Administrative Regulation of Philippine Health Care Professionals

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This study evaluated complaints against health personnel filed with the Professional Regulation Commission (PRC), in order to describe the complaint patterns; identify providers' lapses in professionalism; compare the administrative outcomes between patient care-related and other cases; and infer the critical areas in health personnel regulation.

Data was collected from a retrospective records review of complaints involving health professionals filed with the PRC from January 2013 to December 2016. Case summaries were written based on the submitted complaints and other documents. The anonymous summaries of all the cases were reviewed by the authors, and attribution of errors and causes were made. Specialists were consulted to review selected cases.

Only 358 case files were retrieved, nearly equally divided between those concerning patient care and those which did not. Among the former, deaths occurred in 30% of cases. Physicians, dentists, nurses and midwives had the most complaints. Clinical management lapses were the most commonly identified errors for professionals. For some, the adverse events were perceived as due to system deficiencies and even the patients' severity of illness. Most of the reviewed cases which had corresponding PRC Board decisions were either dismissed or settled. There were more and harsher penalties among the non-patient care cases.

Keywords: *professionalism, health personnel, patient safety, quality of health care, government regulation*

INTRODUCTION

Professionalism, as it applies to health personnel, has been variably defined as consistency with aspired attributes or codes of conduct as well as the attainment of specified competencies.[1-4] Due to increasing complexities in the health field, the conferment of professional status has shifted beyond peer recognition to official certification by publicly designated organizations.[5-7] Lapses in professionalism among health personnel can diminish the health care experience and even harm patients. Complaints, aside from other means for redress, may then be brought against health professionals by the offended parties. Being a crystallization of patients' appreciation of apparent service provision oversights, such complaints have been shown to provide important insights on the interrelated concerns of professionalism, patient safety, and quality of care.[8-10] Among other concerns, a comprehensive review of these complaints can define the extent by which professional standards of health practitioners are met and how these affect the provision of health services. The nature and handling of these complaints vary across settings. This is apparent even among Asian countries, given the differences in the prevailing legal or ethical norms, socioeconomic milieu, and even cultural preferences.[11-15]

In Southeast Asia, the Philippines is noteworthy for its health workforce. It has the largest number of physicians, nurses and midwives, sizable even on a per capita basis, among the countries in the region.[16] From a global standpoint, the Philippines is a dominant supplier of health professionals, particularly nurses, for many receiving countries.[17] The Philippines has also been described as having a health regulatory system that has a middle-of-the-road maturity, when compared to other Asia-Pacific countries.[18] The statutory regulation of health workers is centered on the Professional Regulation Commission (PRC). It is an autonomous government agency that is authorized to set training standards and grant licenses to qualified professionals, including health care providers.[19] The licenses are prerequisites for local clinical practice and even for foreign work placements. Private professional organizations, notably those established by medical specialties, have independent self-regulation arrangements for their members. The Department of Health (DOH) sets manpower standards for hospitals and clinics and administers personnel

under its direct employ but does not have any general health professional regulatory responsibility.

The PRC has several constituent Boards which oversee respective professions, including the following health-related occupations: Dentistry, Medical Technology, Medicine, Midwifery, Nursing, Nutrition and Dietetics, Optometry, Pharmacy, Physical and Occupational Therapy, Psychology, Radiologic and X-Ray Technology, and Respiratory Therapy. As the agency also has quasi-judicial functions, its Boards receive, process, and adjudge complaints from the public against health personnel who are either in the process of seeking licenses or are already registered professionals, as well as non-qualified persons who illegally render health services. Complaints lodged with PRC against professionals may relate to adverse patient events or incidents involving supposed inappropriate or immoral behavior in non-health care situations. In the Philippines, complaints concerning the former may be legally considered as negligence cases. These may be pursued with the PRC as administrative cases, or, separately, for civil damages or criminal penalties in regular courts.[20] The PRC only metes out administrative penalties, with license revocation being the harshest. Still, with proceedings in regular courts deemed to be more expensive and protracted, the PRC would be the most convenient route for filing charges against health professionals. Nonetheless, the PRC has procedures similar to those of regular courts.[21] If no conciliation is achieved, hearings proceed and are conducted by a Board member of the same profession as the implicated providers. Complainants and respondents need not be represented by legal counsel although they have a choice to be represented by one.

There is no national registry for ongoing legal cases in regular courts, including those concerning medical negligence or malpractice. There is likewise no central database for complaints against health workers filed in individual health facilities or other venues. The PRC is therefore the default national repository of complaints against licensed professionals and thus provides a unique yet untapped source for obtaining data and insights on what patients or other parties consider to be lapses in professionalism among health workers and determine the implications of these on overall health service quality and safety.

A study was therefore undertaken to assess the status of professionalism and the related concerns of patient safety and quality of care in the country

from the inverse context—from patients' complaints with the PRC that are supposed to document lack or absence of professionalism. This report has the following specific objectives: 1) describe the patterns of PRC complaints against health personnel, with emphasis on those directly related to patient care; 2) identify the correspondingly common or important lapses in professionalism among the involved health care providers or professionals; 3) compare the administrative outcomes between cases which were directly related to patient care and those which were not, and; 4) infer the critical areas in the regulation of health professionals in the Philippines.

METHODS

The study involved a retrospective records review, specifically of the files of complaints against health professionals kept at the PRC. The research protocol was developed in coordination with the PRC, primarily to work out confidentiality and security arrangements, and was reviewed and subsequently approved by the research ethics board of the authors' university. Only those cases implicating health professionals that were accepted by the legal unit at the main PRC office from 1 January 2013 to 31 December 2016, and which could be made available by the same office during the 2 May to 29 September 2017 review period, were included. A supposedly small number of cases which were with the regional PRC offices were excluded from the study.

Using the PRC electronic master list of received complaints as reference, the corresponding case files were requested from the legal staff. Based on the written complaints as well as any supporting documents (including those submitted by the respondents), the research assistants wrote case summaries. For patient care-related cases, additional details were obtained and entered in registry forms, with items loosely based on a JCAHO (Joint Commission on Accreditation of Healthcare Organizations) framework.[22] There were several encoding rules which were adopted, such as case registration being based on individual events (rather than, for example, multiple case entries for different providers but involving the same incident); limiting the listed facility to that which was primarily related to the event (and not the subsequent referral sites); and denoting a single count for providers under the same profession or physician specialization (thus, if several physicians and nurses were implicated in a particular event, only one count would be tallied for each provider type).

The case files were reviewed and the registry forms were accomplished only at a designated secure room within the PRC premises.

The registry data, expunged of all personal and institutional identifying information, were encoded in a secure online spreadsheet. Microsoft Excel and Epi Info 7 software were used to generate frequency distributions and summary figures. The case entries were individually reviewed, details were verified, and the corresponding causes for the patient-related events were deliberated on by the investigators. Cases requiring more nuanced assessments were referred to clinical specialists. Investigators and specialists were inhibited from reviewing any cases which they had been directly or implicitly involved in. Though the cases were evaluated objectively, there was partiality for the patient's perspective in contradictory instances.

RESULTS

Based on the PRC master list, there were 597 filed complaints that implicated health professionals from 2013 to 2016. Of these, only 60%, or 358 cases, could be made available for review. The highest yield was in 2015, at 100%, and the lowest was in 2016, with only 35% of the complaints retrieved. There was nearly an equal number of the compiled cases which were directly concerned with patient care events and those which were not (see Figure 1).

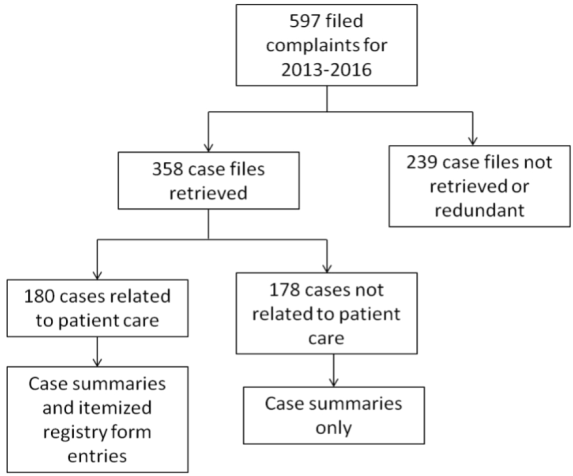

Figure 1. Collection of cases from complaints filed with the PRC against health care providers

Patient Care Events

Most of the complaints which concerned patient care involved adults, with a slight preponderance of females. A large majority of the patients required therapeutic interventions, which also included those for cosmetic and rejuvenation purposes (see Table 1). Deaths as well as resultant moderate or severe physical incapacitation were reported in the majority of the patient care-related complaints. Psychological harm was less often alluded to (see Table 2). A few of the unfortunate outcomes occurred under seemingly disconcerting circumstances. These included the following illustrative cases: maternal deaths from uterine rupture or massive post-partum haemorrhage; unattended recovery room mortalities; post-procedural blindness; severe reactions to non-conventional therapies; and offensive sexual behavior. Most of the incidents occurred in hospitals, particularly in tertiary centers.

Table 1

Distribution of allegedly harmed patients, by selected characteristics, PRC Health Board complaints, 2013-2016

Category	Group	Frequency	%
Age Group (n=180)	Minor (0-17 years old)	33	18%
	Adult (18-59 years old)	108	60%
	Elderly (≥ 60 years old)	35	19%
	Not Specified	4	2%
Gender (n=180)	Female	93	52%
	Male	84	47%
	Not Specified	3	2%
Care Requirement (n=197)*	Therapeutic	163	91%
	Diagnostic	16	9%
	Cosmetic	14	8%
	Rehabilitative	2	1%
	Not specified	2	1%

* category assignments are non-exclusive, with some cases having more than one care requirement

Table 2
Distribution of patient care-related events, by alleged harm, PRC Health Board complaints, 2013-2016

Alleged Harm	Frequency	%	
Physical Harm (n=180)	Death of a complainant's family member	58	32.22
	Moderate to Severe, Permanent	35	19.44
	Moderate to Severe, Temporary	26	14.44
	Moderate to Severe, Unknown Duration	18	10.00
	Minimal, Temporary	12	6.67
	Not Specified	6	3.33
	Minimal, Permanent	3	1.67
	Minimal, Unknown Duration	2	1.11
	None	20	11.11
Psychological Harm (n=180)	Present, Unknown Duration	41	22.78
	Present, Temporary	5	2.78
	Present, Permanent	4	2.22
	Not Applicable or Not Specified	130	72.22

Dental and lying-in clinics were also relatively common sites for adverse events. There were, in cumulative terms, an ample number of cases involving smaller facilities, such as stem cell clinics. Patients' homes, with health workers in attendance, were the sites of untoward events in some cases (see Table 3).

Table 3
Distribution of patient care-related events, by reported location, PRC Health Board complaints, 2013-2016

Health Care institution	Frequency	%	
Hospital (n=128)	Level III	54	30.00
	Level II	35	19.44
	Level I	37	20.56
	Unspecified hospital	2	1.11
Other Health Service Facility (n=42)	Dental clinic	17	9.44
	Lying-in clinic	10	5.56
	Cosmetic surgery/ Dermatology clinic	3	1.67

	Mall clinic	3	1.67
	Private clinic	3	1.67
	Eye clinic	2	1.11
	Stem cell clinic	2	1.11
	Pharmacy	1	0.56
	Work place clinic	1	0.56
Other Venues (n=7)	Home	5	2.78
	Hospice	1	0.56
	Medical Mission	1	0.56
Not specified		3	1.67

Physicians were the object of complaints for most patient care cases. Dentists, nurses, and midwives accounted for smaller but still substantial number of incidents. There were only very few complaints against other health professionals (see Table 4). The respondents were specifically identified as students or trainees in eleven cases. A handful of complaints also referred to physicians in their capacity as facility administrators. There was, in accordance with the JCAHO framework, an extensive listing of apparent errors by health professionals. A summary of the leading types of errors committed by selected professionals is provided in Table 5. While intervention-related problems were more common among physicians and dentists, communication errors were foremost for nurses and midwives.

Table 4

*Distribution of patient care-related events, by type of allegedly involved health professional, PRC Health Board complaints, 2013-2016**

Health Professional	Frequency	%	
Physician		143	72.59
	Surgery	31	
	Obstetrics Gynecology	26	
	Internal Medicine	21	
	Pediatrics	15	
	Anesthesiology	11	
	Ophthalmology	7	
	Orthopedics	6	
	Radiology	5	

	Emergency Medicine	4		
	Primary Care	3		
	Otorhinolaryngology	3		
	Dermatology	2		
	Pathology	2		
	Psychiatry	2		
	Family Medicine	1		
	Neurology	1		
	Rehabilitation Medicine	1		
	Not Specified	2		
Dentist		19	9.64	
Nurse		17	8.63	
Midwife		10	5.08	
Radiation Technologist		2	1.02	
Pharmacist		2	1.02	
Medical Technologist		2	1.02	
Physical Therapist		2	1.02	
Optometrist			0	0.00
Total			197	100.00

* more than one type of professional in some cases

Table 5

Percentage frequency distribution of patient care-related events, by leading inferred error types and selected professions, PRC Health Boards, 2013-2016

Physician	Dentist	Nurse	Mid-wife				
Error Type	**% Freq**	**Error Type**	**% Freq**	**Error Type**	**% Freq**	**Error Type**	**% Freq**
Correct Intervention, with Complication	12%	Correct Intervention, Incorrectly Performed	15%	Inappropriate or Disrespectful Comments	15%	Questionable Advise or Interpretation	15%
Questionable Advise or Interpretation	9%	Questionable Advise or Interpretation	10%	Questionable Advise or Interpretation	10%	Correct Intervention, with Complication	12%

Questionable Tracking or Follow-Up; Omission of Essential Procedure	6%*	Questionable Disclosure; Correct Intervention, with Complication	10%*	Questionable Tracking or Follow-Up	10%	Inappropriate or Disrespectful Comments; Insufficient or Questionable Use of Resources; Inaccurate Diagnosis	9%*

* percentage value applies equally to the error types listed for the third tier of the category

Even as the actual complaints were against professionals, the investigators figured that many of the adverse events were attributable, concurrently or independently, to systems deficiencies (see Table 6). Foremost among these were the apparent absence or inadequacy of clinical or administrative protocols in the health facilities. Instances occured wherein health staff were deemed to be indifferent to patients' needs, epitomizing attitudinal deficiencies from defective organizational cultures. Physical inadequacies, such as the lack of equipment in smaller facilities, were also found to be contributory to adverse patient events. There were a few cases wherein external factors, such as facility incapacitation due to typhoons, were also at play.

Table 6

*Distribution of patient care-related events, by attributed causes, PRC Health Boards, 2013-2016**

Attributed Cause	Frequency	% for Group		
Systems	**Organizational**			
		Service Protocols/ Processes	71	39.01
		Administrative Procedures	41	22.53
		Organizational Culture	40	21.98
	Technical			
		Facility	27	14.84
		External	3	1.65

Human	Health Professional		171	74.35	
		Rule-based	109		
		Knowledge-based	71		
		Skill-based	59		
	Patient			48	20.87
	Other Person		11	4.78	

* more than one cause attributed in some cases

Nevertheless, specific persons were identified by the investigators as either being primarily responsible for or contributory to the supposed incidents. The actions of the practitioners accounted for the vast majority of these cases. Their apparent errors were further attributed to non-observance or lapses related to the applicable rules, knowledge, or skills. Patients themselves accounted for the next tier. In the respective cases, the investigators surmised that the severity of the patients' medical conditions was a primary factor that had caused the reported adverse outcome. A few of the supposedly untoward cases were deemed to be contentious mostly due to the divergent perceptions or expectations of the patient's relatives and other parties who considered the actions of the health professionals as inappropriate or detrimental, but these claims could not be substantiated by the investigators.

Non-Patient Care Events

For the 178 cases which were not directly related to patient care, only the alleged offenses of the professionals were tallied. As classified in general terms, and ranked in decreasing frequency of cases, the leading infractions were as follows: marital infidelity (29%), swindling (19%), misrepresentation/ falsification (15%), inter-professional conflict (7%), and sexual harassment/ violence (4%). Among the complaints were those lodged by the Philippine Health Insurance Corporation (PhilHealth), the country's social health insurance agency, and pertained mostly to supposedly bogus procedures.

Regulatory Outcomes

Most of the cases which were included in this study were ostensibly still undergoing hearings, or had not yet otherwise been decided upon by the

respective PRC Boards (see Table 7). A majority of the resolved cases did not beget any regulatory sanction, having been dismissed by the Boards or because the contending parties had apparently reached amicable settlements. In only a few cases were penalties meted out against health workers. There were fewer providers penalized, and the disciplinary actions were also much less severe among the adjudged patient-related cases.

Table 7
Distribution of patient care-related events, by outcomes and main event types, PRC Health Boards, 2013-2016

Case Status	Patient care events	Non-patient care events			
	n	%	n	%	
Ongoing	91	51%	83	47%	
Dismissed/ Settled	86	48%	74	42%	
Penalty for Professional	Reprimand	3	2%	1	1%
	Suspension		6	3%	
	Revocation of license			6	3%
	Other/ Unspecified			8	4%

DISCUSSION

A premise of the study is that the PRC provides a comprehensive patient complaints resource, providing a bellwether of health care professionalism, safety, and quality. But while the PRC may be the least expensive route, the process can still be financially burdensome particularly for poor families. This would have deterred them from filing complaints, especially for less serious incidents. Some events may, for various reasons, including non-recognition, have not been pursued at all. Studies in other Asian countries have shown how cultural preferences and social gradients deterred complaints from filing, a phenomenon which could just as well apply to the Philippine context.[23-25] Many untoward events could have also been

addressed in other venues, such as within the concerned hospitals. Civil and criminal suits could have also been filed in regular courts, even among those who had already filed complaints with the PRC. There may have been divergent case details and outcomes for these venues, but these were beyond the study's scope. These issues could have contributed to the total number of PRC-tendered complaints, being low relative to the figures reported for other countries, considering the overall count of the country's health professionals.[11,15,26]

The study had additional intrinsic limitations. A good number of complaints could not be provided by the PRC, affecting the quantity and quality of the available data. For the complaints which were included, the findings and inferences were gleaned from abstracted files. Relevant but undocumented details would have therefore been missed. The practitioners cited in the complaints were aggregated and not individually counted, leading to lower tallies of implicated professionals. In compliance with privacy and confidentiality restrictions, not only were the identities of specific persons or institutions withheld, but relationships between surmised lapses and Board decisions could also not be delved into. These logistical and methodological factors would have affected the study's findings, leading to, among others, differences in attributions of accountability and due sanctions with those decided upon by PRC Boards.

The large number of mortalities, and severe morbidities, that were collated among the care-related events are consistent with a "tip of the iceberg" complaints-filing bias. It would have been expected that the more serious cases were to have been complained about. It was in anticipation of this occurring that the JCAHO framework, with its added focus on the safety and quality dimensions of health services, was utilized in data collection and processing.[22] The identified errors and their inferred causes were thus not only attributed to individual professionals, but also to systems lapses that undermined the quality and safety of patient care.[8,9,26] Some adjustments in the framework were adopted, such as additional error categories (e.g., inappropriate statements), to also reflect local quality of care concerns. The non-patient care cases were not segregated to the same extent as, while providers' professionalism may have been questioned, the events would not have as direct a bearing on patient safety and quality of care. These would,

therefore, not have provided added insights on professionalism or patient care concerns at the systems level.

The demographics of the patients in the safety events are consistent with documented health care demand patterns.[27] The higher proportion of female patients is due to a good number of reported mishaps involving obstetric care. That therapeutic interventions were predominant is also to be expected, as patients are more likely to seek such services from health professionals – and do so in the hospital setting. Higher level hospitals would have dealt with more serious cases, which, due to the complexity of required care, would have been anticipated to have more complaints. The researchers did identify such cases primarily in tertiary hospitals, wherein the unfavourable outcomes of some patients were mostly attributable to the gravity of their conditions. There were cases wherein the patient's status was apparently compromised by care given at lower echelon facilities, but the staff at the receiving hospital got to be blamed for the patient's deterioration. The contrary expectation would also be that lower level facilities – which presumably dealt principally with less morbid cases – would have had fewer safety events. The investigators were nonetheless struck by an array of morbidities and mortalities which were specific for smaller scale facilities. These ranged from problems attendant to cosmetic procedures, to those related to obstetric cases. Adverse events that occurred in lower level settings were often due to lack of adequate equipment. Among the very few cases involving malicious actions on the part of practitioners, the small staffing pattern in smaller facilities would seem to have contributed to opportunities for such incidents. There are also inherent ambiguities in assigning accountability in these specific contexts, such as the incidents that involved close patient contact as well as unproven treatments, as have been previously raised.[28,29]

Physicians were by far the providers who had the most complaints. They had either directly provided health services, or overseen such. In a minority of cases, the physicians were implicated in their capacity as administrators of health facilities. The complaints had to do mostly with perceived failures in these roles. Procedure-based specialists comprised the majority of those cited, in line with what has been reported in foreign literature.[30,31] The study pointedly reveals though that physicians, for the most part, performed the appropriate interventions but complications ensue. Such suggests that the

informed consent process was wanting in many instances, with physicians not having relayed realistic risks to patients and family members. While few, and therefore not highlighted with the leading errors, there were cases wherein unproven therapies were administered by physicians, with severe consequences on patients. Diagnosticians had also been found wanting, in that wrong information was relayed. Patients also found the apparent dismissive attitude of physicians objectionable. While not having really caused physical harm, these oversights nevertheless created a hostile environment which further compounded the felt gravity of the actual or perceived safety event.

Cosmetic interventions were sought from most of the concerned dentists, and a skill-based cause was inferred for most of the dental cases. On the other hand, nurses had more communication-related errors, including the most complaints concerning inappropriate comments. Nurses for the most part have a supportive role in health care. In the hospital setting, they would have the most patient contact among the health professionals. Communications skills are therefore important. While uncalled-for remarks may not be directly injurious to patients (but can, as discussed earlier, aggravate already detrimental circumstances), the importance of proper and adequate exchange of information in specific situations, such as in reported patient handover incidents, cannot be underestimated. Midwives perform both procedural and assistive roles in caring particularly for obstetric patients. The cited errors involving midwives were therefore a mix of those alluded to for the preceding procedure-based as well as support-centred professionals.

Trainees constituted only a small fraction of the health providers implicated to in the safety events. However, the study presents an underestimate of the involvement of trainees. The designation and tally of trainees were based on what were stated in the complaints. In accordance with the recording rules of the study, only one count in a respective medical specialty could be given even if, for example, several residents training in the same field were mentioned. What is more problematic, however, is that patients or family members may not have known, or at least not indicated, that the health providers they complained of were actually trainees. The position of trainees makes them vulnerable to being involved in safety events. Even as they may not possess all the essential knowledge and skills, they may

have to provide front-line services to patients, often under urgent care or resource-constrained situations. That adverse events involving trainees can and do happen and calls attention to the need for more adequate supervision, whether by direct or vicarious means (e.g., ready and responsive protocols).

Lapses in protocols and processes were the leading system-related causes for most institutions. These concerned clinical management protocols, which, for the greater part, were either breached or non-existent. Management operations as well as organizational culture were also wanting in some cases. Management flaws refer to inefficiencies or ineffectiveness of administrative or organizational systems and processes. These occurred more in higher level facilities, possibly due to their more complex services. Cultures which were inimical to patient safety were more rife in lower level facilities. It is apparent that different health care environments, with the corresponding health staff complement, bear upon health care safety and quality.

The categorization of cases in this study provides a convenient dichotomy of the key dimensions of professionalism that apply to health personnel. On the one hand are those for which the related lapses have a more immediate affinity with patient care, such as those concerning technical competency as well as ethical and compassionate practice. These aspects have been the onus of prior studies and pronouncements regarding professionalism in health services.[1-4,32] The other group of complaints were lodged against providers for supposed immoral conduct, even as the acts in question were not directly related to the actual provision of health services. These kinds of complaints have not received as much attention in the related regulatory literature.[33] The PRC's mandates have consistently referred to professional and ethical (which, among physicians, refers mainly to professional ethics, as expounded in the Code of Ethics of the Board of Medicine) lapses as grounds for administrative complaints.[19,21] Immoral behavior, and other non-patient care-related basis, were only specified in the PRC rules on investigations, which has since been revised.[34] It would seem then that an expanded social contract is tacitly upheld by the PRC, wherein providers are expected to not only be technically competent but also to abide by social conventions and laws conscientiously, in line with their stature as professionals.

Given the frequency and severity of the reported adverse events, the relatively benign administrative outcomes for patient care cases seemed to be incongruous. Nonetheless, as earlier discussed, circumstances other than those

attributed to health professionals may have also been borne upon many of these cases. Likewise, it must be noted that not every adverse event that occurs in the course of treatment is necessarily a result of provider error, and even the occurrence of the latter does not always equate with the administrative or legal requirements of professional negligence.[20]

Still, some patient care cases were deemed by the investigators to be attributable to grave professional shortcomings, such as those involving erroneous interventions. There were also cases with apparent serious ethical lapses and even deliberate malice committed by health care providers. It would have been therefore expected that, even with due consideration of the study's limitations as well as the occurrence of extenuating circumstances, there would be more cases deserving of sanctions, and possibly harsher ones at that, against the professionals with patient care-related complaints. The mostly non-punitive outcomes for the latter that may have involved amicable settlements may have been mutually agreeable, and, any compensations provided to the aggrieved parties would have also effectively penalize culpable practitioners. Such, however, can work against giving due recognition to the gravity and frequency of providers' errant behaviors, particularly for cases amounting to professional negligence. There is therefore some cause for concern in having less and lighter penalties meted out for patient care cases, as compared to the other set of complaints.

The evident discrepancy may be attributed to several factors. There may have been a greater inclination for patients or their affected family members to settle, or alternatively, for Health Boards to dismiss or give lighter penalties for patient care cases. On the other hand, parties involved in non-patient care incidents may have been more recalcitrant with their positions (e.g., cases involving fraudulent financial transactions), with complainants more determined to seek punitive actions. These are but conjectural, however, and will therefore need to be better elucidated in subsequent studies. Previous reports, conducted over a variety of settings as well as administrative and legal venues, also demonstrated that only a minority of implicated health professionals, particularly physicians, ended up being penalized.[26,35-37] Problems related to conflicts of interest involving health professionals, as well as unjust structural arrangements, may work against complainants.[35,36] The current PRC system, with hearings and deliberations undertaken only by Board members of the same profession as

the plaintiffs and the often circuitous complaints and hearing process, may engender these dilemmas. In the context of perceived deficiencies of the legal or administrative regulation of health professionals in other settings, the Health Court concept, wherein health professionals adjudicate, has been raised.[35,36] To some extent, with health professionals themselves conducting the trials, the said approach is already in place in PRC. While such an arrangement more readily ensures an appreciation of technical details, this also begets questions of partiality. A more inclusive composition may be considered, with non-health persons participating in Board deliberations to better achieve balanced inquiries and decisions.[37,38]

Though the collected complaints may not provide a sufficient representation of adverse patient events in the country, these are still compelling, and should therefore not be taken for granted. Efforts are needed to ensure the technical proficiency of health personnel as well as to instill other equally important yet apparently overlooked aspects of professionalism. Thus, for instance, the value of proper communication, as exemplified by the informed consent process, should be given more attention. This would be in line with universal ethical standards as well as local legal precedents.[20] As averred to in this study, the types of professional lapses vary across different groups of practitioners. Corrective measures thus have to also be adjusted accordingly. Further studies are needed to clarify the determinants and validity of the PRC decisions. These are needed to better guide the subsequent introduction of appropriate corrective measures. A reexamination of the mandates of the Health Boards may need to be undertaken, if only to thresh out their judicial scope. Limiting their administrative adjudication to breaches of professionalism that are clearly related to patient safety or quality of care, an option which is still in line with the Board's existing mandates may be a recourse.[19,21] The regulatory function of the PRC also goes beyond the determination of unprofessional behavior and imposition of corresponding disciplinary action. Its Health Boards have the agency to influence training standards, thereby prospectively advancing professionalism among health personnel. Thus, for example, more emphasis can be given to the teaching of ethics in the undergraduate curriculum. Similarly, professional ethical principles can be highlighted in licensing examinations, license renewal as well as re-acquisition requirements.[26,39] To the extent that standards and processes can be improved, the PRC can

also participate in international initiatives concerning health workforce regulation.[13,18,40]

While concerns regarding the effectiveness of PRC need to be addressed, it must also be recognized that regulation is but one of several levers that needs to be utilized if significant improvements in professionalism, patient safety, and quality of care are to be achieved. The DOH can take the lead in putting systems-level mechanisms in place for this purpose.[41-43] A network can be forged, incorporating the DOH, PRC, educational institutions, professional organizations and even judicial courts. Such will allow, for example, the occurrence of exceptionally disconcerting events to be expeditiously communicated, regardless of the administrative or even legal venue or status, and to have corresponding remedial measures undertaken in a timely and comprehensive manner. As a case in point, the adverse obstetric events brought before the PRC could have been raised with other bodies. Integrative approaches may then be worked out to prevent untoward obstetric events and thereby also contribute to addressing the still high maternal mortality rates in the country.[44]

CONCLUSION

The regulation of health professionals can be difficult in many countries, and the Philippines is no exception to this. The Health Boards of the country's Professional Regulations Commission are important channels for administrative complaints against health providers. Though the number of complaints seem to still be relatively small compared to the overall health service and human resource capacities, many of the attendant events were inimical and tragic for the affected patients and their families. Many of these events could have also been made preventable by adopting systems and cultures that promote professionalism and consequent greater emphasis on patient safety and quality of care. The study shows that while few complaints resulted in professionals being penalized, those unrelated to patient care had relatively more frequent and severe sanctions meted out on them. This implies a double standard that may translate to ineffective health professional regulation. The system therefore needs to be reformed, not just to more effectively sanction apparent provider errors, but more so to contribute to improvements in the overall delivery of patient care.

The ascendance of a more responsive regulatory system, anchored on an enhanced PRC, is vital in promoting professionalism among the country's health workers. Considering their extensive presence, these developments can be expected to greatly contribute to the provision of effective, safe, and quality care across the full spectrum of health service settings.

DISCLOSURES

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