



PRIMARY RESEARCH

Withdrawing life supports therapy in human rights perspective

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Abstract

Indonesia was a country implementing the welfare state concept, and it meant that State's intervention to the citizens' life, from birth to death, was to be a consequence. The enactment of Minister of Health's Regulation (Permenkes) Number 37 of 2014 on Determination of Death & Utilization of Donor Organs was an example of such intervention. From a Human Rights perspective, Indonesia was one of the countries having a Pro-Life standing point. Therefore, euthanasia practice was prohibited because it prioritized the right to life. In line with technological development in medicine, understanding human rights, and changes within the legislation itself, euthanasia was passively regulated in the legislation. One of the provisions said that "for a patient who was in an incurable condition due to his or her illness (terminal state) and medical measures were futile, withdrawing or delay in life support therapy could be taken." However, the term "termination of life" was subject to strict requirements and restrictions. The right to self-determination was one of the requirements that should be fulfilled in the withdrawing life-support therapy procedure.

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I. INTRODUCTION

The initial question of this paper is "if there is a right to health, there is then a right to illness". Health is a healthy state, whether physically, mentally, spiritual or social that allows everyone to live productively socially and economically (article 1 point 1, Law Nr. 36 of 2009 on Health). As for as sick related with illness. There seem to be no uniformity in the ways in which health and illness are defined. Indeed, there have been, and still are, many different ways in which people have thought about the relationship between the two. Rather, the ways in which they are defined seem to depend on a number of different factors. For example, the person doing the defining makes a difference: professional definitions of health and illness may be very different from the ways in which other members of society conceive of them. Also, the more general beliefs in a society, its cosmology, show great diversity both contemporaneously and over time. They form the backdrop that makes specific belief about health and illness sensible ones within any particular society and ones which might seem peculiar to out-

siders in culture, geography and time [1, 2]. How about this statement?" if there is a right to live, there is then a right to die". Advances in medical science and technology have added some fundamental concepts about death. If the previous death is defined as the cessation of heart rate and respiration, the discovery of respirator and the pacemaker the present definition of death will be different. A person who, due to a matter, experiences respiratory arrest or cardiac arrest, he still has a possibility of being helped by using the devices, meaning he has not died. The problem then is how long the person will survive with the devices. Such circumstances will possibly last for days, months and even years without being known when it will end. The life obviously depends on the devices and if they are revoked he will most likely die.

Medically predicted, if the brain recording still shows good function there is then a hope that the patient will regain consciousness. However, if the brain does not work it is almost impossible for him to live without the aid of the devices. In other words, he only has a vegetative life, meaning the only

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body cells that are still showing signs of life. With so, it is now known as brain stem die or brain death (MBO) which indicates that the brain is no longer functioning [3, 4].

In such circumstances the patient's family commonly are to ask the doctor to immediately end the patient's suffering by removing all the supporting devices. The issues arising are: first, will the doctor deliberately remote the devices that will certainly end the patient's life? Secondly, does the doctor have the rights to do so without being subject to legal sanctions? It will be even more complicated if it is a request of the patient's family because of socio-economic reasons so that the family forces to bring the patient home. In this case it is clear that the one having authority to remove all the devices is the doctor in duty [5, 6]. Case examples of appeals for the release of life aids often occur in the field of health services, especially hospital services. For example is the case of Charlie Gard, an 11-month-old British infant who finally had his last breath on Friday (28/7/2017) after his breathing devices were stopped by the Great Ormond Hospital (USA) according to the family spokeswoman as broadcasted by KABC-TV on Sunday (7/30/2017). Charlie suffered from a rare genetic disease, a mitochondrial depletion syndrome, which caused brain damage and made him unable to breathe unaided. The case of Charlie Gard becomes a controversial legal dispute until now and Pope Francis even gave a support to Charlie's parents, Chris Gard and Connie Yates [7].

In Canada, the starting point for the authority to withhold or withdraw treatment of an incompetent patient is the case of R.L. In this case a child, apprehended because of alleged abuse, was in a Persistent Vegetative State (PVS). Child and Family Services, based on their governing statute, obtained an order allowing them to provide consent for the doctors to impose a Do Not Resuscitate (DNR) order on the child. The parents appealed the order. The Manitoba Court of Appeal held that "neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction, where in his or her judgment, the patient is in an irreversible vegetative state." As for the wishes of the parents, or the child's Guardian, their wishes should be taken into account, but their consent or approval is not required [8, 9].

A case happening in Canada could be used as an example of a policy to overcome the dilemma for people in a terminally ill condition. The case story was as follows. Last February, in deciding *Carter v. Canada (Attorney General)*, the Supreme Court of Canada unanimously declared ss. 241(b) and 14 of the Criminal Code to be of "no force or effect" thereby eliminating the prohibition against physician-assisted death for

competent and consenting adults who suffer from an intolerable medical condition. In short, assisted death-in a narrow context-is no longer considered an indictable offence. In rendering its decision the Court suspended this declaration for one year (until February 6, 2016), to allow Parliament time to pass new legislation. Earlier this month, the Attorney General of Canada applied to the Court for a six-month extension of time to draft this legislation. Last week, in a 5/4 ruling (with Chief Justice McLaughlin dissenting), the Court granted the application [10]. Based on the court decision there were fundamental changes related to the treatment given to people in certain medical conditions. Once the law comes into effect, any Canadian facing "a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition" may pursue a physician-assisted death. Parliament has until June 6, 2016 to implement new legislation which will reflect the decision in *Carter* [11].

An appeal to release life aids on October 22, 2004 had been asked by a husband named Panca Satria Hasan Kusuma because he could not bring himself to see his wife named Again Isna Nauli, 33 years old, who was lying comatose for 3 months post Caesarean surgery. Besides, the inability to bear the burden health care costs was to be an excuse too. The application for euthanasia was submitted to the Central Jakarta District Court. This case was one of euthanasia forms that was beyond the patient's wishes. This appeal was eventually rejected by the Central Jakarta District Court (Indonesia) and after having intensive care the patient's condition (7th January 2005) had progressed in her recovery [12].

The case examples above represent many similar cases that often become a dilemma that must be faced by the world of health, especially hospitals. The problems arise in line with technological advances in the field of medicine producing these findings that it allows prediction of a disease. Therefore, it raises consideration to do "life termination" because of some reasons. If a patient or his family is in a "hopeless situation" added with a fact that the cost of health care is not cheap it will be a reason for cessation of life aids under certain conditions.

Problems arise when the cessation of life aids action is confronted with the patient's right to health care which is actually a basic right derived from human rights. Is the cessation of life aids a fulfillment of the right to "die"? The emergence of the right to die problem is caused by continuous patient suffering. Despite the advanced technology is discovered suffering cannot be eliminated altogether. This contin-

uous suffering causes the patient or the family sometimes unable to bear the burden, both moral and material.

II. RESEARCH METHOD (METHOD)

This research used normative-legal approach meaning this is a doctrinal-legal research or is also called library or documentary research. As a doctrinal-legal research this referred only to written regulations and other legal materials before were then analyzed and accomplished based on those materials. A normative-legal research was conducted by considering that the starting point of the research was analysis of legislations or laws conceptualized as rules or norms in positive laws which were used as a benchmark of deemed appropriate human behavior. Therefore, the data type were secondary consisting of primary, secondary, and tertiary legal materials. Besides, this research applied deductive thinking method and coherent truth criterias. Deductive thinking method means as a way of drawing conclusions from general things in nature, which have been verified before, and are then led to special things in nature. The normative-legal approach in this study was done by just elaborating library materials or secondary data. The study was referred to law principles, especially related to human rights and then related to the regulations of life aids termination. An inventory of legal provisions concerning human rights and health services was made. The provisions of the existing positive laws were then systematically analyzed based on legislative hierarchies, namely starting from State's Constitution (UUD 1945), the Acts on Human Rights, on Health, on Hospital, and on Medical Practices beside the Regulation of the Minister of Health Nr. 37 of 2014 Death Determination and Donated Organs Utilization.

The specification of this research was descriptive-analytical meaning that it will make a systematical, factual and accurate description regarding the facts, nature and relationship of the phenomena or symptoms and to analyze them in order to look for a cause and effect relationship between a norm and a principle. These would be then consistently, systematically, and logically described. Specifically this research would make a comprehensive description of the relationship between the provisions regarding the life aids termination and human rights principles.

The data type were secondary consisting of primary, secondary and tertiary legal materials. The primary ones are binding legal materials consisting of basic norms, basic regulations, and legislation. These would provide an overview of the norms in health services related to the act of life aids termination and human rights principles. Secondary legal materials were the materials that would provide explana-

tion to the primary legal materials. These second legal materials could be research results, textbooks and journals and the use of them was to provide a kind of clue or inspiration to researchers. Meanwhile, the tertiary legal materials could be dictionaries, both general and specific dictionaries like law dictionary, medical dictionary, etc. The tertiary legal materials would help researchers in defining and giving understanding the technical terms used in the study.

The next step after getting the data was to make an inventory of articles and paragraphs of the existing rules that would probably be used as research objects. The inventory was then followed by systematization or classification of the materials. A juridical analysis using the human rights principles was made before making a consistent, aesthetic and simple scientific construction covering the whole classified materials obtained. Data processing and analysis were to answer the legal issues that was formulated in the research questions. It of course involved scientific reasoning activities on legal materials analyzed using induction, deduction and abduction reasoning. The data were processed through the stages below:

- a) Data verification: to avoid data errors and incorrectness. The data obtained were reexamined if there were still shortcomings or not.
- b) Data editing: to find out the useful data obtained from various literatures. This stage is necessary to see if data is sufficient or not to proceed to the next process.
- c) Data systematics: to group the data systematically. The edited and marked data according to their classification and problem sequence were reviewed.
- d) Data presentation: to present the analyzed data by describing them in the form of sentences that were consistent, logical, effective and systematic to make the data easier to be interpreted and constructed. This stage also provided a causal relationship of the existing problems and described them consistently and logically in accordance with the research question, namely to describe whether life aids termination met human rights principles.

III. HEALTHY AS HUMAN RIGHTS

Human rights that are today named, among others, "human rights, the right of man" which in principle can be defined as "the rights which are possessed by human being by natures which are inseparable from his essence and is therefore sacred". Thus, human rights can be regarded as a basic right possessed by the human being as a God-given gift born. Human rights cannot be separated from the existence of the human being itself. From this understanding it is actually a struggle to defend human rights that may be as the age of

mankind itself [5]. Rights are justified claims that individuals and groups can legitimately make upon other individuals or a social group or institution. To have a right is to be in position to determine by one's choices what others should or should not do [5]. The main substance of human rights, is freedom and the right to privacy. Freedom is the ability of a person to make his choice. Philosophically the essence of human freedom lies in man's self-determination [13]. This year marks the 70th anniversary of both the birth of human rights law through the Universal Declaration of Human Rights (UDHR) and the birth of global health governance through the World Health Organization (WHO). Over the past 70 years, human rights have developed under international law as a basis for public health, providing a foundation for human rights realization through public health practice. Yet this "health and human rights" movement now faces unprecedented threats amidst a shift toward populism—with the populist radical right in ascendance in the United States and in countries throughout the world [14]. There are still wrong opinions that the human right is identical to the western world. But it can not be the reason not to oblige the human right. The human right is universal's problem, but also contextual. In line to what Magnis-Suseno has said that the human right is a modern phrase. In the traditional context, there are not so many questions about the human right because the traditional social structure are able to protect the individual's rights. Indonesia as the modern country gets the impact, in which the people has turned into more individualistic (than the traditional people). For further explanation, the human right is actually not about individualism. Otherwise, the assurance of human right is the solidarity sign and social care inside the society, such as the protection of those in needs socially and economically. Hence, the human right is universal substantially, but it is contextual for the relevances (actualization) concept [15]. As explained above there is actually a relationship between health and human rights. The condition of one's health may be a reflection of whether the human rights principles have been fulfilled to him or her. The social determinants of health and human rights describe where and how we live and thrive. They express our actual and optimal conditions of housing and nutrition; our social, cultural, and spiritual connections; our access to education, health, and social services; and our ability to be fully involved in our societies through expression, mobility, association, work, and engagement with the formal political process. Ultimately, they are different yet overlapping measures and languages of human well-being and self-actualization. The connection between these deeply related but, until recently,

rarely linked conceptual frameworks was made explicit in the 2008 report of the WHO Commission on the Social Determinants of Health (CSDH). This seminal report comprehensively outlined the imperative to scale up the global focus on the social determinants as a matter of social justice, the absence of which was "killing people on a grand scale" [11]. In health literature there are some terms used to refer to human rights in the health field, such as "human rights to health", "the rights to attainable standard to health"[7]. The idea of the rights to health as human rights remains developing both in national and international laws. Article 4 of the Act Nr. 23 of 1992 on Health (which was amended by the Act Nr. 36 of 2009) stated that "every person has the same rights in obtaining optimal health status" meanwhile in international law various human rights instruments had developed, including International Covenant on Economic, Social and Cultural Rights (ECOSOC) established in 1966. Article 12 paragraph (1) of the Covenant stated that "everyone has the right to enjoy the highest standards that can be achieved for physical and mental health". (The Covenant had been ratified by the Act Nr. 12 of 2005 [7]. One of the rights that sourced from the human right is the right of health. Health is the base of recognition in humanity degree, without health, someone will not be able to get their rights. The right of health as the human right is approved and ruled by various international and national's instrument [3].

In Article 1 point 1 of the Act Nr. 39 of 1999 on Human Rights, hereinafter named as Human Rights Act, human rights are meant as "a set of rights inherent in the nature and existence of human beings as creatures of God Almighty and is His grace which must be respected, upheld and protected by the state, law, government and every person for the honor and protection of human dignity". Human rights are inherent rights of man because of his nature as a human being. Such rights are derived not as gifts from others or gifts from the state. Human rights are given without distinction between one individual and another. The first basic right is the right to life bringing consequences of other rights including the right to health.

The WHO mention in her factsheet no. 31 "right to health" that the right to health is an inclusive right [16]. According The WHO, the right to health contains freedoms: they include the right to be free from non-consensual medical treatment such as forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment [13].

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Health care is a human right, which is afforded protection in all manner of international treaties and Constitution [13]. The right to medical care is part of universal human rights specifically formulated in the Universal Declaration of Human Rights. The right is contained in Article 25 stating that: “everyone has the right to a standard of living for the health and well-being of himself and of his family, including food, clothing, housing, and medical care”.

In Republic of Indonesia Laws number 12 year 2005 about The Ratification International Covenant On Civil And Political Rights, in part of a word determination, it states that “human right is a basic right in which naturally stick to human, universally and long last, thus it should be protected, respected, defended and should not be ignored, reduced or stole by anyone.”

In the human rights concept the right to obtain adequate health care is a constitutional right for every citizen as mandated by Article 28 H paragraph (1) of the 1945 Constitution stating that “every person shall have the right to have a prosperous and spiritual life, to dwell, to get a good and healthy environment and rights to health care”. Health is a part of human rights. Health rights are also formulated in the Human Rights Act Article 9 paragraph (3) which states “everyone is entitled to a good and healthy environment”.

Article 1 point 1 of the Act Nr. 36 of 2009 on Health, hereinafter named as Health Act, defines health as “healthy physical, mental, spiritual and social conditions that enable every person to live socially and economically productive”. Optimal health degree achievement can be realized through the provision of adequate health services for all Indonesian people. Through the provision of health services everyone can easily access health services at health facilities. Article 4 of the Health Act states that “everyone has the right to a healthy life”, then in Article 5 paragraph (2) states that “everyone has the right in obtaining safe, quality and affordable

health services” whereas Article 6 states that “everyone is entitled to a healthy environment for health status achievement”. The mention of the word “every person” in this Act refers any person without exception and there shall be no discrimination in respect of health.

The right to a healthy life is a fundamental right to be guaranteed because health is part of every human's primary needs. A healthy condition of body and soul will enable every human being to perform his activities and his work. Health is also part of the need for prosperity. This right is to be one of the basic rights of health care. In addition, everyone is guaranteed to determine his health needs in accordance with his choice (the right of self determination). As it is known, basic rights in health services are based on human rights principle so human beings in any part of the world have it, including Indonesian people and the cases mentioned above. Therefore, in ensuring the rights of every person to health care it must be based on non-discrimination and humanity principles which means that it should not be against the human rights principles.

IV. GOVERNMENT RESPONSIBILITY AND PUBLIC RESPONSIBILITY

The right to live in the highest degree of health is the government's responsibility. As the WHO determined, “a Further provision of the WHO Constitution provides that Government have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” [8].

In the provisions of the Health Act, it is stipulated that the Government is responsible for fulfilling and ensuring the realization of such rights. The government is obliged to maintain and improve qualified health services that are equitable and affordable by all levels of society. Therefore, the responsibility that should be taken by the government in the health sector is to ensure the availability of health resources as needed and to ensure all forms of health care to fulfill the community's right to health. Health resources here include health workers, health facilities, medical equipments and pharmaceutical supplies as well as other resources. This is defined in Article 14 up to Article 20 of the Health Act. The responsibility of the Government is also regulated in the Act Nr. 44 of 2009 on Hospitals particularly Article 6 paragraph (1) stating that “the government and regional governments are responsible for providing protection to hospital service users in accordance with the provisions of the legislation”. In this obligation fulfillment it is required the involvement and cooperation between the Government with various parties because it is impossible the Government to

bear it all alone. Therefore, the responsibility to meet the needs of healthy life is also the responsibility of the community. The government then regulates public participation in health services. In practice the rights are often privileged and lack of attention to obligations. Right to healthy living and the right to health care are everyone's rights and the Government is responsible for making it happen.

Even though government is responsible for almost everything, it is also the responsibility of the people to participate in carrying out the health right. The right to live healthy can be achieved by fulfilling the responsibility to live in a healthy behaviour as well as responsible in embodying the right of healthy life for the family and environment [18]. As defined in Article 9 up to Article 11 of the Health Act as follows: Article 9 paragraph (1) "every person is obliged to participate, maintain and improve the highest public health level." while paragraph (2) states that "the obligations as referred to paragraph (1) refers that the implementation shall include individual health and public health efforts and health-minded development." Furthermore, Article 10 states that "everyone is obliged to respect the rights of others in the effort to obtain a physically, biologically and socially healthy environment". Article 11 stipulates that "every person has the obligation to live a healthy life to realize, maintain, and promote the highest possible health."

Based on these provisions above the fulfillment of the right of prosperous-healthy life is not only the Government's obligation but it also becomes community's obligation. Meanwhile, the Government is responsible for the fulfillment of the community's rights to health and health services through its authority by regulating, fostering and supervising the implementation of health service efforts. The goal is to improve the highest degree of public health.

The description above shows the importance of the guarantee of the rights to a healthy life so that all parties, namely the Government and society, have obligations to realize the rights, not just the rights to "live" but the rights to live healthy in its highest degree.

On the other hand, the public is also obliged to participate in the realization of the right to health. Partly on account of these international human rights instruments that recognize a right to participate, a community participation movement that places value on involving communities in the provision of public health services has grown. This movement argues that community participation in the provision of health services increases a sense of responsibility and conscientiousness among the public, given a perceived increase in skills, information, and control over health resources.

The organization and delivery of health services also benefit from community participation due to a better determination of the need for health facilities, their ideal location and size, the number and types of health workers required, employment practices, and health worker policies. Ana Ruano et al., in presenting findings from the research consortium Goals and Governance for Global Health, have also argued that through meaningful participation and community engagement, a more horizontal and inclusive approach replaces the top-down process of decision making [17].

The government has the responsibility to provide legal protection for the realization of the right to health for the public. Legal protections are an important tool to ensure the fulfillment of human rights, as they provide a framework for restitution and justice when necessary. To this end, governments have adopted and ratified international agreements that create binding legal obligations to protect human rights. The norms and protections provided in the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the International Covenant on Economic, Social and Cultural Rights and other global and regional human rights instruments have been interpreted as applying to people in health care [19].

V. RIGHTS TO LIFE AND DEATH

Right are manifestation of freedom in society but the bring consequences named responsibilities in the form of obligations. Therefore, in everyday life, freedom is always attached to responsibility and the rights that are always attached to obligations [20]. In Indonesian language human rights is called hak asasi manusia that are etymologically formed from three words, namely hak (rights), asasi (basic) and manusia (human). Rights here means true, real, definite, permanent, and obligatory whereas the word asasi means everything that is fundamental and always attached to the object. Seeing this explanation, human rights can be interpreted as fundamental rights to human beings. Soetandyo Wignjosoebroto defines human rights as "fundamental rights that are universally recognized as rights inherent in humans because of their nature as human beings." Further, Soetandyo says that the rights are called 'universal' because the rights are expressed as part of the humanity of every human being, regardless of skin color, gender, age, and cultural and religious backgrounds. While the word 'inherent' is used because these rights are owned by every human being solely because of their existence as human beings and not because of gifts from any organization of power. Since their 'inherent' characteristic, human

rights cannot then be deprived or revoked [21]. According to Soemantri, the development of the human rights concepts reached three stages and the rights could be grouped into three categories, namely first generation, second generation and third generation human rights. The first generation were human rights in the civil and political sphere as T. Koopmans mentioned them as *de klassieke grondrechten* (classical basic rights) [11].

The rights to health in relation with the human rights categories are often included into second generation and third generation. If the rights to health are associated with "individual health" they will be included into economic, social and cultural rights but if they are associated with "public health" they will then be included into the rights to development. According to Muladi the third generation human rights is given to collective rights on the basis of solidarity of human beings and brotherhood that are verily necessary. These human rights include, among others, "the right to development; right to peace; and the right to healthy and balanced environment" [22].

If there is a right to live there will be a right to die? Rights to life and death are parts of human rights affairs. Indonesia's standing point is obvious, that is "pro life", not "pro choice". Therefore, Indonesia gives priority to the rights to life. Broadly speaking, human rights principles, according to the Human Rights Law, are stipulated in the aspects of life as follows:

- a. the right to life: everyone has the rights to live, to maintain life, to improve the standard of living, to live peacefully, safely, happily, prosperously physically and spiritually and has rights to a good and healthy environment.
- b. the right to obtain justice: everyone, without discrimination, has the right to obtain justice by submitting requests, complaints and claims in criminal, civil and administrative cases, and to be tried by a free and impartial judicial process, in accordance with the law. Fair or just could be meant as in accordance with the law and what comparable is or what should be. Therefore, social justice would be realized if everyone got what he or she should be entitled to.

Based on the description above it is clear that Indonesia follows "pro-life" concept because it respects life and that is the reason that it regulates the right to life, not the right to die. As a consequence of "pro-life" concept the Indonesian positive law firstly did not allow an elimination of life or commonly named euthanasia. For whatever reason euthanasia were allowed to be done.

Why the rights to death? As mentioned in the beginning of this paper advances in medical science and technology had appeared some new fundamental concepts of death.

Death used to be defined as the heart and breathing cessation. However, since the discovery of a respirator (respiratory device) and a pace maker someone who, for some reasons, experienced respiratory arrest or sudden cardiac arrest remained having a possibility of being helped by using the tools. This means that the patient has not died.

The problem arising then was how long the patient would be able survive with the helping tools. This situation could possibly last for days, months and even years without being known when it would end. It was obvious that the patient's life depended on the tools and if the tools were revoked he or she would soon die. Medically, it is now known if the brain record remains performing good function there is a hope that the patient will regain consciousness but if the brain is not functioning it is almost impossible for him or her to live without the tools. In other words, the patient only vegetatively lives, namely only his or her body cells that still show signs of life. Since then there is a term of brain death which means an indication that the brain is no longer functioning.

In such a situation the patient's family oft to ask the doctor to immediately end the patient's suffering by removing all assistive devices or helping tools. The problems are then, first, will the doctor be hearted to intentionally release the tools that will end the patient's life. Second, does the doctor have rights to do so without being subject to legal sanctions? It will be even more complicated if the patient or the patient's family request to bring the patient home because of socio-economic reasons (costs). If it happens it will be obvious that the doctor will be the only one who remove the helping tools or assistive devices. This means that should be responsible for that action [23].

In reality euthanasia would not only be for people who are "terminally ill." Increasingly, however, euthanasia activists have dropped references to terminal illness, replacing them with such phrases as: "hopelessly ill", "desperately ill", "incurably ill", "hopeless condition", meaningless life. "An article in the journal "Suicide And Life-Threatening Behavior" describes about assisted suicide guidelines for those "with a hopeless condition". What is meant by "hopeless condition" is to include: terminal illness; severe physical or psychological pain; physical or mental debilitation or deterioration; and a quality of life that is no longer acceptable to the individual. That means just about anybody who has a suicidal impulse. Euthanasia has adjacent meaning to "let death come" (letting die). In the literature, euthanasia is distinguished into two, namely active and passive. The active euthanasia means doing certain actions so that the patient dies, for example by ending the provision of artificial

breath through a respirator or removing the ventilator in the sense of terminating the artificial breathing. Passive euthanasia, on the other hand, means not starting to take any action to prolong the patient's life because it will not be useful anymore (not initiating life support treatment). Even it probably will add the patient's sufferings, for example an elderly patient having chronic heart disease who gets a heart attack for the umpteenth time and has been unconscious for a long time will not be given a shock therapy or to be connected to a ventilator [10].

As a consequence of a welfare state concept all citizens' lives are then interfered by the State from their birth until they die. Similarly, in terms of determining the right to live and the right to die. Indonesia interfere these rights through provisions on the determination of death and organ donation. Indonesia is a country that belongs to the category of "pro-life" but to accommodate technological developments in the field of medicine the determination of death and organ donation are needed to be stipulated. This can be interpreted as a form of "passive" euthanasia provision but it is based on very strict restrictions.

One of the strict requirements is a decision to provide assistance is not taken by just one person. A decision to provide assistance must always involve a doctor who will issue a prescription regarding the drug or material to be used. The decision of providing assistance and judging whether the assistance is necessary really need maximum accuracy and thoroughness in accordance with applicable decency, for example by inviting a discussion involving several colleagues and other experts [24].

VI. REGULATION ON EUTHANASIA IN INDONESIA

Indonesian positive law does not distinctly regulate euthanasia. In the Book of Criminal Code (KUHP), euthanasia is implicitly regulated in Article 344 of KUHP stating that the doers will probably be imprisoned for a quite long time. This Article says that those who terminate someone's life based on wholehearted request will be punished by < 12 years imprisonment and will be added with 1/3 if the doers are medical doctors. This article is assumed to be a legal base for those who assisted to terminate someone's life as wholehearted request of the one him/herself There are two kinds of euthanasia.

1. (frequently said) Active euthanasia → there is an explicitly spoken or written request (termination as request).
2. Passive euthanasia → there is no request (termination without request).

As mentioned before euthanasia is basically prohibited. In accordance with the development of technology in medical

field and the legislation changes in Indonesia, euthanasia is passively regulated in the Minister of Health's Regulation (Permenkes) on Death Determination and Donated Organ Utility. However, there should be some strict conditions and limitations to do that. The reasons behind are: the main principle is human rights; the rights of self-determination. This is the reason why a regulation on the legal subjects having the rights, especially patients, is necessary.

A. Legal Basis

1. Act Nr. 29/2004 on Medical Practises
2. Act Nr. 36/2009 on Health
3. Act Nr. 44/2009 on Hospital
4. Government Regulation (PP) Nr.18/1981 on Clinical Corpse Surgery and Anatomical Corpse Surgery and Device and Human Body's Tissue Transplantation
5. Government Regulation (PP) Nr.32/1996 on Health Human Resources that was recently changed by the Act Nr. 36/2014 on Health Human Resources
6. Minister of Health's Regulation (PERMENKES) Nr. 269/2008 on Medical Records
7. Minister of Health's Regulation Nr 290/2008 on Medical Action Approval
8. Minister of Health's Regulation Nr. 1438/2010 on Medical Services Standard
9. Minister of Health's Regulation Nr. 755/2011 on the Medical Committee Administration at a Hospital
10. Minister of Health's Regulation Nr. 2052/2011 on Practice Permit and Medical Practice Administration
11. Minister of Health's Regulation Nr 012/2012 on Hospital Accreditation

B. Why Death Determination Needs to be Regulated?

The reason why death determination needs to be regulated can be seen in the considerations of the Health Minister's Regulation Nr. 37 of 2014 stating that "to implement the stipulation of Article 123 paragraph (3) of the Act Nr. 36/2009 on Health, it is necessary to make a Minister of Health's Regulation on Death Determination and Donated Organs Utilization". Article 2 of the Health Act states that "health development is conducted based on the principles of humanism, equilibrium, utility, protection, honor to rights and duties, justice, gender non-discrimination, and religious values and norms. This may mean that one of the principles of the death determination is based on the humanity principles to accommodate human rights in doing so. The Attribution of Article 123 paragraph (3) of the Health Act says "further provision on death determination and donated organs utility as mentioned at paragraph (1)

and paragraph (2) will be regulated by Ministerial Regulation" Through the mandate of the Health Act it was issued a form of regulation on death determination and organ donation through the Health Minister's Regulation Nr. 37 of 2014. The Regulation stipulates the limitation of understanding of withdrawing life supports as set forth in Article 1 Paragraph (1): withdrawing life support therapy is to withdraw some or the whole life support devices.

The objectives of regulating death determination and organ donation utility were formulated in Article 2, namely to provide legal certainty; and b. to provide legal protection to the patients and patients' families, health manpower, and health service facilities.

Article 3 of the Health Minister's Regulation Nr. 37/2014 stipulates the scope of regulation that includes:

- a. died brain-stem confirmation that the dying process happened when the patient was getting services at the health service facility
- b. withdrawing of life support therapy
- c. postponement of life support therapy
- d. donated organ utility

How to determine the death? This can be seen in Article 4 and Article 12. Article 4 of the Health Minister's Regulation Nr. 37 of 2017 states that:

- (1) patient's death confirmation could be in the health service facility or out of the health service.
- (2) the death confirmation as mentioned in the paragraph (1) should respect to religious values and norms, morality, ethics, and law.

Article 12 of the Regulation states that "patient's death time was detected when it was declared that the patient had got died brain-stem, not when the ventilator was taken from the body or the heart stopped beating".

The regulation of death determination especially in relation with the termination of life aids is closely related to the legal relationship in health services. As it is known that the legal relationship in health services specifically involves a minimum of three parties namely: doctors (medical personnel), patient (patient's families) and health facilities (hospital). The legal relationship establishes the rights and the obligations of each party domiciling as the subjects of the health service law.

Legal subjects involving in death determination matters: patient; patient's family; health manpower or human resources; and director or head of the hospital. Patient's family members who have the rights are:

1. husband or wife
2. family members having up and down straight lines (sons, daughters, or parents)

3. if not available, then the family members have side line (siblings).

In regulating the requirements for health workers in relation with the services of life aids termination and organ donation, Article 5 of the Health Minister's Regulation Nr. 37 of 2014 define:

1. death determination at health service facility should be done by medical human resource
2. medical human resources as mentioned in (1) are, in priority, a medical doctor
3. in case there are no medical human resources as mentioned in (2), the death determination can be done by a nurse or a midwife Chapter III of Health Minister's Regulation Nr. 37 of 2014, particularly Article 14, regulates the withdrawing or postponement of life support therapy. They mentions, among others, as follows:

1. Patients suffering from unhealed diseases (in a terminal state) and when every medical action would be futile. To these patients withdrawing or postponement of life support therapy could be done.
2. The judgment and decision about patient's terminal state condition and the head of the hospital.
3. The decision on withdrawal or medical attention to the patient as mentioned in paragraph (1) was made by a team of medical doctors appointed by medical staff Committee or Ethics Committee.
4. The plan of withdrawing or postponement of life support therapy should be informed and should get approval from the patient's family or the representatives of the family.
5. Life Support Therapy that could be withdrawn or postponed were only therapeutic acts and/or extra-ordinary services, including:
 - a. services at Intensive Care Unit
 - b. heart and lungs resuscitation
 - c. disrhythmia control
 - d. tracheal intubation
 - e. mechanic ventilation
 - f. vasoactive medicine
 - g. parenteral nutrition
 - h. artificial organs
 - i. transplantation
 - j. blood transfusion
 - k. invasive monitoring
 - l. antibiotics, and
 - m. other acts that decided in the medical service standard.
6. Life support therapy that could not be withdrawn or postponed include oxygen, enteral nutrition, and crystalloid liquid.

The provision of Article 14 paragraph (6) is an exception.

Based on the article, respiratory supporting devices are included as "could be withdrawn" because it is dealt with oxygen life support therapy.

To ensure human rights protection the regulation on the termination of life aids should provide a limitation of the procedure. The procedure of withdrawing life support therapy according to Article 15 is formulated as follows: (1) The patient's family could request the doctor to do withdrawing or postponement of life support therapy or to ask the doctor to assess the patient's condition for the withdrawing or postponement.

(2) The decision of withdrawal or treatment of life support therapy, medical acts to patient, as mentioned in paragraph (1) was made by the medical doctor team appointed by Medical Committee or Ethic Committee.

(3) The request of patient's family as mentioned in paragraph

(1) could only be done in some circumstances:

a. The patient was not competent but he could have his message dealing with the case (advanced directive) that could be:

1. a message specifically telling to do withdrawing or postponement of life support therapy if reached futility condition.

2. a message telling that a decision was delegated to a certain person (surrogate decision maker)

b. Uncompetent patient and had not willed his or her family (4) It will be excluded from the stipulation as mentioned in paragraph (1) and paragraph (2) if the patient remained being able to make a decision and to declare his own will.

(5) In case the request was declared by the patient as mentioned in paragraph (3), the patient's request should be fulfilled.

(6) In case there was incompatibility between the request of the patient's family and the recommendation of the team appointed by the Medical Committee or Ethic Committee and the family remained requesting to withdraw or postpone the life support therapy, the responsibility was in the side of the patient's family.

Article 15 paragraph (5) and paragraph (6) as provisions on the legal standing of terminally ill patient state:

a. a terminally ill patient remained to be the main legal subject so that he had the right to decide his own will - see Article 15 Paragraph (5) and paragraph (6).

b. in case the patient could not declare his or her own will, his legal standing was then replaced by his family's member having the rights.

VII. CONCLUSION

Withdrawing life supports therapy is indeed a dilemmatic problem in Indonesia. On one side it deals with a choice that requires rational and practical considerations whereas on the other side it deals with "a right to live" that is mandated by Universal Declaration of Human Rights issued by UNO and national legislations as well. This problem is not only faced by hospitals but also the patient's family and even the patient himself. Considering this dilemmatic situation some provisions are made in the efforts of getting the solution. The Indonesian Government, particularly the Ministry of Health, has a deep concern with this problem and then made some provisions dealing with withdrawing life supports therapy. Here are some points of consideration dealing with the provisions:

1. Indonesian positive law does not distinctly regulate euthanasia, because Indonesia is one of "pro-life" concept followers. The essence of human rights provision is a right to life.

2. Euthanasia is basically prohibited, because euthanasia is an act of ending life so that it is contrary to the right to life originated from human rights.

3. The Health Act commits to make a regulation on withdrawing of life support therapy. This is done to accommodate the needs of providing legal protection to the patient concerned as a result of technological development in the medical field as well as the social development.

4. The regulation on withdrawing of life support therapy could be categorized as passive euthanasia. This regulation provide a way out for a dilemma faced by the doctors and the patient's family who are in a hopeless situation.

5. Withdrawing of life support therapy can be done on strict conditions. The intention of this limitation is ensure that the action is carefully conducted, taking into account guarantees of legal certainty, justice and usefulness as values on which a law is made.

6. The conditions are:

a. place: in or out of the health service facility

b. authorized legal subjects: patient or his or her family

c. the main medical resources are medical doctors; if there is no doctors it could be done by a nurse or a midwife

d. the procedure could be as requested or not requested.

7. respiratory supporting devices are excluded because they deal with oxygen life support therapy. This provision is meant that although 'withdrawing of life support therapy' is permitted to be conducted the main tool, namely the respirator, is not allowed to be revoked.

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