EXPLORING THE OPTION OF PROFESSIONAL SELF-REGULATION IN PHILIPPINE MEDICAL NEGLIGENCE CASES*

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The medical profession is the most heavily self-policed field of any. There are many official professional committees and unofficial forms of peer pressure geared to correct poor conduct and encourage excellence. Of course, even such intensive self-policing is far from perfect, for the sanctity of the physician-patient relationship and the civil rights of the physician must be protected also. Nevertheless, overall the public interest has been well served by the medical profession's sense of noblesse oblige.[1]

INTRODUCTION

For so many centuries, the medical profession has been esteemed as one that is noble, effective and erudite. Because of this impression, people looked up to healers and physicians as gods. They believed healers are messiahs of good health whose orders should not be questioned, lest they be not cured of their diseases. This mentality carried on for so long that people became complacent and confident that doctors can heal anything through their craft or science. Rare were the times that they thought these men were also fallible, prone to reasonable hunches and to say the obvious, human.

The practice of medicine is not an exact science. Nor is it a precise application of a formula that is foolproof. Rather, the practice of medicine is nothing more than the application of medical knowledge to arrive at the most reasonable and substantiated scientific hunch. However, scientific hunches they may be, they are judgment calls which involve the application of science and logic. This means that they are neither plain guesswork nor luck, but technology in its simplest and most neutral form. It is the misuse of such technology with resulting adverse effects that leads to the incident of medical malpractice.

In a line of cases decided by the Supreme Court, medical malpractice or medical negligence arises when a doctor or medical professional fails to exercise

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[1] MYRON SCHOENFELD, STRICTLY CONFIDENTIAL: HOW DOCTORS MAKE DECISIONS (1990).

the standard of care required by his profession in the treatment or handling of patients. This means that even though the doctor employed science and his skills, his failure to exercise the diligence that the profession exacts would still make him liable of malpractice.

Thus, the elements of medical malpractice are duty, breach, injury and causation[2]. Duty refers to those standards which the medical profession requires in the conduct of the practice. Breach is the failure to abide by such standards. Injury is the adverse effect on the patient which resulted from the breach of the duty. Causation is the link between the breach and the injury which shows that the former indeed gave rise to the latter.

In the context of the Philippines, several attempts[3] at legislating against medical malpractice have been initiated. However, these did not become laws because of several legal, moral and cultural issues, which drive home the point that neither the public nor the profession is ready to comply and bear the consequences. Moral issues such as the duty to provide medical service to the people and to protect the profession or their peers weigh heavily on the shoulders of medical practitioners. Cultural issues such as the familial relationship between the doctors and their patients, as well as the value of *amor propio*, lead to the reluctance in filing or pursuing medical malpractice claims. Lastly, legal issues such as negligence, sufficiency of evidence, causation, prescription and others, the nature of which admits equally valid yet contrasting merits, make it hard to legislate against medical malpractice.

Ultimately, the core issues during debates on these initiatives revolve on whether or not the existing general laws and code of ethics are sufficient to address medical malpractice; and if not, what system can be offered to address it. These options will be the main inquiry of this legal paper.

This paper, however, will be of limited scope. The discussion will focus on the practice of medicine[4] by physicians. There is an assumption that the physicians contemplated herein are licensed to practice medicine. Before delving into the options on addressing the medical malpractice problem, it is proper to

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[2] Reyes v. Sisters of Mercy Hospital, G.R. No. 130547, 396 Phil. 87, Oct. 3, 2000.

[3] Different House and Senate Bills on medical malpractice i.e. House Bill No. 4955, Senate Bill Nos. 2303, 2298, 808, 2235, and 2359 to name a few.

[4] PETER NG & PHILIPP PO, MEDICAL LAWS AND JURISPRUDENCE (LEGAL ASPECTS OF MEDICAL PRACTICE) 91 (2006).

> The practice of medicine includes the diagnosis, treatment, correction, advisement, or prescription for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary.

explore first the sources of duties and obligations of physicians to determine the legal parameters surrounding each option.

I. SOURCES OF DUTIES AND OBLIGATIONS

A. Medicine as a Profession

The medical profession is traditionally imbued with the desire to render service. It is said that the desire to render public service is a factor that distinguishes a profession from a business.[5] Although it can easily be said nowadays that doctors also need to be businessmen if they are to survive the cutthroat competition and generally rising cost of living, it still cannot be denied that they are first and foremost, professionals. Their vocation to heal should trump their desire to profit. Not only are they expected to be professionals because of the knowledge and skill that they have acquired from education and practice, they are also ordained as professionals in the traditional sense, as stated in the Hippocratic Oath[6].

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[5] RUBEN AGPALO, LEGAL ETHICS 1 (2009).

[6] HIPPOCRATIC OATH

> I swear by Apollo the Healer, by Aesculapius, by Health and all the powers of healing and to call witness all the Gods and Goddesses that I may keep this oath and promise to the best of my ability and judgment. I will pay the same respect to my master in the science as to my parents and share my life with him and pay all my debts to him. I will regard his sons as my brothers and teach them the science, if they desire to learn it, without fee or contract. I will hand on precepts, lectures and all other learning to my sons, to those of my master and to those pupils duly appointed and sworn and to none other.
>
> I will use my power to help the sick to the best of my ability and judgment. I will abstain from harming or wrong doing any man by it. I will not give a fatal draught to anyone if I am asked, nor will I suggest any such thing. Neither will I give a woman means to procure an abortion. I will be chaste and religious in my life and in my practice. I will not cut, even for the stone, but I will leave such procedures to the practitioners of that craft. Whenever I go into a house I will go to help the sick and never with the intention of doing harm or injury. I will not abuse my position to indulge in sexual contacts with the bodies of women or of men whether they be freemen or slaves. Whatever I see or hear, whether professionally or privately which ought not to be divulged I will keep secret and tell no one. If therefore, I observe this oath and do not violate it, may I prosper both in my life and in my profession, earning good repute among all men for all time. If I transgress and foreswear this oath, may my lot be otherwise.

In the same way that the Lawyers' Oath guides lawyers in the practice of their profession, the Hippocratic Oath also lays down the duties and ideal conduct in the practice of medicine. Essentially, it emphasizes the application of skills and good judgment, the expectation to set a good example, the preservation of human life, and the cultivation of relationships with patients and peers.

Although the Hippocratic Oath is hardly seen in itself as a concrete legal ground for a cause of action, it still provides the general conduct expected of a doctor, which in turn is operationalized in subsequent legislation and code of ethics.

B. Medicine as an Occupation

Medicine as an occupation is mainly governed by a Code of Medical Ethics. In the Philippines, medical professionals follow the Code of Ethics of the Board of Medicine of the Philippine Regulatory Commission (PRC) and the Code of Ethics of Medical Profession of the Philippine Medical Association (PMA).[7] The PRC Modernization Act of 2000 also lays down the functions[8] of the

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[7] Ng & Po, *supra* note 4, at 101.

[8] Rep. Act. No. 8981, §9, (2000).

> Powers, Functions and Responsibilities of the Various Professional Regulatory Boards. – The various, professional regulatory boards shall retain the following powers, functions and responsibilities:
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> (a) To regulate the practice of the professions in accordance with the provisions of their respective professional regulatory laws;
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> (b) To monitor the conditions affecting the practice of the profession or occupation under their respective jurisdictions and whenever necessary, adopt such measures as may be deemed proper for the enhancement of the profession or occupation and/or the maintenance of high professional, ethical and technical standards, and for this purpose the members of the Board duly authorized by the Commission with deputized employees of the Commission, may conduct ocular inspection in industrial, mechanical, electrical or chemical plants or establishments, hospitals, clinics, laboratories, testing facilities, mines and quarries, other engineering facilities and in the case of schools, in coordination with the Commission on Higher Education (CHED);
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> (c) To hear and investigate cases arising from violations of their respective laws, the rules and regulations promulgated thereunder and their Codes of Ethics and, for this purpose, may issue summons, subpoena and subpoena duces tecum to alleged violators and/or witnesses to compel their attendance in such investigations or hearings: Provided, That, the decision of the Professional Regulatory Board shall, unless appealed to the Commission, become final and executory after fifteen (15) days from receipt of notice of judgment or decision;
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> (d) To delegate the hearing or investigation of administrative cases filed before them except in cases where the issue or question involved strictly concerns the practice of the profession or occupation, in which case, the hearing shall be presided over by at least one (1) member of the Board concerned assisted by a Legal or Hearing Officer of the Commission;

constituent regulatory boards of the PRC, among which is the Board of Medical Examiners. Some of the functions of the Board of Medical Examiners are to study the conditions affecting the practice of medicine in all parts of the Philippines, and to exercise the powers conferred upon it with the view of maintaining the ethical and professional standards of the medical profession.[9]

In the Philippines, physicians who are authorized to practice medicine are those who passed the Medicine Licensure Board Exams and registered with the PRC. Hence, they are bound by the PRC Board of Medicine Code of Ethics. The Philippine Medical Association (PMA) Code of Ethics, on the other hand, only governs around a majority of these physicians since membership in the PMA is optional. Out of 130,000 registered doctors with the PRC, only 65,000 are PMA members.

These codes of ethics lay down the general principles and duties of a physician. These duties are further categorized into duties to their patients, to their colleagues and to the profession. In short, they point out the different stakeholders of the medical profession and the proper conduct required of physicians in their transactions with them. It has been said that the importance accorded to ethics in medical decision-making differentiates doctors from

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(e) To conduct, through the Legal Officers of the Commission, summary proceedings on minor violations of their respective regulatory laws, violations of the rules and regulations issued by the boards to implement their respective laws, including violations of the general instructions to examinees committed by examinees, and render summary judgment thereon which shall, unless appealed to the Commission, become final and executory after fifteen (15) days from receipt of notice of judgment or decision;

(f) Subject to final approval by the Commission, to recommend registration without examination and the issuance of corresponding certificate of registration and professional identification card;

(g) After due process, to suspend, revoke or reissue, reinstate certificate of registration or licenses for causes provided by law;

(h) To prepare, adopt and issue the syllabi or tables of specifications of the subjects for examinations in consultation with the academe; determine and prepare the questions for the licensure examinations which shall strictly be within the scope of the syllabus or table of specifications of the subject for examination; score and rate the examination papers with the name and signature of the Board member concerned appearing thereon and submit the results in all subjects duly signed by the members of the Board to the Commission within ten (10) days from the last day of examination unless extended by the Commission for justifiable cause/s; and subject to the approval by the Commission, determine the appropriate passing general average rating in an examination if not provided for in the law regulating the profession; and

(i) To prepare an annual report of accomplishments on programs, projects and activities of the Board during the year for submission to the Commission after the close of each calendar year and make appropriate recommendations on issues or problems affecting the profession to the Commission.

[9] Rep. Act. No. 2382, §22, (1959).

"scientific savages". In the absence of ethics, the medical profession would cease to exist.[10]

These codes of ethics can, therefore, be sources of rights and obligations. The breach of the standard of conduct prescribed therein can constitute a cause of action for the aggrieved party. The text of the provisions on Human Relations[11] can reasonably be construed to transform these codes of ethics into codified morals, the willful breach of which would be sufficient to give rise to a cause of action. Hence, a complaint can be taken cognizance of by the Commission on Ethics[12] of the PMA or by the Board of Medical Examiners[13] of the PRC on the basis of a breach of their respective codes of ethics; or by the regular courts as a violation of the Human Relations provisions in the Civil Code.

C. Doctors as Citizens of the State

Doctors are citizens of the state before they became medical professionals. They did not cease to be such when they were admitted into the medical profession. Hence, as members of such profession, they wear two hats: 1) as citizens, and 2) as physicians. As physicians, their conduct is governed by the Hippocratic Oath and the Codes of Medical Ethics. As citizens, they are bound by the Civil Code of the Philippines (hereinafter Civil Code).

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[10] Schoenfeld, *supra* note 1, at 19.

[11] *See* notes 16-18 for the complete texts of the provisions on Human Relations (Civil Code arts. 19-21).

[12] PMA By-laws, § 3(A)

> Commission on Ethics. The Commission on Ethics shall govern the conduct of members in their relationships with each other, with the Association, and with the public. It shall establish its procedures for dealing with complaints raised and/or referred to it, and make recommendations for the resolution of such cases. The Commission shall also proclaim, with the approval of the Board, a Code of Ethics for the guidance of the members of the Association.

Interview with Dr. Bu Castro, former PMA President, Manila, October 18, 2010.

> "The PMA Commission on Ethics was formed under the PMA Bylaws and it is tasked to look into the ethical conduct of its members in relation to the patient, a colleague in the profession, the doctors' social duties and his duties to the community, and in relation to the allied health workers and the pharmaceutical industry.
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> It has 5 members appointed by the PMA President and confirmed by the PMA Board of Governors. The position has 3 years tenure except the position of the Chairman which the PMA President may appoint every year.
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> There is no written qualification of the members of the PMA Commission on Ethics but most of the members are mostly elders (former Presidents), ethicists, and now most are doctor-lawyers or doctors with background in law."

[13] Rep. Act. No. 2382, §22, (1959).

In cases of medical malpractice, the most common provisions used by the aggrieved and complaining party are Articles 2176[14] and 2180[15] of the Civil Code. Article 2176 is used to hold a physician liable for negligence or quasi-delict, while Article 2180 is used to hold a hospital liable for the negligence of a physician in its employ.[16]

In cases when Article 2176 is not applicable, the provisions on Human Relations i.e. Articles 19[17], 20[18], and 21[19] may be applied. The last two provisions may be used against intentional medical malpractice since they clearly cover cases where damage is caused "willfully".[20] Moreover, the provisions on Damages in the

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[14] CIVIL CODE, art. 2176

> Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called a quasi-delict and is governed by the provisions of this Chapter. (1902a)

[15] CIVIL CODE, art. 2180

> The obligation imposed by Article 2176 is demandable not only for one's own acts or omissions, but also for those of persons for whom one is responsible.
>
> The father and, in case of his death or incapacity, the mother, are responsible for the damages caused by the minor children who live in their company.
>
> Guardians are liable for damages caused by the minors or incapacitated persons who are under their authority and live in their company.
>
> The owners and managers of an establishment or enterprise are likewise responsible for damages caused by their employees in the service of the branches in which the latter are employed or on the occasion of their functions.
>
> Employers shall be liable for the damages caused by their employees and household helpers acting within the scope of their assigned tasks, even though the former are not engaged in any business or industry.
>
> The State is responsible in like manner when it acts through a special agent; but not when the damage has been caused by the official to whom the task done properly pertains, in which case what is provided in Article 2176 shall be applicable.
>
> Lastly, teachers or heads of establishments of arts and trades shall be liable for damages caused by their pupils and students or apprentices, so long as they remain in their custody.
>
> The responsibility treated of in this article shall cease when the persons herein mentioned prove that they observed all the diligence of a good father of a family to prevent damage. (1903a)

[16] Professional Services, Inc. v. Agana, G.R. No. 126297, 513 SCRA 478, 507, Jan. 31, 2007.

[17] CIVIL CODE, art. 19

> Every person must, in the exercise of his rights and in the performance of his duties, act with justice, give everyone his due, and observe honesty and good faith.

[18] CIVIL CODE, art. 20

> Every person who, contrary to law, wilfully or negligently causes damage to another, shall indemnify the latter for the same.

[19] CIVIL CODE, art. 21

> Any person who wilfully causes loss or injury to another in a manner that is contrary to morals, good customs or public policy shall compensate the latter for the damage.

[20] Joseph Joemer Perez, Ronald Policarpio and Anna Nerissa Paz, *Medical Malpractice Law in the Philippines: Present State and Future Directions,* 78 Phil.L.J. 687, 696 (2004).

Civil Code can also be used to claim for damages arising from the injury which resulted from medical negligence.

D. The Medical Profession as a Subject of Public Policy

Public interest demands that the relation between government and private physicians should be friendly and cordial. The promotion and protection of public health depend greatly upon the cooperation between government and private physicians.[21] Being a profession imbued with public interest, the medical profession is a state concern, thus, governed by the Revised Penal Code of the Philippines (RPC). Though not explicitly designated therein as medical malpractice or medical negligence, the case of medical malpractice or negligence still comes within the purview of Article 365[22] of the RPC, Imprudence and Negligence.

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[21] Board of Medicine Code of Ethics, §18.

[22] REV. PEN. CODE, art. 365

> Imprudence and negligence. — Any person who, by reckless imprudence, shall commit any act which, had it been intentional, would constitute a grave felony, shall suffer the penalty of *arresto mayor* in its maximum period to *prision correccional* in its medium period; if it would have constituted a less grave felony, the penalty of *arresto mayor* in its minimum and medium periods shall be imposed; if it would have constituted a light felony, the penalty of *arresto menor* in its maximum period shall be imposed.
>
> Any person who, by simple imprudence or negligence, shall commit an act which would otherwise constitute a grave felony, shall suffer the penalty of *arresto mayor* in its medium and maximum periods; if it would have constituted a less serious felony, the penalty of *arresto mayor* in its minimum period shall be imposed.
>
> When the execution of the act covered by this article shall have only resulted in damage to the property of another, the offender shall be punished by a fine ranging from an amount equal to the value of said damages to three times such value, but which shall in no case be less than twenty-five pesos.
>
> A fine not exceeding two hundred pesos and censure shall be imposed upon any person who, by simple imprudence or negligence, shall cause some wrong which, if done maliciously, would have constituted a light felony.
>
> In the imposition of these penalties, the court shall exercise their sound discretion, without regard to the rules prescribed in Article sixty-four.
>
> The provisions contained in this article shall not be applicable:
>
> 1. When the penalty provided for the offense is equal to or lower than those provided in the first two paragraphs of this article, in which case the court shall impose the penalty next lower in degree than that which should be imposed in the period which they may deem proper to apply.
>
> 2. When, by imprudence or negligence and with violation of the Automobile Law, to death of a person shall be caused, in which case the defendant shall be punished by *prision correccional* in its medium and maximum periods.
>
> Reckless imprudence consists in voluntary, but without malice, doing or falling to do an act from which material damage results by reason of inexcusable lack of precaution on the part of the person performing of failing to perform such act, taking into consideration his employment or occupation, degree of intelligence, physical condition and other circumstances regarding persons, time and place.

In addition to article 365 of the RPC, there are also other felonies applicable to medical malpractice cases. To a certain extent, the provisions for these other felonies are akin to the Human Relations provisions in the Civil Code because they apply to instances where physicians intentionally inflict injury on their patients.[23] These are homicide[24], murder[25], infanticide[26], mutilation[27], physical injuries[28], abortion[29], and giving assistance to suicide[30].

With the foregoing sources of obligations, negligence in medical malpractice cases is dichotomized to be civil or criminal in nature. The quantum of proof in civil cases is preponderance of evidence while that in criminal cases is guilt beyond reasonable doubt. The burden of proof in civil cases lies with the one who alleges a claim, which is usually the plaintiff. In criminal cases, the burden of proof lies with the prosecution and the presumption of innocence is conferred on the accused.

Thus, article 365 of the RPC is rarely used because of the higher quantum of proof and presumption of innocence. The less stringent quantum of proof in civil cases explains why article 2176 of the Civil Code is frequently used.

In sum, the various sources of obligations (the Hippocratic Oath, the codes of ethics, the Civil Code, and the Revised Penal Code) provide the aggrieved party with several venues from which he can simultaneously obtain redress for his or her injury. These venues are the regular courts, the PMA Commission on Ethics, and the PRC Board of Medical Examiners.

E. Doctrines in Jurisprudence

The interplay of duties and expectations arising from sources of obligations previously mentioned is better shown by and appreciated in jurisprudence. The cases on medical malpractice or medical negligence decided by

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> Simple imprudence consists in the lack of precaution displayed in those cases in which the damage impending to be caused is not immediate nor the danger clearly manifest.
>
> The penalty next higher in degree to those provided for in this article shall be imposed upon the offender who fails to lend on the spot to the injured parties such help as may be in this hand to give. (As amended by R.A. 1790, approved June 21, 1957).

[23] Perez, et. al., *supra* note 20, at 698.
[24] REV. PEN. CODE, art. 249
[25] REV. PEN. CODE, art. 248
[26] REV. PEN. CODE, art. 255
[27] REV. PEN. CODE, art. 262
[28] REV. PEN. CODE, art. 263-266
[29] REV. PEN. CODE, art. 259 in relation to art. 256 *(provisions related by* Perez, et al.*)*
[30] REV. PEN. CODE, art. 253

the Supreme Court of the Philippines (hereinafter "Supreme Court") operationalize the applicable provisions in general laws. When there was still scarce Philippine jurisprudence on the subject, American cases and doctrines were applied in deciding medical malpractice cases. Though not binding, American cases were accorded persuasive effect.[31] With time, the number of medical negligence cases decided by the Supreme Court has increased.[32] Nevertheless, American doctrines such as the "captain-of the-ship doctrine"[33] and the "agency principle of apparent authority or agency by estoppel"[34] are still applied.

The most discussed provision in medical negligence jurisprudence is article 2176 of the Civil Code. Three doctrines relevant to its application are observable. These are 1) the definition of medical malpractice or medical negligence, 2) the elements of medical malpractice or medical negligence, and 3) the required evidence to prove medical negligence.

A medical negligence case is a type of claim to redress a wrong committed by a medical professional, that has caused bodily harm to or the death of a patient.[35] Medical malpractice is a particular form of negligence which consists in the failure of a physician or surgeon to apply to his or her practice of medicine that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions, and in like surrounding circumstances.[36] The said degree

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[31] Enrique Teehankee, *The Liability of Physicians for Professional Negligence,* 49 Phil.L.J. 462, 462 (1974).

[32] Based on the author's manual count, the Supreme Court decided eleven (11) cases of medical negligence in the period of 2001-2009, while only four (4) in the years before that.

For the **2001-2009 period**, the cases are: *Reyes v. Sisters of Mercy Hospital* (Oct. 3, 2000), *PRC v. De Guzman* (June 21, 2004), *Nogales v. Capitol Medical Center* (Dec. 19, 2006), *Professional Services, Inc. v. Agana* (Jan. 31, 2007), *Garcia v. Salvador* (Mar. 30, 2007), *Cantre v. Go* (Apr. 27, 2007), *Ilao-Oreta v. Ronquillo* (October 11, 2007), *Board of Medicine v. Ota* (Jul. 14, 2008), *Flores v. Pineda* (Nov. 14, 2008), *Cayao-Lasam v. Ramolete* (Dec. 18, 2008), *Lucas v. Tuano* (Apr. 21, 2009).

The four cases **prior to the 2001-2009 period** are: *Batiquin v. Court of Appeals* (Jul. 5, 1996), *Garcia-Rueda v. Pascasio* (Sept. 5, 1997), *Cruz v. Court of Appeals* (Nov. 18, 1997), *Ramos v. Court of Appeals* (Dec. 29, 1999).

[33] Ramos v. Court of Appeals, G.R. No. 124354, 378 Phil.1198, 1239, Dec. 29, 1999, *also applied in* Professional Services, Inc. v. Agana, G.R. No. 126297, 513 SCRA 478, 494, Jan. 31, 2007.

> [FN73] Under this doctrine, the surgeon is likened to a ship captain who must not only be responsible for the safety of the crew but also of the passengers of the vessel. The head surgeon is made responsible for everything that goes wrong within the four corners of the operating room. It enunciates the liability of the surgeon not only for the wrongful acts of those who are under his physical control but also those wherein he has extension of control.

[34] Professional Services, Inc. v. Agana, G.R. No. 126297, 513 SCRA 478, 502, Jan. 31, 2007.

> Thus, in cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital, then the hospital will be liable for the physician's negligence.

[35] Flores v. Pineda, G.R. No. 158996, 571 SCRA 83, 91, Nov. 14, 2008.

[36] Cayao-Lasam v. Ramolete, G.R. No. 159132, 574 SCRA 439, 454, Dec. 18, 2008, *citing* Reyes v. Sisters of Mercy Hospital, G.R. No. 130547, 396 Phil. 87, Oct. 3, 2000.

of care and skill is set by the specialty societies of the PMA. This is very important because the testimony of an expert witness within the specialty society of the respondent-physician is required to show that he or she was indeed guilty of breaching the society's duty of care to the plaintiff-patient.[37]

Medical negligence is similar to common negligence. The only difference is that the former occurs in the course of medical or health care. In both cases, the legal issues are the same as the legal elements.[38] The four elements involved in medical malpractice or medical negligence cases are: 1) duty, 2) breach, 3) injury, and 4) proximate causation.[39] As to duty, the physician has the duty to use at least the same level of care that any other reasonable competent physician would use to treat the condition under similar circumstances.[40] There is actionable breach or improper performance of this duty when a patient is injured in body or in health.[41] To recover for an injury, it must be shown that the "injury for which recovery is sought must be the legitimate consequence of the wrong done; the connection between the negligence and the injury must be a direct and natural sequence of events, unbroken by intervening efficient causes".[42] The critical and clinching factor in a medical negligence case is proof of the causal connection between the negligence which the evidence established and the plaintiff's injuries.[43]

In proving both injury and breach, expert testimony is required evidence.[44] This has been the consistent holding of the Supreme Court on matters of evidence concerning medical malpractice cases. Expert testimony is necessary because the causes of the injuries ordinarily involved in the malpractice action are technical and determinable only in light of scientific knowledge.[45][46] *Ramos v. Court of Appeals*[47] provides an exception to this, ruling that the application of the doctrine of *res ipsa loquitur*[48] dispenses with the required expert testimony.[49]

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[37] PETER NG & PHILIPP PO, MEDICAL LAWS AND JURISPRUDENCE (LEGAL ASPECTS OF MEDICAL PRACTICE) 88 (2006).

[38] *Id.* at 297.

[39] *See* note 36, *supra* at 454, *citing* Reyes v. Sisters of Mercy Hospital, G.R. No. 130547, 396 Phil. 87, Oct. 3, 2000., *which also cited* Garcia-Rueda v. Pascasio, G.R. No. 118141, Sept. 5, 1997..

[40] Lucas v. Tuano, G. R. No. 178763, 586 SCRA 173, 200, Apr. 21, 2009.

[41] Garcia-Rueda v. Pascasio. G.R. No. 118141,,344 Phil. 323, 332, Sept. 5, 1997 , *citing* Hoover v. Williamson, 236 Md 250 (1964).

[42] *See* note 40, *supra* at 202,

[43] *See* note 35, *supra* at 99.

[44] *Id.* at 200.

[45] Enrique Teehankee, *The Liability of Physicians for Professional Negligence,* 49 Phil.L.J. 462, 482 (1974).

[46] The expert testimony of a physician in medical malpractice case is an exception to the general rule that the opinion of a witness is not admissible in evidence; *see* Rule 130, § 48-49 of the RULES OF COURT.

[47] Ramos v. Court of Appeals, G.R. No. 124354, 378 Phil.1198, Dec. 29, 1999. In this case, the testimony a relative of the patient who was present during the operation was admitted as competent evidence by the Supreme Court to prove medical negligence of the head physician surgeon. Her (the relative's) testimony contained her observations on the conduct of the physicians during the operation which patently showed that there was something amiss or improperly done during the procedure. The court ruled

It can be gleaned in the cases that the usual trigger in the filing of a medical malpractice suit is the injury or death of a patient which allegedly resulted from an operation or procedure handled by the physician or surgeon. This is because of the physician-patient relationship which existed between the doctor and the victim,[50] and the prestations between the parties are enforced based on the contractual nature of such relationship. In such relationship, the agreement is that the patient pays the doctor so that the doctor will cure the patient. This does not take into account the fact that medicine is not an exact science, and that however skilled and knowledgeable a physician is, he is still not capable of accounting for all the possibilities accompanying his or her patient's case.

It could be that the doctor made a correct diagnosis and/or performed the proper procedure based on the facts diligently acquired at that time. Or, there may be significant facts long concealed or hidden that only surfaced after the diagnosis or procedure thereby materially altering the doctor's theory on the patient's case. Or, it could just be that the disease or illness is of a rare or a novel kind that the conventional or textbook way of dealing with it is insufficient to arrive at a proper diagnosis. Some physicians even go so much and say in good faith that it should be the sickness that should be blamed, not the physician who has done everything in his or her power to heal. However, despite all these possibilities, gross negligence or recklessness still cannot be discounted.

On the other hand, the usual defense of the physician in a medical malpractice suit is that the doctor exercised the standard of care, skill and diligence ordinary employed by the profession. The doctor will reason out that despite the existence of a contractual physician-patient relationship, the prestations therein are different from what the patient assumed they would be. He or she will argue that the contract involves the payment of the patient for the physician's services to do everything he or she *can* to cure the patient. The only guarantee the physician made was to exercise the required diligence by employing everything within his or her power to help the patient rid his or her body of the disease or illness. The law holds that the patient takes an inherent risk when submitting him or herself to the doctor. There is an implied contract between them in which the patient is told,

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that since her testimony on the conduct of the physicians during that time was not technical in nature, then she is competent to testify on such matters.

[48] *Id.* at 1219. "*Res ipsa loquitur* is a Latin phrase which literally means 'the thing or the transaction speaks for itself...[It] is simply a recognition of the postulate that, as a matter of common knowledge and experience, the very nature of certain types of occurrences may justify an inference of negligence on the part of the person who controls the instrumentality causing the injury in the absence of some explanation by the defendant who is charged with negligence."

[49] *Id.* at 1221.

[50] See note 40, *supra* at 199.

"Medicine is not an exact science. I will use my experience and best judgment. You take the risk that I might be wrong. I guarantee nothing."[51]

In a way, the doctor is impliedly saying that he or she has control only over the degree of diligence to exercise, in the belief that it will give rise to the expected result. And if the result is still otherwise despite said diligence, then the doctor should not be blamed for such unwanted result. That unfortunate result was never his or her intention, as shown by the degree of diligence employed. The Supreme Court faces the unique difficulty in adjudicating medical negligence cases because physicians are not insurers of life and, they rarely set out to intentionally cause injury or death to their patients.[52] Again, it is in this kind of conflict between duties and expectations that the court deems expert testimony indispensable.

II. LEGAL AND MORAL PREDICAMENTS

A. License to Practice Medicine versus Medicine as Not an Exact Science

Despite the fact that medicine is not an exact science, it is nevertheless undeniable that to some extent, medicine represents itself to be capable of delivering results. It is common knowledge that physicians study medicine so that they can put themselves out as capable of healing people and curing illnesses. A physician or surgeon, by taking charge of a case, impliedly represents that he or she possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he or she practices in, and which is ordinarily regarded by those conversant with the employment as necessary to qualify him or her to engage in the business of practicing medicine and surgery.[53]

Because public health is viewed as a public good, the medical profession, as one of the providers of health care, is considered a significant sector in society. This is because the profession helps make citizens productive by keeping them in good physical condition. Because of this public interest, the state deemed its regulation an important agenda. Hence, the practice of medicine is regulated under a licensing regime.

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[51] Teehankee, supra note 45, at 471.

[52] Ramos v. Court of Appeals, G.R. No. 124354, 378 Phil.1198, Dec. 29, 1999

> However, intent is immaterial in negligence cases because where negligence exists and is proven, the same automatically gives the injured a right to reparation for the damage caused.

[53] Teehankee, *supra* note 45 at 464.

The grant of license[54] to practice medicine is an act of regulation by the state to make sure that those who are allowed to practice the profession are competent and equipped with the minimum required skills and qualifications. The practice of medicine is a privilege and not a right; hence the state can take it away anytime, once the provisions of section 24 of the Medical Act of 1959, as amended, is violated.[55]

The question now arises as to what extent a license authorizes the physician to perform acts[56] in the exercise of his or her profession and also to what extent such exercise is justified or excused. There is a gray area of judgment call which involves the exercise of doctor's discretion. This gray area is especially prevalent in diagnoses and prescriptions. As a result, the final step in medical decision-making usually consists of the imposition of that particular doctor's own value-judgments on the data, thereby, characterizing medical decision-making as an art form.[57]

There is also the nebulous concept of negligence -- the determination of which varies from physician to physician. What may be due diligence to one would not be due diligence to the other. It could either be that one was just too cautious or that the other was just too complacent. Moreover, the appreciation of medical treatment may be so subjective as to give rise to a disconnect between the quality of care actually provided to patients and that which they expected to receive. In such case, the patients may find it hard to evaluate the quality of care

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[54] Rep. Act No. 2382, §8 (1959).

> Prerequisite to the practice of medicine. No person shall engage in the practice of medicine in the Philippines unless he is at least twenty-one years of age, has satisfactorily passed the corresponding Board Examination, and is a holder of a valid Certificate of Registration duly issued to him by the Board of Medical Examiners.

[55] Ng & Po, *supra* note 37, at 77.

[56] Rep. Act No. 2382, §8(1959).

> Acts constituting practice of medicine. A person shall be considered as engaged in the practice of medicine (a) who shall, for compensation, fee, salary or reward in any form, paid to him directly or through another, or even without the same, physical examine any person, and diagnose, treat, operate or prescribe any remedy for any human disease, injury, deformity, physical, mental or physical condition or any ailment, real or imaginary, regardless of the nature of the remedy or treatment administered, prescribed or recommended; or (b) who shall, by means of signs, cards, advertisements, written or printed matter, or through the radio, television or any other means of communication, either offer or undertake by any means or method to diagnose, treat, operate or prescribe any remedy for any human disease, injury, deformity, physical, mental or physical condition; or (c) who shall use the title M.D. after his name.

[57] MYRON SCHOENFELD, STRICTLY CONFIDENTIAL: HOW DOCTORS MAKE DECISIONS 226 (1990).

they receive. Hence, when there is a bad outcome, patients may not be able to readily determine whether bad luck or bad medicine was the cause.[58]

B. Self-Preservation versus Duty to Do No Harm

Another aspect in dealing with medical malpractice cases is the equally weighty issue of the doctor's self-preservation vis-à-vis his duty to do no harm. The perfect example of this debate is the issue on defensive medicine. In such a case, the physician requires the patient to undergo numerous tests, sometimes to the point of being unnecessary, just to show that he or she exercised due diligence.

Defensive medicine is a mode of self-preservation because the physician does not want to jeopardize his license to practice medicine, to the prejudice of his income and the welfare of his family. It may be in the form of defensive omissions such as the refusal to undertake procedure or to treat patients whom the physician believes to pose a high risk of suit.[59]

When defensive medicine is juxtaposed with a physician's duty to do no harm, it initially seems to complement rather than contrast against it. However, upon closer examination, it impinges on such duty. The costs accompanying numerous tests discourage patients from availing of the doctor's services, thereby leaving them unaided in their illnesses. Thus, defensive medicine, as the physician's act of self-preservation, really does indirect harm to existing and prospective patients, particularly those who are economically deficient.

In places where medical insurance figures prominently in the costs of defensive medicine, the cost of injuries is not internalized to the physician. This is because insurance payments cushion the blow of damages in medical malpractice suits to the erring physician. In effect, the tort system is frustrated in its potential role of correcting incentives for injury prevention because the actual burden of compensating the patient is reduced.[60]

There is also a profit aspect in this dilemma, as in the case where the physician, who is either the stockholder or owner of the hospital he or she is working for, orders unnecessary tests which are expensive. To cover up the profit motive, a doctor generally justifies or rationalizes such (laboratory or other) tests as a precaution against the risk of malpractice suits, which is rather remote in this

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[58] David Hyman & Charles Silver, Symposium, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid,* Vanderbilt Law Review 1085, 1102, May 2006.

[59] PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 146 (1985)

[60] *Id.* at 86.

country. Because these tests hurt the patient financially, they violate the ethical principle to do good and do no harm.[61]

C. Equal Protection *versus* Unequal Playing Field

Lastly, there is the issue of equal protection versus an unequal playing field. Members of the medical profession have been quite vocal that the medical malpractice legislation violates the equal protection clause for singling out the medical profession. Physicians argue that they are not the only profession which deals with human life. They cite as example the engineering profession, which also affects human life when buildings collapse, leading to many deaths.

In reconciling the conflict between equal protection and the unequal playing field, it is proper to keep in mind that the purpose of legal rights is to protect the weak and vulnerable in society. This is a class which the doctors can not truly claim to fit in since they belong to the most wealthy, powerful and respected. But despite having better circumstances in life, doctors still have rights. An example of this right is the right to impose the conditions for their practice such as consultation hours or the kind of patients that they will cater to.[62]

The sentiment of the public to level the unequal playing field between the physicians and the patients is also another consideration in this conflict. The playing field is unequal because the physicians have greater leverage to fix the price of their services because of the inelastic demand for them. This now puts the patients or the public, especially the economically deficient, at the mercy of the physicians. This inelastic demand still continues even if death or injury occurs or results from a physician-patient relationship. Nevertheless, the dearth of physicians in the country still makes it more practical to have them around rather than scare them away with malpractice suits.

III. THE CONTEXT

Given the issues surrounding medical malpractice, it is proper to explore the options and alternatives available to address them. In addition to the usual litigation in regular courts, various proposals to curb the problem have been put forth. These are medical malpractice legislation, professional self-regulation, specialized courts, and out-of-court settlements and/or alternative dispute resolution. Although there is no one and only way to forming the ultimate

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[61] Alfredo F. Tadiar, *Ethical and Legal Considerations for Today's Medical Professionals and Hospitals,* 6 J Reproductive Health, Rights and Ethics 1, 2 (2000).

[62] *Id.* at 8-9.

solution, hybrids can be created to suit the Philippine setting. The four additional proposals will be discussed *ad seriatim*, and the author will attempt to strike a hybrid proposal which will suit the Philippine version of medical malpractice.

However, before discussing the proposals, certain assumptions have to be laid down to clearly delineate the boundaries of the study. These assumptions are the following: 1) Filipino patients are not as litigious as the American ones in the author's US references; 2) the non-confrontational culture of Filipinos and the value of *amor propio* figure significantly in their treatment of doctors as family and in their avoidance of litigation; 3) the excess demand for health practitioners, especially physicians, is aggravated by the diaspora of health care practitioners abroad; and 4) medical malpractice insurance is not yet a trend in Philippine medical practice.

Having laid down those assumptions, we now go to the conflicts and options surrounding the subject, and examine them in light of the Philippine setting.

In ascertaining which among these proposals suits the Philippine medical malpractice setting, a cursory view of the conflicts must be made. The author sees two conflicts. The first concerns the medical profession which involves the conflict between the physician's duty to his patient (i.e. to do no harm), and his duty to his profession and the community (i.e. to perpetuate the image of a healer). The second involves society as the third party and entails the conflict between professional self-regulation (professionalism) and government interference (public health).

The Philippine Constitution confines the practice of medicine to Filipino citizens.[63] Admission to the profession is guarded by institutionalized educational standards, examinations, licensing and ongoing review of standards of medical practice. Physicians are expected to hold each other accountable for their behavior and for the outcomes they achieve for their patients.[64] In short, the physician is expected to pursue the welfare of his or her patient without compromising the interests of his or her profession as a medical practitioner.

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[63] CONST. art. XII, § 14, par.2

> The practice of all professions in the Philippines shall be limited to Filipino citizens, save in cases prescribed by law.

[64] Zorayda Leopando, *Medical Professionalism: A Key to Quality Health Care*, 44 Fil Fam Phy 35, 35 (March 2006).

As to the first conflict, what is significantly involved is the trust relationship between the physician and his or her patient. A physician has to take great pains at preserving this relationship by way of reasonable disclosure of relevant information to the patient. He must be able to honestly set reasonable expectations on what services and results he or she can provide, and be honest about any errors he or she might have committed that could put the safety of the patient at risk. In the same manner, the physician must conduct him or herself as someone capable, competent and confident to maintain authority and credibility to the patient, and protect the medical profession from any conduct that would discredit it.

The public also has heightened awareness in the advocacy of patient's rights. In the past, people looked up to doctors as professionals who know everything. This level of esteem for the profession led to "physician paternalism", to the point that everything the doctors said was followed. At present, many patients have become more conscious of their rights, some even asserting them to the extent of determining the "right to die in dignity." They now claim the right to choose which among the tests and procedures "suggested" by the doctors will be followed.[65] Because of this shift in the patients' attitude, doctors and other health practitioners are enjoined to maintain an open disposition, respect and tolerance for the right of patients to autonomy and dignity, either by way of full disclosure of all relevant information or acceptance of the fact that the patients will always have the last say on the procedure or tests he or she will undergo.[66]

As one author said, the physician-patient relationship must first be put in jeopardy before it can be redeemed.[67] This means that despite the risk posed by the physician's disclosure of his or her lapses of judgment or the difficulty to offer cure or recovery to a patient, it is still the doctor's duty to disclose to earn the patient's trust and confidence. The only issue here then is on how to strike a balance between reasonable disclosures and incriminating confessions.

As to the second conflict, two factors are involved: economics and regulation. The main actor here is the government. It is expected not only to oversee the efficient and effective functioning of the health care market, but also to make sure that there is no or minimal market failures (limitations to agency, lack of information, restrictions on choice, and barriers to exit)[68] resulting from non-

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[65] William Buot, *Hospital Ethics Committees: Their Development and Functions,* 6 J Reproductive Health, Rights and Ethics 13, 14 (2000).

[66] Alfredo Tadiar, *Ethical and Legal Considerations for Today's Medical Professionals and Hospitals,* 6 J Reproductive Health, Rights and Ethics 1, 8 (2000).

[67] Marlynn Wei, Note and Comment, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws,* Journal of Health Law 107, 150 (Winter 2007).

[68] Gail B. Agrawal, Article, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace,* Missouri

government interference. Economics in this case takes the form of patient demand as a function of the quality of health care services provided by the medical profession; however, it is not the only determinant of the proper functioning of this market.

The ideal medical market has been characterized as an integrative model based on mutual recognition and acceptance by patients and physicians of rights and responsibilities, which are enforced by traditional professional values, as well as market incentives and government regulation.[69] The health care market becomes an ideal medical market when all of these factors figure significantly and predictably in how the market moves. This basically means that the demand and supply of medical services are transparently affected by those factors, and its movement or behavior is directly predictable from their movement.. This is not the case in the Philippines.

That there is no ideal medical market in the country is manifested by the underreporting of medical malpractice cases. According to PRC data, only 638 cases were lodged with the Philippine Regulatory Commission (PRC) in a span of 11 years (from 2000 to 2010), only 266 of which has been decided.

It is important to note that a lot of these cases, not including those pending in or already resolved by regular courts, may have either been settled out of court or compromised. Some incidents may not have even been reported because of the high costs of litigation (filing fees, attorney's fees, expert witness' fees, etc.), or out of fear or reluctance to strain personal relations with the physician who may be the only one in the locality and who has already been treated as family or a friend, or to avoid the publicity and inconvenience of a trial.

IV. THE OPTIONS

The options for addressing medical malpractice issues are 1) specialized courts, 2) out-of-court settlements and/or alternative dispute resolution, 3) medical malpractice legislation, and 4) professional self-regulation. For a better appreciation of these options in terms of government participation, complexity, enforceability and regulatory standpoint, please see Annex A at the end of this paper.

Law Review 341, 369-77 (Spring 2001).

[69] *Id.* at 381.

A. Specialized Courts

Specialized medical malpractice courts are those equipped with judges who are trained to understand and assess the input of experts.[70] These courts are more competent to appreciate a medical malpractice case, either by virtue of the training of judges and/or the involvement of expert assistance.

The advantage of this system is that the trained judges are more familiar and qualified with the nature and intricacies of a medical malpractice case. Coupled with expert assistance, they are not only expected to understand the technical evidence proffered by the parties, but are also deemed more competent to rule on their admissibility and weight than judges in regular courts. In short, the judges, the experts and the parties *(as represented by their counsels)* are, more or less, on the same page in appreciating the evidence presented.

The problem with this system is that it entails a lot of costs, from the setting up of the courts, to the recruitment and training of judges and court employees. Moreover, the fraction of medical malpractice cases is not so significant vis-à-vis the total number of cases litigated in regular courts, thereby, making the establishment of these specialized courts premature and not yet necessary.

B. Out-of-court Settlements and/or Alternative Dispute Resolution

Out-of court settlement is a form of terminating litigation by settling the issue outside of court, *while* litigation is going on or pending. On the other hand, alternative dispute resolution is a mode of resolving conflicts either by mediation, arbitration or compromise *prior* to the filing of a case in court. They are similar in the sense that a full-blown trial is dispensed with early on, or before a trial is carried on to its conclusion.

Out-of-court settlements are the usual eventualities in medical malpractice cases, as can be seen from the patent underreporting of medical malpractice incidents. Either these incidents are settled informally by way of forgiveness or payment of costs incurred from the injury, or by a compromise agreement embodied in a written instrument where the aggrieved party waives his or her right to sue in exchange for a sum of money. In other countries, there are "right to sue waivers" which are one of the aggressive responses to avoid liability in medical malpractice suits.[71]

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[70] Eric Feldman, *Law, Society, and Medical Malpractice Litigation in Japan,* Washington University Global Studies Law Review 257, 273 (2009).

[71] Allen Kachalia, Niteesh Choudhry, David M. Studdert, Symposium, *Physician Responses to the*

Alternative dispute resolution, on the other hand, usually involves mediation, arbitration or conciliation. Settlement of a damage claim by an injured patient may be undertaken directly by the patient with the doctor through negotiations. However, as Atty. Alfredo Tadiar pointed out, it is unfortunate that this mode is generally not successful as an initial effort. In the cases that he has narrated, it became successful only after an initial resort to litigation has shown the strong determination of the patient to pursue his or her claim. Mediation through the intervention of a neutral third party is also hardly ever used. This could be because there is no institutional mechanism for implementing this mode.[72]

One author also put forward arbitration, which offers a less formal, potentially cheaper private forum than the courts. She said that Filipinos are slow to adopt arbitration partly because of the lack of incentive for the individual patient to opt for arbitration, under the current fee-for-service health care system (*i.e.* the patient pays after each service he or she avails). One reason could be the notion of patients that once a medical transaction is closed upon payment for the services, recourse for post-transaction problems or complications is already foreclosed. She further said that courts have been - and should be - more willing to uphold binding arbitration agreements included in such health insurance contracts than those signed just prior to treatment.[73]

The advantage of this system (out-of-court settlement and/or alternative dispute resolution) is that it gives the physician and the complaining party more freedom to resolve disputes, especially because the court and its rules of procedure and evidence are absent. It saves both parties the publicity involved in open-court trials. Moreover, it preserves the trust relationship between the physician and the complaining party. Both are able to arrive at a compromise based on their own negotiated terms. Because of this freedom, out-of-court settlements and/or alternative dispute resolution are deemed to provide the most speedy and efficient resolution of the complaint. This also suits the non-litigious culture of Filipinos.

The disadvantage here, however, is that they do not deter physicians from future negligent conduct. The thought of being able to settle a complaint out of court or before any litigation, without the shame of having to go through a public trial, and in light of the unequal bargaining power between the physician and the aggrieved party, trivializes medical malpractice incidents.

Malpractice Crisis: From Defense to Offense, Journal of Law, Medicine and Ethics 416, 422 (Fall 2005).

[72] Alfredo Tadiar, *Ethical and Legal Considerations for Today's Medical Professionals and Hospitals,* 6 J Reproductive Health, Rights and Ethics 1, 10 (2000).

[73] PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 203-204 (1985).

C. Medical Malpractice Legislation

Medical malpractice legislation is the enactment of laws dealing with medical malpractice and the proposal of solutions addressing the said problem, by way of creating rights, providing penalties or establishing institutions to implement them.

The positive effect of having medical malpractice litigation is that it makes the issue a state concern and of general application. It is a more concrete measure at addressing the problem since its impact on the profession is more felt. The internal and administrative rules governing the profession would change in order to accommodate the substantial provisions of such a law. It is a form of oversight on the disciplinary function of medical societies, in cases when it is inadequate to police its members. The law regulates the practice of the medical profession to protect the public from the incompetent and unscrupulous practitioners.[74] Moreover, the country is already behind in medical malpractice legislation; hence, it is high time to enact reasonable laws on patients' rights and medical malpractice.[75]

The downside, however, to medical malpractice legislation is that it entails too costly and too lengthy a process, especially in the time and resources expended in the research, deliberations and readings of the medical malpractice bills. It involves a lot of stakeholders – the medical profession, the public, as well as the government. It also affects several generations because as soon as the bill is enacted into law, it will take effect prospectively and generally, unless struck down as unconstitutional.

Several unresolved constitutional and policy considerations attend medical malpractice legislation. Bills pushing for medical malpractice legislation are assailed for violating due process and equal protection, and for singling out the medical profession as a whole. They are also seen as disincentives for medical practitioners to practice in the country, and a cause for higher health care costs by giving rise to defensive medicine. Problems as to the definition of medical malpractice and on the scope of its injury also abound. The effectiveness of medical malpractice legislation in addressing, deterring or eliminating the problem

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[74] Tadiar, *supra* note 72 at 4.

[75] Dr. Rudyard Avila, *Report on the Public Hearing of the Committee on Health and Demography joint with the Committees on Social Justice and Finance on Patient's Rights and Medical Malpractice*, Sept. 28, 2004, 10:30 a.m., Sen. Tañada Room, Senate of the Philippines.

at hand is still even dubious.[76] This is because various constitutional (e.g. equal protection and due process) and policy (e.g. implementation) issues have already been raised prior to the passage of a medical malpractice law. Failure to address these issues, despite the passage of such a law, would put to question its feasibility and constitutionality. Moreover, there are already sufficient existing laws to address the problem of medical malpractice, as enumerated earlier. Rather, what is needed is the improvement of the health care system by improving medical facilities and infrastructure and training health care practitioners.[77]

Further, medical malpractice legislation has the tendency to cause a shift from a culture of responsibility to a culture of rights.[78] This means that the boundaries created by codified regulation may tempt physicians to freely do any conduct circumscribed by those boundaries, even at the expense of professionalism. Codification of the parameters of professionalism seems to occur where both society and professionals themselves have lost faith in the capacity of a profession to regulate itself.[79] In short, because Medicine does not self-regulate, the Law must set the standards and guidelines to regulate Medicine.[80] In effect, the need for medical malpractice legislation indicates that the medical profession and its regulatory body are already found to be wanting of the standard of conduct expected of them, thus warranting a law to compel them to conform again to such conduct.

Lastly, in a country like the Philippines where there is a dearth of physicians and limited access to health care, it would be an unwise move to antagonize the medical providers.

D. Professional Self-Regulation

Self-regulation is the means by which a profession establishes the standards that govern and explain its behavior and the conduct of its individual members.[81] It gives deference to the profession in disciplining its ranks in the way it deems best since it is more qualified to comment on things within its functional

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[76] Joseph Joemer Perez, Ronald Policarpio and Anna Nerissa Paz, *Medical Malpractice Law in the Philippines: Present State and Future Directions,* 78 Phil.L.J. 687, 702-706 (2004).

[77] Dr. Bu Castro, *Report on the Public Hearing of the Committee on Health and Demography joint with the Committees on Social Justice and Finance on Patient's Rights and Medical Malpractice*, September 28, 2004, 10:30 a.m., Sen. Tañada Room, Senate of the Philippines.

[78] Andrew Fichter, Article, *The Law of Doctoring: A Study of the Codification of Medical Professionalism,* Health Matrix: Journal of Law-Medicine 317, 344 (Spring 2009).

[79] *Id.* at 385.

[80] Evelyn Yea Tyng Tang, Book Review, *First Do No Harm: The Cure for Medical Malpractice by Ira E. Williams,* Journal of Health and Biomedical Law 143, 147 (2006).

[81] Gail B. Agrawal, Article, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace,* Missouri Law Review 341, 377 (Spring 2001).

specificity. In this option, generation and sharing of new medical knowledge as well as voluntary compliance are encouraged because the regulating entity can relate with the functional specificity of the profession.[82] One downside to this option, however, is that it raises concerns of self-protectionism,[83]especially in the perceived code of silence within the medical profession when it comes to medical malpractice cases. Another downside is the lax enforcement of its code of conduct.[84]

To be able to appreciate the concept of regulation and the nuances between government regulation (PRC) and professional self-regulation (PMA), it is better to first lay down the current procedures of availing them and their modes of review.

Philippine Regulatory Commission-Board of Medical Examiners (Government Regulation)

The Philippine Regulatory Commission (PRC) has quasi-judicial, quasi-legislative, and administrative powers as well. The quasi-judicial power of the PRC lies in its power to investigate cases against erring examinees and professionals. It undertakes administrative investigations on complaints filed against allegedly erring physicians. The PRC's decisions have the force and effect of the decisions of a court of law, with the same level of authority as a Regional Trial Court. After the lapse of the period within which to file an appeal, the Commission's decisions become final and executory.[85]

The medical malpractice cases filed with the PRC are handled by its Board of Medical Examiners. Administrative investigations may be conducted by not less than four members of the Board of Medical Examiners; otherwise the proceedings shall be considered void. The existing rules of evidence shall be observed during all administrative investigations. The Board may disapprove applications for examination or registration, reprimand erring physicians, or suspend or revoke registration certificates, if the respondents are found guilty after due investigations.[86]

Within five days after the filling of written charges under oath, the respondent physician shall be furnished a copy thereof, without requiring him or

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[82] *Id.* at 396.

[83] *Id.* at 378.

[84] *Id.* at 400.

[85] PETER NG & PHILIPP PO, MEDICAL LAWS AND JURISPRUDENCE (LEGAL ASPECTS OF MEDICAL PRACTICE 67-68 (2006).

[86] Rep. Act No. 2382, §22, par. 2 (1959).

her to answer the same, and the Board shall conduct the investigation within five days after the receipt of such copy by the respondent. The investigation shall be completed as soon as practicable.[87]

The decision of the Board of Medical Examiners shall automatically become final thirty days after the date of its promulgation unless the respondent, during the same period, has appealed to the Commissioner of Civil Service and later to the Office of the President of the Philippines. If the final decision is not satisfactory, the respondent may ask for a review of the case, or may file in court (Court of Appeals) a petition for *certiorari*.[88]

After two years, the Board may order the reinstatement of any physicians whose certificate of registration has been revoked, if the respondent has acted in an exemplary manner in the community where he resides in and has not committed any illegal, immoral or dishonorable act.[89]

Philippine Medical Association
(Professional Self-Regulation)

The codes and regulations governing the functions of the Philippine Medical Association (PMA) in the discipline of its members are its Code of Ethics, the Constitution and By-laws, and Administrative Code[90]. These provide for the rights and obligations of its members as well as the grounds for disciplinary sanctions and termination of their membership. One of the grounds for the termination of their membership in the PMA is "any act inimical to the profession as provided for in the Code of Medical Ethics, and/or any act inimical to the Association"[91].

In an interview with Dr. Bu Castro, former PMA President and Commission on Ethics member, he explained the procedure and mode of review of medical malpractice cases filed with the PMA. He detailed them in this wise:

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[87] Rep. Act No. 2382, §23 (1959).
[88] Rep. Act No. 2382, §26 (1959).
[89] Rep. Act No. 2382, §27 (1959).
[90] By-laws of the Philippine Medical Association, art. 9, §3

> There shall be *collections of rules, regulations, and procedures necessary for the implementation of the By-Laws and the resolutions of the Association*, to be known as the Administrative code of the Association, as well as other Codes corresponding to the Commissions listed under Article VII of these By-Laws. These Codes shall be proclaimed and may be amended by the Board. (italics supplied)

[91] By-laws of the Philippine Medical Association, art.1, §5(B) *as reiterated in* the Administrative Code of the Philippine Medical Association

> The procedure for filing a complaint with the PMA is initiated by the filing of a duly sworn complaint filed by any aggrieved party, usually the patients, with the PMA Secretariat. As of now, there are no filing fees required but because of the ever increasing volume of complaints, the PMA is contemplating on collecting filing fees. However, such thought is not yet taken up with the PMA Board of Governors. The cases before the PMA Commission on Ethics are in the nature of an administrative proceeding. Hence, the technical rules on evidence and the prescription periods for the filing of a case are not strictly observed. A hearing is required only when the documents submitted are not sufficient to resolve the issues. The issues are deliberated based on the PMA Code of Ethics, and the standard of care used in the deliberations are those required in international medical practice as set forth by the World Medical Association, of which the PMA is a very active member. The quantum of proof is substantial evidence, i.e., such reasonable proof, not even preponderant, that convinces the mind of the Commission that the act of the respondent is unethical or not.
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> The penalties range from Censure (Admonition), to Suspension from PMA membership (indefinite to definite) or expulsion from PMA membership. It must be emphasized that the PMA has no power or authority to decide on the doctor's license to practice medicine because this is within the authority of the Professional Regulation Commission (PRC).
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> The gravity of the offense is determined by (1) how much damage was caused to the medical profession in the eyes of the public because of the act of the PMA member; (2) how much damage was suffered by the complaining party because of the act of the respondent doctor; (3) how many times the respondent was involved in similar acts complained of; (4) was there willful or intentional act or malice on the part of the respondent doctor? Repeated acts (a.k.a. recidivists), deliberate acts, malice and similar situations are confronted with more severity by the Commission.
>
> The only mode of appeal from the decision of the PMA Commission on Ethics is to the PMA Board of Governors although the decision of the Commission on Ethics is seldom reversed by the PMA Board of Governors. At most, it is the gravity of the penalty that is modified, lowered or increased.[92]

The reinstatement of a member whose membership has been terminated either for cause or for the revocation of his license to practice medicine shall be made only upon approval by the Board of Governors.[93]

Oftentimes, the decision of both the PMA and PRC are parallel. Once a member is suspended from the PMA, the doctor's accreditation with the

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[92] Interview with Dr. Bu Castro, former PMA President, Manila, Oct. 18, 2010.

[93] Administrative Code of the Philippine Medical Association, chap.I (5.3)

PHILHEALTH is also suspended. In other words, the suspended doctor cannot attend to Philhealth patients.[94]

The regulatory function of the PMA and the PRC overlaps because both exercise supervision and control over its members. While that which is done by the PMA is a voluntary act of the medical society, the one undertaken by the PRC is not. It is the government which takes the initiative to regulate the profession as matter of public policy. Hence, for purposes of this paper, *regulation* would mean the regulation by both the PMA (regulation by a private entity) and the PRC (regulation by a government entity), while professional self-regulation would be confined to regulation done by the PMA.

In the United States, medical societies self-police the profession, which is governed by their Principles of Medical Ethics. These medical societies function through their boards of censor in carrying out this policing function. These boards of censors have primary jurisdiction on unethical conduct, prior to the appeals in the state and national levels. It is because of this professional clout that membership or affiliation in these medical societies are deemed important. Hence, when it comes to medical practice, medical practitioners are faced with the limited choice of affiliating with these societies or completely isolating themselves from such professional organizations.[95]

In the Philippines, the PMA and the PRC have concurrent jurisdiction on medical malpractice cases in the sense that the aggrieved patient may file in either or in both of them to obtain redress. In short, the filing of a complaint in the PMA does not bar one from filing a case with the PRC, and *vice versa*. This means that one is not guilty of splitting a cause of action nor forum-shopping when he or she simultaneously files complaints with the PMA and the PRC. This is because they have different codes of ethics and jurisdictions. The jurisdiction of PRC covers all licensed physicians in the Philippines while that of PMA extends only to its members, the membership therein being optional. The only forum-shopping recognized by the PMA is when more than one complaint is filed within its framework (e.g. a complaint is filed with the respondent-physician's medical society, and another one with the PMA Commission on Ethics). That case, however, is not a ground for the dismissal of the complaint. The complaint will only be reassigned to the medical society to which the respondent-physician belongs.[96]

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[94] *See* note 92, *supra*.

[95] WILLIAM CURRAN, LAW AND MEDICINE TEXT AND SOURCE MATERIALS ON MEDICO-LEGAL PROBLEMS 677-678 (1960).

[96] Interview with Dr. Bu Castro, former PMA President, Manila, Apr. 2, 2011.

V. THE CHOICE

A. Weighing the Options

It is difficult to ascertain the best choice among the options because of their overlaps and shortcomings. Here are some examples of these overlaps. One is when medical malpractice legislation is able to provide for all the options mentioned. Another is when out-of-court settlement is dispensed with by alternative dispute resolution early on in the dispute. Still, another overlap is when professional self-regulation is supplemented by medical malpractice legislation by providing for additional grounds for disciplinary sanctions and additional powers to the regulatory body. Specialized courts may also complement professional regulations, especially at the appeals stage when the administrative or regulatory body ceases to have jurisdiction over the dispute and courts of technical expertise are needed to further resolve the case on appeal.

What then is the big picture? The big picture is that the options mentioned are not at all mutually exclusive. They are a spectrum of remedies available to the aggrieved party. Some may be exclusive of others, as in the case of alternative dispute resolution and specialized courts. Others may be pursued cumulatively, as in the case of medical malpractice legislation and specialized courts. Because of these flexibility and freedom of choice, the concerned party is not left without a remedy. He or she may even avail of hybrid remedies in the form of a combination of one or two.

Based on the options mentioned, the most extreme would be medical malpractice legislation because its operation affects numerous stakeholders, encompasses several generations, and entails a lot of time and resources. The least extreme would be the out-of-court settlement and/or alternative dispute resolution. This is because it has a limited scope of operation in terms of people affected, transaction costs, and period of effectivity. How then to strike a balance between these poles? By getting just the good in both and merging them into a fruitful compromise. That would be professional self-regulation.

Professional self-regulation is not as exacting as passing a medical malpractice law, and not as inexpensive to the point of non-deterrence of injurious conduct. Its penalties are more regulatory than monetary in the sense that the risk of losing one's authority to practice outweighs the convenience of resolving the case without judicial intervention. Its operation is not as costly as the enforcement of medical malpractice law but not as toothless as out-of-court settlements and/or alternative dispute resolution either.

In this option, the profession itself is the one regulating its own ranks, regardless of government funding and initiative. It does not necessarily yield to government policy as it is granted a certain degree of autonomy, provided that it maintains the quality of services expected of it by the public. However, the regulatory force only extends to medical practitioners registered under the self-regulatory body. In this case, it would be the Philippine Medical Association.

Because of our limited budget for health care, specialized medical malpractice courts are not feasible in the Philippines. Rather than setting up specialized courts, the budget is better off spent in improving health care. Notwithstanding the underreported medical malpractice incidents, there is not much medical malpractice litigation warranting the establishment of specialized courts. The Filipinos, too, are not as litigious as their American counterparts. They are more concerned with compensatory damages than harassment. Hence, administrative tribunals and regular courts are already capable of hearing these cases as the usual complaint for damages.

As to medical malpractice legislation, there are already too many bills on the subject passed by Congress. The reasons why they have not reached fruition and enacted into law must say something about the difficulty or near-impossibility of drafting a law embodying an acceptable compromise among the stakeholders. Nevertheless, it is not always true that the absence of medical malpractice legislation forecloses its prospect of effectively addressing medical malpractice problems. It is just a wrong move to hasten the enactment of a medical malpractice law without addressing all the issues concerning it. Moreover, medical malpractice legislation should be drafted in a manner that would make it flexible and accommodating of the changes in the times, e.g. technology, patient preferences, economics, laws, etc. In achieving this, much time and effort is needed. Hence, such law should not be passed merely for the sake of having a medical malpractice law and catching up with the level of legislation in other countries.

Out-of-court settlement and/or alternative dispute resolution are viable options except that there is information asymmetry and unequal bargaining power between the physician and the patient. Moreover, economics is not the only consideration in settling or resolving these incidents. There are other concerns such as pride, reputation, irreversible injury, breach of trust, or deterrence of future conduct. The intervention or oversight or supervision of a neutral third party when it comes to this kind of disputes is therefore necessary.

Nevertheless, options to resort to court action and government intervention should not be foreclosed since they supplement the shortcomings of professional self-regulation. One notable shortcoming is the extent of penalty by the PMA. The gravest penalty is the exclusion of the physician from the medical society while other penalties merely involve reprimand and suspension.

When these shortcomings are viewed in light of the injury and damage suffered by the aggrieved party, it can be said that the disciplinary functions of the PMA are not enough to compensate or repair the wrong done. This then opens up the options to resort to courts or to the PRC for penalties grave enough to satisfy the aggrieved party or set an example to deter future negligent conduct.

Legislation providing for additional administrative sanctions must only be pushed in cases where professional regulation is deemed inadequate. However, the question as to who will be the judge of such inadequacy will also have to be dealt with.

B. A Discussion on Professional Self-Regulation

Medicine, as a profession, has certain attributes that qualify it to regulate itself. These attributes are 1) functional specificity, 2) trust, 3) disinterestedness, and 4) self-regulation.[97] These attributes are described briefly in this Report of the American Bar Association Commission on Professionalism, where Eliot Freidson observed that social science classifies an occupation as a profession when it is determined:

> 1. That its practice requires substantial intellectual training and the use of complex judgments (functional specificity);
> 2. That since clients cannot adequately evaluate the quality of the service, they must trust those they consult (trust);
> 3. That the client's trust presupposes that the practitioner's self-interest is overbalanced by devotion to serving both the client's interest and the public good (disinterestedness); and
> 4. That the occupation is self-regulating--that is, organized in such a way as to assure the public and the courts that its members are competent, do not violate their client's trust, and transcend their own self-interest (self-regulation).[98]

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[97] Andrew Fichter, Article, *The Law of Doctoring: A Study of the Codification of Medical Professionalism,* Health Matrix: Journal of Law-Medicine 317, 317 (Spring 2009).

[98] *Id.* at 335.

Professional self-regulation has four key functions: 1) rule-making, 2) policing, 3) adjudicating, and 4) providing notice.[99] Rule-making involves the formulation of rules of conduct of the members of the professions, for their guidance. Policing entails making sure that these members comply with the rules set forth. This function is better elucidated below:

> The policing function is informal, and the formal sanctions that result from the adjudicatory processes are limited to expulsion from the group. This is not to say, however, that this type of self-regulatory activity is without legal effect. Codes of conduct create and limit expectations about another's behavior. The publication of a private code of conduct to the general public may give rise to a legally cognizable right to rely on a commitment to the published standards in an individual case. It is reiterated that self-regulation and professional standards are a necessary counterweight to economic incentives.[100]

Adjudicating comes in when complaints are filed against breach of the rules of conduct and there is a need to determine whether such complaints should prosper and which party is liable. Lastly, providing notice is pursuant to due process, that is, appraising the member of the complaint lodged against him. In adjudicated cases, it involves the giving of a notice to the whole profession of the action taken on the complaint.

Its fundamental policy goals are 1) maximizing quality, 2) maximizing access, and 3) controlling costs.[101] For this kind of regulation to succeed, it must be clear, targeted and enforced.[102] To be clear, its Code of Conduct must be understandable and enforceable. It must not be vague nor ambiguous, and must be a guide rather than a scapegoat. To be targeted, it must be able to point out the stakeholders and subjects of the regulation. It must be able to make the Code of Ethics work for the betterment of the profession. Lastly, it must be enforced in order to give the Code of Ethics potency and effectiveness. In such case, the Code of Ethics would not only have the status of a law but also the teeth to punish and penalize the erring members.

Having zoomed in on the choice of professional self-regulation, it is now timely to determine the conditions for its effectivity. Given the fact that certain procedures and grievance mechanisms are already set in place by this regulatory body (PMA), the next most important factor to consider would be on the liberty

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[99] Gail B. Agrawal, Article, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace,* Missouri Law Review 341, 378 (Spring 2001).

[100] *Id.* at 378-79.

[101] Thaddeus Mason Pope, Column, *Health Care Regulation in America: Complexity, Confrontation, and Compromise by Robert I. Field,* Journal of Law, Medicine and Ethics 427 (Summer 2010).

[102] Philip Bovey, Article, *Company Law Lecture – Self-Regulation,* Company Lawyer (1991).

and ease for people, physicians and patients alike, to avail of them. Here are some conditions which may make the system serve its purpose more.

On the side of the physicians, incentives must be put in place in order to encourage them to submit themselves to the system. Some of these incentives should focus on disclosure, the Good Samaritan Rule, and on the fact that medicine is not an exact science. This means that disclosure and apology by physicians when it comes to errors in their practice should not be penalized automatically. This is to encourage openness and healing between both the physician and the aggrieved party, and to allow them to settle the issue between them while keeping their trust relationship intact.

The same move to encourage disclosure can further be supported by the Good Samaritan rule which basically means that the good intent of the physician to heal should be given primary importance over the adverse result that did not come about from his or her own negligence. In addition to encouraging disclosure, this also fosters an environment conducive to the exercise of their duty to heal, without always being on the defensive.

Lastly, for the public and the profession to uphold the Good Samaritan Rule and encourage disclosure without any apprehension of compromising their welfare, it is important to realize that medicine is not an exact science and that as long as the physician exercises the standard of care expected of him, his or her duty will have already been served. In this respect, the physicians may very well be at ease at the thought of the PMA community being able to relate to such fact.

On the side of the patients, the system can be taken advantage more by creating in them the consciousness that though it is dominantly within the control of the profession, it still exercises the objectivity and justice expected of regular courts. The more expedient and convenient process of the system (no filing fees, immediate supervisory and regulatory control, no lawyer or expert witness necessary, etc.) can be played up in order to promote preference of it over the more lengthy and tedious process of the usual litigation in regular courts. Together with this objective to promote a trustworthy impression on the medical profession and its own private regulatory agency, it is also important to inform the patients that despite the information asymmetry, that unequal playing field is still taken notice of.

It would also be helpful to keep in mind the Doctrine of Primary Jurisdiction[103] as well as the Doctrine of Exhaustion of Administrative Remedies[104] for a more orderly and efficient implementation of professional self-regulation. The former is essential because of the highly technical nature of the medical profession while the latter affords both parties more chances of appeal.

C. An Assessment of Professional Self-Regulation

It is conceivable that the regulation by the PMA will be able to achieve the fundamental policy goals of self-regulation for the following reasons. First, self-regulation maximizes quality because the character of the regulation is voluntary. It is the profession itself which polices its members. This is different from government intervention because in that case, the regulation is imposed on the profession. With professional self-regulation, physicians are more satisfied with the authority supervising them because it is one of their own, and presumably is able to understand their circumstances and the technical nature of their profession more.

Second, self-regulation maximizes access because of the absence of filing fees. This means that grievance mechanisms are accessible by everyone. Lastly, it can limit costs because the services of lawyers or expert witnesses may be dispensed with since trial is not mandatory in PMA proceedings.

Professional self-regulation is also able to deliver its four key functions. It is able to exercise its rule-making powers by promulgating a Code of Ethics, Administrative Code and Constitution and By-laws. It is able to police its members with the use of those rules. Lastly, subsumed in that policing power are the notice and adjudication of controversies of its members by its Commission on Ethics.

Professional self-regulation can also be appreciated more in terms of its strengths and weaknesses. Basically, the three strengths of this mode of regulation are that it is the most competent, the most convenient and the lesser evil among

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[103] Sta. Ana v. Carpo, GR 164340, Nov. 28, 2008

> The doctrine of primary jurisdiction precludes the courts form resolving a controversy over which jurisdiction has initially been lodged in an administrative body of special competence.

[104] Andrew Fichter, Article, *The Law of Doctoring: A Study of the Codification of Medical Professionalism,* Health Matrix: Journal of Law-Medicine 317, 378 (Spring 2009).

> One specific instance of deference to medical professionalism is the rule, known as the exhaustion rule, providing that judicial review ... is not available until the physician has exhausted all administrative procedures and the ...determination thus becomes final and appealable.

the options previously mentioned. It is the most competent because it is undertaken by a medical society which is obviously well-versed in the specialized field of medicine. Hence, the technical aspects of a medical malpractice case could be easily appreciated by the regulatory committee, i.e., the Commission on Ethics which is composed mostly of doctor-lawyer or doctors with background in law. It is the most convenient because the PMA is presumably the immediate supervisory body of the members registered with it. It is also equipped with administrative sanctions for its erring members. Lastly, it is the lesser evil to both the profession and the public. By allowing the PMA to police its members, respect for the autonomy of the medical profession is still maintained.

The downside to this process, however, is the weak policing and enforcement of the members. In the case of the PMA, the penalties to the erring members range from censure to suspension or expulsion from PMA membership. It does not have the power to revoke the license to practice medicine because such power is lodged with the PRC. In effect, the range of penalty is not enough a deterrent to erring doctors who can still practice despite being meted the highest level of penalty by the PMA. Moreover, its jurisdiction is also limited only to its members or the physicians who applied and were admitted to its membership.

However, there are also other non-administrative sanctions which may also result from the penalties imposed by the PMA. These may be in the form of shame, guilt, tainted reputation and low esteem accorded by the medical community and future patients. Myron Schoenfeld pointed out that the training of doctors is so regimented, and their peer pressure (the approval or disapproval of colleagues) is so strong, that deviant behavior is kept at a remarkably low level. The most direct kind of peer pressure is the awareness of a doctor that he has (or has not) the respect, and hopefully, the admiration, of his colleagues.[105] Sometimes, this kind of consequence is even more emotionally and professionally impairing than the formal penalties imposed by the PMA.

VI. PROPOSALS FOR PROFESSIONAL SELF-REGULATION

The main proposal for professional regulation in this paper is to strengthen the role of the PMA by promoting the Doctrine of Primary Jurisdiction and Exhaustion of Administrative Remedies in medical malpractice cases. Basically, the gist of all the proposals is to create a partnership between the PRC and the PMA, and empower such partnership to primarily take cognizance of a medical malpractice complaint. The PMA should not and need not be attached to

[105] MYRON SCHOENFELD, STRICTLY CONFIDENTIAL: HOW DOCTORS MAKE DECISIONS163 (1990).

the PRC. Though not attached to the PRC, its certification of all the medical malpractice cases to the PRC, grants it the autonomy, authority and jurisdiction to self-regulate.

Several sub-proposals are presented by the author, *to wit*:

A. Mandatory Membership of All Medical Practitioners with PMA

Dr. Bu Castro made mention that there is a pending Physicians Act of 2009 which aims to require the membership of all doctors in the PMA for the efficient and effective policing and control of its members. He said that right now, membership with the PMA is only optional.

With this level of control over the medical practitioners in the country, it is difficult to imagine a strong enforcement regime by the PMA of its Code of Ethics since only the PMA members will be affected by its policies. It is in this state of affairs that mandatory membership with the PMA is necessary, in addition to the medical practitioners' registration with the PRC. This is to further strengthen the control and regulatory power of the PMA over the profession. It is only when the medical profession is affected as a whole will the PMA be seriously taken as a regulatory body with the teeth to discipline its erring members.

B. Primary Jurisdiction of PRC, with the PMA as its Mediating Arm, over Medical Malpractice Cases

The author adopts the set-up in the Physicians Act of 2009 where there is a partnership between the PMA and the PRC when it comes to medical malpractice cases filed with the PRC. In this partnership, the cases filed with the PRC are first directed to the PMA for mediation, and then later on forwarded to the PRC for the trial stage. This is also one efficient way of streamlining the avenues for redress of the aggrieved party because the proceedings in both regulatory bodies are coordinated.[106] As an attempt to reconcile such conflict, the PMA should instead be treated as a partner agency of the PRC, and not a regulatory body subordinate to it. This then partly addresses the conflict between the PMA as a private entity and the PRC as a government entity.

This primary jurisdiction of the partnership of PRC and PMA over medical malpractice cases (assuming all medical practitioners are PMA members) is necessary in order to drive home the point that professional self-regulation is indeed espoused by the government. The technical nature of these cases and the

[106] Interview with Dr. Bu Castro, former PMA President, Manila, April 2, 2011.

medical background of the Commission of Ethics also make it easier for the latter to appreciate the facts of the case and resolve the issue on factual and ethical grounds.

C. PMA's Case Certification to PRC

It is only the termination/resolution of the case in the PMA level that would lead to the entry of the case in the PRC dockets, as certified by the PMA. It is to be emphasized that the findings of fact and the decision by the PMA should be given binding effect at the PRC level if upon review by the latter, no error in judgment was made.

The said partnership by the PMA and the PRC should also jointly formulate the rules and procedure for the complaints filed before it. By doing so, the PMA is able to supplement its disciplinary and enforcement powers by having a say in the new set-up for medical malpractice cases.

With these proposals, it will be comforting to know that the procedure is made more efficient by minimizing the venues from three (with PMA and PRC as separate venues) into two: regular courts and regulatory bodies (the partnership of PMA and PRC).

VI. THE FRUIT OF COMPROMISE AND THE ROAD FORWARD

As has been repeatedly mentioned throughout this paper, there is no one and only solution to the medical malpractice problem in the country. This is because a lot of factors and motives attend the issue. There is the law, economics, technology, culture, advocacy, or personal interest. Nonetheless, the urgency of addressing this problem is undeniable.

The reason why the author chose professional self-regulation among the options presented, is because in light of economic condition of the Philippines, the Filipino culture and the scarcity of medical practitioners in the country, it seemed to be the most viable option at this time. Professional self-regulation appeared to be the perfect compromise between a government wanting to provide adequate health care to its people and a profession wanting to retain its autonomy.

Patent in that scenario is the bargaining power of the medical profession, mainly because there is more demand for their services than they can supply. Thus, the government has got to give and make some concessions, at least for now. One of these concessions would be holding in abeyance the pursuit of

medical malpractice legislation or specialized courts, and spending the budget that would have been allotted to them on the improvement of health care facilities and training of medical professionals instead. In any case, postponing medical malpractice legislation is not that urgent a concern since the present laws and codes of ethics are more than sufficient guides, incentives and deterrents in the conduct of medical practice.

However, it should be kept in mind that this state of affairs i.e. with professional self-regulation as the most viable option, is subject to change when demanded by the exigencies of the times. In this respect, professional self-regulation should just be viewed as the road forward – to a conscientious social experiment, to a more accountable medical profession and to a continuous search for solutions that would address the health care problems besetting the country these days.

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