health care and treatment, specifying a preference to be cremated or for certain organs to be donated. The concept of living wills is relatively new and is, therefore, inevitably the subject of much debate. The ethical and legal problems that arise in making decisions about starting, continuing, and stopping medical treatments are complex and are shaped by many factors. Among these are legal traditions — the traditions of ethics in medicine and in moral philosophy more generally — and also cultural, social, and religious values, which are quite diverse and may vary subtly from one region or country to the next.[9]

The influence of medical technology has been a significant factor in the debate over living wills. Cases on end-of-life care usually involve patients whose lives could be prolonged by new medical treatments and technologies, but whose health, functioning, quality of life, and even conscious awareness could not be restored.[10] Before advances in modern science made it possible to prolong life through artificial heart and lung machines, death was fairly easy to notice. When the beat of the heart stopped, one was considered dead. Now, with technology developed to resurrect the dying, the once clear-cut line between life and death has been blurred, inciting a fury of discussion.[11]

7. *Living Will, in* INVESTOPEDIA, http://www.investopedia.com/terms/l/livingwill.asp (last accessed Sep. 18, 2007).
8. NEW YORK STATE BAR ASSOCIATION, LIVING WILL AND HEALTH CARE PROXY BROCHURE (1999).
9. Alan Meisel & Bruce Jennings, *Ethics, End-of-Life Care, and the Law: An Overview, in* LIVING WITH GRIEF: ETHICAL DILEMMAS AND END-OF-LIFE CARE 63 (2005).
10. *Id.*
11. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Guidelines for the Determination of Death*, 246 JAMA 2184, 2184-86 (1981).

One legal controversy that has been the subject of much debate deals with the legal definition of brain death.[12] Death is legally defined as the irreversible cessation of circulatory and respiratory functions or the irreversible cessation of all functions of the entire brain, including the brain stem.[13] Due to medical advancements, however, it is now possible to revive some people after a period without respiration, heartbeat, or other visible signs of life using life support treatments. The concept of "brain death," thus, emerged from these developments. In the Philippines, the start of a person's life is clear,[14] but the definition of death in Republic Act No. 7170, lends itself to ambiguity especially in cases where a person is diagnosed to be in PVS.[15]

Under Republic Act No. 7170, a person is medically and legally dead if either:

> (1) In the opinion of the attending physician, based on the acceptable standards of medical practice, there is an absence of natural respiratory and cardiac functions and, attempts at resuscitation would not be successful in restoring those functions. In this case, death shall be deemed to have occurred at the time these functions ceased; or,
>
> (2) In the opinion of the consulting physician, concurred in by the attending physician, that on the basis of acceptable standards of medical practice, there is an irreversible cessation of all brain functions; and considering the absence of such functions, further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such natural functions. In this case, death shall be deemed to have occurred at the time when these conditions first appeared.[16]

12. James J. Hughes, *Brain Death and Technological Change: Personal Identity, Neural Prostheses and Uploading*, *available at* http://www.changesurfer.com/Hlth/BD/Brain.html (last accessed Sep. 18, 2007).

13. An Act Authorizing the Legacy or Donation of All or Part of a Human Body After Death for Specified Purposes [ORGAN DONATION ACT OF 1991], Republic Act No. 7170, § 2 (j) (1991).

14. An Act to Ordain and Institute the Civil Code of the Philippines [CIVIL CODE], Republic Act No. 386 (1950). Article 41 provides:

> For civil purposes, the fetus is considered born if it is alive at the time it is completely delivered from the mother's womb. However, if the fetus had an intra-uterine life of less than seven months, it is not deemed born if it dies within twenty-four hours after its complete delivery from the maternal womb.

15. The Organ Donation Act of 1991 defines death as "the irreversible cessation of circulatory and respiratory functions or the irreversible cessation of all functions of the entire brain, including the brain stem," which is inconsistent with the definition of persistent vegetative state, where there is generally presence of circulatory and respiratory functions. *See generally, Persistent Vegetative State*, *in* WIKIPEDIA, *at* http://en.wikipedia.org/wiki/Persistent_vegetative_state (last accessed Sep. 18, 2007).

Death is deemed to have occurred at the time when the above conditions first appear, and should be "determined in accordance with the acceptable standards of medical practice and shall be diagnosed separately by the attending physician and another consulting physician," both of whom must also be qualified and suitably experienced in the care of such parties.[17]

The controversy surrounding the determination of what constitutes *brain death* stems from two schools of thought, namely, those who advocate for a "whole-brain" criteria for determining death versus those who believe that a "higher-brain" criteria should be used as a standard of death.[18] While "whole-brain" advocates essentially equate the death of the human person with an irreversible cessation of total brain function, those that believe in the "higher-brain" criteria look at certain neurological criteria for brain death based upon functional differences between the different parts of the brain. The issue of concern between advocates of "whole-brain" and "higher-brain" death criteria is essentially a question of which brain structures and functions an individual should lose to certify that the body no longer has power over the capacity for spontaneous regulation of vital processes.[19]

Another issue connected with the determination of death is a condition known as PVS. Patients in a PVS are usually in a comatose state with severe brain damage, or in a state of wakefulness without detectable awareness. They have lost all higher brain functions; however, brain stem functions remain largely intact.[20] Using the "higher-brain" criteria, those in a PVS would be considered dead.[21] Nevertheless, being in this state is still not

16. ORGAN DONATION ACT OF 1991, § 2 (j), ¶ 1.

17. *Id.* § 2 (j), ¶ 2.

18. Lydia Parnell, Living Dead, Walking Life, http://serendip.brynmawr.edu/biology/b103/f02/web1/lparnell.html (last accessed Sep. 18, 2007).

19. *Id.*

20. James Mulligan, Caring for the Unconscious, *available at* http://www.lifeissues.net/writers/mul/mul_01uncounscious.html (last accessed Sep. 18, 2006).

21. David L. Perry, Ethics and Personhood: Some Issues in Contemporary Neurological Science and Technology, *available at* http://www.scu.edu/ethics/publications/submitted/Perry/personhood.html (last accessed Sep. 18, 2007).

recognized as death in any known legal system.[22] From the definition of death in Republic Act No. 7170, it is clearly shown that our jurisdiction adheres to the "whole-brain" death criteria, such that a person in a PVS, who is awake but without any awareness, will be considered alive. The conflict in this area thus arises between those who believe that individuals in a PVS should be allowed to die a natural death, if they so choose, and those who believe that care should continue despite the dim prognosis.[23] Meanwhile, some terminally ill patients are in constant pain and experience an intolerably poor quality of life; thus, they would prefer to *die with dignity* by refusing medical treatment that would only serve to prolong their life rather than continue unnecessary or extraordinary treatment that would only subject them to more pain and suffering without restoring their quality of life.

Ultimately the question that needs to be answered is: Should a person who is terminally ill, who feels that he is near the end of his life, and who actively refuses medical treatment by virtue of a living will, be given the right to die?[24] Although laws should protect the interests and well-being of vulnerable individuals who are near death and who are unable to protect themselves, laws should also safeguard the rights of individuals to determine the course of their own medical care, to be free from unwanted and burdensome medical treatment, and to preserve the dignity and integrity of their person and body. Since death deals with not just the legal, but also the socio-cultural and religious, aspects of society, the law should also be attuned to the existing unique socio-cultural and religious values of a specific nation or group of people.

At present, Philippine laws do not specifically recognize the rights of patients and address the challenges of end-of-life medical care. Hence, this article aims to answer the following questions:

1. Are living wills constitutional in the Philippines?
2. Is there a need for a law governing living wills in the Philippines?
3. Considering the cultural and religious background of the Philippines, what are the practical and operational hazards facing the recognition, implementation, and enforcement of living wills?

22. *Persistent Vegetative State*, *in* WIKIPEDIA, *at* http://en.wikipedia.org/wiki/Persistent_vegetative_state (last accessed Sep. 18, 2007).

23. *Id.*

24. ReligiousTolerance.org, Euthanasia and Physician Assisted Suicide: Further Information, *at* http://www.religioustolerance.org/euth2.htm (last accessed Sep. 18, 2007).

The right of an individual to make his own decisions about his life and medical care is the basic principle underlying patients' rights.[25] Patients have the right to be informed about treatments and ultimately have the right to make their own decisions about the health care they receive or do not receive.[26] Where, however, a patient cannot express their wishes — especially in situations where they are incapacitated, permanently unconscious, or in a PVS — and decisions are needed with regard to withdrawing life-sustaining treatment, doctors have no way of knowing the extent of care a patient would have preferred. In such cases, doctors and hospitals have to follow prevailing medical standards, sometimes exposing themselves to liability. In the Philippines, when a patient is incapacitated or is permanently unconscious, by custom, it is his spouse, siblings, or children who make end-of-life decisions, but there is no specific rule in Philippine law that provides for a hierarchy of who should make end-of-life medical decisions. Although Philippine law provides for guardianship proceedings in case of incompetents, this involves a petition in court and lengthy determination regarding the fitness of a guardian; this is essentially ineffective and useless since, oftentimes, decisions about medical treatment have to be made in a split second. Current practice in the Philippines sometimes results in a moral dilemma for the family and often leads to family conflicts kept hidden from public view.

The recognition of living wills and a subsequent Philippine law governing and enforcing it will address this problem, boost and improve the situation of patient's rights, and even strengthen the medical industry. Not only will a law on living wills bolster every patient's right to self-determination, but doctors will also have the means to enforce a patient's wishes over that of his family, especially with regard to life-sustaining medical treatments. A law regulating living wills will also limit the liability of doctors and hospitals since they cannot be sued as long as they follow the instructions of patients who have executed a living will to withhold or withdraw life-sustaining treatment according to prevailing medical standards.

25. *See*, The Center for Unhindered Living, Your Right to Refuse Medical Treatment or Testing, *at* http://www.unhinderedliving.com/medicalrights.html (last accessed Sep. 18, 2007).

26. *See generally*, Advocate Health Care, Patient Consent and Rights of Care, *at* http://www.advocatehealth.com/system/services/homehealth/rights.html (last accessed Sep. 18, 2007).

II. DEVELOPMENT OF THE LAW ON LIVING WILLS

The debate over the legal, ethical, and political implications of death and dying is a relatively recent phenomenon. Prior to the scientific and technological revolutions of the 19th and 20th centuries, most people died at home, often quite rapidly from viral or bacterial infections, or other diseases for which there were no effective treatments.[27] The modernization of health care in the 20th century dramatically changed the character of death and dying. In 1900, the average lifespan was 47.3 years, and by 1997, it had increased to 76.5 years — a gain of 29.2 years in less than a century.[28] More importantly, new technologies — such as ventilators, feeding tubes, monitoring devices, and drugs to control bodily functions and fight infections — can keep a person alive for months or years after major illness or trauma.[29]

The term *living will* was coined by American lawyer Louis Kutner[30] in 1969 as a simple device to allow patients to say no to life-sustaining treatment that they do not want, even if they were too ill to communicate.[31] In his paper, Kutner stated that, at the time, the law did not recognize the right of a patient to die if he so desired, even if such an individual may be "in a terminal state suffering from an incurable illness and literally forced to continue a life of pain and despair,"[32] and he argued that "such a denial of an individual's refusal to treatment may well infringe upon such individual's right of privacy."[33] Similar arguments advocating the right of an individual to refuse of medical treatment gained wider acceptance in the 1960s, as the civil rights movement, the sexual revolution, and other social movements — more specifically, those involving voluntary euthanasia — facilitated the

27. The Pew Forum on Religion & Public Life, Supreme Court Considers Challenge to Oregon's Death with Dignity Act, *at* http://pewforum.org/publications/reports/Gonzales-vs-Oregon.pdf (last accessed Sep. 18, 2007) [hereinafter The Pew Forum on Religion & Public Life].

28. ELLEN KRAMAROW, ET AL., HEALTH, UNITED STATES, 1999 WITH HEALTH AND AGING CHART BOOK 19 (1999).

29. Paul Root Wolpe, *Technology alters dying in America*, THE PHILA. INQUIRER, Apr. 30, 2006, http://www.philly.com/mld/inquirer/news/special_packages/sunday_review/14460828.htm (last accessed June 30, 2006).

30. Louis Kutner, *Due Process of Euthanasia: The Living Will, a Proposal*, 44 IND. L.J. 539 (1969).

31. British Broadcasting Corporation, Religion and Ethics, *at* www.bbc.co.uk/religion/ethics/euthanasia/euth_living_will.shtml (last accessed June 30, 2006).

32. Kutner, *supra* note 30, at 543.

33. *Id.*

expansion of the notion of personal freedom.[34] By this time, people had already begun to question the drive of medicine to keep patients alive for as long as possible, even at the cost of painful and ultimately futile treatments.[35] From this impetus grew the movement for hospice care as an alternative to dying in hospitals.[36] As a consequence, in 1967, the first *right to die* bill was introduced in the Florida legislature. It, however, failed; as did a similar measure in the Idaho legislature in 1969.[37]

In the 1970s, the end-of-life debate was vaulted onto the national stage, due to the highly publicized case of Karen Quinlan.[38] New Jersey Chief Justice Richard J. Hughes found that Karen, and ultimately her father, had the right to terminate her life support and based this on the constitutional right to privacy. Under the circumstances of the case, the State had no compelling interest that could outweigh an individual's liberty to control what medical treatment Karen would undergo. Following this decision, the California Natural Death Act[39] was passed. This law allowed declarations to physicians by adult patients directing them to withhold or withdraw life-sustaining procedures when in a terminal condition or permanent unconscious state.[40] Hence, the California Natural Death Act became the first dying statute that gave legal standing to living wills. The Act primarily prevented physicians from being sued for failing to treat incurable illnesses. After the passage of the California Natural Death Act, several U.S. states followed suit and this paved the way for similar dying statutes to be passed elsewhere around the U.S. and the globe. By 1984, 22 U.S. states and the District of Columbia recognized advance health care directives.[41]

In 1990, the U.S. Supreme Court finally recognized and gave constitutional protection to an individual's "right to die" in the case of

34. *Id.*

35. Deborah Stone, *Die Hards*, THE AMERICAN PROSPECT ONLINE EDITION, Apr. 8, 2006, http://www.prospect.org/web/printfriendly-view.ww?id=11310 (last accessed June 30, 2006).

36. *Id.*

37. The Pew Forum on Religion & Public Life, *supra* note 27, at 3.

38. *In re* Quinlan, 355 A.2d 647 (N.J. 1976).

39. California Natural Death Act, HEALTH & SAFETY, §§ 7185-94.5 (1976).

40. *Id.*

41. Derek Humphry, Chronology of Euthanasia and Right-to-Die Events During the 20th Century and into the Millennium, *at* http://www.finalexit.org/more-chronology.html (last accessed Sep. 18, 2007).

Cruzan v. Director of Health of Missouri.[42] In its decision, the Missouri Supreme Court ruled in favor of the state's policy over Cruzan's right to refuse treatment. The Court recognized a competent patient's constitutional right to refuse medical treatment but held that this right must be balanced against State's competing interests. The State has a right to require "clear and convincing evidence" of an incompetent patient's wishes and has the right to decline to accept the decision of a surrogate exercising "substituted judgment." While individuals enjoyed the right to refuse medical treatment under the due process clause, incompetent persons were not able to exercise such rights. Absent "clear and convincing evidence" that Cruzan desired treatment to be withdrawn, the State's actions, designed to preserve human life, were constitutional.

The Court also upheld the State's heightened evidentiary requirement and recognized that its law was a valid exercise of police power but, at the same time, a regulation of the right of an individual to refuse medical treatment. This was because there was no guarantee that family members would always act in the best interests of incompetent patients, and because erroneous decisions to withdraw treatment were almost always irreversible. Following *Cruzan*, the next big step in the development of living wills was the passage of the U.S. Patient Self-Determination Act,[43] which acknowledged patients' general rights to refuse medical treatment even if such refusal eventually results in death. At present, all 51 states in the U.S. have laws on Advance Health Care Directives,[44] but their requirements differ from state to state.

Countries like the United Kingdom, Australia, New Zealand, Canada, India, and Singapore also have legislations recognizing and enforcing living wills; and more countries are following suit.[45] The enactment around the world of various laws on living wills reflects an increased interest and a growing concern for end-of-life medical decisions[46]

42. Cruzan v. Director of Health of Missouri, 497 U.S. 261 (1990).

43. The Patient Self Determination Act, 42 U.S.C. §§ 395cc (f) (1) & 1396a (w) (1) (1990).

44. ROLAND DWORKIN, LIFE'S DOMINION — AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 180 (1993).

45. *See*, Michio Arakawa, *Living Wills and Advance Directives in the World: Current State and Outlook*, The World Federation of Right to Die Societies, *at* http://www.worldrtd.net/news/federation/?id=713 (last accessed Sep. 18, 2007).

46. Melissa Terry & Steven Zweig, *Prevalence of Advance Directives and Do-Not-Resuscitate Orders in Community Nursing Facilities*, 3 ARCH. FAM. MED. 141, 145 (1994).

III. INDIVIDUAL RIGHTS V. STATE INTERESTS

A. The Right to Refuse Medical Treatment

The Universal Declaration of Human Rights[47] and the Alma Conference Declaration of 1978[48] recognize health as a fundamental human right. Corollary to the right of every individual to receive medical treatment is the right to refuse medical treatment. The right to refuse medical treatment evolved from the concept of the right to self-determination, first recognized in the 1914 case of *Schloendorff v. Society of New York Hospital*,[49] where Justice Cardozo expressed that "every human being of adult years and sound mind has a right to determine what shall be done with his own body."[50] A person's right and interest in refusing medical treatment, it was held, has constitutional underpinnings in the due process clause of the Fourteenth Amendment,[51] which is based on the concept of individual autonomy.[52] Jurisprudence on the right to refuse medical treatment developed from cases involving parents who refused to have their children treated invoking the freedom to profess their family's religious belief. In these cases, the Court distinguished between beneficial and non-beneficial treatment before asserting its role and responsibility as *parens patriae* over the objections of the parents and even prosecuting the latter for a crime in the proper cases.[53]

In adults, the basis for acknowledging the right to refuse medical treatment is based on the doctrine of informed consent, which, according to courts, should be balanced with the State's interest in protecting its citizens' lives. Informed consent is a legal condition under which a person can be said to have given consent based upon an appreciation and understanding of the

47. Universal Declaration of Human Rights, G.A. Res. 217 III(A), U.N. GAOR, 3d Sess., Supp. No. 127, at 71, U.N. Doc. A/810 (1948) [hereinafter UDHR].

48. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 Sep. 1978, Declaration of Alma-Ata, *available at* http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (last accessed Sep. 18, 2006).

49. Schloendorff v. Society of New York Hospital, 105 N.E. 92 (1914).

50. *Id.* at 93.

51. *In re* Fetus Brown, 689 N.E.2d 397 (1997). *See also*, U.S. CONST. amend. XIV (1898).

52. This is the first principle of liberalism, in which individuals are left unimpeded to create themselves in any direction according to their own individual reason or will.

53. *In re* Green, 292 A.2d 387 (1972).

facts and implications of any action.[54] The individual needs to be in possession of all of his faculties, meaning he is not mentally retarded or mentally ill, or he is without impairment of judgment at the time of consent. A physician who performs a medical procedure on a patient without the latter's agreement to be subject to such treatment opens himself to liability.[55] Ultimately, a competent patient has the right to refuse medical treatment after factoring all the risks and benefits involved in a medical treatment or intervention.[56] Consent drawn from incapacitated patients with regard to refusals to medical treatment is, however, not as clear.

The increasing ability of medical technology to sustain life has certainly made cases on refusal to treatment more problematic. In essence, there are two classifications of treatments that are usually involved in this issue, namely, life-sustaining versus life-saving medical treatment. Life-sustaining medical treatment does not offer any hope for curing a medical disorder or restoring an individual's *normal* bodily functions and serve only to postpone the moment of death. Often, these treatments use artificial means to supplant the body's vital functions and only prolong the terminally ill patient's death. These procedures are also referred to as *extraordinary means* of preventing death. Life-saving treatment, on the other hand, offers hope of curing a medical condition and of restoring a person's normal bodily functions.

In *Quinlan*, the Court, through Chief Justice Hughes, used a simple formula to determine whether the treatment provided to Karen can be discontinued.[57] He said that,

> the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law.[58]

54. *Informed Consent*, *in* WIKIPEDIA, *at* http://en.wikipedia.org/wiki/Informed_consent (last accessed Sep. 18, 2007).

55. 61 AM. JUR. 2d *Physicians, Surgeons, and Other Healers* § 155 (1990); *See generally*, Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (Cal. 1972).

56. Cavuoto v. Buchanan County Department of Social Services, 605 S.E.2d 287 (Va. Ct. App. 2004).

57. Ryan V. Laureano, Life Worth Living: An Analysis of the Constitutionality of Mandatory Life-Saving Medical Treatment 13 (2003) (unpublished J.D. thesis, Ateneo de Manila University School of Law) (on file with the Ateneo Professional Schools Library) [hereinafter Laureano].

58. *In re* Quinlan, 355 A.2d 664 (N.J. 1976).

The case of *Superintendent of Belchertown State School v. Saikewescz*,[59] the Massachusetts state court enumerated these four countervailing state interests that should be balanced against the right to refuse medical treatment. When a state's interest is weak, a patient's right to refuse treatment should prevail.

In *Cruzan*, the U.S. Supreme Court acknowledged that such freedom was not absolute and that the right is subordinate to the authority of the State to promote the unqualified interest in preserving the life of each of its subjects. The Court upheld the State of Missouri's heightened evidentiary requirements as, absent "clear and convincing evidence" that a patient desired treatment to be withdrawn, because there was no guarantee that family members would always act in the best interests of incompetent patients, and that erroneous decisions to withdraw treatment were irreversible.[60]

Even after the decision in *Cruzan*, however, many courts still struggled with the right to refuse medical treatment.[61] *In re Guardianship and Protective Placement of Edna M.F.*,[62] a case involving a 71-year-old woman diagnosed with Alzheimer's, the Wisconsin Supreme Court ultimately held that a guardian could only order the withdrawal of life-sustaining treatment if the patient was in a persistent vegetative state and the guardian made such decision to refuse treatment in the best interests of the patient.

It is a sad reality that most of the cases dealing with the right to refuse medical treatment illustrate conflicts between family members and the great difficulty of choosing what is best for a loved one. In all the cases discussed, there was no living will that was executed that could have expressed the patient's wishes. Thus, through the recognition of living wills, the law can provide a vehicle by which patients may clearly express their wishes not to be kept alive by artificial means, thus avoiding family conflict and endless litigation that can lead to more hurt and suffering for family members.[63]

B. The Right to Privacy

59. Superintendent of Belchertown State School v. Saikwescz, 370 N.E.2d 417 (1977).

60. Cruzan v. Director of Health of Missouri, 497 U.S. 261, 282 (1990).

61. Sam J. Saad III, *Living Wills: Validity and Morality*, 30 VT. L. REV. 71, 89 (2006) [hereinafter Saad].

62. *In re* Guardianship and Protective Placement of Edna M.F., 563 N.W.2d 485 (1997).

63. Saad, *supra* note 61, at 100.

The right to privacy of an individual has, since the case of *Quinlan*, been made a basis for the right to refuse medical treatment. In *Quinlan*, the Court balanced state interests with the right to privacy to see when a state may interfere with and frustrate an individual's refusal to receive medical treatment. The right to one's person may be said to be a right of complete immunity or the right to be let alone.[64] This is, in essence, the basis of the right to privacy. Although the word privacy does not specifically appear in the U.S. Constitution, a number of decisions have held that the Fourth,[65] Fifth,[66] Ninth,[67] and Fourteenth[68] Amendments offer some constitutional backing for a right to privacy. During this time, several aspects of a person's life were already regarded as private, such as the right of parents to rear their children and the right to send them to a school of their choosing. Also, laws that sought to regulate marriage and procreation, as well as laws that restrict a parent's freedom of choice were already held to be unconstitutional.[69] In

64. THOMAS M. COOLEY, A TREATISE ON THE LAW OF TORTS 29 (2d ed. 1888).

65. U.S. CONST. amend. IV.

> The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

66. U.S. CONST. amend. V.

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

67. U.S. CONST. amend. IX ("The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.").

68. U.S. CONST. amend. XIV § 1.

> All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

69. Laureano, *supra* note 57, at 16.

Union Pacific R. Co. v. Botsford,[70] the Court recognized that a right of personal privacy specifically "the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law,"[71] is lodged under the First Amendment.

The recognition of the right to privacy began in 1890 when Warren and Brandeis opposed the intrusion of newspapers into the private lives and affairs of individuals, essentially saying that each individual has an "inviolate personality" that should be protected from intrusions.[72] Although the right to privacy is now well-settled, it was not until the 1960 case of *Griswold v. Connecticut*[73] that it was formally recognized. After the decision in *Griswold*, this right to privacy to marry and to procreate was extended to individuals regardless of race[74] or economic[75] or marital status.[76] In *Roe v. Wade*,[77] the court even extended the right to privacy to include the freedom of a woman to terminate a pregnancy. This is, however, qualified by the recognition of the State's interest in preserving life, thus meaning that such freedom may be restricted. The court also said that the right to privacy is limited only to areas that are "fundamental" or implicit in the concept of ordered liberty by society[78] and extends only such areas that deal with private rights, such as marriage,[79] procreation,[80] use of contraceptives,[81] and child-rearing and

70. Union Pacific R. Co. v. Botsford, 141 U.S. 250 (1891).

71. *Id.* at 251.

72. Samuel D. Warren and Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

73. Griswold v. Connecticut, 381 U.S. 479 (1965).

74. Loving v. Virginia, 388 U.S. 1 (1967). The Court declared Virginia's anti-miscegenation statute, the Racial Integrity Act of 1924, unconstitutional, thereby ending all race-based legal restriction on marriage in the United States.

75. Zablocki v. Redhail, 434 U.S. 374 (1978). A Wisconsin law that required persons under obligation to pay support for the children of previous relationships to obtain permission of a court to marry was declared a violation of the Equal Protection Clause.

76. Eisenstadt v. Baird, 405 U.S. 453 (1972). The Court granted the freedom to use contraceptives previously only guaranteed to married couples to unmarried couples.

77. Roe v. Wade, 410 U.S. 113 (1973).

78. *Id.* at 152 (citing Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

79. *Id.* (citing Loving v. Virginia, 388 U.S. 1, 12 (1967)).

80. *Id.* (citing Skinner v. Oklahoma, 316 U.S. 535, 541-42 (1942)).

education.[82] Hence, destructive acts could not and will not be protected by the right to privacy.[83]

In re Yetter,[84] the California Superior Court put forth a seemingly absolute right to privacy, when it held,

> [t]he constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests; in short, that the right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals.[85]

The decision in *Quinlan* departed from such a notion of an absolute right to privacy, holding that, although the constitutional right to privacy is broad enough to encompass a patient's decision to refuse medical care, it should be balanced against the interests of the State.[86] In applying the right to privacy to refusal of treatment, the Court, in *Lane v. Candura*,[87] held that a 77-year-old widow's constitutional right to privacy entitled her to refuse to consent to the surgical amputation of her gangrenous leg, as the instant case did not involve certain countervailing state interests that may outweigh the right of a competent individual to refuse life-saving or life-prolonging treatment.

C. The Right to Bodily Self-Determination

The origins of the right to bodily self-determination can be traced from the decision in *Botsford*, where the U.S. Federal Supreme Court stated that "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[88] The right to bodily self-determination is the freedom of each individual to choose a lifestyle or course of action.[89]

81. *Roe*, 410 U.S. at 152 (citing Eisenstadt v. Baird, 405 U.S. 453, 453-54 (1972)).
82. *Id.* (citing Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925)).
83. *See*, Von Holden v. Chapman, 450 NYS.2d 623 (1982). In this case, Mark David Chapman, the assassin of John Lennon, asserted that the State of New York violated his constitutional right to privacy when it intervened to prevent him from committing suicide by starvation.
84. *In re* Yetter, 62 Pa.D & C.2d 619 (1973).
85. *Id.* at 623.
86. *In re* Quinlan, 355 A.2d 664, 671 (N.J. 1976).
87. Lane v. Candura, 376 N.E.2d 1232 (1978).
88. Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891).
89. *See*, Rodriguez v. British Columbia (Attorney General), 3 S.C.R. 519 (1993).

This specific right to self-determination, or the right to determine what happens to one's self, has been recognized since 1914 in *Schloendorff*, when then Judge Benjamin Cardozo stated that, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[90] When applied to the context of medical care, this means that no treatment should be given in the absence of a valid consent.[91] Based on the concept of individual autonomy, the law of consent enables people to decide whether or not to accept the medical treatments offered to them. Consent is required regardless of whether the contact occurs in everyday life or during examination by a doctor intent on diagnosis or treatment.[92] This generally ensures the protection of personal bodily integrity and individual autonomy. Therefore, "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[93]

Medical treatment usually has foreseeable physical harms which would not usually be legitimated by consent and would generally attract criminal liability.[94] There is a presumption, however, that any physical contact occurring in the course of medical treatment will be for the patient's benefit and, ultimately, in the public interest and can be sanctioned by valid consent.[95] To avoid any civil or criminal liability, doctors are thus charged with the duty to obtain valid consent before commencing treatment. Valid and effective consent is founded on sufficient information upon which patients can base their decisions.[96]

Nevertheless, there are certain instances where care without consent can be justified, such as during a medical emergency, where doctors are supposed to act out of necessity.[97] In order to legitimize treatment, the emergency must be authentic, such as where it would be "unreasonable, as opposed to merely inconvenient, to postpone until consent could be sought."[98] The failure to treat patients in an emergency situation is contrary to the ethics of

90. Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (1914).
91. HAZEL BIGGS, EUTHANASIA: DEATH WITH DIGNITY, AND THE LAW 70 (2001) [hereinafter BIGGS].
92. *Id.*
93. *Schloendorff*, 105 N.E. at 93.
94. BIGGS, *supra* note 91, at 71-72.
95. *Id.*
96. *Id.*
97. *Id.* at 83.
98. *Id.*

medicine and may constitute a breach of a professional obligation. Administering treatment without consent, however, even in an emergency, is still an invasion of a person's bodily integrity in neglect of a person's individual autonomy. Hence, the emergency treatment to be given must be confined only to such treatment as is necessary to meet the emergency and nothing more.[99]

Cases of patients who are permanently incapacitated who require routine treatment cannot be regarded as an emergency. While there is a custom where doctors treat incapacitated patients without consent, either out of their own initiative or through the proxy consent of relatives, this custom has no legal authority.[100] Courts have repeatedly used the "best interests" criteria to legitimize treatment without consent in these cases.[101] Another instance where care without consent can be legitimized involves activities which do not need to be consented to because they are insignificantly intrusive. It covers nursing care dealing with personal hygiene, dressing, and feeding, which are generally tasks which an individual can do in the ordinary conduct of daily life.[102]

The right to bodily self-determination is, however, not without limitations. It has never been immune from reasonable state interference. In instances where public interests outweigh the individual's right to self-determination, restrictions on individual autonomy may be justified. Such justification, however, must be backed up by a compelling moral principle and the extent of the restraint must be limited.[103] In certain cases, the state's interest in preserving life extends to the protection of patients against uninformed, incompetent, and involuntary decisions on life-saving medical care, akin to state supervision of important decisions in other areas of life, such as wills and adoption laws.[104]

D. The Right to Free Exercise of Religion

As some individuals argue that their right to refuse medical treatment is based on their right to free exercise of religion,[105] a few pointers about the

99. *Id.* at 84-85.

100. BIGGS, *supra* note 91, at 86.

101. *Id.* at 87.

102. JONATHAN MONTGOMERY, HEALTH CARE LAW 237, 240 (1997).

103. Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 48 (1993).

104. Philip Peters, Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L. J. 891, 911 (1989).

105. Among the denominations that assert their religious beliefs to refuse medical care are the following: Jehovah's Witnesses, who refuse, as a matter of faith, blood transfusions; Church of Christ, Scientist; and numerous other smaller sects — such as the Followers of Christ Church and the General Assembly and Church of the First Born, who believe that only God heals and reject medical treatment by doctors, relying on their belief on spiritual or faith healing. Most of these sects have been criticized largely due to their refusal to treat children who have curable diseases based on religious grounds.

origins and developments of this right are essential. The free exercise clause states that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."[106]

The free exercise clause of the Constitution guarantees both the freedom to believe and the freedom to act upon such religious beliefs. The freedom to believe means that the government cannot interfere or even attempt to regulate any citizen's religious beliefs, nor can the government force a citizen to affirm beliefs that are repugnant to his religion, nor can the government directly penalize or discriminate against a citizen for having beliefs contrary to those of anyone else.[107] The freedom to act, on the other hand, prevents and guards against intrusions of the state on an individual's exercise of religious traditions, rituals, and beliefs.[108] The former liberty is absolute, while the latter is subject to reasonable state restrictions.

In relation to health, American courts are inclined to rule that state interest outweighs the right to the free exercise of religion. In *Holcomb v. Armstrong*,[109] the Court held that mandatory x-rays as a condition for registration for university students was not in violation of the exercise of religion.[110] Similarly, fluoridation and chlorination of water for the safety of the public in general do not violate the free exercise clause. Also, in *Cude v. State*,[111] the court ruled that the right of a parent to practice religion does not include the liberty to expose the community or children to communicable diseases or the latter to ill health or death and that it is within the police power of the state to require that school children be vaccinated

106. PHIL. CONST. art III, § 5.

107. 16A AM. JUR 2d *Constitutional Law* § 424 (1990).

108. *Id.*

109. Holcomb v. Armstrong, 39 Wash.2d 860 (1952).

110. Maurice Holcomb, member of Christian Scientists, sought to compel the respondent board of regents to permit her to register as a student at the University of Washington. She was not permitted to register because she refused to comply with the requirement of respondents that, before registration, all students have an x-ray examination of the chest for the purpose of discovering possible tubercular infection.

111. Cude v. State, 237 Ark. 927 (1964).

against smallpox and that such requirement does not violate the constitutional rights of anyone on religious grounds or otherwise.

Although the U.S. Supreme Court has historically recognized the right of parents to rear their children in accordance with their personal and religious beliefs, this must give way when the health or safety of children is threatened or when parental conduct poses some substantial threat to public safety.[112] Government interference with the right of parents to nurture and to manage their children is grounded upon both the State's general police power to protect and promote public welfare and the doctrine of *parens patriae*.[113] A state's *parens patriae* power supports the authority granted to courts to interfere in the withdrawal of medical treatments from a patient if it is manifest that such action would further the patient's best interests. Nevertheless, when the illness of the child is clearly not life–threatening, or if the treatment does not have a good prognosis or will only subject the child to more suffering without offering a good chance of survival, the interest of the state does not outweigh the right to the free exercise of religion.[114] In *Walker v. Superior Court*,[115] parents who are members of the Church of Christ Scientists who relied merely on faith healing to cure their son, who died of meningitis, were convicted of manslaughter. *In re Petra*,[116] the court ordered medical treatment for a child's serious burns despite the parents' desire to treat her with herbal remedies in accordance with their religious beliefs.

With adults, the courts cannot be dictated by its view of what would be in the best interests of the patient but must look to the validity of the refusal in terms of the capacity of the patient to give it to determine whether it must be respected.

In *Malette v. Shulman*,[117] a 57-year-old woman was seriously injured in a car accident and was rendered unconscious. She had on her a religious document that requested that no blood transfusions be given to her. Her doctor nevertheless administered blood transfusions. The woman later sued the doctor for negligence, assault, battery, and religious discrimination. The trial judge accepted the plea of battery, concluding that the card

112. *See*, Prince v. Massachusetts, 321 U.S. 158 (1944); Wisconsin v. Yoder, 406 U.S. 205 (1972); Stanley v. Illinois, 405 U.S. 645 (1972); Jehovah's Witnesses v. King County Hospital, 390 U.S. 598 (1968).

113. *See*, Santosky v. Kramer, 455 U.S. 745, 766 (1982); Prince v. Massachusetts, 321 U.S. 166,169 (1944).

114. 48 A.L.R. 4th 67, § 7 (c) (1986).

115. Walker v. Superior Court, 47 Cal.3d 112, 121 (1988), *cert. denied*, 491 U.S. 905) (1989).

116. *In re* Petra, 265 Cal. Rptr. 342 (1989).

117. Malette v. Shulman, 2 Med L.R. 162 (1991).

validly restricted the doctor's right to give the patient blood transfusions. In contrast, in *In re. T*,[118] an unconscious patient's mother, on her religious beliefs alone, influenced the decision of her daughter to refuse a life-saving blood transfusion. On the appeal of an order secured by the hospital authorizing the transfusion, it was held that the presumption of capacity to refuse medical treatment can be overridden upon a determination that factors such as confusion, unconsciousness, fatigue, or shock affect the patient's decision. Doctors must consider the importance of the treatment and whether the patient's capacity was reduced when treatment is refused. Doctors must also consider whether the patient's decision was made independently.

The prevailing rule seems to be that, with regard to children who need potentially life-saving medical care, parents cannot use the free exercise clause as a defense to refuse medical treatment based on religious grounds. But where there are competent adult patients who refuse medical treatments, their wishes must prevail, no matter the consequences, as long as there is consent. Such consent must be indicated in advance or made independently, voluntarily, knowingly, competently, and in relation to the treatment given, for the refusal of treatment to be validated and respected.

E. Preservation of Life

According to *In re Conroy*,[119] the first state interest which is the preservation of life, focuses on the sanctity of life and on individual dignity and worth. From a humanist or non-religious point of view, life is sacred because of man's qualities, his abilities to exercise free will and to direct one's life through his choices. Humanists believe in dignity of the individual and, thus, also believe that individuals should be allowed to exercise the choice of refusing medical treatment while they are still capacitated to make such choice.[120] The state's inherent interest in the preservation of the life of its citizens can be achieved through the exercise of police power.

Under the concept of police power, the state may regulate its internal affairs for the promotion of the health, safety, morals, and welfare of its citizens even when it proves convenient or offensive to a particular

118. *In re* T, All ER 649 at 652, 665 (1992).

119. *In re* Conroy, 486 A.2d 1209 (1985).

120. Paul Mejia, Pulling the Plug: A Call for the Decriminalization of Giving Assistance to Suicide as a Form of Euthanasia 42 (2005) (unpublished J.D. thesis, Ateneo de Manila University School of Law) (on file with the Ateneo Professional Schools Library).

individual.[121] In *Hamilton v. McAuliffe*,[122] the court indicated that a patient's refusal to consent to medical treatment would be denied where the state had a substantial interest in preserving the patient's life. Although there is an inherent state interest in protecting its citizens' lives, this is based on the assumption that the individual would want to enjoy that protection. In cases where a terminally ill adult patient competently refuses life-sustaining medical treatment, the state's interest in such patient's life and welfare would not outweigh the patient's right to self-determination and privacy.[123] Also, where human life is doomed to continue indefinitely in a vegetative state, a state's interest in the preservation of life does not foreclose a court order enforcing the right of an individual to decline to be kept alive. In *In re Severns*,[124] the court held that a state's interest in preservation of life is diminished by individual rights and, at some point, is overcome by it. Under the circumstances of the case, the state interest was weakened primarily because the value of life was diminished by a denial of the right to privacy of the comatose person. In *Conroy*, the court called the state's interest in the preservation of life as the most significant of the four state interests.[125] It stated, however, that "insofar as the 'sanctity of individual free choice and self-determination [are] fundamental constituents of life,' the value of life may be lessened... 'by the failure to allow a competent human being the right of choice,'" thus, maintaining that the individual's choice to refuse treatment of the individual's own body was paramount to any state interest.[126]

F. Prevention of Suicide

The second state interest is the prevention of suicide, which relates back to the state's interest in preserving life. In the debate on living wills, this interest appears due largely to the fact that some people argue that the removal of life support is tantamount to suicide. In the case of *In re Caulk*,[127] the Court held that the attempt of an otherwise healthy prisoner to starve himself to death because he preferred death to life in prison was tantamount to attempted suicide, and that the state, to prevent such suicide, could force him to eat. American courts have rejected the idea that one may infer a patient's

121. *Id.* at 27 (citing Halter v. Nebraska, 205 U.S. 34 (1906)). Police power is the inherent authority of a government to impose restrictions on private rights for the sake of public welfare, order, and security.

122. Hamilton v. McAuliffe, 353 A.2d 634 (1976).

123. Matthew Previn, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 GEO. L.J. 551, 605 (1996) [hereinafter Previn].

124. *In re* Severns, 425 A.2d 156 (1980).

125. *In re* Conroy, 486 A. 2d 1209, 1223 (1985).

126. *Id.* at 1223-24.

127. *In re* Caulk, 480 A.2d 93, 96-97 (1984).

intention to commit suicide where simple treatments, such as blood transfusions, are rejected and categorically state that the withdrawal from treatment is not a form of suicide.[128] In *Conroy*, the court said that "declining life sustaining medical treatment may not properly be viewed as an attempt to commit suicide" and "refusing medical intervention merely allows the disease to take its natural course."[129] In *Quinlan*, the court said that "death comes from the underlying disease and not some affirmative act by the patient," and that "often the patient does not harbor the 'specific intent' to die that a person committing suicide does."[130] In *Bouvia v. Superior Court*,[131] the court upheld a competent 28-year-old arthritic quadriplegic's right to refuse oral feedings and have her feeding tube removed. The court actually upheld the patient's right to dictate care surrounding her death by requiring the hospital to continue to treat her and provide pain control, essentially while she was starving herself. It ruled that her resignation to an earlier death and her allowing nature to take its course are not equivalent to an election to commit suicide.

Thus, courts usually follow the principle of autonomy as long as the patient's wishes can be reasonably established, especially if the competent adult has a non-self-inflicted and irreversible condition. The state interest in the prevention of suicide does not preclude recognition of the right of an individual to forego life-sustaining treatment. As long as there is a competent and rational decision to refuse treatment, the treatment offered gives no hope of cure, and active causation and specific intent to commit suicide are absent, refusal of the treatment is valid and should prevail. In such cases, patients exercising their right to refuse medical treatment that would eventually result in their death simply wish to live free from "unwanted medical technology, surgery, or drugs, and without protracted suffering."[132]

G. Protecting Innocent Third Parties

The third state interest deals with the protection of third parties. It focuses primarily on situations where a person's choice to refuse treatment would harm an unborn or minor child. When a patient's exercise of his free choice would directly affect the health, safety, or security of others, the courts have

128. Superintendent of Belchertown State School v. Saikwescz, 370 N.E.2d 417, 423 & 426 (1977).

129. *Conroy*, 486 A.2d at 1224.

130. *In re* Quinlan, 355 A.2d 664 (N.J. 1976).

131. Bouvia v. Superior Court, 179 Cal. App.3d 1127 (1986).

132. *Id.*

decided cases to the effect that the right of the patient to refuse treatment must give way. Courts have ordered competent adults to undergo medical examination against their will if necessary to protect the public health.[133] In cases where the patient is pregnant,[134] or has small children dependent on such patient for support, the court has repeatedly stated that the state has an overriding interest in preserving the patient's life such that it could rule against a patient's refusal to medical treatment.

The case most often cited in support of the proposition that the state's interest in protecting the well-being of the patient's children outweighs the patient's right to refuse life-saving treatment is *Application of the President & Directors of Georgetown College, Inc.*[135] In that case, the patient, a 25-year-old mother of a seven-month-old infant refused a blood transfusion for religious reasons. The court held that she had the "responsibility to the community to care for her infant" and that the state, as *parens patriae*, had an interest in preserving her life as a mother, so the court ordered the blood transfusion. It is important to note, however, that in this case, the patient was not competent to decide for herself whether to consent to the blood transfusion. Under such circumstances, "it may well be the duty of a court to assume the responsibility of guardianship for her, as for a child, at least to the extent of authorizing treatment to save her life."[136]

However, courts have also upheld the right to refuse treatment if there is another parent or an extended family to care for the children. In *Fosmire v. Nicoleau*,[137] Nicoleau refused a blood transfusion after hemorrhaging when she gave birth prematurely by caesarean section. She and her husband were Jehovah's Witnesses, and she made her intention to refuse treatment clear. The court held that an asserted state interest in preventing a parent from

133. Jacobson v. Massachusetts, 197 U.S. 11 (1905).

134. *See*, Janice MacAvoy-Smitzer, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987). The subject of a pregnant woman's right to refuse medical treatment is debatable. An argument for its prohibition is that the state has an interest in the fetus and that interest is to allow the fetus to be born. This interest may be based on the concept that a fetus is a person and may have certain rights independent of the mother. Some have criticized the concept that a fetus is a person separate from the mother and that such a concept would make the mother only a *container* for the fetus. These critics argue that the mother and fetus are one, the fetus depending on the mother for life and development until birth, and indeed, needs a mother after delivery. Also whether *personhood* begins before birth or after delivery is another point of contention.

135. Application of the President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

136. *Application of the President*, 331 F.2d at 1008.

137. Fosmire v. Nicoleau, 75 N.Y.2d 218 (1990).

intentionally abandoning a child did not outweigh the patient's statutory and common law right to refuse medical treatment. In *Norwood Hospital v. Munoz*,[138] Munoz refused, on religious grounds, to receive a blood transfusion. The court found no compelling interest in protecting the minor child of respondent because there was no evidence that the father was unwilling to take care of the child. It was also shown in court that the spouse had financial resources to take care of the child and that his sister and brother-in-law, who likewise supported the decision, promised that they would help in caring and rearing the child. Looking at these circumstances, the court concluded that "the State does not have an interest in maintaining a two-parent household in the absence of compelling evidence that the child will be abandoned if he is left under the care of a one-parent household."[139]

In most of the right-to-die cases considered by courts, one observes that (1) the patient has no minor children, and (2) recovery of the terminally ill individual, even with aggressive treatment, is futile. As such, no case of refusal of medical treatment by a competent terminally ill patient, with no hope of recovery, has yet been overridden by the state interest to protect dependent children. Nevertheless, if there was, it can be argued that a state's interests must still give way to the choice of the competent terminally ill individual, whether grounded in one religion or another or without reference to religion, as how best to still live, when there is no hope for recovery.[140]

H. Maintenance of the Integrity of the Medical Profession

The fourth and final state interest that is most frequently asserted as a limitation on a competent patient's right to refuse medical treatment is the interest in safeguarding the integrity of the medical profession. This is because hospitals have the duty to attend to the sick and dying. As long as a physician conducts himself according to prevailing medical standards, he does not become liable, even for the non-treatment of a patient. In such cases, the state's interest in maintaining the integrity of the medical profession is not

138. Norwood Hospital v. Munoz, 564 N.E.2d 1017, 1024-25 (1991).

139. *See*, Foody v. Manchester Memorial Hospital, 40 Conn. Supp. 127, 482 A.2d 713 (1984). The Court, in approving withdrawal of a respirator which sustained the life of the patient, said that the interest of third parties was minimal or nonexistent and must be outweighed by the patient's right to refuse medical treatment where the patient was in a permanent and irreversible semi-comatose state and had no children who might suffer emotionally or materially from the decision to withdraw life sustaining systems.

140. *In re* Conroy, 486 A. 2d 1209, 1225 (1985).

offended.[141] Also, the state's interest in the maintenance of the integrity of the medical profession is considered the least persuasive of the state interests because the medical profession does not ethically require doctors to intervene in the treatment of disease at all costs. In 1624, Francis Bacon wrote, "I esteem it the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage."[142] As such, this interest, like the interest in preventing suicide, is not particularly threatened by permitting competent patients to refuse life-sustaining medical treatment.

If a patient was competent, the doctor's duty would only be to inform the former of the risks of refusing treatment and then accept the patient's decision if he chose to refuse medical treatment. Medical ethics does not require doctors to go beyond advising their patients of the risks of treatment and convincing the patient to accept such treatment.[143] Current ethical practices in medicine already recognize that a dying patient is often more in need of comfort than treatment. Thus, a doctor's recognition of a patient's right to refuse medical treatment in circumstances where there is no hope of recovery is consistent with existing medical standards and does not undermine the integrity of the medical profession, nor does it threaten the role of hospitals in properly caring for such terminally ill patients or the state's role in protecting them.

III. PHILIPPINE LAWS AND JURISPRUDENCE ON INDIVIDUAL RIGHTS V. STATE INTERESTS

Although death is a universal occurrence that crosses all ages and cultures, there are many aspects of dealing with the issue of end-of-life medical care that may vary depending on one's social, cultural, historical, and religious background. Culture and religion play a very important role in an individual's choice in accepting or refusing medical treatment. It is, thus, necessary to examine existing Philippine law and jurisprudence that concern these matters.

141. *See*, Superintendent of Belchertown State School v. Saikwescz, 370 N.E.2d 417 (1977). The court held that the state interest in maintaining the ethical integrity of the medical profession was satisfied in connection with its decision that potentially life-prolonging treatment not be administered to a severely retarded adult patient. In explanation, the court cited the fact that the decision was in accord with the testimony of the patient's attending physicians and with the generally accepted views of the medical profession.

142. Francis Bacon, *Of the Proficience and Advancement of Learning Divine and Humane (1605), reprinted in* 30 GREAT BOOKS OF THE WESTERN WORLD 1, 52 (Robert Maynard Hutchins, *et al.* eds., 1952).

143. *Conroy*, 486 A.2d at 1224-25.

A. Philippine Law and Individual Rights

Although the Philippine Constitution does not specifically provide for a right to refuse medical treatment, section 15, article II of the present Constitution recognizes a right to health.[144] From this recognition of a right to health, based on the principle that "no person shall be deprived of life, liberty, or property without due process of law,"[145] it can be argued that there is such a thing as a right to medical treatment. The Universal Declaration of Human Rights, to which the Philippines is a party, recognizes that everyone has a right to medical care.[146] This right is founded on an individual's dignity as a human person. Aside from this right to adequate medical care, a patient also has a corollary right to refuse medical treatment and to be informed of the medical consequences of his action and a right to receive from his physician information necessary to give an informed consent prior to the start of any procedure.[147] There are basically two kinds of patient's rights that are involved in this issue, namely, the social rights of patients to quality health care and a patient's individual rights, which are already enshrined under existing laws. A patient's individual rights, such as the rights to information and to refuse medical treatment, as in American jurisdictions, are based on the tenets of the due process clause. It is also guaranteed by an individual's right to privacy and, in some instances, invoked together with the right to the free exercise of religion.

In the Philippines, the constitutional right to privacy was first recognized in the case of *Morfe v. Mutuc*.[148] In this case, the periodical submission of sworn statement of assets and liabilities under section 7 of Republic Act No. 3019[149] after a government officer or employee had declared his financial condition upon assumption of office was challenged for being violative of

144. PHIL. CONST. art II, § 15 ("The State shall protect and promote the right to health of the people and instill health consciousness among them.").

145. PHIL. CONST. art II, § 1.

146. UDHR, art. 25 (1) ("(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.").

147. De La Salle University Health and Services Campus Website, Patient's Bill of Rights, *at* http://www.hsc.dlsu.edu.ph/Bioethics/patient'.htm (last accessed Sep. 18, 2007).

148. Morfe v. Mutuc, 22 SCRA 424 (1968).

149. Anti-Graft and Corrupt Practices Act [ANTI-GRAFT AND CORRUPT PRACTICES ACT], Republic Act No. 3019 (1960).

due process and for being an unlawful invasion of the constitutional right to privacy. The Supreme Court held that,

> The challenged statutory provision does not call for disclosure of information which infringes on the right of a person to privacy. It cannot be denied that the rational relationship such a requirement possesses with the objective of a valid statute goes very far in precluding assent to an objection of such character. This is not to say that a public officer, by virtue of the position he holds, is bereft of constitutional protection; it is only to emphasize that in subjecting him to such a further compulsory revelation of his assets and liabilities, including the statement of the amounts and sources of income, the amounts of personal and family expenses, and the amount of income taxes paid for the next preceding calendar year, there is no unconstitutional intrusion into what would otherwise be a private sphere.[150]

Speaking through the late Chief Justice Enrique Fernando, the Supreme Court adopted the ruling in *Griswold*, which recognized that there is a constitutional right to privacy that has come into its own.[151] Justice Fernando went on to say that such right of privacy also exists in our jurisdiction and "the right to privacy ... is accorded recognition independently of its identification with liberty ... and it is fully deserving of constitutional protection."[152] In *Ople v. Torres*,[153] the Court also had the opportunity to discuss the constitutional right to privacy further. Here, the Court decided the issue posed by Administrative Order No. 308, issued by then President Fidel Ramos. The said executive issuance sought to establish a National Computerized Identification Reference System, which according to dissenters was "a system of identification that is all-encompassing in scope," which "affected the life and liberty of every Filipino citizen" and was violative of their right to privacy.[154] The right to privacy, however, is not absolute. As noted in *Ople*, "intrusions into the right must be accompanied by proper safeguards and well-defined standards to prevent unconstitutional invasions ... any law or order that invades individual privacy will be subjected by this Court to strict scrutiny."[155]

This right to the free exercise of religion can be traced back to the Spanish colonial period. Although article 21 of the Spanish Constitution of 1869 provided for a state religion, it also guaranteed the privilege of freely practicing, both in public and private, the forms and ceremonies of other

150. *Morfe*, 22 SCRA at 445-46.

151. Griswold v. Connecticut, 381 U.S. 479, 484 (1965).

152. *Morfe*, 22 SCRA at 444.

153. Ople v. Torres, 293 SCRA 141 (1998).

154. *Id.*

155. *Id.* at 169.

sects, subject only to the restrictions imposed by general law and morality.[156] After Spanish rule, the freedom to exercise one's religion was guaranteed in the Treaty of Paris of 1898, which provided that "The inhabitants of the territories over which Spain relinquishes or cedes her sovereignty shall be secured in the free exercise of their religion."[157] The present free exercise clause was patterned after the United States' Bill of Rights, incorporated in the Philippine Autonomy Act of 1916, popularly known as the Jones Law.[158]

The right to the free exercise of religion is enshrined in section 5 of the Bill of Rights of the 1987 Philippine Constitution:

> Section 5. No law shall be made respecting an establishment of religion, or prohibiting the free exercise thereof. The free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed. No religious test shall be required for the exercise of civil or political rights.[159]

According to Fr. Joaquin Bernas, S.J., the basis of this free exercise clause is the respect for the inviolability of the human conscience.[160] The right to religious freedom is considered a fundamental human right. The Universal Declaration of Human Rights defines freedom of religion and belief in this wise:

156. José Antonio Souto Paz, *Perspectives on Religious Freedom in Spain*, 2 BYU L. REV. 669-710 (2001) (citing CONSTITUCIÓN DE ESPAÑA DE 1869 art. 21, cl. 2, *reprinted in* JOAQUÍN MANTECÓN SANCHO, EL DERECHO FUNDAMENTAL DE LA LIBERTAD RELIGIOSA: TEXTOS, COMENTARIOS Y BIBLIOGRAFÍA MANTECÓN SANCHO, 265, 266 (1996)). The article reads, "*El ejercicio público ó privado de cualquier otro culto queda guarantizado á todos los extranjeros residentes en España, sin más limitaciones que las reglas universales de la moral y del derecho.*"

157. Treaty of Peace between the United States of America and the Kingdom of Spain, Dec. 10, 1898, U.S.-Spain, art. X, 30 Stat. 1754.

158. An Act to Declare the Purpose of the People of the United States as to the Future Political Status of the People of the Philippine Islands, and to provide a more Autonomous Government for those Islands [PHILIPPINE AUTONOMY ACT OF 1916] (1916). Section 3 of which includes,

> [t]hat no law shall be made respecting an establishment of religion or prohibiting the free exercise thereof, and that the free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed; and no religious test shall be required for the exercise of civil or political rights.

159. PHIL. CONST. art III, § 5.

160. JOAQUIN G. BERNAS, S.J., THE 1987 CONSTITUTION OF THE REPUBLIC OF THE PHILIPPINES: A COMMENTARY 321 (2003) [hereinafter BERNAS].

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship, and observance.[161]

In *Ebralinag v. Division Superintendent of Schools of Cebu*,[162] the Court quoted Chief Justice Teehankee's dissent in *German v. Barangan*,[163] where he discussed the proper regulation of a religious freedom pursuant to a compelling state interest:

> [t]he sole justification for a prior restraint or limitation on the exercise of religious freedom is the existence of a grave and present danger of a character both grave and imminent, of a serious evil to public safety, public morals, public health or any other legitimate public interest, that the State has a right (and duty) to prevent.[164]

In the absence of such compelling interest, acts done in the exercise of religious freedom may not be curtailed. As in American courts, Philippine courts are quick to add that the free exercise of religion is not absolute. In *People v. Diel*,[165] the Court of Appeals, in finding the accused guilty of illegal practice of medicine, said that the free exercise of religion may not be used to justify a criminal action inconsistent with general welfare of society.

B. Philippine Law and the Countervailing State Interests

Section 1, article III of the Philippine Constitution, which states that "no person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the laws," essentially, is the foundation of the state's interest in the protection and preservation of life. According to Fr. Bernas, the Philippines places life at a higher value than both liberty and property. He further opines that "the constitutional protection of the right to life is not just a protection of the right to be alive or the security of one's limbs against physical harm. The right to life is also the right to a good life."[166] This is mirrored in the social justice provisions of the Constitution which mandates that the state "adopt an integrated and comprehensive approach to health development,"[167] and

161. UDHR, art. 18.

162. Ebralinag v. The Division Superintendent of Schools of Cebu, 219 SCRA 256 (1993).

163. German v. Barangan, 135 SCRA 514 (1985).

164. *Ebralinag*, 219 SCRA at 270-71; *German*, 135 SCRA at 517.

165. People v. Diel, 44 O.G. 590 (Court of Appeals 1947).

166. BERNAS, *supra* note 160, at 102.

167. PHIL. CONST. art XIII, § 11.

> The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health, and other social services available to all the people at affordable cost. There shall be priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers.

to establish a system that is responsive to the country's health needs and problems.[168] The Constitution also provides for the integration of people with disabilities into mainstream society,[169] and recognizes and protects the life of the unborn.[170] Aside from this, the restrictive policy on the death penalty reflects the higher value that the Constitution places on life.[171]

The penal provisions of the Revised Penal Code that deal with various crimes against persons also highlight the importance that the government places on life. It penalizes homicide, murder, parricide, infanticide, abortion, and even assistance to suicide with severe penalties. Coupled with this is the restrictive nature of the currently suspended Death Penalty Law,[172] the repeal of which had been submitted by the previous Congress to the President. This underscores the government's utmost respect for the sanctity of life.

The Philippines also has an interest in preventing suicide. As the Constitution values life more than liberty and property, it is not hard to deduce that the Philippines abhors self-destruction, as well. The Philippines also has a state interest in the protection of innocent third parties or dependents of a patient who refuses medical treatment in behalf of their

168. PHIL. CONST. art XIII, § 12 ("The State shall establish and maintain an effective food and drug regulatory system and undertake appropriate health, manpower development and research, responsive to the country's health needs and problems.").

169. PHIL. CONST. art XIII, § 13 ("The State shall establish a special agency for disabled persons for their rehabilitation, self-development, and self-reliance, and their integration into the mainstream of society.").

170. PHIL. CONST. art II, § 12 ("*It shall equally protect the life of the mother and the life of the unborn from conception.*") (emphasis supplied).

171. PHIL. CONST. art II, § 19 (1) ("Excessive fines shall not be imposed, nor cruel, degrading or inhuman punishment inflicted. Neither shall death penalty be imposed, unless, for compelling reasons involving heinous crimes, the Congress hereafter provides for it. Any death penalty already imposed shall be reduced to *reclusion perpetua*.").

172. An Act to Impose the Death Penalty on Certain Heinous Crimes, Amending for that Purpose the Revised Penal Laws, and for Other Purposes, Republic Act No. 7659 (1993).

children. The Philippine courts, like its American counterparts, have been quick to note that a state has the right to order the compulsory vaccination of children, the confinement of the insane or those afflicted with contagious diseases. The police power of the state extends to the protection of the lives, limbs, health, comfort, and quiet of all persons, and the protection of all property within the state.[173]

The 1987 Constitution, under section 12, article II, recognizes the sanctity of family life and declares to protect and strengthen the family as a basic autonomous social institution. Article 209 of the Civil Code of the Philippines also states that parents have the natural right and duty to take care of the person and property of their unemancipated children, and this parental authority and responsibility shall include the caring for and rearing them for civic consciousness and efficiency and the development of their moral, mental, and physical character and well-being. Under the Child and Youth Welfare Code, "a child is considered as one of the most important assets of the nation such that every effort should be exerted to promote his welfare and enhance his opportunities for a useful and happy life."[174] Every child is also "endowed with the dignity and worth of a human being from the moment of his conception and has the right to be born."[175] Likewise, every child has the right to "protection against exploitation, improper influences, hazards, and other conditions or circumstances prejudicial to his physical, mental, emotional, social and moral development,"[176] and has the right "to the care, assistance, and protection of the State, particularly when his parents or guardians fail or are unable to provide him with his fundamental needs for growth, development, and improvement."[177] Thus, parents should provide adequate support to their children and criminal liability shall attach to any parent who "abandons a child under such circumstances as to deprive him of the love, care and protection he needs."[178]

Related to the interest in preserving life is the maintenance of the integrity of the medical profession. In the Philippines, the first act regulating the medical profession was Public Act No. 310,[179] which created the Medical Board of Examiners on 4 December 1901, regulating both the medicine and midwifery professions. The said act gave the Board the power to "examine candidates desiring to practice medicine in the Philippine

173. Collins v. Wolfe, 5 Phil. 285, 298 (1905).

174. The Child and Youth Welfare Code, Presidential Decree No. 603, art. 1 (1974).

175. *Id.* art. 3 (1).

176. *Id.* art. 3 (8).

177. *Id.* art. 3 (10).

178. *Id.* art. 59 (2).

179. Public Act No. 310 (1901).

Islands, and to issue a certificate of registration to such persons who are found to be qualified,"[180] and also provided that, after 1 March 1902, it shall be unlawful for any person to practice medicine, surgery, among others, in any of its branches in the Philippines, unless such individual holds a certificate of registration. The Board also had the power to revoke licenses for "immoral or dishonorable conduct, or for unprofessional conduct."[181]

On 29 June 1959, Republic Act No. 2382, or the Medical Act of 1959,[182] was enacted. The said law called for the standardization and regulation of medical education and provided for the examination for registration of physicians and the supervision, control, and regulation of the practice of medicine in the Philippines. The Medical Act of 1959 was amended by Republic Act No. 4224[183] in 1965 and by Republic Act No. 5946[184] in 1969. The Court explained that this power of the state to regulate the medical profession is under its police power. In the case of *United States v. Gomez Jesus*,[185] the Supreme Court held that the:

> state has general powers, first, to enact [such] laws ... as may promote public health, public morals, and public safety, and the general prosperity and welfare of its inhabitants; and, second, to make reasonable provisions for determining the qualifications of those engaging in the practice of medicine and surgery, and punishing those who attempt to engage therein in defiance of such provisions.[186]

In *Tablarin v. Gutierrez*,[187] the Court, in the words of Justice Feliciano, said that,

> the *regulation of the practice of medicine* in all its branches has long been recognized as a reasonable method of protecting the health and safety of the public. ... [L]egislation and administrative regulations requiring those who

180. *Id.* § 1 (b).

181. *Id.* § 4.

182. The Medical Act of 1959, Republic Act No. 2382 (1959).

183. An Act to Amend Certain Sections of Republic Act Numbered Twenty-Three Hundred and Eighty-Two, Otherwise Known as "The Medical Act of 1959," Republic Act No. 4224 (1965).

184. An Act to Amend Certain Sections of Republic Act Numbered Twenty-Three Hundred and Eighty-Two, Otherwise Known as "The Medical Act of 1959" as Amended by Republic Act Numbered Forty-Two Hundred and Twenty-Four, Republic Act No. 5946 (1969).

185. United States v. Gomez Jesus, 31 Phil. 218 (1915).

186. *Id.*

187. Tablarin v. Gutierrez, 152 SCRA 730 (1987).

> wish to practice medicine first *to take and pass medical board examinations* have long ago been recognized as valid exercises of governmental power. Similarly, the establishment of minimum medical educational requirements — i.e., *the completion of prescribed courses in a recognized medical school* — for admission to the medical profession, has also been sustained as a legitimate exercise of the regulatory authority of the state.[188]

Similarly in the case of *Department of Education, Culture and Sports v. San Diego*,[189] the Court said that, "The subject of the challenged regulation is certainly within the ambit of the police power. It is the right and indeed the responsibility of the State to insure that the medical profession is not infiltrated by incompetents to whom patients may unwarily entrust their lives and health."[190] The proper exercise of the police power requires the concurrence of a lawful subject and a lawful method. Thus, police power is validly exercised if "(a) the interests of the public generally, as distinguished from those of a particular class, require the interference of the State, and (b) the means employed are reasonably necessary to the attainment of the object sought to be accomplished and not unduly oppressive upon individuals."[191] "The State has the responsibility to harness its human resources"[192] and to see that these "resources must be applied in a manner that will best promote the common good."[193] Because the medical profession is a profession imbued with public interest, the state has the duty and obligation to make sure that the profession is vigilantly regulated. Finally, the Court said that "The medical profession directly affects the very lives of the people"[194] and this is perhaps the reason why a more stringent set of regulations is required of doctors, unlike in other careers.

Philippine laws balance state interests against the individual's rights to refuse medical treatment, to privacy, to free exercise of religion, and to bodily self-determination. Only when these state interests are considered compelling do they outweigh the individual liberties enshrined in Philippine law.

IV. CONSTITUTIONALITY AND RECOGNITION OF LIVING WILLS

A. Living Wills are Constitutional

188. *Id.* at 742.

189. Department of Education, Culture and Sports v. San Diego, 180 SCRA 533 (1989).

190. *Id.* at 537.

191. *Id.*

192. *Id.* at 538.

193. *Id.*

194. *Id.*

As discussed, the Philippine Constitution guarantees an individual's right to health, right to adequate and appropriate medical treatment, and, corollarily, the right to refuse medical treatment subsumed under the due process clause, which guarantees every Filipino's "right to life, liberty and property." These individual rights are usually invoked in cases of refusal of treatment in connection with the right to privacy and the right to the free exercise of religion already enshrined in existing provisions of the Bill of Rights. In the previous chapter, the author discussed the need for these individual rights to be balanced against countervailing state interests of preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of the medical profession. Only when these individual rights pose a threat compelling enough to warrant state intrusion will the state interfere with an individual's right to self-determination and invalidate a refusal of treatment made by a competent individual. This careful balancing of individual rights versus state interest is a reflection of the policy under section 11, article II of the Constitution which says that "the State values the dignity of every human person and guarantees respect for human rights." Under a Constitution that recognizes an individual's right to medical treatment and freedom to refuse medical treatment, the creation of living wills is therefore not proscribed.

The Civil Code also does not proscribe the execution of living wills. A living will is just a document where an individual can request to be or not to be kept alive by medical life-support systems in the event of a terminal illness. This can also include a provision designating a surrogate decision-maker in case a patient becomes incompetent to address certain decisions that need to be made in relation to treatment. A living will may also provide for certain incidental preferences of an individual after his death, like funeral arrangements and the donation of his organs. It is, in this wise, no different from provisions in normal wills that provide for the testator's last wishes. Like regular wills, living wills are: (1) revocable; (2) unilateral; (3) free and intelligent; (4) solemn and formal; and (5) executed with testamentary capacity and intent.[195]

A will is defined in this Code 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."[196] A living will is also *an act* of a person, but instead of controlling the disposition of an estate after death, a living will operates before a person dies and controls the

195. *See*, RUBEN F. BALANE, JOTTINGS AND JURISPRUDENCE IN CIVIL LAW: SUCCESSION 31 (2d ed. 2002).

196. CIVIL CODE, art. 783.

administration of certain life-sustaining and extraordinary medical treatment that will only serve to artificially prolong life. In most cases, refusal of a patient to administer these life-sustaining treatments would eventually result in death.

Under the Civil Code, "[a] will may be revoked by the testator at any time before his death,"[197] and "[a]ny waiver or restriction of this right is void."[198] This is also true of living wills. Most living will statutes provide that any individual making a living will has the right to revoke such document at any time. It is also executed unilaterally, meaning, it is made at the will or direction of one only party, usually called the testator or declarant. Such declarant's consent, like a will, should also not be vitiated by any of the conditions that invalidate a regular will, such as fraud, mistake, undue influence, insanity, violence, or intimidation. The requirements regarding the formalities of living wills vary, but most living will statutes provide that it should be a written document, signed by the testator in front of two or more witnesses, and acknowledged before a notary public. Some statutes even go so far as to provide restrictions on the kind of witnesses needed, such as witnesses that: (1) are not related to the declarant by blood or marriage; (2) would not be entitled to any portion of the estate of the declarant upon the declarant's decease under any testamentary will of the declarant, or codicil thereto, and would not be entitled to any such portion by operation of law under the rules of succession at the time of the execution of the living will; (3) are neither the attending physician nor an employee of the attending physician nor an employee of the hospital or skilled nursing facility in which the declarant is a patient; (4) are not directly financially responsible for the declarant's medical care; and (5) do not have a claim against any portion of the estate of the declarant.

Living will statutes are also of a particular form that contains a form of consent or refusal to consent to any care, treatment, service, or procedure that maintains, diagnoses, or otherwise affects the physical or mental condition of the testator. It includes a declaration made by the testator approving or disapproving certain diagnostic tests, surgical procedures, and programs of medication. There is also a provision regarding the withdrawal of artificial nutrition and hydration, and all other forms of health care, including cardiopulmonary resuscitation. Furthermore, it may incorporate a provision making anatomical gifts, authorizing an autopsy, and directing disposition of remains. Virtually all individuals who have testamentary capacity can make a living will. Living will statutes all over the world require that a declarant be a natural person of legal age, not otherwise disqualified by law. Most living will statutes, however, disqualify pregnant women from making living wills for reasons of public policy, depending on their position about the rights of the unborn.

197. *Id.* art. 828.

198. *Id.*

Unlike regular wills, however, living wills: (1) may or may not be purely personal; (2) may or may not be *mortis causa*; (3) are still not expressly provided statutorily, although certain provisions can be made to apply to it generally; and (4) not dispositive of property, unless an organ can be considered property.

Under article 784 of the Civil Code, "the making of a will is a strictly personal act" and "cannot be left in whole or in part of the discretion of a third person, or accomplished through the instrumentality of an agent or attorney."[199] This is not true with living wills, where the exercise of the power to refuse may be delegated to a third person, called a health proxy, which may be designated by the declarant in the will itself. The declarant may, however, also specify that no person be allowed to make medical decisions for him in the event of incapacity.

A living will may operate before the point of death and after. Certain provisions of living wills, especially those that involve consent or refusal of medical treatments, operate while a person is still legally alive, despite being in a persistent vegetative state, where there is a thin line between life and death. On the other hand, a provision in a living will making anatomical donations, or a provision directing funeral arrangements, clearly operate after the declarant's decease. A living will, unlike a regular will, does not dispose of a person's estate. It is also not provided for, statutorily, in our jurisdiction, although its execution is not proscribed. By looking at analogous Philippine laws, it is to be noted that Republic Act No. 7170 already recognizes organ donation, which allows individuals a right to make advanced end-of-life choices. By being an organ donor, an individual is given the choice to dispose of his organs to take effect after his death.[200] This is akin to the concept of a living will which allows an individual to direct the course of his medical treatment in case of terminal illness. In essence, the right to dispose one's organs is also based on the principle of self-autonomy and one's freedom to determine what happens to one's body, which to certain extent, is also the point of living wills.

Designating a health care proxy or making durable powers of attorney for health care in a living will is also not unconstitutional. The scope of the powers contained in a health care proxy provision is very much similar to other ordinary powers of attorney, except that they are called *durable* because they can operate even after a person's death. In these cases, the health care proxy acts as a surrogate decision-maker in the event of the declarant's

199. *Id.* art. 784.

200. *Id.* § 3.

incapacity. The only difference is that the rights and obligations and the *fiduciary* nature of relationship between a declarant and a designated health care proxy is broadened in light of the nature of the decisions that a health care proxy makes. In essence, a health care proxy acts as a guardian of the incompetent with regard to medical treatments only.

Under the Rules of Court, the definition of an incompetent:

> includes persons suffering the penalty of civil interdiction or who are hospitalized lepers, prodigals, deaf and dumb who are unable to read and write, those who are of unsound mind, even though they have lucid intervals, and persons not being of unsound mind, but by reason of age, disease, weak mind, and other similar causes, cannot, without outside aid, take care of themselves and manage their property, becoming thereby an easy prey for deceit and exploitation.[201]

This definition is inclusive and could also be made to apply to situations where health proxies are needed. The Rules of Court also provide that, in situations where an individual becomes incompetent, any relative, friend, or other person of the incompetent may petition the court having jurisdiction for the appointment of a general guardian for the person, or estate, or both, of such incompetent.[202] This means that the concept of designating a surrogate decision-maker is already acceptable under present Philippine law.

Although the provisions on guardianship are similar to the idea of designation of a health care proxy, there are very major differences between the two. First, the rules on guardianship contemplate an instance where the individual is already incompetent while a health care proxy is designated in advance during such time when an individual is still competent. Second, it is the declarant who chooses a proxy. In guardianship, the court has to determine for the incompetent the best person to protect his interest. Third, a health care proxy only decides issues relating to the medical treatment of the incompetent, especially life-sustaining but non-beneficent treatment, while guardians have broader duties and responsibilities and can even decide issues regarding the property of the incompetent. Also, a designation in a living will of a health care proxy may seem to be more advantageous because it eliminates the tedious process of going to court for a guardian.[203]

Aside from not being proscribed by the Constitution, the Civil Code, the Rules of Court, and other special laws, the concept of living wills is also not against public policy and is certainly not against good morals and good customs. Every person has the individual autonomy and the right to be let alone, which is recognized and enshrined in our existing laws. These individual rights take precedence over state interests, especially when such

201. 1997 RULES OF CIVIL PROCEDURE, rule 92, § 2.

202. *Id.* rule 93, § 1.

state interests are not compelling enough to warrant intrusion into an individual's right to bodily self-determination.

Some people mistake refusal of medical treatment with voluntary euthanasia, which are two separate things. Euthanasia is defined as "the intentional killing by act or omission of a person whose life is felt not to be worth living."[204] Nevertheless, the enforcement of living wills is not a form of euthanasia. Euthanasia is about a positive intervention to bring about the death of an individual, while a living will concerns itself with refusal to have treatment in certain circumstances. Everyone has the right to refuse treatment when they are mentally competent, and, in fact, before any medical procedure, the patient should be informed of the risks involved in the treatment and should give proper consent. Living wills just allow the exercise of a patient's right to refuse treatment in advance and provide written evidence of a patient's preferences; thus, giving the patient a measure of control over medical decisions, even if he is incapacitated, which would not exist if no instructions were left. Living wills also protect medical caregivers and doctors from civil and criminal liability for following its instructions and give an opportunity to discuss what may be difficult issues about end-of-life care especially after an illness is diagnosed.

It should be emphasized, however, that living wills should also not be used as an instrument of abuse and should be limited, especially with regard to the kind of treatment being refused. Refusal of medically beneficent and non-futile treatment should be disallowed on grounds of public policy. The purpose of a living will is to provide dignity in dying when there is no hope of recovery and the treatment provided will serve only to prolong life without raising the quality of a patient's life and, in most cases, only prolonging a patient's suffering. This should not be made a scapegoat for people with self-destructive behavior who, instead of finding a suitable treatment unbearable, find living life intolerable.

B. Proposed Laws Recognizing the Right to Refuse Medical Treatment and Living Wills

At present, there is still no specific recognition of the right to refuse medical treatment nor the validity of living wills. Nevertheless, there were several bills filed in the 13th Congress that, if passed, would recognize a patient's

204. Paul Lambert & Rebecca Lambert, Facing the Issue: Euthanasia, *at* http://www.request.org.uk/issues/topics/euthanasia/euthanasia01.htm (last accessed Sep. 18, 2007).

right to refuse medical care and, in essence, also validate the constitutionality of living wills.

House Bill No. 261,[205] proposed by Representative Rodriguez Dadivas, and the identical Senate Bill No. 3,[206] proposed by Senator Juan Flavier, both dubbed as the "Magna Carta for Patients' Rights and Obligations," both recognize and enshrine, among others, the (1) right to appropriate medical care and humane treatment; (2) right to informed consent; (3) right to privacy and confidentiality; (4) right to information; and the (5) right to self-determination.

According to the proposed bills, "every person has a right to health and medical care corresponding to his state of health, without any discrimination and within the limits of the resources, manpower and competence available for health and medical care at the relevant time."[207] As to the right to informed consent, the bills provide that every "patient has a right to a clear, truthful and substantial explanation, in a manner and language understandable to the patient, of all proposed procedures, whether diagnostic, preventive, curative, rehabilitative or therapeutic."[208] Informed consent shall be obtained from a patient concerned if he is of legal age and of sound mind. The bill also states that a patient should likewise be informed of the "possibilities of any risk of mortality or serious side effects, problems related recuperation, and probability of success and reasonable risks involved in the procedure"[209] and should provide his written informed consent before any procedure, except in emergency cases, when the patient is at imminent risk of physical injury, decline, or death if treatment is withheld or postponed.[210]

205. An Act Declaring the Rights and Obligations of Patients and Establishing a Grievance Mechanism for Violations Thereof and for Other Purposes, House Bill No. 261, 13th Cong. (2004).

206. An Act Declaring the Rights and Obligations of Patients and Establishing a Grievance Mechanism for Violations Thereof and for Other Purposes, Senate Bill No. 3, 13th Cong. (2004).

207. H.B. No. 261, § 4 (1), ¶ 1; S.B. No. 3, § 4 (1), ¶ 1.

208. H.B. No. 261, § 4 (2), ¶ 1; S.B. No. 3, § 4 (2), ¶ 1.

209. H.B. No. 261, § 4 (2), ¶ 1; S.B. No. 3, § 4 (2), ¶ 1.

210. The bills provide the same set of exceptions to the need for the patient's informed written consent. They are as follows:

1. in emergency cases, when the patient is at imminent risk of physical injury, decline or death if treatment is withheld or postponed. In such cases, the physician can perform any diagnostic or treatment procedure as good practice of medicine dictates without such consent;

2. when the health of the population is dependent on the adoption of a mass health program to control epidemic;

In cases where the patient is incapable of giving consent and a third party consent is required the bills list an order of priority: (1) spouse; (2) son or daughter of legal age; (3) either parent; or (4) brother or sister of legal age, or guardian. If the patient is a minor, consent shall be obtained from his parents or legal guardian. If next of kin, parents, or legal guardians refuse to give consent to a medical or surgical procedure necessary to save the life or limb of a minor or a patient incapable of giving consent, the bills give redress to the courts upon the petition of the physician or any person interested in the welfare of the patient in a summary proceeding and such courts may issue an order giving consent.

The bills further provide that,

> Any person of legal age and of sound mind may make an advance written directive for physicians to administer terminal care when he/she suffers from the terminal phase of a terminal illness provided that (a) he is informed of the medical consequences of his choice; (b) he releases those involved in his care from any obligation relative to the consequences of his decision; and (c) his decision will not prejudice public health and safety.[211]

Similarly, Senate Bill No. 588,[212] proposed by Senator Manuel Villar, Jr., also called the "Magna Carta for Patient's Rights," recognizes advance health care directives and the right of a patient to self-determination. The bill defines advance directives as:

> a duly notarized document executed by a person of age and of sound mind, upon consultation with a physician and family members, which directs health care providers to refrain from providing prolonged life support when

3. when the law makes it compulsory for everyone to submit a procedure;

4. when the patient is either a minor, or legally incompetent, in which case, a third party consent is required;

5. when disclosure of material information to patient will jeopardize the success of treatment, in which case, third party disclosure and consent shall be in order; and

6. when the patient waives his right in writing.

See, H.B. No. 261, § 4 (2), ¶ 1; S.B. No. 3, § 4 (2), ¶ 1.

211. H.B. No. 261, § 4 (6); S.B. No. 3, § 4 (6).

212. An Act Declaring the Rights of Patients and Prescribing Penalties for Violations Thereof, Senate Bill No. 588, 13th Cong. (2004).

the situation arises that the person who executed such directive suffers a condition with little or no hope of reasonable recovery.[213]

Senate Bill No. 588 recognizes that, "every person has a right to health and medical care corresponding to his state of health, without any discrimination and within the limits of the resources available for health and medical care at the relevant time."[214]

As to informed consent, which the bill defines as "the voluntary agreement of a person to undergo or be subjected to a procedure"[215] This is primarily based on his understanding of the relevant consequences of receiving a particular treatment, which should be clearly explained by the health care provider. The bill provides that such "permission may be written, conveyed verbally, or expressed indirectly through an overt act."[216]

All three bills use section 1, article XIII of the Constitution, which states that Congress shall give the highest priority to the enactment of measures that protect and enhance the right of all people to human dignity, as basis to ensure and protect the rights of patient to decent, humane, and quality health care.

V. ANALYSIS

These proposed laws underscore the fact that even the Philippine legislature recognizes that there is a right to adequate and quality health care, the right to informed consent, the right to refuse medical treatment, and the necessity for living wills. The Philippines, being a third-world Catholic country, end-of-life decisions, especially regarding life-sustaining but non-beneficent treatments usually result in a moral dilemma for the family and sometimes result in family conflicts. These choices are difficult enough to face when the patient is mentally alert and can make, or at least participate in, decisions. When the patient is incapacitated or no longer capable of making decisions or communicating his wishes, the experience can be agonizing. Since 85% of Filipinos are Roman Catholic and another six percent belong to other Christian groups, it is not hard to see why end-of-life choices for terminally ill Filipinos, especially those incapable of making their own decisions, are often distressing for the family and sometimes result in conflict.

This is the reason why a Philippine law on living wills is necessary. The custom of making a patient's spouse or immediate family as the default decision-makers to choose the course of action in end-of-life medical care is ineffective. A person's spouse or immediate family may not always represent the true wishes of the patient. In a situation where a patient wants to get all

213. S.B. No. 588, § 3 (1).

214. *Id.* § 4 (1), ¶ 1.

215. *Id.* § 3 (10).

216. *Id.*

the medically beneficent help possible to stay alive, and his spouse or immediate family decide to discontinue medical treatment, Philippine law and custom do not provide a way for a medical practitioner to continue medical care in line with the wishes of the patient. A person's spouse or immediate family may also be motivated by other factors that will not be beneficent to the patient. In such cases, having an advance declaration of an individual's wishes or a designation of someone who will ultimately make medical decisions is most advantageous.

The completion of living wills with a designation of a health care proxy is not repugnant to Catholic beliefs, especially if limitations are set with regard to the kind of treatments that can be refused. Catholic doctrines do not "insist that a dying or a seriously ill person should be kept alive by all possible means for as long as possible." The Catholic Church has also said that terminating "extraordinary means of treatment" is not considered as euthanasia.[217] It even argued that a patient could ultimately decide whether to receive or refuse treatment and that, if the treatment was extraordinary, the patient had no obligation to accept such treatment and that interruption of resuscitation would only be an "indirect cause of the cessation of life" and, thus, the choice to terminate these "extraordinary means" of medical treatment is considered moral according to the Catholic Church.[218]

Filipino families' attitudes towards respecting a dying patient's wishes also do not conflict with the idea of making living wills. Filipino culture even dictates that utmost respect should be given to the last wishes of a dying relative at the time of death. In a study of critically ill Filipinos and their families in the United States, attitudes of the terminally ill Filipino and their families towards the completion of advance directives such as living wills were positive.[219]

Current Philippine laws, customs and practices are also inadequate and do not address the issue and situations contemplated and covered by living wills. It is true that the Civil Code of the Philippines in article 305 provides for an enumeration of who may have the right to decide in cases of funerals, which follows article 429 of the Civil Code on support. The enumeration lists the following in order: the spouse, the descendants of the nearest degree, the ascendants, also of the nearest degree, and the brothers and sisters[220] and

217. *In re* Quinlan, 355 A.2d 664, 658 (N.J. 1976).

218. *Id.* at 658-59.

219. Jennifer L. McAdam, et al., *Attitudes of Critically Ill Filipino Patients and their Families toward Advance Directives*, 14 AM. J. CRIT. CARE 17-25 (2005).

220. CIVIL CODE, art. 305.

that Republic Act No. 7170 provides that, aside from the testator the following persons:

> ... in the absence of actual notice of contrary intentions by the decedent or actual notice of opposition by a member of the immediate family of the decedent, may donate all or any part of the decedent's body for any purpose:
>
> 1. spouse;
> 2. son or daughter of legal age;
> 3. either parent;
> 4. brother or sister of legal age; or
> 5. guardian over the person of the decedent at the time of his death,[221]

and these enumerated persons may make the donation after or immediately before death. It is clear that the enumeration in article 305 only applies to funerals and the provision in Republic Act No. 7170 only applies to organ donations after death and not to end-of-life medical decisions.

Although current rules on guardianship would generally cover the situations contemplated by a law on living wills, the procedural aspect of guardianship is not only very tedious but costly. With the current backlog in Philippine courts, such a proceeding could take months and time is something that cannot be sacrificed in medical treatment decisions. A law on living wills will likewise strengthen the medical industry. Doctors will be able to enforce a patient's wishes, especially with regard medically beneficent treatments which ultimately limit their liability with regard to patients who refuse treatment or family members who wish to discontinue treatment of particular patients.

Everyday, families are placed in the painful position of having to make decisions for a sick or disabled person with no indication of what the person himself would have wanted. Further, without written evidence of the person's wishes, or without a formally designated decision-maker, health care providers who fear being sued or criminally prosecuted may refuse to terminate treatment, even if it merely prolongs the patient's suffering while offering no hope of recovery. Families may be forced to go to court to obtain permission to carry out the decision that they believe the patient would have made. Not only can the involvement of outsiders be an unwelcome intrusion into this private matter, but the publicity that such cases often generate can be painful.

221. ORGAN DONATION ACT OF 1991, § 4 (a).

VI. CONCLUSION

Every person has an inherent right to adequate and appropriate medical treatment and a corollary right to refuse medical treatment. Every person has the right to be let alone, the right to determine the course of one's life as an intrinsic part of his liberty. All choices, even choices about end-of-life medical care which can eventually result in death, should be respected, unless there is a compelling public interest to warrant a state's intrusion upon an individual's liberty. The right to refuse medical treatment is not absolute and must be balanced against the four countervailing state interests: (1) the preservation of life; (2) protection of third parties; (3) prevention of suicide; and (4) maintenance of the integrity of the medical profession. These state interests are not, by themselves, compelling enough to warrant a state's interference to intrude into a patient's right to self-determination and autonomy.

Nonetheless, when a patient is not terminally ill and refuses medical treatment because, instead of finding the treatment unbearable, he finds living intolerable, the state has an interest to intrude and compel a patient to be treated. Although a state's interest in the preservation of life may be the most significant of the four state interests, based on a state's duty to promote the well-being of its people, this is only based on the assumption that the individual wants that protection. Where a terminally ill adult patient competently refuses life-sustaining and non-beneficent medical treatment in a living will, the state interest in such patient's life and welfare does not outweigh the patient's right to self-determination and privacy. In such a case, the state lacks a legitimate interest in extraordinarily prolonging a patient's life.[222] Insofar as the sanctity of individual free choice and self-determination are fundamental constituents of life, the value of an individual's life may be lessened by a state's failure to allow a competent human being the right of choice. Thus, respect of every competent individual's choice to refuse treatment is paramount to any state interest,[223] especially when such treatment: (1) is non-beneficent and merely life-sustaining; (2) is invasive and compels an individual regular and painful treatment that does not improve his quality of life; and (3) does not offer any hope of recovery and merely prolongs a patient's suffering while being financially burdensome for the family. While a state's interest in the prevention of suicide can be found compelling under certain circumstances, an individual's refusal of treatment *per se* is not a form of suicide.[224]

222. Previn, *supra* note 123, at 605.

223. *In re* Conroy, 486 A.2d 1209, 1223-24 (1985).

224. Superintendent of Belchertown State School v. Saikwescz, 370 N.E.2d 417, 426 (1977).

Declining life-sustaining and non-beneficent treatment is not an attempt to commit suicide" and "refusing medical intervention merely allows the disease to take its natural course."[225] Catholic doctrine does not even insist that a dying individual should be kept alive by all possible means using extraordinary means of treatment for as long as possible. Terminating "extraordinary means of treatment" is not considered as euthanasia[226] and is considered moral according to the Catholic Church.[227] The Catholic Church even respects that a patient could ultimately decide whether to receive or refuse treatment and that, if such treatment is extraordinary, he has no obligation to accept such treatment and that interruption of resuscitation would only be an "indirect cause of the cessation of life." With regard to the state's interest in protecting dependents, it is important to distinguish whether or not parents refuse routine and potentially life-saving medical treatment or life-sustaining and non-beneficent treatment. This is important to consider if a patient had minor children who would be essentially abandoned in case the patient dies, especially if there was reasonable hope that the patient would recover after treatment. Nevertheless, a state's interests must still give way to the choice of the competent terminally ill individual if such individual refuses non-beneficent treatments and there is no hope for recovery, even if there are dependents involved. This is because the "right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death."[228]

As to the state's interest in the maintenance of the integrity of the medical profession, it is well-settled that it is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical practitioners. A doctor's recognition of a patient's right to refuse medical treatment in circumstances where there is no hope of recovery is consistent with existing medical standards. It does not undermine the integrity of the medical profession, nor does it threaten the role of hospitals in properly caring for such terminally ill patients or the state's role in protecting them. "If the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole."[229] Furthermore, current ethical practices in medicine already recognize that a dying patient is often more in need of comfort than treatment. The medical profession does not ethically require doctors to intervene in the treatment of

225. *Conroy*, 486 A.2d at 1224.

226. *In re* Quinlan, 355 A.2d 664, 658 (N.J. 1976).

227. *Id.* at 658-59 (citing Pope Pius XII, Address to International Congress of Anaesthesiologists (Nov. 24, 1957)).

228. *In re* Conroy, 486 A.2d 1209, 1225 (1985).

229. *Id.* at 1224-25.

disease at all costs. Hence, it can be concluded that, in cases where a patient is terminally ill or in a persistent vegetative state, the state cannot deny a patient the right to discontinue medical treatments or procedures that would only prolong his life. State intrusion, in such instances, to a patient's autonomy and right to self-determination, is not in line with the policy of the state to give the "highest priority to the enactment of measures that protect and enhance the right of all people to human dignity."[230] The state cannot also justify an intrusion to such an individual right on the basis that such an act is self-destructive because, in cases where treatment only serves to prolong life, the eventuality and certainty of an individual's death cannot be prevented.

The Philippines, as a country that values the life, health, and the welfare of its citizens, must also balance these state interests against the individual's rights to refuse medical treatment. The Philippine experience is parallel to that of the United States. The Philippines' interest in the preservation of life, prevention of suicide, protection of dependents, and maintenance of the medical profession, do not outweigh an individual's right to refuse life-sustaining and non-beneficial treatments. Since there is no compelling state interest to warrant an intrusion to a competent individual's right to refuse life-sustaining and non-beneficial treatment, and living wills are merely an expression of the that right, it is safe to deduce that there is no hindrance to the recognition of living wills in the Philippines.

First of all, living wills are considered constitutional under Philippine law. It is not proscribed by the Constitution and is recognized as an exercise of an individual's right to liberty and protected by the policy of the state to give highest priority to the enactment of measures that protect and enhance the right of all people to human dignity. It is not proscribed by any statutes or special laws. Neither is it immoral nor against public policy or good customs. A living will just generally provides guidance and expresses a person's preferences for medical care, usually dealing with consent to or refusal to receive medical treatments. It is intended to anticipate a situation wherein an individual is in an incurable or an irreversible mental or physical condition, with no reasonable expectation of recovery. It is usually intended to apply only if the person is in a terminal condition or in a persistent vegetative state with no hope of recovery. Living wills also provide for any expression whatsoever of a declarant's wishes before death, such as designating a surrogate decision-maker, or even after death, as in declaring a preference for cremation, or inserting a provision for anatomical donations. Because Philippine laws, customs, and practices are inadequate and do not

230. H.B. No. 261, § 2; S.B. No. 3, § 2; S.B. No. 588, § 2.

address the issue and situations contemplated and covered by living wills, it is necessary to have legislation specifically recognizing and governing living wills. Having an advance declaration of patient's wishes, regarding his medical care or the designation of surrogate decision-maker who will ultimately make medical decisions, is helpful in preventing conflicts and moral dilemmas within the family and truly boosts patient's rights in line with the Philippine's policy to "enhance the right of all people to human dignity."