

# LEGITIMATING<sup>1</sup> CHANGE: THE EXPANDED ROLE OF THE FILIPINO PROFESSIONAL PARAMEDICAL<sup>2</sup> IN THE DELIVERY OF FAMILY PLANNING SERVICES

ALFREDO F. TADIAR\*

## *Introduction*

Law has traditionally performed the conservative function of reflecting the morals and values of society.<sup>3</sup> For a country seeking to modernize its society, however, law must be and is being made to perform a more radical function of changing, or at least attempting to change, values and patterns of behavior based thereon, that are perceived as impeding the attainment of its developmental goals. Filipino values based on the extended family system, for instance, whereby mutual assistance and support can be relied upon by its members, are now seen as contributing to irresponsible parental decision-making as to the number and spacing of children, resulting in rapid population growth with its accompanying problems of hunger and poverty.<sup>4</sup> Through legally imposed education for responsible

\* *Associate Professor of Law and Director of Legal Aid, University of the Philippines; Chairman, Committee on Law and Population and Governing Board Member, Family Planning Organization of the Philippines (FPOP).*

<sup>1</sup> The author has deliberately chosen the verb "legitimizing" over "legitimizing" in the title by reason of and to underscore its analogy to the theme of this paper. Article 271 of the Civil Code provides that recognized natural children, although "born out of wedlock" are "considered legitimated by subsequent marriage" of their parents. Similarly, the expanded role of the paramedical professionals were assumed by them outside the legal framework of medical care statutes but is now being "legitimated" within it.

<sup>2</sup> A nurse-trainor reports some objection to the use of the word "paramedical" by reason of its popular confusion with "parachutist". They resent being made the butt of jokes that tend to degrade their status.

Other objections to the use of the word are its lack of precision as to exactly who is actually being referred to, as well as a negative connotation of a subservient, subordinate or lower status of health personnel. "Allied health workers" is a term preferred by some. See, in this connection, PAXMAN, LEE & HOPKINS, *EXPANDED ROLES FOR NON-PHYSICIANS IN FERTILITY REGULATION: LEGAL PERSPECTIVES*, fn. 4, at pp. 52-53 (1976).

Notwithstanding the foregoing objections, the author chose the term by reason of its official adoption by the POPCOM when it chose the title "Paramedic Certifying Board of the Commission on Population". The text of the Memorandum of Agreement with the Professional Regulation Commission dated March 16, 1967 specifically refers to nurses and midwives as the only ones meant by that term.

<sup>3</sup> The "reflective" and "prescriptive" functions of law, or the "is" and the "outright" of the law, are pervasive themes that run through the writings of various legal philosophers.

<sup>4</sup> Recognition that rapid population growth "hampers the struggle against hunger and poverty" and delays achieving "adequate standards of living,

parenthood and family planning,<sup>5</sup> this behavioral value is sought to be changed. In other areas, however, particularly in the field of health care, changes arising from pressures to fill unmet needs, have taken place without benefit of enabling legislation. Analysis and evaluation of these changes must be made and, in proper cases, law must catch up with this development and provide legal bases for continuance. It is the purpose of this paper to show that the Filipino professional paramedical has naturally assumed or evolved to an expanded role in the delivery of health care services, including family planning services, by reason of the difficulty of access to professional medical care arising from the scarcity and maldistribution of physicians and the high cost of their services.<sup>6</sup> There is a need, therefore, to evaluate such expanded role and provide the legal bases for continuance with adequate safeguards to protect the public health and well being.

#### *Realities of Health Care Delivery*

Only 32% of the Philippines' 42 million people<sup>7</sup> live in population clusters called *poblaciones* located within the central core of political subdivisions numbering about 1,455 municipalities or towns and some 59 cities.<sup>8</sup> This is what has been classified as the urban sector. Here are located the hospitals, medical clinics, puericulture centers, pharmacies or drugstores, physicians' offices, family planning clinics and all other facilities related to health care. Here also reside the physicians and most of the country's health personnel. The rest (68%) of the population live in widely dispersed households over the vast countryside among the hills and mountains, the flooded ricefields and the sand dunes along the seashore. These are divided arbitrarily into political units traditionally called *barrios* and more

---

including food, clothing, housing, medical care, social security, education and social services, thereby impairing the full realization of human rights" was made at the U.N. CONFERENCE ON HUMAN RIGHTS AT TEHRAN, UN Doc. A/CONF. 32/41 (1968).

<sup>5</sup> Presidential Decree No. 79 entitled the Revised Population Act of the Philippines, enacted December 8, 1972, states in Section 4(e) as one of its objectives, "To make family planning a part of a broad educational program." Three departments of the government, Education, Social Welfare and Local Governments, are implementing this information and education objective for both the in-school and out-of-school population. See Department of Education Memorandum No. 29 (1973) and No. 76 (1972).

<sup>6</sup> That the problem of physician shortage and inaccessibility is worldwide in scope is well-documented in the excellent study of PAXMAN, LEE & HOPKINS, *supra*, note 2, at 7-9.

<sup>7</sup> Data are supplied by the Bureau of Census and Statistics.

<sup>8</sup> MIJARES, *THE POPULATION OF THE PHILIPPINES: ITS GROWTH AND DEVELOPMENT* 3 (1973).

recently named *barangays*.<sup>9</sup> These are generally accessible only by a lonely dirt road or a rickety footbridge over a river or creek that frequently gets washed away during the season of monsoon rains. Rare indeed is the physician who lives in such isolation bereft of amenities that are taken for granted in modern homes, of recreational facilities or of opportunities for personal and professional growth. No hospital, clinic or drugstore<sup>10</sup> exists in these boondocks.<sup>11</sup>

Of the country's 33,741 registered physicians,<sup>12</sup> only 14,000<sup>13</sup> have been found to be engaged in active medical practice. If all of them were proportionately distributed, there will be a ratio of one doctor for every 3,000 people. Unfortunately, however, this is not the case. For there is a gross distortion in physician distribution among the populace such that 70% practice in the cities the combined population of which amount to only 20% of the national population. Thus, a mere 30% of the physicians engage in rural medical practice. Translating these statistical percentages in terms of ratios, this means that only 24,200 doctors tend to the health needs of 33.6 million rural Filipinos, or a ratio of one physician for every 8,000 people. When considered with the finding that this so-called "rural practice" is actually located in the urbanized *poblacion*, it will become readily apparent that the really rural *barrio* population are actually left without any doctor care at all. 68% of the population or 28.56 million, therefore, live in "doctorless" areas. In deplorable contrast that accentuates the maldistribution, there are 9,800 doctors in urban medical practice serving the health needs of only 8.4 million people, or a proportion of one physician for every 860 people. This compares favorably with the ratio in the developed countries, particularly in the United Kingdom with one per 900 and the United States with one per 760.<sup>14</sup>

A significant corollary to the shortage and maldistribution of medical doctors, is the greater and ever-increasing number of nurses

<sup>9</sup> The change in nomenclature from *barrio* to *barangay* was effected on September 21, 1974 by Presidential Decree No. 557.

<sup>10</sup> An ongoing FPOP project is the *Botika sa Nayon* whereby rural drug-stores to dispense over-the-counter drugs and non-clinical contraceptives are established in the rural areas of San Jose City in Nueva Ecija. The facility will be under the charge of a trained pharmaceutical aide who is a resident of the area to be served with supervision of a non-resident registered pharmacist. The project seeks to determine, among other objectives, acceptability and consequent effectivity of this facility.

<sup>11</sup> "Boondocks" is one of a growing number of words contributed by the Philippines to the English language. It comes from the Pilipino word "bundok", meaning mountain. See HAYAKAWA, READER'S DIGEST, USE THE RIGHT WORD, A MODERN GUIDE TO SYNONYMS (1969).

<sup>12</sup> Civil Service Board of Examiners Registration Section, cited in the NEDA STATISTICAL YEARBOOK 1974, 368.

<sup>13</sup> Statistics were taken from *Solon Delivery of Integrated Health Services to An Organized Community*, in BULATAO, ED., PHILIPPINE POPULATION RESEARCH.

<sup>14</sup> *Op. cit.*, *supra*, note 2, at 7.

and midwives. As of latest count, there are 43,703 nurses and 18,312 mid-wives registered in the country.<sup>15</sup> Because of lower training costs, in the annual production for these two auxiliary health professions are much greater than that for physicians.

Although the public health system mandates that a Rural Health Unit, composed of a team headed by a physician assisted by a nurse, a midwife and a sanitarian, service the health needs of every town, the fact that their base of operations is a health center located in the *poblacion* coupled with scarce resources, regrettably limits their effectiveness to an area less than 5 kilometers radius from that central district.<sup>16</sup> Thus it is that the health problems of the rural population that live at a farther distance than this radius of influence, are generally attended to by a *herbolarios* (traditional herbal practitioners) and/or *hilots* (traditional birth attendants). Where the nurse or midwife is accessible, the rural populace turn to them for solution of their health problems. They are regarded in high respect and are even accorded the status of an authority figure in the community. In the intimate society that is the Philippines, the persuasive influence of the nurse and midwife gains added strength from the intermeshing relationship<sup>17</sup> that she forms through religious rituals of marriage and baptism that make her a *comadre* or a *ninang* to many of her patients and their children.

In contrast to this social acceptance of the nurses or midwife, there is a social distance or barrier that separates the physician from his rural patient. For consciousness of rank and status has always pervaded Philippine society.<sup>18</sup> Perhaps consequentially related, the physician also gradually develops "elitist attitudes" that further alienates him from his rural patient. In addition, there is the culturally induced modesty of women belonging to the lower socio-economic scale that makes them reluctant to undergo pelvic examinations by a male doctor.<sup>19</sup> When all of these are considered in relation to the cost of medical consultation and treatment, which most people regard with anxiety if not dread, it is not surprising that the people in general shy away from the physician whom they will consult only with great reluctance when the need becomes imperative, sometimes with tragic results.

<sup>15</sup> Data as of 1972, *supra*, note 11.

<sup>16</sup> *Supra*, note 12.

<sup>17</sup> A perceptive description of the interweaving relationship in Philippine society is given by a Filipino-American co-authored book, GUTHRIE & JACOBS, *CHILD REARING AND PERSONALITY DEVELOPMENT IN THE PHILIPPINES* 24-43 (1966).

<sup>18</sup> Robertson, *The Social Structure of and Ideas of Law Among Early Philippine Peoples; and a Recently Discovered Pre-Hispanic Criminal Code in the Philippine Island*, in STEPHEN & BOLTON, *THE PACIFIC OCEAN IN HISTORY* (1917).

<sup>19</sup> MacCorquodale, *Philippine Physicians' Influence on Acceptor's Selection of the IUD*, 5 *STUDIES IN FAMILY PLANNING* 141 (April, 1974).

*Expanded Role of Nurses/Midwives in Medical Care*

Nurses and midwives who are or had been assistants to doctors in Rural Health Units, or private practice or who are wives of physician-husbands, soon develop some sort of credibility as to their competence and ability to render medical service beyond their own professional training. The success of the physician somehow produces a "halo effect" that affects this credibility. The success is rubbed off on the nurse/midwife who is now seen as the "alter-ego" or extension of the physician. Check-ups, subsequent illness of the same patient, his relatives or friends may thereafter be brought to the nurse or midwife who, though initially reluctant, on numerous insistent demands, ultimately accepts the added responsibility thrust upon her. Physical examination, diagnosis, prescription and treatment, legally and by custom regarded as part of protected medical practice, are thus taken over by the nurse or midwife with the knowledge, tolerance, consent and/or even active encouragement of the physician, at least for rural practice of medicine where the only other alternative is the unacceptable one of no medical care whatsoever.<sup>20</sup> Dressing of wounds and injuries, diagnosis and treatment of skin diseases, administration of injectables, both intramuscular and intravenous, and even prescribing drugs, generally copying the physician's prescription which proved successful in the treatment of the same or similar disease, as perceived by the paramedic, are undertaken by the nurse/midwife practitioner. Since the Rural Health Doctor is paid by the government a monthly salary irrespective of and unaffected by the amount of work he does, he not only does not object but even trains the paramedic assistant to perform his medical functions for him. This assumption of medical practice by the paramedic is abetted by the laxity of the pharmacist in dispensing drugs on the "prescription" of the non-physician health personnel. The extent of this practice may be gauged by the fact that it is not uncommon for rural folks to address the nurse/midwife practitioner with the honorific title of "doctora". Justifying her expanded role, the paramedic rationalizes that in any case she is giving far more competent medical care than the *herbolario* or *hilot*. Further, she is aware of her own limitations and will therefore refer cases beyond her competence to the physician. Since such referrals result in added "business" to the medical practitioner, hospital or clinic, no opposition is registered to such expanded role. To the contrary, some possibly isolated cases of professional fee-splitting, for referrals lend

<sup>20</sup> Garcia, "Some Experiences and Observations on the Role of the Auxiliary Health Worker in Community Health", a paper presented at the Workshop on Auxiliary Health Personnel on September 9-14, 1975 at the Siliman University Medical Center, Dumaguete City.

acceptability and even give active encouragement to such arrangement.<sup>21</sup>

*Legal Regulation of Family Planning Activities*

It was in the foregoing factual situation where, by reason of the scarcity, maldistribution and cost of physician care, nurse and midwives have assumed an expanded role in medical care, particularly of the rural population, that the family planning movement was first introduced in the Philippines. This gained momentum in the early-sixties as physicians were sent to Singapore by the Planned Parenthood Movement of the Philippines (PPMP) and Family Planning Association of the Philippines (FPAP), through the International Planned Parenthood Federation<sup>22</sup> (IPPF) for training in concept and methods of fertility regulation.

During this time frame, population problems were still only in the periphery of national concerns. Legal constraints<sup>23</sup> which classified contraceptive "articles, instruments, drugs and substances", as well as "any printed matter which advertises describes or gives information" about contraception, as prohibited articles of commerce that are detrimental to public health and morals, loomed heavy in the minds of family planning workers. Activities in fertility regulation, particularly by physicians, were therefore done covertly under mental unease from threat of legal penalties.

It was only in 1966 that legislation<sup>24</sup> was enacted seeking to regulate the sale, dispensation or distribution of contraceptive drugs or devices. Requirements of physician prescription and pharmacy dispensation were imposed with not insubstantial penalties prescribed for violation thereof. In 1969, the Pharmacy Law<sup>25</sup> reinforced these two requirements.

Notwithstanding these legal restrictions, the dispensing of pills accelerated. In practice, distinction was made between initial use, for which the prescription requirement was complied with, and re-use or re-supply, for which, it was assumed, no prescription was necessary. There is no legal basis for making this distinction. Logic, based on the practical consideration that, having been given an initial prescription after physical examination certifying to the acceptor's

<sup>21</sup> No official confirmation of any professional fee-splitting arrangement could be obtained. This is a subject that physicians will openly admit among themselves but will refuse to be quoted on.

<sup>22</sup> In 1969, these two family planning associations merged into one organization. Since these two were formerly dominated by the Roman Catholics and by the Protestants, the merger is cited as the first successful ecumenical union of organizations in the Philippines.

<sup>23</sup> TARIFF & CUSTOMS CODE, sec. 102 (d).

<sup>24</sup> Rep. Act No. 4729 (1966).

<sup>25</sup> Rep. Act No. 5921 (1969).

fitness to use the oral contraceptive, subsequent examination and prescription were no longer required unless complaints for side effects or complications have been made, provided the justification for making this practical distinction.

On the restriction of the orals to a pharmacy outlet, the requirement has been honored more in the breach than in observance. This is a fact of notorious public knowledge in the Philippines.

As to the other non-clinical contraceptives, such as the condoms, foams and jellies, the practice has always been to treat them as "over-the counter" articles that may be secured through commercial outlets.<sup>26</sup>

Considerations different from the foregoing are, however, taken with respect to IUD insertion. While self-administration of the other contraceptives may be done with relative ease, this is not the case with IUD. The insertion of this device requires a knowledge of human anatomy and manual skill beyond those possessed by an untrained non-physician. This has generally been assumed to be a medical operation or procedure within the special competence of the physician. There is, however, no specific legislation restricting the insertion of an IUD to the authority of a physician alone. Neither is there any regulation seeking to confine its insertion in a hospital or medical clinic.<sup>27</sup>

Legal regulation of other fertility regulation services, such as sterilization, abortion and menstrual regulation, will not be taken up here as being beyond the scope of this paper. There has been so far no serious attempt, legally or in practice to have professional paramedicals take over these types of family planning activities which continue to be regarded as properly belonging to the physician's sphere of special competence and lawful authority.

#### *Changes in Legal Regulations of Contraceptives*

In the main, changes in the legal regulation of contraceptives have been accomplished through liberal interpretation by the Sec-

<sup>26</sup> In 1975, a lot of publicity was generated in the celebrated "Condom War" caused by the outraged protest of the Catholic Women's League over the sale of condoms in retail stores, groceries, department stores, supermarkets and other commercial outlets. See, Apelo, "The Recent Condom War in the Philippines", a paper prepared for the Joint Consultant of Regional Medical Committee and Regional Information, Education and Communication Committee, held in Hongkong on March 2 and 3, 1976.

<sup>27</sup> It would strain linguistic usage to construe the provision of Republic Act No. 4729 regulating the "dispensation" of a "contraceptive device" by requiring "prescription of a qualified medical practitioner" as including IUD insertion. Even with such a strained interpretation, no restriction as to place of operation can be found.

retary of Justice, of legislation in favor of family planning activities. His formal opinions on legal issues are not only accorded great respect but considered binding upon government prosecutors and other officials in the executive branch of the government.<sup>28</sup> It is probably for this reason that no litigation has reached our courts of justice that could provide the authoritative answer to doubtful questions in this relatively new field of law.

Thus, in 1969, the Justice Secretary opined that the 1966 legislation regulating the dispensation of contraceptives had the effect of impliedly repealing the earlier 1957 law classifying these articles as contraband and prohibiting their importation.<sup>29</sup>

Such favorable legal opinion was of course presaged by a change in official government policy toward population control—from unawareness or unconcern to hostility during the period prior to the mid-sixties, then acceptance to active endorsement thereafter.<sup>30</sup>

In 1972, official policy was declared that the government shall undertake "a national program of family planning involving both public and private sectors."<sup>31</sup> A few years later in 1975, the Justice Secretary rendered another Opinion<sup>32</sup> holding that the prior law (1966) imposing place of sale restriction and requiring physician prescription for dispensation of contraceptives, have been impliedly repealed by the later 1972 population law.

The above-contraceptive opinion, notwithstanding, some confusion still prevails for several reasons. While the Opinion held the 1966 law impliedly repealed, it did not touch on the 1969 Pharmacy law buttressing the same legal requirement with the imposition of specific duties upon the pharmacist in charge. Further, the interpretation of implied repeal, which abolishes these requirements for contraceptive dispensation, seems to run counter to the provisions of the supposed repealing statute itself which merely provides for an expansion of the prescription requirement by a physician to prescription by a nurse or midwife after training and authorization through certification by the Commission on Population in consultation with the Professional Regulation Commission. Stated otherwise, it

<sup>28</sup> Prior to the 1973 Constitution which empowered the Supreme Court to "have administrative supervision over all courts and the personnel thereof" (Article X, Section 6) such power was exercised by the Secretary of Justice.

<sup>29</sup> Opinion dated April 28, 1969, 48 PHIL. L. J. 440 (1973).

<sup>30</sup> Official government awareness of the population problem started with the Philippine President's signing in 1967 the Declaration on Population on the United Nations Human Rights Day.

<sup>31</sup> Presidential Decree No. 79, Sec. 2. Declaration of Policy.

<sup>32</sup> Opinion No. 82 dated June 6, 1975. It was this opinion that apparently provided the basis for the decision to start selling condoms in retail stores. This triggered the "condom war", *supra*, note 25.



would seem to be inconsistent to hold that the prescription requirement has been abolished and at the same time hold that only the class of authorized "prescribers" have been expanded to include the nurse and midwife along the physician.

*Expanded Role of Paramedicals in Fertility Regulation*

*A. Oral Contraceptives*

The physician's professional concern for the well-being of his individual patient requires as a precondition to signing a prescription for an oral contraceptive that a medical case history be taken, personal interview be conducted and a physical examination, including pelvic examination, be made for a determination of fitness to use the drug. However, in the context described earlier of the inaccessibility of physicians to the rural sector by reason of numerical, geographical and economic considerations, as well as cultural inhibitions, utilization has to be made of the more numerous and accessible professional paramedicals. In so far as the latter were concerned, pill dispensing including giving instructions for proper use, meant no more than merely adding to the expanded duties that they had assumed in giving medical care. Almost from the beginning therefore, and perhaps also to diffuse and share responsibility for what was then an illegal activity, many physicians gave informal instructions to their assistants in contraceptive dispensing and giving advice for proper use. Where no intentional training is given, the paramedical assistant nevertheless learns by example from the physician. Even after physician-prescription was made a legal requirement for pill dispensing in 1966, such informal training by individual physicians continued. Even more, however, formal training courses were developed and actual training given to paramedicals to carry out this activity without any legal authority. And going even farther, training has been given to *Hilots*, the traditional birth attendants who have yet to be given any official recognition by the government, to undertake the same function.<sup>33</sup>

The device previously mentioned, of distinguishing between initial use which requires physician prescription, and re-use or re-supply, which does not, was the basis for the CBD program of the FPOP. In an effort to check the drop-out rate of acceptors caused by geographical distance to place of sale, nationwide re-supply points were established in rural places by the FPOP program. A trained resident was appointed as community distributor of contraceptives with some financial incentives given. Contrary to the high hopes

<sup>33</sup> In 1974, the Institute of Community and Family Health undertook to train 120 *hilots* in Marinduque "to enable them to prescribe pills with the aid of an illustrated checklist and to serve as a resupply agent through the use of coupons in the remote barrios."

that went with the program, its performance was a dismal failure. Only 10% of acceptors went to the community distributor for re-supply. The rest preferred to travel long distances to get their re-supplies from the physician or paramedic at the family planning clinic in town. Speculative reason given for this program failure is lack of credibility as to technical competence of the non-professional community distributor.<sup>34</sup>

### B. IUD Insertion

As already mentioned, IUD insertions have generally been assumed to be within the physician's special competence. Until 1972 when authority was granted to the POPCOM to undertake the training of paramedics for this purpose, no individual or group training of paramedics has been given to acquire this skill. In 1974, however, a 12-week training course entitled Nurse Practitioner Training Program for IUD insertion and pill prescription was given by the EPOP. In early 1975, this program was continued under a different title, *viz.*, Intensive Family Planning Course, and for a shortened period of 7 weeks. In the latter part of the same year, the training program now named Comprehensive Family Planning Course, was expanded to include midwives with the nurses as trainees. A total of 56 trainees actually qualified under this program.

More than 3 years after having been given statutory authority therefore, the POPCOM finally concluded an agreement with the Professional Regulations Commission for the purpose of accrediting and certifying the competence of nurses and midwives for IUD insertion and pill dispensing. Three training institutions<sup>35</sup> have been authorized to give the training required.

Supporting the theme of this paper, the training given to the 56 nurses and midwives prior to legal authorization, has been legitimated upon their certification.

### CONCLUSIONS AND RECOMMENDATIONS

The Philippines, in 1968, became a signatory to the United Nations Conference on Human Rights in Teheran.<sup>36</sup> Resolution XXIII of the Proclamation declares that "couples have a basic human

<sup>34</sup> This information was supplied by FPOP's Director Oribello of the Program Planning and Research Evaluation Division.

<sup>35</sup> The training institutes are the FPOP (Family Planning Organization of the Philippines), the IMCH (Institute of Maternal and Child Health) and the JFMH (Jose Fabella Memorial Hospital). All these institutions have sent nurse-trainers to undergo a trainor's course in paramedic training at the Downstate Medical Center, State University of New York. These nurse trainers have in turn undertaken the training of other nurse trainors and supervisors.

<sup>36</sup> *Supra*, note 4.

right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect." In 1969, the United Nations Declaration on Social Progress and Development went further by declaring it a duty of governments to provide these "couples" not only information and education but even more importantly, the "means necessary to enable them to exercise" that recognized right meaningfully.<sup>37</sup> By its own Constitution which "adopts the generally accepted principles of international law as part of the law of the land",<sup>38</sup> the Philippines legally bound itself to provide the resources and services to effectuate this human right. It has been sufficiently shown that physician-related services in this respect has been woefully inadequate. The need to utilize the more numerous and accessible professional paramedicals has thus been established.

Although foreign based studies<sup>39</sup> have shown that non-physicians could be trained to achieve a level of proficiency at par with general practitioner physicians in the performance of family planning activities, there is as yet no Philippines study in this regard. Particularly because of the prevailing confusion in the state of the law requiring physician prescription and restricting the place of dispensing, this seems to be a most opportune time to make such a study. It is now possible to compare under near-laboratory conditions contemporaneous experience with both physician and non-physician (including the non-professional traditional birth attendants) dispensed contraceptives and IUD insertions. The results of such a study evaluating the performance of the non-physician in terms of public health and safety could be a sound basis for a policy decision whether to retain prescription (by physician or non-physician) requirements or do away with such safeguard if found to be unnecessary and unduly restrictive of the basic human right to family planning services.

In terms of practical administration, law must to a large extent depend on self-application of the laws for its effectivity. Self-application must in turn depend on the clarity of legal provisions. The confusion hovering over the law in this area at present, prevents the operation of these principles. Further, such confusion or at least vagueness, contributes to a growing disregard of laws that will

---

<sup>37</sup> *Supra*, note 4.

<sup>38</sup> Const., Article II, Section 3.

<sup>39</sup> Pakistan's Lady Family Planning Visitors (LFPV) have inserted between 70 to 80% of more 500,000 IUD insertions done at the village level; China's "barefoot doctors" not only insert IUDs but also perform vasectomies and early abortions; in Bangladesh, non-physician health personnel have been trained to perform tubectomies on women safely and competently. All these studies are collated in the PAXMAN, LEE & HOPKIN, *supra*, note 2.

eventually lead to a general disrespect for law. Such a situation "invites every man to become a law unto himself; it invites anarchy."<sup>40</sup> Legal reforms that will eliminate the prevailing confusion and harmonize conflicting provisions, in order to avert this deterioration of respect for law, is a duty of Government that must be undertaken without delay. Particularly, the re-casting of proper functions for physicians and non-physicians must be made. Especially is this necessary in the case of midwives whose profession is legally defined as "the care of normal child-bearing women from the beginning of pregnancy until the end of puericulture (sic)".<sup>41</sup> It does not take much reasoning to perceive that family planning activities clearly fall outside the time frame of authorized midwifery practice. The continued technical violation of such laws condoned by a liberal governmental policy conceivably breeds disrespect for and even contempt of law. This must be averted.

As matters now stand, the problem of scarcity of physicians is compounded by the fact that their level of professional competence in family planning activities leaves much to be desired. In practice, only the gynecologist or obstetrician without further training, may safely be said to be truly competent in this narrow specialty. Post-graduate physician training, however, is both longer and more costly than a similar training for the professional paramedical. It is therefore recommended that specialized training in family planning activities be integrated in the medical course of study and training at the undergraduate level.

In the field of fertility regulation as well as in other areas of social ordering, it is well to bear in mind that laws cannot be formulated to operate in the abstract. In the ultimate analysis laws must be made to relate to specific social needs. The task of legal reform, therefore, must be based on continuing studies to evaluate whether, how and to what extent these needs are being met through the impact of laws.

---

<sup>40</sup> Quoted from the concurring opinion of Justice Brandeis in *Olmstead v. United States*, 277 U.S. 438, 48 S.Ct. 564, 72 L.E. 944 (1928).

<sup>41</sup> Midwifery Law, Republic Act No. 24 (1969), Sec. 24.



# PHILIPPINE LAW JOURNAL

Published by the College of Law, University of the Philippines  
Diliman, Quezon City, Philippines

---

VOL. 51

DECEMBER, 1976

NUMBER 5

---

## EDITORIAL STAFF

HAYDEE B. YORAC  
*Faculty Editor*

EDUARDO A. LABITAG  
*Business Manager*

MYRNA S. FELICIANO  
*Assistant Faculty Editor*

---

## STUDENT EDITORIAL BOARD

ALEXANDER J. POBLADOR  
*Chairman*

LITO A. MONDRAGON  
*Vice-Chairman*

## MEMBERS

ARIEL F. ABONAL  
FERDINAND A. BACORRO  
EDGARDO A. CAMELLO  
ENRIQUE Q. FERNANDO, JR.  
MAE R. GALVEZ  
ANDRES H. HAGAD  
CYNTHIA Q. HALAGUEÑA  
TERESITA J. HERBOSA

LORNA PATAJO-KAPUNAN  
ANTERO L. MARCELO  
REYNALDO P. MELENDRES  
ANTONIO V.D. OCAMPO  
REGINA P. PADILLA  
JOSEPHINE Y. RAMIREZ  
DANTE T. RAMOS  
PELAGIO T. RICALDE

FLORINDA L. MORALES  
*Administrative Assistant*

---

The Editorial Staff and the College of Law publish contributions of interest and value to law students and the legal profession, but the views of the contributors to the PHILIPPINE LAW JOURNAL do not necessarily reflect those of the College of Law and the Journal.

Communications of either an editorial or business nature should be addressed to the PHILIPPINE LAW JOURNAL, Malcolm Hall, University of the Philippines, Diliman, Quezon City, Philippines.

It will be assumed that a renewal of subscription is desired, unless a notice of discontinuance is received by the Journal on or before the expiration date.