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**Culturally Sensitive Response to Ethical Tensions:**

**The Philippine COVID-19 Pandemic Experience[[1]](#footnote-1)**

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Abstract

 This essay illustrates ethical decisions that the policy makers, healthcare providers, and non-government organizations can use as guide in their day to day activities and engagements. The paper does not attempt to provide a definitive menu on how to act on certain situation, but it discusses principles that are congruent with our treasured Filipino values. Likewise, the essay neither imposes nor provides universal solutions to dilemmas but rather it encourages deep practical reasoning to arrive at culturally sensitive decisions.

Keywords: Ethics, Filipino Values, Covid-19 Pandemic, Ethical Dilemmas, Philippines

**Introduction**

In badly hit countries like Italy and Spain, news and rumors proliferate about how elderly population stricken by COVID-19 are being treated like dispensable human beings. Newspaper articles during the second week of March 2020 exploded about Italy’s utilitarian approach. *Italy prioritizes Young COVID-19 patients over the elderly* (Orecchio-Egresitz, 2020) was a banner that shocked the world. Even the New York University based ethicist Arthur Caplan was alarmed over this news. "People would protest the idea that young lives are worth more inherently than older lives," Caplan warned (As quoted in Egresitz, 2020). The government of Italy neither denies nor affirms this utilitarian measure as institutionalized. In Spain, there has been a number of elderly people who were abandoned and left to die in many retirement homes (AFP, 2020). Apparently, there are reports that Spanish and Italian health care systems are beginning to collapse due to the gravity of the pandemic (See Horowitz, 2020; Donadio, 2020; Legido-Quigley, et.al., 2020). These countries, considered to have best healthcare systems in the world (World Population Review, 2020), are surprisingly on the brink of a logistical meltdown.

In a 2012 report, Italy has 187,000 beds in public hospitals and 45,500 in private accredited hospitals or a total bed capacity of 232,500 or with a rate of 2.8 per 1000 population (Donatini, 2016). Eighty percent of hospitals in Italy are public and healthcare services is free to all Italian citizens and legal foreign residents. Spain, on the other hand, has a total of 160,483 hospital bed capacity (Spanish Ministry of Health, 2008). To compare, as of 2008, Philippines only has around 94,199 bed capacity with a rate per 1000 population of 1.04 (Department of Health, 2012). Also, private hospitals outnumber public hospitals in all categories (Level 1 to Level 4). Almost 56 percent of the total number of hospitals in the country are categorize as Level 1 (Department of Health, 2009). These hospitals can only offer general medicine services and can only serve as emergency hospital and barely provide for immediate medical care in their immediate localities.

As of this writing, the Philippine government’s health resources remain sufficient relative to the number of confirmed COVID 19 cases needing medical intervention. But should the catastrophe escalate, the country’s health infrastructure could not endure a long-drawn crisis of great magnitude. From the official statement of Undersecretary Marie Rosario Vergerie of Department of Health, it was said that experts of World Health Organization projected that sans proper government management and intervention the country would hit around 75,000 confirmed cases in June 2020 (Magsino, 2020). From the current global mortality rate of the disease at 2%, the country would roughly encounter around 1,500 deaths. The national mortality rate, however, is greater at 6.4% (with 5,453 confirmed cases and 349 deaths) (Department of Health, 2020). So, approximately the country is looking at around 5000 deaths.

With the situation and the state of the national healthcare system as above explained, it is certain that a logistical disaster greater than that experienced by Italy and Spain is forthcoming. Therefore, other than the government’s efforts and initiatives to limit the spread of the contagion through contact and case management, ethical framework should be put in place in order to address anticipated ethical dilemmas especially relating to healthcare services fairly and reasonably without harming our cultural, social, legal and religious/moral standards. This essay illustrates ethical decisions that the policy makers, healthcare providers, and non-government organizations can use as guide in their day to day activities and engagements. The paper does not attempt to provide a definitive menu on how to act on certain situation, but it discusses principles that are congruent with our treasured Filipino values. Likewise, the essay neither imposes nor provides universal solutions to dilemmas but it encourages deep practical reasoning to arrive at culturally sensitive decisions.

**Context and Culture**

Filipinos are known to have a culture that valorizes the concept of family, which is considered as the very center of social life. Family is often the most potent source of emotional support. Family bonds are tight knit. It is common to find three generations living together in one roof. Also, familial relationships are not only confined within the nuclear family unit, they extend beyond bloodlines to include friends, distant relatives and neighbors. It is ordinary to most Filipino communities to adopt neighbors’ or friends’ elderly parents and grandparents as their own.

Filipinos possess a deep filial piety. As emphasized above, this extends not only to the parents and siblings; it also includes the grandparents, *titas* (aunts), *titos* (uncles), and other relatives. Usually, family members manifest this family devotion, among others, thru respect, generosity and reverence to their elders. Filipinos, for example, accompany their parents to clinics during medical check-ups, confinements, and they shoulder all expenses related to medicines and other hospital bills. These are unwritten obligations that children imposed upon themselves as a show of respect, honor and gratitude to their parents.

Across islands and across ethnolinguistic traditions, Filipino families value parent-child relations and such are neither severed by age nor by marriage. Elderly parents are cared for by the children themselves. Children serve as caregiver, assistant, therapist, and nurse of their parents when requiring age care. Those who send their old and sickly parents to home care are considered ungrateful and the family would be a topic of “*usap-usapan*” (rumors) in the community. The Filipino elderly usually live with their families for economic support, emotional support, and for their health care needs (Concepcion & Perez, 2018). It was claimed that living with the family is the best arrangement for older people for their well-being (Concepcion & Perez, 2018). Like in other Asian countries, particularly those in the South East Asia, Families assume exclusive responsibility for health and old age security of the elderly members. This also holds true even when the elderly lives separately from the rest of the members. This is the reason perhaps why home-for-the-aged centers in the country are very few and usually run by non-government organizations and foundations. Private entities do not see such centers as good money-making enterprise.

Unlike in some foreign countries, in the Philippines age is often a very important factor. It is an obligation, for example, of those younger members of the family to show respect to the older ones. Filipinos do have label for their siblings like *Kuya* (older brother), *Ate* (older siter), *Diko* (older brother), etc. to address them. It would be highly disrespectful for a *bunso* (youngest sibling) to call his older siblings by their names. Opinions of the younger ones are usually dwarfed when the older ones in the family have contrary opinions. In major decision-making process, thoughts of younger ones are inferior notwithstanding their sense and/or reasonableness, while those of the older ones often prevail sometimes despite apparent and inherent falsity. Obviously, there is a certain hierarchy that is in place in Filipino homes. The elderly members are usually at the top of this structure, the younger ones at the bottom.

When news about the pandemic spread around the country and that the most vulnerable population are the elderly, panic enveloped Filipino homes. Even during the time when the virus was not within the Philippine boundaries yet, Filipinos started to outline strategies on how they can protect their parents and grandparents should it arrive. All means necessary to shield the elderly population from the virus were undertaken. There were those who started to quarantine their elders even prior to the formal declaration by the national government. Others bought volumes upon volumes of medicines, food supplements and other herbal medicines which were reported, albeit spuriously, to be effective protection from the deadly virus. The government incessantly and repetitively reminded the entire population about the dangers of the virus specially to the elders. It is felt that the anxiety is not for the entire population, at least during the earlier phase, but for the elders or the senior citizens that Filipino culture so values.

*Utang na Loob (Debt Cycle)*

Filipinos believe in the cycle of debt which is more appropriately called *Utang na Loob*. *Utang na loob* is a principle of reciprocity. The commencement of this cycle is marked by an unsolicited or solicited favor given freely to another person. The favor must emanate from a person’s inner goodwill (*kabutihang loob*) and the recipient thereof immediately transforms it into an obligation---obligation to repay (Matienzo, 2017). Matienzo quoted Holnsteiner: “…the children’s obligation to respect and obey their parents and show their gratitude by taking care of them in old age…continues even when the parents’ duties have been largely fulfilled”(p.55). In other words, the parent-child relationship and the reciprocal obligations surrounding it is illustrative of *utang na loob*. Here, it can be deduced that utang na loob can be intergenerational. The debt is received by one generation from another generation; and the repayment goes the same way back. The cycle is ever running because *utang na loob* is unquenchable---never satisfied. No amount of repayment can ever satisfy the debt.

Perhaps, this is because the favors involved in the cycle are more often unquantifiable; or no equivalent pecuniary value such as care, love or affection, and others of same import. Though sometimes these favors are accompanied with quantifiable value like money, food, medicines, etc., the recipient’s inner personal freewill (*loob*) is motivated, or aptly obligated, to return the favor not because of these material things but those which are impossible to measure. This is what separates *utang na loob* from ordinary repayment of debts (*utang*). The love, care, respect and concern that the younger Filipino generation provides to their elderly are manifestations of *utang na loob*. Filipino families are very particular about this belief. As the popular saying goes, “*ang hindi lumingon sa pinanggalingan ay hindi makakarating sa paroroonan.*” Those who failed to give back the favor usually suffer from *hiya* (shyness or sense of propriety).

The elderly population sort of invested their youth in the care and love for their children with or without a view of getting pay back in return. However, the society demands from the recipients a kind of repayment that would ensure the elderly the much-needed love and care until their last breath. Hence, in situations of great crisis like this COVID 19 pandemic, Filipinos seem to know how to act and what to act in certain eventuality which may involve the elderly population. The trajectory of action seems to point to a decision where the elderly people are given priority over the young ones. Otherwise, the very culture and belief that establish and even embellish the social relationships in the country would be put aside. Hence, policy makers, government and non- government stakeholders, health care workers, among others would have to anticipate a worst scenario, while of course hoping for the best, and be better prepared to face squarely the potential ethical dilemmas in the future.

*Collectivist Culture*

Filipinos, like their Asian neighbors, are known to be collectivist (Hofstede, 1980). In collectivist societies, decisions are made by the society, group, family, or community and not by individuals. In health care situations, all the members of the family (from the eldest to the youngest) are informed about the diagnosis, records and prognosis of the patient. Sometimes, there are designated decision makers (usually the eldest son or daughter) who are chosen by all the members of the family. Unlike in the United States, the Philippines does not have advance directive where the individual patient fills up an advance instruction or will relating to procedures and decisions to be made in worst eventuality. This directive prevails over the decisions or will of the family.

 Other families spend millions to save a family elder for a disease that they are told to be incurable despite of the fact that the patient herself/himself already refuse the treatment because of fatigue and pain. Families would sometimes decide to continue with the treatment because they do not want to appear in the community to have abandoned their relative or sometimes, they just could not simply let go of their relative.

 When deciding on matters regarding the health of a family member, it is always a decision of the entire family. Not even the patient can prevail. The decision must emanate from a thorough deliberation and evaluation by each member until a common ground is met and until the decision is acceptable to all.

**Foreseeable Ethical Challenges and Possible Ethical Decisions**

Should the national and local government mess up in managing the mechanisms and strategies to curb this pandemic and engagement or active participation from the citizenry is wanting, the worst eventuality is a gloomy expectation. The country could face foreseeable ethical dilemmas that would test the wisdom of those who are on the ground like doctors, frontliners, military, government officials, etc. With this, preparation on the level of ethics and moral actions must be undertaken; just like when we prepared to cease the spread of the virus.

Administrators and clinicians must, even at this stage of the pandemic while the crisis is manageable, reflect early on and pose practical questions and anticipate situations and problems that may arise. They also must review their processes and policies under normal conditions and suit them to situations beyond normality. This is to minimize surprises and hasty decisions in the future. Their reflection must consider various factors such as culture, beliefs, law, professional ethics, and other important standards.

 Some of the ethical problems that may arise, among others, are the following: allocation of scarce resources, physicians’ duty to family vs duty to community, and individual freedom vs public health.

*Allocation of Scarce Resources*

 Countries which had gone to worst of this pandemic were caught off guard in dealing with several ethical dilemmas. They were surprised at the magnitude of the problem. Fortunately, or unfortunately, these countries have an off-the-shelf basic standard that they can conveniently apply to situations. This standard is utilitarianism or that principle which focuses on the consequence of the action or decision. It is where the decision always seeks for the good of the great number of people. It is a simple mathematics of benefits/utility minus the potential harm. Should the action or decision’s results possess benefits greater than the harm, that course of action will be taken at once. The action, in other words, should produce the most overall happiness.

Resolving for example the problem of *who gets treated* or *who gets the available resources* is easy for them. For instance, there is only one ventilator available and the doctors are to choose between an elderly and sickly COVID-19 patient and a young athlete stricken with the same disease, most probably the athlete would get the medical resources he/she needs. Of course, the situation would have to be evaluated thoroughly before arriving at such decision. But most certainly, the priority will be given to the younger patient. Apparently, the athlete has greater chances at surviving the disease, while the elderly is likely to die because of her/his relatively weak and aging/aged lungs. This is medical utilitarianism. This decision is not acceptable to Filipinos who, as I discussed above, value their elderly. Hence, it is more difficult to resolve same dilemma should it occur in the country due to the inherent value system that the Filipinos have.

How can clinicians resolve this problem without being insensitive to the Filipino culture? There is no sure answer to this. There are virtually hundreds of combinations of actions or decisions that would be considered. Filipinos will not be easily persuaded to just choose between limited options. Filipinos would surely provide hundreds of choices and hundreds of approaches with infinite number of calibrations for both patients to survive. Remember that Filipinos do not decide on their own because of their collectivist attitude, there are as many choices and decisions as there are as many members of the family before a consensus is arrived at.

Filipino clinicians would really have a hard time dealing with situations like this. They have to avoid *tampo* (sulky/sulk/sulking) from the family of any of the patients. Filipino families cannot just accept that their relative was not chosen to survive because of limited resources and because of a subjective ethical decision made by the clinicians. Filipinos would take personal grudge against the clinicians. No amount of atonement could ever appease the family and the fault (*sisi*) will surely be at the hands of the clinicians.

But of course, decisions would have to be made no matter how difficult. And decisions must be swift and reasonable. Physicians’ duty to family vs duty to community. Likewise, engagement with the family is foremost. Meaning, the decision would have to be made in consultation with the families. The decision should not be arbitrarily imposed. It should be a mutual decision thru dialogue or from a persuasive and respectful conversation. It would only be a real challenge because the clinician must convince each and every family member.

Rather than debating or bickering, Filipinos love *pakikiusap* or *pakiusapan* (persuasive communication). The clinician, therefore, should appear *nakikiusap* (pleading). *Pakikiusap* was the key element, for example, of the non-violent February Revolution in 1986 that toppled the Marcos dictatorship. Gen. Ramos, Sec. Enrile and Cardinal Sin were always on air, *nakikiusap,* persuading the military commanders to join the revolution (Dy, nd).

Clinicians, during the *usapan* (dialogue), would have to show *sinseridad* (sincerity), *awa* (compassion), *galang* (respect) and *hustisya* (justice) when talking to the families. Filipinos are feeling beings. They would not demand *usapan*. They will usually wait for the clinicians to initiate the dialogue. Often, they call this *pakiramdaman* (sensing). Hence, by engaging the families to a dialogue, the families would somehow feel their importance and their feelings respected. Filipinos love to feel that their *pakiramdam*/*damdamin* (innermost emotions) are considered in the decision-making process involving their sick relative.

However, this is not to say that there would be no complications and *usapan* would be a sure solution. At times, families could not really accept whatever decision no matter how valid, reasonable and practical the justifications are. Simply because the family member, more so an elderly member, is always precious and valued.

*Physicians’ duty to family vs duty to community*

 As of this date, there have been more than a dozen Filipino healthcare workers who perished due to their exposure to the virus while caring for their patients. Because of the growing statistics of death in this pandemic, Filipinos are starting to ask question on whether doctors or other health care practitioners can refuse to work in order not to endanger their lives and the safety of their beloved families. Can the physician refuse not to go and care for the victims of the pandemic despite them having taken the proverbial Hippocratic Oath?

 Again, the Filipino filial devotion would be factored in in deciding and resolving the dilemma. As Filipinos are inclined to prioritize the family more than anything else, how can this dilemma be resolved? What if the physician lives in a dwelling where most of his relatives belong to the most vulnerable population (elderly, sickly, etc)? Would it make any difference?

 In the Philippines, refusal to work during pandemics may be allowed especially when the health workers honestly and reasonably believe that their safety would be compromised or their life endangered. But it is important that they can prove that even other members of the profession would incline to believe the reality of the danger. In Canada, for instance, concerns of this nature must be communicated to their supervisor in the most professional manner. The supervisors must be duly notified about the reasons and justifications of the refusal (Davies & Shaul, 2010). The health care worker must prove that the danger is so serious to justify the refusal and not only emanating from unfounded fear and panic.

 The Philippine Medical Association’s Code of Ethics, particularly Article III, Section 1 provides that

A physician should cooperate with the duly constituted health authorities in the education and enforcement of laws and regulations for the promotion of health. Furthermore, in times of **epidemic and public calamity, except when his or her personal safety is at stake, the physician must attend to the victims, alert the public and duly constituted health authorities on the dangers of communicable diseases and enforce measures for prevention and cure in accordance with existing laws, rules and regulations**. [Emphasis Supplied] (Philippine Medical Association, 2008)

As a rule, the physician must attend to the victims of epidemic or public calamity, but the rule accepts exceptions. And clearly, the physician has the right to refuse when his or her personal safety is already at stake. The code does not however explicitly mention about the safety of the the physicians’ family being considered. This is only construed implicitly.

The physician has a duty to protect the household he belongs. This is a Filipino treasured belief. But this belief is not exclusive to Filipinos as it is a universal principle. The care for the family is an instinctive emotion and impulse, but arguably the response is more intense in Filipino hearts because of the stronger bond that ties Filipino families.

How to decide in this situation? What one ought to do? Again, situations would have to be studied thoroughly. For example, if the physician is working in a medical facility which is relatively bigger and there are a number of physicians who can fill his shoes, he/she can easily refuse to report for work during pandemic because obviously no apparent endangerment of lives is on sight. Otherwise, the physician is compelled to report for work.

The Filipino concept of *hiya* (shame) would also come in when the physician is a graduate of state universities. The physician would have to repay his *utang na loob* to the Filipino taxpayers who virtually spent for his education. And refusing to pay back would be a cause for *hiya* and *kawalan ng utang na loob* (ingratitude). He/she must strike a balance between his *hiya* and his love and devotion for family. This is not easy because both values are important in Filipino culture and social psychology.

The Filipino community may not be forgiving to those clinicians who cowardly and unreasonably refuse to provide care when needed. There are terms which can capture what the community can possibly do. *Huhubadan ka ng Karangalan* or the community will strip off all your dignity and worth. However, should your refusal be fair and reasonable, the Filipino society can be accepting and forbearing. In other words, should the physician choose to stay home and protect his family from being infected from the virus, this may be tolerable when the physician shows *katapatan* (honesty) and *katarungan* (fairness) and not *karuwagan* (cowardice).

*Individual Freedom vs Public Health*

With Filipino’s collectivist culture, striking a balance between individual freedom and public health seems easy to resolve. It is expected that Filipinos tend to altruistically sacrifice their freedom in favor of common good. When the Philippine government announced that there will be a total lockdown of the entire island of Luzon, there was no major aggressive dissent that came from the population. Apparently, Filipinos were willing to stay home for a while until the contagion is managed. This indicates the Filipino sense of community. The move of the government was supported and welcomed by Filipinos despite the hazy part of the announcement, Filipinos stayed home. There are some reports, however, of violations but these are only insignificant compared to those who conformed and followed the quarantine regulations.

This sense of community should not be mistaken, however, to blind obedience and loyalty to the national government, neither loyalty to the President of the Republic—Rodrigo Duterte. This is to be looked at more as a manifestation of Filipinos loyalty to the Filipino nation as a whole. Filipinos, as collectivists, exercise what is called group-thinking. Sans my personal subjectivity, Filipinos always consider the welfare of their *kapwa* (other) as they also consider their kapwa’s negative perception when they commit transgressions or misdeeds.

 Western approach to the tension may not be applicable to Filipinos, Americans (for instance) are individualists. Hence, demonstrations against lockdowns, quarantine and other measures that limit their freedom and mobility have become commonplace. These were held in states like New Hampshire, Texas, Minnesota, Washington State, Michigan and Virginia (The Journal, 2020). These demonstrations were heavily criticized because of the danger that they pose to the society. But, demonstrations continue nonetheless.

In the Philippines, when *Kadamay,* an activist organization of urban poor, went to congregate along a major highway, and demanded to be given relief goods, majority of Filipinos condemned their acts. Most of them were jailed and incarcerated. Social media that day was burning fumes criticizing *Kadamay*’s seeming foolishness. The President of the Republic even gave a stern warning to those who would do the same (Mendez, 2020). Hence, no other demonstration against lockdown was ever recorded since.

This should not be misconstrued. Filipinos value freedom and liberty. In fact, in the 90’s, Filipinos show the world that thru non-violent demonstrations, democracy can be restored. This collective action of Filipinos was even made a model by countries in the Eastern Europe to escape despotic governments. But Filipinos know how to temper their own personal or individual freedom when faced with a larger responsibility---that is responsibility towards their *Kapwa.*

**Conclusion**

Some ethical values or principles can be of help to clinicians when confronted with situations like those above discussed. These principles should be taken into account along with legal, professional codes of conduct and other guidelines that may be applicable. These values are consistent with the cultures and beliefs of Filipinos especially when arriving at acceptable decisions. It is not necessary that all these principles are considered in a given situation. What is important is to be careful in dealing with situations ensuring that cultural sensibilities are not disregarded but respected and highlighted.

As discussed above, respect is very important to Filipinos. Decisions can be made acceptable when these decisions recognize the dignity and humanity of the individuals involved or those who are likely be affected. Like what was illustrated above, the family can accept a decision to least prioritize an elderly family member when there is scarcity of medical resources as long as the patient’s dignity is protected. And as long as the family is involved in the decision-making process. Filipinos do not want to be dictated upon.

When clinicians ask the involvement of the family in the decision making, the principle of inclusiveness is considered. Inclusiveness is the that value that ensures “that people are given a fair opportunity to understand situations, be included in decisions that affect them, and offer their views and challenge” (UK Department of Health and Social Care, 2020). This value recognizes the collectivist nature of a Filipino society and hence, can be very helpful to clinicians who are faced with ethical dilemmas.

Of course, in all decisions, the clinicians would have to ensure that there is justice and reasonableness. “This principle is defined as ensuring that decisions are rational, fair, practical, and grounded in appropriate processes, available evidence and a clear justification” (UK Department of Health and Social Care, 2020). Filipinos do have an appropriate term for this---*katarungan*/*makatarungan* (justice/relating to justice). Hence, for decisions to be acceptable, clinicians would have to ensure that they observed fairness and justice.

Lastly, Filipinos do have a sense of community. One of the core values of Filipinos is the concept of *kapwa* (shared identity/the other). They value the opinion, suggestions, and perception of the ‘other’ as they recognize their inherent connection with their fellow Filipino. This is perhaps the reason why the concept of *hiya* is important. The Filipino decides and acts not only according to his own thinking processes, he/she decides and acts according to the perceived acceptability of his action by his *kapwa*.

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