

LAW & SOCIAL POLICY | RESEARCH ARTICLE

Legal and Bioethical Implications of Do Not Resuscitate (DNR) by Doctors in Indonesia

Harmin Sarana¹, Sutarno², Boedi Prasetyo³

^{1,2,3} Department of Law, Sekolah Tinggi Hukum Militer (STHM), Jakarta Timur, Indonesia.

Email: harminasaranasthm1@gmail.com¹, sutarno@hangtuah.ac.id², boedip70@gmail.com³

ARTICLE HISTORY

Received: May 26, 2025

Revised: June 13, 2025

Accepted: June 30, 2025

DOI

<https://doi.org/10.52970/grlspr.v4i2.1337>

ABSTRACT

This paper examines the legal and bioethical implications of Do Not Resuscitate (DNR) decisions made by physicians in Indonesia, using a juridical and literature analysis approach. DNR decisions, which involve withholding or discontinuing life-sustaining treatment, are complex and fraught with legal, ethical, and cultural challenges. In Indonesia, the lack of explicit legal guidance regarding DNR creates significant ambiguity for healthcare professionals. This paper examines the relationship between the legal framework, medical ethics, and cultural influences that shape these decisions. It highlights the role of autonomy, beneficence, impartiality, and justice in ethical considerations surrounding DNR. Furthermore, it considers the influence of Indonesia's largely religious and collectivist culture, which often places family decisions above patient autonomy. Through a literature review and legal analysis, this paper suggests the need for clearer guidelines and greater protections for healthcare providers involved in DNR decisions. It also proposes enhanced bioethics education for medical professionals and increased public awareness of patient rights in end-of-life care.

Keywords: Do Not Resuscitate, Bioethics, Medical Law, Physician Decision Making.

I. Introduction

End-of-life care decisions are among the most challenging aspects of medical practice, requiring physicians to navigate a complex interplay of ethical, legal, and cultural considerations. A crucial element of such care is the "Do Not Resuscitate" (DNR) order, which is an order not to perform cardiopulmonary resuscitation (CPR) in cases of cardiac or respiratory arrest (Aksoy & Ilkilic, 2024; Alias et al., 2024; Yu et al., 2024). While DNR orders are widely recognized in many countries, their implementation in Indonesia presents unique challenges due to the country's diverse legal, cultural, and religious landscape. In Indonesia, the legal framework governing end-of-life decisions remains ambiguous, often placing healthcare providers in a difficult position. Doctors must balance their professional duty to preserve life with respect for patient autonomy and the principles of beneficence and non-maleficence (Nuraeni et al., 2024). However, the absence of explicit laws or guidelines regarding DNR orders often creates legal uncertainty and ethical dilemmas, which are further complicated by a lack of public awareness and understanding of such directives (Desdiani et al., 2024; Larasati et al., 2024).

Indonesia's legal framework regarding end-of-life decisions, particularly Do Not Resuscitate (DNR) orders, remains unclear, creating challenges for healthcare providers who must navigate ethical and legal uncertainty. This ambiguity is compounded by a lack of public awareness and understanding of such orders,



which complicates the balance between preserving life and respecting patient autonomy. The absence of explicit laws or guidelines regarding DNR orders often places physicians in a difficult position, as they must reconcile their professional duties with ethical principles such as beneficence and non-maleficence. The Indonesian healthcare system currently lacks clear legal guidance on advanced medical directives (AMDs), including DNR orders, complicating end-of-life care decision-making for healthcare providers. (Alias et al., 2024). Dominant medical paternalism often overrides patient autonomy, a crucial aspect of informed end-of-life decision-making. (Alias et al., 2024; Desdiani et al., 2024).

In addition, patient autonomy within Indonesia's National Health Insurance system remains largely underutilized, with paternalism dominating healthcare decision-making. (Desdiani et al., 2024) Public awareness and understanding of end-of-life directives are also limited, hindering their effective implementation and respect for patient choices. (Desdiani et al., 2024; Larasati et al., 2024) Therefore, the integration of AMD into Indonesia's healthcare framework is recommended to ensure better management of medical resources and promote a more inclusive healthcare system. (Alias et al., 2024) Legal reform is also needed to clarify legal uncertainties and support healthcare providers in making ethically sound decisions. (Alias et al., 2024; Farnesty et al., 2024). From a bioethical perspective, DNR decisions involve fundamental principles, including patient autonomy, consent, and the right to die with dignity. (Toy et al., 2024) However, these principles can conflict with deeply rooted cultural and religious values in Indonesia, which often prioritize the sanctity of life and may discourage discussion of death and dying. (Akhtar et al., 2024; Alias et al., 2024) This cultural context creates additional barriers to the implementation of DNR orders, as patients, families, and even healthcare providers may struggle to reconcile ethical ideals with societal norms.

This paper aims to analyze the legal and bioethical implications of DNR decisions by physicians in Indonesia through a juridical and literature-based approach. It explores the existing legal framework, bioethical principles, and cultural influences that shape end-of-life care in Indonesia. By identifying gaps in regulations and practices, this study seeks to provide insights and actionable recommendations to improve clarity, consistency, and ethical soundness in DNR decision-making in Indonesia. The main objectives of this study are as follows:

- a. Analyzing the legal framework surrounding Do Not Resuscitate (DNR) decisions in Indonesia, identifying existing regulations and gaps in the law that influence the decision-making process in the healthcare sector.
- b. To explore the bioethical implications of DNR decisions, focusing on the principles of autonomy, beneficence, non-maleficence, and justice, and how these principles are applied or challenged in the Indonesian context.

To examine cultural and religious factors that influence DNR decisions, particularly in relation to the collectivist nature of Indonesian society and its impact on patient autonomy and family involvement in end-of-life care.

II. Research Method

This study uses a normative juridical approach, complemented by a comprehensive literature review, to analyze the legal and bioethical implications of "Do Not Resuscitate" (DNR) decisions by physicians in Indonesia. The normative juridical approach focuses on examining relevant laws, regulations, and legal principles to assess their adequacy and applicability in DNR decision-making in the Indonesian healthcare context. By integrating legal analysis with bioethical considerations, this study seeks to explore the balance between patient rights, medical autonomy, and ethical responsibilities in end-of-life care. This study employed a qualitative design, aiming to provide an in-depth analysis of the intersection between legal norms and bioethical considerations. It employed descriptive and analytical methods to evaluate the existing legal framework, ethical principles, and their practical implications in the healthcare sector. This approach allows

for a comprehensive assessment of how Indonesian law and ethical guidelines influence physicians' decision-making processes regarding DNR orders. Data for this study were collected from two primary sources. Primary legal materials include Indonesian laws, regulations, and court decisions related to healthcare, patient rights, and end-of-life care, such as the Health Law (Law No. 36 of 2009), the Medical Practice Law (Law No. 29 of 2004), the Health Law (Law No. 17 of 2023), and professional ethics guidelines issued by the Indonesian Medical Association. Secondary legal materials consist of academic journals, books, and articles discussing the legal and bioethical aspects of DNR decisions in both national and international contexts, providing a comparative perspective and theoretical basis for analyzing DNR practices.

III. Results and Discussion

3.1. Legal Framework for DNR Decisions in Indonesia

The decision to "Do Not Resuscitate" (DNR), or not to perform medical resuscitation on a patient in a terminal or incurable condition, poses significant challenges in medical law in Indonesia. Although the Health Law (Law No. 36 of 2009) and the Medical Practice Law (Law No. 29 of 2004) provide the legal basis for patient rights and medical personnel obligations, neither regulation specifically regulates DNR decisions. As a result, medical personnel often face uncertainty regarding the procedures, criteria, and legal protections associated with DNR decisions, which can have significant legal and ethical consequences.(Sanjaya, 2024). Thus, the emergence of the Law on Health (Law No. 17 of 2023). The importance of legal protection for physicians making DNR decisions is a major concern. Without clear legal guidelines, medical professionals are at risk of facing legal and ethical dilemmas. Although the principle of patient autonomy underpins DNR decisions, their implementation is often hampered by concerns about potential lawsuits if the patient's family disagrees with the decision.(Putra & Hufon, 2024)The conflict between patient autonomy and family wishes is a major obstacle, necessitating more specific legal reforms and guidelines that support this practice ethically and legally.(Sagala et al., 2022; Susanti et al., 2024).

Other factors that influence DNR decisions include patient and family beliefs, resource limitations, and perceptions of the futility of medical intervention.(Wijilestari et al., 2022). Public awareness of the concept of a dignified death and life satisfaction has a positive correlation with attitudes towards DNR decisions, so education and awareness-raising programs are important in improving this decision-making process.(Lee, 2023)To address these challenges, Indonesia is advised to develop specific legal guidelines that cover procedures, decision-making criteria, and legal protection for medical personnel.(Sanjaya, 2024; Wijilestari et al., 2022). In addition, training on end-of-life ethics and DNR decision-making for medical personnel is important to improve ethical compliance and provide better services to patients.(Sagala et al., 2022; Susanti et al., 2024).

3.2. Ethical Implications of DNR Decisions

DNR decisions are closely linked to fundamental principles of bioethics, including patient autonomy, beneficence, non-maleficence, and justice. In Indonesia, the implementation of these principles is often hampered by cultural, social, and religious factors that influence views on life and death.

a. Patient Autonomy

The principle of autonomy states that patients have the right to make decisions about their own medical care, including the decision to discontinue treatment that is not providing benefit. However, in the Indonesian context, patient autonomy is often hampered by family intervention. A strong collectivist culture, in which families play a central role in medical decision-making, often overrides patients' wishes. (Desdiani et al., 2024)This has the potential to create tension between the patient's right to self-determination and the wishes of the family, who may prefer to continue treatment even if there is no hope of recovery. (de Pediatría

& Subcomisiones, 2024). Patient autonomy refers to an individual's right to make medical decisions regarding their own body and health. In the context of a DNR order, a terminally ill patient has the right to refuse resuscitation to avoid unnecessary suffering. This principle is a cornerstone of many global healthcare systems, particularly in countries that have adopted Advance Directives or Living Wills as legal documents guaranteeing patients' rights to determine end-of-life care.

However, in practice in Indonesia, patient autonomy is often hampered by interventions from family and medical personnel. In Indonesia, patient autonomy, particularly in end-of-life care, is often compromised by cultural norms and the involvement of family and medical personnel. A strong collectivist culture results in family members playing a significant role in medical decision-making, sometimes overriding the patient's explicit wishes. This cultural dynamic, coupled with the lack of a clear legal framework regarding Do Not Resuscitate (DNR) orders, creates a conflict between the patient's right to autonomy and family decisions, ultimately impacting the patient's right to receive care consistent with their values and preferences. To address this challenge, broader education about patient rights and the establishment of a legal framework that recognizes and protects DNR decisions based on competent patient consent are needed. (Alias et al., 2024; Anggra, 2024).

In addition to cultural challenges, legal ambiguity also hinders the implementation of DNR decisions in Indonesia. Unlike the UK, which has a clear legal protocol regarding DNR, Indonesia still lacks specific regulations to support these decisions, making it difficult to uphold patient autonomy in end-of-life care. (Anggra, 2024) Therefore, legal reform is a crucial step in ensuring that DNR decisions can be implemented ethically and in accordance with international standards. Furthermore, increasing awareness and education regarding patient rights, both among healthcare professionals and the public, is key to respecting patient autonomy. (Desdiani et al., 2024; Lee, 2023). The implementation of Advanced Care Planning (ACP) can also be a solution in protecting patient rights by allowing individuals to express their wishes regarding end-of-life care early on, as has been implemented in several other Asian countries. (Lee, 2023) While it is important to increase patient autonomy, these legal and educational reforms must be implemented gradually while still taking into account cultural values that prioritize family involvement in medical decisions, in order to achieve a balance between individual rights and social dynamics. (Bhatti et al., 2025; Lee, 2023).

b. Beneficence and Non-Maleficence

The principle of beneficence requires medical personnel to act in the best interests of the patient, while the principle of non-maleficence requires them not to cause harm to the patient. In the case of DNR, these two principles can conflict. (Yu et al., 2024). Often, even though resuscitation does not provide significant medical benefit to a terminally ill patient, medical personnel still feel compelled to attempt medical intervention because of their obligation to "save lives." The decision to discontinue treatment may be perceived as avoiding further harm, either physical or psychological, to the patient. (Putra & Hufon, 2024; Yu et al., 2024). Therefore, it is important to consider not only the medical effects of the decision but also the patient's quality of life and respect for their wishes. In bioethics, the principle of beneficence requires that medical professionals act for the benefit of the patient, while non-maleficence emphasizes that they should not cause unnecessary harm. In the case of DNR, these two principles can conflict.

1) From the perspective of beneficence

The decision not to perform resuscitation can be considered an action that promotes the patient's well-being. Cardiopulmonary resuscitation (CPR) in terminally ill patients often provides no significant benefit and can actually cause greater suffering, such as rib fractures or brain damage due to lack of oxygen. The decision not to perform resuscitation, particularly in terminally ill patients, can be understood in the context of beneficence as an action that prioritizes the patient's well-being by reducing unnecessary suffering. Cardiopulmonary resuscitation (CPR) in such cases often provides no significant benefit and can actually cause physical injury or neurological damage. This perspective aligns with the principle of beneficence in medical

ethics, which emphasizes that medical action should benefit the patient and avoid unnecessary suffering. (Alshawaf et al., 2024).

In the decision-making process, physicians must balance the benefits and risks of resuscitation measures while considering the patient's quality of life and dignity. Ethical dilemmas often arise when the principle of beneficence clashes with patient autonomy, particularly in end-of-life care, where the patient's preferences and quality of life should be the primary considerations. (Alshawaf et al., 2024) From a legal and cultural perspective, the implementation of Do Not Resuscitate (DNR) varies widely across countries. In the UK, DNR decisions are protected by robust legal protocols to ensure compliance with patient rights and medical ethics, while in Indonesia, the lack of specific regulations regarding DNR remains a barrier to its implementation. Cultural and religious factors also influence public perception of this decision, often encouraging aggressive medical treatment even when the patient's prognosis is unfavorable. (Anggra, 2024) The lack of clear legal guidelines can also complicate the implementation of DNR decisions, necessitating regulations that are more sensitive to cultural aspects while respecting patients' rights to autonomy. (Anggra, 2024) In clinical practice, research on extracorporeal cardiopulmonary resuscitation (ECPR) shows that the decision to withhold or withdraw life-saving therapy is often based on poor prognosis, particularly regarding the patient's neurological status. (Naito et al., 2023) This highlights the importance of a thorough neurological evaluation and ethical considerations in determining whether resuscitation is still appropriate or will actually increase the patient's suffering. (Naito et al., 2023).

2) Non-maleficence perspective

Resuscitation in patients with a poor prognosis can be categorized as actions that cause more harm than benefit. In this situation, a DNR decision can be considered a form of avoiding aggressive medical interventions, but it does not improve the patient's quality of life. The decision to implement Do-Not-Resuscitate (DNR) in patients with a poor prognosis is often based on the principle of non-maleficence, which emphasizes the importance of avoiding actions that could cause harm. In many cases, resuscitation can actually prolong suffering without improving the patient's quality of life, so the DNR decision is considered a step to prevent aggressive medical interventions that do not provide significant benefit. This perspective is supported by various factors and ethical considerations discussed in the literature. One prognostic tool used in DNR decision-making is the GO-FAR score, which helps predict the likelihood of survival with good neurological outcomes after in-hospital cardiac arrest. This tool allows for more informed decision-making by identifying patients with a low chance of survival, thus avoiding futile resuscitation efforts. (Alao et al., 2024).

Furthermore, DNR decisions also face ethical and legal dilemmas, particularly for nurses who must balance patient care with moral and legal obligations. Factors such as religious beliefs, life expectancy, and resource constraints also influence how these decisions are made. (Susanti et al., 2024; Wijiwisata et al., 2022). Patient and family involvement in the decision-making process is a crucial aspect, ensuring that DNR decisions align with the patient's wishes and medical ethical standards. (Wijilestari et al., 2022). In terms of impact, a DNR order aims to prevent invasive procedures that do not contribute to improving the patient's quality of life, especially for those in terminal conditions where resuscitation will not result in a meaningful recovery. (Coulden & Cairns, 2024) Public awareness of the concept of well-dying and life satisfaction also has a positive correlation with more supportive attitudes toward DNR decisions, so educational programs and awareness-raising are important in improving the decision-making process regarding end-of-life care. (Lee, 2023). However, implementing these two principles is not always easy. Many medical personnel in Indonesia still feel obligated to "do everything possible" to save a patient's life, as they face significant social and legal pressure. Furthermore, the fear of legal action from families who disagree with DNR decisions also makes medical personnel hesitant to implement this policy.

c. Justice: Equal Access to Care

DNR decisions must also be viewed within the context of social justice. In a limited health system, especially when faced with expensive intensive care, equity in the distribution of resources is crucial. The

decision to perform or withhold resuscitation can be influenced by economic considerations and the distribution of medical resources. However, equity concerns not only the distribution of resources but also the fair treatment of patients without discrimination based on social, economic, or other factors. (Herrington et al., 2024; Shah et al., 2024). Therefore, policymakers must ensure that DNR decisions are implemented fairly and transparently, while respecting the patient's rights and dignity. In the context of DNR, the principle of justice refers to the fair distribution of medical resources and the equal treatment of all patients. In resource-constrained health systems, the decision not to resuscitate can be part of a more equitable allocation strategy. From a resource efficiency perspective, resuscitation often requires intensive care units (ICUs), ventilators, and trained medical personnel. When performed on patients with a very poor prognosis, this procedure can prevent other patients with a better chance of recovery from receiving the care they need. From a social justice perspective, DNR decisions must be implemented fairly and non-discriminatory. Every patient, regardless of their social, economic, or background status, should have the equal right to choose not to undergo resuscitation if they feel it is inconsistent with their wishes and values. However, in practice in Indonesia, DNR decisions are often not made based on principles of justice. Economic factors, the availability of facilities, and even the financial capacity of the patient's family can influence whether these decisions are respected. Therefore, clearer guidelines and an oversight system are needed to ensure that DNR decisions are based on medical and ethical considerations, not financial factors or discrimination.

d. Responsibilities of Medical Personnel in Implementing DNR

Healthcare professionals have a moral, ethical, and professional responsibility in implementing DNR decisions. They must ensure that these decisions are based on the informed consent of a competent patient, or, in the case of patients unable to make their own decisions, on transparent discussions with the patient's family and in accordance with bioethical principles. Some of the main responsibilities of medical personnel in implementing DNR include:

- 1) Provide clear information to patients and families regarding the patient's condition, prognosis, and the consequences of resuscitation measures and DNR decisions.
- 2) Assist patients and families in making decisions based on medical facts and patient values, not just on unrealistic expectations.
- 3) Clearly document the DNR decision in the medical record to avoid misunderstandings and ensure compliance in medical practice.
- 4) Implementing DNR decisions with empathy and ensuring that patients continue to receive optimal palliative care to reduce pain and provide comfort at the end of life.

In practice, many medical personnel in Indonesia face ethical dilemmas when dealing with terminally ill patients. Without clear national guidelines on DNR procedures, medical personnel are often forced to make decisions based on personal interpretation or hospital policies, which can vary from one healthcare facility to another.

3.3. The Influence of Culture and Religion on DNR Decisions

In Indonesia, medical decision-making is heavily influenced by cultural and religious factors. Indonesia's collectivist culture, which places a high value on family, often results in medical decisions being influenced more by the family's wishes than by the patient's individual decisions. Furthermore, religious factors also play a significant role in life-and-death decisions.

a. Influence of Religion

In Indonesia, the majority of the population is Muslim, who have a particular view of life and death. In Islamic teachings, life is considered a gift from God, and all medical efforts are considered an effort to

preserve life. Therefore, the decision not to perform resuscitation may be considered contrary to religious values that teach the importance of life-saving efforts. Likewise, other religions in Indonesia, such as Christianity, Hinduism, and Buddhism, generally view life as a gift and place great value on medical efforts to preserve life. (Kusuma et al., 2024; Saputra et al., 2024). Therefore, the DNR decision can be seen as a difficult decision to accept in Indonesia's religious society.

b. Cultural Influence

On the other hand, Indonesian culture, which highly values family harmony, often results in medical decisions involving the patient's family more than the patient themselves. In many cases, families will decide not to implement a DNR due to emotional reasons, fear of loss, or an inability to accept that the patient may no longer have a realistic life expectancy. (Alias et al., 2024). This cultural influence can hinder acceptance of the principle of patient autonomy, which should be the basis for medical decision-making regarding DNR. (Desdiani et al., 2024).

3.4. Comparison with Other Countries

In countries with more developed legal and ethical frameworks, such as the United States, the United Kingdom, and the Netherlands, the implementation of DNR decisions is clearer. These countries have regulated DNR decisions within clear medical guidelines and provide legal protection for medical personnel who implement these decisions according to agreed-upon procedures. In the United States, for example, the legal system allows DNR decisions to be regulated in legal documents such as Living Wills or Advance Directives, which give patients the right to specify their preferences regarding future medical care. Furthermore, DNR decisions are protected by law there, so medical personnel need not worry about lawsuits if they implement the decision in good faith. (Fazail, 2024; Ramadianto & Imaniyati, 2024). In Indonesia, although the principle of patient autonomy is recognized in law, its implementation in medical practice remains limited and often ambiguous. Therefore, stronger legal reforms are needed to clearly regulate DNR decisions, taking into account the country's cultural and religious context.

IV. Conclusion

The issue of Do Not Resuscitate (DNR) decisions in Indonesia requires a balanced approach that integrates legal, ethical, and cultural perspectives. The current legal framework provides limited guidance on DNR, creating uncertainty among healthcare providers. Bioethical principles, including patient autonomy, beneficence, and non-maleficence, play a crucial role in the decision-making process, but cultural influences, particularly family involvement and religious beliefs, often complicate the process. The legal ambiguity surrounding DNR decisions can create ethical dilemmas for physicians, potentially putting them at risk of legal liability. To address these challenges, Indonesia needs to establish clearer legal guidelines that protect patients' rights and the decision-making process of healthcare professionals. Furthermore, there is an urgent need for comprehensive bioethics education for healthcare providers and efforts to raise public awareness of patient rights, particularly regarding end-of-life care. This will ensure a more transparent, respectful, and ethically sound approach to DNR decision-making within the Indonesian healthcare system.

References

- Akhtar, M. U., Bhatti, M. E., & Fredericks, S. (2024). What factors influence patient autonomy in healthcare decision-making? A systematic review of studies from the Global South. *Nursing Ethics*, 09697330241272794.
- Aksoy, E., & Ilkilic, I. (2024). Medical utility at the end of life: the first qualitative study of ethical decision-making methods among Turkish doctors. *BMC Medical Ethics*, 25(1), 122.

- Alao, D.O., Abraham, S., Dababneh, E., Roby, R., Farid, M., Mohammed, N., Rojas-Perilla, N., & Cevik, A.A. (2024). Do-not-attempt-resuscitation decision making: physicians' recommendations differ from the GO-FAR score predictions. *International Journal of Emergency Medicine*, 17(1), 86.
- Alias, F., Martina, D., Susila, ME, & Anggriawan, R. (2024). Preserving patient autonomy at the end of life: A legal appraisal of the position of advanced medical directives in Malaysia and Indonesia. *Malaysian Journal of Sharia and Law*, 12(2), 296–310.
- Alshawaf, AH, Alghamdi, AS, Shaikh, AA, Kabli, MF, Binobaid, AO, & Alshabib, ZA (2024). Ethical Considerations in End-of-Life Decision Making: Balancing Autonomy and Beneficence. *Methodology*, 2(3), 5.
- Anggra, P. (2024). The Urgency of Legal Regulation for Do Not Resuscitate Orders in the Indonesian Healthcare System: A Comparative Study with the United Kingdom. *Journal of Law, Politics and Humanities*, 5(1), 592–600.
- Bhatti, M. O., Hamza, A., & Eman, N. U. (2025). Withholding diagnostic and prognostic information from patients in Pakistan: ethical and cultural perspectives. *JPMA. The Journal of the Pakistan Medical Association*, 75(2), 358.
- Coulden, A., & Cairns, H. (2024). Do early DNACPR decisions prevent inappropriate CPR attempts? *Resuscitation*, 195.
- De Pediatría, S.A., & Subcomisiones, C. (2024). Entre el paternalismo médico y la autonomía de los pacientes: 25 siglos de historia. *Arch Argent Pediatr*, e202310297.
- Desdiani, D., Mulatsih, S., & Puspendari, DA (2024). Implementation of Respect for Autonomy in Hospital Services Within the Indonesian National Health Insurance System. *National Journal of Community Medicine*, 15(10), 830–841.
- Farnesty, E., Sari, FRS, Dzaky, R., Septia, RB, Alayya, SM, & Adinda, VK (2024). Legal professional ethics: Revealing violations of the code of ethics in lawyer bribery cases. *Journal of Law, Education, and Social Humanities*, 105.
- Fazail, IP (2024). Key Characteristics of Autonomy, Confidentiality, Beneficence, Non-maleficence, Justice, and Privacy Principles in Medical Law within the Context of Human Rights.
- Herington, J., Shand, J., Holden-Wiltse, J., Corbett, A., Dees, R., Ching, C.-L., Shaw, M., Cai, X., & Zand, M. (2024). Investigating Ethical Tradeoffs in Crisis Standards of Care through Simulation of Ventilator Allocation Protocols. *MedRxiv*.
- Kusuma, AS, Wiryanto, FS, & Widodo, P. (2024). Analysis of the Rapid Response Action Controversy Based on the Maqashid Syariah Perspective. *Indonesian Journal: Informatics and Communication Management*, 5(3), 2484–2495.
- Larasati, T., Fardiansyah, AI, Saketi, D., & Dewiarti, AN (2024). The Ethical and Legal Aspects of Health Policy on Electronic Medical Records in Indonesia. *Cepalo*, 8(2), 103–112.
- Lee, H.-R. (2023). Factors Influencing DNR(Do-Not-Resuscitate) Decisions in General Adults. *Korean Association For Learner-Centered Curriculum And Instruction*. <https://api.semanticscholar.org/CorpusID:264064260>
- Naito, H., Sakuraya, M., Hongo, T., Takada, H., Yumoto, T., Yorifuji, T., Hifumi, T., Inoue, A., Sakamoto, T., & Kuroda, Y. (2023). Prevalence, reasons, and timing of decisions to withhold/withdraw life-sustaining therapy for out-of-hospital cardiac arrest patients with extracorporeal cardiopulmonary resuscitation. *Critical Care*, 27(1), 252.
- Nuraeni, R., Tampubolon, MT, Atmoro, A., Habib, H., & Handono, T. (2024). Same-Sex Marriage: A Review of Rights and Obligations Under the Marriage Law. *Journal Syntax Admiration*, 5(10), 4207–4218.
- Putra, YRP, & Hufron, H. (2024). Legal Responsibilities of Doctors in Terminating Life-Sustaining Therapy for Terminal Patients. *Activa Juris: Jurnal Hukum*, 4(2).
- Ramadianto, AY, & Imaniyati, NS (2024). Legal Certainty of Patients' Right to Autonomy Protection in High-Risk Health Services. 2(03), 269–278.
- Sagala, R., Agustina, HR, & Pahria, T. (2022). Decision-making regarding do-not-resuscitate end-of-life patients from a family perspective. *HEALTH SCIENCE MEDIA*. <https://api.semanticscholar.org/CorpusID:264576945>
- Sanjaya, G. (2024). LEGAL REVIEW OF DOCTORS IN IMPLEMENTING DO NOT RESUSCITATE (DNR) DUE TO LIMITED VENTILATOR DEVICES. *Tambusai Health Journal*, 5(4), 10485–10500.
- Saputra, A., Rahman, NA, & Kurniati, K. (2024). The Death Penalty: The Dilemma Between the Maslahat Mursalah and Human Rights in Indonesia. *ALADALAH: Journal of Politics, Social, Law and Humanities*, 2(4), 148–159.
- Shah, K., Neshatvar, Y., Shum, E., & Nayan, M. (2024). Optimizing the fairness of survival prediction models for racial/ethnic subgroups: A study on predicting post-operative survival in stage IA and IB non-small cell lung cancer. *American Society of Clinical Oncology*.
- Susanti, A., Paramitasari, KC, Putra, KAD, Cintariasih, P., Suryani, NW, & Wulandari, IAP (2024). Ethical Dilemma of Do Not Resuscitation (DNR) in Nursing Practice. *Babali Nursing Research*, 5(2), 370–385.
- Toy, S. M., Ndoen, E. M., & Ndun, H. J. N. (2024). Traditional beliefs and practices of postpartum care in rural East Nusa Tenggara, Indonesia. *International Journal of Public Health Science (IJPHS)*, 13(4), 1783. <https://doi.org/10.11591/ijphs.v13i4.24294>

Wijilestari, MI, Suharso, YL, & Nugroho, HP (2022). Description of Factors Influencing Do Not Resuscitate (DNR) Decisions and Their Legal Consequences. *Soeptra Journal of Health Law*, 8(2), 164–176.

Yu, S.-Y., Lee, Y., Shin, S. J., Woo, G., Kim, D., Kwon, J. H., & Suh, E. E. (2024). Navigating Shared Decision-Making after the Life-Sustaining Treatment Decision Act: A Qualitative Study by In-Depth Interviews with Terminal Cancer Patients, Families, and Healthcare Professionals.