
# The Less than Ideal Care in the World of Health Care: Morally Relevant Considerations and Recommendations

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In the context of an increasingly pluralistic society, moral analysis and judgment grow more complex especially as they apply to the practice of medicine. There are varied sources of influence which may exert their effects either on the realm of one's consciousness or one's unconscious–effects that may compromise professional integrity and patient care.

This essay first considers the concept of an ideal physician's world of health care ethics as articulated in the Law of Hippocrates, the Code of Ethics of the Philippine Medical Association, and the mission statement of the Philippine Obstetrical and Gynecological Society, Inc. Correspondingly, the concept of a patient's ideal world of health care ethics from both civil and Roman Catholic perspectives using excerpts from the United Nations' International Covenant on Economic, Social and Cultural Rights, *Gaudium et Spes, Catechism of the Catholic Church*, and writings of moral theologians is also presented. A juxtaposition of these two worlds serves as a framework for the moral analysis of four actual cases of forced contraception on women. More commonly, patient rights are violated and the behavior of physicians falls short of complying with both professional and religious ethical standards.

Additionally, the essay puts forward contextual considerations that can mitigate a medical practitioner's culpability in moral failure. These considerations that stem from existing limitations in the profession and its particular culture, from dual loyalty as well as from societal issues that relate to health care, allow one to proactively address the roots of moral failure in these far-from-ideal situations.

**Keywords:** *forced contraception, moral analysis, standards of health care ethics, dual loyalty, human rights education, virtue ethics, patient rights education, moral vision*

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## Introduction

Within the highly pluralistic Philippine milieu, the Catholic Church's stand on the use of artificial contraception as a method of family planning and the government sanctioning of its widespread use remains a contentious issue. Experts from different fields (sociology, economics, politics, religion/theology, health, etc.) as well as ordinary citizens still passionately advocate for the repeal of RA 10354 or the Responsible Parenthood and Reproductive Health Act of 2012. The persistent and mounting protest began even before the date of its official implementation. True dialogue apparently continues to be evasive with suspicions still running high among various stakeholders. The fact is that the country has a relatively long history of reproductive health bills that attest to the weight of the matter.[1]

On its website, the Social Weather Stations published the result of its 2008 Third Quarter Survey conducted September 24-27 of that year revealing that 71 percent favored the passage of the RH Bill. From its data, it concluded that support for both family planning education and the passage of the RH Bill is very high regardless of whether they were members of the Catholic Church or not. Among Catholics, attendance in church services and level of trust in the Church allegedly had no effect on their support of the bill. This attitude also cuts across gender, civil status, geographic location, and socioeconomic class.[2]

With the lingering absence of a consensus between the Catholic Church (as the dominant Christian denomination) and the government, certain groups in society risk excessive vulnerability, their rights violated perhaps inadvertently by the

[1] "According to the Senate Policy Brief titled *Promoting Reproductive Health*, the history of reproductive health in the Philippines dates back to 1967 when . . . President Ferdinand Marcos signed the *Declaration on Population*. . . . Thus, the Population Commission (Popcom) was created to push for a lower family size norm and provide information and services to lower fertility rates. . . . Starting in 1967, USAID started shouldering 80% of the total family planning commodities (contraceptives) of the country, which amounted to US$ 3 Million annually. . . . In 1989, the Philippine Legislators' Committee on Population and Development (PLCPD) was established, 'dedicated to the formulation of viable public policies requiring legislation on population management and socio-economic development. . . .' In 1998, the first reproductive health measure was introduced to Congress, but died in committee long before reaching the floor. Similar bills have been introduced almost every year. In October 2008, a reproductive health bill introduced by Cong. Edcel C. Lagman reached plenary debate on the House floor for the first time. In the 14th Congress (2009-2010), the RH bill passed the first reading and stalled in the second. In the 15th Congress (2010-2011), five similar bills were introduced to the House and consolidated in . . . [February] 2011 by the House Committee on Population and Family Relations" (Tony Ahn, "RH Bill History" [no date of posting], http://rhbillph.wordpress.com/rh-bill-history/ [accessed 28 February 2011)]. The consolidated version, House Bill 4244 was separately approved by the House of Representatives and the Senate on December 17, 2012.

[2] Social Weather Stations, "Third Quarter 2008 Social Weather Survey: 76% Want Family Planning Education in Public Schools; 71% Favor Passage of the Reproductive Health Bill," http://www.sws.org.ph/ pr081016.htm (accessed 28 February 2011).

myriad of opinions, expert or otherwise. The ongoing debate gets palpably messier as it enters the arena of the patient-doctor relationship; an arena that is by and large one of unequals.

## Into the (Under) World of Reproductive Health Care

"At this my body is racked with pain, pangs seize me, like those of a woman in labor. . . ." (Isaiah 21:3 NIV).

In the nine long months when a woman is with child, she is beset by many physical and psychological adjustments that often demand increasing sacrifice. When the moment for birthing arrives, strong mixed emotions build up–often of fear or anxiety mixed with joyful anticipation. Sleep becomes an impossibility and major physical exertion seemingly drains a mother of her last ounce of energy. It is a moment of great vulnerability.

My clinical practice of nearly twenty years in the Philippines (as a general practitioner) and Papua New Guinea (as an HIV/AIDS counselor particularly to pregnant mothers and as a doctor/health-worker trainer to the villages), in both public and private health facility settings, gave me access to stories of women who have suffered physical, mental, and spiritual anguish in the hands of health care professionals that forced them to "agree" to some form of artificial contraception. I cite a few cases here,[3] two in the Philippines and two in Papua New Guinea: [4]

Malou is an indigent and illiterate woman in her mid-30s living with her husband and eight children in what used to be part of the sewerage system of the city. She just delivered her ninth healthy baby in a government medical center. As with previous deliveries, this one was a spontaneous vaginal delivery without complications. In the post-natal ward, she was told by the attending physician that she would be charged for the health services unless she agreed to a series of Depotrust[5] injections for the coming twelve months. No other rationale was articulated to her

[3] Pseudonyms are used in all cases.

[4] On account that the writer of this essay is a medical practitioner and the attending physician as well of the patients whose care are discussed hereto, it is perceived that facts are better propounded with the use of first person pronouns.

[5] Medroxyprogesterone acetate 150mg suppresses ovulation with the possible side effects of amenorrhea, menorrhagia and continuous bleeding, blood clots, increase in body weight and blood pressure, decreased libido, dizziness, nausea, convulsions, disturbed liver function, sleep disturbances, etc. . . . It is secreted in breastmilk and its effects on the infant have not been determined. See Omudhome Ogbru, PharmD, MedicineNet.com, s.v. "Medroxy progesterone, Provera, Depo-Provera, Depo-Sub Q Provera 104," http://www. medicinenet. com/medroxy progesterone/article. htm (accessed 1 March 2011) and the *MIMS*, 128th ed., s.v. "Depotrust," by Umeda Co Ltd, edited by Leong Wai Fun BSc Pharm and others (Singapore: UBM Medica Asia Pte, 2011), 226; "Provera," by Pfizer Inc. (ibid., 228).

for its administration. Malou did not have the means to pay and thus reluctantly complied.

Neneng, 28 years old, was in lithotomy position[6] on the delivery table in active labor with her second child. The resident physician of the government hospital casually walked up to her and continually slapped her inner thigh as she shouted, "Misis, pangalawa mo na ito! Magpatali ka na!" ("Mrs. this is already your second child! Have yourself ligated!") Neneng groaned with the pain of labor and refused to answer. The doctor continued to behave with her in this way for sometime then left. I was attending to another woman in the adjacent cubicle so I walked up to Neneng and asked if she understood what had been told her and if she would consent. As she writhed in pain, she nodded to my first query and said, "Ayoko po magpatali. . . ." ("I do not want to have a tubal ligation …")

Susan, a 40-year old woman from a mountain village, has had a good obstetric history and remains healthy despite her scant resources. She was admitted to the government general hospital in active labor for her fifth child. As labor progressed, a medical team of four entered the delivery cubicle and told her to sign a consent form for tubal ligation under pain of not being assisted. She refused, insisting she was Catholic. The team began to leave. In panic, the woman screamed that she would sign the form. One week post-partum, she came to my clinic complaining of acute abdominal pain and pus draining from the operative site. She was suffering from pelvic inflammatory disease. As I attended to her, she began to weep saying that she had sinned by "giving her consent" for sterilization.

An educated couple in their mid-20s came to the Catholic private clinic to consult me about apparent infertility. They had one child and were trying to have a second for over a year but without success. The woman handed me her previous obstetric record from a non-religious private clinic. After inspecting the document, I asked if the contents were ever explained to her. She answered in the negative. I told her that it indicated that a bilateral tubal ligation had been performed right after her delivery by elective caesarian section. However, the condition that warranted the sterilization was not specified. I then gently informed her that she can no longer conceive. The couple was incredulous. They were not consulted prior to the procedure nor recall ever having signed a consent form for it to be done.

All these women were Catholics and had resort to me as a Catholic doctor.

[6] This is a position in which the patient is on their back with the hips and knees flexed and the thighs apart. The position is often used for vaginal examinations and childbirth. See *MedicineNet.com*, s.v. "Lithotomy position," http://www. medterms.com/script/main/ art.asp? article key=25628 (accessed 13 March 2011).

**The Ideal Physician's World**

[The first article in the Law of Hippocrates[7] states that] medicine is of all the arts the most noble; but, owing to the ignorance of those who practice it . . . it is at present far behind all the other arts. Their mistake appears . . . to arise principally from this, that in the cities there is no punishment connected with the practice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it. Such persons are the figures which are introduced in tragedies, for as they have the shape, and dress, and personal appearance of an actor, but are not actors, so also physicians are many in title but very few in reality.[8]

This reveals the mind of a physician that would impose high ethical standards in the practice of the medical profession and pronounces a harsh judgment on those who do not comply. Indeed, in the famous Oath attributed to the same and traditionally used by new graduates of medicine even to this day, physicians swear to use their ability and judgment for the good of their patients, abstaining from "voluntary acts of mischief, corruption" and harm. It is perhaps remarkable (for the issue under study) that Hippocrates particularly articulates avoidance of "giving a woman a pessary to produce abortion."[9]

The Philippine Medical Association (PMA) also espouses a code of ethics that includes the stipulations found in the succeeding sentences. Section 1 of article I on its General Principles declares that its primary objective is service to humanity without discrimination and that in practice, reward or financial gain should be a subordinate consideration. Section 2 states that the physician must provide competent medical care in accordance with "compassion" and "respect for human dignity." Section 3 of the same article mandates the physician's compliance with the laws and cooperation "with the proper authorities in the application of medical knowledge for the promotion of the common welfare." Section 7 states that the "promotion and advancement of the health of the patients should be prioritized over the benefits of the physicians." Section 5 of article II on the Duties of Physicians to Their Patients safeguards a patient's right to refuse medical treatment and ensures

[7] "Hippocrates, (born c. 460 [BCE], island of Cos, Greece—died c. 375, Larissa, Thessaly), ancient Greek physician who lived during Greece's Classical period and is traditionally regarded as the father of medicine. It is difficult to isolate the facts of Hippocrates' life from the later tales told about him or to assess his medicine accurately in the face of centuries of reverence for him as the ideal physician. About 60 medical writings have survived that bear his name, most of which were not written by him. He has been revered for his ethical standards in medical practice. . . ." (Wesley D. Smith, "Hippocrates," in *Encyclopedia Britannica*, http://www.britannica.com/ EBchecked/topic/ 266627/Hippocrates (accessed 29 October 2012).

[8] David Gersten, MD, "The Oath of Hippocrates," DavidGerstenMD.com, http://www.imagerynet.com/ hippo.orig.html (accessed 1 March 2011).

[9] Ibid.

that a physician must obtain voluntary informed consent from every patient that can give it.[10] Section 1 of article III on the Duties of Physicians to the Community states that a physician must cooperate with "the duly constituted health authorities in the education and enforcement of laws and regulations for the promotion of health. . . ."[11]

Likewise, on its Web site, the Philippine Obstetrical and Gynecological Society (Foundation), Inc. (POGS), has stated in its Mission Statement, a commitment to provide the highest quality of women's healthcare. It sees itself as "composed of highly competent, compassionate, God-loving Obstetrician-Gynecologists who uphold the highest ethical standards of practice in providing excellent health care."[12]

Medical ethics is directed by four basic principles:[13] Simply put, "*beneficence* is the obligation to do good for the patient and others; *nonmaleficence* is the obligation not to harm the patient or others; *autonomy* is the right of the patient to decide what is to be done (to her/him); *justice* means treating people fairly."[14]

Thus far, it would appear that the physician must practice her/his profession without even a prudent regard for self. However, the PMA Code of Ethics provides for basic human freedom and the exercise of at least some degree of personal preference. Article II, section 2 says that a physician should be free to choose patients. No criteria, guidelines or qualifiers on which such choices are to be made are provided within the same document save for consideration of personal safety (art. II, sec.3). In its position statement on the proposed 2010 Reproductive Health Bills,[15] the POGS

[10] "In case of unconsciousness or in a state of mental deficiency the informed consent may be given by a spouse or immediate relatives and in the absence of both, by the party authorized by an advanced directive of the patient. Informed consent in the case of minor should be given by the parents or guardian, members of the immediate family that are of legal age" (see art. II, sec. 5 of the Code of Ethics of the Philippine Medical Association, https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf (accessed 6March 2011).

[11] Philippine Medical Association, "CODE OF ETHICS OF THE PHILIPPINE MEDICAL ASSOCIATION," https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS 2008.pdf (accessed 6 March 2011).

[12] Philippine Obstetrical and Gynecological Society, "Mission and Vision," http://www.pogsinc.org/ v2index.php/about-us/mission-and-vision (accessed 2March 2011). The source, however, does not provide an elaboration of what either "highest quality of women's healthcare" or "excellent health care delivery" consist of.

[13] The "Four Principles" approach was developed in the 1970s by a philosopher, Tom Beauchamp, and a theologian, James Childress. It is comprised of four clusters of moral principles that serve as an analytical framework, expressing general values underlying rules of a common moral commitment. These can serve as guidelines for ethical decision–making in medicine and bioethics. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 12.

[14] David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington: Georgetown University Press, 2004), 66.

[15] Philippine Obstetrical and Gynecological Society (Foundation), Inc., "Position Statement on the Proposed 2010 Reproductive Health Bills," http://www.pogsinc.org/v2/index.php/component/

supports certain *prohibited acts* including the refusal "to extend quality health care services and information . . . *provided that, the conscientious objection of a healthcare service provider based on his/her ethical or religious beliefs shall be respected. . .*" This is an explicit provision for respecting the personal beliefs of the physician.

Yet, such protective clauses are scarce and hardly proportional to the conditions which pertain to the patient's condition and rights. Why is this so?

**Our Human Reality**

Illness or disease, as well as conditions like pregnancy, thrust upon us a vulnerability that "can erode our well-being on the physical, psychological, spiritual, and even social levels."[16] What is more, illness can make us vulnerable to exploitation in the anxiety to obtain relief from pain and suffering.[17] "To deal with these issues, we seek medical care and enter into a relationship with health care professionals"[18] particularly doctors. In Philippine culture,

Doctors are considered persons with status because they usually belong to the high economic and social class and . . . are perceived to "hold the key to life and death." They are also "benevolent" father [and mother] figures to be respected and obeyed. Patients are usually submissive and inhibited in participating in their own care. . . It is unthinkable for a Filipino patient to refuse . . . treatment proposed by his physician.[19]

Truly, doctors' academic background and rigorous training, combined with their years of practice, ordinarily makes patients assume they are right and know what is best, even if it means that the latter defy their own instincts, values and personal preferences. "Every patient, to the extent he or she can, should be an equal partner with his doctor in getting well and staying well, but this near-holy view of physicians does not for a moment suggest an equal partnership."[20]

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content/ article/10-articles/53-pogs-position-statement-on-rh-bill (accessed 2 March 2011) [published online last December 14, 2010].

[16] Jozef D. Zalot and Benedict Guevin, *Catholic Ethics in Today's World* (Winona: Saint Mary's Press, Christian Brothers Publications, 2008), 187.

[17] Judith Asher, *The Right to Health: A Resource Manual for NGOs* (London: Commonwealth Medical Trust c/o BMA House, 2004), http://www.ifhhro.org/images/stories/ifhhro/Right_to_Health/3_2_5_rt_health_manual.pdf (accessed 1January 2011).

[18] Zalot, *Catholic Ethics in Today's World,* 187.

[19] Fausto B. Gomez, O.P., Vicente G. Rosales, Jr., M.D., and Hanzy F. Bustamante, RPh., eds., "Philippine Culture and Bioethics," in *Bioethics: The Journey Continues* (Manila: UST Publishing House, 1997), 88.

[20] "Knowing Your Medical Rights," http://www.thehealthpages.com/articles/ar-mdrts.html (accessed 1 January 2011).

Doctors too, for their part, "often tend to think that their greater knowledge, experience and skills justify interventions which clash with the patient's prevailing preferences, granted these. . . are expected to benefit the patient in the future." This is related to the concept of *caring control* defined as "medical action and inaction which may frustrate patients' desires or restrict their freedom but which is defended by claiming that it will in the end serve the patients' own best interest." A distinction is made between types of control that include coercive, constraining, or harmful elements (HARD) and those that do not (SOFT). The latter includes information campaigns and general education that do not need to be justified while the former "is prima facie condemnable"[21] and is further classified into "weak" or "strong" intervention. Strong interventions "irrevocably violate the autonomy of persons who are capable of competent decision-making" and are immoral because it is "impossible to further the best interests of a person through violations of their autonomy." On the other hand, weak interventions, while being "coercive or constraining in nature do not amount to actual violations of personal autonomy" but must be justified by two conditions: these interventions must prevent considerable harm which would have befallen the person if not interfered with; and the recipient of the "authoritative action in question must substantially be incompetent"[22] as regards important decision-making.[23]

**The Patient's Ideal World: A Secular Perspective**

The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. Article 12.1 provides a definition of the right to health. . .

The right to health contains both freedoms and entitlements. The freedoms include the *right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation*. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

. . . the right to health must be understood as a *right to the enjoyment of a variety of facilities, goods, services and conditions* necessary for the realization of the highest attainable standard of health.

[21] Heta Häyry, *Individual Liberty and Medical Control* (Aldershot: Ashgate Publishing, 1998), 40 and 42.

[22] Such recipients include very young children, senile persons, people suffering from severe mental defects or those with only slight mental defects but whose decision-making capacity vary considerable over time and prevailing circumstances.

[23] Häyry, *Individual Liberty and Medical Control*, 42.

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular . . . country.[24]

These elements include: (1) availability (functioning public health and health-care facilities, goods and services, as well as programs); (2) accessibility (health facilities, goods and services have to be accessible to everyone without discrimination) with four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility (includes the right to seek, receive, and impart information and ideas concerning health issues, without impairing the right to have personal health data treated with confidentiality); (3) acceptability (must be respectful of medical ethics and culturally appropriate) and; (4) quality (must be scientifically and medically appropriate and of good quality).[25]

## The Patient's Ideal World: A Roman Catholic Perspective

"Catholic moral theology has traditionally argued that *ethics* (what we ought to do) must be based on anthropology (who we are)."[26] To be sure, one of the most important principles of Catholic social teaching is the view of the human person whose life is sacred and inherently endowed with dignity.[27] The first chapter of *Gaudium et Spes* (*GS*) is devoted to an exposition on the dignity of the human person. Article 12b in particular cites the biblical foundation of that dignity: women and men are created in the image of God. An essential part of our humanity is that we are made up of body and soul.[28] From this derives the reality of our moral conscience

[24] Committee on Economic, Social and Cultural Rights, "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14 (2000) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)," http://www.unhchr.ch/tbs/doc.nsf/(symbol) /E.C.12.2000.4.En (accessed 1 January 2011). Italics supplied.

[25] Ibid.

[26] Kelly, *Contemporary Catholic Health Care Ethics*, 11. Italics supplied.

[27] United States Conference of Catholic Bishops, "Seven Themes of Catholic Social Teaching," http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm (accessed 2 March, 2011).

[28] "The human person, though made of body and soul, is a unity. In itself, in its very bodily condition, it synthesizes the elements of the material world, which through it are thus brought to their highest perfection and are enabled to raise their voice in spontaneous praise of the creator. For this reason human beings may not despise their bodily life. They are, rather, to regard their bodies as good and to hold them in honor since God has created them and will raise them up on the last day. . .Women and men . . . When they are drawn to think about their real selves they turn to those deep recesses of their being where God who probes the heart awaits them, and where they themselves decide their own destiny in the sight of God. So when they recognize in themselves a spiritual and immortal soul, this is not an illusion, a product of their imagination, to be explained solely in terms of physical or social causes. On the contrary, they have grasped the profound truth of the matter" (*Gaudium et Spes*

where we discover a law which we have not laid upon ourselves and which we must obey. Its voice, calls us at the right moment, to do what is good and to avoid evil (*GS* 16). However, we can only accomplish this in freedom.

…[G]enuine freedom is an exceptional sign of the image of God in humanity. For God willed that men and women should 'be left free to make their own decisions' so that they might of their own accord seek their creator and freely attain their full and blessed perfection by cleaving to God. Their dignity therefore requires them to act out of conscious and free choice, as moved and drawn in a personal way from within, and not by their own blind impulses or by external constraint (*GS* 17).

The *Catechism of the Catholic Church,* no. 1731[29] also affirms the value of human freedom. "It has two levels which are morally relevant: freedom of self-determination (basic freedom) and freedom of choice (moral freedom).[30] There is also religious freedom.

[In *Dignitatis Humanae,* the Second Vatican Council declares that all] are to be immune from coercion on the part of individuals or of social groups and of any human power, in such wise that *no one is to be forced to act in a manner contrary to his own beliefs,* whether privately or publicly, whether alone or in association with others, within due limits. This right of the human person to *religious freedom is to be recognized in the constitutional law* whereby society is governed and thus it is to become a civil right.

. . . It is in accordance with their dignity as persons. . . They are also bound to adhere to the truth, once it is known, and to order their whole lives in accord with the demands of truth. However, men cannot discharge these obligations in a manner in keeping with their own nature unless they *enjoy immunity from external coercion as well as psychological freedom.*

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no. 14. See Office for Social Justice St. Paul and Minneapolis, "*Gaudium et Spes* [Pastoral Constitution on the Church in the Modern World] Second Vatican Council, 1965 - Part One," http://www.osjspm.org/document.doc?id=62 [accessed 2 March 2011]).

[29] "Freedom is the power, rooted in reason and will, to act or not to act, to do this or that, and so to perform deliberate actions on one's own responsibility. By free will one shapes one's own life. Human freedom is a force for growth and maturity in truth and goodness; it attains its perfection when directed toward God, our beatitude."

[30] Basic freedom enables a person to determine her/his present and future for herself/himself; its purpose is to actively appropriate the events of life into the person one is now and can become. Moral freedom, on the other hand, is the day-to-day exercise of that basic freedom that enables a person to become what she/he wants (Richard M. Gula, S.S., *Reason Informed by Faith: Foundations of Catholic Morality* [New Jersey: Paulist Press, 1989], 77).

. . . In the exercise of their rights, individual men and social groups are bound by the moral law to have *respect both for the rights of others and for their own duties toward others* and for the common welfare of all.[31]

From these teachings originate principles that must govern the patient-doctor relationship that safeguard the dignity of each, with the belief that both have their own set of moral values and assumptions concerning the nature and purpose of medical care.[32] Only two will be defined in light of the moral analysis and judgment that bear upon the aforementioned cases: the closely related principle of autonomy and self-determination and the principle of informed consent. In fact, one flows logically from the other.

**How Autonomous Can Autonomy Be?**

*"Autonomy* is the ability to make and act upon free, informed decisions resulting from capable and uninfluenced deliberation." As such, it is understood as *self-determination*.[33]

"Women and men as individuals and as members of society crave a life that is full, autonomous, and worthy of their nature as human beings" (*GS* 9c). There is a moral duty to make choices for ourselves and determine our own welfare. These choices that arise from our intrinsic dignity and capacity to reason must be respected by others even when these are not always morally correct or in the best interest of our health. When a patient seeks the help of a doctor for a physical or psychological health concern, it may be that he/she "gives importance to certain spiritual and social issues as well." Tension arises when restoration to health clashes with upholding spiritual or social values. [34] "The kinds of decisions that must be made in regard to medical care often interact with quite personal features of a life (reproduction, bodily integrity, lifestyle issues, dying, etc.)."[35] While not surrendering their own

[31] Vatican II, *Declaration on Religious Freedom (Dignitatis Humanae)*, 7 December 1965, Vatican Archive, http://www.vatican.va/archive/hist_ councils/ii_vatican_council/documents/vat-ii_ decl_19651207 _dignitatis-humanae_en.html (accessed 2 March 2011) nos. 2 and 7. Italics supplied.

[32] Depending on the perspective and approach, different sets of principles and rights– also articulated in different ways– govern the patient-doctor relationship. The health and human rights approach includes and begins with the *principle of respect for persons* in connection with that of autonomy and non-discrimination. However, regardless of approach, there are basic similarities. In this paper, the principles discussed will be from the Catholic perspective.

[33] Sara Goering, "Postnatal Reproductive Autonomy: Promoting Relational Autonomy and Self-trust in New Parents," *Bioethics* 23, 1 (2009): 11. The author cites this as the prevailing view of autonomy but in reality, there is no deliberation that is completely uninfluenced.

[34] Zalot, *Catholic Ethics in Today's World,* 188-89.

[35] Goering, "Postnatal Reproductive Autonomy," 11.

value system, doctors must "respect the patient's right to choose or refuse medical intervention and the patient's quest for health in the widest sense."[36]

Nevertheless, the principle of autonomy is not absolute and can be superseded by other moral obligations such as: "if our choices endanger public health, potentially harm innocent others or require a scarce resource for which no funds are available."[37]

The respect for autonomy or self-determination is often translated concretely into the principle and rule of informed consent.[38] This "consists in providing relevant information and ensuring that the patient comprehends that information, acts on it in a way that demonstrates competence, and does so free from undue influence (usually conceived of as pressuring relatives or physicians, and sometimes related to overwhelming financial constraints)."[39] Four essential components are easily identified. First is relevant *information* which refers to the purpose of the medical intervention in question, its anticipated risks and benefits, its probable results, and alternatives. Second is *comprehension* which is facilitated by the clear articulation of the aforementioned information by the health care provider and an attempt to verify if it has been understood as explained. Third is *competence* referring to the capacity for decision-making gauged through one's understanding of the nature but especially of the consequences of alternative choices. And fourth, *voluntariness* understood as the patient not being coerced or unduly influenced to choose or act in a particular way.[40]

If all these components are met and the patient consents to a medical intervention, then the principle of informed consent would have been respected and applied.[41] It must be recognized that at times the natural reactions to illness and the

[36] Zalot, *Catholic Ethics in Today's World,* 188-89.

[37] Tom L. Beauchamp and James F. Childress, *The Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994), 126.

[38] James Stacey Taylor in his book, *Practical Autonomy and Bioethics*, argues that concern for autonomy is not the ethical foundation for informed consent, bringing in the factor of the health care provider's lack of intentionality to withhold relevant information that will affect decision-making (see James Stacey Taylor, *Practical Autonomy and Bioethics* [New York: Routledge, 2009], 130-31). This paper shall adopt the conventional view that concern for autonomy is the ethical foundation of the doctrine of informed consent. Nonetheless, one must also bear in mind that respect for autonomy cannot be reduced to the duty of obtaining an informed consent. See Carolyn McLeod, *Self Trust and Reproductive Autonomy* (Cambridge: MIT Press, 2002), 133.

[39] Goering, "Postnatal Reproductive Autonomy," 11.

[40] Zalot, *Catholic Ethics in Today's World,* 191-92.

[41] "During medical emergencies, doctors are not required to obtain permission to save individuals' lives or end the emergency, in the absence of any advance directive from patients notified them of (sic). Also, patient consent for routine treatments or procedures such as having blood drawn or providing a urine sample, are presumed by the fact that the patients have solicited a medical assessment and diagnosis from their doctors" (See Robert Derlet, M.D., "Patient Rights," in *Encyclopedia of Everyday Law*, http://www.enotes.com/everyday-law-encyclopedia [accessed 7 March 2011]).

ordinary circumstances of health care can potentially affect the patients' capacity for comprehension and limit one's freedom in deciding. "Their consent cannot be 'informed' if they are intoxicated, under chemical influence of drugs or medicine, or (sometimes) in extreme pain[42] or quasi-conscious; the law will presume that their judgment or consent was impaired under those circumstances."[43]

**The Less-Than-Ideal Meeting of Ideals**

From all that has been laid out as the ideal physician's world and the ideal world of a patient, a moral judgment will be made in relation to the situation and stories of Malou, Neneng, Susan, and the young couple.

With a quick glance, in *all* these stories, the rights to basic freedom and religious freedom as well as the principle of human dignity were violated. The principles of autonomy and informed consent were also transgressed. More specifically, articles 1 (sections 1 and 2), 2 (section 5) of the PMA Code of Ethics, article 12.1 of the International Covenant on Economic, Social and Cultural Rights on accessibility and acceptability of health care and the tenets of Catholic moral teaching on freedom were disregarded.

Malou is a grand multipara[44] and while she remains healthy, it can be argued that her uterus may be considerably thinned out and pose a serious threat to her life should she conceive again. Still, she was not in any immediate danger, a state of nonemergency. The principle of therapeutic privilege[45] for withholding information cannot apply. Her illiteracy may lead one to doubt her competency but again this is not an excuse for the direct withholding of relevant information; no attempt was made to obtain a health care proxy or surrogate[46] for Malou. The active component of Depotrust has the potentially serious or at least distressing side effect of abnormal bleeding; it is secreted in breast milk and its effects on the infant have not been determined, yet no forewarning was provided to Malou who was already breastfeeding regularly when she came to me.[47] There is reason to say that her condition of being

[42] Extreme pain occurs during child birthing.

[43] Derlet, "Patient Rights."

[44] A grand multiparous woman is one who has given birth at least five times.

[45] "A doctor may temporarily withhold some information if the doctor believes in *good faith"* that a patient's condition will be substantially worsened by the knowledge of her diagnosis. This is referred to as "therapeutic privilege" (Derlet, "Patient Rights"). Italics supplied.

[46] A proxy or surrogate is one who is authorized to give consent on behalf of the patient. In the Philippine context, this is often a spouse or close relative.

[47] It is beyond the physicians' control that there is no available information as such but even this fact can be relayed to the patient so that she can be alerted to generally abnormal signs and symptoms in the infant.

financially constrained was used to discriminate against her[48] and coerce her into accepting an injectable contraceptive without adequate information. In fact, her basic right to health as officially defined by the United Nations Committee on Economic, Social and Cultural Rights has been violated.

The physical and mental state of a woman in active labor is "unlikely to provide opportunities for extended or clear-headed critical reflection . . . as such, [the] capacity for autonomy may be compromised."[49] It can be very well be one of the worst settings for obtaining an informed consent. The behavior of the physician attending Neneng's delivery was deplorable on a least two counts. One, her words disclose a mentality that is quite pervasive–but perhaps largely unconscious– in the medical field: the "'Cartesian' paradigm of embodiment (i.e., a dualistic notion that separates mind and body and which conceptualizes the physical body in purely mechanistic terms). . . When science treats the person as a machine and assumes the body can be fixed by mechanical manipulations, it ignores, and it encourages us to ignore, aspects of ourselves, such as our emotions. . ." A study by Emily Martin on the experience of women giving birth provides details on how the technology of obstetrics mechanizes the human body. The woman in labor is described "not as a person, a woman, a new mother, but as a birthing-device. . ." Scriptures and the Catholic Church always consider the human body as a person and a subject but "in order to be [a] subject, the human body needs its own voice. . . [T]he need to give voice to the human body concerns pain. . . Ironically . . . the body in pain is often unable to express itself."[50] Herein lies the second reason for the lamentableness of the physician's behavior. Neneng was already in severe pain when the doctor took the liberty to repeatedly slap her on the thigh in that compromising position.

"The cause of pain is not always found within the body."[51] On top of the added physical pain is the one of *hiya* so characteristic of the Filipino.[52] "The Filipino tries to be non-offensive when [s]he has to disagree."[53] Neneng's circumstances are

[48] Article 12 of the International Covenant on Economic, Social and Cultural Rights states that violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. One of the core obligations under this agreement is to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.

[49] Goering, "Postnatal Reproductive Autonomy," 9.

[50] James F. Keenan, S.J., "Christian Perspectives on the Human Body," *Theological Studies* 55 (1994): 341, 342, and 343.

[51] Ibid.

[52] This has been "defined by Bulatao as 'a painful emotion arising from a relationship with an authority figure or with society that inhibits self-assertion in a situation which is perceived as dangerous to one's ego'" (Gomez, *Bioethics: The Journey Continues,* 85).

[53] Ibid., 84.

almost akin to torture[54] even though the source of the more severe physical pain was consequential to her medical condition and not to the physician's actions (which can be argued, were probably not intentionally meant to torture the patient). In that state, however, she is more likely to succumb to the choice of the doctor, which was against her own.

Susan's story is comparable to Neneng's in the aforementioned sense. She was experiencing the pangs of labor when she was forced to sign a consent form for permanent sterilization. She was not in a conducive state to make a decision regarding a non-emergency procedure and no information was given her. She apparently raised her initial objection based on what she knew of the teaching of her denomination. The approach used by the medical team in making her submit to the unwanted procedure was a form of hard caring control called "paternalism."[55] The doctors coerced Susan by an explicit threat of punishment: that of abandoning her in her need for emergency medical attention.[56] In this instance, there was also an attempt to violate the right to health but also and more gravely, there was a violation of the right to religious freedom. Susan explicitly and emphatically expressed her being Catholic and this was completely ignored.

[John Paul II in "On the Human Family," states that it] is a grave offense against human dignity and justice for governments or public authorities to attempt to limit the freedom of couples in deciding about children. Consequently, any coercion applied by such authorities in favor of contraception, or still worse, of sterilization and procured abortion, must be altogether condemned and forcefully rejected. *The Catechism of the Catholic Church,* no. 2287, says the same.[57]

[54] "*In The Body in Pain,* Elaine Scarry examines the structure of torture . . . torturers derive their power from the voices of the tortured. The primary aim of the torturer is not to exact confession or to learn information, but rather to make the tortured person cry out, not only in pain but also in submission to the torturer. . . [T]he object of torture is to cause so much pain that the body is unable to keep the voice from submitting to the active power of the torturer. . . [T]he aim is to tear the voice from the body. . ." (Keenan, "Christian Perspectives on the Human Body," 343-44).

[55] There are three main types of wrongful caring control. First is paternalism which is analogous to a father's control over the family; an example would be the withdrawal of certain social benefits by the state from citizens who refuse to assume a healthy lifestyle. Paternalism is characteristic of the attitudes of public authorities towards the uneducated masses. Second is maternalism which is the use of emotional blackmail designed to make patients feel guilty and eventually to alter their behavior. It is typically employed in face-to-face situations by medical workers who don't have much formal power over patients, e.g., nurses. And finally, there is censorism that involves the use of half-truths and evasive answers to sensitive questions, e.g., physician telling his/her patient comforting lies. See Häyry, *Individual Liberty and Medical Control,* 45-46.

[56] A fifth pregnancy is considered a high risk pregnancy.

[57] Benedict M. Ashley, O.P. and Kevin D. O'Rourke, O.P., *Health Care Ethics: A Theological Analysis,* 4th ed. (Washington, D.C.: Georgetown University Press, 1997), 288.

It is to be noted that Susan, while not willfully deciding to submit to the procedure was deeply disturbed in her conscience. Fear[58] can reduce responsibility for decisions made[59] and it was along this line of reasoning as well as a correction of her false image of God that I appeased her conscience.

The story of the couple is one that involves all the aforementioned violations and more. Clearly a criminal offense has taken place and legal action against the attending physician/s as well as the private clinic where she was permanently sterilized is justifiable. The wife has been deprived of the basic human capacity to reproduce, without her knowledge and without any justification. Furthermore, her right to physical integrity was transgressed. The reproductive rights[60] of both spouses have been violated.

[Furthermore, from the Catholic perspective,] direct sterilization is intrinsically unethical because it is contrary to both the principle of personalized sexuality as a form of contraception and to the principle of totality and integrity because it sacrifices a basic human function without the necessity of preserving life.[61]

[According to the principle of personalized sexuality,] God made us sexual not only for the survival of our species, but for the complete expression of a married person's mutual self-giving love that finds its complete fulfillment not just in orgasm but in children.[62]

[The principle of totality and integrity insists that] the total human good requires respect for all the essential human functions – physical, psychological, social and spiritual – so that it is not right to sacrifice one to the other unless this is necessary to preserve life, without which none of the goods can be achieved. [Therefore] surgery may not be used to excise or damage a part of the body unless

[58] "Patients who are ill may be 'easily frightened into overriding their own preferences and following expert advice rather than risking abandonment by their caregivers by rejecting the advice" (Goering, "Postnatal Reproductive Autonomy," 11).

[59] Thomas Davitt, "Value Judging and Decision-Making," *Ethics in the Situation* (Milwaukee: Marquette University Press, 1970), 102.

[60] Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence. See United Nations International Conference on Population and Development, "Basis for Action of Reproductive Rights and Reproductive Health," in *Programme of Action of the United Nations International Conference on Population & Development*, http://www.iisd.ca/cairo/program/p07002.html (accessed 1 January 2011), no. 7.3.

[61] Ashley, *Health Care Ethics: A Theological Analysis,* 288.

[62] Ibid., 240.

the continued presence or functioning of a particular organ causes serious damage to the whole body or threatens life. . . [63]

By the couple's own recall, the woman was not in any life-threatening condition during the delivery of her first child by elective caesarian section.

Both by professional[64] and religious ethical standards then, the attending physicians' behavior in all cases, failed. And yet, one may perhaps raise some considerations.

**The Physician's Distinctive Social World: A Consideration**

When judging the morality of an action we must ask if the actor had adequate freedom and knowledge in deciding to do the act. Diminished freedom as well as inadequate or wrong knowledge can lessen the culpability for an action. We are cautioned against making final and absolute judgments about persons because we cannot possibly know all the elements that shape their exercise of freedom and sense of values. [65]

There is quite a long list of core theoretical problems in bioethics that can bear upon the physician's decisions and actions.

[With regards to autonomy:] Are autonomous choices always to be respected? Are there some choices people should not make? Is the limitation of a person's autonomous choices for paternalistic reasons always wrong? Are not all choices culturally shaped, anyway, so that real autonomy is not possible?[66]

With regard to consent, "Is the consent of a patient . . . a sufficient protection against abuse?"[67]

[63] Ibid., 291.

[64] ". . . applicable to the health professional as citizen, are specific obligations imposed by the nature of professionalism, reinforced by the authority given through licensing. Professionalism entails a social pact in which society and its institutions accord the health professional status, power and prestige in exchange for a guarantee that he or she will meet certain standards of practice. It is these expectations that bestow upon health professionals a particular obligation to respect their patients' human rights" (International Dual Loyalty Working Group, *Dual Loyalty and Human Rights In Health Professional Practice; Proposed Guidelines and Institutional Mechanisms* [Boston: Physicians for Human Rights, 2002], 19; http://physiciansforhumanrights.org/library/report-dualloyalty-2006.html [accessed 9 March 2011]).

[65] See Richard M. Gula, S.S., "Freedom and Knowledge," in *Reason Informed by Faith: Foundations of Catholic Morality,* (New Jersey: Paulist Press, 1989), 75-88.

[66] R. G. Frey and Christopher Heath Wellman, eds., *A Companion to Applied Ethics* (Malden: Blackwell Publishing, 2005), 301.

[67] Ibid., 302.

What might be some possible factors affecting the behavior of the doctors that can mitigate the judgment leveled against them?

It has been argued that the issue of rapid population growth is inversely related to economic development and poverty reduction and that the practice of contraception (and even abortion) is a priority solution. Indeed, in some parts of the world this may have actually led to "compulsory or forced sterilizations and abortions in the context of population control policies."

At the 1984 UN World Population Conference in Mexico City, population control policies came under attack from women's health advocates who argued that the policies' narrow focus led to coercion and decreased quality of care, and that these policies ignored the varied social and cultural contexts in which family planning was provided in developing countries.[68]

In the Philippines, the total fertility rate of women as of 2008 was at 3.3 (higher than the replacement rate of 2.1 – 2.29) and the annual increase in population is almost at two million since the beginning of the third millennium.[69] In a paper published by some members[70] of the UP School of Economics dated August 11, 2008 and entitled, "Population, Poverty, Politics and the Reproductive Health Bill," they claim there is evidence that the poor prefer smaller families but are unable to achieve their preference; that "on the average, among the poorest 10 percent of women of reproductive age, 44 percent of pregnancies are unwanted (FPS 2006)."[71] Still, faculty representatives from the same academic school (together with some students and alumni)[72] as well as the Catholic Church affirm that the complexity of the population problem cannot be addressed by mere control of fertility and poverty has

[68] Lara M. Knudsen, *Reproductive Rights in a Global Context: South Africa, Uganda, Peru, Denmark, United States, Vietnam, Jordan* (Nashville: Vanderbilt University Press, 2006), 2 and 5.

[69] John J. Carroll, S.J., "Social-Political and Demographic Issues Related to Population Control and Poverty" (Lecture Presentation at Theological Hour, Loyola School of Theology, Quezon City, 2010).

[70] Ernesto M. Pernia, Stella Alabastro-Quimbo, Maria Joy V. Abrenica, and others.

[71] Given the commendable background of at least some of the authors of this paper, it is reasonable to assume that their data is well-founded on research. However, in the same document, there was a more than slight tendency to blame the Catholic Church's "hard-line" against modern family planning (FP) methods, particularly modern (also referred to as "artificial") contraceptives for the mess we are in. However, on close reading of the section entitled, "The Real Score on Population and Poverty," two of the more blatant reasons for ineffective population control identified are the lack of information and access to contraceptives of a significant percentage of the women population. This can hardly be blamed on the Catholic Church.

[72] Jose C. Sison, "Secular View of the RH Bill" (A Law Each Day (Keeps Trouble Away), *The Philippine Star,* February 21, 2011, http://www.philstar.com/Article.aspx?articleId=659483&public ation SubCategoryId =64 (accessed 22 February 2011).

several factors responsible for it.[73] In reality, "The growing opposition to the narrow population control focus led to a significant departure in the early 1990s from past population control policies."[74] Interestingly, Timothy Reichert, an economist based in the USA, conducted a socioeconomic analysis on the impact of contraception in their Western context and concluded that: contraception is socially damaging; it is a sexist practice; and the behaviors engendered by artificial contraception have resulted in a massive redistribution of wealth and power from women and children to men. Regarding this last conclusion, he further writes: "When the social fabric of society is geared to move welfare from the weak to the strong, rather than the other way around, it cannot survive in the long run."[75]

Given this ongoing debate in our pluralistic society, it is not unimaginable that physicians who seriously wish to address population-level concerns may perceive that they have a moral obligation[76] to better society through drastic measures.[77] On casual interview of colleagues working in both private and public health facilities, I was told that there is no departmental nor hospital policy that requires or insists that health care providers "push" any method of family planning. There is no quota to be fulfilled by anyone in terms of acceptors of family planning methods. On the other hand, those employed in the government sector may sincerely believe it part of their duty to implement the state's stand on population control and contraception (even before House Bill 4244 was passed into law). "[E]levating state over individual interests may serve social purposes often accepted as justifiable."[78] This happens in the context of what is known as the phenomenon of dual loyalty.

Dual loyalty is "defined as clinical role conflict between professional duties to a patient and obligations, *express or implied, real or perceived*, to the interests of a third party such as an employer, an insurer or the state."[79] There are "extensive examples of health professionals' succumbing to pressure from states to subordinate the human rights of patients," including demands that health professionals "deny information on

[73] "Poverty is a complex phenomenon, and many factors are responsible for it. Rapid population growth alone cannot explain poverty. Bad governance, high wealth and income inequality and weak economic growth are the main causes" (Carroll, "Social-Political and Demographic Issues").

[74] Knudsen, *Reproductive Rights in a Global Context*, 5.

[75] Reichert also argues rather convincingly that contraception increases the incidence of infidelity and creates a demand for abortion (Timothy Reichert, "Bitter Pill," *First Things* [May 2010]: 25 -34).

[76] Their decisions and actions might stem from an erroneous conscience through ignorance of what is morally acceptable as well as ignorance of the hierarchy of values. However, the dignity and inviolability of their conscience remain.

[77] In principle, one may not do something morally intrinsically evil to avoid a greater physical evil such as overpopulation (Ashley, *Health Care Ethics: A Theological Analysis,* 286).

[78] International Dual Loyalty Working Group, *Dual Loyalty and Human Rights In Health Professional Practice,* 12.

[79] Ibid. Italics supplied.

reproductive health to women; and provide a lower standard of health care to members of disfavored ethnic or racial groups; among other instances."[80] "The pressure may be a product of legal requirements, threats of professional or personal harm for non-compliance, the culture of the institution or society where the professional practices, or even the professional's own sense of duty to the state."[81] However, one must insist that "an evil action cannot be justified by reference to a good intention" (*CCC* 1759), i.e., the end does not justify the means.

Another possible mitigating factor for the negative moral judgment on the conduct of the attending physicians in the stories cited is the lack of initial and/or ongoing education and formation on human rights as well as bioethics including a more person-centered application of the right to informed consent.

Normally in medical practice, informed consent occurs as a discrete event where physicians fulfill their legal obligation to disclose to patients whatever a reasonable person would want to know about the harms and benefits of a recommended procedure. . . The physician will then ask whether the patient understands and agrees with the recommended procedure and will sometimes have the patient sign a consent form. . . Rarely does significant communication about the patient's options occur beyond that point.[82]

Lastly, somewhat related to the preceding issue, is that there are extant problems with an informed consent, autonomy-based medical ethic. A quick rundown of these would include:

1. [The focus of such an ethic] on who is to choose rather than on what is chosen.

2. The assumption that information is always a positive good and that obtaining informed consent is the physician's primary moral task.

3. The wishes of family members and physicians are considered morally irrelevant.

4. The implication . . . that egotism is more dependable than altruism for health care decisions.

[80] Physicians for Human Rights, "New "Dual Loyalty" Report Offers Guidelines for Health Professionals to Protect Patients from Rights Violations," *Physicians for Human Rights Library*, http://physiciansforhuman rights.org/library/2003-03-06.html (accessed 1March 2011).

[81] International Dual Loyalty Working Group, *Dual Loyalty & Human Rights In Health Professional Practice,*13.

[82] McLeod, *Self Trust and Reproductive Autonomy*, 134-35.

5. The excessive emphasis on patient choice also splits facts from values, medical science from medical ethics, and clinical thinking from moral reasoning.

6. Autonomy is considered more important than beneficence and elaborate justifications are necessary to treat the patient for the patient's good without consent.

7. The framework assumes that a political (or legal) model is the most appropriate for the physician-patient relationship.

8. The patient preference ethic tends to confuse medical values with the individual physician's personal values . . .

9. The fundamental task of medical ethics . . . is to justify legal coercion.

10. Physicians risk demoralization and de-professionalization if medical therapeutics is grounded in subjectivist preferences.[83]

While one may not agree with one or all of the above, and such a view tends to "polarize the discussion into an autonomy-beneficence dichotomy,"[84] the long list effectively indicates the lack of consensus on the matter.

## Conclusions and Recommendations: Towards an Approximation of the Ideal in Our Philippine Context

The reasons given for a reconsideration of a severe moral judgment on the behavior of the attending physicians, albeit few and not applicable for all the cases presented, are not meant to condone their behavior. Rather, these are in view of making recommendations that may curb the occurrence of wrongful and immoral actions in the patient-doctor relationship.

The first recommendation is to ensure the presence of human rights education[85] in the basic curriculum of health professionals-to-be. Bioethics is a course that is incorporated into the earlier years of education in a number of medical

[83] David Schiedermayer, "Honor Thy Patient," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, 2d ed., ed. Stephen E. Lammers and Allen Verhey (Michigan: William B. Eerdmans Publishing Co., 1998), 773.

[84] Ibid.

[85] "Many health professionals are generally familiar with bioethical frameworks to assist in resolving difficult clinical dilemmas, typically arising in end-of-life situations or in the context of limited resources. Less familiar to health professionals is analysis of the human rights dimensions to healthcare practice" (International Dual Loyalty Working Group, *Dual Loyalty and Human Rights In Health Professional Practice,*13).

schools like the University of Santo Tomas (Catholic) and the University of the Philippines (public non-religious) for at least a couple of decades now. However, there is apparently inadequate if any ongoing training in this field during the medical residency training programs when new doctors increasingly experience direct management of clinical cases. It would be constructive for an ethical practice of medicine to revisit the content of existing bioethical courses in order to guarantee sufficient coverage of human rights relevant to health care. A full course can then be designed and made compulsory for all aspiring professionals in the field beginning in the early years of training but especially in the phase where they are involved directly in patient management and clinical decision-making.

As a particular focus, the concept of the principles of self-determination and autonomy and the ensuing right to informed consent could be discussed firstly, in its wider scope; secondly with a less individualistic focus; and thirdly, with a more explicitly religious or spiritual motivation. In considering that these principles and right have a wider scope and a less individualistic focus, one takes into account that a patient's choice "fits into a larger habitual set of practices which themselves often rely heavily on views and norms external to individual choices" that affect their freedom. Therefore, the physician can more fully respect the aforementioned principles by helping patients develop the skills and confidence to monitor their own health, evaluate their needs and assess when their trust in themselves or in their health care providers should be questioned. [86]

In short, "to be in a position to help patients understand their options in the relevant way, it is crucial that physicians develop relationships with them"[87] and appreciate that other "supportive personal relations can provide the conditions under which autonomy is even possible."[88] These promote a truly shared decision-making and partnership in the patient-doctor relationship.

Meanwhile, it is hoped that a more explicit religious or spiritual motivation may move the physician to see beyond the rights of patients and his/her own duties to an authentic practice of "Honor thy patient by talking to him or her as a person, as Jesus talked to people he encountered. . . . [T]he concept of informed consent at its deepest level is mutual love and respect."[89]

Secondly, and still along this line, it may also be worthwhile to consider incorporating a program of virtue ethics in the formation of health care professionals

[86] Goering, "Postnatal Reproductive Autonomy," 11 and 12.
[87] McLeod, *Self Trust and Reproductive Autonomy*, 137.
[88] Goering, "Postnatal Reproductive Autonomy," 12.
[89] Schiedermayer, *On Moral Medicine*, 774.

in order to inform their decisions not just for the extraordinary times when they face a conflict of values in their practice (dilemma ethics) but even for the daily decisions they make in their routine work. This may help veer the practice of bioethics away from a mere emphasis on following rules and principles towards character formation and an appreciation and application of values that yield a more humane practice of health care.

Thirdly, even though informed consent is normally acquired for medical interventions and procedures, patients are rarely, if ever, informed about their rights and duties. There is a Philippine Patient's Bill of Rights[90] and a handbook for patients on informed decision-making published by the Philippine Health Social Science Association in 2001 which are both apparently underutilized. The government, health-related NGOs, and concerned private sectors can invest in its translation into the major Philippine dialects and its dissemination starting in public health facilities. In fact, it would be propitious to mandate that this bill of rights be posted conspicuously in all health care delivery institutions, e.g., in hospital rooms/wards, department offices, doctors' private clinics, canteens, etc. The private institutions can make it a policy and practice to give a simple printout of the same as part of a patient's admission kit. In addition, patient education on such matters in various health settings can be part of the practicum for students of the medical and other allied health professions during the course on Bioethics or its equivalent.

Fourthly, as ambitious as this may be, experts in concerned fields may want to earnestly embark on a project to bring a moral vision into public health.

Bioethics is adept at bringing into focus the moral salience of very small-scale relationships. It has elucidated . . . the nature of the relationships between doctor and patient. . . It has struggled to bring the same moral vision to the macro scale. . . to provide a satisfactory account of how to think about the ethics of health on a population level.[91]

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[90] There is a record of a Senate Bill No. 812 during the 14th Congress called Magna Carta of Patient's Rights and Obligations (Long title: An Act Declaring the Rights and Obligations of Patients and Establishing a Grievance Mechanism for Violations Thereof and for Other Purposes; Scope: National) filed July 3, 2007 by Senator Ramon A. Revilla Jr. but still pending in the Committee(s) on Health and Demography and Social Justice, Welfare and Rural Development as of September 3, 2007 (see http://www.senate. gov.ph/lis/bill_res.aspx?congress=14&q= SBN-812 (accessed 7 March 2011) and Senate Bill No. 146 during the 15th Congress with the same short title (Long title: An Act Proclaiming the Rights and Obligations of Patients, Providing a Grievance Mechanism Thereof and for Other Purposes; Scope: National) filed July 5, 2010 by Senator Pia S. Cayetano also still pending in the same aforementioned committees as of August 2, 2010 (see http://www. senate.gov.ph/lis/bill_res.aspx? congress=15&q =SBN-146 [accessed 8 March 2011]).

[91] Daniel B. Rubin, "A Role for Moral Vision in Public Health," *Hastings Center Report* 40, 6 (2010): 22.

Daniel Rubin, who proposes this in the published article quoted above, writes that for the engagement between public health and bioethics to be fruitful, bioethics must

. . . respond to the needs of public health by crafting a compelling theory of value — a moral lens — that can better discern the value-laden questions that emerge when health is viewed from a population level. . . To do this, bioethics must aid public health in identifying *achievable* moral goals, not just ideal ones. This means grappling with issues of practicability.[92]

Nonetheless, while the "identification of intermediate goals for population health which may be less than ideal, but are practicable, attainable, and manifestly better than the status quo"[93] is possible with an appeal to the moral principles of compromise and tolerance, the potential for resultant scandal is greater and much more harmful at this macro-level. Therefore in reality, it is one thing for Christian bioethics to influence the approval and enactment of morally sound public policies[94] and another to set concrete goals.

To summarize: empowerment through education of both doctor and patient in the realm of human rights and bioethics; provision of meaning through motivation in their relationship, that of mutual love and respect as persons of equal dignity; and incorporation of virtue and moral vision into both realms may hopefully make for approximating the "highest ethical standards of practice in providing excellent health care."

This paper began with the dilemma regarding the widespread use of artificial contraception in our highly pluralistic society, its impact (directly or indirectly) in the doctor-patient relationship in the reproductive health care world, as well as the (im)morality of the dynamics that stem from that impact. While there seems to be enough bases to condemn the behavior of the attending physicians in the cited cases, there is much more to consider in making a moral judgment than what meets the eye. Certainly, the current debate on contraceptives is not the only issue wherein the ideal doctor-patient relationship gets compromised. Could one even claim that such an ideal relationship is at all possible? It is most surely not an easy relationship. This

[92] Ibid., 21.

[93] Ibid.

[94] "Gerald Dworkin has presented a workable list of attitudes, norms and preferences which are usually associated with respect for autonomy in all [health] policy-making" (see Häyry, *Individual Liberty and Medical Control,* 63-65). Practical guidelines for a health education (and I believe also for a health care delivery system, in general) can be derived from this list. These would aim towards improvement in the physical well-being of individuals and even populations without forcing them regardless of their self-determined decisions.

paper has presented what is ideal for both the doctor's and the patient's world from the secular and the Christian perspectives. Could these ideal worlds ever coalesce completely with reality? Notwithstanding the many complexities and challenges (moral and otherwise), Catholic moral teaching exhorts all to aim at the ideal situation where values, as well as principles and human rights are fully realized, and to seek the maximum possible good in any concrete situation. Through our constant striving, we may yet see the birthing of the best in both worlds as they meet in the concreteness of our daily lives.■

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