# The Filipino Physician and End-of-Life Decisions
## Culture and Ethical Decision-Making

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**Abstract:** Making ethically correct end-of-life decisions (ELDs) can be one of the most difficult tasks the Filipino doctor has to face because it is counter-cultural to directly speak of death with a patient. A group of urban-trained Filipino doctors were surveyed to determine criteria they were most likely to consider for: use of aggressive treatment, diagnosis of medical futility, and preparation for death in a terminally-ill patient. They were also asked to identify the "best person" to prepare a patient for death and to make choices about unconditional prolongation of life, euthanasia, and physician-assisted suicide. The ethical soundness of their decisions was then analyzed through the lens of Catholic moral teaching.

Results signify an apparent tendency towards pragmatism and technological brinkmanship, a strong bias in favor of the unconditional prolongation of life but against euthanasia and physician-assisted suicide. Overall the survey indicates there is much to improve in terms of ELDS among Filipino doctors. This situation calls for possible interventions at the different phases of medical training, interpersonal relationships, and human resources and working styles at health facilities. Elements of the indigenous culture may account for some of the choices and provide a framework for affirming the moral strengths as well as empathizing with yet challenging the moral flaws.

**Keywords**: *ethics, end-of-life decisions, terminally-ill, Filipino doctors, indigenous culture, Catholic moral teaching*

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## Introduction

In the year 2000, the Dominican priest Rodel Aligan wrote a book entitled, *The End as the Beginning: The Filipino View on Death.* There, he cites a survey by Dr. Robert Walter and others on the attitudes of Filipino physicians toward dying patients wherein 87 percent of "the respondent-doctors reported that their dealings with a dying patient are the most unpleasant aspect of their profession."[1] Perhaps it would not be far-fetched to assume this as true of physicians across many cultures. However, among Filipinos, it is countercultural for a physician to initiate talk about death or its imminence to a patient. This makes it at times extremely difficult even professionally to present options and make decisions near the end of life.

When confronted with the terminally ill and the approach of death, several questions arise: *What* kind of treatment or intervention is appropriate? *When* (i.e., at what phase of the disease and medical encounter) does one decide that it is better to withhold or withdraw treatment? There is also the *"why"* to think about: If one decides to surrender to death at a given point in time, what would be the reasons, the conscious motivations: Patient's wishes? Medical futility? Financial constraints? Family pressure? Escape from responsibility or pain and suffering? Something religious, perhaps? *Who* will tell the sick person that he/she is terminally-ill or near death and then accompany him/her through the dying process? All these bear upon whether a true peaceful and dignified death can occur, that is a death that is also morally acceptable.

How unbiased and skillful can a physician be in stating the real score and presenting the stakes between extending life and "extending death?" It is one thing to present options when treatment has become undeniably futile and another when the boundary between life and death is obscured or the patient rejects the medical "facts."

What's more, often the family of the patient must also deliver a line or two in this emotionally-charged time. Marked confusion, deep suffering, and a haunting guilt can become bedfellows that ensure the "presumption to treat" imperative prevails.

A good number of doctors may unwittingly exercise diverse forms and degrees of "caring control" that color a patient's decision-making process. They may unconsciously impose their own belief and value system, violating that of their patients.

[1] Rodel Aligan, O.P., *The End as the Beginning: The Filipino View on Death* (Manila: UST Publishing House, 2000), 61.

"It is often said that good training in medicine does not qualify the physician to make good ethical decisions. . . ."[2] "Medico-moral decisions are always highly personal decisions — decisions about persons . . . [and there] are many dimensions to personal good-dimensions that range beyond the special expertise and perspective of the physician."[3]

How then does the Filipino physician cope with and perform in making ethical end-of-life decisions?

This essay is an initiative to first identify the factors Filipino physicians are more likely to prioritize in making end-of life decisions (ELDs). Then, assuming that certain Filipino values and attitudes[4] are operative in their choices, this essay analyzes the results by the current standards of Christian morality particularly from documents released by the Catholic Magisterium and others in support thereof[5] (given that Christianity is the dominant faith tradition in the country). The premise is that the indigenous culture will undoubtedly impact the praxis of morality in so far as it reflects what the people consider true and good. In addition, "the underlying moral content and cultural presuppositions of Filipinos will determine which medical interventions are accepted as morally licit or illicit, as well as which medical policies will underlie what is considered to be effective heath care."[6]

To date, there is apparently no consensus regarding a precise definition of end-of-life even while its components have been articulated. Various articles dealing

[2] Gabriel Pastrana, *Medical Ethics: Ethical Reasoning in Medical Practice* (Manila: UST Faculty of Medicine and Surgery, 1979), 2.

[3] Ibid., 12.

[4] For the purposes of this essay, Fr. Rodel Aligan's definitions for Filipino values and attitudes will be adopted: "*Filipino values* are the things considered good, important and desirable in the Filipino way of life" and "*Filipino attitudes* are orientations toward or away from some objects, concepts, or situations, and a readiness to respond in a predetermined manner to these related objects" (Aligan, *The End as the Beginning,* 4). Nonetheless, it is to be acknowledged that "values are never static. [T] hey mutate and evolve and are subject to changes as human interactions shape them" (Rolando M. Gripaldo, ed., *Filipino Cultural Traits: Claro R. Ceniza Lectures,* Cultural Heritage and Contemporary Change Series IIID, Southeast Asia, no. 4, ed. George F. McLean [Washington D.C.: The Council for Research in Values and Philosophy, 2005], 129.

[5] There are no country-specific moral norms and directives issued by the Catholic Bishops Conference of the Philippines' Episcopal Commission on Health or the Office of Bioethics related to these concerns. A somewhat general description of Catholic health care for the terminally ill was authored by Nancy Russell Catan, Pasquale T. Giordano, S.J., and Mitos Rivera in a book entitled *Evangelizing Presence: Caring for Life* (Makati: Brotherhood of Christian Businessmen and Professionals, 2005). However, it does not refer to any local pronouncements on matters pertaining to end-of-life.

[6] Angeles Tan Alora and Josephine M. Lumitao, eds., "An Introduction to an Authentically Non-Western Bioethics," in *Beyond a Western Bioethics: Voices from the Developing World* (Washington DC: Georgetown University Press, 2001), 5.

with its related issues seem to take this for granted but for simplicity's sake, this essay shall adopt the view taken by the U.S. National Institutes of Health.[7]

## Catching a Glimpse of What Is

A survey questionnaire[8] was fielded via internet to *Filipino doctors* who all had their basic *medical training in urban-based colleges/ universities and graduated between 1990 and 2011.* Respondents were asked to rank criteria for decisions they will make in relation to: pushing for *aggressive treatment*[9] (10 factors); assessment of *medical futility*[10] (10 factors); the consideration of *preparation for death* (14 factors), and *who will preferably carry this out* (4 choices with an option to identify another besides those specified). They were also asked to state their choice concerning *unconditional prolongation of life, euthanasia,* and *physician-assisted suicide all in the context of the terminally-ill patient.*[11]

[7] "There is no exact definition of end-of-life; however, the evidence supports the following components: (1) the presence of a chronic disease(s) or symptoms or functional impairments that persist but may also fluctuate; and (2) the symptoms or impairments resulting from the underlying irreversible disease require formal (paid, professional) or informal (unpaid) care and can lead to death. Older age and frailty may be surrogates for life-threatening illness and comorbidity; however, there is insufficient evidence for understanding these variables as components of end of life" (National Institutes of Health State-of-the-Science Panel, "Statement on Improving End-of-Life Care: National Institutes of Health State-of-the-Science Conference Statement December 6–8, 2004," http:// consensus.nih.gov/ 2004/2004EndOfLifeCare SOS024html.htm [accessed 25 September 2011]).

[8] See the Appendix.

[9] "A patient receiving aggressive care will receive the benefit of every medication, technology, tool, and trick that doctors can devise to treat his or her illness. Chemotherapy, dialysis, radiation therapy, surgery, antibiotics, and other medical interventions designed to preserve and prolong life would be considered aggressive care. If a patient is receiving aggressive care, it is an indication that there is a belief -- among medical professionals, or at least among family members authorizing the treatment -- that the patient will recover or will receive an extension of life of a quality considered to be acceptable" (Terri Mauro, "Aggressive Care," http://special children.about.com/od/medical issues/g/aggressive.htm [accessed 29 September 2011]).

[10] Medical futility is defined as the absence of a useful purpose or useful result in a diagnostic procedure or therapeutic intervention. It is related to the situation of a patient whose condition will not be improved by treatment or to instances in which treatment preserves permanent unconsciousness or cannot end dependence on intensive medical care (*Lawrence J. Schneiderman*, M.D., *Nancy S. Jecker*, PhD, and *Albert R. Jonsen,* Ph.D., "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine* 112, 12 [June 1990]: 949).

[11] A terminal illness is generally an active and progressive illness for which there is no cure and the prognosis is fatal. It is . . . an irreversible illness that . . . will result in death in the near future or a state of permanent unconsciousness from which recovery is unlikely. Some examples, among others, of terminal illnesses may include advanced cancer, some types of head injury, and multiple organ failure syndrome. The length of life expectancy may vary from entity to entity ([Anonymous], "Terminal Illness: Law & Legal Definition, http://definitions.uslegal.com /t/terminal-illness/ [accessed 29 September 2011]).

The factors included *patient characteristics (both personal and medical),*[12] those that are *physician-related,*[13] *technology-related,*[14] and *financial-related.*[15] In addition, choices and corresponding reasons for or against unconditional prolongation of life as well as a consideration to practice euthanasia and physician-assisted suicide in the terminally ill were elicited.

**Summary Results of Survey**

*Sixty-two physicians* responded to the survey, 56 percent were female and 44 percent male. In terms of faith affiliation, there is a preponderance of Catholics. They *practice in various fields of medical specialization* with those into Internal Medicine comprising the majority. Only 3 percent had some training in Hospice and Palliative Care. Eighty-two percent work in an *urban setting* either locally or abroad from a few months to as long as 20 years. *Nearly half* (42 percent) *had no formal bioethical background at all.* Meanwhile, about a fourth (27 percent) had attended a course for at least a semester as part of the four-year basic medical curriculum. The rest had varying backgrounds from attendance only in a single bioethics lecture or occasional conferences to full post-graduate courses.[16]

The top five criteria chosen when deciding on the *use of aggressive treatment* in the terminally-ill are: success rate of the treatment option, patient's wishes, level of consciousness, availability of expert on the treatment procedure, and presence of co-morbidities.[17]

Both *technology-related* factors—the *success rate of a treatment option* and *availability of an expert*—are in the top five, chosen by 92 percent and 56 percent of the total number of respondents respectively. The *personal wish of the patient* was chosen

[12] The *medically-related* patient characteristics are: age, current level of consciousness (referring to the range from full wakefulness to coma), presence of comorbidities (especially chronic ones which may not necessarily be debilitating), and presence of physical or mental disability. The *personal* characteristics included the patient's wishes for him/herself, wishes of his/her family, as well as the degree of suffering (biological, i.e., pain or other physical symptoms; psychological, i.e., anxiety or fear or depression; and social, i.e., family problems, financial issues), considering that these are quite subjective. The survey does *not* consider the specific agent/s that led to a status of being terminally-ill.

[13] These include the doctor's personal wishes and his/her assessment of medical futility. Other factors in this category that may influence the doctors' considerations include: the presence/absence of training in bioethics; (without details of the course or curriculum) the fact that they all had their medical training in urban-based colleges/universities in the Philippines within the last two decades; the geographical area of their professional practice; and their faith background/life stance.

[14] These factors refer to: (in) accessibility of extraordinary treatment, availability of an expert on the treatment procedure, and success rate of a treatment option.

[15] These pertain to cost of treatment and its affordability to patient.

[16] See table 1 in the Appendix for the general profile of the respondents.

[17] See table 2 in the Appendix for details.

by 84 percent of respondents and comes in second. The *level of consciousness, co-morbidities,* and *age*[18] are patient characteristics, *medical givens* significant for weighing the benefits and burdens of treatment. They are at ranks 3, 5, and 6 respectively. The factor involving *wishes of the family* ranks at number 7 and chosen only by a third (34 percent) of the respondents. *Financial matters* was chosen by more respondents (48 percent) yet it did not make it to the overall top five.

On the other hand, the top choices (in order of preference) as factors in making the *assessment of medical futility* include: level of consciousness, success rate of the treatment option, presence of comorbidities, patient's wishes, and the patient's age.[19]

The patient's *level of consciousness* was chosen by 84 percent of respondents while the *success rate of a treatment option* and *presence of co-morbidities* were both chosen by 82 percent. *Age* was in fifth rank, chosen by 55 percent of respondents. Again, the patient's "medical givens" and a technological consideration reign. The *patient's wishes* is down to rank 4 with only 50 percent selecting this criterion. Interestingly, 42 percent selected *mental or physical disability* (also a medical given) for assessment of medical futility, with a weighted score that places it at rank 6.

Meanwhile, the top factors that will make a physician think of *preparing a patient for death* are: the doctor's assessment of medical futility, the patient's level of consciousness, the patient's wishes, the low success rate of the treatment option, and the severity of expressed biological (physical) pain experienced by a patient.[20]

It is notable that a physician-related criterion—*doctor's assessment of medical futility*—lands not only in the top five list but is in fact at rank 1, chosen by 65 percent of respondents. It is followed by the patient's *level of consciousness* (a medical given), choice of 61 percent. Significantly *patient's wishes,* while making it to rank 3, was chosen by only a little over half (56 percent) of respondents. *Low success rate of the treatment option* (a technology-related factor) was chosen by 63 percent. *Biological suffering* (caused by pain and other physical symptoms) was the most frequently indicated criterion (66 percent) but only ranks 5$^{th}$. Other types of suffering were conspicuously not in the top preferences. Both psychological/emotional suffering (anxiety or fear or depression) at rank 7 and spiritual suffering (sense of meaninglessness; need related to forgiveness and reconciliation) at rank 9 were chosen by only about a third of the respondents. Social suffering (family problems, financial issues) was down at 12$^{th}$ place.

[18] Age is at rank 6 but its weighted score is only one point less than comorbidities at rank 5. One can perhaps be allowed to consider them tied at the same ranking.

[19] See table 3 in the Appendix for details.

[20] See table 4 in the Appendix for details.

When one scrutinizes the factors in relation to use of *aggressive treatment, assessment of medical futility,* and *preparation for death together,*[21] the survey reveals that the *success rate of a treatment option* (technology-related) was chosen the most number of times and garnered the highest weighted score. This is followed by the *patient's wishes* (personal factor) and *level of consciousness* (medical factor). These three were chosen by the respondents more than a hundred times and were the only criteria that acquired weighted scores above four hundred.

The doctors' top preference as to *who should prepare a patient for death*[22] is the *spiritual expert*—ordinarily a priest, pastor, or religious acting as a pastor or one with whom the patient or his/her family is acquainted. Nevertheless, the weighted score for the *family member* at rank 2 is only one less than the score for the spiritual expert. The *attending physician* was often placed at rank 1 even though its total weighted score only placed it third in overall ranking. The *friend* of the patient is at 4th place, being most popular as either a 3rd or 4th choice among respondents. Finally, note that a few spontaneously indicated that the patient should herself/himself make this preparation for death. In the survey questionnaire, there was neither an attempt to define "preparation for death" nor to indicate what it entails. This was left instead to the spontaneous interpretation of the physician and none of the respondents raised questions or clarifications.

For the query on *unconditional prolongation of life,*[23] 79 percent of the physicians indicated that regardless of other conditions, if there was something they could do to prolong life, they would. Most of the reasons given are directly about or relate to their self-understanding of their *professional duty/responsibility.* A few supported their stance with the view of life as a good or a right. Fewer still were those who expressed a religious reason; the same number as those who chose to not state any reason at all. Nonetheless, the bias is certainly in favor of continuing life.

Of the thirteen (21 percent) who *would not unconditionally prolong life,* the more common rationale had to do with what they referred to as *quality of life having primacy* over its continuation. About a third of them also invoked the value of *patient autonomy* influencing their choice.

Would these respondents consider the possibility of performing *euthanasia or physician-assisted suicide (PAS) in the terminally ill*?[24] Once more, it must be noted that neither of these terms were defined for the respondents. *If the bias in favor of continuing life is strong, it seems even more so with regard to not willfully taking another's*

[21] See table 5 in the Appendix for details.
[22] See table 6 in the Appendix for details.
[23] See table 7.1 in the Appendix for details.
[24] See table 7.2 in the Appendix for details.

*life.* Eighty-nine percent wrote "no" to euthanasia and PAS. The most common reason forwarded is a *conflict with their religious belief* followed by a *conflict with their oath/ philosophy as doctors.* A handful stated a preference to "let nature take its course." One seemed ambivalent, stating his "discomfort" with euthanasia and PAS but apparently had no qualms about referring the patient to other colleagues for such interventions. Twenty percent of those who would not support such interventions simply chose not to indicate their reasons. Could it be perhaps a matter of instinct against killing?

On the other hand, 11 percent answered "yes" with reasons related to rights—*patient autonomy* dominating—and burdens. One gave quite a lengthy and interesting answer that apparently implies that when doctors offer treatments, they are also facilitating death through informed choice because at least some of these treatments carry considerable risks to life. He seems to consider euthanasia as a "treatment" that simply differed in extent and intention with other alternatives. Another rationalized the choice by the commonly held understanding of euthanasia as a means *to relieve suffering* while another gave a description of what might actually be equivalent to terminal sedation for palliative care. Still another said that prolonging life could be harmful and did not see euthanasia and PAS in this same light. Rather he actually saw these as *ways of avoiding harm* which he did not specify. In spite of this, this same respondent answered "yes" to unconditionally prolonging life.[25] A couple of respondents were willing to perform euthanasia and PAS if these were legalized.

[25] These responses can be attributed to the fact that the word "euthanasia" is quite imprecise and thus, subject to ambiguous interpretations. It is important to observe a hint of this dynamic—which is possibly quite pervasive— particularly among the respondents with very limited, if any, background on bioethics.

"Historically and etymologically, the word 'euthanasia' means 'a peaceful death without suffering and pain'. In present-day usage, the word implies performing an action or omitting to perform an action, with the intent of shortening the life of a patient . . . the Working Group is of the opinion that, at least in Catholic milieu, a terminology should be used which does not include the word 'euthanasia' at all:

1) *neither to designate the actions involved in terminal care which aim at making the last phase of an illness less unbearable* (rehydration, nursing care, massage, palliative medication, keeping the dying person company . . .);

2) nor to designate the decision to stop certain medical therapies which no longer seem to be required by the condition of the patient. (Traditional language would have expressed this as "decision to give up extraordinary measures.") It is thus not a matter of deciding to let the patient die but, rather, of using technical resources proportionately following a reasonable course suggested by prudence and good judgment;

3) nor to designate an action taken to relieve the suffering of the patient at the risk of perhaps shortening his life. This sort of action is part of a doctor's calling: his vocation is not only that of curing diseases or prolonging life but—much more generally—also that of taking care of a sick person and relieving his suffering.

"The strict meaning of the word: 'Euthanasia' must be used only to mean 'to put an end to a patient's life by a specific act'. . . . Despite the fact that, in practice, the distinctions stated above are sometimes difficult to make, they are nonetheless capable of giving to the word "euthanasia" a meaning free of ambiguities." See Pontifical Council "Cor Unum," "Question of Ethics Regarding the Fatally Ill and the Dying" (June 27, 1981), http://bioetiikka.word press.com/2010/03/11/pontifical-council-cor-unum-question-of-ethichs-regarding-the-fatally-ill-and-the-dying/ (accessed 6 June, 2012).

## Through the Lens of Christian Morality

There is a plethora of opinions and writings on what a good doctor is. It may be safe to assume that many of these would converge on the necessity of some kind of ethics that must govern this noble profession with its unparalleled and very delicate task of caring primarily for physical or biological life. So much—if not the totality—of the quality of our human existence is interdependent with the state of our body as the notion of "transcendent embodiment" proposes.[26] As doctors deal with life, they also unavoidably deal with death. "Human life . . . is the life of a creature and, therefore, temporal, finite and mortal. . . . Death is part of the story of every human being . . . [and] must also be accepted and respected."[27]

> [Furthermore, it may also be worth bearing in mind that] . . . pain alone does not constitute the anguish of the dying. . . . The anguish of the dying consists in the knowledge that they are dying—that is the terror—and that is what makes the *dying person so special, so deserving of our reverence* and yet a bit frightening. The dying remind us of something we prefer not to remember. They are pioneers, living on a border that we all must cross someday. . . .[28]

## The Principles

Nowadays, hardly anyone would contest that the ideal doctor-patient relationship must be one that involves dialogue, team approach, and shared decision-making. Without doubt, the doctor is one of the two principal players, the patient being the other. Now, while technical clinical competence and biomedical knowledge

[26] Margaret Farley's notion of "transcendent embodiment" proposes that human personhood is made up of two aspects: body and spirit which though distinguishable, are one and unified. She provides evidence of this in our experience of *profound suffering* of the body that can relegate the spirit into a mere abstraction while the same intensity of suffering in the spirit can render the body useless and thus treated with consequent neglect; any suffering that we are acutely aware of as beginning in either body or spirit, eventually affects and leads to suffering of the other aspect as well. The same evidence can be found in our human experience of *aging* and *dying*: *Aging* is often associated with our embodiment (alone) which becomes a burden, limit, hindrance to opportunity, and threat to identity and relationships; thus it seems to be disunited from (the desires and hopes of) the spirit. However, aging is also spiritual whether this experience be one of diminishment (in consonance with the biological/bodily deterioration) or enhancement (incongruent to the aging of the body). Meanwhile *death*, while seemingly only an experience of the body, is actually also of the spirit as both rebel against and attempt to transcend death; as one frantically tries everything to save the body, the anticipation and struggle to understand death and the seeking of extreme unction, spiritual accompaniment, and prayers prove that there is also a concern to save the spirit from death. See Margaret A. Farley, *Just Love: A Framework for Christian Sexual Ethics* (New York: Continuum, 2006), 116-27.

[27] Aligan, *The End as the Beginning*, 65-66.

[28] Patricia Wesley, MD, "Physician Assisted Suicide (A Physician's View)," in *The Interaction of Catholic Bioethics and Secular Society: Proceedings of the Eleventh Bishops' Workshop Dallas, Texas* (Braintree: Pope John Center, 1992), 35-36. Italics supplied.

are indispensable, health care-giving also essentially includes a moral dimension.[29] Certainly, this is even truer in rather sensitive end-of-life situations where ethical questions abound. Some experts from the medical world, from the perspective of professionalism, advocate user-friendly frameworks to aid clinical ethical decision-making especially when conflict is present.[30] The Roman Catholic Church also makes a contribution by providing principles as well as ethical and religious directives for Catholic health care services. These are invaluable for Catholic doctors who desire to integrate their faith into their professional practice.[31] Without a claim to being exhaustive, what follows is a list of those principles relevant to making ELDs.

### A Patient-Centered and Holistic Practice of Medicine

Since a person in the dying process must hold us in awe, in this phase of human life—perhaps more than at any other—the doctor ought to be not a mere technician but one who *relates to the whole of the patient*, and painstaking in identifying the uniqueness of each person from the sensitivity of human values.[32] A sufficient degree of empathy and assiduity are indispensable for this task.

### The Sanctity of Human Life (not the Quality of Life)

*Sanctity of life* is the core presupposition of Catholic moral theology in bioethics[33] on the immense value of human life based on the inherent dignity of the human person created in the image and likeness of God. "Every decision, every policy, every rule must both reflect and promote this value if medicine is to remain humane. . . ."[34]

[29] See Arthur Kleinman, "Caregiving as Moral Experience," *The Lancet* 380 (2012): 1550–551.

[30] An example of such is the four topics approach to clinical ethics case analysis described by Jonsen, Siegler, and Winslade. Each of these topics is actually a set of specific questions concerning medical indications, patient preferences, quality of life, and contextual features that are to be considered in making decisions for a medical case. In this "secular/scientific" approach, it is worth noting that the contextual features include both family and health care provider issues that might influence treatment decisions; financial and economic factors; religious or cultural factors; problems in resource allocation; the effect of law on treatment decisions; the involvement of research and teaching and conflict of interests on the part of the health care providers or institution. See John H. Schumann, MD, and David Alfandre, MD, MSPH, "Clinical Ethical Decision Making: The Four Topics Approach," *Seminars in Medical Practice* 11 (2008): 36 and 37.

[31] "When . . . the concrete ethico-medical situation is approached and understood from the point of view of faith and religion, at [sic] it is expected to be the case of the believing physician, a new and enormous relevance is added. One's whole outlook on the meaning of life, death and suffering; life-after-death, etc., is brought into play" (Pastrana, *Medical Ethics*, 11-12).

[32] Ibid.

[33] This is expressed in magisterial documents like *Gaudium et Spes*, *Donum Vitae*, and *Evangelium Vitae*.

[34] Pastrana, *Medical Ethics,* 15.

*Quality of life* is a term not uncommon in health care but is to be avoided in as much as John Paul II cautioned that this is "preferentially and exclusively interpreted as economic utility, intemperate consumptionism, physical beauty, and pleasure."[35] According to this standard, doctors have mistakenly classified some lives as not valuable enough to continue and thus, have established an ethics of discrimination.[36]

## The Christian Value of Suffering

Suffering can have a positive value[37] yet the Church recognizes that there is needless demoralizing and unrelenting pain which doctors are duty-bound to relieve if not at least bring to a bearable state.[38]

> The Christian belief is that when suffering is unavoidable it can be vested with a positive interpretation and a creative power. But it is also a fact that pain can diminish human living, and can be a crushing and disintegrating experience . . . voluntary acceptance of suffering can be a personal vocation, but it is not one to be foisted or forced on others for, as it were, their own spiritual good.[39]

Indeed, while doctors have devised certain tools for patients to more objectively articulate the kind of pain they experience and measure its severity, pain is a very personal, subjective experience. "The capacity for suffering varies from person to person."[40] However, this does not mean that the tools are useless or that doctors should not even bother assessing pain.

> It is for the doctor, the nurses, and the hospital chaplain (let him not be overlooked!) to determine what spiritual and psychological effects

[35] Dong-Ik Lee, "The Bioethics of 'Quality of Life' and 'Sanctity of Life,'" *Dolentium Hominum* 65 (2007): 34.

[36] Ibid., 33 and 34.

[37] "Christianity teaches that it is God's providence: 'The Lord punishes everyone he loves and chastises everyone he accepts as a son' (St. Paul to Hebrews, 12, 6). Suffering makes the person more mature and helps him find his roots and connect with God. The philosophers believe that suffering serves internal and external needs, which constitute the stimulus for life and action, and hence helps man to overcome difficulties. Man must fight and struggle to overcome suffering and, in so doing, he is able to conquer life and achieve his destiny" (from Luke G. Oreopoulos, "The Meaning Of Suffering," *Humane Medicine Health Care: A Journal of the Art and Science of Medicine* 1, 2 [2001], http://www.humanehealthcare.com/Article.asp?art_id=128 [accessed 3 July 2011]). Moreover, Christians believe that Jesus Christ has transformed pain and suffering through the Cross, giving it redemptive and life-giving power.

[38] Gail Quinn, "Physician Assisted Suicide (Catholic Perspective)," in *The Interaction of Catholic Bioethics and Secular Society: Proceedings of the Eleventh Bishops' Workshop Dallas, Texas* (Massachusetts: Pope John Center, 1992), 52 and 67. Quinn writes: "All indications are that the pain of terminal illness is in fact controllable." And even Derek Humphry (founder of Hemlock Society in 1980) admits that 90-95 percent of cancer pain can be controlled (ibid., 53).

[39] John Mahoney, *Bioethics and Belief* (London: Sheed & Ward, 1984), 40.

[40] Pontifical Council "Cor Unum," "Question of Ethics," 2.3.2.

> suffering and pain are having on a patient, and to decide whether a certain treatment is to be carried out or not. What the patient says must also be carefully listened to, in order to determine what the real nature of his suffering is: for he, after all, is the best judge of it.[41]

These viewpoints are very significant in the issues of euthanasia and PAS seeking absolution in the motivation of relieving pain and/or suffering. *Pain and suffering can have positive value and so need not be eliminated at all costs and by all means including intending and causing the death of the patient.* At the same time, confronted with an excruciating condition, doctors must be ready to alleviate the pain and suffering—sometimes through medical means, sometimes through psycho-emotional or spiritual support; often through all these. Ensuring a comprehensive compassionate approach to pain and suffering can inhibit thoughts of willfully ending one's life to obtain relief.

## The Christian Meaning of Death

The *Catechism of the Catholic Church* quite extensively lays out *death* from a Christian perspective, from its origins to its conquest. In summary, it states that death is the consequence of sin (413, 1008). It reminds us of our mortality and marks the end of the limited time through which we are to bring our lives to fulfillment (1007). This "end," this death has been transformed by Christ (1009) such that a resurrection to eternal life is possible for those who have done good (998). Death is God calling man and woman to Himself (1011) and therefore the Church urges us to prepare ourselves for this moment (1014). "'For . . . whether we live or whether we die, we are the Lord's' (Romans 14:8). Our attitude toward the dying must be inspired by this conviction, and must not merely be reduced to an effort made by science to put off death as long as possible."[42]

## Proportionate Reason

> There are times when preserving life would go against our deepest convictions about its meaning and sanctity; there are other times when making a decision about the quality of life would seem to be an attack on the sanctity of life itself, an assumption of power we tremble to accept . . . there comes a time when living is no longer human life – and to take the consequences of this admission.[43]

Therefore, the Vatican *Declaration on Euthanasia* (1980, Part IV) and the Pontifical Council "Cor Unum" in the *Question of Ethics Regarding the Fatally Ill And*

[41] Ibid.
[42] Ibid., 2.2.1.
[43] Pastrana, *Medical Ethics,* 15.

*The Dying* (1981) teaches: ". . . in the matter of cares to be taken for maintaining good health and preserving life, a *correct proportion* must be arrived at" (art.2.1.1). This means that in rendering basic health care as well as medical therapy, the *criteria of benefits and burdens* are to be used, considering the nature and extent of the pathology/illness, the possible effects of a given medical treatment, as well as the specific situation of the sick person with his/her material, psycho-emotional, moral, and spiritual resources[44] and environment. In brief, the objective and subjective givens need to be sufficiently deliberated.

*Benefits* are to be understood primarily in terms of the "preservation or restoration of health and the alleviation of pain" which in turn indirectly offer social and/or spiritual benefits that enable one "to pursue the goods of life . . . ordered toward the ultimate good of life, [which is] friendship with God."[45] Meanwhile, *burdens* are also multi-dimensional and must be assessed according to: *types* (economic, physiologic/physical, psychological, social, and spiritual) and the *bearer* (primarily the patient but includes the family, caregivers such as medical professionals and health facilities, and society at large). Burdens are relative to the *person* (assessment of excessive burden is highly individualized and it pertains to the conscience of the sick person or his/her legitimate proxy to decide);[46] relative to the *situation* (persons' assessment of what is burdensome changes when in good health and when one is already in need of certain medical interventions); and relative to *duration* (burden often increases with the length of time).

It is opportune to bring up an important point made by "Cor Unum" in its document on the fatally-ill and dying. Article 7.2 on the choice of one therapy or another, states:

> As a general rule . . . a doctor does not ask himself whether to allow or not allow a patient to die. He decides upon a certain medical treatment: what are its indications, what are its contra-indications ... For, if there exist moral reasons for prolonging life, there also exist moral reasons for nor [sic] opposing death with what is known as 'therapeutic obstinacy.'
>
> [And also in article 2.4.3:] The fundamental point is that the decision should be made according to rational arguments that have taken well into account the many and various aspects of the situation, including what

[44] Benedict M. Ashley, O.P., Jean Deblois, C.S.J., and Kevin D. O'Rourke, O.P., *Health Care Ethics: A Catholic Theological Analysis,* 5th ed. (Washington, D.C.: Georgetown University Press, 2006), 184-90. See also United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 5th ed., 17 November 2009, http://www.usccb.org/about/doctrine/ethical-and-religious-directives/ (accessed 6 June 2012), 29.

[45] Ibid., 186.

[46] See John Paul II, *Evangelium Vitae,* 25 March 1995, Vatican Archive, http://www.vatican.va/ holy_father/ john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_Evangelium-vitae_en.html (accessed 11 July 2012), no. 65.

> effect will be had upon the family. The principle to follow is, therefore, that no moral obligation to have recourse to extraordinary measures exists; and that, incidentally, a doctor must follow the wishes of a sick person who refuses the measures.

Obviously, the weighing of benefits and burdens can be tedious and more of a taxonomic process rather than the completion and comparison of checklists if doctors together with their patients are to reach ethically-sound decisions.

**Principle of Autonomy and its Limits: Obligation of a Well-Formed Conscience**

> A sick person cannot simply be made the object of decisions which he himself does not make or of which, if he is unable to make them, he would not morally approve. Each human individual, as the person principally responsible for his life, must be at the center of all assistance. Others are present in order to help him, not substitute [sic] him.[47]

In secular bioethics, this is what one would refer to as the principle of autonomy.[48] A doctor may not dispose of someone else's life.

Nonetheless, while the decision of a competent patient "should always be respected and normally complied with," the Catholic physician is not bound to do so when such is contrary to the Church's teaching.[49] Every patient "is obliged to inform his/her conscience as completely as possible, to judge (decide) based on this conscience, to act according to the judgment..." This is the principle of a well-formed conscience which considers "information and recommendation of doctors... values and teachings of the Church, the good of the community, and the fruits of discerning prayer" in making a healthcare decision.[50]

[To be sure], doctors or members of the family may ... at times find themselves in the position of having to take decisions for a sick person ... [but] it is absolutely forbidden to make an attempt on the life of the patient, even out of compassion and pity.[51]

That last statement refers to euthanasia, defined by the Sacred Congregation for the Doctrine of the Faith as "an action or omission which of itself or by intention

[47] Pontifical Council "Cor Unum," "Question of Ethics," 2.1.2.

[48] However, Pius XII as early as 1952 in his address to the First International Congress of Histopathology, stressed that even the patient "is not absolute master of himself . . . He cannot freely dispose of himself as he pleases . . . he does not possess unlimited power to allow acts of destruction..." (Quinn, "Physician Assisted Suicide [Catholic Perspective]," 71).

[49] The United States Conference of Catholic Bishops, *Ethical and Religious Directives,* no. 59.

[50] See Kevin D. O'Rourke, O.P. and Philip Boyle, "Formation of Conscience," in *Medical Ethics: Sources of Catholic Teaching,* 3d ed. (Washington DC: Georgetown University Press, 1999), 16-28.

[51] Pontifical Council "Cor Unum," "Question of Ethics," 2.1.2.

causes death, in order that all suffering may in this way be eliminated."[52] As aforementioned, this and physician-assisted suicide are not permissible under any circumstance.

In addition, Paul VI, in his address to the European Association of Hospital Doctors in April 28, 1973, said:

> ... the physician must act according to his or her 'conscience, enlightened by the principles of true ethics and faith' and should induce the person relying on their advice and competence to consider a 'solution that is more genuinely human and respectful of his upright conscience and the inalienable norms of morality ... What is legal, does not become for that reason moral ...'[53]

Thus the doctor too has the obligation to acquire a well-formed conscience rather than merely relying on expertise, empathy, and legality in order to arrive at ethically-sound decisions.

**The Social Dimension and Responsibility toward the Dying**

Christian morality accentuates the necessary social dimension of attending to the terminally ill and dying. "The dying person feels sadness, guilt, anxiety, fear, and depression, and all of that along with physical pain. Worst of all for him [or her], is the isolation, the loneliness, which seriously influence him [or her] psychosomatically."[54] There are occasions when certain therapies require an almost total isolation of the sick from others including the family. However, it is not "out of place to state that the right to die as a human being with dignity demands" that the dying be surrounded by his/her significant others.[55]

Meanwhile, they who surround are called upon to inform the sick one of the possibility of dying. "The family, the chaplain, and the group providing medical care, must assume their share in this duty. Each case is different, depending on the sensitivities and capabilities of all concerned, and on the condition of the patient and his ability to relate to others."[56]

[52] Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia,* 5 May 1980, Vatican Archive, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_ euthanasia_ en. html (accessed 10 November 2012), Part II. The United States Conference of Catholic Bishops in their *Ethical and Religious Directives* no. 60 recommends: Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

[53] Quinn, "Physician Assisted Suicide (Catholic Perspective)," 59 and 66-67.

[54] Pontifical Council "Cor Unum," "Question of Ethics," 6.2.1.

[55] Ibid., 2.2.2.

[56] Ibid., 6.1.2.

**The Reading: What Morality Is at Play**

This reading seeks to determine the ethical soundness of the Filipino physician's decisions in end-of-life situations while being attentive to the possible influence of indigenous cultural values and attitudes. The analysis is not exhaustive and highlights only a number of observations about the survey results to achieve the aforementioned objective.

In the three variables (aggressive treatment, futility of treatment, and preparation for death) relating to medical intervention during terminal illness and end-of life, the results of the survey reveal that the Filipino physician-respondents consider both the potential of the available technology and expertise as well as the unique condition of their terminally-ill patients — their personal wishes and their medical givens. *There seems to be a striving to arrive at least at balanced if not consciously ethically sound decisions.*

A closer look, however, will show that the preferences were skewed in favor of technological factors. The *success rate of a treatment option* was both the most popular choice for inclusion in the top five criteria to be used for decision-making and the one with the highest cumulative weighted score (which means that it was often indicated as either a rank 1 or 2 choice). The patient's wishes, although noticeably placed in the top 5 for all three variables, came in only as a second overall.

It seems that the respondents are eager to use the technology even more than conferring closely with the patient to whom it can be applied. This may be suggestive of pragmatism and technological brinkmanship[57] which can override a patient's decision[58] to avail of or refuse treatment near the end of life regardless if it will be truly of benefit or not. In addition, the patient's medical conditions (level of consciousness, existence of co-morbidities, and age) which determine health benefits and burdens, have also been subordinated to this technology-related criterion.

The order of priority as manifested by the results is: technology first, the wishes of the affected person, second and the factors related to the medical condition, third. The ingredients proposed by the standards of Christian morality for an ethical decision are present yet the order of priority is questionable. In other words,

[57] Technological brinkmanship is defined as "a powerful clinical drive to push technology as far as possible to save life while at the same time, preserving a decent quality of life." However, technology that is pushed too far can be harmful to a person because medicine does not possess the ability to manage technology and its consequences with delicacy and precision. See Daniel Callahan, The Troubled Dream of Life: In Search of a Peaceful Death (Washington D.C.: Georgetown University Press, 2000), 40-41.

[58] "Because of the focus on technological intervention, the human relationships are often neglected, judged less important, more dispensable . . . machines and lab results . . . replace conversation with the patient" (ibid.).

confronted with end-of-life situations, the physician asks first: "Does the available treatment for the cause of a terminal illness have a high chance of working?" If not, the physician is not likely to recommend and administer it. If it has a reasonably high success rate, the second question the physician asks is: "What does the patient want?" "What are his/her deeply held beliefs and values?" and "What are his/her personal goals and expectations?" assuming that he/she has been provided with sufficient pertinent information and understands it. Only after will the physician ask: "Apart from the primary cause of terminal illness, what are the other medical conditions of the patient that can affect management?" The survey results[59] signify the logic that the younger, more alert patient with none or little other pathologies will likely get the treatment. Its corollary may also apply: the older, more obtunded patient afflicted with more diseases is less likely to be given the treatment even if it will be effective.

Perhaps it seems unfair that respondents were asked to rank their criteria and one could argue that each of the types of criteria (personal, medical, physician-related, technology-related, and economic) will be considered "equally." Yet, in real clinical situations, conflicts arise between these categories. Decisions will somehow constrain a doctor to weigh her/his values, prioritize, decide, and act accordingly.

On the other hand, it is also worth considering that perhaps the respondents' focus on technology is only in view of doing everything for the patient who is considered part of an extended family (a strong cultural tendency). Both in private and public clinical practice, it is not uncommon for doctors to address their patients as "*nanay/tatay, tita/tito, ate/kuya, anak*" and maybe unconsciously decide and treat them as if they actually had blood ties.

In the assessment of futility of treatment, it is particularly important to mention that the presence of a *physical or mental disability*, while making it only to rank 6, was nevertheless chosen by nearly half the respondents. Could this be indicative of "a certain narcissistic intolerance of physical and cognitive dysfunction that characterizes [Western] society (despite all rhetoric about the disabled). . ."[60] creeping into ours in this age of globalization? Or is it simply proof that "Filipino culture is a complex blend of Eastern and Western influences"? That the "global, highly technological, materialistic, culture developing in and intruding from the West has a strong influence on a developing country such as the Philippines"?[61] This is highly probable with Filipino doctors given that the philosophy and practice of medicine locally is very much westernized.

[59] See table 5 in the Appendix.
[60] Wesley, "Physician Assisted Suicide (A Physician's View)," 33.
[61] Alora, *Beyond a Western Bioethics*, 6.

At the same time, this inclination can also be a sincere but misguided expression[62] of *awa* (considered an extension of charity),[63] opposite to its more common manifestation of doing everything for the sick person.[64] Here instead, the physician may presume that the terminally-ill with such disability has a "lower quality of life" or is miserable and would be "better off" without treatment. There is a common belief that those who cannot or have less ability to enjoy life or be productive are useless to treat. The sanctity of such lives and the value of suffering (not just for the sick but for those around him/her) are inadvertently ignored.

The *wishes of the patient's family* was another criterion being proposed which can address the essential social dimension of illness and dying. However, in the decision-making for or against use of aggressive treatment, it only ranked 7th (out of 10 criteria); in assessment of futility of treatment only 9th (out of 10); and in deciding to prepare for death only 10th (out of 13). In combining the three variables, its weighted score only placed it 8th and yet the family member is the second most popular choice for who can best prepare a patient for death; in fact almost tied at rank 1 with the spiritual expert! This is rather surprising and perhaps somewhat unfair—that the family is given a seemingly peripheral role in decision-making then given a primary role once a decision (about withholding or withdrawing treatment) has already been made. Within the context of the indigenous culture which is known to be family-oriented and family-centered, the sick member "accepts a role of dependency and passive tolerance . . . assured that others will care for and support . . . especially when terminally ill."[65] Personal autonomy and control are easily given up in times of sickness and generally viewed as principles which are "individualistic, atomistic, and marked by a degree of anomie."[66] The trend in the survey results to value the patient's own wishes (rank 2 with all variables combined) might be commendable by certain moral norms that exalt the principle of autonomy. Yet it is remarkable, and perhaps even quite dangerous in the context of the local culture. Filipino patients are generally "inhibited in participating in their own care" (autonomy tends to be a non-value) and "prone to shaping their thoughts and behavior" according to the doctor's advice and deferring to the doctor's decisions because he/she knows best.[67] One must bear in mind that in the decision to prepare a patient for death, the doctor's

[62] See also John Paul II, *Evangelium Vitae*, no. 66b.

[63] Aligan, *The End as the Beginning*, 111. Furthermore, "one of the institutions of Filipino society is to show a spontaneous and sincere effort to ease the burden of the afflicted" (ibid., 3).

[64] "An interplay of the *sakop mentality, awa, hiya,* and authoritarianism confronts the physician and the family in decision-making. From the dissertation's survey, many Filipinos believed that everything possible should be done for a dying person" (ibid., 66).

[65] Fausto B. Gomez, O.P., Vicente G. Rosales Jr., M.D., and Hanzy F. Bustamante, R.Ph., eds., *Bioethics: The Journey Continues* (Manila: UST Publishing House, 1997), 83.

[66] Alora, *Beyond a Western Bioethics,* 15.

[67] Gomez, *Bioethics,* 88.

assessment of medical futility ranks first and the patient's wishes only third. Death is not a topic directly spoken of among Filipinos and this is easily verified in the behavior of the hospital health care team around patients assessed to be terminally ill. If the topic of death is evaded and the family is bypassed, ELDs may really and ultimately be the decision only of the doctors.[68] If doctors actually try to bring in death into a conversation with their patients, how acceptable has this approach been for these patients? How much value do doctors give a patient's and his/her family's wishes once they have already made up their minds that treatment is futile?

*Financial matters* was not a popular choice, ranking only 8th (10th being the lowest) for both considering use of aggressive treatment and considering a patient futile to treat. It ranked last among the criteria for deciding to prepare a patient for death. In their chapter entitled "An Introduction to an Authentically Non-Western Bioethics," Alora and Lumitao posit that "even when health care costs become prohibitive," the family of the patient may not have treatment withdrawn (or withheld), pursue all that is medically technologically possible, "while hoping the financial problem will resolve itself." This is consistent with the Filipino's sense of *hiya* or *delicadeza*[69] as well as the *sakop* mentality.[70] This might mean that money matters can be ignored perhaps to the detriment of the limited resources of the family, the health facility/ institution, and the country (in the area of health care). The principles of stewardship, justice/ fairness, and proportionate reason[71] are then possibly compromised.

Among the types (or alternative causes) of suffering, *physical pain (biological)* was the most popular and of primary importance to the respondents in the consideration of preparing a patient for death. This is perhaps to be expected because doctors are obviously trained to manage primarily physical pain and not some other kind or source of suffering. It is interesting that it would seem the doctors are willing

[68] The other high-ranking criteria for deciding to prepare a patient for death are probably not distinct but rather contribute to the doctor's personal assessment of futility. There is a clear pattern that the patient with a lower level of consciousness, suffering from other medical conditions and with treatment alternatives of low success rate, will be "surrendered" to death. Comparing tables 3 and 4, there is almost perfect correspondence between the top criteria chosen, even in terms of ranking: level of consciousness, success rate of treatment option, patient wishes, and presence of comorbidities.

[69] "*Dahil sa Hiya, hindi magandang banggitin sa usapan ang anumang nababatay sa 'salapi'...*" See Teresita Garcia, *Sosyolohiya sa Filipino* (Manila: National Book Store, 1991), 84.

[70] This mentality includes closeness of family ties, group belonging, extended family system, and the local community (Aligan, *The End as the Beginning*, 59).

[71] The use of (health) "resources must be in proportion to the health condition of the health care beneficiary, *to his own or his family's capacity to avail of such resources given their cost*, and to the good and needs of the community as a whole. . . ." Or again, any treatment imposing excessive expense on a patient, his family or the community is judged to be disproportionate treatment and doctors are not obliged to deliver such treatment (Leonardo Z. Legaspi, O.P., D.D., "Bioethical Challenges in the New Millennium," *Impact* 40, no. 5 [May 2006]: 10).

to surrender a patient to death when that patient's pain (presumably intractable) causes suffering. Can these proclivities predispose a physician to perform euthanasia or assisted suicide? Given the Christian value of suffering, it is unethical to take pain or any kind of suffering alone—no matter how severe—as a reason to consider death.

The majority of respondents seem to comply with the Catholic teaching. The minority who do not comply rationalize euthanasia/PAS as an exercise of autonomy or as a means to end suffering or avoid harm. Fifty percent of those who answered that they favor euthanasia and PAS said they would also not unconditionally prolong life. These choices put together seem consistent with one another. Paradoxically, the other fifty percent in favor of euthanasia and PAS said they would unconditionally prolong the life of a patient.[72] Could this be supportive of the observation that there is in the Filipino a propensity for a split-level value system observed and described in the extant religiosity? [73] Even though medical decisions may not be explicitly religious—and those who favor euthanasia and PAS certainly did not forward any reason of such nature—many of those who refuse euthanasia and PAS gave a religious reason.

There are four alternative causes of suffering proposed as criteria to consider in preparing for death. Dionisio Miranda, SVD, claims that for the Filipino, the psychological (anxiety or fear or depression) and spiritual suffering take precedence over the biological.[74] *Psychological suffering* (due to anxiety, fear, and/or depression) is in rank 7 while *spiritual suffering* (due to a sense of meaninglessness or unmet need related to forgiveness and reconciliation) is in rank 9. Both were chosen by only an estimated third of the respondents. *Social suffering* (due to family and financial issues) in rank 12 was chosen by much less. All three paled in comparison with biological pain. This may be revelatory of a failure to value the other non-physical dimensions of the sick person and a possible weakness in delivering holistic care.

Meanwhile, the doctors' *choice of the person to prepare the terminally ill for death* is the *spiritual expert* almost tied with *family member*. The ranking of choices

[72] See tables 7.1 and 7.2 in the Appendix.

[73] "This a [sic] phenomenon consists of the coexistent [sic] within the same person of two or more thought and behavior systems which are inconsistent with each other. One who practices a split-level religiosity is convinced that two objectively inconsistent thought and behavior systems really fit each other. This inconsistency is either not perceived at all or is pushed into the rear portions of consciousness" (Aligan, *The End as the Beginning*, 50).

[74] "In the Filipino view, the core of one's person is *loob,* one's subjectivity. In relationships of conflict one prefers to be hurt more in one's body than in one's *loob;* emotional sensitivity is greater than physical sensibility. *Saktan mo na (ang katawan) ko, huwag lang ang loob ko* (Hurt me physically if you must, but not my feelings). At the same time, intervention on a person's body is always potential intervention on the whole person: its values, concerns and commitments" (Dionisio M. Miranda, SVD, *Pagkamakabuhay [On the Side of Life]: Prolegomena for Bioethics from a Filipino-Christian Perspective* [Manila: Logos Publications, 1994], 296).

in this category is typical of the local culture. The choice of the *spiritual expert* who is perceived as having an eminent relationship with the God of life and death is consistent with the Filipino's religiosity. Many Filipinos pray and ask for prayers in times of sickness and more so with approaching death.[75] The choice of the *family member* is consistent with the dynamics of close family ties. The *attending physician* comes in 3rd rank. This may indicate that the respondents, as doctors, seem to shy away from having a primary role in preparing a patient for death and would rather give it to others. Just the same, as Filipinos, this may be in harmony with their own religiosity (entrusting the "duty" to a pastor/religious) which may be further expressed by how they continue to spend time with these patients and sometimes even pray with and for them.[76] Yet this may also reveal the effect of Western mentality that finds discomfort in taking any active religious role in the physician-patient relationship.[77] It may be enlightening to study how Filipino patients would actually rank their doctors in this role because of the role of the shaman in this culture.[78] The bottom line is that each of these persons has an important role to play at the bedside of the dying; one that they may not simply transfer to another.

To the query whether as doctors, they would unconditionally prolong the life of a patient, 79 percent answered "yes," mostly stating reasons related to a doctor's duty, oath, or training which they may or may not see as vocation and thus cannot be hypothesized as having a link to religiosity. As is common in the West, the respondents seem to act out of a nonreligious view:

> The presumption of the medical community is still in favor of aggressive treatment, even in the face of death. People who chose comfort, hospice, or home care with family, are often denigrated or seen as quitting, giving up, not fighting with everything possible for as long as their bodies will stand the assault.[79]

The bias is always in favor of promoting and respecting life but its preservation is not absolute and therefore is conditional. As stated earlier, the doctor is not to

[75] "The Filipino patient is often seen clutching a rosary . . . surrounded by holy pictures and blessed objects," seeking "God's help . . . even when 'accepting' a terminal illness. . . ." (Gomez, *Bioethics,* 86).

[76] Alora, *Beyond a Western Bioethics,* 16.

[77] Ibid.

[78] "The shamanic figure *(in the Philippines)* reminds us in its comprehensiveness as a symbol that all healers are part of a healing community. . . . Unless one makes it explicit, patients assume that their healer shares the tradition and is willing to act not only as a professional but also as a political patron and religious minister or whatever else is implied. On the other hand, unlike the shaman, most scientific healers prefer to distinguish and separate the many functions assigned to them and select only those they feel comfortable with according to their interests. Failure to examine these expectations born by unconsciously type-casting the doctor as *baylan,* can lead to confusion, disappointment and even resentment— on the part of clients if they are not realized, on the part of healers if they are demanded" (Miranda, *Pagkamakabuhay,* 83).

[79] Charles Meyer, *A Good Death: Challenges, Choices and Care Options* (Mystic: Twenty-Third Publications, 1998), 36.

administer treatment that will be overly burdensome to the patient or against the wishes of the same. The choice for unconditional prolongation that so often implies over-treatment and yields a non-peaceful death negates the principle of patient-centered care, proportionate reason, and a Christian attitude towards death.

It is plausible that the Filipino perspective of "the moral world as organized around a network of personal obligations [e.g., to provide physical care, emotional support, and mutual assistance] rather than as objective moral standards"[80] consequently lead to "Filipino families instructing the doctor to do everything possible" for their patient. "They would not want to suffer the guilt of not doing everything possible for a dying member."[81] Other cultural nuances include:

> 'Death as a failure' attitude of physicians . . . some physicians will not give up hope of doing something; they would not want to be blamed for the death of a terminally ill patient or they would not want to be accused of not doing everything for the patient.
>
> Filipino doctors are more likely to consider the teaching of the Church on refusing and withdrawing extraordinary/disappropriate [sic] treatment for prolonging life too liberal and afraid to apply it. They sometimes say that they will not 'play God' keeping the patient 'artificially alive' beyond his/her allotted years created by our contemporary hi-tech medical advances ... This attitude of doing everything possible to keep a person alive ... can be traced to the *sakop mentality*...[82]

As for euthanasia or physician-assisted suicide, the popular choice is in accordance with Catholic moral teaching. This is clearly aligned to the Filipino's deeply ingrained religiosity while not presuming that these doctors have any in-depth reflection and consistent application of such a belief in the different dimensions of their daily living.

The argument given by one respondent in favor of euthanasia[83] is deeply flawed. First, there is no such right as the "right to die"[84] because it is human dignity

[80] Alora, *Beyond a Western Bioethics*, 9.

[81] Aligan, *The End as the Beginning*, 67.

[82] Ibid., 66-67.

[83] "Everyone with a rational and mature mind has the right to die. If doctors are willing to offer treatments to patients with the risk of damage and disease and [patients] undertake these [as] an informed choice, then euthanasia should be one of these choices. The difference is a matter of extents and intentions. Of course, euthanasia should come with airtight rules and regulations. But if, for instance, doctors present the option of excision of a large tumor with a 50 percent chance of death and a 50 percent chance of life, and the patient eventually dies, isn't that, in a way, facilitating death through informed choice? If these are viable options, then euthanasia should be."

[84] In Catholic parlance, the "right to die" "expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity" (Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia,* Part IV).

(not human autonomy) that grounds human rights. Human dignity is a permanent attribute of every person which expresses his/her intrinsic and inestimable value. Rights are directed toward human flourishing, not annihilation.[85] Second, the option of euthanasia is not about risk of damage or disease from treatment. Euthanasia is about permanent loss of life. Indeed it is a matter of extents and intention! When a doctor carries out a treatment with considerable risk, the consenting patient is right and justified to assume that the doctor is facilitating the restoration or preservation of life, not facilitating death. The intending of death is crucial a distinction. It is unethical for doctors to offer to eliminate their patients irrespective of any "good" motive the former may have.[86] As for those who would favor euthanasia and PAS if it were legal, morality does not follow from legality.

**Conclusion and Recommendations**

The results of the survey seem to indicate that there is much to improve in making ethical decisions in end-of-life situations among Filipino doctors. This can be expected since only 27 percent of respondents underwent a formal course on bioethics and the rest had very little or no formal background in it. At least a handful expressed that while they were grateful for the chance to mull over the options. They regarded the experience as extremely challenging, even difficult.

The role of cultural attitudes and values account for some of the choices and provide a framework for affirming the moral strengths as well as empathizing with the moral flaws. It gives us answers to "[W]hat sort of reasons would be *good reasons* for a person in such-and-such circumstances to accept such-and-such standards and rules?"[87]

Apart from "a certain idea of what a doctor ought to be," there is a series of assumptions and presuppositions pertinent to biomedical ethics that includes the level of ethical sensitivity in a given culture. There are "values, attitudes, customs, and traditions . . . [that] will have a considerable influence at the time the medico-moral decisions are to be made."[88]

[85] Brigid Vout, M.D., "Is There a Right to Die?," in *Celebrating the Gospel of Life: Basic Issues in Bioethics (Proceedings of the International Congress on Bioethics),* ed. Fausto B. Gomez, O.P. (Manila: University of Sto. Tomas Publishing House, 2006), 146-47 and 148.

[86] Ibid., 144.

[87] Pastrana, *Medical Ethics,* 2. The author writes, "When a stable set of rules and standards governs the choices and conduct of most of the people in a given society, we speak of the norms shared by a whole culture. Such norms, which make up the *actual* morality of that people, are embodied in the society's customs, traditions, and laws. They define its moral outlook and give form to its way of life. They have a special function in practical life. Whether they are chosen by an individual as norms for judging his own character and conduct, or form a society's *actual* moral code, they serve as action-guide" (ibid.).

[88] Richard A. McCormick, S.J. cited by Pastrana, *Medical Ethics,* 10 and 13.

Some aspects of the prevailing attitudes and values do facilitate a more sound ethical decision-making from the Christian perspective. Miranda in his book, *Pagkamakabuhay,* lists a few of these including the Filipino's (non-Western) view of reality as "more palpably religious than secular;" the concept of health and suffering as not just physical but more mental and spiritual and wholistic; the emphasis on personalist procedures, the efficiency and effectiveness of which "are not measured by physical recovery alone but a sense of personal well-being and integration;" the acceptance of death as part of life rather than a tragedy against which one must be anesthetized.[89] Thus, the first recommendation is that attending physicians become adept and comfortable members of a team in making ELDs—a team that includes the patient, his/her family (or significant others), a chaplain/pastoral worker, other professionals, and the ethics board (where it exists)—that can think and work together, lessening any fears and making possible sound ethical choices that include the courageous acceptance of an imminent death.

The second recommendation is corollary to the first: those major health facilities without an ethics board and a pastoral team may seriously consider setting these up for more holistic medical care. Those health facilities that already have an ethics board and pastoral team must ensure proper updating and coordination between the various team players.

On the other hand, there are also aspects of the Filipino culture that can hinder ethical decision-making such as authoritarianism, respect, and submissiveness to persons with status (authority figures).[90] "Doctors are considered persons with status . . . because they are perceived to 'hold the key to life and death,'" [91] "second only to God in healing power,"[92] and as "'benevolent' father figures to be respected and obeyed … the highest authority in the hospital."[93] The doctor's exalted status makes it one of the primary concerns in the Filipino healthcare context because of the potential for abuse of authority[94] (wittingly or unwittingly). He/She is "understood to be in authority over the patient's medical care" and often made to "bear the burden of timely declarations regarding the inappropriateness of further treatment." Yet the doctor "may not take the time or effort to obtain what Western bioethicists would consider morally appropriate informed consent" because the "paternalistic context of Filipino medicine does not regard consent as a necessary aspect of the

[89] Miranda, *Pagkamakabuhay,* 39.

[90] Gomez, *Bioethics,* 88.

[91] See Aligan, *The End as the Beginning,* 179. In the same section, he presents the Filipino value of *pagkatitulado* (having earned a degree) as having the same effect.

[92] Alora, *Beyond a Western Bioethics,*17.

[93] Aligan, *The End as the Beginning,* 67.

[94] Alora, *Beyond a Western Bioethics,*17.

physician-patient relationship."[95] Ultimately, culture cannot naively justify the moral "weaknesses" brought to light in this survey.

> [W]e all have been brought up with some set of moral beliefs, and every society has some moral code as part of its own way of life. But an individual may either blindly accept the moral code of his society, or he may come to reflect upon it and criticize it. If he blindly accepts it, we may speak of his morality as 'conventional' or 'customary.' Such an individual might well have strong moral convictions and might well be a good person, in the sense that he lives up to his norms. But he remains a child of his culture and lacks the ability to support his convictions by rational arguments.[96]

Note that while the respondents are fairly recent graduates of medical training, nearly half of them indicated that a course on bioethics or its equivalent was not part of their curriculum of studies. Consider that there are many more Filipino physicians in current practice who have experienced this lacuna. "Cor Unum" notes that "medical ethics are for many persons a matter of speculation." They "consider such courses as supplementary or 'extra' only for those who wish to take them out of curiosity." [97]

> [Rather, the physician must consider that] if progress in knowledge and techniques is providing [him/her] with new instruments and new therapies, the immediate result is . . . being confronted by ever more complex moral questions . . . [I]t is for the physician, in the last analysis, to make his[or her] decision by referring to objective moral criteria. This means, however that he [or she] must have been taught what these criteria are and must have been trained to apply them to specific individual cases. The teaching of moral theory and of codes of medical ethics is rightly, therefore, an essential part of the training of doctors and nurses.[98]

> [Moreover], Filipino health care providers seeking to be authentic bioethicists must listen more self-consciously to their own culture to meaningfully capture its moral vocabulary and speak [as well as decide] in terms of its ethical grammar.[99]

The third and main recommendation then is that medical colleges facilitate and guarantee a foundation in bioethics for their faculty and students, preferably one that is sensitive to indigenous cultural nuances. By their doing so, one may reasonably expect not only more ethically sound ELDs but also the birth and development of bioethics for and by Filipinos.

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[95] Ibid., 16 and 17.
[96] Pastrana, *Medical Ethics,* 5.
[97] Pontifical Council "Cor Unum," "Question of Ethics," 1.2 and 7.1.
[98] Ibid.
[99] Alora, *Beyond a Western Bioethics,* 5.

This endeavor, being only an initial step in looking at how Filipinos doctors do bioethics, has many obvious limitations. The researcher chose a topic related to end-of-life decisions which involve issues with many ramifications in various fields of society. The resources for a local praxis of bioethics are also still limited. Only general statements have been published particularly for this topic. A final recommendation is that others do similar studies[100] (more systematic and comprehensive) or build/improve on this one using a statistically significant sample size involving preferences of Filipinos—both doctors and patients— concerning ELDs. Surely there are other potentially significant factors influencing ELDs vis-à-vis aspects of Filipino culture. Some may wish to focus on one aspect of this study and expound on it (e.g., determining who should ultimately make ELDs for the terminally-ill Filipino). By contributing to the exploration of the crossroads between bioethics and culture (including religion/faith affiliation), perhaps our medical teams and facilities can also develop a more comprehensive and integrated health care delivery system.PS

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[100] Miranda suggests a scheme that may be useful for similar studies involving secondary inculturation of moral theology. The "process would proceed in this manner: (a) Examine the scientific medical facts and judgments. (b) Examine the cultural philosophy of the human being with regard to these facts and judgments. [Then] (c) Examine the traditional Christian theology with regard to both" (Miranda, *Pagkamakabuhay,* 54).

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**Appendix**

Survey Questionnaire

A patient has been diagnosed to have a terminal illness[101]

1. Choose and rank the top 5 factors that you would personally consider in pushing for the use of *aggressive treatment*[102] (number 1 being your highest priority for making a decision):

| | |
|---|---|
| | Age of patient |
| | Availability of an expert on the treatment procedure |
| | Current level of consciousness (conscious, vegetative, etc.) |
| | Financial matters (cost of treatment and affordability to patient) |
| | Patient wishes |
| | Presence of other illness / comorbidities (especially a chronic one) |

[101] A terminal illness is generally an active and progressive illness for which there is no cure and the prognosis is fatal. It is . . . an irreversible illness that . . . will result in death in the near future or a state of permanent unconsciousness from which recovery is unlikely. Some examples, among others, of terminal illnesses may include advanced cancer, some types of head injury, and multiple organ failure syndrome. The length of life expectancy may vary from entity to entity ([Anonymous], "Terminal Illness: Law & Legal Definition, http://definitions.uslegal.com /t/terminal-illness/ [accessed 29 September 2011]).

[102] A patient receiving aggressive care will receive the benefit of every medication, technology, tool, and trick that doctors can devise to treat his or her illness. Chemotherapy, dialysis, radiation therapy, surgery, antibiotics, and other medical interventions designed to preserve and prolong life would be considered aggressive care. If a patient is receiving aggressive care, it is an indication that there is a belief—among medical professionals, or at least among family members authorizing the treatment—that the patient will recover or will receive an extension of life of a quality considered to be acceptable (Terri Mauro, "Aggressive Care," http://special children.about.com/od/medical issues/g/aggressive.htm [accessed 29 September 2011]).

| | |
|---|---|
| | Presence of physical or mental disability |
| | Success rate of treatment option |
| | Wishes of patient's family |
| | Your wishes as the attending physician |

2. Choose and rank the top 5 factors that will affect your assessment on whether it is *futile to treat*[103] this patient or not (number 1 being your highest priority for making an assessment and assuming it is you who will decide on medical futility):

| | |
|---|---|
| | Age of patient |
| | Availability of an expert on the treatment procedure |
| | Current level of consciousness (conscious, vegetative, etc.) |
| | Financial matters (cost of treatment and affordability to patient) |
| | Patient's wishes |
| | Presence of other illness (especially a chronic one) |
| | Presence of physical or mental disability |
| | Success rate of treatment option |
| | Wishes of patient's family |
| | Your personal wishes as the attending physician |

3. In the context of this terminal illness, choose and rank the top 5 factors you will consider in *preparing the patient for death* (number 1 being your highest priority for making a decision):

| | |
|---|---|
| | Accessibility of extraordinary treatment |
| | Age of patient above 60 (senior citizen) |
| | Current level of consciousness (conscious, vegetative, etc.) |
| | Degree/severity of suffering: biological (pain or other physical symptoms) |
| | Degree/severity of suffering: psychological (anxiety or fear or depression) |
| | Degree/severity of suffering: social (family problems, financial issues) |
| | Degree/severity of suffering: spiritual (sense of meaninglessness; need related to forgiveness and reconciliation) |
| | Doctor's assessment of medical futility |
| | Financial matters (cost of treatment and affordability to patient) |

[103] The absence of a useful purpose or useful result in a diagnostic procedure or therapeutic intervention; the situation of a patient whose condition will not be improved by treatment or instances in which treatment preserves permanent unconsciousness or cannot end dependence on intensive medical care (Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine* 112, 12 [June 1990]: 949).

| | |
|---|---|
| | Patient wishes |
| | Presence of other illness (especially a chronic or debilitating one) |
| | Presence of physical or mental disability |
| | Low success rate of treatment option |
| | Wishes of patient's family |

4. Who do you think would be best in preparing a patient for death? Rank them according to your personal preference (number one being your most preferred):

| | |
|---|---|
| | Attending physician |
| | Family member |
| | Friend of patient |
| | Spiritual expert: priest/pastor or religious |
| | Others (pls specify): |

5. For ANY patient, regardless of other conditions, IF there is something you could DO as a doctor to *prolong life*, would you?

_____ YES _____ NO

Why? _____

6. Would you consider the option of *euthanasia or physician-assisted suicide* in a terminally ill patient? _____ YES _____ NO

Why? _____

7. Please also fill up the information asked below:

Gender: _____ Area of Expertise/specialization: _____

Country and Setting of medical practice and no. of years in such setting: (e.g. Phil-urban-10yrs): _____

*Medical Ethics or Bioethics* Course taken (if any; please specify course name and duration if possible e.g., bioethics integrated in medical school 2 semesters; 1 lecture in a medical symposium, etc.):

_____

Religious/Faith affiliation: _____

THANK YOU FOR YOUR TIME!

Table 1. General Profile of Respondents

| | | |
|---|---|---|
| Year graduated from Basic Medical Curriculum (i.e., year of completion of basic medical training) | 1991 – 2011 (20-year period) | |
| Gender distribution | Female – 56% | Male – 44% |
| Age range | Between 20 and 50 years old | |
| Faith Affiliation | Christian<br>• Roman Catholic<br>• Other denominations | <br>79%<br>10% |
| | Iglesia ni Cristo | 3% |
| | Atheist | 3% |
| | No answer | 3% |
| | "Undefined" | 2% |
| Medical Specialization | Internal Medicine | 32% |
| | Pediatrics | 15% |
| | Family and Community Medicine | 11% |
| | Surgery | 10% |
| | Ophthalmology | 6% |
| | General Medicine | 5% |
| | Obstetrics and Gynecology | 5% |
| | Physical and Rehabilitation Medicine | 5% |
| | Psychiatry | 3% |
| | Anesthesiology | 2% |
| | Orthopedics | 2% |
| | Otorhinolaryngology | 2% |
| | Public Health | 2% |

| | | |
|---|---|---|
| Setting of Clinical Practice | Philippine urban | 63% |
| | Philippine rural | 11% |
| | USA urban/suburban | 19% |
| | No answer | 7% |
| Duration of Clinical Practice | Few months to 20 years | |
| Background on Bioethics | With background[1] | 48% |
| | Without background | 42% |
| | No answer | 10% |

[1] These include those who had attended at least some random but formal lectures on bioethics to those who had a full course on bioethics in addition to a semester of bioethics integrated in their basic medical curriculum.