

Live and Let Die: Establishing the Legal Status of Advance Directives for Refusal of Life-Sustaining Medical Treatment, Their Enforceability, and Limitations

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I. ADVANCE DIRECTIVES: HISTORY, LEGALITY, AND DEFINITIONS...	491
II. MEDICAL-ETHICAL CONSIDERATIONS: RECOGNIZING PATIENT AUTONOMY	494
A. <i>The Patient-Physician Relationship</i>	
B. <i>Informed Consent: Protection and Procedure as the Highlight of Patient Autonomy</i>	
III. A PATIENT’S RIGHT TO SELF-DETERMINATION: LAYING THE FOUNDATIONS.....	507
A. <i>The Extent of Patient Self-Determination</i>	
B. <i>Analysis: The Legal Basis of Patient Self-Determination as a Right to Refuse Life Saving or Sustaining Treatment</i>	
C. <i>The Extent and Foundations of Patient Self-Determination</i>	
IV. THE LIMITS OF PATIENT SELF-DETERMINATION AND ITS ENFORCEMENT THROUGH ADVANCE DIRECTIVES	533
A. <i>The Limits of Patient Self-Determination</i>	
B. <i>The Adoption of Advance Directives as a Measure of Protection for the Patient’s Right to Self-Determination</i>	
V. A LEGAL FRAMEWORK FOR PATIENT SELF-DETERMINATION....	550
A. <i>Ascertainment of Medical Futility</i>	
B. <i>Ascertainment of the Existence of an Advance Directive</i>	
VI. PROTECTING THE LIMITED RIGHT TO DIE.....	571

I. ADVANCE DIRECTIVES: HISTORY, LEGALITY, AND DEFINITIONS

An advance directive is a “health care directive ... ‘either stat[ing] a person’s wishes and instructions regarding future medical treatment in the event of incapacity or appoint[ing] someone to act as a proxy.’”¹

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An advance directive may “detail circumstances under which treatment should be discontinued, such as coma, brain death, or a terminal condition.”² It may also indicate particular “treatments or medications to suspend (for example, invasive surgery, artificial nutrition or hydration, and measures that serve no purpose except to delay death) and which to maintain (for example, kidney dialysis and drugs for pain).”³ Apart from treatment or curative preferences, a patient may also express “which ‘heroic measures’ (for example, emergency surgery and [Cardiopulmonary Resuscitation (CPR)]) should and should not be used,”⁴ the patient’s “preferences regarding organ donation, autopsy, and alternative treatments,”⁵ as well as the “[designation of] an agent to carry out these wishes if the patient is incapable of making decisions.”⁶

The emergence of advance directives — and the legal, medical, and ethical controversies that surround it — is inextricably linked with the growing awareness of end-of-life care. With progress in the field of medicine, it now becomes possible to extend the in-between of life and death practically indefinitely. Yet, despite such progress, the capability to prolong the eventuality of death has proven to be a medical purgatory for the patient, given the disputations of healthcare practitioners, the patient’s family or guardian, and even the patient himself or herself, on the preferences and propriety of the care actually received. Ironically, what results is that the once very personal and solitary experience of death has become a moral tug-of-war between different parties with substantial interests to protect, at times even turning into media-hyped public interest debate. Robert H. Blank, a published health and biomedical policy expert,⁷ writes —

Until recent decades, death and the dying process were largely a manner of private decisions made within specific religious and cultural frameworks. Increasingly, however, questions of how societies make decisions about the

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1. Sam J. Saad III, *Living Wills: Validity and Morality*, 30 VT. L. REV. 71, 74 (2005) (citing LAWRENCE A. FROLIK & ALISON MCCHRYSTAL BARNES, *ELDER LAW: CASES AND MATERIALS* 567 (2d ed. 1999)).
2. KAREN JUDSON & CARLENE HARRISON, *LAW & ETHICS FOR MEDICAL CAREERS* 290 (5th ed. 2006).
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. Robert H. Blank, Author Profile, *available at* <http://us.macmillan.com/author/roberthblank-1> (last accessed Sep. 6, 2012).

ending of life have become a matter of public policy and of ethical debate. Advances in medicine have the capacity to extend life indefinitely, but often with poor quality and with escalating dependence on medical technologies. Demographically, the aging populations in most developed countries and the increasing incidence of ... chronic diseases in developing countries promise to complicate end-of-life decision making in the coming decades. As a growing proportion of societal resources are concentrated at the end of people's lives, the ethical and policy issues are bound to intensify. Thus, the more we can understand and debate the issues now, the better the chance we will have of dealing with their mounting consequences for all countries.⁸

Corollary, or even consequent to such medical progress, some commentators have noted a trend in recent decades of empowering patients as to the direction of their treatment, or what has been termed as *patient autonomy*, and, since the 1960s and 1970s, advance directives have been one of the most prominent mechanisms to recognize such autonomy.⁹ One commentator has also noted how societal attitudes towards death have "medicalized" it, stemming from a purported attitude of distancing oneself "from the realities of mental degeneration and death,"¹⁰ such that the "responsibility for care of the mentally incapacitated, the elderly, and the dying has been increasingly confined to institutions, hospitals, and health professionals."¹¹ With this "medicalization"¹² came apprehensions towards the medical establishment itself, given the apparent loss of patient control over what treatment they receive, such that these misgivings manifested into "increasingly misplaced fear of overtreatment at the end of life, mistrust in medical technology or lack of confidence that health professionals recognized when 'enough is enough.'"¹³ As a measure to curb such "medicalization," advance directives thus "permit individuals to have a voice in situations where they are otherwise unable to control what is done to them."¹⁴

The most evident advantage seen in advance directives is that "they allow a person to express in an explicit manner how he or she wishes to be

8. Robert H. Blank, *Introduction: Issues at the End of Life*, in *END OF LIFE DECISION MAKING: A CROSS-NATIONAL STUDY I* (Robert H. Blank & Janna C. Merrick ed., 2005).

9. *Id.* at 3.

10. Ann Sommerville, *Are Advance Directives Really the Answer? And What Was the Question?*, in *DEATH, DYING AND THE LAW* 30 (Sheila A.M. McLean ed., 1996).

11. *Id.* at 30.

12. *Id.* at 31.

13. *Id.*

14. *Id.* at 30-31.

treated before treatment is needed”¹⁵ so as to recognize the autonomy of the individual, in that “[even] though unconscious or comatose, a person can continue to exert control over his or her life.”¹⁶ More poignantly, patients have been given “the ability to control the dying process, primarily by refusing life-extending interventions.”¹⁷ This recognition of autonomy, put in the negative, evinces the attractiveness of advance directives in its avoidance of “putting treatment decisions in the hands of others.”¹⁸

These rights, however, remain virtually unrecognized in the Philippines. Owing to a host of factors such as Filipino religiosity, family values, fatalism, and deference, Philippine laws have been slow to recognize and protect such right. This, however, cannot mean that the precepts advance directives protect do not exist within the local setting.

II. MEDICAL-ETHICAL CONSIDERATIONS: RECOGNIZING PATIENT AUTONOMY

Underlying the patient’s ability to assert end-of-life care preferences is the relationship between patient and physician. This Chapter serves to elucidate the scope and complexities of such relationship, with a view to defining the obligations and duties of both parties in light of accepted practices in the medical field, particularly in end of life care. A consideration of the ethical concerns surrounding end-of-life care, the Author will argue, is essential in grounding end-of-life care considerations for the creation of any viable legal framework to recognize a patient’s right to self-determination.

A. The Patient-Physician Relationship

i. Under the Ethical Lens

a. From Medical Paternalism to Patient Autonomy

Highlighting patient dependence on his or her physician, the traditional concept of the patient-physician relationship was patently a paternalistic one. Under the Paternalistic Model,

[the] physician is in the best position to dictate and decide the medical interventions for the best interest of the patient because of his [or] her clinical skills, knowledge and expertise. This model assumes that whatever the physician does is for the best interest of the patient; hence, the patient is

15. RICHARD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS (7th ed. 2004).

16. *Id.*

17. *Blank, supra* note 8, at 3.

18. Rebecca S. Dresser, *Treatment Decisions for Incapacitated Patients*, in PRINCIPLES OF HEALTH CARE ETHICS 307 (2007 ed.).

expected to be thankful for the physicians in all cases. Also known as parental or priestly model, it authorizes the physician to authoritatively make decision as to what, how[,] and when the intervention will be performed on the patient. The physician is deemed the patient's guardian, who is obliged not only to articulate [and] implement what is best for the patient but also to ... place his patient's interest above his or her own. ... In case of conflict or 'tension between the patient's autonomy and well-being between choice and health, the paternalistic physician's main emphasis is toward the latter.¹⁹

One definition has gone so far to say that medical paternalism covers "action[s] taken by one person in the best interests of another without their consent."²⁰ Under such model, one author has commented "giving patients the liberty to make their own treatment decisions 'was never part of the ethos of medicine.'"²¹ Another author had written that "[the] doctor decided what was best for the patient, and the patient accepted the decision, usually without questioning, [without] understanding, or perhaps even [without] a real choice."²² Evidently, the monopoly of knowledge and expertise in the medical field creates a great disparity between the physician and the patient. Such disparity, since the time of Hippocrates,²³ justifies several doctrines that today would seem backwards, patently unfair, and overly empowering physicians in the making of medical decisions, especially as regards information sharing.

A fundamental principle under the paternalistic model — a principle originating from Ancient Greek physicians — was that patients rightly played no part in the medical decision-making process, in that participation was superfluous since their common ultimate goal was treatment.²⁴ Patient exclusion "went so far as to recognize a duty of deceit, which encouraged physicians to conceal the patient's true condition — especially from the

19. *Id.* at 593.

20. Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 338 (2009) (citing David C. Thomasma, *Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship*, 98 ANNALS INTERNAL MED. 243, 244 (1983)).

21. *Id.* at 338.

22. *Id.* (citing JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 1-2 (2004)).

23. Hafemeister & Gulbrandsen, Jr., *supra* note 20, at 338.

24. *Id.* at 338-39 (citing Julie M. Spanbauer, *Breast Implants as Beauty Ritual: Woman's Sceptre and Prison*, 9 YALE J.L. & FEMINISM 157, 187 (1997)).

patient.”²⁵ The practice of withholding medical information about the patient from the patient was based on belief in the “healing effects of fair words,”²⁶ such that even promising to cure the incurable was a physician’s duty; under such model, “optimism and confidence were essential to the healing process.”²⁷ This paternalism pervaded medical ethics up to the middle of the 20th Century, with physicians having no duty to apprise their patients of treatment options, under the primacy of limited disclosures, optimism, and physician monopoly of the decision-making process.²⁸

By the 20th Century, valuations on the patient-physician relationship began to shift to accommodate patient participation, and in fact, patient primacy. In 1914, *Schloendorff v. Society of New York Hospital*²⁹ recognized that “[every] human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”³⁰ The case was “the first major limit to physician authority,” at least in the United States (U.S.), and the first step to bridging the information exclusivity of physicians over patients.³¹ Although initially ruled on the basis of contract law provisions,³² and although the physician’s duty under *Schloendorff* was only to provide simple consent, a 1957 California decision, *Salgo v. Leland Stanford Jr. University Board of Trustees*,³³ furthered patient participation by introducing the concept of informed consent. *Salgo* held that “[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”³⁴ Slowly, by the 1950s and 1960s, and with the advent of the American Civil Rights Movement, the concept of patient autonomy was born.³⁵

25. Hafemeister & Gulbrandsen, Jr., *supra* note 20, at 339 (citing Lori B. Andrews, *The Right and Rite of Informed Consent*, 21 LAW & SOC’Y REV. 765, 766 (1987)).

26. KATZ, *supra* note 22, at 6.

27. *Id.*

28. See Hafemeister & Gulbradsen, Jr., *supra* note 20, at 339-41.

29. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125 (1914) (U.S.).

30. *Id.* at 129-30.

31. Amir Halevy, *Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance*, 18 HEALTH MATRIX 261, 266 (2008).

32. Hafemeister & Gulbrandsen, Jr., *supra* note 20, at 341.

33. *Salgo v. Leland Stanford Jr. University Board of Trustees*, 154 Cal. App.2d 560 (1957) (U.S.).

34. *Id.* at 578.

35. See Hafemeister & Gulbrandsen, Jr., *supra* note 20, at 342-43.

Under the Patient Autonomy Model, the underlying principle was that “physicians do not treat typical patients; rather, they take care of particular patients and the particular patient knows his values and goals and thus is in the best position to make decisions regarding his life and health.”³⁶ Moreover, under this Model,

patients make the ultimate decisions concerning their healthcare[.] ... To determine which procedures are in their best interest, patients are entitled to know their viable options and the material risks and benefits associated with each option. The doctor is responsible for dispensing information; the patient is responsible for making the decisions.³⁷

To say that “doctor knows best” can no longer be entirely accurate, and the Patient Autonomy Model has the effect of greater patient awareness of their rights “in the midst of the physicians modernizing or fashioning their professional practices and adjusting their medical edict and ethical standards in accordance with the advances in medicine and technology and for their own professional benefits and interests.”³⁸ In short, “patients have realized their vulnerabilities as recipients of medical care. [They now] advocate for the expansion of their rights, including the rights to know and be informed of what the physicians intend to do.”³⁹

b. A Basic Principle of Biomedical Ethics

Patient autonomy is not only the current model for the patient-physician relationship. It is a central tenet of contemporary medical ethics, recognized as one of, if not *the* primary principle of biomedical ethics, along with *non-maleficence*,⁴⁰ *beneficence*,⁴¹ and *justice*.⁴² In physician-patient transactions regarding health care, a respect for this principle “requires that a physician must not interfere with the effective exercise of patient autonomy”⁴³ and that there is the underlying assumption that patients, being rational agents, have “the capacity to act intentionally, with understanding, and without

36. Halevy, *supra* note 31, at 266.

37. Hafemeister & Gulbrandsen, Jr., *supra* note 20, at 343-44 (citing Martha S. Swartz, “Conscience Clauses” or “Unconscionable Clauses”: Personal Beliefs Versus Professional Responsibilities, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 316 (2006)).

38. RUSTICO T. DE BELEN, MEDICAL JURISPRUDENCE 591 (2009).

39. *Id.*

40. PETER P. NG & PHILIPP U. PO, MEDICAL LAWS AND JURISPRUDENCE: LEGAL ASPECTS OF MEDICAL PRACTICE 102 (2005).

41. *Id.* at 103.

42. *Id.*

43. *Id.* at 102.

controlling influences that would mitigate against a free and voluntary act and will.”⁴⁴

Such autonomy has been recognized as one of the principal rights of patients. No less than the World Medical Association (WMA), an international organization representing physicians,⁴⁵ has recognized patient autonomy (or patient self-determination) as one of the most basic privileges of all patients in its Declaration of the Rights of the Patient.⁴⁶ The WMA recognizes that “[while] a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice.”⁴⁷ The Declaration, on the Patient’s Right to Self Determination, states the following basic precepts:

- (a) The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decision.
- (b) A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.
- (c) The patient has the right to refuse to participate in research or the teaching of medicine.⁴⁸

Locally, the Philippine Medical Association (PMA) in its Code of Ethics⁴⁹ likewise mandates physician respect for patient autonomy, and also incidentally, the Patient Autonomy Model, in this wise —

Section 5. A physician should exercise good faith and honesty in expressing opinion/s as to the diagnosis, prognosis, and treatment of a case under his/her care. A physician shall respect the right of the patient to refuse medical treatment. Timely notice of the worsening of the disease should be given to the patient and/or family. A physician shall not conceal nor exaggerate the patient’s condition except when it is to the latter’s best. A physician shall obtain from the patient a voluntary informed consent. In

44. *Id.*

45. World Medical Association, What is the WMA?, *available at* <http://www.wma.net/en/60about/index.html> (last accessed Sep. 6, 2012).

46. World Medical Association, *Declaration of Lisbon on the Rights of the Patient* (Oct. 1981, as amended Sep. 1995, revised Oct. 2005) [hereinafter WMA Declaration].

47. *Id.* pmb1.

48. *Id.* Principle 3.

49. Philippine Medical Association, Code of Ethics, *available at* <https://www.philippinemedicalassociation.org/images/lesson.pdf> (last accessed Sep. 6, 2012) [hereinafter PMA Code of Ethics].

case of unconsciousness or in a state of mental deficiency the informed consent may be given by a spouse or immediate relatives and in the absence of both, by the party futhorized by an advanced directive of the patient. Informed consent in the case of minor[s] should be given by the parents or guardian, members of the immediate family that are of legal age.⁵⁰

c. No Statutory Recognition of Patients' Rights

It is evident from the above discussion that what constitutes patients' rights are primarily ethical tenets (violations of which can at most lead to possible administrative liability) or general laws of application that deal with the obligations between parties in certain contractual relationship, i.e., that of agency. Moreover, on a statutory and jurisprudential level, patients' rights are mostly read and interpreted from various sources, and some of these sources need to be applied analogously to a patient-physician relationship.

As pointed out by one commentator, patients, as a sector of society, are not protected by some form of all-encompassing legislation detailing their rights and obligations, as in other basic sectors —

The basic sectors ... have their *magna carta* laws, i.e.[.] overseas workers, health workers, disabled persons, women, children, senior citizens, and others, recognizing, protecting[,] and promoting their respective rights, privileges[,] and interests, thus making them legally binding and enforceable. Sadly, there is neither an enacted *magna carta* law nor a legally mandated patient's bill of rights to specifically safeguard and enforce the rights and interests of the patients of the Philippines, in spite of their evident susceptibility to risks, compromises and neglect by medical, legal, social, governmental, medical insurance, health[,] and other financial personnel and entities in the health sector, both private and public.⁵¹

The Philippine legal framework, evidently, is deficient in recognizing patients as having actionable rights under the law, or more properly, defining the scope of such rights. But, this has not been for want of trying on the part of Philippine legislature.

Every Congress, since 1992 (Ninth Congress), has failed to act upon bills recognizing patients' rights. Since that year, no less than 15 bills⁵² have been

50. *Id.* at art. II, § 5.

51. Rustico T. De Belen, *Preface* to RUSTICO T. DE BELEN, *MEDICAL JURISPRUDENCE* (2009).

52. *See* Patients' Rights Act, S.B. No. 702, 9th Cong., 1st Reg. Sess. (1992); Magna Carta of Patients, S.B. No. 1893, 9th Cong., 2d Reg. Sess.(1994); Patients' Rights Act, S.B. No. 676, 10th Cong., 1st Reg. Sess. (1995); Patients' Rights Act, S.B. No. 2367, 10th Cong., 2d Reg. Sess. (1997); Magna Carta of Patients' Rights, H.B. No. 564, 11th Cong., 1st Reg. Sess. (2000); Magna Carta of Patients' Rights, S.B. No. 898, 12th Cong., 1st Reg. Sess. (2001); Consent to Medical Treatment & Hospice/Pallative Care Act, S.B. No. 907, 12th Cong.,

filed in the Senate proposing some form of *magna carta* of patients' rights, all of which never moved past technical working group meetings. The various rights sought to be recognized and protected under these bills include the right to appropriate medical care and treatment (variably termed as the right to medical care and humane treatment),⁵³ to informed consent,⁵⁴ to privacy,⁵⁵ to information,⁵⁶ to privileged communication,⁵⁷ to choice of physician,⁵⁸ to self-determination (variably termed as the right to refuse treatment),⁵⁹ to religious belief,⁶⁰ to medical records,⁶¹ to leave,⁶² to refuse

2d Reg. Sess. (2001); Magna Carta of Patients' Rights, S.B. No. 2235, 12th Cong., 1st Reg. Sess. (2002); Magna Carta of Patients; Rights, S.B. No. 2539, 12th Cong., 2d Reg. Sess. (2003); Magna Carta of Patients' Rights & Obligations, S.B. No. 2621, 12th Cong., 2d Reg. Sess. (2003); Magna Carta of Patients' Rights & Obligations, S.B. No. 3, 13th Cong., 1st Reg. Sess. (2004); Magna Carta of Patients' Rights & Obligations, S.B. No. 588, 13th Cong., 1st Reg. Sess. (2004); Magna Carta of Patients' Rights & Obligations, H.B. 261, 13th Cong., 1st Reg. Sess. (2004); Magna Carta of Patients' Rights & Obligations, S.B. No. 812, 14th Cong., 1st Reg. Sess. (2007); Patients' Rights Act, S.B. 977, 14th Cong., 1st Reg. Sess. (2007); Mental Health Patients' Bill of Rights, S.B. No. 1767, 14th Cong., 1st Reg. Sess. (2007); Magna Carta of Patients' Rights & Obligations, S.B. No. 2371, 14th Cong., 1st Reg. Sess. (2008); Magna Carta of Patients' Rights & Obligations, S.B. No. 146, 15th Cong., 1st Reg. Sess. (2010); & Advanced Directives Education Act, S.B. 2573, 15th Cong., 2d Reg. Sess. (2010).

53. *See generally* S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2539; S.B. No. 2621; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 2537.
54. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 907; S.B. No. 2235; S.B. No. 2539; S.B. No. 2621; S.B. No. 3; S.B. No. 588; & S.B. No. 2537.
55. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2621; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 2537.
56. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 67; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 2537.
57. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 2537.
58. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 2537.
59. *See generally* S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 907; S.B. No. 2235; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; S.B. No. 146; & S.B. No. 2537.

participation in medical research,⁶³ to correspondence and visitors,⁶⁴ to express grievances,⁶⁵ and to be informed of such rights.⁶⁶ Furthermore, such bills either provide for penal liabilities for any violation of the rights enumerated therein,⁶⁷ or some form of grievance mechanism in case of dispute.⁶⁸

A. Informed Consent: Protection and Procedure as the Highlight of Patient Autonomy

Despite the legislative shortcomings, there is still the unquestionable shift in dynamic in the patient-physician relationship, both in the Philippines and abroad, which has created a practice of patient empowerment. Perhaps central to this modern dynamic, as discussed above, is patient autonomy, or patient self-determination, as variably termed. Enshrined in the ethical codes of medical regulatory bodies, the medical profession has adopted (to borrow the slogan of The Medical City, a “tertiary care hospital” located in Pasig City)⁶⁹ a “patients-as-partners”⁷⁰ model that allows the patient to determine his or her preferences in treatment modalities.

60. See generally S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

61. See generally S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

62. See generally S.B. No. 702; S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2621; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

63. See generally S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2621; S.B. No. 3; S.B. No. 588; & S.B. 146.

64. See generally S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

65. See generally S.B. No. 1893; S.B. No. 676; S.B. No. 898; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

66. See generally S.B. No. 1893; S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2621; S.B. No. 2539; S.B. No. 3; S.B. No. 588; S.B. No. 1767; S.B. No. 2371; & S.B. No. 146.

67. See generally S.B. No. 676; S.B. No. 2367; S.B. No. 898; S.B. No. 2235; S.B. No. 2539; & S.B. No. 3.

68. See generally S.B. No. 2621; S.B. No. 588; S.B. 1767; S.B. No. 2371; & S.B. No. 146.

69. See The Medical City, About Us, available at <http://www.themedicalcity.com> (last accessed Sep. 6, 2012).

70. *Id.*

The expression of such preferences are founded on informed consent, or that “consent that is voluntarily given (or refused) in response to a prior, explicit disclosure, detailing the nature, risks, costs, benefits, and side-effects of a proposed course of action (perhaps with a specification of the risks, costs, benefits[,] and side effects of all alternative courses of action, or of taking no action at all).”⁷¹ But, being a contractual relationship, which by definition has consent of the contracting parties as an essential requisite, how is informed consent in the relationship of patient and physician any different from basic contractual consent? Put another way, what is this animal called “informed consent,” and why is it so essential in a patient-physician relationship that recognizes patient autonomy?

1. Informed Consent v. “Simple” Consent

To reiterate: why this special form of consent? Consent’s dictionary meaning is that of acquiescence, “compliance in or approval of what is done or proposed by another,”⁷² or “agreement as to action or opinion.”⁷³ In Philippine contract law, it is simply “the meeting of the offer and the acceptance upon the thing and the cause which are to constitute the contract.”⁷⁴ Is not consent *informed* one way or another?⁷⁵

The answer is grounded on tort jurisprudence. American common-law, from which doctrines on self-determination, bodily integrity and privacy are rooted, “has appreciated a right to be secure against battery, a right not to be touched, ... grounded in the authority of individuals over themselves.”⁷⁶ In the medical field, the lack of consent in “medical interventions and treatments would constitute morally impermissible actions: assault; battery; false imprisonment,”⁷⁷ precisely those corollary doctrines to informed consent enumerated above.

Under the laws of the U.S., informed consent cases have been drawn along two general theories of liability: the *battery theory*, where “the defendant is held liable for any intended ... action that results in physical

71. Neil C. Manson, *Consent and Informed Consent*, in PRINCIPLES OF HEALTH CARE ETHICS 299 (2007 ed.).

72. Merriam-Webster Online Dictionary, Definition of “Consent,” available at <http://www.merriamwebster.com/dictionary/consent?show=1&t=1308147599>, (last accessed Sep. 6, 2012).

73. *Id.*

74. An Act to Ordain and Institute the Civil Code of the Philippines [CIVIL CODE], Republic Act No. 386, art. 1319 (1950).

75. Manson, *supra* note 71, at 299.

76. Mark J. Cherry, *Non-Consensual Treatment is (Nearly Always) Morally Impermissible*, 38 J.L. MED. & ETHICS 789, 790 (2010).

77. Manson, *supra* note 71, at 299.

contact for which the plaintiff has given no permission,”⁷⁸ in that “[a] defendant need not have an evil intent, nor must injury result[,] the unpermitted contact ... itself considered wrongful”⁷⁹ and the *negligence theory*, to compare, states that “unintentional, careless action or omission is the source of liability,”⁸⁰ where such “carelessness occurs in regard to some activity in which the defendant has a duty to take care or to behave reasonably toward others[.]”⁸¹

Without pre-empting the discussion in the succeeding Chapter, Philippine law would also permit such a construction under its tort jurisprudence, as any unconsented treatment — particularly those of an especially invasive nature — could constitute a tort under Article 2176 of the Civil Code.⁸²

Given these considerations, one commentator enumerates two general orders of rights that exist as to “why the specific communicative action central to informed consent is taken to be of importance for medical ethics.”⁸³

On the one hand, the first order of rights serves to *protect both patient and physician*. As to the patient, “[i]nformed consent procedures provide a protection ... against coercion, deception, battery, false imprisonment, and the like.”⁸⁴ This need for informed consent serves to reduce, if not totally eliminate, instances of “morally impermissible actions in the medical sphere.”⁸⁵ Patient protection as an underlying principle of informed consent has been “explicitly specified in most codes of good practice for medical professionals,”⁸⁶ as detailed earlier in this Chapter, “and this indicates that certain kinds of communicative action are to be expected as a precondition to many medical actions.”⁸⁷ The integration of this consideration in the

78. Tom L. Beauchamp, *Informed Consent*, in *MEDICAL ETHICS* 197 (Robert M. Veach ed., 2d ed. 1997).

79. *Id.*

80. *Id.*

81. *Id.*

82. CIVIL CODE, art. 2176. This Article provides that “whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there be no pre-existing contractual relation between the parties, is called a *quasi-delict* and is governed by the provisions of this Chapter.” *Id.* (emphasis supplied).

83. Manson, *supra* note 71, at 300-03.

84. *Id.* at 300.

85. *Id.*

86. *Id.*

87. *Id.*

ethical practices of medical practitioners has its grounding on the rejection of the Paternalistic Model, and the history of abuses that mar such model, in that it

rule[s] out a clinician claiming that it is *her* responsibility to exercise professional judgment as to how much her patients ... ‘need to know.’ Similarly, it becomes harder — but not impossible — to routinely deceive when [patients] *expect* such communication, and might be suspicious if such communication were not forthcoming. Explicit informed consent disclosure documents provide a reference point should there be a dispute about the outcome or effects of a medical intervention[.] Such documents are also available to parties *other* than those who are immediately involved in seeking or giving consent: ethics committees, auditors, professional bodies[,] and others who might play a role in monitoring the behavior of medical practitioners. The adoption of such procedures provides an assurance to patients ... that medical practitioners and medical institutions are committed not just to refraining from coercion and deception but also to monitoring medical actions and sanctioning those who breach codes of good practice. Explicit informed consent procedures may also secure *trust* in the medical profession with the line of reasoning: ‘They are not trying to hide anything from me, so they can be trusted.’⁸⁸

These first-order rights of patients give rise to correlative first-order obligations of physicians, in that it is “important for medical practitioners to *obtain* consent and to be able to *show* that consent has been obtained.”⁸⁹ Informed consent thus serves to protect not only patients (from harm) but also medical professionals (from liability). The inherent risks (to the patient) and complexities (for the medical practitioner) of medical interventions, coupled with the inherently limited nature of medical records as a source for understanding a patient’s medical history, give little “guarantee that any particular intervention ... will always have the same effects and consequences each time it is performed.”⁹⁰ For a doctor to obtain informed consent, usually done by some standard hospital waiver form, “serve[s] as an invaluable form of legal documentation for the medical profession by showing that the patient ... was told about the nature of, and risks involved in, a certain course of action and, importantly, that the patient has acknowledged understanding and accepted whatever risks were explicitly mentioned.”⁹¹ Such an obligation on the part of medical practitioners exists, to enumerate, because:

- (a) [t]here is reason to provide explicit evidence of non-deceptive, non-coercive medical practice;

88. *Id.* (emphases supplied).

89. Manson, *supra* note 71, at 300.

90. *Id.* at 301.

91. *Id.*

- (b) [t]here are reasons to provide assurance that the first order obligations are being met;
- (c) [t]here is a perceived need to provide explicit evidence that might be used in the case of medical litigation; and
- (d) [m]edical practice has become standardized and formalized in such a way as to favor the routine production and storage of standardized documentation.⁹²

Informed consent, from the point of view of the medical practitioner, therefore “allows much needed medical actions to be performed without a breach of these first-order rights and obligations.”⁹³

The second order right, on the other hand, pertains to the *decision-making* of patients, wherein they are given the “*liberty* to waive rights by giving consent,”⁹⁴ or more accurately, “the right to *decide* whether to consent to, or refuse, a proposed course of action.”⁹⁵ Again, the underlying principle for this right is the rejection of the Paternalistic Model, in that medical paternalism had limited patients’ capacity to decide under a tenet of physician monopoly over information. Such a model “denies adults the right to *make their own decisions* about how to lead their lives[] and about what is to be done for them or to them,”⁹⁶ an attitude that is “ultimately, disrespectful and demeaning.”⁹⁷ This second order right created by indoctrinating informed consent serves to put into practice, and is the end effect of, the acceptance of patient autonomy.

Embracing the autonomy model thus creates a right-obligation dichotomy that mandates “the *obligation* to proactively provide explicit and specific information about proposed courses of action, their risks, [and] side effects,”⁹⁸ corollary to “a patient’s *right* to receive information about ... [these] risks [and] side effects ... *from* medical practitioners.”⁹⁹ Only from a physician’s disclosure of all relevant conditions and consequences of all available treatment options can a patient’s consent to any sort of medical intervention be considered informed.

92. *Id.* (emphasis supplied).

93. *Id.*

94. *Id.* at 301-02 (emphasis supplied).

95. Manson, *supra* note 71, at 301-02. (emphasis supplied).

96. *Id.* at 302 (emphasis supplied).

97. *Id.*

98. *Id.* at 302 (emphasis supplied).

99. *Id.* (emphasis supplied).

2. Elements of Informed Consent and its Two Meanings

There is a general consensus across various disciplines and fields as to what elements constitute informed consent. “The postulate is that a person gives an informed consent to an intervention only if the person is *competent* to act, receives a thorough *disclosure* about the procedure, *comprehends* the disclosed information, acts *voluntarily*, and *consents*.”¹⁰⁰ Five fundamental elements may be noted, namely: (1) Disclosure; (2) Comprehension; (3) Voluntariness; (4) Competence; and (5) Consent.¹⁰¹

As is manifest from either classification, these principles “delineate an *obligation to make disclosures* so that consent can be informed, rather than a *meaning of informed consent*.”¹⁰² This evokes the idea of informed consent as a process in the patient-physician relationship integral to every medical decision.

With a construction of informed consent as *a process*, one view suggests that informed consent is actually analyzed in two senses: the first, as *autonomous authorization by individual patients or subjects*, and the second, as *institutional and policy rules of consent* “that collectively form the social practice of informed consent in institutional contexts.”¹⁰³ As to the first, it recognizes that informed consent is only given “if and only if the person, with substantial understanding and in substantial absence of control by others, intentionally authorizes a [healthcare] professional to do something ... [or] intentionally refuses to authorize an intervention.”¹⁰⁴ As to the second, “informed consent refers only to a legally or institutionally effective approval given by a patient or subject,”¹⁰⁵ under which “[a]n approval is ... effective or valid [only] if it conforms to the rules that govern specific institutions, whatever the operative rules may be.”¹⁰⁶ On this second sense of informed consent, most health-care institutions’ policies are founded more “from some concept about what the rules must be to promote effective authorizations in these institutions, [and were] rarely premised on a conception of autonomous authorization.”¹⁰⁷

This Chapter has sought to establish the shift in the relationship between patient and physician that is more inclusive of the former as to information

100. Beauchamp, *supra* note 78, at 192 (emphasis supplied).

101. *Id.*

102. *Id.* at 193 (emphasis supplied).

103. *Id.* at 194 (citing RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986)).

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.* at 195.

and decision-making. This newer paradigm not only creates rights for the patient as to what treatment he or she can and will undergo, but also creates obligations on the part of the medical practitioner to inform the patient of all the circumstances and consequences such treatment will entail — prior and anterior to the patient's decisions.

These precepts have been established and indoctrinated in medical ethics, and have been a lingering subject matter in the Philippine legislative mill. Some jurisdictions have, to a considerable extent, already recognized these precepts in their statute books and case law, realizing that the rights and obligations created by such an ethical grounding warrants state enforcement and protection.¹⁰⁸ The need for legislative measures is made all the more evident in cases where informed consent cannot be had, and where the patient's preferences — which must always be considered and, within the bounds of what is ethically and legally permissible, respected — are unclear.

III. A PATIENT'S RIGHT TO SELF-DETERMINATION: LAYING THE FOUNDATIONS

Patient autonomy is unquestionably established as a basic principle in medical ethics. It is one of those tenets that underlie the relationship between patient and physician. It mandates due regard for a patient's bodily integrity, but more than that, an active respect for the treatment preferences of patients. Therefore, the next logical questions are: what is the extent of self-determination? What treatments may a patient validly ask for? Can patient self-determination extend to the refusal of life-saving or life-sustaining care? Can patient autonomy go to the extent of allowing a limited right to die?

A. *The Extent of Patient Self-Determination*

In answering this question, there is an absence of any case law within the Philippine jurisdiction that would be instructive. American law has provided a host of cases involving withdrawal of treatment for the medically futile; yet only three cases have gone all the way to the U.S. Supreme Court.

No case highlights the extent to which patient self-determination can really be "claimed" than the controversial *Cruzan v. Director, Missouri Department of Health, et al.*¹⁰⁹ With a view to moving further after having established the ethics of patient autonomy, the present discussion will now move to its legal foundations, as introduced by *Cruzan*.

1. *Cruzan v. Director* — The Right to Refuse or Withdraw Treatment as the Extent of Patient Self-Determination

108. See generally Roberto Andorno, et al., *Advanced Health Care Directives: Towards a Coordinated European Policy?*, 207 EUR. J. HEALTH L. 16 (2009).

109. *Cruzan v. Director, Missouri Department of Health*, 467 U.S. 261 (1990).

On January 1983, Nancy Cruzan was driving on an icy county road in Missouri when she lost control of her car and caused it to overturn.¹¹⁰ She “was discovered lying face down in a ditch without detectable respiratory or cardiac function.”¹¹¹ The state trooper and paramedics who responded to the scene “were able to restore [her] breathing and heartbeat;”¹¹² however, “[an] attending neurosurgeon diagnosed the woman as having sustained probable cerebral contusions compounded by significant oxygen deprivation, or anoxia[,] ... [for an] estimated length of ... 12 to 14 minutes.”¹¹³ Six minutes in an anoxic state, it has been found, results in permanent brain damage.¹¹⁴ In other words, though the ambulance had responded quickly enough to save Nancy’s life, it was “not [quick] enough to save her from suffering irreversible brain damage.”¹¹⁵ Nancy had suffered “what is known medically as a persistent vegetative state, awake but unaware. The higher brain functions responsible for recognition, memory, comprehension, anticipation, and other cognitive functions had all been lost.”¹¹⁶

She was unable to eat on her own and was merely “sustained by a feeding tube surgically implanted in her stomach.”¹¹⁷ She was admitted to a rehabilitation center, but all “rehabilitative efforts proved unavailing.”¹¹⁸ After eight years of rehabilitative care, and “[after] it had become apparent that Nancy ... had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures”¹¹⁹ that had been keeping her alive.¹²⁰ Officials and employees of the rehabilitation center where Nancy had been admitted refused her parents’ request, and it was then that Joe and Louise Cruzan were constrained to seek judicial authority for the discontinuance of Nancy’s artificial feeding and hydration.¹²¹

A Missouri trial court held that “artificially prolonging the life of Nancy Cruzan violated her ... fundamental right ... to liberty, which permits an individual to refuse or direct the withholding or withdrawal of artificial

110. *Id.* at 266.

111. *Id.*

112. *Id.*

113. MUNSON, *supra* note 15, at 700.

114. *Id.*

115. *Id.* at 701.

116. *Id.*

117. *Id.*

118. *Cruzan*, 467 U.S. at 266.

119. *Id.* at 267.

120. *Id.*

121. *See generally Cruzan*, 467 U.S. 261 (1990).

death-prolonging procedures when the person has no cognitive brain function.”¹²² The State Supreme Court reversed, ruling that “although [she] was in a ‘persistent vegetative state,’ she was neither dead within the meaning of [Missouri law] nor terminally ill”¹²³ and that “[her] right to refuse treatment — whether such right proceeded from a constitutional right to privacy or a common-law right to refuse treatment — did not outweigh Missouri’s strong policy favoring the preservation of life.”¹²⁴ On appeal, the U.S. Supreme Court upheld the State Supreme Court, saying that the State of Missouri could validly “[require] that evidence of an incompetent individual’s wishes as to the withdrawal of life-sustaining be proved by clear and convincing evidence”¹²⁵ in that a State

could legitimately seek to safeguard the personal element of the choice between life and death of an incompetent individual through the imposition of heightened evidentiary requirements, since a state was entitled ... to guard against potential abuse in [such] situations ... [and to] assert an unqualified interest in the preservation of human life, which interest would be weighed against the constitutionally protected interests the individual.¹²⁶

Although, obviously, the decision “came as a cruel disappointment to Nancy Cruzan’s parents, because it meant they lost their case,”¹²⁷ nonetheless this was the “first time in U.S. judicial history [that] the court recognized a strong constitutional basis for living wills and for the designation of another person to act as surrogate in making medical decisions on behalf of another.”¹²⁸ The decision of the Court is pertinently summarized thus —

[The] Court decision in *Cruzan* appealed to a Fourteenth Amendment ‘liberty interest.’ The interest involves being free to reject unwarranted medical treatment[.]

...

The Court regarded this as the basis for requiring that a patient give informed consent to medical treatment. The ‘logical corollary’ of informed consent, the Court held, is that the patient also possesses the right to withhold consent. A difficulty arises, though, when a patient is in no condition to give consent. The problem becomes one of knowing what the patient’s wishes would be.

122. MUNSON, *supra* note 15, at 702.

123. *Cruzan*, 467 U.S. at 261.

124. *Id.*

125. *Id.*

126. *Id.* at 262.

127. MUNSON, *supra* note 15, at 702.

128. *Id.*

...

[The] decision ... placed much emphasis on the wishes of the individual in accepting or rejecting medical treatment. In doing so, it underscored the importance of the living will as a way of indicating our wishes, if something should happen to render us incapable of making them known directly.

[However], the Court decision left undecided the question of the constitutionality of assisted suicide. Some state courts have held that, although individuals have a right to die, they do not have a right to the assistance of others in killing themselves. While more than twenty states have passed laws against assisted suicide, only the state of Oregon has made it legal for physicians to prescribe drugs to help patients end their lives.¹²⁹

Cruzan, decided in 1990, was the first case of its nature to reach the U.S. Supreme Court. Despite being the landmark decision in the so-called “right to die debate,” the issue of the case, penned by Chief Justice William H. Rehnquist, was narrowly construed as a determination of whether the State of Missouri, in “[requiring] clear and convincing evidence of a person’s intent to refuse medical treatment in order to support the refusal of such treatment”¹³⁰ was prohibited by the U.S. Constitution from doing so.

In ruling on the assertion of Nancy Beth’s parents that “Missouri’s evidentiary requirement violated their daughter’s constitutional right to due process of law,”¹³¹ the majority held that “Missouri has permissibly sought to advance [state] interests through the adoption of a ‘clear and convincing’ standard of proof to govern [whether Nancy Beth’s parents can request the cessation of life-sustaining care for their daughter].”¹³² Rehnquist writes —

Whether or not Missouri’s clear and convincing evidence requirement comports with the U.S. Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States — indeed, all civilized nations — demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

But[,] in the context presented here, a State has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately

129. *Id.* at 702-03.

130. Michael P. Allen, *Justice O’Connor and the “Right to Die”: Constitutional Promises Unfulfilled*, 14 WM. & MARY BILL RTS. J. 821, 825 (2005).

131. *Id.*

132. *Id.*

seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decision makers. And even where family members are present, '[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.' A State is entitled to guard against potential abuses in such situations. Similarly, a State is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it. Finally, we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.¹³³

Moreover, the majority ruled (in light of the evidentiary standards of Missouri) that there was insufficient evidence of Nancy Beth's express desire to hasten her death if ever she were afflicted with a condition similar to her being in a persistent vegetative state¹³⁴ and that the substituted judgment of Nancy Beth's parents was fraught with too many conceivable dangers.¹³⁵

133. *Cruzan*, 467 U.S. at 280-82 (citing *In re Jobes*, 108 N.J. 394, 419 (1987) (U.S.)).

134. *Id.* at 265. The Supreme Court of Missouri held that —

[i]n this case the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. ... The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a 'vegetable,' and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.

Id.

135. *Id.* at 286-87. The Supreme Court of Missouri further held —

[b]ut we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling — a feeling not at all ignoble or unworthy, but not entirely disinterested, either — that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. [T]here is no automatic assurance that the view of close family members will necessarily be the same as the patient's[.] All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that

More liberal right to die activists find greater points of discussion in the separate opinions of the other justices, citing Justice Sandra Day O'Connor's particularly, noting that she had consistently written on the Constitution's treatment of end-of-life matters in her opinions, discussing subjects like palliative care and the right of surrogate decision making.¹³⁶ In discussing Justice O'Connor's concurrence as being "far more receptive to end-of-life rights than that of the majority,"¹³⁷ commentator Michael P. Allen discusses two important points in O'Connor's argument —

First, ... Justice O'Connor was not equivocal about the constitutionally-protected status of a right to refuse medical treatment. Far from merely assuming that the right was protected as a matter of due process, [] O'Connor explained in detail why such a right is part of due process ... by stating without qualification that 'the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.' ... At this point, [] O'Connor's concurrence was a tantalizing vision of what could be; to many it no doubt had the nature of a constitutional promise that would-or at least might-come to be.

Second, Justice O'Connor went beyond the majority in dealing with the exercise of the right to refuse medical treatment by incompetent persons. In particular, ... she stated that the duty to 'give effect to the decisions of a surrogate decision maker ... may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.' Once again, such a right could be quite significant as a constraint on governmental action. It would suggest, for example, that a state would need to accord deference to a living will or other advance directive. And, perhaps, that a state would need to allow oral evidence concerning an incompetent person's desires.¹³⁸

Writing on the unelaborated discussion on refusal of unwanted medical treatment in the majority, Justice O'Connor remarks —

As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. ... Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause. ... The State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored

the State may choose to defer only to those wishes, rather than confide the decision to close family members.

Id.

136. See *Cruzan*, 497 U.S. at 287-92 (J. O'Connor, concurring opinion.).

137. Allen, *supra* note 130, at 825.

138. *Id.* at 825-26.

may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion[.]¹³⁹

Elaborating on Rehnquist's warning of the dangers of surrogate decision-making, O'Connor comments on how several States' own rules on power of attorneys can be instructive for the Court and for the state courts

[T]he Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decision maker. ... In my view, [a State's duty to give effect to the decisions of a surrogate decision maker] may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment. Few individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent. States which decline to consider any evidence other than such instructions may frequently fail to honor a patient's intent. Such failures might be avoided if the State considered an equally probative source of evidence: the patient's appointment of a proxy to make health care decisions on her behalf. ... Moreover, as patients are likely to select a family member as a surrogate, giving effect to a proxy's decisions may also protect the 'freedom of personal choice in matters of ... family life.'

Today's decision ... does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment.¹⁴⁰

Ultimately, Justice O'Connor left to the "laboratory of states"¹⁴¹ the proper procedures as to the protection of the liberty interests of persons similarly afflicted with the condition of Nancy Beth Cruzan.¹⁴² One commentator noted just how correct Justice O'Connor's "middle-road" concurrence on various states' treatment of surrogate decision-making was, in how these states, unbound by the U.S. Constitution "to be as protective of an individual's right to have life-sustaining treatment as New Jersey under *In re Quinlan*¹⁴³ nor as protective of human life in all its forms as Missouri under *Cruzan*"¹⁴⁴ took varied jurisprudential paths in their own respective

139. *Cruzan*, 497 U.S. at 287.

140. *Id.* at 289-92.

141. *Id.* at 292 (citing *New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932) (J. Brandeis, dissenting opinion)).

142. *Id.*

143. *In the Matter of Karen Ann Quinlan*, 70 N.J. 10 (1976) (U.S.).

144. Annette E. Clark, *The Right to Die: The Broken Road from Quinlan to Schiavo*, 37 LOY. U. CHI. L.J. 385, 400-01 (2006).

constructions of the right to die.¹⁴⁵ These methods “ranged from empowering guardians and other surrogates to make life-and-death decisions for incompetent individuals without judicial oversight to requiring a judicial proceeding and clear and convincing evidence before allowing medical treatment to be withdrawn,”¹⁴⁶ all these methods being moved by outrage from the Supreme Court ruling that “the State of Missouri could essentially hold Nancy Cruzan captive because she had not appointed a surrogate decision-maker or adequately conveyed her wishes while still competent.”¹⁴⁷

It seemed that the problem of ascertaining the end of life care preferences of incompetent patients had been resolved by the door left open in Justice O’Connor’s dissent by simply “enact[ing] or update[ing] living will and durable power of attorney legislation.”¹⁴⁸ For a full eight years, it seemed a recurrence of the legal issues surrounding *Quinlan* and *Cruzan* would be highly unlikely, because, simply put —

[if] individuals could plan ahead through the execution of advance directives and health care durable powers of attorney, or at least have serious conversations with loved ones about whether they would want life-sustaining treatment continued or withdrawn should they lapse into a coma or persistent vegetative state, we would have no need for the kind of gut-wrenching litigation that marked the years between *Quinlan* and *Cruzan*.¹⁴⁹

2. *Washington v. Glucksberg* and *Vacco v. Quill* — The Limits of Self-Determination

Advocates for physician-assisted suicide hoped that the statements in *Cruzan*, particularly Justice O’Connor’s separate opinion, would fan the flames of their cause. Barely a decade later, the U.S. Supreme Court dealt them a substantive blow through the related decisions of *Washington v. Glucksberg*¹⁵⁰ and *Vacco v. Quill*.¹⁵¹ Both cases, though ostensibly rejecting petitions that sought to de-criminalize physician-assisted suicide based on the *dictum* in *Cruzan*, ultimately settled one loose end in the earlier case: patient self-determination is no warrant for physician assisted-suicide.

Decided in June 1997, *Glucksberg* involves four Washington physicians who, along with three gravely ill pseudonymous patients (who had since died by the time the decision was promulgated) and a non-profit

145. *Id.*

146. *Id.*

147. *Id.* at 401.

148. *Id.*

149. Clark, *supra* note 144, at 401.

150. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

151. *Vacco v. Quill*, 521 U.S. 793 (1997).

Washington-based organization that provides counseling to terminally-ill patients considering physician-assisted suicide, sought to have a Washington statute¹⁵² criminalizing assistance to suicide as constitutionally invalid, being violative of the Fourteenth Amendment of the U.S. Constitution.¹⁵³

Calling on 700 years of legal history, the strongly-worded decision penned by Chief Justice Rehnquist (and joined by Justices O'Connor, Antonin G. Scalia, Anthony M. Kennedy, and Clarence Thomas)¹⁵⁴ detailed how suicide and assistance to suicide has been prohibited in nearly every jurisdiction,¹⁵⁵ citing that such prohibitions “are not innovations ... [but] longstanding expressions of the States’ commitment to the protection and preservation of all human life.”¹⁵⁶ Acknowledging that “States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues,” and “[against the U.S.’] backdrop of history, tradition, and practice,” the *Glucksberg* court ruled that the respondents’ claim for a liberty interest to choose to die, and in consequence an assistance in doing so, is not a protected liberty under the Due Process Clause.¹⁵⁷ Thus, “confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults,”¹⁵⁸ the court said that “[to] hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State.”¹⁵⁹

In its answer for the respondents’ use of *Cruzan* as precedent to assert the right to die, the U.S Supreme Court opined —

The right assumed in *Cruzan*, however, was not simply deduced from abstract concepts of personal autonomy. ... The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. ... In *Cruzan* itself, we recognized that most

152. WASH. REV.CODE, § 9A.36.060 (1) (1994) (U.S.). This Provision states that “a person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.” *Id.*

153. *Glucksberg*, 521 U.S. at 703.

154. See NEIL M. GORSUCH, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 14 (2006).

155. *Glucksberg*, 521 U.S. at 710. “In almost every State — indeed, in almost every western democracy — it is a crime to assist a suicide.” *Id.*

156. *Id.*

157. See *Glucksberg*, 521 U.S. at 719 & 723.

158. *Glucksberg*, 521 U.S. at 723.

159. *Id.*

States outlawed assisted suicide — and even more do today — and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.¹⁶⁰

Similarly citing a leading decision on liberty interests, *Planned Parenthood v. Casey*,¹⁶¹ which had stated that “[at] the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State,”¹⁶² the court answered respondents’ contentions, thus —

The history of the law’s treatment of assisted suicide in this country has been and continues to be one of the rejections of nearly all efforts to permit it. [O]ur decisions lead us to conclude that the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington’s assisted-suicide ban be rationally related to legitimate government interests. ... As the court below recognized, Washington’s assisted-suicide ban implicates a number of state interests.¹⁶³

The *Glucksberg* court enumerates such state interests as: “(1) preserving life; (2) preventing suicide; (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding future movement toward euthanasia and other abuses.”¹⁶⁴

In any case, the same court held that Washington’s ban on assisted suicide was not in violation of the Fourteenth Amendment “either on its face or ‘as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.’”¹⁶⁵

Quill, again penned by Chief Justice Rehnquist,¹⁶⁶ was consolidated with *Glucksberg* and heard on oral arguments on 8 January 1997, with the Court deciding the case on the same date. Similar to *Glucksberg*, three New York physicians with three terminally-ill persons (who also died before the case was decided) “[asserted] that although it would be ‘consistent with the standards of [their] medical practice[s]’ to prescribe lethal medication for ‘mentally competent, terminally ill patients’ who are suffering great pain and

160. *Id.* at 725-26.

161. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

162. *Id.* at 851.

163. *Glucksberg*, 521 U.S. at 728.

164. *Id.*

165. *Id.* at 735.

166. GORSUCH, *supra* note 154, at 14.

desire a doctor's help in taking their own lives, they are deterred from doing so by New York's ban on assisting suicide."¹⁶⁷ Their claim was based on the permissibility in New York for "a competent person to refuse life-sustaining medical treatment,"¹⁶⁸ and that since "[such] refusal of ... treatment is 'essentially the same thing' as physician-assisted suicide,"¹⁶⁹ the ban was constitutionally infirm for being violative of the Equal Protection Clause.¹⁷⁰

Evidently then, *Quill* was an assertion of a right to physician-assisted suicide on the level of Equal Protection, while *Glucksberg* was a Due Process litigation. Rehnquist, in *Quill*, writes on the validity of respondents' argument, thus —

On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. Generally speaking, laws that apply even-handedly to all 'unquestionably comply' with the Equal Protection Clause.¹⁷¹

The *Quill* decision based the variation between physician-assisted suicide and the refusal of lifesaving treatment along the lines of causation and intent, declaring these to be the fundamental differences between the two, with such reasoning relying heavily on state decisions that have upheld the validity of patient refusal of lifesaving treatment —

[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication[.]

Furthermore, ... when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead.' ... Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.¹⁷²

Citing a long line of U.S. Supreme Court decisions that have relied on "actors' intent or purpose to distinguish between two acts that may have the

167. *Quill*, 521 U.S. at 797.

168. *Id.* at 798.

169. *Id.*

170. *Id.*

171. *Id.* at 800. (emphases supplied).

172. *Id.* at 801-02.

same result,”¹⁷³ Rehnquist did not find it “surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide.”¹⁷⁴ The decision also finds that an “overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter,” ultimately concluding that “even as the States move to protect and promote patients’ dignity at the end of life, they remain opposed to physician-assisted suicide.”¹⁷⁵

The court ultimately granted that “the line between the two may not be clear, but certainty is not required, even were it possible.”¹⁷⁶ The court concluded by saying that the two acts are distinct “[b]y permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a long-standing and rational distinction.”¹⁷⁷

3. *Cruzan*, *Glucksberg*, and *Quill* — The Scope and Limits of Patient Self-Determination

From the above cases, five points may be highlighted:

First, the O’Connor concurrence in *Cruzan* had expressly founded the right to refuse medical treatment on a negative construction of informed consent, when it said —

The State’s imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual’s liberty interests as much as any state coercion.¹⁷⁸

Evidently, Justice O’ Connor believed that unwanted medical treatment, *even life-saving treatment* (because she did not qualify), may not be imposed against the wishes of a patient, based on established doctrine on battery and bodily intrusion, first enunciated in *Schloendorff*. Moreover, as to the aspect of “unwantedness” of treatment, recall that the point at which *Cruzan* turned was on Missouri’s evidentiary standards of ascertaining patient preferences in case of incapacity. Justice O’Connor’s concurrence, therefore, took into

173. *Quill*, 521 U.S. at 802.

174. *Id.* at 802-03.

175. *Id.* at 805-06.

176. *Id.* at 808.

177. *Id.*

178. *Cruzan*, 497 U.S. at 288.

consideration instances when patient preferences are clear and convincing, consistent with Chief Justice Rehnquist's opinion that "the [D]ue [P]rocess [C]ause of the ... Fourteenth Amendment did not forbid a state from requiring that evidence of an incompetent individual's wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence."¹⁷⁹

Second, the liberty interest in Justice O'Connor's concurring opinion in *Cruzan* was (in the words of the same court eight years later in *Glucksberg*), founded on both "the common-law rule that forced medication was a battery"¹⁸⁰ as well as "the long legal tradition protecting the decision to refuse unwanted medical treatment,"¹⁸¹ and *could not* thus be extended to physician-assisted suicide.¹⁸² Even though it "may be just as personal and profound as the decision to refuse unwanted medical treatment,"¹⁸³ physician assisted suicide simply does not benefit from the established legal protection of the right to refuse unwanted medical treatment since, as tautologically reasoned by the *Glucksberg* court, "most States [have] outlawed assisted-suicide."¹⁸⁴ Indeed, "the heart of liberty is the right to define one's own concept of existence;"¹⁸⁵ but it cannot be taken to mean that "the rights and liberties protected [by recognizing] personal autonomy ... warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."¹⁸⁶

This is evidently the *first and most extreme limit* to self-determination: patient self-determination as manifested through the right to refuse medical treatment does not warrant physician-assisted suicide.

Third, such conclusion also incidentally implies that patient self-determination and physician-assisted suicide are two different things, in that they are disparately treated under the law. This was, in fact, more than merely implied in *Quill*, which was a petition that assailed the ban on physician-assisted suicide on Equal Protection grounds, arguing that no substantial distinction existed between physician-assisted suicide and withdrawal of life-saving treatment.¹⁸⁷ The *Quill* court ascertained the

179. *Id.* at 261.

180. *Glucksberg*, 521 U.S. at 725.

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. *Casey*, 505 U.S. at 851.

186. *Glucksberg*, 521 U.S. at 727.

187. *See Quill*, 521 U.S. at 796-98.

difference between refusal of treatment and assisted-suicide along the lines of causation and intent.¹⁸⁸

Fourth, in *Glucksberg*'s enumeration of interests that the State seeks to protect,¹⁸⁹ it may be argued that these interests may still apply to cases of withdrawal of treatment. The enumeration still serves as an instructive guideline for Congress and the courts in drafting and enforcing possible legislation regarding patient self-determination and advance directives, in that absent any legislation or developed case law, the *Glucksberg* enumeration still identifies the general interests of the State in matters of patients' treatment preferences at end-of-life. These State interests constitute the *next implicit limit* to self-determination: the State's interest in protecting against abuse.¹⁹⁰

Lastly, returning to Justice O'Connor's concurrence in *Cruzan*, one finds a prophetic pronouncement on the possibility of advance directives, so as to ensure the right of patients to determine their preferences at end of life in the event of incompetence or incapacity.¹⁹¹ In such pronouncement, of considerable import is that Justice O'Connor recognizes the right of self-determination even in *incompetent* patients, a consideration that is a "condition precedent" to effecting advance directives.

These five key points provide an overview of the scope of patient self-determination, the extent of its limitations, and the manner by which such right is protected and its limitations enforced. With this overarching framework, the Note now explores the possibility of patient self-determination to the extent of allowing patients to refuse life-saving or life-sustaining treatment within the Philippine legal framework.

B. Analysis: The Legal Basis of Patient Self-Determination as a Right to Refuse Life Saving or Sustaining Treatment

As previously noted, there is no statute or case law in Philippine law that recognizes patient-self determination; such absence of legal recognition, however, is not without want of trying from some Philippine legislators, as will be seen later. In hoping to lay the predicate, the discussion now turns into an analysis of how, and from where, a patient's right to self-determination can be read into existing law.

From a survey of the Philippine legal landscape, principles such as liberty interests,¹⁹² privacy,¹⁹³ the inviolability of persons,¹⁹⁴ and the exaltation of

188. *Id.* at 801-08.

189. *See Glucksberg*, 521 U.S. at 728.

190. *See Cruzan*, 497 U.S. at 281.

191. *See Cruzan*, 497 U.S. at 287-92.

192. *See* PHIL. CONST. art III, § 1.

human dignity¹⁹⁵ emerge, which serve to highlight the inescapable fact that the Philippine legal system already has in place principles which recognize the integrity of persons — physical or otherwise — as well as their capacity for autonomous thought and action. Extensions of the right to life and liberty under the first section of the Bill of Rights have found themselves in other provisions¹⁹⁶ of Article III, as well as in tort jurisprudence, backed by a wealth of American case law from which, to begin with, the Philippines largely bases its Bill of Rights and tort law.¹⁹⁷

Under the Philippine Constitution, particularly the Due Process Clause, there is a guarantee of protection of life and liberty.¹⁹⁸ As to the *right to life*, the provision guarantees the *right to a good life*, and not merely “the right to be alive or to the security of one’s limb against physical harm.”¹⁹⁹ This interpretation, espoused by distinguished constitutionalist Fr. Joaquin G. Bernas, S.J., is supported by the underlying considerations in various State Policies, such as the provisions on social justice,²⁰⁰ the protection of the life of the unborn,²⁰¹ the policy against nuclear arms,²⁰² and the abolition of the death penalty²⁰³ as “reflective of the high value the Constitution places on life”²⁰⁴ and the “importance of quality of living.”²⁰⁵ The protection of the right to life secures is not limited to the enjoyment of mere existence, but extends to all those qualities which make life worth living, guided solely by conscience, and limited only by compelling State interests, or those societal limitations that ensure that the enjoyment of freedoms of some do not trample on the freedoms enjoyed by others.²⁰⁶ More elegantly worded by

193. See PHIL. CONST. art III, §§ 2, 3, & 6. See also CIVIL CODE, arts. 26 & 32.

194. See, e.g., PHIL. CONST. art. III, § 2.

195. See PHIL. CONST. art II, § 11.

196. See, e.g., PHIL. CONST. art. III, §§ 12 & 14. These provisions on criminal due process echo the right enshrined in Section 1 of the Bill of Rights (Article III of the 1987 Constitution).

197. See generally PHIL. CONST. art. III & CIVIL CODE, arts. 2195-2235.

198. PHIL. CONST. art. III, § 1. This Section provides that “[n]o 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.” *Id.*

199. JOAQUIN G. BERNAS, S.J., *THE 1987 CONSTITUTION OF THE REPUBLIC OF THE PHILIPPINES: A COMMENTARY* 110 (2009 ed.).

200. See PHIL. CONST. art. XII, § 2 & art. II, §§ 9-11.

201. See PHIL. CONST. art. II, § 12.

202. See PHIL. CONST. art. II, § 8.

203. PHIL. CONST. art. III, § 19 (1).

204. BERNAS, *supra* note 199, at 112-13.

205. *Id.*

206. *Id.*

retired Associate Justice Isagani A. Cruz, the guarantee of the right to life “[includes the] right to give full rein to all his natural attributes, to expand the horizons of his mind, to widen the reach of his capabilities, [and] to enhance those moral and spiritual values that can make his life more meaningful and rewarding.”²⁰⁷

The *right to liberty* protects the latter value of quality of life. Jurisprudence has enunciated that the protection of liberty is what makes a “civilized community,”²⁰⁸ a negative right preventing “arbitrary personal restraint and servitude.”²⁰⁹ The right to liberty protects more than just a person’s “freedom from bodily constraint,”²¹⁰ but more importantly, a person’s capacity to “engage in [the] common occupations of life” guided only by “the dictates of conscience.”²¹¹ So broad, in fact, is this grant of liberty, that it is further expounded and defined in numerous other provisions in the Bill of Rights.²¹²

It is the broad *right to privacy* that best enunciates this general grant of liberty. Although appearing in several provisions, case law sheds light on common underlying considerations. The prohibition against unreasonable searches and seizures²¹³ not only guarantees the inviolability of a person’s home²¹⁴ but even “the sanctity of the person himself,”²¹⁵ whether in the form of a pat-down search or a police checkpoint.²¹⁶ The privacy of communication and correspondence²¹⁷ is likewise inviolable, and it is of note that this privacy’s limitation is akin to that of unreasonable searches and seizures — when probable cause exists that would warrant intrusion or when the public safety or order requires it.²¹⁸ As for the liberty of abode and the

207. ISAGANI A. CRUZ, PHILIPPINE POLITICAL LAW 98-99 (1989 ed.).

208. BERNAS, *supra* note 199, at 106 (citing *Rubi v. Provincial Board of Mindoro*, 39 Phil. 660, 705 (1919)).

209. *Id.*

210. *Id.*

211. *Id.* at 106-07 (citing *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923)).

212. *See* BERNAS, *supra* note 199, at 107 (citing *People v. Hernandez*, 99 Phil. 515, 551-52 (1956)).

213. *See* PHIL. CONST. art. III, § 2.

214. BERNAS, *supra* note 208, at 167 (citing *U.S. v. Arceo*, 3 Phil. 381, 384 (1904)).

215. *Id.* at 168.

216. *Id.* (citing *People v. Escano*, 323 SCRA 754 (2000)).

217. *See* PHIL. CONST. art. III, § 3 (1).

218. JOAQUIN G. BERNAS, S.J., THE 1987 PHILIPPINE CONSTITUTION: A COMPREHENSIVE REVIEWER 60 (2011 ed.) (citing *Material Distributor Inc. v. Natividad*, 84 Phil. 127, 136 (1949)).

right to travel,²¹⁹ one may decipher a similar import in Fr. Bernas' terming Section 6 as "freedom of movement."²²⁰

But the whole is greater than the sum of its parts. The concept of privacy has progressed, under American law, from a simple assertion of a "right to be left alone,"²²¹ to a right, for example, to abortion and control over child-bearing,²²² or to exclude the long arm of the state from actions and decisions in the bedroom.²²³

With such a progression of permissible rights, there has been an inability to find a unanimous basis from where, textually, the right to privacy comes from. From an understanding of privacy by "reading substantive content into the Due Process Clause,"²²⁴ as in the 1920s cases of *Meyer v. Nebraska*²²⁵ and *Pierce v. Society of Sisters*;²²⁶ to *Griswold v. Connecticut*'s²²⁷ reading of privacy as a "non-textual 'penumbral' right protected by a matrix of constitutional provisions;"²²⁸ to the privacy doctrine's culmination in *Roe v. Wade*,²²⁹

219. See PHIL. CONST. art. III, § 6.

220. BERNAS, *supra* note 199, at 375.

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

222. See *Roe v. Wade*, 410 U.S. 113, 153-54 (1973). The Supreme Court of the United States held that —

The right of privacy ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

...

We therefore conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.

Id.

223. See generally *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Bowers v. Hardwick*, 478 U.S. 186 (1986); & *Lawrence v. Texas*, 539 U.S. 558 (2003).

224. Oscar Franklin B. Tan, *Articulating the Complete Philippine Right to Privacy in Constitutional and Civil Law: A Tribute to Chief Justice Fernando and Justice Carpio*, 82 PHIL. L.J. 78, 91 (2008).

225. *Meyer v. Nebraska*, 262 U.S. 390 (1923).

226. *Pierce v. Society of the Sisters of the Holy Name of Jesus and Mary*, 264 U.S. 510 (1925).

227. *Griswold*, 381 U.S. 479.

228. THE CONSTITUTION OF THE UNITED STATES OF AMERICA: ANALYSIS AND INTERPRETATION 2008 SUPP. (Analysis of Cases Decided by the Supreme Court of the United States to June 26, 2008), S. DOC. NO. 108-17, at 1766 (2008) (citing *Griswold*, 381 U.S. at 482) [hereinafter U.S. CONST. ANALYSIS & INTERPRETATION 108-17].

where “the right to privacy and the spurned substantial due process was reconciled,”²³⁰ the U.S. Supreme Court has not been unanimous in its application of the doctrine because the bases have varied from case to case as explained below —

Part of the reason that the Court may have been slow to extend the rationale of [*Wade*] to other contexts was that ‘privacy’ or the right ‘to be let alone’ appears to encompass a number of different concepts arising from different parts of the Constitution[.]

For instance, the term ‘privacy’ itself seems to encompass at least two different but related issues. First, it relates to ... the right of individuals to determine how much and what information about themselves is to be revealed to others. Second, it relates to ... the freedom of individuals to perform or not perform certain acts or subject themselves to certain experiences. These dual concepts, here referred to as ‘informational privacy’ and ‘personal autonomy,’ can easily arise in the same case, as government regulation of personal behavior can limit personal autonomy, while investigating and prosecuting such behavior can expose it to public scrutiny. Unfortunately, some of the Court’s cases identified violations of a right of privacy without necessarily making this distinction clear.²³¹

To keep up, the U.S. Supreme Court in *Whalen v. Roe*²³² bifurcated privacy into “decisional privacy” and “informational privacy.”²³³ Decisional privacy has been defined as “the interest in independence in making certain kinds of important decisions,”²³⁴ whereas informational privacy is the “individual interest in avoiding disclosure of personal matters.”²³⁵ Of particular interest, as regards asserting patient self-determination, is decisional privacy, or as similarly termed, personal autonomy, which is “the freedom of individuals to perform or not perform certain acts or subject themselves to certain experiences.”²³⁶

After *Wade*, succeeding cases recognized that “the concept of privacy still retains sufficient strength to occasion major constitutional decisions.”²³⁷ Ultimately, however, based on the pronouncements in *Wade* itself, the

229. *Wade*, 410 U.S. 113.

230. Tan, *supra* note 224, at 91.

231. U.S. CONST. ANALYSIS & INTERPRETATION 108-17, *supra* note 228, at 1778-79.

232. *Whalen v. Roe*, 429 U.S. 589 (1977).

233. Tan, *supra* note 224, at 89.

234. *Id.*

235. *Id.*

236. U.S. CONST. ANALYSIS & INTERPRETATION 108-17, *supra* note 237, at 1778.

237. *Id.* at 1785 (citing *Carey v. Population Services International*, 431 U.S. 678 (1977)).

decision's underlying doctrine as to decisional privacy has so far been only been limited to a "relatively narrow range of behavior,"²³⁸ when the majority wrote in this wise —

These decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' ... are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to *marriage, procreation, contraception, family relationships, and child rearing and education*[.]²³⁹

Furthermore, in a review of decisions involving sexual conduct like *Bowers v. Hardwick*²⁴⁰ and *Lawrence v. Texas*,²⁴¹ despite the dearth of "limiting principles ... available in evaluating future arguments based on personal autonomy;"²⁴² or the fact that "the Court has still not explained what about the particular facets of human relationships — marriage, family, procreation — give rise to a protected liberty, and how ... these factors vary significantly enough from other human relationships,"²⁴³ privacy has begun to take shape as an established liberty interest.²⁴⁴

Yale Law professor Jed Rubenfeld has commented that decisional privacy has "little to do with privacy[,] nothing to do with the Constitution, and everything to do with delineating the legitimate limits of governmental power."²⁴⁵ Decisional privacy, writes Oscar Franklin B. Tan, "is a necessary or even implied Due Process outgrowth that restrains government from intruding into certain personal decisions deemed fundamental in human experience, and not just those pertaining to narrow aspects of sexuality and family life."²⁴⁶

But as to whether a similar "decisional privacy" right exists in the Philippines is still unclear, given that *Wade*, "the line's most prominent case, is a jurisprudential taboo because it justified abortion."²⁴⁷ Nevertheless, despite such reluctance to even consider *Wade's* privacy aspects,

238. *Id.*

239. *Id.* at 1784 (citing *Wade*, 410 U.S. at 152) (emphasis supplied).

240. *Bowers v. Hardwick*, 478 U.S. 186 (1986).

241. *Lawrence v. Texas*, 539 U.S. 558 (2003).

242. U.S. CONST. ANALYSIS & INTERPRETATION 108-17, *supra* note 228, at 140.

243. *Id.* at 141.

244. *See* U.S. CONST. ANALYSIS & INTERPRETATION 108-17, *supra* note 228, at 140.

245. Tan, *supra* note 233, at 97 (citing Jed Rubenfeld, *The Right to Privacy*, 102 HARV. L. REV. 737 (1989)).

246. *Id.*

247. *Id.*

“[s]ubstantive due process concepts ... are firmly established in Philippine jurisprudence.”²⁴⁸

*Morfe v. Mutuc*²⁴⁹ is arguably the leading case on privacy rights. *Morfe* involved a judge of a Court of First Instance challenging the validity of a provision in the Anti-Graft and Corrupt Practices Act,²⁵⁰ which mandates that public officers periodically file “a true detailed and sworn statement of assets and liabilities, including a statement of the amounts and sources of [their] income, the amounts of [their] personal and family expenses and the amount of income taxes paid for the next preceding calendar year,”²⁵¹ for being violative of a person’s right to privacy and the “guarantees against unreasonable search and seizure and against self-incrimination.”²⁵² In holding that there was no invalid intrusion or violation in the assailed provision, Chief Justice Enrique M. Fernando had occasion to discuss issues on privacy and liberty, in which he “explicitly linked what he called [‘]privacy[’] to due process.”²⁵³ He quoted a U.S. Supreme Court pronouncement that privacy existed as a liberty interest,²⁵⁴ and said that “[t]he concept of liberty would be emasculated if it does not likewise compel respect for his personality as a unique individual whose claim to privacy and interference demands respect.”²⁵⁵

Although “Chief Justice Fernando did not consider decisional privacy part of his conception of privacy [] or rather considered it part of substantive due process’ liberty,”²⁵⁶ and, evidently, the privacy interests being protected in *Morfe* were more along the lines of *informational privacy*, nonetheless, it can be argued that “[w]hether one calls it liberty or privacy, it is nevertheless clear that the foundations of decisional privacy exist in Philippine jurisprudence.”²⁵⁷

248. *Id.*

249. *Morfe v. Mutuc*, 22 SCRA 424 (1968).

250. Anti-Graft and Corrupt Practices Act, Republic Act. No. 3019 (1960).

251. *Id.* § 7.

252. *Morfe*, 22 SCRA at 446.

253. Tan, *supra* note 224, at 98.

254. *See Morfe*, 22 SCRA at 442.

255. *Morfe*, 22 SCRA at 442.

256. Tan, *supra* note 224, at 99.

257. *Id.* *See also* United Employees Union of Gelmart Indus. Phils. v. Noriel, 67 SCRA 267, 275 (1975), where “Chief Justice [Enrique M.] Fernando spoke in passing of ‘the privacy of religious freedom, to which contractual rights, even on labor matters, must yield’ [and where he] spoke of the freedom to practice one’s religion in the context of choosing not to join a labor union, which was a clear issue of autonomy.” *Id.*

Forty-five years after *Morfe*, Philippine case law once again “hint[ed] that decisional privacy is in fact integrated into the Philippine definition of privacy[.]”²⁵⁸ In *Estrada v. Escritor*,²⁵⁹ the majority “recognized decisional privacy’s logic ... but felt it was superfluous [given the claim of religious freedom, an explicit constitutional right],” and “[left] it to be emphasized in [a] separate and broader [concurring opinion].”²⁶⁰ Justice Josue N. Bellosillo’s concurrence, however, made reference to decisional privacy bases, when he wrote —

More than religious freedom, I look with partiality to the rights of due process and privacy. Law in general reflects a particular morality or ideology, and so I would rather not foist upon the populace such criteria as ‘compelling state interest,’ but more, the reasonably foreseeable specific connection between an employee’s potentially embarrassing conduct and the efficiency of the service. This is a fairly objective standard than the compelling interest standard involved in religious freedom.

Verily, if we are to remand the instant case to the Office of the Court Administrator, we must also configure the rights of due process and privacy into the equation. By doing so, we can make a difference not only for those who object out of religious scruples[,] but also for those who choose to live a meaningful life even if it means sometimes breaking ‘oppressive’ and ‘antiquated’ application of laws but are otherwise efficient and effective workers. As is often said, when we have learned to reverence *each individual’s liberty* as we do our tangible wealth, we then shall have our renaissance.²⁶¹

Although the concurrence “lacked both the specific term decisional privacy and any reference to *Whalen* or a related precedent,”²⁶² and though it was “not frame[d] ... along *Morfe*’s lines of liberty and privacy,”²⁶³ the “‘specific connection’ ... discussed [in the opinion was] not the language of liberty as a deeper personal autonomy,”²⁶⁴ but was in fact a reference to privacy as *decisional privacy*.²⁶⁵

Three points may be made that could indicate Justice Bellosillo’s recognition of decisional privacy: *Firstly*, the case “involved a possible dismissal from government service due to [Escritor’s] romantic

258. Tan, *supra* note 224, at 100.

259. *Estrada v. Escritor*, 408 SCRA 1 (2003).

260. Tan, *supra* note 224, at 102.

261. *Escritor*, 408 SCRA at 207-08 (emphases supplied).

262. Tan, *supra* note 224, at 101.

263. *Id.*

264. *Id.*

265. *Id.*

relationship,”²⁶⁶ neither touching upon an issue of “any undue disclosure of [her] relationship,”²⁶⁷ nor any “compulsion to disclose the relationship, as in *Morfe*.”²⁶⁸ *Secondly*, Justice Bellosillo had cited *Mindel v. Civil Service Commission*,²⁶⁹ a case that had “invoked privacy in the context of decisional privacy under similar facts, minus the claim of religious freedom.”²⁷⁰ *Thirdly*, Justice Bellosillo “closed [his separate opinion] by proposing individual liberty as the value it defended, beyond religious freedom,” which is in fact “the personal autonomy specifically protected by decisional privacy[.]”²⁷¹

Admittedly, there is a dearth in Philippine law of privacy jurisprudence as developed as in the U.S. A variety of reasons are raised for this scarcity, as can be seen from the present discussion: from the textual limitations of the Constitution itself, to the rejection of what are otherwise valid precepts in American privacy jurisprudence that would have contributed to the growth of Philippine privacy jurisprudence,²⁷² to the prevalence of Philippine Supreme Court decisions that fail to decide on the basis of privacy because of the availability of the religion clauses,²⁷³ and even, plainly, just missed opportunities.²⁷⁴

Despite the “Philippine privacy doctrine ... thus far [having] not emphasized decisional privacy, or at least [having] had far less opportunity to do so than the [U.S.]”²⁷⁵ and that the Philippine Supreme Court has had some missed opportunities to develop such doctrine,²⁷⁶ the Philippine tradition in substantive due process jurisprudence could be open to accommodate the existence of decisional privacy.

266. *Id.*

267. *Id.*

268. Tan, *supra* note 224, at 101.

269. *Mindel v. Civil Service Commission*, 312 F. Supp. 485 (N.D. Cal. 1970) (U.S.).

270. Tan, *supra* note 224, at 101.

271. *Id.*

272. *Id.* at 83. Oscar Franklin B. Tan notes that *Wade* is “one of the most important American privacy decisions ... [that] is ignored by Philippine scholars simply because of the constitution’s prohibition of abortion,” despite the fact that “[its] logic has broad applications far beyond abortion.” *Id.* See *Wade*, 410 U.S. 113.

273. *Id.* at 100 (citing *Escrito*, 408 SCRA at 192 (2003) (J. Velasco, Jr., separate dissenting opinion)). Tan writes: “[t]he majority opinion did not mention privacy, which would arguably have been superfluous [anyway] given the claim of religious freedom, an explicit constitutional right.” *Id.*

274. *Id.* at 83.

275. *Id.* at 102–04. See *Duncan Ass’n of Detailman-PTGWO and Tecson v. Glaxo Wellcome Philippines, Inc.*, 438 SCRA 343 (2004).

276. *Id.*

From all the above considerations about privacy manifested in the scattered provisions of the Bill of Rights, as well as in the amorphous American conception of privacy that *Whalen* had broadly categorized as decisional and informational privacy, the true *animus* of the right to privacy is reflected. If privacy were truly an assurance of one's personal integrity, then privacy is not only a guarantee against unwarranted publicity (which *informational privacy* essentially is), but must encompass *decisional* privacy as well, which American jurisprudence seems to suggest is that liberty in what a person can and cannot do with his or her own body, or within his or her own home. It has been discussed along the lines of sex, contraception, abortion, domestic relations, and (under *Cruzan*) death and to what extent the State may intrude into these most intimate of matters. Philippine law is arguably open to such an interpretation, based on *Morfe* and Justice Bellosillo's concurrence in *Escritor* and despite a general aversion to *Wade*.

This respect for personal integrity is also found in statutory law, particularly Philippine tort law.²⁷⁷ Unsurprisingly, in much the same way that early American cases discussing the constitutional right to privacy were in fact tort cases, Philippine tort law is founded on similar tenets. Judge Cezar S. Sangco, an authority in Philippine tort law, writes of the Civil Code treatment of the right to privacy in this wise —

The preponderance of authority supports the view that independently of the common rights of property, contract, reputation, and physical integrity, there is a legal right called the right of privacy, the invasion of which gives rise to a cause of action, but some courts have held that in the absence of statute, there is no such thing known to the law as the right of privacy which, as a distinctive legal right and independently of established principles relating to property, contract, libel, etc. will support an action at law or equity. Article 26 settles whatever doubt there may be about such a right in our jurisdiction.²⁷⁸

The pertinent provision is the special tort²⁷⁹ of Article 26, which provides —

Every person shall respect the dignity, personality, privacy[,] and peace of mind of his neighbors and other persons. The following and similar acts, though they may not constitute a criminal offense, shall produce a cause of action for damages, prevention[,] and other relief:

- (a) Prying into the privacy of another's residence;

277. See generally CIVIL CODE, art. 2176.

278. J. CEZAR S. SANGCO, PHILIPPINE LAW ON TORTS AND DAMAGES 836 (1994).

279. See CIVIL CODE, arts. 19-28 & 1314. Not all claims under quasi-delict require proof of the damage — fault or negligence — causal connection requisites to recover for supposedly tortious conduct. Special torts, for example, are tortious actions generally founded only on bad faith, and pertain to particular actions which, if committed, need no finding of the three requisites under Article 2176.

- (b) Meddling with or disturbing the private life or family relations of another;
- (c) Intriguing to cause another to be alienated from his friends; [and]
- (d) Vexing or humiliating another on account of his religious beliefs, lowly station in life, place of birth, physical defect, or other personal condition.²⁸⁰

Central to all the correlative rights under the special tort of Article 26, according to distinguished civilist Arturo M. Tolentino, is the exaltation of the human personality.²⁸¹ This is made evident in the Code Commission's considerations in adopting the present Article 26, to wit —

The sacredness of human personality is a concomitant of every plan for human amelioration. The touchstone of every system of laws, of the culture and civilization of every country, is how far it dignifies man. If in legislation, inadequate regard is observed for human life and safety; if the laws do not sufficiently forestall human suffering or do not try effectively to curb those factors or influences that wound the noblest sentiments; if the statutes insufficiently protect persons from being unjustly humiliated; in short if human personality is not properly exalted — then the laws are indeed defective.²⁸²

Moreover, this exaltation of the human personality is also evident in the Commission's intention of supplementing deficient penal laws, in this wise

To remedy [the lack of statutes that do not exalt human dignity] is one of the principal aims of the Project Civil Code. Instances will now be specified[.]

The privacy of one's home is an inviolable right. Yet, the laws in force do not squarely and effectively protect this right.

The acts referred to in No. 2 [of Article 26] are multifarious, and yet[,] many of them are not within the purview of the laws in force. Alienation of the affection of another's wife or husband, unless it constitutes adultery or concubinage, is not condemned by the law, much as it may shock society. There are numerous acts, short of criminal unfaithfulness, whereby the husband or wife breaks the marital vows, thus causing untold moral suffering to the other spouse. Why should not these acts be the subject matter of a civil action for moral damages? In American law they are.

...

280. CIVIL CODE, art. 26.

281.1 ARTURO M. TOLENTINO, COMMENTARIES AND JURISPRUDENCE ON THE CIVIL CODE OF THE PHILIPPINES 92 (1990 ed.).

282. *Id.* at 92 (citing NAPOLEON R. MALOLOS & TEODORICO C. MARTIN, REPORT OF THE CODE COMMISSION ON THE PROPOSED CIVIL CODE OF THE PHILIPPINES WITH ANNOTATIONS 32 (1951)).

Of the same nature is that class of acts specified in No. 3: intriguing to cause another to be alienated from his friends.

Not less serious are the acts mentioned in No. 4: ... The penal laws against defamation and unjust vexation are glaringly inadequate.

Religious freedom does not authorize anyone to heap obloquy and disrepute upon another by reason of the latter's religion.

Not a few of the rich people treat the poor with contempt because of the latter's lowly station in life. To a certain extent this is inevitable, from the nature of the social make-up, but there ought to be a limit somewhere, even when the penal laws against defamation and unjust vexation are not transgressed. In a democracy, such a limit must be established. The courts will recognize it in each case. Social equality is not sought by the legal provision under consideration, but due regard for decency and propriety.

Place of birth, physical defect, and other personal conditions are too often the pretext of humiliation cast upon persons. Such tampering with human personality, even though the penal laws are not violated, should be the cause of civil action.

The article under study denounced 'similar acts' which could readily be named, for they occur with unpleasant frequency.²⁸³

Tolentino describes the *right to privacy* as "the right of an individual to be let alone, or to be free from unwarranted publicity, or to live without unwarranted interference by the public in matters in which the public is not necessarily concerned."²⁸⁴ He writes on the underlying considerations of this right, thus —

This right is derived from natural law; it has its foundations in the instincts of man. Every individual instinctively resents any encroachment by the public upon his rights and affairs which are of a private nature.

The decencies of civilization require a certain consideration on the part of society for the desire of the individual to live, in some respects, to himself, in the same manner that they require, in certain respects that he live unto others. In a large measure, the culture and well-being of society will depend upon the wisdom of the determination of what matters are of sufficient social importance as to justify public knowledge, and, perhaps, interference. Certainly some aspects of a man's life may be entirely claimed by him as his own.²⁸⁵

Also of note is the Code Commission's own treatment of privacy, discussing it under the rubric of Article 26 (1) —

283. MELENCIO S. STA. MARIA, JR., *PERSONS AND FAMILY RELATIONS LAW* 45-46 (5th ed. 2010) (citing MALOLOS AND MARTIN, *supra* note 292, at 32-34).

284. TOLENTINO, *supra* note 281, at 108 (citing *Deon v. Kirby Lumber Co.*, 162 La. 671, 111 So. 55 (1925)).

285. *Id.* at 108-09 (citing 54 C.J. 817).

Our Code specifically mentions ‘prying into the privacy of another’s residence.’ This does not mean, however, that only the residence is entitled to privacy, because the law covers also ‘similar acts.’ A business office is entitled to the same privacy when the public is excluded therefrom and only such individuals as are allowed to enter may come in. Even the privacy of correspondence should be within the rule, when the defendant has no interest in the correspondence of the plaintiff; this right is expressly guaranteed by the Bill of Rights ... and an independent action for damages for its impairment is given in [A]rticle 32 of this Code.²⁸⁶

Local jurisprudence has had occasion to rule on cases under Tolentino’s conception of the right to privacy. In *St. Louis Realty Corporation v. Court of Appeals*,²⁸⁷ the Court affirmed the award of damages to a doctor whose house was mistakenly attributed as owned by another person in a realty corporation’s published advertisement.²⁸⁸ The aggrieved party had noted that the advertisement, “which boldly depicted [his] house ... [as] belong[ing] to another person”²⁸⁹ and which advertisement was made “[without] any permission or authority,” was “not only a transgression to [his] private property but also damaging to [his] prestige in the medical profession.”²⁹⁰ When the errant realty company failed to publish an *erratum*, the aggrieved doctor filed for and was granted damages, based on Articles 21 and 26 of the Civil Code.²⁹¹ The Supreme Court upheld the lower court’s award of damages because “[p]ersons, who know the residence of [the aggrieved doctor] were confused by the distorted lingering impression that he was renting his residence ... or that [his residence had been leased to another]. Either way, his private life was mistakenly and unnecessarily exposed. He suffered diminution of income and mental anguish.”²⁹²

C. The Extent and Foundations of Patient Self-Determination

Culled from all the bases above, it can be said that Philippine laws protect autonomy, integrity, and dignity under general grants of liberty in the Constitution and in statute. The State guarantees individuals being able to be who they want to be, think how they like, believe whatever they believe in, relate with whomever they choose to, and expect that neither the State nor his fellow man will intrude into such affairs.

286. *Id.* at 110 (citing MALOLOS AND MARTIN, *supra* note 292).

287. *St. Louis Realty Corporation v. Court of Appeals*, 133 SCRA 179 (1984).

288. *Id.* at 181.

289. *Id.* at 180.

290. *Id.*

291. *Id.* at 181-82.

292. *Id.* at 183.

Returning to the relevant doctrine in *Cruzan*, as affirmed by *Glucksberg* and *Quill*, there is pliability in Philippine law that would allow for a similar liberty interest to assert a right to refuse life-saving treatment. The Philippine legal landscape is rife with grants and guarantees of such autonomy, integrity and dignity, both under the Constitution and under civil law. Although untested in Philippine courts, analyzing the underlying principles of the grants of life, liberty, and privacy — whether from case law (albeit regarding controversies not squarely on point as *Cruzan*), from the intendment of the drafters, or from the American law precepts from which both Philippine Constitutional law and tort law provisions are based — the inescapable conclusion that the bases of a patient’s right to self-determination to the extent of refusing life-saving or -sustaining care, exists.

The bases for patient self-determination take form especially as regards Philippine privacy rights. Under the Constitution, though emphasis in local case law has generally been on informational privacy, and possible “liberty of conscience” cases were ruled under the religious clauses of Section 5,²⁹³ a reading of jurisprudence of the “extended” liberty rights throughout Article III reveal some underlying interests that could be comparable to the more developed privacy interests in U.S. law — the sanctity of conscience, the protection against physical intrusion, and a guarantee of quality of life — all doctrinally similar to the Fourteenth Amendment liberty interest *Cruzan* was ruled under.

Philippine tort law is no different. The varying rights enumerated by Tolentino under Article 26 protect similar tort law interests cited in *Cruzan* — the respect for a person’s inherent dignity, the proscription of unwanted touching under battery, the zone of privacy created in family and social relations, and the right to privacy as the right to be let alone.²⁹⁴ Although generally untested by the courts, Tolentino’s analysis of Article 26 still reveals the common law values and bases adopted by said provision.²⁹⁵ These bases are established doctrine in U.S. law — the same doctrines relied on by *Cruzan* and, as will be discussed in the next part, *Quinlan*.²⁹⁶

IV. THE LIMITS OF PATIENT SELF-DETERMINATION AND ITS ENFORCEMENT THROUGH ADVANCE DIRECTIVES

293. PHIL CONST. art. III, § 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.” *Id.*

294. See generally TOLENTINO, *supra* note 291, at 92.

295. *Id.*

296. *Quinlan*, 70 N.J. 10.

Although *Cruzan*, *Glucksberg*, and *Quill* had the benefit of calling on all the richness of American common law, as well as privacy jurisprudence that was not merely limited to the inviolability of communication and correspondence or to unreasonable searches and seizures, a reading of local decisions, the interpretations of local commentators, and even the practice of adopting foreign jurisprudence when necessary, all point to how a patient has a say in what is done to his or her body, subject only to his or her valid consent, and balanced by what is held as permissible by the state and what is viewed as permissible by interested third persons.

A. The Limits of Patient Self-Determination

No right is absolute. Even the enjoyment of the most primordial of rights, the right to life, is limited by due process; what more a right such as refusing life-saving treatment, a field that is undoubtedly in a moral, ethical, medical, and legal gray area. And for such a contentious issue as the withdrawal of life-saving care, such right must be properly delimited and nuanced so as not to become a warrant for assisted-suicide (the first and most extreme limit to patient self-determination) nor be subject to abuse (the second and more implicit limit to patient self-determination).

1. Revisiting Informed Consent — Protection and Procedure as a Limitation of Patient Self-Determination, as a Protection of the Integrity of the Medical Profession, and the Problem with Incompetents

As discussed, informed consent is both a *measure of protection*²⁹⁷ and a *procedure*.²⁹⁸ The former concept of informed consent, to recall, protects the patient from harm (from unconsented medical intervention) and the physician from suit (for any such unconsented medical intervention).²⁹⁹ The latter concept is understood in the sense that informed consent is both an autonomous authorization by individual patients and an institutionalized set of policy rules ensuring the authorization of patients as condition precedent to medical intervention.³⁰⁰

Evidently, informed consent limits patient self-determination in both respects. Construed as a *protective measure*, informed consent can serve as a measure of insurance on the part of the physician, in that this view regards informed consent as “an invaluable form of legal documentation for the medical profession by showing that the patient ... was told about the nature of, and risks involved in, a certain course of action and ... that the patient has acknowledged understanding and accepted whatever risks were explicitly

297. See Manson, *supra* note 71, at 300-03.

298. See Beauchamp, *supra* note 78, at 192-95.

299. Manson, *supra* note 71, at 300-01.

300. Beauchamp, *supra* note 78, at 194.

mentioned.”³⁰¹ Moreover, this protective aspect “allows much needed medical actions to be performed without a breach” of a patient’s right against unconsented intervention.³⁰²

Construed as a *process*, informed consent is understood as “a legally or institutionally effective approval given by a patient or subject [which is] effective or valid [only] if it conforms to the rules that govern specific institutions, whatever the operative rules may be.”³⁰³ This process, therefore, is also a form of protective measure that ensures patient approval, manifested in whatever manner the physician or the hospital deems acceptable, prior to any medical procedure.

Note that under either construction, the interests to be protected by the limitation of patient self-determination are the physician’s, which under *Glucksberg*, is one of the contrary interests that must be taken into consideration in weighing the interests of a patient in asserting self-determination with that of the State and other relevant third persons (like the medical community).³⁰⁴ The *Glucksberg* Court had said that “physician-assisted suicide could ... undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.”³⁰⁵ While the right to refuse medical treatment and physician-assisted suicide are different animals, to be sure, even more fundamental than whether a physician can assist patients in killing themselves is whether a physician has obtained the proper assent from patients before they even *consider* any procedure or treatment.

There is one more obvious limiting effect in informed consent. Informed consent, as established in Part II, is informed decision-making or the ability to choose knowing all the circumstances surrounding a certain course of action and the consequences of such choice.³⁰⁶ Informed decisions, writes one commentator, are essentially “rational decisions, implying the evaluation and acceptance of each reason upon we act. Being informed is the cornerstone of rational autonomous decision-making.”³⁰⁷

301. Manson, *supra* note 71, at 301.

302. *Id.*

303. Beauchamp, *supra* note 78, at 194.

304. Alexa Hansen, *Unqualified Interests, Definitive Definitions: Washington v. Glucksberg and the Definition of Life*, 36 HASTINGS CONST. L.Q. 163 (2008). See *Glucksberg*, 521 U.S. at 729-53.

305. *Glucksberg*, 521 U.S. at 731.

306. See Part II.

307. Malcolm de Roubaix, *Are There Limits to Respect for Autonomy in Bioethics?*, 27 MED. & L. 365, 369 (2008).

Informed consent, however, can only be given by a patient who is *capable* of giving it. What then of the instances when a patient is in a highly debilitated (i.e., where capacity is significantly reduced) or otherwise unconscious state where he or she is incapable of giving any form of informed consent to treatment procedures? The discussion on informed consent so far has already detailed that informed consent serves to both protect patient integrity and prevent physician liability. In cases where a patient cannot give consent to a necessary but particularly invasive medical intervention, a physician's hands are apparently tied. How then must a physician proceed?

The PMA Code of Ethics provides for the procedures concerning certain patients unable to give informed consent. In the case of patients who are “unconscious or in a state of mental deficiency[,] the informed consent may be given by a spouse or immediate relatives and in the absence of both, by the party authorized by an advance directive of the patient.”³⁰⁸ In the case of a minor, the same Code prescribes that “[i]nformed consent ... should be given by the parents or guardian, members of the immediate family that are of legal age.”³⁰⁹

To be sure, the PMA Code of Ethics recognizes the primacy of patient autonomy and informed consent, albeit through surrogates like family members.³¹⁰ Also, the Code's explicitly recognizes of the patient having the power to designate a healthcare proxy to determine the patient's treatment preferences.³¹¹ However, some glaring deficiencies must be pointed out. The Code provides no dispute mechanism in case of conflict between the provided surrogates or an explicit hierarchy of preferences as to which surrogate's decision prevails. Most importantly, the Code lacks the teeth, scope and enforceability of a statute, recalling that the PMA Code of Ethics mandates no explicit liability in case a medical practitioner does not conform to the above “procedure.” There is a gap in the law in terms of how patients can manifest their advance consent for any medical procedure that they may need in case they are not capacitated to make such a decision.

2. *The Concept of Medical Futility* — The Limit Against the “Slippery Slope” to Euthanasia and Protecting Medical Professionals from Liability

The avowed purpose of this Note is to delineate the extent of a patient's right to self-determination in exercising a limited right to die, by expressing end-of-life care preferences — particularly the withdrawal or refusal of life-saving treatment — through advance directives. This Author seeks to argue

308. PMA Code of Ethics, art. II, § 5.

309. *Id.*

310. *Id.*

311. *Id.*

that advance directives, in the spirit of patient autonomy, can and must be respected, and create enforceable rights for patients as regards their treatment preferences.

But a question must be raised: *when* can a patient express his or her preferences in end of care, preferences that could include withdrawal of life saving treatment? Surely, a limit must be imposed, especially in light of *Glucksberg's* declaration that assistance to suicide cannot be read from the jurisprudential recognition of the right to refuse treatment.³¹² This “temporal” limit, if it may be so termed, is the ascertainment of medical futility.

So, what is medical futility? In answering the query, one truism must be raised. Doctors are *healers*. This is the overt first purpose of medicine.³¹³ When a person is sick, he or she goes to a doctor for diagnosis and cure. It is the elementary perception one has of doctors and the medical profession in general. But what of those instances when treatment, when *healing*, is no longer possible? What of those instances when, despite the doctor's best efforts, any medical course of action to cure some form of ailment or condition — particularly one that is life-threatening — is futile? What then are doctors tasked to do?

Medical futility came about as the opposite end of the spectrum of patient autonomy: patient or surrogate-driven overtreatment.³¹⁴ Designated by some as “the reverse right to die,” medical futility (or, more properly, a medical futility dispute) pertains “to the ... circumstance in which physicians have provided their expert opinions that further treatment is medically futile, yet the family desires to continue treatment.”³¹⁵ One commentator provides a short history of the concept of medical futility, thus —

A medical futility dispute emerges when a physician believes further treatment is no longer appropriate but the patient's family or surrogate wants treatment continued. The family or surrogate might want treatment to be continued because they believe the physician's prognosis is wrong, they are in denial about the patient's realistic chances of recovery, or they believe a miracle will occur. Alternately, the physician might want treatment discontinued for reasons of professional integrity, due to concern for the patient's well-being, so as to prevent the patient's family from experiencing false hope, and to maximize limited health resources.

312. See *Glucksberg*, 521 U.S. at 719 & 723.

313. *Id.* at 748.

314. Halevy, *supra* note 31, at 271.

315. Philip Kim, *Navigating the Maze of End-of-Life Decisions Regarding the Rejection of Life-Sustaining Treatment, Medical Futility, Physician-Assisted Death, and Abortion*, 14 SMU SCI. & TECH. L. REV. 127, 128 (2010).

The concept of medical futility began with physician- or provider-advocated withholding or withdrawal of life support systems or the removal of food and hydration from a patient in a prolonged vegetative state. Under such circumstances, the physician or provider found the prolonging of the patient's life to be 'legally, ethically[,] and medically inappropriate.'

...

While the notion of treatment that constitutes 'medical inappropriateness' in medical futility disputes was initially limited to providing life support or food and hydration to a patient in a persistent vegetative state, that definition has expanded. Now[,] there is no consensus in the medical community, the bioethical community, or among the public as to what constitutes medical inappropriateness.³¹⁶

Definitional problems have historically been some of the difficulties in assessing whether a patient's condition is medically futile or not. The term has been used synonymously with "uselessness and ineffectiveness ... hopelessness and failure."³¹⁷ But such negative connotations have made it "difficult to talk to a patient or family about the futility of treatment before and after a patient loses decision-making capacity,"³¹⁸ as well as "creat[ing] ... problems for the family, who may not want the responsibility of making decisions for the patient under ... life and death circumstances."³¹⁹ It is this "difficulty in expressing futility concepts and their implications to patients and their families" that is most troublesome, for there would at times be a dispute of interests between the patient's family or guardian and the medical practitioner: that while the latter may say that further treatment is futile, the former may comprehend such statement with contempt, suspicion, and false hope.³²⁰

Important is the consideration that the existence of a futility dispute is its being founded on a basic privilege of the physician: that he or she has no duty to provide medical treatment that has no chance of success.³²¹ One

316. Alicia Seibel, *The Limits of Life: What the D.C. Circuit's Decision in Abigail Alliance v. Von Eschenbach Means for Medical Futility Statutes*, 53 ST. LOUIS U. L.J. 1321, 1322-23 (2009).

317. Carolyn Standley & Bryan A. Liang, *Addressing Inappropriate Care Provision at the End of Life: A Policy Proposal for Hospitals*, 15 MICH. ST. U. J. MED. & L. 137, 140 (2010).

318. *Id.* at 141.

319. *Id.*

320. *Id.*

321. See Standley & Liang, *supra* note 317, at 141.

writer noted six reasons for a medical practitioner to refuse giving life-saving treatment to a patient as requested by that patient's surrogate:³²²

- (a) The prevention of patient suffering from overly aggressive treatment;³²³
- (b) The protection of patient autonomy from the patient's surrogate healthcare decision-makers;³²⁴
- (c) The prevention of family distress;³²⁵
- (d) The preservation of the integrity of the medical profession;³²⁶
- (e) The reduction of moral distress for physicians themselves;³²⁷ and
- (f) The conservation of scarce medical resources.³²⁸

These considerations constitute valid interests of physicians as to when treatment may be permissibly ceased or withdrawn. Understandably, patients and their families may be disbelieving of such assessment, even untrusting of a physician's motivations. How a doctor imparts to a patient or a patient's family that hope must be abandoned is a matter of communicative skill, a trait better left to a medical practitioner's people skills than it is on erudition in the field of medicine. But the fact of the futility remains.

Simply put, a determination of medical futility is an acknowledgment from the medical practitioner that all valid medical recourses would be unavailing, even harmful, and that allowing the patient's disease to run its course — allowing the natural progression of things — is not unethical, nor necessarily a failing on the part of the physician.³²⁹ Most importantly, the ascertainment of futility serves as a protective measure for the medical practitioner, and another valid contrary interest that serves to limit the right of self-determination. This protective measure, like the protective aspect of informed consent, is a protection against *liability*.

All such liabilities — criminal, civil, or administrative — constitute valid limits to a patient's exercise of his or her right to self-determination in

322. Thaddeus Mason Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 183, 194-99 (2010).

323. *Id.* at 194-95.

324. *Id.* at 195.

325. *Id.* at 195-96.

326. *Id.* at 196-97.

327. Pope, *supra* note 322, at 198.

328. *Id.* at 198-99.

329. See Halevy, *supra* note 31, at 271-77.

refusing life-saving or life-sustaining treatment, depending on whether informed consent was obtained or medical futility was ascertained.

3. The Wide Scope of Police Power — Protecting Life and the Interests of Vulnerable Groups

Recognizing a patient's capability to refuse medical treatment on the basis of a right to self-determination would, in effect, give a patient a limited right to die. One need not look far and to find that such a right seems contrary to several state policies.

For the State, the wide scope of police power under the general welfare clause proscribes activities that, either because they are detrimental to the freedoms of others or are illegal in themselves, the State has compelling interest to interfere with, as an exception to the general rule that the State may not intrude into such freedoms. Particularly with end-of-life care, *Glucksberg*, although really a decision on physician-assisted suicide, enumerates several state interests that could also be similarly raised in the less controversial field of withdrawal of care.³³⁰ But, summarizing *Glucksberg*'s enumeration of the competing interests, the real threat that the State would work to protect against is *abuse*. Given the innate finality of such a decision as termination of care, the greater the threat of abuse, the greater the warrant for State intervention.

The first enumerated interest of the State according to *Glucksberg* is protecting the preservation of life.³³¹ Under the Philippine Constitution, “[t]he state values the dignity of every human person and guarantees full respect for human rights.”³³² It also “equally protects the life of the mother and the life of the unborn from conception.”³³³ In a provision that undoubtedly protects the sanctity of life, the wording of the section suggests “[that] the life of the unborn may [not] be sacrificed merely to save the mother from emotional suffering or to spare the child from a life of poverty.”³³⁴ The provision states that protection starts from conception or, more accurately, fertilization; the obvious intent of the provision is to “protect life from its beginning;” and, despite ambiguity as to when life actually starts, the provision's inexact words “reflects the view that, in dealing with the protection of life, [the framers took] the necessary approach.”³³⁵

330. Hansen, *supra* note 304, at 174. See *Glucksberg*, 521 U.S. at 729-53.

331. *Glucksberg*, 521 U.S. at 728.

332. PHIL. CONST. art. II, § 11.

333. PHIL. CONST. art. II, § 11.

334. BERNAS, *supra* note 199, at 84.

335. *Id.*

In light of the extent of the interest of the State into the lives of the citizenry, one commentary is especially insightful. It characterized the right to life into a *personal interest* and a *detached interest*, with the former “aim[ed] at the protection of the rights and interests which the respective person himself would have supposedly,” and the latter “a general social interest ... materialized in the protection of human life as a sacred, intrinsic value, beyond the implied personal value.”³³⁶ Under this dichotomy, there is an interplay between this personal right to life, which “concerns the person at issue strictly[,] [and is] the interest protected between the moment of the person’s appearance and the moment of his death”³³⁷ and a detached right to life, which “consists in the interest of society, represented by the state, to have members, to protect their life, in order to refresh itself, in order to develop[,] and in order to survive,”³³⁸ that makes itself most evident towards the end of life.³³⁹ In light of doctrinal considerations on the scope and extent of the right to life (i.e., legal doctrines such as *Wade*, which define when the liberties of a mother end and a fetus is given personality to have an interest in life),³⁴⁰ it may be said that this interplay rises and falls or pushes and pulls depending on the chronology in a person’s life —

The strength of the detached interest, closely bound to the level of protection accorded to this, is situated on a sinusoidal graphic. It increases from the moment the human embryo appears, being much reduced at the beginning, as the potentiality of life is yet small, and it increases in intensity gradually until the moment of birth, when the potentiality of life is sure. [On the one hand,] [t]he strength of this social interest decreases beginning with the moment when the person’s life is endangered by a terminal disease, in which situation is only protected by the personal interest. On the other hand, the personal interest appears in the third trimester of the pregnancy and disappears with the person’s death.³⁴¹

The State policy for the preservation and protection of life is intricately laced in various provisions of the Constitution. But, apparently, even the “limit” has a limit — persons do *generally* have a say as to their ultimate fates, especially when they reach points where the State has a progressively diminishing interest in their lives.

Glucksberg also indicates the State’s “interest in protecting vulnerable groups — including the poor, the elderly, and disabled persons — from

336. Chirita Radu, *The Legal Nature of the Right to Life: The Consequences of Voluntary Interference with Life*, XIII PHILOBIBLON 44, 47 (Agnes Korondi trans., 2008).

337. *Id.* at 50.

338. *Id.* at 55.

339. *Id.* at 50 & 55.

340. *See Wade*, 410 U.S. 113.

341. *Id.* at 58.

abuse, neglect, and mistakes.”³⁴² Citing *Cruzan* and earlier federal court decisions, *Glucksberg* raised the possibility of economic coercion of these disadvantaged groups, in that their economic depravity could lead to an “insidious bias” against their continued existence, for the sake of cushioning the financial burdens associated with care for incapacitated individuals at the end of life.³⁴³ The Court cited the need to protect these disadvantaged groups from “societal indifference and antipathy.”³⁴⁴

The Philippines has impelled Congress to “give highest priority to the enactment of measures that protect and enhance the right of all the people to human dignity, reduce social, economic[,] and political inequalities[] and remove cultural inequities by equitably diffusing wealth and political power for the common good.”³⁴⁵ Moreover, the Constitution has recognized the need to prioritize such underprivileged sectors in terms of health care.³⁴⁶ Again, these are policy measures that express the State’s general interest in protecting precisely those who do not have the capacity to give informed consent; the end effect of these policy measures does not just limit patient-self determination. In fact, it even ensures informed consent.

All these measures limit, in one way or another, the extent of patient self-determination. Based on the interests expressed in *Glucksberg*, the above discussion explicated the policies and measures throughout the law that delineate the right, setting it against the framework of valid contending interests of the State and of medical practitioners.

Having now set the scope and limitations of patient self-determination, the next logical step is the creation of means that would protect and reinforce such right and its limits. This is the function of an advance directive.

B. The Adoption of Advance Directives as a Measure of Protection for the Patient’s Right to Self-Determination

Patient self-determination has been recognized as inclusive of the right to refuse life-saving treatment.³⁴⁷ Principles in medical ethics and established doctrines in foreign laws suggest that it is but the logical consequence of the

342. *Glucksberg*, 521 U.S. at 731.

343. *Id.* at 732.

344. *Id.* (citing *Compassion in Dying v. State of Washington*, 49 F.3d 586, 592 (1995) (U.S.)).

345. PHIL. CONST. art. XII, § I.

346. PHIL. CONST. art. XIII, § 11.

347. Martha Alys Matthews, *Suicidal Competence and the Right to Refuse Life Saving Treatment*, 75 CAL. L. REV. 707, 721-22 (1987).

liberty and privacy interests that patients, especially those near the end-of-life, particularly possess.

Despite legislative hurdles in recognizing a right to self-determination, the *lacuna legis* in the Philippine *habitus* should be no impediment to protecting liberties that properly belong to patients. As discussed previously, the legal grounding is there, and it can be presumed that the legislators were at least implicitly aware of that fact, owing to the 17 years they have sought to codify patient self-determination. Simply put, patient self-determination exists, and it is high time Philippine lawmakers begin creating legal frameworks for protecting such right.

With the overarching principle of preserving patient autonomy and with patient autonomy being founded on the protective and procedural aspects of informed consent, advance directives serve to ensure this primordial respect for the integrity and dignity of the patient by ensuring that the dynamic between patient and physician — necessarily invasive and intrusive in nature — will always be founded on informed consent.

1. The Legal Grounding of Advance Directives

Unlike patient self-determination, advance directives cannot just be read into Philippine laws. It is therefore necessary to create some framework that would codify it. A review of Philippine law on succession proves instructive. Such an analysis is relevant in that an advance directive, especially the instructional type, operates in much the same way as a will does under Philippine law, save for fact that an advance directive neither disposes of property (instead, it imparts treatment preferences) nor takes effect after death (instead, taking effect upon the happening of a particular medical contingency and incapacity). The Author finds that the Civil Code provisions on how wills operate may work as a procedural basis for how advance directives are made and how they function.

a. Substantive Considerations

Again, the purpose of an advance directive is the expression of treatment preferences in case of future incapacity of the patient. What advance directives protect, foremost, is informed consent: a patient will *always* have a say, though not always the *final say*, as to what treatment preferences he or she may want or not want.³⁴⁸

The same characteristics enumerated above that describe a will must, for the most part, be deemed as what characterizes an advance directive. Save for those characteristics that pertain to disposition of property, or to its *mortis causa* aspect, an advance directive is also purely personal, executed with

348. Halevy, *supra* note 31, at 265–71.

freedom and intelligence, revocable, individual, executed with contractual capacity (as opposed to *testamentary* capacity, recalling that Professor Ruben F. Balane considers soundness of mind as defined by an awareness of one's estate and other similar considerations), unilateral, and granted by statute.³⁴⁹

Firstly, as to the *interpretation* of an advance directive,³⁵⁰ it must be remembered that the person for whom an advance directive is intended is a *healthcare practitioner*, who has neither the training for legalese nor the time to read lengthy directives in an emergency room. An advance directive, to recall, is employed in tense, if not emergency, situations; a physician cannot afford to lose precious time to read the fine print. Conversely, a person who will primarily be drafting an advance directive is a patient who, if he or she is not by profession an attorney, will likewise have no skill to draft in thick “all-bases-covered” legalese. Therefore, excepting again as to “dispositive” characteristics, the same rules on interpretation of wills may be deemed to apply to interpretations of advance directives.

As for capacity and intent of the patient, as earlier mentioned, basic capacity will apply as a requirement for making advance directives, given that the provisions in the law on succession defines soundness of mind in relation to the dispositive characteristic of wills.³⁵¹

Since the Author submits that advance directives be governed by the principles of the law on succession, it is important to recall that there are two types of wills: *attested* and *holographic*.³⁵² For reasons that will be expounded on in the next subsection, the only workable form of instructional directive will have to be similar to an attested will.

That the rules on attested wills are the only workable framework is primarily because the Author submits that an advance directive need not, and in fact should not, go through probate.³⁵³ With the same considerations as to the *interpretation* of advance directives, it must always be recalled when advance directives are employed and to whom they are intended for — in situations where time is practically of the essence and by medical practitioners who must be able to ascertain on the face of the directive the wishes of the incapacitated patient. Physicians must have a quick and ready reference to a patient's wishes and preferences. Verification of the validity of an advance directive cannot suffer the long and drawn-out court proceedings

349. See RUBEN F. BALANE, *JOTTINGS AND JURISPRUDENCE IN CIVIL LAW: SUCCESSION* 47 (2010 ed.).

350. See CIVIL CODE, arts. 788-792.

351. See BALANE, *supra* note 349, at 58-62.

352. CIVIL CODE, arts. 805 & 810.

353. See CIVIL CODE, art. 838 & 1997 RULES OF CIVIL PROCEDURE, rule 76.

that characterize the process of probate of wills, or else, the entire purpose of the directive may be defeated.

b. Formal Considerations

Earlier, a distinction had been drawn between an instructional directive and a proxy directive. Differing rules and procedures apply to both.

In the case of an *instructional* directive, it is proposed that the general form of wills under the Civil Code can be a sufficient guide, if not the governing law itself, for any legislation that will operationalize advance directives for end-of-life care. Recalling the relevant provisions on succession, an instructional directive must be written in a language or dialect known to the patient; subscribed at the end of the directive by the patient himself or by his or her name written by another in the patient's presence and under the patient's express direction; and signed by three or more witnesses, who possess all of the qualifications of instrumental witnesses, in the presence of the patient and of one another.³⁵⁴ All of them (the patient and the instrumental witnesses) must also sign each and every page of the directive, paginate, and attest to the proper execution of the foregoing requirements.³⁵⁵ Finally, the directive must also be notarized.³⁵⁶

The Author submits, as had been mentioned above, that holographic wills are unworkable as regards advance directives for medical care, in that notarization is a much faster process of ascertaining the authenticity of the advance directive than verification of handwriting and signature, as well as being less prone to fraud and forgery. With the assurance of a notarial seal, and even without probate, physicians, patients, and the patient's surrogates must be able to rely on advance directives on their face. The only time the issue of validity of an advance directive should reach a courtroom is if it is disputed as to its validity, i.e., whether the grounds for disallowance of a will under Article 839 of the Civil Code exist.³⁵⁷

354. CIVIL CODE, arts. 804 & 805.

355. *Id.*

356. CIVIL CODE, art. 806.

357. CIVIL CODE, art. 839. This Article provides —

The will shall be disallowed in any of the following cases:

- (a) If the formalities required by law have not been complied with;
- (b) If the testator was insane, or otherwise mentally incapable of making a will, at the time of its execution;
- (c) If it was executed through force or under duress, or the influence of fear, or threats;

In the case of a *proxy directive*, the Author submits that the appointment of the surrogate, who shall make the necessary treatment decisions for the patient, be manifested in an instrument with the same formalities as the living will detailed above. In that one of the purposes of an advance directive is dispute avoidance, the implementation of certain formal standards as to the manner of appointment of the recognized surrogate decision-maker must minimize if not totally eliminate the chance of fraud, which will have, as a consequence, the minimizing or elimination of disputes.

Recalling the discussion in Part I about the purpose of the formalities of an advance directive,³⁵⁸ it is important to note that these functions do not apply to instructional directives alone; they must also apply to proxy directives as well, precisely because even the validity of the *selection* of a surrogate decision-maker must be protected and enforced with the same veracity as an instructional directive.

2. Case Studies — Highlighting the Need for Advance Directives

The problem of informed consent is, put simply, when it is not possible for it to be obtained. Incompetent patients are especially problematic in the sense that they cannot give their informed consent, whether of the simple or “informed” variety; ensuring their autonomy thus becomes complicated in that ascertaining treatment preferences are, at best, either only presumed or by nature limited to the asseverations of surrogates.

No better example of this limited nature than in the case of patients suffering from persistent vegetative states.³⁵⁹ The following cases, apart from their doctrinal value, serve to highlight the difficulty of obtaining and ensuring informed consent in those who cannot give them.

-
- (d) If it was procured by undue and improper pressure and influence, on the part of the beneficiary or of some other person;
 - (e) If the signature of the testator was procured by fraud;
 - (f) If the testator acted by mistake or did not intend that the instrument he signed should be his will at the time of affixing his signature thereto.

Id. Instead of being ruled upon by a probate court, an aggrieved party may file an injunction from possible compliance with the advance directive. See 1997 RULES OF CIVIL PROCEDURE, rule 58.

358. See Peter C. Harman, ‘Locked-In’ to Their Decisions: Investigating How the States Govern Revocation of Advanced Directives and How Three States Make Revocation Impossible for People with Locked-In Syndrome, 3 HASTINGS SCI. & TECH. L. J. 193, 196-97 (2011).

359. See Carl E. Fisher and Paul S. Appelbaum, *Diagnosing Consciousness: Neuroimaging Law and the Vegetative State*, 38 J.L. MED. & ETHICS 374, 375 (2010).

a. In re Quinlan

In 1976, the case of a young woman who, like Nancy Cruzan, suffered a significant loss of oxygen to the brain and therefore entered into the same degenerative condition, became a public interest piece and the presented the first issues in the so-called right to die debate.³⁶⁰

Karen Ann Quinlan was 22 years old when she fell into a “chronic and persistent vegetative state.”³⁶¹ While confined, she was “described as emaciated, having suffered weight loss of at least 40 pounds, and undergoing a continuing deteriorating process.”³⁶² It was further concluded that “no form of treatment which can cure or improve that condition is known or available”³⁶³ at that time. As such, “she can never be restored to cognitive or sapient life.”³⁶⁴

Karen Ann “did not have advanced directives and could not consent to the termination of treatment, yet her father sensed from prior conversations that she would not have wanted to continue living in a vegetative state.”³⁶⁵ As such, he “sought guardianship over his daughter and petitioned the court to terminate her treatment.”³⁶⁶

In the first decision of its kind, the New Jersey Supreme Court ruled in favor of Karen Ann’s father, noting the particular exigencies of the case, and said that her futile condition permitted a privacy claim for which the State had a minimal interest in —

Karen’s present treatment serves only a maintenance function; [her] respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion *contra* by the present attending physicians. [This] distinction is significant. ... *We think that the State’s interest []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.

360. *See Quinlan*, 70 N.J. 10 (1976).

361. *Quinlan*, 70 N.J. at 25.

362. *Id.* at 26.

363. *Id.*

364. *Id.*

365. Janna Satz Nugent, “*Walking into the Sea*” of Legal Fiction: An Examination of the European Court of Human Rights, *Pretty v. United Kingdom*, and the Universal Right to Die, 3 J. TRANSNAT’L L. & POL’Y 183, 204 (2003) (citing *Quinlan*, 70 N.J. 10 (1976)).

366. *Id.* at 204-205 (citing *Quinlan*, 70 N.J. 10 (1976)).

It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law.³⁶⁷

The *Quinlan* court had found a privacy interest that allowed a person (an *incompetent* at that) to refuse life-saving treatment. The court had ruled based on a previous, arguably off-hand, conversation Karen had made years before she fell into a persistent vegetative state about what her end of life treatment would be.³⁶⁸ It is evident that the case turned on ascertaining Karen Ann's wishes, precisely because of her not being able to explicitly do so.

However, the manner by which the court arrived at the ascertainment of her wishes, notes one commentator, was not by honoring her privacy right "under circumstances where there was some degree of legal certainty regarding the choice she would have made were she competent,"³⁶⁹ but instead said that "[t]he only practical way to prevent destruction of [her] right is to [privacy is to] permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances."³⁷⁰

Were Karen Ann's end-of-life care treatment preferences really respected in *Quinlan*?

b. The Story of Theresa Marie Schiavo

The media frenzy surrounding the Schiavo saga in 2005 was cannon fodder for a public interest debate between liberal and conservative America. In a dispute spanning almost a decade and several court litigations, the Schiavo saga can be summarized thus —

On 25 February 1990, Theresa Marie (Terri) Schiavo suffered a cardiac arrest at the age of 27 as the result of a potassium imbalance of unknown cause. Despite being treated by paramedics and rushed to the hospital, she never regained consciousness and was ultimately diagnosed as being in a [persistent vegetative state], dependent upon a feeding tube for nutrition and hydration. Michael Schiavo, Terri's husband, was appointed guardian[,] and with the help of Terri's parents, the Schindlers, cared for Terri for years. In the early 1990s, Michael pursued a malpractice lawsuit against Terri's physicians for failure to diagnose the potassium imbalance that resulted in a sizable monetary award for her care.

When Michael sought a court order authorizing the withdrawal of her feeding tube almost 10 years after Terri's cardiac arrest, the Schindlers questioned his motivation, accusing him of wanting his wife dead so that he could be free to remarry and inherit the remaining money from the

367. *Quinlan*, 70 N.J. at 40-41 (emphasis supplied).

368. *Id.*

369. Clark, *supra* note 147, at 391.

370. *Id.*

malpractice award. Likewise, Michael thought the Schindlers wanted to keep Terri alive[,] because if he were forced to divorce her so that he could marry the woman with whom he had since had two children, the Schindlers would then inherit whatever money remained from the malpractice lawsuit. Thus, each thought the other was divining Terri's wishes regarding withdrawal of life-sustaining treatment through the prism of his or her own monetary self-interest.

Because of the conflict between family members, Michael Schiavo, as Terri's guardian, sought adjudication from a Florida trial court in 1998 and asked the that he be appointed as Terri's surrogate decision maker with regard to withdrawal of the feeding tube. The trial court concluded, despite conflicting testimony, that there was clear and convincing evidence that Terri would have chosen, if competent, to have the artificial nutrition and hydration withdrawn, a conclusion that was upheld on appeal.

The guardianship court's order authorizing the discontinuation of life-prolonging procedures spawned a legal battle between Michael Schiavo and the Schindlers that spanned more than seven years. This protracted and public dispute produced numerous judicial opinions in both the Florida state courts and the federal court system, a national debate over whether Terri had some cognitive functioning or was really in a persistent vegetative state, and intervention by the Governor of Florida, the Florida state legislature, and the [U.S.] Congress. By the end of March 2005, the Schindlers had exhausted all avenues of appeal and recourse, and Theresa Marie Schiavo died on [31 March 2005], more than ten days after the court order to discontinue life-sustaining procedures was given effect.³⁷¹

Again, this was a case that turned on the preferences and valuations of the incapacitated patient. And, once again, the courts had to rule on the basis of surrogate decision-making, in spite of the long-standing conflict between her two primary surrogate decision makers.

Could the Schiavo saga have been spared of the years of court bickering between Michael Schiavo and the Schindlers if it had been made clear what Terri would have done?

c. Guidelines for a Legal Framework Protective of Patients' Rights at End of Life

To be sure, *Quinlan*, *Schiavo*, and even *Cruzan* are exceptional instances where the incapacitated person's medical condition so straddles the fine line between living and dying that the only way through was litigation. But, these cases do stress how much ascertaining treatment preferences are the central query in any issue involving incapacitated patients and contentious cases where medical futility is at issue. How do the State, the doctor, and the patient himself protect the sanctity of patient autonomy and patient self-determination?

371. *Id.* at 402-03.

V. A LEGAL FRAMEWORK FOR PATIENT SELF-DETERMINATION

The lobbying for a Magna Carta of Patients' Rights has proved incessant, though ultimately unfruitful. This, by no means, is any indication that patients' rights have no place in the Philippine legal system; the sorry state of healthcare and the prevalence of medical malpractice cases (cited by the authors of the bills themselves) make such a statute all the more necessary.

A leading Filipino bioethicist now based in Singapore, Dr. Leonardo de Castro,³⁷² comments that the tenor of a majority of the bills proposed would create a "climate of litigation" over the patient-physician relationship that would negatively affect the manner by which medical practitioners relate to their patients, in that those in the medical profession "would feel freer and more flexible in dealing with cases without the threat of legalities hanging over their heads."³⁷³ A more detached relationship cautious of suit, a denser hospital bureaucracy of endless consent forms and waivers, and the creation of a fundamental mistrust for the medical profession because of such a law likely underlie the medical profession's trepidation when it comes to patients' rights bills. Even if the bills propose grievance mechanisms instead of outright penal provisions in case of any transgression of patients' rights, the effect is arguably the same.

In response to these concerns, the Author argues that patients' rights need not be diametrically opposed to doctor's rights and interests; the two interests need not be contentious ones. While it is unfortunate that the name of the proposed bill evokes images of 12th Century feudal England and the tensions between the powerful and the oppressed, the previous chapters have detailed how the power relations between patient and physician have been equalized. True, there is a give and take between a patient's interests and that of his or her physician's, but the objective of both parties within the patient-physician relationship is, without surprise, exactly the same: *treatment*.

372. Dr. Leonardo D. de Castro is affiliated with the National University of Singapore's Centre [for Biomedical Ethics]'s program for Capacity Development in Biomedical Ethics, the United Nations Educational, Scientific and Cultural Organization's Advisory Expert Committee for the Teaching of Ethics, and the University of the Philippines where he set up a regional Research Ethics Training Program. He is also a consultant to the European Commission and World Health Organization, and a member of the Steering Committee for the International Summit on Organ Trafficking and the Asian Working Group Against Organ Trafficking. See National University of Singapore, Our Staff, available at <http://cbme.nus.edu.sg/ourstaff.html> (last accessed Sep. 6, 2012).

373. E-mail correspondence with Leonardo de Castro, Ph.D., Member, Capacity Development in Biomedical Ethics program, National University of Singapore, (May 25, 2011) (on file with author).

Steps towards recognizing and codifying patients' rights embody State policies regarding health and social justice.³⁷⁴ The bills mentioned are (presumably) the product of a lengthy deliberative process of lawmakers, backed by hard data and good intentions. The rights proposed are substantially the same as those recognized in the bioethical field, and although creating a law to recognize them may seem like an exercise in superfluity, legislation makes patients' rights state-protected, a matter of public policy and publicity, and (if the need arises) actionable in a court of law.

After the first step of recognition and limitation comes now the problem of enforcement. In light of the doctrine of informed consent, it may be plainly said that there no real issue arises when a patient from whom consent is sought has the capability to give it and, thus, no real necessity for an advance directive — a patient himself or herself can be *asked* and *apprised* by a doctor about treatment options and their correlative consequences. Moreover, by definition, the use of advance directives is by no means exclusive to situations at end-of-life, nor must they exclusively impose the obligation of withdrawing care. To reiterate, an advance directive is merely an expression of “a person's wishes and instructions regarding future medical treatment in the event of incapacity.”³⁷⁵

If there were any identifiable precondition to the employment of an advance directive, plainly, it is the fact of the patient's incapacity. The difficulty as to ensuring patient self-determination and securing informed consent lies in those instances when a patient is *incapable* of giving informed consent by some factual incapacity. This, as has been discussed, is the primary procedural limitation of informed consent, and the principal contingency addressed by an advance directive.

In ensuring the existence of some kind of informed consent, the Author thus recommends the foregoing procedure that would enforce autonomy and self-determination, as well as a dispute settlement mechanism that would not create a legal environment of *Quinlans*, *Cruzans*, and *Schiavos* in the Philippines.

A. Ascertainment of Medical Futility

As detailed previously, medical futility is that point when medical treatment can no longer be effective and, in terms of end of life care, when death is an inevitability.³⁷⁶

374. See PHIL. CONST. art. II, § 15 & art. XIII, § 1.

375. Saad, *supra* note 1, at 74.

376. See Seibel, *supra* note 326, 1322–23.

Upon the ascertainment of medical futility by a physician, the option for withdrawing or refusing further care becomes legally and ethically permissible.³⁷⁷ A physician would then terminate care and treatment with the end effect of allowing nature to take its course. Treatment was, first of all, merely an intervention anyway, meant to either delay the inevitable or even restore the patient to health. Necessarily, however, the physician has the final word on when a case is futile or not, subject only to contentions under the doctrine of *res ipsa loquitur*.³⁷⁸

This determination of futility, more than anything, is a protective measure. Without a determination of futility, a doctor may be open to liability under Article 248 or Article 253 of Revised Penal Code on murder or assistance to suicide respectively, or to a civil suit alleging medical negligence.³⁷⁹ The ascertainment of medical futility is a necessary first step whenever there is any expressed preference of withdrawal of treatment of the patient.

But, what makes an ascertainment of futility the basis for exemption from liability? The reason is somewhat semantic: when further treatment is futile, a physician who accedes to a patient's preference for withdrawal of life-sustaining care does not *actively* or intentionally kill the patient; the physician merely *omits* treatment of the patient, and this omission *may* lead (though it almost always *does*, especially when there is already talk of withdrawal of care) to the death of the patient.³⁸⁰

Any consideration, therefore, of advancing a patient's wishes for withdrawal of treatment must necessarily be preceded by a declaration of medical futility.

B. Ascertainment of the Existence of an Advance Directive

After such determination of medical futility and in case a patient cannot give consent to any treatment or intervention, the next step is the ascertainment of the existence of an advance directive. This step is aimed to protect the patient's right to self-determination, even (in fact, *especially*) when a said patient is unable to give (or withhold) consent to any medical intervention. In an interview with Dr. Robert Tanchangco, a consultant nephrologist and consultant director of the Kidney Transplant Program at The Medical City and a member of the Institutional Review Board, cessation of treatment is in fact ethically permissible "when the benefit [derived] from an intervention is

377. See *Quill*, 521 U.S. at 801-02.

378. See *Batiquin v. Court of Appeals*, 258 SCRA 334, 344 (1996).

379. REVISED PENAL CODE, arts. 248 & 253 & CIVIL CODE, art. 2176.

380. See GORSUCH, *supra* note 158, 48-57. The Author discusses the action-omission and causation based distinctions between physician-assisted suicide and refusal of life-saving care through the lens in *Quill*. *Id.*

not worth the harm, the cost and the risk, then you might [even] be violating the first principle of ‘do no harm.’”³⁸¹

One caveat, however, must be explained. Dr. Tanchangco makes an insightful observation regarding when exactly advance directives come into play in end of life care —

If [it is] obviously a reversible medical condition, and time is of the essence, and there is *no* time to go through a lengthy process of determining and educating and waiting for the family to come to a decision, in such situations, the physician is bound to make a decision on the spot and take it from there, guided by the principle that if you can save a life, then you should try.

*I suppose when we talk about these things, advance directives, [we are] talking more about chronic illnesses, where you do have time to go through things and to determine what really is the best course to take. And[,] the best course to take might not always be very clear, that [is] why [it is] such a contentious issue because we are operating in shades of grey. ... The best thing to say really is that we would look at it on a case to case basis, but guided by [the principle of patient autonomy].*³⁸²

Evidently, talk of respecting advance directives are only relevant in cases where there is actually time for a deliberative process. Doctors are ethically — and *legally*³⁸³ — bound to exert all efforts for emergency cases. This is what Dr. Tanchangco pertained to in his explanation on the applicability of advance directives. Furthermore, this Note has established that the one of the limits to patient self-determination is an ascertainment of medical futility — which is not the case in an emergency situation similar to what Dr. Tanchangco hypothesized.

Relatively current bills pending in the Senate are instructive and, perhaps, offer a glimmer of hope for a statutory recognition for advance directives. Furthermore, it could even lend to making the drafting of advance directives, if not compulsory by provision of law on the part of the patient, at least compulsory on the part of the *physician* to inform the patient of the availability of having such directives as a formal and legally binding expression of said patient’s end-of-life care preferences.

381. Interview with Robert Tanchangco, Ph.D., Consultant Nephrologist and Consultant Director of the Kidney Transplant Program at the Medical City, Ortigas Avenue, Pasig City (on file with author) [hereinafter Tanchangco Interview].

382. *Id.* (emphases supplied).

383. See An Act Requiring Government and Private Hospitals and Clinics to Extend All Medical Assistance in Emergency Cases, Republic Act No. 6615 (1972).

In 2008, Senator Pilar Juliana S. Cayetano's Magna Carta of Patient's Rights Bill³⁸⁴ was the latest and, to the Author, most comprehensive and well-drafted incarnation of the proposed law in terms of defining a patient's right to informed consent and to refuse treatment. It will also serve as the Author's springboard for arguing the necessity in either the drafting of an advance directive or for informing a patient of the benefits of such drafting. Quoting at length, Senator Cayetano defines a patient's right to informed consent and the right to refuse treatment as follows:

- e. *Right to Informed Consent* — The Patient has a right to self-determination and to make free decisions regarding himself [or] herself. However, the attending physician shall inform the Patient of the consequences of his [or] her decisions.

A Patient who is mentally competent and is of legal age, or in his incapacity or age of minority, his legal representative, has a right to a clear explanation, in layman's terms, of all proposed or contemplated procedures, whether diagnostic or therapeutic, including the identity and professional circumstances of the person or persons who will perform the said procedure or procedures. The explanation shall include the amount of information necessary and indispensable for him to intelligently give his consent, including, but not limited to, the benefits, risk[s], side effects[,] and the probability of success or failure, as a possible consequence of said proposed procedure or procedures, including the implications of withholding consent. In the explanation, the comprehensive ability of the patient shall also be considered, taking into account his level of education, the dialect or language that he speaks and understands, and[,] if possible, with the use of anatomic sketch or any materials or visual aids that may aid the Patient, or his legal representative, in fully understanding the proposed procedure or procedures.

The right to informed consent shall likewise consider the voluntariness in which the Patient or his [or] her legal representative has given his [or] her consent, seeing to it that the Patient or his legal representative was allowed to ask questions, or that he [or] she is given the chance to consult his [or] her kin, or to seek another expert opinion. If the Patient is unconscious or is unable to express his [or] her will, informed consent must be obtained whenever possible from a legal representative, *Provided however*, That when medical intervention is urgently needed, the consent of the patient may be presumed, *Provided further*, That a physician should always try to save the life of a Patient who is unconscious due to suicide attempt.

In the case of a Patient who is legally incompetent or is a minor, the consent of a legal representative is required, *Provided however*, That the Patient must be involved in the decision making process to the fullest extent allowed by his mental capacity. If the legally incompetent

Patient can make rational decisions, his [or] her decisions must be respected, and he [or] she has the right to forbid disclosure of such information to his [or] her legal representative. If the patient's legal representative forbids treatment, but, in the opinion of the physician, it is contrary to the patient's best interest, the physician may challenge this decision in court, *Provided however*, That in emergency cases, the physician shall act in the patient's best interest, *Provided further*, That in emergency cases where there is no one who can give consent on the patient's behalf, the physician can perform any emergency diagnostic or treatment procedure in the best interest of the patient.

- f. *Right to Refuse Diagnostic and Medical Treatment* — The Patient has the right to refuse diagnostic and medical treatment procedures, provided that the following conditions are satisfied;
- (a) The Patient is of legal age and is mentally competent;
 - (b) The Patient is informed of the medical consequences of his/her refusal;
 - (c) The Patient releases those involved in his care from any obligation relative to the consequences of his/her decision; and
 - (d) The Patient's refusal will not jeopardize public health and safety.
- ...
- h. *Right to Religious Belief and Assistance* — The Patient has the right to receive spiritual and moral comfort, including the help of a priest or minister of his [or] her chosen religion. He [or] she also has the right to refuse medical treatment or procedures which may be contrary to his religious beliefs, subject to the limitations described in paragraph 6 of this Section.³⁸⁵

Some aspects of the above definitions are noteworthy. The second paragraph on the right to informed consent sets out to define, in no uncertain terms, the breadth of the information that a patient is entitled to before any contemplated procedure. Of greater interest is the next paragraph, which sets out that the consent of a patient unable to express such consent is to be obtained from a legal representative, except in case of an emergency or a suicide attempt, where the doctor may (and in fact, under current law and established bioethical principles, *should*) treat the patient. Equally of interest is the subsection's last paragraph, which states the need for court adjudication in cases where the wishes of the legal representative and the physician are contradictory. With due respect, and despite the particularity with which the Bill describes the right to informed consent, the *proviso* on having a legal representative express a patient's informed consent is a mere throwback to the status quo, with all the difficulties that the status quo already presents.

385. *Id.* § 4.

This is precisely the instance when advance directives are utilized to preserve the patient's own preferences, especially in those instances when he or she will be unable to express them. It cannot be overemphasized that the doctrine of patient self-determination is premised on that very *personal* right of patients to have a say in what are to be done to their own bodies. To let a legal representative decide for a patient in case of incapacity, although on its face logistically feasible, will not respect patients' rights nor the impelling desire for reform — in law, in medical administrative policy, and in medical ethics — that many commentators, both local and abroad, find the need for.

Of course, the first hurdle towards reform is the lack of mandatoriness of advance directives. The high deference accorded to patient autonomy and informed consent would all be for naught if a patient would fail to exercise such rights. Ultimately, even with good-intentioned legislation like Senator Cayetano's bill, patients' rights would still be inadequately protected. What, then, is the State to do? Surely, hospital policy could mandate the execution of advance directives in cases of patients suffering from life-threatening and chronic illnesses in case of future incapacity, but hospital policy lacks the breadth and compulsion of statute, apart from the fact that "hospital policy" is different from hospital to hospital. If the State is truly cognizant of the rights of patients, the next logical step after putting these rights into law is the establishment of mechanisms that would protect them; it has been the argument of this Note that advance directives are one such mechanism, at least in terms of protecting a patient's right to informed consent and to refuse medical treatment.

Senator Miriam Defensor-Santiago was even more forward thinking than her colleagues when she proposed not just recognizing patient's rights but effecting measures to protect them. In Senator Santiago's Advance Directives Education Bill,³⁸⁶ she prefaced the State Policy of protecting and promoting the right to health of the people and instilling health consciousness among them, in this wise —

According to the National Health Institute of the University of the Philippines, six of ten Filipinos who succumb to sickness die without ever seeing a doctor. Hence, it is time for Filipinos to discuss and learn about future health care decisions for themselves and their family and possibly start thinking about options that can help them with these choices, like advance directives.

Advance directives are decisions that can be written down prior to medical treatment, so the family can carry out a person's wishes for health care if this person is unable to communicate them.

Thus, this bill directs the Secretary of Health, directly or through grants, contracts, or interagency agreements, to develop a national campaign to inform the public of the importance of advance care planning and of an

386. S.B. No. 2573.

individual's right to direct and participate in his or her health care decisions. The comprehensive public education campaign shall raise awareness of the importance of planning for care near the end of life.³⁸⁷

The Defensor-Santiago Bill mandates public education programs that would help the public recognize the benefits of end-of-life care planning, but, perhaps, more than that, that patients have the right to direct their end-of-life care, especially in instances when they will not be able to do so.

In implementing a public education program on advance directives, the Bill accepts the general definition of advance directives as a "will, medical directive, health care power of attorney, or other written statement by a competent individual that is recognized under existing laws and indicates the individual's wishes regarding medical treatment in the event of future incompetence."³⁸⁸ Moreover, Senator Defensor-Santiago seems cognizant of the need for advance directives as corollary to the mandatory nature of obtaining informed consent, in the proposed definition of "advance care planning," to wit:

'Advance care planning' means the process of:

- (a) determining an individual's priorities, values and goals for care in the future when the individual is no longer able to express his or her wishes;
- (b) engaging family members, health care proxies, and health care providers in an ongoing dialogue about:
 - (i) the individual's wishes for care;
 - (ii) what the future may hold for people with serious illness or injuries;
 - (iii) how individuals, their health care proxies, and family members want their beliefs and preferences to guide care decisions; [and]

387. *Id.*

388. *Id.* at § 2 (b). The same Bill defines a "will," in § 2 (f), as

any legal document, with formalities prescribed by law, which is used to specify the type of medical care, including any type of medical treatment, including life-sustaining procedures if that person becomes permanently unconscious or is otherwise dying, that an individual wants provided or withheld in the event the individual cannot speak for himself or herself and cannot express his or her wishes; and that requires a physician to honor the provisions of upon receipt or to transfer the care of the individual covered by the document to another physician that will honor such provisions.

Id.

- (iv) the steps that individuals and family members can take regarding, and the resources available to help with, finances, family matters, spiritual connections[,] and other issues that impact seriously ill or dying patients and their families; and executing and updating advance directives and appropriating a health care proxy.³⁸⁹

The Author argues that, while the Defensor-Santiago Bill makes headway in implementing advance directives as a means to protect patient autonomy and ensure respect for the doctrine of informed consent, it is deficient in effecting real means to protect such rights. A public education campaign is without argument, invaluable in protecting patients' rights. But more than that, some compulsion, by law, is needed to make advance directives a means to protect these rights. Such compulsion could take either two forms: to make it mandatory for patients to make an advance directive, or to make it mandatory to make doctors inform patients that they (patients) could, if they wanted to, make an advance directive. However, the Author foresees some difficulties with both forms.

While the former would be a more direct means to implement advance directives within the Philippine medical milieu, it could be of questionable constitutionality and would be difficult to enforce and implement, barring some provision that penalizes the failure to make an advance directive. Furthermore, such compulsion on patients invites the possibility of mere routinary compliance with such law, with the patient making out a document poorly and ambiguously written and not truly expressive of said patient's preferences. The latter form of compulsion, on the other hand, while less direct, will be implemented by doctors and physicians as part of their already existing duties under bioethics and, upon the passage of the Magna Carta of Patients' Rights, under law. Such duty on the part of doctors can be construed as part of their duty to obtain informed consent, and the failure to do so can validly be a cause of action in the courts. However, institutional reluctance and inertia may make this form of compulsion difficult to implement, and again barring the inclusion of some penal provision in case of breach of such obligation, the risk of court litigation is an unhealthy and counterproductive threat to the practice of medicine.³⁹⁰ Although the need for some mandatory measures is unquestionable, the intricacies of such implementation are, to the Author, better left to the deliberative processes of legislation.³⁹¹

389. *Id.* § 2 (a).

390. *See* Patients' Rights Bill, Committee on Health and Demography Joint with the Committees on Social Justice and Finance, S. Rep., 12th Cong., 1st Reg. Sess. (2003).

391. *Id.*

1. In Case an Advance Directive Exists, Implementation of the Advance Directive

If a patient has executed a valid advance directive, respect for patient autonomy demands that a healthcare practitioner comply. If such directive instructs that extraordinary care is not to be given or that treatment is to be withdrawn, and there is no greater competing interest against such directive, the directive must be followed. In the same way, however, an advance directive could likely direct *continuance* of extraordinary care.

In the absence of explicit statutory provisions regarding advance directives and as a starting point for future legislation on the matter, the current provisions on the characteristics of wills (discussed previously) should be sufficient in determining when an advance directive is *valid*. But, for reference in the hope of the passage of future legislation, the Author wishes to propose further formal and substantive requirements.

Firstly, as to the advance directive's form, the formal validity of wills in the Civil Code needs several requirements as to attestation and acknowledgment of the witnesses to the execution of the will before a notary public.³⁹² While these requirements are necessary for the will's probate, which is the prior step to the settlement of the testator's estate, no such disposition of property is present in an advance directive.

Take for example the requirement of acknowledgment of the notary public. While notarization lends some stability in terms of the will's evidentiary weight in probate proceedings, the purpose of an advance directive is primarily for the patient's doctors to have some written manifestation of a patient's end-of-life care preferences on file for quick reference in case of said patient's incapacity to make any informed consent. Considerations of evidentiary weight in court proceedings will only be relevant in the event of an actual court case, and the very purpose of advance directives is in avoiding a *Schiavo/Cruzan/Quinlan*-type situation. Perhaps, the more pertinent question, then, is the advance directive's availability in *all* hospitals, in a form prescribed by law, and mandated by law to be readily available and in fact offered to patients who are more likely to need advance directives. Future legislation on advance directives must therefore dwell more on its availability — for patients who will need them and for doctors who will be referring to them — than on matters like notarization.

A second possible “rethinking” of a conventional will under the Civil Code for purposes of legislation in advance directives is the actual content of the advance directive. Some commentators on advance directives in the U.S. have noted difficulties in prescribing what an advance directive would actually look like: is it a questionnaire to be filled out by the patient? Is it a

392. CIVIL CODE, arts. 805 & 806.

blank piece of paper which a patient fills out detailing his treatment preferences? Must it also be signed by the patient's attending physician? Must it be witnessed, like in the case of wills in the Civil Code?

The Author proffers that, as in the case of conventional wills, an advance directive may *not* direct what the law proscribes: a patient cannot ask to be euthanized or ask for medication and treatment prohibited by law. In such cases, a physician would be under no obligation to follow the patient's directive.

As to what is actually written in the directive, the Author subscribes to the so-called "Five-Wishes Document" created by a Florida-based non-profit organization called Aging with Dignity in 1996.³⁹³ According to Aging with Dignity, the Five Wishes Document "helps [patients] express how [they] want to be treated if [they] are seriously ill and unable to speak for [themselves],"³⁹⁴ intending to "speak to [patients] in their own language, not in 'doctor speak' or 'lawyer talk'"³⁹⁵ and "be used in the living room instead of the emergency room."³⁹⁶ This document details, in question-and-answer form, the following details:

- (a) The person you want to make health care decisions for you when you cannot make them for yourself;
- (b) The kind of medical treatment you want or do not want;
- (c) How comfortable you want to be;
- (d) How you want people to treat you; and
- (e) What you want your loved ones to know.³⁹⁷

The document's appeal is in its simplicity. Aging with Dignity's website boasts circulation of over 11 million copies of the document in 15,000 healthcare organizations, with such document compliant with the advance directive requirements of over forty states³⁹⁸ and with such "patient-friendly" language, the document ostensibly claims to rid advance directives of the difficulties in formalities that several states encounter in their own respective laws. While the Five-Wishes Document is not without criticism — some objections include the informality of its language,³⁹⁹ or, conversely,

393. Ray J. Koenig III & MacKenzie Hyde, *Be Careful What You Wish For: Analyzing the 'Five Wishes' Advance Directive*, 97 ILL. B.J. 242, 242 (2009).

394. *Id.*

395. *Id.*

396. *Id.* at 242-43.

397. *Id.*

398. *Id.*

399. The argument on informality is as follows —

the specificity of its language in some aspects⁴⁰⁰ — the simplicity of the document is the reason for its effectiveness. The Author views that the objection against the document's non-legal language forgets the principle behind informed consent that medical procedures must be effectively explained by physicians to their patients, which especially means taking the doctor's communication with the patient out of the realm of legalese and doctor-speak. Furthermore, the document will have to be executed with the assistance of the patient's attending physician, who would (and should) have verbally explained the risks and benefits of the patient's treatment options. As for the objection against the document's specificity, the Author argues that the principle of patient self-determination upholds the tenet that *patient*, not doctor, knows best, and that the patient's preferences will still nonetheless be

A document like the Five Wishes, which is designed to meet the requirements of the majority of the states, will inevitably lack the specificity that ensures the document's appropriateness in each state. These criticisms may not appear important at the time of execution, but ... could potentially become critical once an agent is required to act.

The Five Wishes document should not be used as a replacement for statutory advance directives because it contains legally ambiguous language and may conflict with the authority delegated under a separate power of attorney for property.

Id. at 243.

400. The argument on specificity is as follows —

Wish 2 goes beyond the declaration included in section 35/3(e) [of the Illinois Living Will Act] in that the principal may specify directions for the agent to follow if a doctor and another health care professional determine that the principal is (1) close to death, (2) in a coma and not expected to wake up or recover, or (3) has permanent and severe brain damage and is not expected to recover. For each of these scenarios, the principal can indicate that he (1) wants life support treatment, (2) does not want life support treatment and if it has been started should be stopped, or (3) wants his doctor to determine if life support treatment would help and if it should be discontinued.

At first glance, the specificity provided in the Five Wishes document seems advantageous. After all, it gives the principal's doctor more specific instructions about how to care for the principal.

Specificity, however, is not always a plus. Assume, for example, the doctor determines that the principal has severe brain damage and is close to death. What if the principal indicated that he wanted life support if he was close to death but not if he was brain damaged?

Which 'wish' should take precedence, and who should decide? Ultimately, a judge might, at a high emotional and financial cost to the principal's family.

Id.

limited by the bounds of the law (as in the case of a patient asking to be euthanized).⁴⁰¹

Moreover, the patient may, in the spirit of patient autonomy, simply appoint a healthcare power of attorney in the advance directive, designating an agent who will make end-of-life care decisions in case of the patient's incapacity. In this instance, perhaps there will be need for acknowledgment by a notary public who will certify that the patient did indeed appoint an agent to make treatment decisions for him or her.

In any case, the paramount consideration is the respect for the patient's preferences.

*a. In Case of Dispute as to the Validity of an Advance Directive,
Commencement of a Conciliation Proceeding in the Hospital Ethics
Committee*

Ethics committees are set up in most hospitals for the resolution of disputes for ethically complex cases, such as when there are disputes regarding treatment modalities in end of life care, as an administrative check for complicated issues.⁴⁰² Owing to the medical community's apprehension of legislation that could create an environment of litigation, the first recourse of any dispute must be to the hospital ethics committee for conciliation between the disputing parties.

In the U.S., from the time that New Jersey Supreme Court Chief Justice Richard J. Hughes proposed the creation of so called hospital ethics committees in his decision in *Quinlan*, there has been a widespread attempt "to establish committees at the local hospital level to make, review, or advise in decisions regarding the care of the terminally ill."⁴⁰³ They exist to "form a consensus toward resolution and assist in bioethical decision making."⁴⁰⁴ Specifically, six roles can be identified for hospital ethics committees:

- (1) *Education* — Educating hospital staff about issues in ethical decision making and about how to use the hospital ethics committee.
- (2) *Multidisciplinary discussion* — Providing a locus for interdisciplinary participation in value clarification and prioritization, leading to conflict resolution.

401. Koenig & MacKenzie, *supra* note 393, at 243.

402. Standley & Liang, *supra* note 317, at 151-52.

403. Robert M. Veach, *Hospital Ethics Committees: Is There a Role?*, in *BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS AND PRACTICE* 227 (2d ed. 2007).

404. John F. Monagle & Michael P. West, *Hospital Ethics Committees: Roles, Memberships, Structure, and Difficulties*, in *HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY* 252 (2d ed. 2009).

- (3) *Resource allocation* — Recommending in-hospital allocation policies to maintain quality of care in the face of cost-containment measures.
- (4) *Institutional commitments* — Expressing the spirit of the hospital regarding its stated mission, philosophy, image, and identity (most often applicable to religious and private hospitals).
- (5) *Policy formulation* — Developing policies and guidelines regarding ethical issues.
- (6) *Consultation* — Assisting attending physicians regarding difficult decisions.⁴⁰⁵

Of particular importance are the last two roles. As regards policy formulation, one commentary has noted that a “hospital ethics committee’s preliminary work serves as a starting point for more detailed analysis by ethical policy subcommittees appointed to study and recommend policy on specific areas of ethical uncertainty.”⁴⁰⁶ This same commentary proposes that a hospital ethics committee be an over-arching mother body that consists of smaller subcommittees in various departments (whether administrative or medical) in a hospital, said subcommittees being themselves “composed of physicians, some members of the hospital ethics committee, and other health professionals with expertise in the subject area,” who would transmit to the mother committee their analysis of certain key ethical conundrums, which can then adopt such findings as part of hospital policy.⁴⁰⁷

As regards consultation, hospital ethics committees can then create, adopt, and enforce hospital policies that may serve as guidance when cases involving ethical issues are brought up to it. A so-called ethics advisory group would be created by the hospital ethics committee *ad hoc* for specific cases brought up to the ethics committee, like an issue as to the validity of the treatment proposed in an advance directive or the validity of the advance directive itself, composed of the attending physician, the patient’s family members, significant nurses in the case, members of the clergy or a bioethicist, a physician or other member of the ethical policy subcommittee of the subject area, and, perhaps, in *abuntante cautelam*, an attorney for the hospital.⁴⁰⁸

While these are the varied roles of a hospital ethics committee, there are also various kinds of committees, based on the role or roles it wishes to take. One commentator has found four such possible tasks for hospital ethics committees.⁴⁰⁹

405. *Id.* at 252.

406. *Id.* at 256.

407. *Id.* at 256-57.

408. Monagle & West, *supra* note 404, at 257.

409. Veach, *supra* note 403, at 227-30.

The first kind is a committee that reviews ethical and other values in individual patient care decisions.⁴¹⁰ Of particular import in this kind of committee is determining when treatment is extraordinary or futile, certainly a question of ethical consideration, for which there will be need for a broad membership such as that proposed above.⁴¹¹

The ethical and policy decisions may cover a broader aspect, as in the second type of committee which makes institutional, not particularized, decisions, as in the case when “[q]uestions arise that clearly involve ethical and other values, yet which in principle cannot be resolved by referring to the individual patient for the patient’s own decision or, in the case of the incompetent, to the guardian and family.”⁴¹²

A third kind or function of the committee is as a “prognosis committee.”⁴¹³ In *Quinlan*, there had been some suggestion that one of the primary functions of a hospital ethics committee would be to confirm prognoses, or more accurately, “to confirm the prognosis that no reasonable possibility exists of the patient’s return to a cognitive, sapient state.”⁴¹⁴

Perhaps as a consequence of *Quinlan*, the state of New Jersey adopted guidelines for prognosis committees — such as the composition of the committee (physicians trained in general surgery, medicine, neurosurgery or neurology, anesthesiology) and the procedure for withdrawing life-support (the attending physician, guided by the committee’s decision with the concurrence of the family, may then proceed with the appropriate course of action and, if indicated, shall personally withdraw life-support systems) — with these guidelines instructive as to the role of a hospital ethics committee as a “prognosis committee.”⁴¹⁵

A fourth kind or function of the committee is in counseling, where such a committee “could be established to deal with specific terminally ill patients ... for the purpose of counseling and support rather than actual decision making.”⁴¹⁶ Again of particular interest is one such “expanded” function of the committee in this role —

Although the committee should not have a role in making the actual decision to stop treatment, occasionally there may be cases where the decision made by a parent or other guardian is so questionable that the physician, nurse, or other hospital personnel are convinced that it should be

410. *Id.* at 227.

411. *Id.*

412. *Id.* at 228.

413. *Id.* at 229.

414. *Id.*

415. Veach, *supra* note 403, at 229-30.

416. *Id.*

reviewed. The morally and legally appropriate course is to bring the matter to court. If the court finds that the parental judgment is so unreasonable that it cannot be tolerated, it will appoint a new guardian for the purposes of authorizing treatment. In such cases, however, the hospital staff member may want some guidance before deciding to initiate the court review. A hospital committee ... could provide a sounding board for the health care professional who had such doubts. The committee could even initiate the court review proceedings itself. In such cases, however, the court, not the committee, would finally override the guardian's judgment.⁴¹⁷

Perhaps the role and function of a hospital ethics committee, from the point of view of this Note, is a conglomeration of all the above-mentioned roles and functions. The committee must be the over-arching policy-maker in the hospital, providing both the hospital's institutional ethical standards and its case-to-case assessments of particular cases. Being a multi-disciplinary body, it is not only an arbiter (for lack of a better term, as will be explained later) of ethical policies, but also of prognoses. Most importantly, a hospital ethics committee is a body for both counseling and consultation, owing to the fact that decisions made in questions involving the withdrawal of treatment involve not just medical prognoses, or even just institutional values, but also the values of the patient and his or her family and guardians.

Dr. Tanchanco noted that these ethics committees serve not as arbiters, but conciliators, who do not adjudicate but mediate.⁴¹⁸ The Author views such a process of mediation and conciliation as conducive to speedy decision-making, preventive of acrimonious relations between the hospital and the patient's family, and a deterrent to litigation that will no doubt, in a culture such as ours, be even more of a public relations issue than any *Schiavo* or *Cruzan*. In fact, current law encourages such methods of dispute resolution, wherein some form of institutional mediation may be created to handle contentious and possibly litigious issues like the withdrawal of life-sustaining care in relation to a disputed advance directive.⁴¹⁹

b. In Case of Failure to Conciliate, the State Institutes a Guardianship Proceeding Over the Patient, through the Municipal, City, or Provincial Health Officer, and Under the Direction of the Department of Health (DOH) and Department of Social Welfare and Development (DSWD)

⁴¹⁷ *Id.* at 229.

⁴¹⁸ Tanchanco Interview, *supra* note 381. When asked if there are any hospital bodies or mechanisms that deal with ethically complicated cases, Dr. Tanchanco replied: "There is a hospital ethics committee that you can refer to. But it is not a judge. [It] is, in the end, just a guide. It will bring the parties together and try to help each party move forward and come to a consensus." *Id.*

⁴¹⁹ See CUSTODIO O. PARLADE, ALTERNATIVE DISPUTE RESOLUTION ACT OF 2004 (REPUBLIC ACT NO. 9285) (ANNOTATED) 15 (2004).

If the attempts at conciliation still prove fruitless, the hospital through its hospital ethics committee may request the local municipal, city, or provincial health officer that guardianship proceedings be instituted and that the petition name said local health officer as general guardian for the person of the patient, invoking the State's claim as *parens patriae* over the patient.⁴²⁰

Under Section 1, Rule 93 of the Rules of Court, on the subject of the appointment of guardians, “[a]ny relative, friend, or other person on behalf of a resident ... incompetent who has no parent or lawful guardian ... may petition the court having jurisdiction for the appointment of a general guardian for the person or estate, or both, of such ... incompetent.”⁴²¹ Subject to some formal requirements in the petition for general guardianship,⁴²² the guardianship court shall set a date for hearing and send notices thereof,⁴²³ await opposing petitions,⁴²⁴ and appoint a guardian,⁴²⁵ taking into account whether or not the guardians are personally “subject to the jurisdiction of the courts here.”⁴²⁶ The allowance by the court of the health officer as judicial guardian, acting for the State, empowers said officer over the person of the ward⁴²⁷ to aid in dispute as to the end of life care preferences of the incompetent ward.⁴²⁸

420. See Caroline Klosko and William J. Frisk, *Terminating Treatment for Incompetent Persons: The Need for Objective Standards*, 6 NAELA J. 181, 185 (2010) (citing In the Matter of Conroy, 98 N.J. 321, 364-65 (1985)).

421. REVISED RULES ON CIVIL PROCEDURE, rule 93, § 1.

422. *Id.* at § 2.

423. *Id.* at § 3.

424. *Id.* at § 4.

425. *Id.* at § 5.

426. 2 FLORENZ D. REGALADO, REMEDIAL LAW COMPENDIUM 121 (2004 ed.) (citing Guerrero v. Teran, 13 Phil. 212, 216 (1909)).

427. *Id.* at 122.

428. 1997 RULES ON CIVIL PROCEDURE, rule 92, § 2. This Section provides —

[T]he word ‘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.

Id. (emphasis supplied).

As for the propriety of the health officer, one can see that he may be given such duty, under the grant of powers and functions enunciated under the Section 478 of the Local Government Code.⁴²⁹

429. An Act Providing For A Local Government Code of 1991 [LOCAL GOVERNMENT CODE OF 1991], Republic Act No. 7160, § 478 (1991). This Section provides —

- (b) The health officer shall take charge of the office on health and shall:
 - (1) Take charge of the office on health services, supervise the personnel and staff of said office, formulate program implementation guidelines and rules and regulations for the operation of the said office for the approval of the governor or mayor, as the case may be, in order to assist him in the efficient, effective and economical implementation of a health services program geared to implementation of health-related projects and activities;
 - (2) Formulate measures for the consideration of the sanggunian and provide technical assistance and support to the governor or mayor, as the case may be, in carrying out activities to ensure the delivery of basic services and provisions of adequate facilities relative to health services provided under Section 17 of this Code;
 - ...
 - (4) In addition to the foregoing duties and functions, the health officer shall:
 - (i) Formulate and implement policies, plans, programs and projects to promote the health of the people in the local government unit concerned;
 - (ii) Advise the governor or mayor, as the case may be, and the sanggunian on matters pertaining to health;
 - (iii) Execute and enforce laws, ordinances and regulations relating to public health;
 - (iv) Recommend to the sanggunian, through the local health board, the passage of such ordinances as he may deem necessary for the preservation of public health;
 - ...
 - (viii) Coordinate with other government agencies and non-governmental organizations involved in the promotion and delivery of health services; and
 - (ix) In the case of the provincial health officer, exercise general supervision over health officers of component cities and municipalities; and

*c. In Either Case, the Hospital Ethics Committee and the Guardianship Court
Ascertains the Will of the Patient Through the Following Objective
Tests:430*

In case of a valid advance directive, the only “test” that can be spoken of is a *subjective* one.⁴³¹ Under a proxy directive, the selected surrogate functions through determining the values and preferences of the patient based on such proxy’s knowledge of the patient himself or herself, and the treatment options that would have been selected had he or she been capacitated.⁴³² As for the instructional directive, no real “test” can be spoken of, or values and preferences to be ascertained, simply because these have already been expressly set out on paper.⁴³³

However, in case an advance directive is disputed or non-existent, how, then, will other persons — who are *not* privy to the personal values and preferences of the patient — decide what is best for the patient? Could such decision-making run the risk of being a throwback to the outdated paternalistic model? The Author submits an objective test that will still ensure some form of patient autonomy.⁴³⁴

i. Test of Bodily Integrity

This first objective test can be explained in this wise: if the patient’s body has degenerated to such a degree that not only is treatment medically futile, but no person can be assumed to want to live in such a state, life saving treatment may be withdrawn.⁴³⁵ What does bodily integrity mean?

(5) Be in the frontline of health services, delivery, particularly during and in the aftermath of man-made and natural disasters and calamities; and

(c) Exercise such other powers and perform such other duties and functions as may be prescribed by law or ordinance.

Id.

430. The Author subscribes to the observations and suggestions enunciated in Klosko & Frisk, *supra* note 436, at 191-200 & Pope, *supra* note 332, at 208-14. These recommendations adopt the tests and hierarchies suggested by the two articles.

431. See Klosko & Frisk, *supra* note 420, at 181 (citing Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 376 (1988)).

432. See Pope, *supra* note 322, at 210-11.

433. *Id.* at 211.

434. See Klosko & Frisk, *supra* note 420, at 191-92.

435. *Id.* at 181-82. “When a court decides, applying the objective test, to authorize withdrawal of treatment, it has decided that the patient would be better off dead than alive.” *Id.*

Firstly, this is not a test based on pain levels. Such a standard has its limitations, especially to cases such as *Schiavo*, *Cruzan*, and *Quinlan*, where pain levels, absent any distinct expression of pain from the patient, is mere conjecture.⁴³⁶

Second, this is not a test based on aesthetics alone. Disease, side effects, and even the mere fact of an extended confinement has degenerative effects on the body. Karen Ann Quinlan lost 40 pounds, or over a third of her body weight, while she was in a persistent vegetative state. Terri Schiavo was a deplorable shadow of her former self, a young and attractive woman before her anoxia took everything that made her life worth living. But this alone cannot be the standard.

Under this test of bodily integrity, the “objectivity” lies in human nature: no person wants to continue living in a condition where their body slowly, cruelly, and inevitably wastes away to eventual death.⁴³⁷

ii. Test of Independence

An underlying presumption also pervades this test: reliance on instruments and machinery to be kept alive is undesirable. Also supported by jurisprudence, “being in a constant state of physical dependence on others is a bad thing, whether or not one is in a position to know that one is dependent.”⁴³⁸ Of note is that in *Cruzan*, *Quinlan*, and *Schiavo*, each of the surrogates requesting the withdrawal of treatment from Nancy Beth, Karen Ann, and Terri had expressed a sentiment that “*they would not have wanted to live like this.*”⁴³⁹

iii. Test of Capacity for Subjective Critical Thought

Although a subjective test is impossible when there is no real personal link between the patient and surrogate decision maker (in this case, a court or the physician), it has been suggested that the ability of the patient to *form* subjective critical interests and to act according to them, is an important characteristic of what is a good human life.⁴⁴⁰

Given that a person’s quality of life is what he or she says it is, this test can and should only determine if such person can ever really pursue any activity remotely meaningful in life.

436. See Klosko & Frisk, *supra* note 420, at 197.

437. *Id.* at 198.

438. *Id.*

439. *Id.* (emphasis supplied).

440. *Id.*

2. In Case an Advance Directive Has Not Been Executed, a Surrogate Decision-Maker is Recognized by the Physician to Exercise Substituted Judgment in Ascertaining the Treatment Preferences of the Patient

In this instance which is the *status quo*, a physician is directed by a recognized surrogate — a spouse, an adult child, a parent — as to what treatment preferences a patient may have. Expressed in the words of Thaddeus M. Pope, Associate Professor of Law at Widener University School of Law and Adjunct Professor of Medical Education, Albany Medical College —

Sometimes, there is no reliable evidence of either the patient's expressed wishes [as in the case of an existing instructional directive] or her values and preferences [as in the case of a proxy directive]. In such cases, neither the subjective nor the substituted judgment standard can be applied. Therefore, the surrogate must shift her focus from the autonomy of the patient to the welfare of the patient. In the absence of patient-centric evidence, the surrogate must rely on more objective grounds. This decision-making criterion is referred to as the 'best interest standard.'⁴⁴¹

To determine what are in the "best interests" of a patient, Pope cites several factors, from "the pain and suffering associated with treatment, the degree of and potential for benefit, and any impairments that may result from treatment,"⁴⁴² to "[the patient's] physical, sensory, emotional, and cognitive functioning[;] the quality of life, life expectancy[,] and prognosis for recovery with and without treatment[;] the various treatment options[;] and the degree of humiliation, dependence, and loss of dignity resulting from the condition and treatment."⁴⁴³

Despite the relative ease of such a procedure and its permissibility within Filipino culture as to deference to family members in important decision-making, this model ultimately does not fully recognize patient autonomy, and is fraught with complications in case of dispute among interested persons. But, with the limitations of the situation — i.e., the lack of any indication of the incompetent patient's treatment preferences — the treatment decisions of the patient will depend on the rectitude and probity of the surrogate. Hence, the Author argues, the need for education and legislation on patients' rights and advance directives as a means to protect such rights.

a. In Case of Dispute or Absence of any Available Surrogate, the Medical Practitioner Determines

441. Pope, *supra* note 322, at 212-13.

442. *Id.* at 213.

443. *Id.* (citing *Woods v. Commonwealth of Ky.*, 142 S.W.3d 24, 35 (Ky. 2004) (U.S.)).

Ultimately, however, when the patient's preferences are not ascertainable, the physician may determine what the best interests are for the patient. In spite of it reeking of the paternalistic model, it cannot be said that every physician, had it not been for the contemporary autonomy model, would be deceitful and disrespectful to patients. On the contrary, it has *always* been a principle for medical practitioners to do no harm to patients, and to have their best interests as the primary consideration, owing to the fiduciary nature of the relationship of patient and physician.

VI. PROTECTING THE LIMITED RIGHT TO DIE

Patient autonomy exists as a guarantee that the integrity of a patient's body, his or her very *dignity*, is respected. The concept was the natural consequence of the evolution from a Paternalistic Model, where physicians had a monopoly of information and influence over the patient's very body. Yet the belief in the power of "healing words" under medical paternalism transformed into the high respect for the sanctity, dignity and inviolability of the patient's body and the patient's choice. The new Patient Autonomy Model espoused the balancing of power relations between patient and physician, refashioning the entire dynamic between the two parties.

The new dynamic is fully expressed and perfectly highlighted in the doctrine of informed consent. First enunciated in *Schloendorff*, informed consent declared that a person has the *right to determine what shall be done with his own body*, a right founded on American tort law provisions. Informed consent became a protective and procedural tenet that highlights the contemporary respect for the autonomy of patients, existing to ensure against harm to patients and liabilities of physicians, as well as evolving, for better or worse, into its own bureaucracy of consent and waiver forms in the medical field.

But Philippine law has been slow to adopt these tenets. Established as these principles may be, they still lack the efficacy and scope of a statute or a court ruling. And try as Philippine lawmakers might, the legislative mill has been reluctant to recognize these rights, largely due to the apprehensions of the medical field itself.

Regardless, a survey of Philippine laws will reflect a permissibility of such principles. One such principle is the very extent of patient autonomy, of patient self-determination: the right to refuse life saving or sustaining medical treatment. One finds in the dictum of *Cruzan*, limited by the dicta of *Glucksberg* and *Quill*, the depth and breadth of the legal framework of patient self-determination: *Cruzan* laid down constitutional recognition of a common law doctrine allowing patients the right to refuse treatment, *Glucksberg* declared that such right did not extend to assisted suicide, and *Quill* ruled that there was a fundamental difference between the two.

One finds in Philippine laws various liberty interests that enunciate a right to bodily integrity that could extend to the right to refuse. Primarily under privacy laws, albeit untested in the courts, there are similar values and *ratios* that would permit a reading allowing for the right to refuse treatment.

But what “limits” are there, culled from the Philippines’ own legal tradition, to the right to refuse life-saving or sustaining treatment? Medical futility is the first true limit of the right: anything less than a futile case would subject the physician to liability, and would impel the State to intervene. Informed consent can be read not just as a privilege, but also as a limit, with the procedural aspects of informed consent also protecting physicians from liability. Ultimately, however, it is the long arm of the State and its police power that ultimately delimits the extent of the liberty interest.

This Note has also outlined a general framework for protecting such right, through the use of advance directives. Operating akin to a will, and considering the same requirements under the law on wills, advance directives are effective mechanisms through which a patient’s healthcare preferences for contingencies where he or she may not be able to express them is put on paper and respected. These instruments ensure autonomy and self-determination, and prevent the long and tumultuous litigations of the *Cruzans*, *Schiavos* and *Quinlans*.

The Note started by saying it was one about death. That is in some respects true, but in some respects not entirely accurate. The Note is about the human person’s liberties and to what extent he or she can claim the inviolability of his or her thoughts and actions. Particularly, the Note has been about how far the human person can claim his or her life as his or her own and determine the choices that people may make in their dying.

The Note has been about the right to life, liberty, privacy, and a dignified death — and the scope and extent that these personal interests can be weighed with the interests of the State and of those in the medical profession. The Author hopes that he has contributed to the definition of what these rights mean, what they entail, how they are enforced, and to what extent they may be protected.