10

Advance Directives in the Philippines: In Search of a Legal Framework

LEONARDO D. DE CASTRO, RENATO B. MANALOTO & ALEXANDER ATRIO L. LOPEZ

10.1 Introduction

The Philippines is a country located in Southeast Asia with a land area of around 300,000 square kilometres distributed across more than 7,000 islands in the western Pacific Ocean. Its population of 110 million is the second largest in the region and the 13th largest in the world. The country's archipelagic layout partly accounts for the inequitable distribution of healthcare resources across the population and for the concentration of large populations in under-resourced centres.

Many situations have arisen in the Philippines that suggest a possible role for advance directives (ADs) or similar instruments in that they give healthcare professionals and relatives the confidence to withdraw or withhold life-saving interventions from incompetent patients. The mounting cost of healthcare for people with chronic diseases and conditions associated with advancing age puts pressure on the resources that can be allocated for the care of all people in general. At the individual level, increasing healthcare expenses put pressure on ailing persons and their families to reconsider their "treat-at-any-cost" stance and explore ways of coping that are consistent with autonomous decision-making in anticipation of the point at which a person has lost mental competence.

Nevertheless, previous attempts to pass AD legislation have met with little success in the Philippines owing to religious and sociocultural influences. Given the practical need for ADs, as discussed previously, and highlighted by the pressures of the ongoing COVID-19 pandemic, hospitals have stepped in with their own institutional guidelines.

This chapter begins with an exploration of the religious and sociocultural factors that may account for the limited success of AD legislation in the Philippines. It then considers the specific context in which the country does have such legislation, namely, psychiatric ADs, and the

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

difficulties that legislation faces. Lastly, the chapter examines the ways in which healthcare professionals have adopted alternative ways to offer greater legal certainty, such as the creation of specific guidelines at the institutional level, to avoid the pitfalls created by the gaps in AD legislation.

10.2 Religious and Sociocultural Influences

Religion and culture exert significant influences on the conception and practice of ADs in the Philippines. The country has long been known for its status as the only predominantly Christian country in Asia, and Christian values are enshrined in the Constitution of the Republic of the Philippines, the basic law of the land.[1] In addition to Christianity, Filipinos are also strongly influenced by cultural attitudes in relation to disease causation and family. The influence of religion and culture on ADs in the Philippines can be seen in two ways: through the Filipino understanding of what Christian values mean for ADs and what Filipinos' cultural attitudes towards disease, such as *bahala na* (what will be will be), and family mean for the end-of-life context.

The Christian faith frequently exerts an impact on legal developments in the Philippines, with the heated debates surrounding legal proposals often resulting in the upholding of Christian (often specifically Catholic) values to the point of violating human rights or disregarding essential human interests. Whilst there have been no significant public debates over ADs in the country, and there is a lack of high-quality empirical research on attitudes towards ADs or on how they are practised on the ground, there appears to be a general lack of sympathy for a legal framework for ADs. This lack of sympathy is likely due to ADs being seen – rightly or wrongly – as a rejection of the Christian commitment to upholding the value of a life that God has given and that only God can therefore take away.

With regard to cultural attitudes, the key theme in the characterisation of Filipino psychology concerning diseases and their causation has been the idea that people do not find it necessary – or useful – to prepare documents indicating their future treatment preferences because uncertainty generally does not worry them. It has been posited that Filipinos attribute unexpected negative or positive events in their lives to the grace

[1] Constitution of the Republic of the Philippines 1987.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

of God, as doing so enables families to cope with challenges and accept their life experiences.[2] As well as being a coping mechanism, such an attitude also brings hope to families. It allows Filipinos to feel able to surrender their problems to a higher being who is all knowing and almighty, and exercises sovereign will, thus rendering ADs redundant for situations in which a patient is mentally incompetent. Rather than manifesting weakness on the part of the patient, readiness to offer his or her predicament to God allows the patient to experience a level of personal empowerment that reflects spirituality and is not incompatible with the concept of self-determination.

The phenomenon can also be explained in terms of the Filipino attitude of *bahala na*, which involves resignation to whatever may happen without any active participation in making it happen.[3] A person does not have to document treatment preferences for future contingencies through an AD because there is nothing to fear about a situation to which one is resigned. Recognising that human skills are not sufficient to overcome difficulties, the Filipino patient seeks the intercession of a higher being and resolves to accept whatever happens.

Many academics see the situation as a historical given, something that is especially highlighted, for example, by Filipino migrants in a country like the United States, where they have "built 'bonds' and 'bridges' with religious, civic, governmental, business and social institutions by means of. . . (1) transnational influence, (2) adaptive spirit, and (3) intergenerational cohesion. . .as they Filipinize elements of the cultural, political and economic arenas within the San Francisco Bay Area . . . in which they have settled . . . Because of the prevalence of religious practices in everyday life, daily discourse, verbal and written, is also influenced by religion".[4] The expression *bahala na* captures something essential about the cultural values that influence the way in which Filipino Catholics perceive and interact with society.[5] In addition to helping to explain the importance of religiosity and spirituality in the way that many Filipinos

[2] P.J.B. Abad et al., "Cultural Beliefs on Disease Causation in the Philippines: Challenge and Implications in Genetic Counselling" (2014) 5(4) *Journal of Community Genetics* 399.

[3] M.L. Tan, *Revisiting usog, pasma, kulam* (Quezon City: The University of the Philippines Press, 2008), 45–6.

[4] J.J. Gonzalez, *Filipino American Faith in Action: Immigration, Religion, and Civic Engagement* (New York: New York University Press; 2009), 2, 16.

[5] R.A. Lagman et al., "'Leaving It to God' Religion and Spirituality among Filipina Immigrant Breast Cancer Survivors" (2014) 53(2) *Journal of Religion and Health* 449.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

approach decisions about health and healing,[6] the expression also helps us to understand why it is often difficult to convince a Filipino patient of the utility of ADs.

An example of such difficulty can be found in studies of Filipinos who have migrated to other countries, as the multicultural context allows observations of cultural differences. In a study of Filipino American patients in the United States, for instance, it was reported that "Filipino Americans who believe that the future is in God's hands may refuse to sign advance directives, even though they may recognise the need for hospice support. That is because signing advance directives would take the decision out of God's hands and would not be acceptable in their belief system".[7]

In addition to disease causation, Filipino cultural attitudes towards the role of the family are also relevant, as can be observed in the way that Filipinos prefer palliative care to be administered. Some academics have observed that "when the patient's condition becomes terminal, the home is usually the preferred place of care [and] . . . many Filipinos take a passive role when they become ill and expect the family to care for them".[8] In fact, decision-making tends to fall upon the eldest male in the family as a matter of responsibility,[9] and it may even be considered irresponsible for the family to allow a vulnerable patient to make acute treatment decisions even when he or she still has decisional capacity. Self-care is generally frowned upon for being contrary to the best interests of the patient.

Thus, we can see that there are pervasive religious and cultural traits that are incompatible with Western notions of individual patient autonomy. In Filipino society, families decide as a unit on matters of healthcare, with the eldest male taking the key responsibility, rather than leaving such decision-making to the individual alone. In addition, decision-making takes place within a context characterised by acceptance of an unforeseen fate (*bahala na*), and people choose to surrender their

[6] Ibid.

[7] P.W. Nishimoto and J. Foley, "Cultural Beliefs of Asian Americans Associated with Terminal Illness and Death" (2001) 17(3) *Seminars in Oncology Nursing* 179.

[8] A.D. Cantos and E. Rivera, "Filipinos" in J.G. Lipson et al. (eds.), *Culture and Nursing Care: A Pocket Guide* (San Francisco: UCSF Nursing Press, 1996).

[9] J.L. McAdam et al., "Attitudes of Critically Ill Filipino Patients and Their Families toward Advance Directives" (2005) 14(1) *American Journal of Critical Care* 17. Although this study is based on Filipino Americans, the phenomenon is representative of Filipino medical decision-making more generally.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

future to God's will when faced with difficult healthcare decisions. Reliance on these traits provides an explanation for the historically minimal discourse on ADs in the Philippines. Whilst the absence of a specific legal framework for ADs may be seen by the broader healthcare community as a deviation from the ideal scenario wherein individual patients' rights are protected, what is being manifested is in fact partiality towards an approach that is family rather than individual oriented and that is informed by religious and cultural sensitivities.

In the next section, we turn to an examination of laws that may be relevant to this discussion, with a brief consideration of ADs in the psychiatric context, which, unlike end-of-life ADs, have been legislated in the Philippines.

10.3 Philippine Legislation on Advance Directives

10.3.1 Advance Directives at the End of Life

Since the current constitution was ratified in 1987, numerous attempts to pass end-of-life AD legislation in both houses of the Philippine Congress have ended up in the archives. In a highly positivistic legal system like that of the Philippines, if there is no explicit law on end-of-life ADs (whether in the form of a statute, case law/jurisprudence or executive issuance), no such law can be considered to exist.[10] However, in situations in which an end-of-life AD is said to exist and needs to be ruled upon, the courts may invoke the following in their decision-making.

1. Cases in foreign legal jurisdictions (particularly those in the United States because of the Philippines' colonial history)
2. Philippine medical societies' codes of ethics
3. International documents to which the Philippines is explicitly or implicitly a signatory

Owing to the influence of the US legal system (its common-law tradition in particular) on the history and development of the Philippine legal system, US court decisions have a persuasive (as opposed to mandatory or binding) effect on legal decisions in the Philippines. In the absence of the country's own court decisions in cases involving ADs,

[10] Although ADs in the end-of-life care context are provided for in a number of professional guidance documents (which are further described in Section 10.4).

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

the Philippine courts may borrow US court decisions in interpreting or applying a provision, especially an unclear one.

Whilst the lack of legislative success with end-of-life ADs paints a murky picture concerning whether such instruments are effective, there are certain situations in which an end-of-life AD may be able to apply. In order for an end-of-life AD to be effective, there will likely need to be a finding of medical futility, as determined by a healthcare professional. However, two further conditions likely also need to be confirmed before an end-of-life AD can become operative: (1) the patient lacks decisional capacity and (2) the patient is unlikely to regain such capacity in the near future (i.e. the loss of decisional capacity is associated with the patient's underlying medical condition and will persist along with it).

10.3.2 Advance Directives in the Psychiatric Context

The closest the Philippines has come to legislative success in relation to ADs is a number of provisions in the National Mental Health Act (NMHA) 2018 (Republic Act No. 11036),[11] which defines ADs and the general conditions under which they may be expressed and implemented. The NMHA was signed into law on 20 June 2018 and took effect on 5 July 2020 after publication of its Implementing Rules and Regulations (IRR). In the chapter on treatment and consent, Section 9 makes specific reference to psychiatric ADs, stating: "A service user may set out his or her preference in relation to treatment through a signed, dated, and notarised advance directive executed for the purpose. An advance directive may be revoked by a new advance directive or by a notarised revocation".[12] The same wording is found in the IRR, where a psychiatric AD is held to be important for establishing the service user's or patient's consent, legal representative and supporters.[13]

With regard to consent, a psychiatric AD is important for documenting the authentic preferences of the patient. In Chapter III, Section 9 of the NMHA, it is indicated that the patient's expressed consent in an AD will also guide the healthcare team on what treatment options can be applied to the patient when he or she suffers a temporary impairment of decision-making capacity, such as in a neurologic or psychiatric emergency.

[11] Mental Health Act 2018.
[12] Ibid., s. 9.
[13] Implementing Rules and Regulations of the Mental Health Act 2018, s. 10.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

With regard to legal representatives, Chapter I, Section 4 states that a representative of legal age may be appointed by a patient in his or her AD. Some of the functions of a legal representative specified in Chapter III, Section 11 are to be consulted on the patient's therapy, to assist the patient in various capacities and to act on the patient's behalf, especially when decision-making is impaired. If the patient fails to appoint a legal representative, the following people shall act as one in the specified order: spouse, children of legal age, parent, a medical director of the mental healthcare facility or someone appointed by the courts.

Finally, with respect to supporters, the patient can appoint up to three people in addition to his or her legal representative, as stipulated in chapter III, section 12 of the NMHA. Supporters may access the patient's medical information, consult the patient regarding treatment and be present during the patient's medical appointments. Appointing supporters can be seen as a way of keeping family members involved in the AD process.

Despite the aforementioned provisions in the NMHA, there is little clarity on how the psychiatric AD regime operates in practice. In a way, what has happened in the Philippines is a case of putting the cart before the horse: the NMHA[14] mentions ADs without the benefit of prior legislation specifically defining and describing the procedures for ADs. For this reason, many challenges can arise from disagreements in interpretations of when ADs are due for implementation after a patient loses mental competence. We explore some of these challenges next.

In situations in which patients appoint (in their written psychiatric AD) someone other than their next-of-kin as their legal representative, the NMHA may come into conflict with next-of-kin laws. Under the Philippine next-of-kin regime, the relative nearest in degree is usually the next of kin, with more distant relatives excluded. The Supreme Court of the Philippines describes this determination of the next of kin in the absence of a spouse as "[F]irst descends, then ascends, and finally, spreads sideways. Thus, the law first calls the descendants, then the ascendants and, finally, the collaterals, always preferring those closer in degree to those of remoter degrees".[15]

The next of kin may decide on the patient's behalf in any kind of case, psychiatric or not. By not observing the Philippine next-of kin laws, the

[14] Mental Health Act 2018, s. 9.

[15] *In the Matter of the Intestate Estate of Cristina Aguinaldo-Suntay* v. *Isabel Cojuangco-Suntay* [G.R. No. 183053: June 15, 2010].

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

decision-making granted by a patient to a legal representative who is not his or her next of kin may be held invalid. Accordingly, the legal representative and anyone else who implements the AD may be sued criminally (for physical injuries, assistance of suicide, homicide or murder) or civilly (torts and damages).

In the event that no next-of-kin is appointed, the appointment of a legal representative may still be questioned because of next-of-kin laws,[16] even in psychiatric cases, and the court will, after a trial, appoint a guardian for the patient. In all cases, regardless of whether any next of kin is appointed and who holds the decision-making power, the court has the power to veto choices made by physicians, parents, legal representatives, agents or guardians. The absence of pertinent jurisprudence regarding whether and how legal representatives trump next of kin in ADs makes it unclear whether the provisions in the IRR allow the appointment of legal representatives to make decisions on patients' behalf.[17]

Despite the potential legal complications, health practitioners and institutions have formulated legal instruments and procedures in the hope of providing themselves with legal protection while offering guidance to all, including patients and their families. Such a hope led to the formulation of guidelines relating to ADs by various Filipino hospitals, as well as guidance points pertinent to emergency healthcare practice during the current pandemic, both of which will be explored in the following section.

10.4 Advance Directives in Hospital Practice

Many hospitals in the Philippines have formulated their own guidelines for allowing, documenting and implementing patient preferences as part of a broader advance care planning process in scenarios that would ideally require ADs owing to patients' loss of decision-making abilities. Although these guidelines are not explicitly supported by AD legislation, they are considered part of good professional practice and are taught to

[16] The courts may invalidate the authority to decide granted by a patient to a legal representative (strictly speaking, a representative designated by the patient in a document, but where the designation is not consistent with next-of-kin laws) if that authority conflicts with an existing law or custom, morality or is contrary to the patient's frame of thought as noticed/known of him or her when he or she still had decisional capacity.

[17] Generally, in ruling on the validity of an AD in the context of the NMHA, the court will rely on other relevant laws (e.g. agency, notarial, contract and wills) owing to the lack of any explicit law providing for the procedures and policies for using ADs.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

medical practitioners and students who work or rotate in clinical settings. There is also long-standing government recognition of professional self-regulation, and the medical community has codified its respect for a patient's right to refuse medical treatment in advance. Professional guidelines are also consistent with the contention that whatever their legal status may be, "advance directives are ethically valuable because they give a voice to patients at a time when their decision-making capacity has been lost" and that "such a voice is essential"[18] in the face of a proliferation of medical technologies that can prolong the process of dying almost indefinitely.

Because the practice of ADs has taken place in the absence of a clear legal framework, it is understood that the instruments are being used without the stakeholders being legally protected from any controversies or liabilities that may arise.[19] However, the guidelines could still have the effect of giving patients and their families confidence in the decision-making process, thereby forestalling legal suits. Thus, they continue to be offered routinely to patients. In the next part, we explore some of the AD guidelines and instruments implemented by various Filipino hospitals.

It is important to note briefly here that the concept of an AD is predicated on the idea that a patient has the right to refuse medical treatment or have it withdrawn by the doctor. Although that right is generally recognised, some hospitals impose conditions and limitations. For example, some imply that the right to refuse treatment is possessed by competent individuals alone,[20] and some explicitly stipulate that the refusal of treatment is permitted only to the extent allowed by law.[21] Such a stipulation is obviously problematic because, as already highlighted in

[18] N. Biller-Andorno et al., "Concluding Remarks" in P. Lack et al. (eds.), *Advance Directives* (New York: Springer, 2014), 204.

[19] In the event of a lawsuit, healthcare professionals still have to be able to show that they were acting on the basis of accepted standards of what is medically useful or what is medically futile in the specific circumstances pertinent to the particular patient. This is the standard by which healthcare professionals can justify their decisions and also by which patients or their families can pursue criminal or civil cases. Therefore, notwithstanding any hospital guidelines, there is still a need for a legal framework providing reliable guidance for patient rights claims and professional accountability.

[20] See, for example, Governor Celestino Gallares Memorial Hospital, "Patients Right", https://gcgmh.doh.gov.ph/patients-and-visitors-corner/patients-right and Karmelli Clinic and Hospital Corporation, "Patients Rights", https://karmellihospital.wordpress.com/patients-rights/.

[21] See, for example, Capitol Medical Center, Inc., "Patient's Guide", www.capitolmedical.com.ph/patients/patients-guide/ and Makati Medical Center, "Patient Reference: Advanced Directives", www.makatimed.net.ph/patient-and-visitor-guide/patient-reference/.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

this chapter, existing laws fail to provide a sufficient legal framework. Further, even when legal provisions are in place, there appears to be room for conflict, for example, in relation to next-of-kin laws.

10.4.1 Types of Advance Directive

Taking their cue from their foreign counterparts, including those in the United States, many hospitals in the Philippines explicitly mention "advance directives", "advanced medical directives", "advance care", "living wills" and/or "do-not-resuscitate" (DNR) orders in promoting the services they make available to patients.[22] For example, The Medical City,[23] a well-known private hospital in the Philippines, provides a detailed discussion on its website, defining an AD as a "written document (form) that tells what a person wants or doesn't want if he/she in the future can't make his/her wishes known about medical treatment".[24] The hospital further describes an AD as detailing what a patient's wishes are depending on his or her condition in the future, for example, in the event that he or she is in an unconscious state, a coma or a state that is likely to be terminal.

Hospitals recognise ADs of different kinds: (1) a living will, (2) declaration to withdraw or withhold treatment and (3) a DNR order.

10.4.1.1 Living Will and Declaration to Withdraw or Withhold Treatment

A living will details a patient's preferred treatments in the case of a serious or terminal illness.[25] The patient's stated wishes may include such details as "comfort measures only", "Do not transfer to ICU" or "Do not give IV antibiotics".[26] A living will does not allow a patient to appoint someone to make decisions on his or her behalf; such appointment is instead enabled by a "special power of attorney for

[22] See, for example, Luzon Medical Center, "Patient's Right", https://luzonmedicalcenter.com/patients-right/ and Bataan St. Joseph Hospital & Medical Center Corp., "Patient's Responsibilities", www.stjosephhospitalbataan.com/patients-responsibilities.

[23] As one of the most prominent hospitals in the country (with multiple branches inside and outside the Metropolitan Manila area), The Medical City sets trends in hospital practices that tend to be followed by others.

[24] The Medical City, "Advance Directives and Do-Not-Resuscitate Orders", www.themedicalcity.com/news/advance-directives-and-do-not-resuscitate-orders.

[25] Ibid.

[26] The Medical City, "Myths and Facts of Palliative Care", www.themedicalcity.com/news/myths-and-facts-of-palliative-care.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

healthcare".[27] A "declaration to withdraw or withhold treatment" is a type of AD mentioned by the Makati Medical Center on its website.[28] Such a declaration is useful in cases where a patient suffers from an incurable condition and life-sustaining treatments would only prolong dying. It seems to be similar to a living will.

The fact that different hospitals offer different types of documents to patients reflects the absence of AD legislation, as well as the expectation that, by giving patients and their families a sense that their decisions are being respected, legal controversies can be minimised. Patients and their families are generally expected to make use of whatever documents are on offer at the institution in question.

10.4.1.2 Do-Not-Resuscitate Order

In addition to a living will and declaration to withdraw or withhold treatment, a DNR order can be implemented in the context of a specific AD. Unlike DNR or do not administer cardiopulmonary resuscitation (DNACPR) orders, which are typically instigated by healthcare professionals on the grounds of futility, a DNR order in this context indicates that the patient does not want CPR if his or her heart or breathing stops.[29] Further, as part of an AD, a DNR order is decided by the patient while competent or by his or her next-of-kin in the event of incompetence.

A cancer-related statement issued by the Tumour Board of Ospital ng Maynila Medical Center Hospital gives doctors four criteria to help them decide when to advise terminally ill cancer patients and/or their guardians to make a DNR order: (1) when there is a high probability of the patient going into cardiopulmonary arrest because of cancer, (2) when the patient is in a vegetative state, (3) when the treatment burdens outweigh the benefits and (4) when the patient and/or guardian wants a DNR order.[30] Such an order is important because in the absence of one, healthcare professionals will continue to administer life-saving treatment.[31] A DNR

[27] See note 24.
[28] Makati Medical Center, note 21.
[29] See note 24.
[30] Ospital ng Maynila Medical Center Hospital Tumor Board, "Statements on Certain Cancer Issues", https://omtumorboard.tripod.com/capalliationmgt.htm.
[31] See, for example, Calamba Doctors' Hospital, "Patients' Rights and Responsibilities", www.calambadoctorshospital.com/patientsguide/rightsresponsibilities and Makati Medical Center, "Patient Rights & Obligations", www.makatimed.net.ph/patient-and-visitor-guide/patient-references/patient-rights-and-responsibilities.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

order instructs healthcare providers not to perform CPR but to continue other treatments.[32] The cessation of other treatments can be specified via a declaration to withdraw or withhold treatment. In the next section, we explore some of the instructions relating to ADs that are typically given by various hospitals to their patients.

10.4.2 Instructions Regarding Advance Directives

This section presents a synthesis of the kinds of instructions on ADs that various hospitals give to their patients.[33] To make an AD, a patient may simply write down his or her preferences, use a doctor-provided form or consult a lawyer.[34] Aside from consulting a lawyer, a patient may also want to talk to his or her doctor, loved ones, caregivers and spiritual advisers.[35] The inclusion of spiritual advisers in the preceding list attests to the importance of religious beliefs in the experience of disease discussed earlier. Doctors usually advise patients to talk to religious authorities to obtain advice and comfort.

Instructions are given that an AD should be made when a patient is still competent to anticipate what decisions ought to be made if he or she loses mental competence.[36] Understandably, the absence of a formal legal framework, even within the NMHA, for determining when decisional capacity has been lost makes it absolutely necessary for the healthcare team to explain how it will be assessed to avoid legal controversy should the family become dissatisfied with certain aspects of the treatment given to the patient.

A DNR order can also be mentioned by a patient to his or her doctor, upon which the doctor writes the order in the patient's medical records.[37] A DNR can also be written on a piece of paper, kept as a card in a wallet or worn as medical jewellery such as a necklace or bracelet.[38]

Patients and their families are also told that any changes made to an AD should ideally be signed and notarised.[39] Notarisation provides legal

[32] Makati Medical Center, note 21; note 26.
[33] However, it should be noted that each hospital publicises its own set of guidelines.
[34] See note 24.
[35] Makati Medical Center, note 21.
[36] Metro Iloilo Hospital and Medical Center, Inc., "Patient's Rights", www.metroiloilohospital.com/patients-rights-and-responsibilities.php.
[37] Makati Medical Center, note 21.
[38] Ibid.
[39] Given that some revocations may occur at the last minute or in otherwise urgent situations, the need to notarise the revocation may be administratively burdensome.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

documentation that the AD has been issued upon the patient's authority. Otherwise, the attending physician or family members should be informed of the changes early on.[40]

Patients are told to bring all of their AD documents with them to every hospital admission, with copies provided to all members of the healthcare team.[41] Some hospitals also tell patients to bring their ADs with them if they want them to be applied during a particular admission.[42] There are also hospitals that stipulate that it is patients' responsibility or obligation to bring their ADs or notify their doctor that they have one.[43] More specifically, notifying healthcare personnel of an AD is part of a patient's responsibility to provide complete and accurate information on his or her health status.[44] Details of an AD are usually verified by the healthcare team by checking with the patient's family, a practice that is very much in line with the emphasis on family in the sociocultural context of the Philippines.

Healthcare professionals are instructed to carefully explain to patients how immensely useful an AD can be. Owing to the lack of AD discourse in Filipino culture, such a careful explanation is a necessary step in healthcare delivery. For example, patients are told that preparing an AD can reduce the stress on their family members and doctors in future healthcare decision-making.[45] It is interesting to note that the detailed instructions provided by various hospitals regarding ADs do not appear

Legislating a comprehensive legal framework for ADs is capable of making the process less burdensome by explicitly removing the requirement for notarisation of the pertinent documents.

[40] See note 24.

[41] Makati Medical Center, note 21.

[42] Bataan St. Joseph Hospital & Medical Center Corp., note 22, and Dr Fe Del Mundo Medical Center, "Patient & Visitor Guide", www.fedelmundo.com.ph/patient-visitor-guide/.

[43] See, for example, Davao Regional Medical Center, "Do You Know Your Responsibilities as a Patient?", https://drmc.doh.gov.ph/patient-s-corner/patient-s-responsibility, and Chong Hua Hospital, "Patient Rights and Responsibilities", http://chonghua.com.ph/index.php/patients_visitors_guide/patient_rights_responsibilities.

[44] San Pablo Colleges Medical Center, "Patients Rights & Responsibilities", www.spcmc.com.ph/patients-rights-and-responsibilities/. Of course, ADs are seen not only as part of a patient's responsibilities, but also as his or her right. Some hospitals explicitly mention the ability to make an AD as a patient's right (see, for example, Bayawan District Hospital, "Patient's Rights", http://bdh-stabayabas.weebly.com/patients-rights.html and Calamba Doctors' Hospital, note 31. An AD is also recognised as part of preserving a patient's dignity (see further Chong Hua Hospital, "Advance Directives", http://chonghua.com.ph/index.php/patients_visitors_guide/advance_directives.

[45] Makati Medical Center, note 21; note 24.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

to align well with the aforementioned *bahala na* philosophy. One potential reason for this lack of alignment is that hospitals see a practical need for such instructions, perhaps to shield themselves from potential liability, a need that is driving education and awareness of ADs despite the absence of a formal legal regime for ADs and the concept being contrary to *bahala na*.

10.4.3 The COVID-19 Context

The onset of the pandemic provided an opportunity for stakeholders such as healthcare professionals, ethicists, social scientists, policymakers and administrators to underscore the importance of ADs in anticipation of situations requiring quick decision-making by healthcare professionals when patients lack competence and their relatives are not readily accessible. In the knowledge that the triage mechanisms in hospitals need to take patients' autonomous choices into consideration and that relatives were barred from hospitals, internists took the initiative to propose guidelines that were then vetted by other stakeholders committed to promoting ethical decision-making in the face of the existing challenges.

The resulting document, known as the Ethics Guidelines on COVID-19,[46] consists of 30 guidelines, including 4 that address situations that could require the use of ADs. The participants in the consultation recognised that healthcare professionals would soon be swamped with emergency cases for which they needed to be armed with documentary evidence of patients' preferred treatment options.

Guideline 2 recognises "the rights of patients to autonomy, transparency, privacy, and confidentiality of personal information" and provides that ADs should be considered upon admission.[47] Consistent with such recognition, Guideline 6 urges that "advance care planning should be initiated at the earliest appropriate time and preferably even before hospital admission … and that the patient … [be] encouraged to accomplish an Advance Directive".[48] The Ethics Guidelines also provide an AD template that is sufficiently specific to offer patients a reasonable indication of possible treatment scenarios and enable specific decisions to be made regarding such options.

[46] University of the Philippines Manila, *Ethics Guidelines on COVID-19: Crisis-Level Hospital Care* (Manila: University of the Philippines Manila, 2020).
[47] Ibid., p. 7.
[48] Ibid., p. 10.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

The Ethics Guidelines also include a template for a substitute decision-maker form for use in cases where the patient lacks the competence to accomplish the equivalent form, which implies that an AD is not meant to address disagreements between patients and their families but rather those between patients (and families) and healthcare providers. The guidelines relating to ADs pertain to situations in which timely communication between patients and their families is impossible because relatives are not allowed to join patients in confinement and treatment or medication has to be given very quickly by a healthcare team that may have no opportunity to obtain consent from a patient who lacks mental alertness or competence. Accordingly, decision-makers have to be guided by what they consider to be medically useful or futile while also hoping that ADs will offer them some protection in the event of legal proceedings.[49] In the remote likelihood of legal proceedings (which are rare in the Philippines), healthcare decision-makers can look forward to being protected by acting on the basis of what is professionally determined to be medically useful or medically futile without having to depend on the existence of ADs.[50] This is probably true even with the preponderance of various legal forms in use in medical institutions.

10.5 Conclusion

Although various Filipino hospitals have developed their own guidelines relating to ADs, professional self-regulation is no substitute for a legal framework providing reliable guidance for patient rights claims and professional accountability. In the absence of a clear legal framework that defines the exact parameters for what can be regarded as acceptable documents, ADs are open to inaccurate interpretation and inconsistent application. Legislating a proper framework for ADs would provide consistency in interpretation and, more importantly, greater confidence in the accuracy of the message that incompetent patients are trying to convey to medical professionals and to their families. A legal framework acquires moral significance not simply because it exists and serves as a

[49] Although the Ethics Guidelines cannot replace existing laws, the courts may rely upon them in determining the legal liability of doctors, if any, in absence of explicit laws on the matter at hand.

[50] In addition, the use of the AD template and substitute decision-maker form can provide persuasive evidence that a directive is indicative of a medically accepted procedure or policy and consistent with professional practice, something that the courts may invoke to determine the intent and legal liability of a party.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press

reliable document in the event of disputes but also because, once it has been sufficiently publicised, people can be presumed to understand that when they write an AD, they know that it will be interpreted in light of the ground rules laid out in the legal framework. The NMHA has signalled to healthcare stakeholders that a legal framework for ADs could serve a useful purpose. In addition to filling a gap in mental healthcare practice, the Act also sends the clear message that legal documents are incomplete without the specific guidance that a legal framework can provide. Moreover, it also provides a legal precedent against which ADs of various kinds in non-mental health contexts can be judged by courts of law in the future. These significant effects of legislation are all the more needed in light of the discussion provided in this chapter regarding the cultural stances to which Filipinos default in healthcare decision-making. The presence of legislation could prompt Filipinos to consider alternative or complementary ways of thinking about such decision-making by themselves or their families.

After all, the importance of the kind of decision-making advocated by ADs is already evident in the way in which hospitals have devised their own ways of justifying and encouraging the use of ADs. In addition to the guidelines of various hospitals, the COVID-19-inspired AD and substitute decision-maker templates constitute initial steps towards formalising and disseminating the use of ADs. However, the Philippines needs to push through with legislation if the full benefits of ADs are to be realised by healthcare professionals and patients alike.

https://doi.org/10.1017/9781009152631.013 Published online by Cambridge University Press