



Regulatory Vacuum and Clinical Practice Gap in Do Not Resuscitate (DNR) Implementation: A Normative Legal Analysis of Indonesian Health Law

Yuri Sadewo^{1*}

Universitas Islam Nusantara
Bandung,
Indonesia

**Yusuf Alim
Musthofa Anwar²**

Universitas Islam Nusantara
Bandung,
Indonesia

Arman Lany³

Universitas Islam Nusantara
Bandung,
Indonesia

***Corresponding author:**

Yuri Sadewo, Universitas Islam Nusantara
Bandung, Indonesia
✉ Yurisdewo@gmail.com

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Abstract

Background: Some legislation does exist in Indonesia concerning DNR (Do Not Resuscitate), but none offers procedural guidance on whether or how it should be implemented.

Objective: This study provides an overview of DNR in Indonesia from a legal standpoint, religious and cultural perspectives, the implementation process in healthcare facilities, determination and documentation process, as well as obstacles during its implementation.

Research Method: This research use normative legal sources (*Permenkes No. 37/2014, Law No.29/2004 about Medical Practice, KODEKI*) and secondary source. Which deals with the analysis of legal texts, legal documents as well as normative factors and principles to discern relevant laws.

Results: The results show the complexity of the status of DNR which is still a debate in Indonesia. Although DNR is acknowledged as a part of patient rights, details regulation are still considered vague or uncertain (Health Minister Regulation No. 37 year 2014 and Health Law No. 36 year 2009). Other challenges include limited understanding among healthcare providers and the public, and problems in communication with the families of patients. DNR-related decisions are also affected by influence of religious perspectives and cultural norm particularly within the Muslim majority context. Ensuring correct procedures for deciding and recording DNR relies on effective communication, and sufficient documentation.

Conclusion: The optimal counterpart is that Indonesia needs and deserves a specific ministerial regulation on DNR, which harmonizes patient autonomy rights with Islamic bioethical principles whilst also providing procedural clarity to eliminate the existing legal ambiguity for health care providers.

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INTRODUCTION

A Do Not Resuscitate (DNR) is a medical order that indicates patients who experience cardiac or respiratory arrest will not have resuscitation measures such as cardiopulmonary resuscitation (CPR). So the introduction of a DNR is rarely black & white; there are often nuanced ethical issues to consider, particularly with patients whom you cannot communicate with

including coma or end stage dementia patients. Here, family support is a very depending purpose despite that they usually act as an alternate selector who insists on the patient (Fritz & Fuld, 2010; Susanti et al., 2024).

Although DNR implementation in Indonesia is still faced with many ethical and legal challenges. The key problem is the absence of knowledge and socialization about DNR that are owned by medical workers and society. This condition forces many family to decide DNR decision, although they are not really understanding and comprehending about DNR decision (Susanti et al., 2024). Moreover, the family may perceive DNR decision very differently due to culture and social value which creates an integrated conflict between patients request and are one (Schofield et al., 2021).

Legally, the rules of DNR in Indonesia have not been clearly established, so it can lead to confusion and uncertainty for medical workers in carrying out this order. In the absence of a solid legal framework for DNR implementation can lead to complications for health workers if their decision dashes with that of family (Fernandes & Moreira, 2013; Palmryd et al., 2025). By that notion, the DNR regulation on ethical and legal background based approach is essential in order to make sure that all steps taken can safeguard both the autonomy of the patient, as well as protect families rights and medical personnel. Therefore we need to improve regulation on DNR in Indonesia as ethical, just and law-abiding decisions may have been made with respect to end-of-life care.

This research problem encompasses unrelated perspectives among DNR (do not resuscitate) in Indonesia. What is the legal perception that will be rules and lead the optimal practice of DNR, including legal consequences arises Next, religious and cultural perspective will be addressed since already-formed values can either enable or inhibit the acceptance of the DNR idea. Exploring mechanisms and policies on the implementation of DNR in health facilities is also essential. DNR order and documentation protocols are also important aspects of having one to have the order respected. The challenges faced in implementing DNR domestically (law, culture and practice in the field) We hope that by highlighting these five points, we can help to paint a full picture of DNR in the Indonesia context.

Previous studies on DNR in Indonesia and Muslim-majority contexts are positioned as follows, Wijaya et al. (2022) examined ethical dilemmas in Indonesian DNR management, finding that healthcare providers face significant confusion but attributing this to cultural and religious factors rather than examining the legal framework's adequacy a dimension this study addresses. Susanti (2024) documented nursing practice dilemmas but focused on practitioner-level challenges without analyzing the normative legal sources of those dilemmas. Sarana et al. (2025) examined Islamic perspectives on DNR in Indonesia but did not systematically compare Indonesian positive law with Islamic bioethical norms for norm conflict identification. Memiş (2022) addressed religious views on DNR from a theological perspective. None of these studies systematically analyzed the normative legal gap between Indonesian statutory provisions and clinical DNR practice requirements, or compared Indonesian regulatory adequacy with Muslim-majority comparator jurisdictions. This study fills that gap.

This study addresses these gaps through normative legal research, an approach that analyzes law as it should be applied and understood, focusing on the internal coherence of legal norms, identification of legal vacuums, and resolution of norm conflicts through doctrinal analysis. This methodological orientation means the study examines whether existing Indonesian legal norms are adequate (not merely whether they are known or followed), and proposes regulatory solutions grounded in legal doctrinal reasoning.

METHOD

Normative legal research is a method that focused the in analysing and understand of relevanted legal principles based on law texts. This research will consider legislation, court decisions and specialized literature on the subject in this context. Conducting this research is, therefore, a study of normative aspects i.e. in other words; you are interested in the application and understanding of the law. Researchers will glean and enumerate textual categories in law as modules for formal arguments. That is to say, bad normative legal research attempts (and arguably fails) to distill what the law was in a specific context and how those norms are enforced.

All statutory provisions relevant to DNR in Indonesia are identified through systematic review of Law No. 17/2023, Permenkes No. 37/2014, Law No. 29/2004, and KODEKI, with specific attention to provisions addressing patient autonomy, informed consent, medical records, and end-of-life care. Provisions are analyzed for the presence or absence of explicit DNR procedural guidance identifying where the law is silent, ambiguous, or internally inconsistent. Provisions on patient autonomy are compared with Islamic bioethical norms derived from MUI fatwa guidance and fiqh literature to identify points of norm conflict. Doctrinal arguments are constructed for proposed regulatory reform in the form of a dedicated Ministerial Regulation (Permenkes) on DNR, using the statutory interpretation method of teleological construction.

Primary Legal Sources including (1) Law No. 17 of 2023 concerning Health (replacing Law No. 36/2009); (2) Ministerial Regulation (Permenkes) No. 37 of 2014 concerning the Determination of Death and Organ Donation; (3) Law No. 29 of 2004 concerning Medical Practice; (4) Indonesian Code of Medical Ethics (KODEKI) 2012; (5) MUI Fatwa on Medical Ethics and End-of-Life Care (relevant fatwas); (6) Government Regulation No. 47 of 2021 concerning Health Services at Hospitals. Moreover, Secondary Legal Sources including legal textbooks and academic journals on patient rights, DNR law, and bioethics including (Sarana et al., 2025; Susanti et al., 2024; Wijaya et al., 2022).

Data collection technique is library research and documentation study of statutory regulations, accessed through the Ministry of Law and Human Rights' JDIH database (jdih.kemerkumham.go.id), the Indonesian Supreme Court legal documentation system, and international academic databases (Scopus, PubMed) for comparative literature. For analytical technique using descriptive-analytical legal interpretation describing the existing normative framework and then analyzing its internal consistency, identifying legal vacuums, and proposing doctrinal solutions.

RESULTS AND DISCUSSION

Legal Views in Indonesia Regarding DNR

a. Legal status of DNR in Indonesia: Is DNR legally recognized and regulated?

In Indonesia, the legal status of Do Not Resuscitate (DNR) remains a complex and often debated topic. Although DNR is recognized as an important medical decision, its regulation in law is not entirely clear. DNR is an order not to perform cardiopulmonary resuscitation (CPR) on a patient experiencing cardiac or respiratory arrest, and this decision is often taken in the context of end-of-life care (Doody et al., 2025).

In a legal context, DNR can be considered as part of a patient's right to refuse unwanted medical treatment. According to the Regulation of the Minister of Health No. 37 of 2014 concerning the Determination of Death and the Utilization of Donor Organs, refusal of resuscitation must be stated in writing and protected by law as one of the patient's rights (Doody et al., 2025).

Although this right has been recognized, its implementation is still limited and not well understood by medical personnel as well as the public (Wijaya et al., 2022). Legal and ethical issues concerning DNR also involve communication challenges between healthcare providers and the family of the patient. Adult family members are often forced to make emotionally challenging choices, particularly when they must express the preferences of their patients who cannot speak (J. Lee et al., 2026; Schenker et al., 2012).

Also, the ambiguity over DNR may lead to confusion and uncertainty in clinical practice which can get health workers into legal trouble (Kuusisto et al., 2023). Therefore, although DNR is already acknowledged in the medical context in Indonesia, legal regulations are required to be clearer and more comprehensive so that the decisions taken comply with medical ethics and patient rights.

b. Applicable regulations regarding refusal or termination of medical procedures

In Indonesia, refusal or termination of medical treatment, including Do Not Resuscitate (DNR) orders is governed in various laws, primarily the Health Law No. 36 year 2009 [13]. This law reinforces the individual self-determination or right of patients to obtain information and make a decision regarding their own health care, including (but not limited to) the right to

refuse any medical treatment that is undesirable (Doody et al., 2025).

The Indonesian Code of Medical Ethics likewise guides medical personnel in dealing with cases in which a patient refused treatment. The code thus highlights the need to respect the patient autonomy and making sure that any decisions made are consistent with the wishes of patients especially at end-of-life care (Wijaya et al., 2022). Healthcare providers are expected to have authentic conversations with patients and families regarding care options including DNR and document these discussions in health records (Kuusisto et al., 2022).

Yet, despite regulations in place, DNR use has challenges on the ground. The processes and legal implications surrounding DNR are not fully understood by some medical professionals and families of patients, thus leading to confusion and ambiguity in decision making (J. Lee et al., 2026; Schenker et al., 2012). Additionally, the absence of explicit DNR legislation may create legal hazards for healthcare personnel in case of disagreement with the family of a patient (Kuusisto et al., 2023).

c. Rights and responsibilities of doctors and families in DNR decisions

Both have rights and duties in the Do Not Resuscitate (DNR) decision. Against but: In this regard the doc should explain to the patient and his/her family about what does a DNR decision means for the normal course of treatment. This includes informing the patient about their medical disease, prognosis, and benefits and risks of resuscitation measures (Huang et al., 2013; Ng & Fung, 2023). In addition, if the patient is incapable to communicate directly, the doctor should ensure that any DNR decision is made on ethical principles respecting the autonomy of a patient (Hildén et al., 2004; Refolo et al., 2025). Another thought is that, since the patient is incompetent due to alcohol intoxication, the patients family should be included as part of the decision cascade. Family frequently serves as surrogate and is also expected to embody the wishes of the patient. Research indicates that family participation in the decision to issue DNR orders is associated with less anxiety and higher satisfaction with care provided (J. Lee et al., 2026; Schenker et al., 2012). Despite this, the family also has the obligation to interpret positive information diagnosis and its effects through understanding of values and preferences (M. H. M. Lee et al., 2023; Salottolo et al., 2015). In practice, this leads to difficulties when there is a difference of opinion between the doctor and family about the DNR decision. The doctor, in such cases, would need to pursue open communication and transparency with the family and include them in conversations leading to consensus (Laupacis & Patrick, 2023; Refolo et al., 2025). Finally, comprehensive documentation of the DNR decision and the rationale behind it is important to safeguard rights of all parties in case disagreement arises subsequently. In general, the rights and obligations of doctors and families in decisions around DNRs are one of the most important components to care for a patient at stake. Decisions can honour the patient's wishes and be respectful of medical ethics if there is effective communication and clear expectations between the two.

d. Legal implications of DNR violations: Possible legal action if there is a dispute between the family and the medical team.

If a DNR is broken and there is a disagreement between the patient's family and the medical team, legal issues may arise. The DNR itself, as a form of the patients right to refuse medical treatment, is regulated in various laws and regulations but in Indonesia does not have clear regulation which may create confusion or conflict (Wijaya et al., 2022). Where the medical team disobeys a DNR order, the family of the patient has several legal options. The family can first sue the medical staff or hospital for malpractice or medical negligence. The law says if resuscitation is attempted in spite of the presence of a valid DNR order, it can amount to violation of rights and attract criminal liability for the doctor concerned. In this particular other than for emotional and financial losses due to the violation, families can compensate for their losses (Li, 2023). Second, the family may report it to a health regulatory agency or a professional body (of doctors), for instance Indonesian Doctors Association (IDI). This report can cause an investigation on the actions of the doctor and is followed by administrative or ethical sanctions (Shapovalov & Veits, 2022). At times, the state can impose those disciplinary actions, which could have a significant impact on whether or not the physician gets to keep

practicing. Thirdly, the family can send the case before the judge after mediation or negotiation have be over. The involvement of an attorney who is knowledgeable in health would help family's and patient right (Shapovalov & Veits, 2022). In totality, all the parties involved must be cognizant of this fact in order to identify and understand their rights and duties related to a DNR. Understanding the DNR decision and your wishes should limit or reduce the potential for conflict and/or legal implications later.

Religious and Cultural Perspectives on DNR in Indonesia:

a. Majority religious views on the decision not to resuscitate.

In Indonesia, where the majority of the population is Muslim, religious views on the decision not to resuscitate (DNR) are heavily influenced by ethical principles and religious teachings. In the Islamic context, DNR decisions are often considered based on humanitarian values, the right to life, and respect for the patient's wishes. According to Islamic teachings, preserving life is an obligation, but in situations where the patient is in a terminal condition and there is no hope of recovery, the decision not to resuscitate can be seen as a form of respect for the will of God and the patient's quality of life (Memiş, 2022). The Indonesian Ulema Council (MUI) also provides guidance on issues related to health and medical ethics, including DNR decisions. MUI emphasizes the importance of good communication between medical personnel, patients, and families in decision-making related to end-of-life care. In this case, families are expected to understand and respect the patient's wishes and play an active role in the decision-making process (Sarana et al., 2025). On the other hand, in the context of Christianity, both Catholic and Protestant, there are similar views on DNR. Christian teachings emphasize the importance of respect for life, but also recognize that in certain situations, such as terminal illness, the decision not to resuscitate may be considered an ethical choice (Ma et al., 2025). Families and health care providers are expected to discuss this choice openly, considering the patient's spiritual values and wishes. Overall, the views of the majority religions in Indonesia on DNR decisions reflect a balance between respect for life and recognition of the patient's quality of life. In the context of religious pluralism in Indonesia, it is important to promote interfaith dialogue and mutual respect in decision-making regarding end-of-life care, so that all parties can find common ground that is in accordance with their respective values (Memiş, 2022).

b. The influence of cultural norms on medical decision making, including DNR decisions Cultural norms play a significant role in medical decision-making in Indonesia, including decisions regarding Do Not Resuscitate (DNR).

As a country with rich cultural diversity, societal views on health and end-of-life care are strongly influenced by local values and traditions. In this context, cultural norms can influence how families and patients understand and respond to medical decisions, including DNR (Otto et al., 2011; Zhao et al., 2025). The patriarchal culture that remains strong in many Indonesian communities often places medical decisions, including DNR, predominantly in the hands of male family members, especially the head of the family. For example, an inequity of decision making may occur whereby patients are not heard with the burden falling on other family members (often women or younger ones) to articulate their views (Zhao et al., 2025). If the patient cannot speak, for example if they are in a coma, DNR decisions often fall to the family but may not reflect what the person would have wanted. Moreover, family members may be deterred from selection of DNR even if the patient is in a clinical state that may not benefit from resuscitation (Zhao et al., 2025) because cultural norms value life and hope for recovery. Cultural understanding has to be done for one because it is considered the moral thing in many cultures of saving somebody's life at all few costs which might go against do not resuscitate (Asgary & Junck, 2013; Zhao et al., 2025). Cultural influences, on the other hand, may also be supportive of DNR decisions. Some communities have greater appreciation for quality of life and deference to the patient's wishes. This may lead families toward accepting the DNR to honour the patient's wishes and eliminate unnecessary suffering (Lee et al., 2021). Conclusion Cultural norms around DNR decisions are not uniform in their relation to medical decision making across Indonesia. Thus, it is essential for health care providers to be sensitive

to cultural elements about the patient and his or her family as well as communicate through culturally competent and eliciting conversations in the decision-making process so that decisions are made honoring patient wishes within existing cultural values.

c. Challenges in implementing DNR in communities with strong religious and cultural views.

Implementation of Do Not Resuscitate (DNR) decisions in Indonesia faces several challenges, especially in communities with strong religious and cultural views. Indonesia, as a country with cultural and religious diversity, has diverse values that can influence community attitudes towards medical decisions, including DNR. One major challenge is cultural norms that prioritize the value of life. In many cultures, it is believed that doing everything possible to save a life is a moral obligation. This often makes families hesitate to choose DNR, even when the patient's medical condition suggests that resuscitation may not be beneficial. In this context, social and cultural pressures can prevent families from respecting the wishes of patients who may have expressed a preference not to be resuscitated (Otto et al., 2011; Zhao et al., 2025). In addition, religious views also play an important role in DNR decision-making. In the Islamic tradition, for example, there is an emphasis on the importance of preserving life, but also a recognition that in terminal situations, the decision not to resuscitate can be considered a form of respect for the will of Allah (Memiş, 2022). However, differences in interpretation of religious teachings can lead to confusion and conflict among family members regarding DNR decisions (Sarana et al., 2025). Communication between healthcare providers and families is also a challenge. In many cases, families may not receive sufficient or clear information about the patient's medical condition and the implications of a DNR decision. This can lead to misunderstanding and dissatisfaction, which in turn can exacerbate conflict between the family and the healthcare team. Finally, the lack of clear regulations regarding DNR in Indonesia can lead to confusion among healthcare providers and patients' families. Without strong guidelines, DNR decisions can pose legal and ethical risks, which can worsen the situation when disputes arise. Overall, the challenges in implementing DNR in a society with strong religious and cultural views in Indonesia require a sensitive and collaborative approach. Open dialogue is needed between healthcare providers, patients, and families to ensure that decisions reflect the patient's wishes and respect existing cultural values.

Implementation of DNR in Indonesia:

a. Case study related to DNR decision in hospital

Objective Transplant Did not community-based health care systems study has never published on the patients with pneumonia that examined more than 5 Do Not Resuscitate (DNR) orders and hospital mortality. Results revealed that the mortality associated with DNR orders was higher than in patients without DNR orders. Patients' beliefs and values, the paper noted, greatly shape preferences for end-of-life care, leading to herding behavior with patients in a specific hospital sharing similar views. Methods Rafiq et al designed an analysis of the characteristics and outcomes among patients with partial do-not-resuscitate (DNR) orders at a large community hospital. Of partial DNR orders received, 41% were directed by the family/legal guardian of the patient. Palliative care is an important component for the care planning of critically ill patients, and nearly 90% of United States hospitals have a palliative care team. Chen et al also found factors associated with DNR decisions in terminally ill cancer patients. Results indicated that many hospitalized patients never executed DNR orders independently and concluded with calls for improved communication between health care providers and patients over end-of-life care decisions. Some studies examine when patients with DNR orders during hospitalization are given the order. When they assessed DNR, over half were made by surrogates with no input from patients at all, supporting that the family is often involved in decision making rather than necessarily wishes of patients. One 2012 study examined resuscitation duration and outcomes after in-hospital cardiac arrest. The quality of chest compressions and the performance of the resuscitation team affected decisions about resuscitation care and outcomes, emphasizing the need for effective training and communication within medical teams. Many healthcare providers thought that patients and families should be included in these decisions, they frequently experienced difficulties with conveying clear communication and understanding regarding end-of-life options. A variety of

factors, including patient preferences, healthcare provider–family communication, and the cultural and social climate surrounding DNR decisions in hospitals are reflected in these cases (Otto et al., 2011; Zhao et al., 2025). It is important to approach it carefully and collaboratively, ensuring that decisions reflect the patients wishes and values.

Guidelines on Do Not Resuscitate Orders with explicit procedural guidance for DNR determination criteria, family involvement, medical record documentation and physician liability protection in the event of a properly documented DNR have been developed and issued by Malaysia's Ministry of Health. In Malaysia, DNR is legalised through the parameters defined by the National Fatwa Committee on Ethics in Life, which provides Islamic bioethical justification and clinical authority at both legal and religious levels to address DNR issues. Yet, Indonesia still does not offer comparable guidance and this is the evidence that explains why Indonesia remains in a structurally disadvantageous regulatory framework alongside its Muslim-majority neighbours with culturally-religiously similar landscapes but feasible Islamic bioethical principles.

Background In many hospitals in Indonesia, Do Not Resuscitate (DNR) decisions are faced with a variety of constraints including strong cultural and religious norms. Here we present examples of cases and situations that represent DNR in the hospitals in Indonesia: 1. An elderly patient with the terminal illness was admitted to a regional general hospital. In consultation with the family, DNR was advised due to the terminal prognosis. But because of social/culture history of price qualities in life, the family was pushed to make choice of resuscitation. 1-6) In this case, the doctor needs to be sensitive in voice and able to explain why the patient chose DNR; (2) A patient with terminal cancer at a private hospital in Jakarta made a request for DNR. Doctors had multiple lengthy conversations with the patient and family to confirm it was what the patient wanted. Though the family was resistant to DNR at first, they were on board after learning enough about it. Effective communication is critical in DNR decision-making; (3) Cardiac arrest in a young patient with leukaemia, from the intensive care unit of a teaching hospital. The medical team was under pressure from family members who didn't fully understand the DNR order and pressured them to perform resuscitation regardless of a previously signed DNR. We encountered this dilemma in one of our recent work : on the other hand, this case illustrates the conflict that medical personnel experience to comply with DNR wishes from family members, bc they may themselves suffer distress; (4) Experiences at hospices which specialize in palliative care often lead to DNR actions after several hours spent discussing DNR amin with patient and family. The medical team is working to make sure the decision reflects not just the patient's medical status, but also the patient's preferences and goals. Here the DNR implementation had a more holistic approach that included respecting the wishes of the patients and family support; (5) In a hospital focused on patients with terminal disease, they created internal guidelines of how to decide for a DNR. They included training for doctors and nurses on how to explain DNR decisions clearly and with empathy to patients and families. This work is an attempt at improving knowledge and practice of DNR in the hospital setting. Conclusion The implementation of DNR in the hospitals in Indonesia has been proven by various aspects such as culture, communication and understanding of medical conditions. The decision will demand a careful, collegial process such that the decisions made are done in alignment with the patients' wishes and treating their values with respect.

b. Cases of ethical and legal disputes between families, doctors, and legal institutions.

DNR decisions in Indonesia frequently encounter ethical and legal conflict between family members, doctors, and judicial institutions. These are some examples of cases that elucidate this behavior difference: 1. Case Presentations: A male patient elderly had come to the infectious disease general hospital with terminal illness A DNR was signed after attending a discussion with the medical team. When the patient went into cardiac arrest, however, and his family demanded resuscitation against his wishes. This is a case of the doctor caught in between respecting the patient and trying to make the family happy. However, this a dispute between the doctor and family -- and if the family believes that the treating doctor has breached their duties by violating a patient's rights, legal action may ensue. 2. A young patient collapsed in cardiac arrest in a teaching hospital. All the family was told previously, however,

was that there was a DNR order on file -- but no one in the family felt as if they understood what that meant when it came to this particular case and felt the medical team pressured them to resuscitate. This case demonstrates the difficulties of honoring DNR decisions when families put emotional pressure on doctors to disregard patients' wishes, and it can lead to litigation if a family sues. 3. In a palliative care facility, when the patient received an advance directive not to be resuscitated in case of being thought to be dead, he had terminal cancer. Initially, the family agrees, but when the patient arrests they request CPR to be attempted. In this scenario, the medical team is faced with an ethical and legal dilemma that requires balancing the patient's desires while also accounting for what the family wants. Allegations of malpractice the family can bring a finding to the attention of a health care regulatory body which may result in an official reprimand or pursue litigation. 4. Case 1 – In an independent hospital, Patient with terminal illness signs a DNR form but the family is unaware of the decision. The family ask for resuscitation, arguing that the patient was not informed enough before going to cardiac arrest. If this is the case, doctors could be sued if they are found to have failed to keep the family well-informed regarding the DNR choice. 5. Case in a Palliative care hospital: A specialized hospital that treats palliative patients, the clinician develop intra-institutional guidelines to make decisions on DNR. Now, the family will not respect Deutschlands DNR it had signed when a patient suffers cardiac arrest. These cases highlight the importance of communicating more effectively and understanding DNR decisions better on the part of family members as well as what can happen in terms of rematch legal disputes when a DNR decision is violated. Overall, these cases indicate that there are many factors affecting DNR implementation in hospitals in Indonesia, including cultural norms and communication among medical personnel regarding the patient's condition.

DNR Determination and Documentation Procedures in Indonesia:

a. Guidelines for physicians in discussing and establishing DNR decisions with patients and families

DNR (Do NOT Resuscitate) decisions are part of the care that is allocated to patients suffering from an incurable or terminal disease. Approaching the 'do not resuscitate' decision in life-or-death circumstances can be a sensitive issue which presents an even bigger challenge in Indonesia, where cultural and religious factors hold significant sway over people's lives. We can do this in the following ways: 1. A Clear Education and Information: Physicians must have comprehensively informed them about the medical condition of the patient, their prognosis as well as what would happen if a DNR is made. This description has to be given in comprehensible words, taking into account the degree of motivational and cultural advancement of patient and his/her family; 2. Open dialogue and empathy, which involves having a frank conversation with the patient and family about end-of-life care options. Doctors need to empathise with families who may be grieving or confused. Studies have shown that good communication can mitigate anxiety and increase satisfaction with the care received 3; Including the Family in the Decision-Making Process The family serves as a surrogate decision makers when the patient is unable to make his/her wishes known. To that end, they need to be a part of the conversation about DNR. 4 Physicians are to respect families' views and values and aid them in understanding the patient's feelings; Respect for Patient Autonomy: doctors must respect that patients have the right to decide what happens in relation to their care. Therefore, if the patient has requested DNR, he should obtain it regardless of what the family wants. Research: DNR decisions should be made by the patient, not pressured by family; 5. Section 2 Clear Documentation Every DNR order must be clearly documented in the patient chart. Especially remember to document who was discussed, what decision they landed on and why. This is important for the protection of everyone involved and to prevent a possible future dispute; 6. Training for Health Care Professionals Training health care professionals regarding the ethics and practice of DNR. Such training should comprise communication skills, cultural and ritual sensitivity, and coping with emotional and other stressful situations; 7. Physician-family relationships are the growing, interactive forces between two or more individuals dealing with a dilemma in decision-making. Having a good relationship will help build trust and make it easier to talk about DNR choices. Applying these rules and managers, doctors

in Indonesia may be more successful in making DNR decisions, educate and promote respect for the wishes of the patient, face difficulties arising from Islamic cultural and strong regions.

b. How to ensure DNR decisions are implemented correctly and ethically in hospitals.

Implementation of Do Not Resuscitate (DNR) decisions in hospitals requires a systematic and ethical approach to ensure that the decision is respected and implemented properly. The following are steps that can be taken by medical personnel in implementing DNR: 1. Clear and comprehensive education and information to patients and families; 2. Open and empathetic discussion; 3. Involving families in the decision-making process; 4. Clear documentation; 5. Written consent; 6. Training for medical personnel on communication, ethics and DNR practices; 7. Building good relationships between doctors, patients, and families and the hospital; 8. Evaluation and follow-up that the DNR decision remains relevant to the patient's condition and that all team members understand and respect the decision taken.

Challenges of DNR Implementation in Indonesia:

a. Lack of understanding of the public and medical personnel about DNR.

Do Not Resuscitate (DNR) decisions are an important aspect of medical care, especially for patients with terminal conditions. However, in Indonesia, there are significant challenges related to the lack of understanding among both the public and medical personnel regarding DNR. This can impact on appropriate and ethical decision-making in the context of end-of-life care. 1. Lack of Knowledge Among the Community where many people do not understand what DNR is and its implications. Research shows that lack of information about DNR can lead to misunderstanding of the patient's right to refuse unwanted treatment Sari. For example, some patients and families feel pressured to choose resuscitation even though the patient may have expressed a desire for DNR, because they do not fully understand the consequences of the decision; 2. Lack of Training for Medical Personnel so that they do not have sufficient understanding about DNR. Research shows that many health workers feel uncomfortable discussing DNR decisions with patients and families, which can result in decisions that are not in accordance with the patient's wishes.

Inadequate training and education in health institutions around DNR ethics and practices worsens this situation; 3. Cultural and Religious Factors, also play a role on DNR from public perspective due to strong Cultural factors and religious factors in Indonesia. Many cultures have the view that everything we can do to save a life has to be done as it is deemed morally right. It can make families reluctant to select DNR, despite the fact that resuscitation may not confer benefit based on the patient clinical condition. Studies reveal that poor communication from health workers are responsible for many of the misunderstandings around DNR; 4. Another issue is restrained access to information on DNR in hospitals and different fitness facilities. Patients and families receive insufficient education about at some point end-of-life care options, which include do not resuscitate (DNR). There exists potential for misunderstanding and being let down about how the decisions are made; 5. An effect on Decision Making falsely interpreting DNR is possible and may end in a call that contradicts the patient's choices. Some families do not understand the patient's medical condition and the ramifications of a DNR decision, leading them to make contrary decisions. In conclusion, one major challenge to make this decision is a lack of understanding DNR by Indonesian communities and medical personnel. We need increased education and outreach on DNR among both the community and medical providers to ensure that the decisions being made respect patients' wishes and existing cultural norms.

b. Unclear regulations or hospital policies regarding DNR.

Although Do Not Resuscitate (DNR) is one of advance care decision that has long been particularly in Indonesia, its implementation is still ambiguous due to the lack of regulations or policies governing this. Lack of Formal Guidelines: One of the core challenges limiting DNR implementation is that there are no formal guidelines regarding DNR practices within hospitals (1). There are many regulations that mention patient rights indirectly like Health Law no39 of

2009, but there is no specific regulation explaining the implementation of DNR in clinical practice. It could result in differences DNR implementations at various hospital, depending on each institution internally policy; (2) Lack of clarity on DNR Procedure could lead to legal ambiguity for medical personnel as well. If DNR does not have clear regulations, doctors may not dare to implement the DNR, especially when he is concerned that if there is a dispute with the family of the patient. This ambiguity leads to variability in the provision, which can also harm patients; (3) the conflict between medical authorities and family members of a patient due to differences in understanding DNR. In some situations family members might not have an appropriate understanding of the DNR choice that would tend to favor resuscitation even when the patient was clear about not wanting resuscitation. This indicates the dire necessity of enhancing DNR's promotion and education to patients' families. (4) The recommendation for health professionals to encourages prescribing do not resuscitate as preferred end-of-life care option in public health crisis situations might illustrate strong cultural and religious norms in Indonesia about DNR-related decision-making processes. There is the belief in many cultures that it is a moral duty to do whatever one can to prevent someone from dying. This may lead families to restrict the choice of DNR even where medical condition suggests patients are unlikely to benefit from resuscitation; (5) Another issue is Limited Access to Information about DNR in hospitals and other health institutions. Most patients and, by extension, their families do not know enough about end-of- life care options like DNR. This can cause misunderstanding and dissatisfaction with the decision process.

c. Gaps in Hospitals

In Indonesia, the implementation of Do Not Resuscitate (DNR) decisions is often hampered by gaps in health infrastructure, which can affect patient outcomes. For example, in a public hospital, a patient with end-stage renal disease requires hemodialysis. Although there is an agreement between the family and the doctor to implement DNR due to poor prognosis, the hospital does not have the necessary hemodialysis equipment. When the patient experiences cardiac arrest, there are no adequate treatment options, so the patient is not helped, and the family feels betrayed, which can potentially lead to lawsuits against the hospital.

A further example took place in the emergency room of a teaching hospital where an ill-fated child with catastrophic injuries required CT scanning. However, the facility was unavailable and due to the critical deterioration of the patient that DNR decision could not be implemented appropriately. When that CT scan was not made available, the family of the patient came to feel had it been so, there might not have been a decision to implement DNR, and it led to potential legal action against the hospital. Most remarkable was a report of the complications associated with arterial embolisation of a patient dying from widely metastasised cancer within a palliative care hospital without access to an intensive care unit or other assistance facilities, and subsequently examined the discordant demand from relatives for improved standards of care.

One private hospital has a similar problem, where there is a cardiac arrest in DNR a terminal by heart attack patient and emergency blood transfusion was required but because the hospital does not have its own blood bank so blood could not be provided on time. Since the family is unaware of this limitation, they insist on resuscitation, which can land a hospital with lawsuit for not providing sufficient facilities. In specialized hospitals, notwithstanding clear DNR policy pressures from the family [which opposes the decision] are known to strain relations. These cases highlight that the implementation of DNR decisions is not purely medicinal, but instead relies heavily on the health framework and coordinated communication in order to minimize legal and ethical disputes between medical personnel and family members.

Ideally, DNR guidelines should be enacted AFTER exhausting all resources and hospital efforts will have to stop due to limited infrastructure the family is then led to believe that they cannot do any further if the patient still panics. This underscores the need for clear and unambiguous communication regarding the patient's clinical state and stated attempts at care. These cases illustrate that DNR decisions are not only a medical issue but also crucially

coloured by health infrastructure and the success of communication between doctor and family so as to avoid legal and ethical disputes.

CONCLUSION

The responsibility of providing adequate information about DNR lies with the physicians, and families are involved in decision-making, especially when the patient is not able to communicate. Nevertheless, there are normal variations that need to be openly communicated. DNR (do not resuscitate) violations can have devastating legal implications, including malpractice suits. So for that development to minimise the risk of conflict and legal problems in the future it is important that all involved parties know their position concerning a DNR. Objectives: To understand the religious and cultural perspectives regarding DNRs that may affect the decision-making process in Indonesia. DNR in a Muslim majority context is interpreted both from the humanitarian and reverence for God perspectives, Christian religion also accepts DNR ethics (with restrictions). At many times, it is the cultural norms on which decision-making rests rather than respect for autonomy or informed consent, and at the top of these cultural roots is patriarchy, where the voice of a patient has no meaning (and more so if she is a woman). Moreover, the belief that every life must be saved can prevent families from opting for DNR, even when resuscitation may not work. Misunderstandings are also due to poor communication between health care providers and families. In this absence of clear regulation, a gentle approach is required and DNR decisions should be made collaboratively through open dialogue, which respects the wishes of patient and culture values.

This DNR determination process is crucial in the treatment of terminally ill patients in Indonesia. It is crucial for physicians to educate the patient and family clearly on the medical condition and existential ramifications of DNR, and these discussions need to be conducted openly and sympathetically to help alleviate distress. Decision making should not exclude the family and be in light of it since autonomy cannot be exercised if they are losing their voice. Well documented medical records are vital to protect the rights of all parties. What medical personnel need is some formal ethics and communication training. Systematic measures education, documentation, documented consent, and review of orders over time are required to ensure DNR is used properly and ethically. Several challenging issues remain on the implementation of DNR decisions in Indonesia. First, it impedes ethical decision-making that few in the public and among medical personnel understand DNR, with many feeling they had no choice other than resuscitation. Second, confusion and legal uncertainty can arise between doctors and families due to the unclear guidelines/regulations and hospital policies regarding DNR. Third, available health infrastructure is also important since it delays the implementation of DNR. These challenges highlight where there is a need for further education, regulatory clarification and better health infrastructure to enable DNR to be implemented responsibly and ethically.

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AUTHOR CONTRIBUTION STATEMENT

Yuri Sadewo contributed to the conceptualization of the research, formulation of legal issues, legal analysis, and manuscript drafting. Yusuf Alim Musthofa Anwar contributed to the development of the theoretical framework, methodology design, and critical revision of the manuscript. Arman Lany contributed to literature review, data validation, and editing of the manuscript. All authors have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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