



# Bioetic View Regarding Termination of Medical Actions Brain Stem Dead Patients

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**Abstract.** Discontinuation of medical treatment in patients with brain death (brain death) is often a dilemma in its implementation, considering the patient's clinical condition, on the one hand the brain function has died but on the other hand the heart and lung functions are still running due to artificial aids (ventilators). thus causing the signs of death to appear to be faint. Doctors often don't have the courage to pull out the ventilator in these patients. What is the bioethical view of discontinuing medical action in brain stem dead patients. Research is conducted with a purpose knowing the implementation of discontinuation of medical action in brainstem dead patients and knowing the bioethical view of discontinuing medical treatment of brainstem dead patients. Research with a normative juridical approach and descriptive analysis specifications. From the research results it is known that termination of medical action in brain stem dead patients based on positive law in Indonesia is regulated in PMK No. 290 of 2008 concerning Approval of Medical Actions and PMK No. 37 of 2014 concerning Determination of Mortality and Utilization of Donor Organs. The bioethical view of discontinuing medical procedures for brain-stem dead patients, the actions of a doctor in carrying out his duty to treat a patient, are always aimed at curing his illness and saving his life. Indonesian Code of Medical Ethics (KEKI), chapter II number 9 : "Doctor's Obligations Towards Patients: A Doctor Must Always Bear In Mind The Obligation To Protect Human Life".

**Keywords:** Bioethics, Medical Treatment, Brain Stem Dead

## 1 Bioethical View Against Discontinuation of Medical Action Brain Stem Dead Patients

### 1.1 Introduction

The space and time limiting any human death, invisible to him and to others, this is God's gift and His mercy to humans. Sometimes it happens to doctors who suspect the death of several people will occur at a certain time, then their predictions are missed, and many people survive death after it is thought that many people will die after them.

To die is to lose one's life, to no longer live, Law No. 36 of 2009 concerning Health article 117 states, that: "A person is declared dead if it is proven that the functions of

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the heart, circulation and respiratory systems have stopped permanently, or if brain stem death can be proven".

Meanwhile, according to PP no.18/1981 article 1 (g) concerning Clinical Post-mortem Surgery and Anatomical Post-mortem and Transplantation of Tools or Human Body Tissues states that: "death (death) is a human condition that is believed by an authorized medical expert, that a person's brain function, breathing, and or heart rate have stopped".

#### IDI Statement About Dead:

- a. Dying is a gradual process. Each cell in the human body has a different resistance to the absence of oxygen and therefore has a different time of death.
- b. For doctors, the importance lies not in each of these items, but in the interests of the human being as a unified whole.
- c. In the human body there are three important organs that are always looked at in determining someone's death, namely the heart, lungs and brain (especially the brain stem).
- d. Of the three organs of the body, permanent damage to the brainstem is the most a sign that the human being as a whole cannot be declared alive anymore.
- e. Therefore, after hearing considerations from medical, religious, legal and social experts, IDI is of the opinion that humans are declared dead if the brainstem no longer functions.
- f. Realizing that this statement regarding death will have technical implications in the field, IDI hereby proposes an amendment to the PPNo. 18, 1981, especially with regard to the definition of death as contained in article 1 paragraph g of the regulation.
- g. Every doctor needs to be reminded once again that basically the doctor's job is to reduce the patient's suffering and if possible heal him completely and act in the interests of the patient. Even though doctors face incurable diseases or irreversible disabilities, doctors still have to act for the health of their patients, until the time when the patient can return to his family or is declared dead.

The development of medical science and technology makes the diagnosis of a disease more perfect and treatment of disease can take place quickly. With equipment, it is hoped that the patient's pain can be alleviated and even a person's life can be extended for a certain period of time by using a tool called a ventilator. The development of medical technology gives hope that doctors will have the opportunity to treat patients as an effort for patients to recover to a greater extent, but there are times when it creates difficulties among doctors themselves. Such as the use of a ventilator that is installed to help the patient, where the patient's heart is beating but the brain is not functioning properly, even an EEG (electroencephalography) examination shows brain stem death (brain death). Does the doctor dare to pull out the ventilator on this patient?

Discontinuation of medical treatment in patients with brain death (brain death) is often a dilemma in its implementation, considering the patient's clinical condition, on

the one hand the brain function has died but on the other hand the heart and lung functions are still running due to artificial aids (ventilators). thus causing the signs of death to be blurred.

The criteria for brain death have been a concern since the 1970s. This is caused by the rapid development of medical technology, thus urging the world of medicine to change and reformulate the definition of someone's death. Since several centuries the indication of death has been clear, namely "absence of heartbeat and signs of breathing". If a person's heart rate is no longer beating, and there is no breathing, then that person is considered dead. However, now with increasingly sophisticated technology in the medical field, people can breathe again even though artificially (using a ventilator). A halting heart rate can be accelerated with a pacemaker, or a combination of the 2 devices, a heart lung machine, for example, there is a patient (victim) of a traffic accident and the victim is taken to the hospital and then treated in the ICU and placed on a ventilator. However, it turned out that the patient had a severe head trauma that caused brain stem death. Clinically the person is dead. however, the person appears to be still alive (the heart is still beating and breathing) with an assistive device (ventilator) attached, so that it can be said that the person has become a living corpse. If the aid attached to the person is removed, then breathing and heart rate will medically stop immediately.

A doctor has an obligation to "respect every human life from the moment of conception" in this case it also means that no matter how serious a patient's illness is, every doctor still has to protect and defend the patient's life. In such circumstances, the patient may in fact no longer be cured, or has been in a state of death for months, even in a state of brain stem death. However, in this connection, doctors cannot escape their obligation to always protect human life, as stated in their oath. All actions performed by doctors on patients with the aim of maintaining their health and happiness. By itself the doctor must provide assistance to maintain and maintain human life.

The concept of death that has been held for centuries is that death stops the functioning of the heart and lungs, can no longer be used because resuscitation technology has allowed the heart and lungs that were originally stopped, can now be triggered again and the lungs can be pumped to expand again.

Determination of the time of death is also discussed in the 1968 World Medical Assembly (WMA), known as the Sydney Declaration. . It states here that determining the time of death is the legal responsibility of the doctor. Doctors can determine someone is dead by using the usual criteria (which are known by all doctors) without the aid of special tools.

The heart and lung control center is located in the brain stem, therefore if the brain stem has died (brain stem death) it can be believed that humans are physically and socially dead. In such circumstances the medical community often chooses not to continue resuscitation (do not resuscitate, DNR). The important thing in determining the time of death, is that the death process is irreversible, even using any reanimation technique. Although until now there is no truly satisfactory tool that can be used to determine this moment of death, the encephalography (EEG, a technique for recording the electrical activity of the brain through an intact skull) tool reliable for this purpose.

American Medical Association (AMA) in 1986 has provided a policy, that a doctor can ethically stop all therapeutic actions given to continue life, including food and drink for a patient who is in an irreversible coma. However, this policy is ambiguous, if it is connected that "a doctor may not intentionally cause death". The AMA still has not dared to say that it is permissible to end the enactment of the traditional doctrine which considers it wrong to intentionally end the life of an innocent person.

Report on the results of research on doctors' attitudes towards the decision to continue or discontinue medical treatment in cases of terminal patient care (end of life, vegetative state).

Research with a number of respondents, including 1,465 doctors, 59.6% treating patients in the ICU, in 466 ICUs (59.4%), in 16 countries in the Asian region. Research report patients without a real chance to restore a meaningful life, 1,029 respondents (70.2%) reported almost always or often withholding whereas 303 (20.7%) reported almost always or often withdrawing life-sustaining treatment; 1092 respondents (74.5%) consider withholding and withdrawal ethically different. The majority of respondents reported that vasopressors, hemodialysis, and antibiotics were usually withheld or withdrawn in end-of-life care, but not enteral feeding, intravenous fluids, and oral suctioning. For severe hypoxic-ischemic encephalopathy following cardiac arrest, 1201 responders (82.0% [inter-country range, 48.4%-100%]) would have implemented a no-resuscitate order, but 788 (53.8% [range, 6, 1%-87.2%]) will maintain mechanical ventilation and start antibiotics and vasopressors if indicated.

Based on the above research report data, it can be concluded that physicians in ICUs in Asia often withhold but rarely withdraw life-sustaining care at the end of life, attitudes and practices vary widely across countries and regions. Several factors associated with the country or region, including economic, cultural, religious, and legal differences, as well as personal attitudes, are associated with this variation. Initiatives to improve end-of-life care in Asia must start with a thorough understanding of these factors.

Even though the data above is the result of research in Asia and the author did not get data from research in Indonesia, these cases also occurred in Indonesia. So that the research report can be used as a reference for cases of terminal patient care (end of life, vegetative state).

## 1.2 Brain Stem Dead Cases

1. A young man aged 27 years. At the age of 18 he had a car accident which resulted in damage to his brain, and medically it could no longer be cured. For four years lay in a coma, as if dead. All the ability to think and feel is not there in the young man. Another case is mentioned as a case that may be recorded in the Guinness Book of World Records, as a human being who has been in a coma or self-aware for the longest time. Kasam a firefighter from Ahmedabad, India, suffered a head injury with multiple fractures to one of his ribs when he fell down a ladder while fighting a fire in Ahmedabad, India. At the same time he was rushed to the Ahmedabad Municipal hospital, the capital of Gujarat state. According to the doctors treating him, Kasam had suffered a heart attack and had remained unconscious

ever since he had surgery for a fracture to his bone. Until now (1994) he has been lying there like a living corpse, unconscious for more than twelve years.

2. Jahi McMath of Oakland, California, was declared brain dead last month after experiencing a very rare complication in a tonsillectomy. Her family members had been fighting to keep their daughter alive on a ventilator, but a judge ordered that her life support be switched off next week.

Today, with ventilators, blood pressure augmentation and hormones, the brain-dead body could theoretically survive for a much longer time, perhaps indefinitely, says Greene Chandos. It's just that other factors must also be considered, because a brain dead person is at high risk of infection.

3. After two months of being treated and widely reported, finally the patient at the Ibnu Sina Hospital, Gresik, was declared brain stem dead (MBO) by a team of doctors. A final diagnosis must be made, regardless of the ongoing case controversy.

Brainstem death is a state of permanent damage to the brainstem and the entire brain. It is believed that the function of the brain also means the function of life for humans. Even though the brain is shut down, the function of other organs, especially the heart and lungs, can continue with the help of machines. In history in Japan, there was a patient with MBO who could survive 14.5 years with the help of a machine due to family requests.

The team of doctors at the Ibnu Sina Hospital stated that MBO was enforced after going through strict criteria and examinations so that the patient was declared dead. But, on the other hand, according to the culture of society, the family wants to die naturally. So, the breathing machine is still asked to be installed.

The state of sociopsychological brain death is not a natural "death". It seemed inhumane for the medical team to stop all life support when MBO was enforced. Infusions, breathing machines, even nutrition are still given without giving drugs. One understanding, let die humanely according to Divine will.

The criteria that still protect the culture of our society, the function of the heart and lungs are written, not just the brain. Until now, there are no standard criteria that are the same in each country, even the technical protocols between hospitals are often different. In the UK, loss of brainstem reflexes is the main criterion. In Sweden and Japan, MBO must be diagnosed by EEG (brain record) or brain angiography (cerebral blood flow test).

In Indonesia, the diagnosis of MBO is made clinically with certain prerequisites by a minimum of two competent specialists, but in the United States it can be done by a general practitioner because of the need, which sometimes needs to be done quickly and efficiently. In fact, a certificate to diagnose MBO must be owned as a condition for a general practitioner to work in a hospital.

In Indonesia, death in society has a more "religious" meaning and "social death". We try, but God determines. The IDI criteria are flexible enough to protect this, that is, it is very rare for the MBO criteria to be carried out quickly and rigidly. In the field, machine stops are usually done gradually for a natural impression of stopping the heart and

breathing. In fact, if the family wants to continue to maintain machine assistance, usually aspects of the family approach and explanation from the medical team are gradually put forward until the family accepts it. It certainly takes time.

When MBO is enforced, legally all forms of life support can be terminated. Some argue that doctors have full responsibility and power to stop supportive therapy and not provide alternatives for families. Some argue that it must be with family approval to continue or stop "life". The criteria for death are still under debate. Brain death is a biological death. Is death essentially determined by the malfunction of cells in the brain? Is the soul (soul) or spirit (spirit) located in the brain stem? Hopefully science can answer that.

Ethics at the end of life is an issue faced by health professionals, the problem can be as simple as "can we stop fluid and nutritional therapy on the patient?" to more complicated issues, such as "how far does the family play a role in making medical decisions for patients?", "what is the attitude of doctors when patients ask for minimal therapy?"

Medical actions that are known to be futile are currently considered to be discontinued and are morally justified if the action is stopped. This consideration is actually not a new consideration, but a consideration that already existed at the time of Hippocrates, known as the suggestion "to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless". However, the decision that a medical action is a futile action must be taken after careful consideration.

An example is Cardiopulmonary Resuscitation (CPR) or Cardiopulmonary Resuscitation (CPR), namely the act of restoring heart and lung function, which was originally only intended for acute and reversible cardiac arrest, but in practice CPR is applied to every case of cardiac arrest at home. pain, as if it were standard procedure. Even the patient's family can still sue the doctor if they see the doctor not doing CPR, even though the doctor has actually considered its utility.

In this regard, the American Medical Association (AMA) has decided that doctors are not obliged to consent to a DNR (do not resuscitate) if CPR is considered a futile action.

Medical science is developing so rapidly, among others, marked by increasing life expectancy. Not only does death appear to be postponed, but the definition of death itself changes. In the past, death was considered something routine in everyday life and generally took place simply, occurred at home surrounded by traditional relatives and friends, and was almost untouched by modern science and technology. But in this day and age death is increasingly removed from everyday life. Now the dying patient is in the hospital, surrounded by strangers such as doctors, nurses and medical technologists. Death takes place in a technological setting.

However, medical technology often fails to restore health, only prolongs the process of death. The boundary between life and death is not clear. Everyone agrees that futile medicine is not worth giving. But doctors often can't tell when treatment should be deemed futile. Modern medical science doesn't seem to want to let patients die, and actually doesn't know what place to give to death.

In fact it is not obligatory to prolong life inexhaustible, even though technological imperatives are always pushed in that direction. The traditional medical ethos that tends

to do anything to save the patient's life, in the context of today's medical technology can actually lead to an inhumane situation, if humans are no longer given the opportunity to die properly. It must be realized that death is natural, it will be experienced by every human being.

The definition of death is brain death clinically characterized by irreversible coma confirmed by Electroencephalography (EEG). Later it was suggested that the death of the neocortex, because it can occur in irreversible coma, the brainstem is still functioning, running the nervous system so that the person is still spontaneously breathing and his heart is still beating. The Neocortex was chosen because it is considered a biological prerequisite for consciousness and self-awareness, which characterizes the human being. When the biological basis for self-awareness is no longer there, humans are no longer socially integrated beings. As a person or persona, man is dead, even if paradoxically his physical life continues. From this arises an extremely important religious, philosophical and psychological question,

Based on the facts mentioned above it is not easy for a doctor to stop medical treatment for a patient with brain stem death, considering the patient's condition is still breathing and the patient's heart is still beating, the condition of the patient's family who cannot accept the death of his family and doctor's responsibility from a bioethical point of view.

Human life in the world is basically based on the religions each adheres to and is used as a way of life. and its further implementation in the way of life, attitudes and human behavior using ethical and moral foundations. These factors are important as determination and certainty in the association of everyday life and in relations between human beings. If ethical and moral norms and values fade, then everything becomes vague and unclear. And if there are no agreed arrangements or habits (consensus), then one human being can become a wolf for another human (Hobbes).

However, the consistency of the application of ethics and morals is also very dependent on place and time. In addition, each country has different socio-cultural values which also influence ethical and moral values. If "the time" changes, ethics can also change. As a concrete example, for example about "life ad death".

Western traditional ethics, including medical science based on Hippocrates, is currently undergoing drastic changes. A well-known ethicist and professor from Monash University, Peter Singer in his book "Rethinking Life and Death" says that: "after 2000 years of influencing the mind and decisions taken about life and death, now traditional western ethics has collapsed (collapsed).

Likewise, patients who are already in a "vegetative state" abroad are still in the form of unfinished debate. Medical ethicists are trying hard to find a new formula about death which involves two things:

- a. Arrangements must be made so that seriously ill patients have the right to live and be maintained with modern technological tools.
- b. Patients who are technically dead do not have to be kept alive by respirators.

Cases in health services, especially in the emergency department and in the intensive care unit, which in the past were cases that could no longer be helped. However, in certain cases, the basic problem still arises, namely the dilemma of continuing or not continuing life-prolonging medical procedures.

### 1.3 Problem

1. How to implement discontinuation of medical action in brain stem dead patients?
2. What is the view of bioethics regarding the termination of medical treatment for brain stem dead patients?

### 1.4 Research Methods

Research with a normative juridical approach and descriptive analysis specifications in accordance with the objectives to be achieved from conducting this research and writing are:

1. To find out how the implementation of discontinuation of medical action in brain stem dead patients.
2. To find out how the bioethical view of stopping medical action in brain stem dead patients.

## 2 Bioethical View Against Discontinuation of Medical Action Brain Stem Dead Patients

Discontinuation of medical treatment in brain stem dead patients becomes a dilemma if it is related to the patient's right to self-determination. On one side, the patient's heart rate and breathing are still visible due to the presence of assistive devices, and it seems as if there are still signs of life. But on the other hand, the patient is actually dead. By removing the aids attached to the patient's body, the patient's heart rate and breathing will stop. The problem is how to remove the tool? considering that this is a termination of medical action that requires patient consent, and the patient's own condition is impossible to give consent.

Termination of medical action that requires approval is regulated by PMK No. 290 of 2008 concerning Approval of Medical Actions, wherein the PMK is regulated as follows:

#### **PMK No 290 of 2008 article 1**

1. Approval for medical action is consent given by the patient or next of kin after receiving a complete explanation regarding the medical or dental action to be performed on the patient.
2. The closest family is husband or wife, biological father or mother, biological children, siblings or caregivers.

#### **PMK No 290 of 2008 article 7**

1. An explanation of medical procedures must be given directly to the patient and/or their next of kin, whether requested or not.
2. In the event that the patient is a child or an unconscious person, an explanation is given to the family or the escort.



Termination of medical action in brain stem dead patients requires patient consent, but the patient's condition is very unlikely to give consent. Regarding this matter, it is regulated in PMK No. 290 of 2008 concerning Approval of Medical Actions article 1 paragraph 1 and 2, that approval can be made by the family. even this is emphasized by article 14 paragraphs 1 and 2, which states:

**PMK No 290 of 2008 article 14**

1. The act of discontinuing/delaying life support (withdrawing/withholding life support) in a patient must obtain the approval of the patient's next of kin.
2. Approval for the termination/delay of life support by the patient's closest family as referred to in paragraph 1 is given after the family has received an explanation from the team of doctors concerned.

Implementation of termination of medical action in brain stem dead patients after obtaining family approval is regulated in PMK No. 37 of 2014 concerning Determination of Mortality and Utilization of Donor Organs, as follows:

**PMK No. 37 of 2014 Article 7**

Determination of a person's death can be done using conventional/diagnostic criteria for death or brain stem death diagnostic criteria.

**Article 8 paragraph 1**

Diagnostic criteria for clinical/conventional death as referred to in Article 7 are based on the proven permanent cessation of the functions of the cardiac circulatory and respiratory systems.

**Article 10 paragraph 1**

Examination of a brain stem dead person is carried out in patients as follows:

1. Unresponsive coma/GCS 3 or four score 0;
2. Absence of abnormal postures (such as decortication or decerebration); and
3. Absence of uncoordinated movements or epileptic jerks.

**Article 10 paragraph 2**

The conditions that must be met in order to be able to carry out a brain stem death examination as referred to in paragraph 1 include:

1. There are preconditions in the form of coma and apnea caused by irreversible structural brain damage due to disturbances that have the potential to cause brain stem death; and
2. There are no reversible causes of coma and respiratory arrest, including drugs, intoxication, metabolic disorders and hypothermia.

### Article 11

The brainstem death examination procedure is carried out as follows:

1. Verify brainstem areflexia which includes:
  - a. Lack of response to light;
  - b. Absence of corneal reflex;
  - c. Absence of vestibulo-ocular reflex;
  - d. Absence of motor response in cranial nerve distribution to adequate stimulation in somatic areas; and
  - e. Absence of gag reflex (gag reflex) or cough reflex to stimulation by a suction catheter inserted into the trachea.
2. Ensure persistent respiratory arrest by:
  - a. Preoxygenate with 100% O<sub>2</sub> for 10 minutes;
  - b. Ensure the initial pCO<sub>2</sub> testing is within the range of 40-60 mmHg by using a capnography and or blood gas analysis (AGD);
  - c. Remove the patient from the ventilator, insufflate the trachea with 100% O<sub>2</sub>, 6 L/min via an intra-tracheal catheter across the carina;
  - d. Observation for 10 minutes, if the patient is still not breathing, the test is positive or it means that the respiratory arrest has persisted.
3. If the brainstem areflexia test and respiratory arrest test as referred to in points a and b are found positive, the tests must be repeated once again at intervals of 25 minutes to 24 hours.
4. If the repeat test referred to in point c remains positive, the patient is declared brain stem dead even though the heart is still beating.
5. If a life-threatening cardiac arrhythmia occurs during the respiratory arrest test, the ventilator must be re-attached so that a diagnosis of brain stem death cannot be made.

Taking into account the articles mentioned above, especially article 11 paragraph 2c PMK No. 37 of 2014 concerning Determination of Mortality and Utilization of Donor Organs, the substance is only to ensure that the patient is brain stem dead. Based on article 11, the procedure for diagnosing brain stem death is to remove the ventilator.

### 2.1 Bioethics

Ethics is divided into normative and meta-ethical ethics (analytic ethics). In normative ethics, philosophers try to establish what is morally right and morally wrong in relation to human action. In metaethics, philosophers pay attention to the analysis of the two concepts above.

Basically humans have 4 basic needs, namely 1. physiological needs which are met by food and drink, 2. psychological needs which are met by a sense of satisfaction, rest, relaxation, etc., 3. social needs which are met through family, friends and community, 4. creative and spiritual needs that are fulfilled through knowledge, truth, love, etc.

These needs must be met in a balanced way. If a person chooses to fulfill these needs unequally, then he has determined subjectively what is good for him, which is not necessarily good objectively. Whether due to ignorance or due to moral weakness,

a person may not consider all of these needs in making ethical decisions, resulting in conflicts in the area of moral decisions.

Bioethics is a branch of normative ethics, bioethics or biomedical ethics is ethics related to medical practice and/or research in the biomedical field.

Some examples of questions in bioethics are: Is a doctor morally obligated to tell someone in a terminal stage that he or she is dying? Is disclosing medical secrets morally justified? Is abortion or euthanasia morally justified?

Bioethical questions can also concern whether or not a law can be justified from an ethical perspective, such as: Is it permissible to make a statutory regulation that requires a person to accept life-saving medical action, even if it is against his will? Can it be ethically justified if a law is made that requires admitting a mentally ill person to a hospital, even if it is against the patient's wishes? Can it be justified to make a regulation that allows any medical action requested by the patient to the doctor, even though there is actually no indication?

In determining actions in the field of health or medicine, in addition to considering the four basic needs above, decisions should also consider the patient's human rights. Violation of the patient's rights will also result in violation of the basic needs above, especially the patient's creative and spiritual needs.

Ethics is a scientific discipline that studies the good or bad of an attitude and or action of an individual or an institution in terms of morality. Judgment of good and bad and right and wrong from a moral point of view uses quite a number of ethical theory approaches. There are two ethical theories that many people adhere to, namely the theory of deontology and teleology. In summary it can be said that, Deontology teaches that the good or bad of an action must be seen from the action itself (I Kant), while teleology teaches to judge the good and bad of an action by looking at its results or consequences (D Hume, J Bentham, JS Mills). Deontology is more based on religious teachings, traditions and culture.

Beauchamp and Childress (1994) explained that to reach an ethical decision requires 4 basic moral principles and several rules below them, the four basic rules are:

1. The principle of autonomy, namely the moral principle that respects the rights of patients, especially the right to self-determination, is the moral principle that gave birth to the doctrine of informed consent.
2. The principle of beneficence, namely the moral principle that prioritizes actions aimed at the good of the patient. In beneficence, it is not only known that actions are for good, but also actions whose good side (benefit) outweighs the bad side (harm).
3. The principle of non maleficence, namely the moral principle that prohibits actions that worsen the patient's condition, this principle is known as "primum non nocere" or "above all do no harm".
4. The principle of justice, namely the moral principle that emphasizes fairness and fairness in behavior and in distributing resources (distributive justice).

While the derivative rules are veracity (truthful, honest and open speaking), privacy (respecting patient privacy rights), confidentiality (maintaining patient confidentiality), and fidelity (loyalty and promise keeping).

In addition to the basic moral principles or principles above which must be used as guidelines in making clinical decisions, medical professionals are also familiar with professional ethics as a guide in attitude and behavior (code of ethical conduct). The values in professional ethics are reflected in the doctor's oath and medical code of ethics. The doctor's oath contains a "moral contract" between the doctor and God, while the medical code of ethics contains a "moral obligation contract" between the doctor and his professional community.

Ethical decision-making, especially in clinical situations, can also be approached in a different way. Jonsen, Siegler and Winslade developed an ethical theory that uses 4 essential topics in clinical services, namely:

1. Medical indications, the assessment of aspects of medical indications is reviewed from an ethical perspective, especially using the principles of beneficence and non-maleficence.
2. Patient preferences, paying attention to the patient's values and assessment of the benefits and burdens he will receive, which means a reflection of the principle of autonomy.
3. Quality of life, is the actualization of one of the goals of medicine, namely to improve, maintain or enhance the quality of human life. What, who and how to perform quality of life assessment are ethical questions around prognosis, which are related to beneficence, non-maleficence and autonomy.
4. Contextual features, discusses ethical questions around non-medical aspects that influence decisions, such as family, economic, religious, cultural, confidentiality, resource allocation and legal factors.

The action of a doctor in carrying out his duty to treat a patient, always aims to cure his illness and save his life. Indonesian Code of Medical Ethics (KEKI), chapter II number 9: "Doctor's Obligations Towards Patients: A Doctor Must Always Bear In Mind The Obligation To Protect The Life Of Human Beings".

Hippocratic thought, namely: "Medicine is an attempt to reduce the suffering of patients, get rid of disease and not treat cases that do not require treatment."

Since the beginning of its history, mankind has recognized the existence of several fundamental qualities, which are inherent in absolutely every good and wise doctor. Namely purity of intention, sincerity in work, humility, and scientific and social integrity. Therefore doctors around the world base the medical tradition and discipline on a professional ethic known as the Code of Medical Ethics.

Medical ethics has been used since there were people in society who had the duty to treat sick people. Although unwritten, these norms outline the behavior of the person treating the patient. Among these norms the oldest is the Hindu doctor's oath written in 1500 BC. Among the most important themes contained in this oath is "Do not harm the patient being treated".

The Code of Medical Ethics in Indonesia was refined at the Second National Working Conference on Medical Ethics in 1981, and further refined at the 13th National Working Meeting of the Indonesian Doctors Association, 1983. The Indonesian Code of Medical Ethics consists of four chapters. Where chapter I discusses general obligations, chapter II discusses doctors' obligations to patients, chapter III discusses doctors'

obligations to colleagues, and chapter IV discusses doctors' obligations to themselves. Among the important articles is article nine chapter two concerning the doctor's obligations to patients, which reads: "A doctor must always remember the obligation to protect human life".

From this article it can be understood that every doctor wherever he is is obliged to maintain and maintain human life. This means that regardless of the condition and severity of a patient, every doctor must protect and preserve the patient's life. Even though in such a situation the patient can no longer be cured, or has been in a dying state for months on end, a doctor cannot escape the obligation to protect his life. Even though sometimes he is forced to perform medical procedures which are very dangerous, this is done after careful consideration, that there is no other way to save the patient from the threat of death other than this action.

This is reinforced by the explanation from article 9 chapter II of the pre-revised version: "God calls on all nature to create man and determines that His creation will one day meet its end. No doctor, however clever, could prevent it. The strongest instinct in animate creatures, including humans, is to defend their lives. For this reason, humans are given reason, the ability to think and gather experience. Thus building and developing science and avoiding the danger of death. These are all included in the duties of a doctor. He must strive to preserve and sustain human life.

### 3 Conclusion

Termination of medical action in brain stem dead patients is regulated in PMK No. 290 of 2008 concerning Approval of Medical Actions and PMK No. 37 of 2014 concerning Determination of Mortality and Utilization of Donor Organs. The bioethical view of discontinuing medical procedures in brain stem dead patients, the actions of a doctor in carrying out his duty to treat a patient, are always aimed at curing his illness and saving his life. The Indonesian Code of Medical Ethics (KEKI), chapter II number 9 "Obligations of Doctors towards Patients: A Doctor Must Always Bear in Mind the Obligation to Protect Human Life".

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