Postmodernism in 21st Century Medicine: Implications for Philippine Healthcare and Public Administration

JULIUS A. LECCIONES*

The advent of postmodernism in 21st century medicine opened the doors to the public's new interpretations of health and medical concepts and approaches. Patients no longer solely and completely submit to their physician's instructions and prescriptions. With sufficient information on health and medicine available through books, magazines and the internet, they have become well-informed enough to discern which options are applicable in addressing their specific health concerns/problems, and the rising costs of medical care led the public to alternative medicine that is both practical and more informal. While doctors remain a very important figure in health management, the postmodern concept challenges the medical community and health service administrators to look at the existing practice of medicine and to respond to the new demands of the society with regard to healthcare. These demands not only entail curing the disease or improving the condition of the body, they also entail healing the person spiritually.

Introduction

Modern medicine is responsible for the overall increase in the life expectancy of humans. It conquered many infectious diseases that used to decimate world populations due to global epidemics during earlier periods. Even fatal diseases of degenerative chronic nature or of clonal origin like cancer are managed to a level that can keep pain and human suffering at a tolerable threshold. Indeed, Science and Technology had advanced so much in the detection, diagnosis and control of diseases that it has become synonymous to what we call medical progress today; hence, the decrease in global morbidity and mortality figures due to human ailments is unprecedented compared to the historic past when a person could barely survive to adulthood.

Historians generally agree that the concept of the "modern" dates back to the Enlightenment Period in 18th century France (Arbuckle 2001). French

*Chief Research Officer, Research Development Office, Philippine Children's Medical Center.

thinkers of that age were driven by their enthusiasm about new scientific discoveries, and largely by their disillusionment with the corrupt political and religious systems of their time. Declaring that faith was mere superstition, the advocates of modernity believed that through the correct use of reason, humankind could progress towards a perfect society. This 18th century belief that human progress is inexorable seemed to be supported by classical physics (Arbuckle 2001; Wheatley 1992). Thus, thinkers of the Enlightenment Period saw matter as the foundation of all life. To them, the material world is an orderly machine consisting of elementary parts.

The dawning of this modern era brought in healthcare an increasing professionalization of medicine and the rise of what we have come to call the "medical model" of care (Arbuckle 2001). In this modern view, disease is a biological abnormality located in a particular part of the body. It tends to see the human body as a kind of machine that can be restored to health through scientific detection of disease and scientifically prescribed treatment. Physical signs that the physician can objectively measure (often with the use of instruments) have more emphasis than symptoms felt and described by the patient. The modern view thus downplays the structural, environmental and cultural aspects of healthcare because it assumes that society's health depends primarily on the availability of medical resources and the quality of medical expertise (Arbuckle 2001).

Scientific medicine is based on the premise that people are biological mechanisms operating in logical and reproducible ways. Healthcare professionals and researchers are detached observers capable of detecting consistent patterns such as diseases, diagnoses and syndromes (Meredith 2002). If the body is a machine, the breakdown of this machine is disease, and doctors may be the only one who could fix the machine. Doctors who have the information and knowledge hold power over patients in this arrangement. Patients, in turn, give "total control" of their bodies to doctors. This non-holistic view is often criticized as disregarding the person as a whole and entire creation.

Likewise, this scientific biomedical model identifies health as an efficient physiological and biochemical functioning of the body. Diseases are seen as invasion of pathogens, or perturbations in molecules, that can be ultimately remedied with pharmacology or surgery. This mechanistic model of medicine has, in fact, been extremely successful, resulting in the eradication of many of mankind's maladies. However, "The doctor, brought up to the thinking of biochemistry and physiology as making up the human reality, can be blind to nonphysical aspects of healing" (Bulatao 1992: 313). Furthermore, much of what people call "sick" can be brought about by emotional factors, and thus, need to be healed through emotional means.[1]

The biomedical model can be in contrast to what people call "healing," which is based on the concept that human life, though biological, is but a manifestation of "consciousness," a nonphysical (metaphysical) entity that can exist (e.g., as a "soul") within a physical body, but also has nonphysical (energetic) connections with other consciousness and to a "divine" or "universal" consciousness of some kind (Meredith 2002). To Meredith, "healing" is primarily concerned with underlying abstract metaphysical processes (e.g., beliefs, connections, experiences, meanings, motivations, perceptions and suffering) as well as their material manifestations—disease and dysfunction. Thus, in this view, science should not have as much dominance over what people believe about their health for there can be other options. In the biomedical model, science is the only option, but to a postmodernist, members of society should be able to choose their own methods of healthcare.

The Concept of the Postmodern

A major culture shift, which came to bear the label of "postmodernism," emerged in the Western world in the 1950s and the late 1960s (Arbuckle 2001). Especially in the 1960s, people became increasingly disillusioned with the idea that technological achievement equals progress. Postmodernists do not assume that progress is inevitable. They reject the modernist's assumption that reality is ordered in a way that it can be laid bare by the human mind, making it therefore possible to build a universal culture upon a foundation of rational thought (Arbuckle 2001). People of the postmodern world reject the idea that either objective truth or universal standards of morality can exist (Lyotard 1994; also cited in Arbuckle 2001). For instance, the horrors of World War II, which ended up with the dropping of the atomic bombs on Japan, destroyed any belief in human perfectibility through reason.

By the late 1960s, postmodernism had resulted in what some have called the "revolution of expressive disorder," a middle-class revolt against all certainties and boundaries—political, moral, sexual, educational, artistic and social (Arbuckle 1990). This revolt was an intense effort to enshrine the rights of the individual as a feeling and free person, rejecting all forms of impersonal bureaucracy, political manipulation and hypocrisy. Arbuckle (2001) further pointed out that this rejection of the optimism and certitudes associated with modernity caused erosion of the legitimacy of traditional institutions: government, education, the family and the church. Thus, these institutions were seen to have compromised such values as freedom, creativity or self-expression, and the person's dignity.

Postmodernism and Healthcare

Muir Gray proposes that "Postmodern health will not only have to retain and improve the achievements of the modern era, but also respond to the priorities of postmodern society, namely: concern about values as well as evidence; preoccupation with risk rather than benefits; the rise of the well-informed patient" (1999: 1550). In general, it emphasizes the importance of context, values and partnerships (British Department of Health 1999), with society asking for a different kind of healthcare, and a new deal between health professionals and service users (Bracken and Thomas 2001). These demands create challenges for Medicine, as society's faith in the ability of Science and Technology to resolve human and social problem. This is also an important feature of the 20th century medicine that has diminished (Muir Gray 1999). Nevertheless, these shifts in attitudes and assumptions ironically provided doctors the opportunity to redefine their roles and responsibilities, as they respond to the demands of the government and the society it represents.

In its most positive consequences, postmodernism has contributed significantly to healthcare approaches, or to the view on how healthcare services should be delivered. Arbuckle, for instance, enumerated the following ten positive consequences of postmodernism in medicine (2001).

A Search for the Authentic

"People today are searching for the inner meaning in their lives. They are less satisfied with logical and rational arguments to support their faith and increasingly expect truths to be authenticated through the witness of people's lives" (Arbuckle 2001: 14). Together with the rise of consumerism, patients began to treat with disdain the healthcare organizations which cannot deliver their promises, which cannot manifest the meaning of their organizational vision and mission, and those which treat them as machines to be repaired, and not as human beings with feelings and dignity.

A Willingness to Ask Tough Questions

"*Deconstructionism*, a characteristic postmodernist philosophy, encourages people to critique objectively their own cultures and means of communication. It urges them to become aware, for example, of the way culture can insidiously suppress good impulses and support people who manipulate power for their own bad ends. Like all efforts to uncover the truth, deconstructing or critiquing culture is a healthy, but often painful, process" (Arbuckle 2001: 14). This can also be observed as a consequence of

increasing education of many patients, and the accessibility of sources of information (i.e., the Internet).

A Yearning for Spirituality

"People today seek spirituality, which they understand as a perpetual process of becoming, a continual unfolding of the human spirit" (Arbuckle 2001: 14), thus realizing its powers to heal. This, of course, can vary from one culture to another, but certainly stronger in some countries like the Philippines where religion and rituals may coalesce with science in the process of treatment and healing.

A Reexamination of the Medical Model

Both patients and caregivers are affected by the traditional medical model. It undermines their sense of belongingness, intensifies pain, and dissipates energy. "Postmodernism has encouraged people to critically reexamine the traditional medical model for the treatment of illness. We are finding it impossible to define disease and healing without reference to patients' holistic needs" (Arbuckle 2001: 14).

A Growing Dissatisfaction with Economic Rationalism

Focus on profits may unconsciously influence political and business decisionmaking in healthcare matters; thus, the profitability yardstick is increasingly becoming unacceptable as a measurement of healthcare management.

Impatience with Sexist Traditions

"The postmodernist spirit has also inspired a questioning of healthcare *patriarchalism*, the belief that only men, following a top-down model of command, can provide organizations with strong leadership, and that, moreover, specialized medical practices should be reserved for men" (Arbuckle 2001: 14). The boundaries between men and women have now been broken down completely in many areas of healthcare, with many women now predominating or having been felt in various fields of specialization that were once the domain of men (e.g., surgery).

An Intensifying Critique of Elitism

Michel Foucault (1965), a French philosopher, had pointed out the medical profession's habit of claiming a monopoly on knowledge concerning the human body. Many people today share Foucault's critique of the medical profession's elitism. Patients are now increasingly demanding shared power in decisionmaking, particularly when it involves their own bodies.

A Hunger for Integrity

People are wary of leaders who lack personal integrity. In the same manner, they expect their healthcare professionals to be the vanguard of sincerity and probity.

A Longing for Community

Many yearn for the sense of belongingness in a community. The experience of patients in hospitals or in clinics can be abstract and dehumanizing. "For millions of us, small groups offer friendships, forums for discussing values, and links with wider institutions" (Arbuckle 2001: 14).

An Emphasis on Personal Story-Telling

The patients want their stories to be told and not depend on the doctor's defining the meaning of their lives for them. "They want to be able to tell of their own experiences, of their search for personal meaning, and to be free to share this with others" (Arbuckle 2001: 14).

In all of the foregoing discussions, and within the context of a postmodern society, what does it mean, therefore, to be a "good doctor?" It has to be noted that the medical profession is built around a network of relationships created between doctor and patients. It is centered around "caring" for others. Martin Winckler, a French doctor schooled in the modern medical tradition, in his essay, *The Good Doctor* (2002), summed up well these postmodernistic tendencies in patient care.

> ... no doctor can say with greater assurance than the patient what is best for him. The patient may break off the treatment or question the doctor's decision at anytime. A caring doctor cannot, should not, and may not deny the basic truth that being a doctor does not involve making other people's decisions for them. Being a doctor means above all being a participant. The relationship is not one-sided – with the doctor caring for the patient – but reciprocal. Since you learn everything about the illness from the patient, you cannot give anything

> to the patient – you can only give something back. You cannot order a patient to follow a treatment – you can merely accompany the patient. You cannot decide for the patient – you can merely help patients to decide for themselves. Herein lies a doctor's moral duty. Herein lies the sole justification for a doctor's existence (Winckler 2002: 36).

For a doctor, making a diagnosis is an expression of both personal and professional skills. This involves the combinations of knowledge, intuition and intelligence. Simply establishing a diagnosis is not enough because the whole point is to help; and this could not be possible without establishing a relationship, and listening well to the patient.

Different Medical Systems During Varying Time Periods

Early History

Hippocrates, the Greek physician from the Island of Cos, is considered the Father of Medicine, the first "modern" doctor. The pledge that bears his name, the 2,400-year-old Hippocratic Oath, remains the foundation of the solemn undertaking made by today's medical-school graduates. In essence, Hippocrates' ideas still hold good today: promoting the well-being of the sick, preserving life, and respecting the dignity of the patient. They all remain strong and valid ethical guides for the medical profession.

Unfortunately, the long and distinguished history of medical ethics and of the Hippocratic tradition,which has served medicine and society as well, could be inadequate, even disappointing to some, particularly to those holding postmodernistic views. The Hippocratic tradition wholly failed to address fundamental issues of responsibility such as patients' consent, privacy, resource allocation, and the right to refuse treatment (Beauchamp 2002).The patient's right to choice plays no role in this tradition, or in the views of Thomas Percival, author of the classic *Medical Ethics* published in 1803 which still remains the most influential treatise carried forward into the modern times (Beauchamp 2002).

The Medical Profession. Historically, medicine was provided by doctors, usually male, charging fees based on the ability of the patient to pay. There was an unwritten social contract in which the doctor should not abuse his position. These doctors, as members of the community who fulfilled society's humanitarian commitment to the misfortunes of illness and aging of its members, provided care for all. In its early history, medicine had little impact on the course of illness, but care was rather more of providing support and comfort (Wynne 2000).

The early doctors remained comfortable but not wealthy. In turn, society provided them high status and security. And in order to meet society's

expectations, medical professional associations developed ethical traditions and some forms of control on the basis of the Hippocratic principles. This idealized model worked well, particularly within the context of the medical profession and society's "identification" of it.

The ethical strictures of the Hippocratic tradition protected patients from misuse and controlled the conduct of the profession for centuries (Wynne 2000). They remained strongly supported by professional and community identification with these ideals. Nevertheless, they could also be vulnerable to changing attitudes in society, and unfortunately could bend before powerful forces (e.g., circumstances during Nazi Germany).

The distinguished history of the early medical tradition had not been a guarantee of its adequacy for modern times. Indeed, it is now clear that many of the traditional standards have either faded away or are fading fast (Beauchamp 2002). Changing social attitudes and loss of legitimacy of professional values have been a particular problem during the latter part of the 20th century (Wynne 2000). This is due primarily to the strong market pressures on the clinical encounter resulting in a marketplace culture even in the venerable medical transaction situation. Further wreaking havoc was the denigration of medical professional points of view by corporate interests, economists and politicians (Wynne 2000). The medical professional values and morality which developed through the ages were now judged as being inadequately comprehensive, coherent, or sensitive to conflicts of interests.

Hospitals. It was the charitable church and similar community groups that established hospitals and other similar services for the sick and dying. A system later developed where rich families were billed by the hospitals to support the services to the poor. This type of Samaritan system formed the backbone of medical services in many countries at that time. This later gave way to governments taking care of the poor. Charitable institutions then devoted their profits from their hospitals to support other community services (Wynne 2000).

The Twentieth Century. The tremendous change that accompanied modern medicine into the 20th century had so much impact on health care, resulting in improvements in survival and the alleviation of pain and suffering. Ironically, medical errors likewise proliferated, and therefore became much more devastating to patients. With this change came an increase in medical litigations, destroying the basic trust that society traditionally conferred on doctors. Not only did this require the difficult task of maintenance of professional standards, but also encouraged the costly practice of medicine in the so-called "defensive" medical practice.

The Rising Costs of Medical Care. Independent of the costly preventive medicine, technology and medical specializations in themselves are prohibitive. Thus, the older system of the rich paying for the poor could no longer be sustained in the face of rising costs (Wynne 2000). Government and private insurance both stepped in to fund medical services and other types of service packages likewise developed particularly in the private marketplace.

Payments for medical service are now being made by groups, which may only have peripheral interest in the welfare of patients. On the other hand, they have commercial interests in the care being provided to the patients. In these arrangements, as Wynne pointed out, government would want value for money, while insurers want profit (Wynne 2000). Necessarily in this marketplace transaction, they will intrude into the relationships between doctor and patient, and between the profession and the community in order to meet their market-driven objectives.

In the healthcare marketplace that ensued, some groups "fell through the cracks" so to speak. The poor could not afford most of the costs. Thus, while all accept equity in healthcare between the poor and the rich, it is not realized in practice, resulting in varying degrees of inequality. Government has often taken responsibility for the poor through direct and indirect approaches. The overall result was the breakdown of healthcare services in many sectors leading to widespread dissatisfaction with, and later alienation and isolation from, the healthcare system and established medicine. Many, in fact, would turn to alternative healthcare approaches or to folkloric ways.

The Development of For-Profit Medicine. The profit undertaking in healthcare is not only driven by the capitalist market, but also by corporate business. Ironically, profits from private insurance and from payment of individuals are limited. The potential for large profits lies largely in the access to government funding either through Medicare payments or through government's contracts that provide hospital care to public patients (Wynne 2000). Large market-listed companies have come to dominate health and elderly care in the United States (US) and Australia (Wynne 2000). In fact, in Wynne's account, US multinationals have enlisted the support of the US government in pressing for international trade agreements, which would open all government sources of profit to multinational corporations (Wynne 2000). Thus, in this scenario, it is not private or individual payment which forms the backbone of corporate profit system, but taxpayers' money dispensed through Medicare and by government contracts.

Government and the Market. Government-run national health systems have been characterized by underfunding, a cumbersome bureaucracy, and consequent alienation and loss of staff morale (Wynne 2000); thus, they remain the most economical and equitable method to ration a scarce resource. They, in fact, work well when adequately funded.

The capitalist ideology views all society as a market place—market competition. The underlying assumption is that because humans are competitive, all human activities should be based on competition (Wynne 2000). Healthcare problems can therefore be resolved by turning it into a competitive marketplace. Unfortunately, applying economic rationalist theories to address the problems created by rising costs in healthcare without regard to human consequences may destabilize the society. As Wynne pointed out, lost will be the humanitarian ideals about equity, which have underpinned medical care from its historic roots (Wynne 2000).

Consequently, postmodern thinking challenged the embracing theories of the modern 20th century, such as economic rationalism, fascism, communism and capitalism. Instead of an all-encompassing view, the postmodernist emphasizes "the small narrative based on lived lives, the diverse, the complex and the unique" (J.J. Chan and J.E. Chan 2000: 332). It seeks to understand the limits of the theory.

The writer Hsu-Ming Teo also emphasized the individuality of lived experience and understanding. In speaking of the grandiose all encompassing theories of the modern era (i.e., economy, markets, society, quality and science), she stressed that there was "no real break with the 20th century. The tides of continuity wash over and litter the future with the debris of the past" (Hsu-Ming Teo 2000: 30). Unless the postmodernistic view is appreciated, "we will not understand the limits of theory and we will continue to squeeze all of life into simplistic and distorting frames of understanding" (http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/health/medical_services.html).

The Late 20th Century Healthcare Marketplace

At this time, only the US has had a dominant competitive corporate healthcare marketplace existing for a long time. Experience in the US shows that in a competitive corporate marketplace, church and charitable not-for-profit (NFP) groups are less able to compete and ultimately sell or else merge as "joint ventures" with for-profit (FP) publicly traded groups (Wynne 2000). This allows the for-profit group to maintain the illusion that they are primarily providing community and humanitarian services.

Because NFP religious and community groups had dominated the private system, the service they provide is considered as private care. In Australia and to a lesser extent in the US, corporate groups have entered what has now been reclassified as a "marketplace" under the umbrella of this charitable system and the values, which it espouses.

It is important to clearly understand the difference between the NFP and FP, respectively. There are fundamental differences in the way people in the two systems see their role and their motives, and the cognitive factors that confront them.

Not-For-Profit Groups Versus For-Profit Groups. NFP Groups are usually church and community groups founded to serve the needs of the community. They embrace the ethical traditions of the healthcare professions, the values of their religious orders and the Samaritan traditions of our society (Wynne 2000). Their primary commitment is to the welfare of the patient and the community. Few extraneous pressures have to be dissipated from care. When surplus is generated, they are plowed back into the community in areas that would not otherwise receive funding.

On the other hand, with few exceptions, the FP groups were founded in order to make profit out of healthcare. Profits are made by charging more and by keeping costs down (Wynne 2000). The major cost of the system is care and particularly the staff who provide this care. At the center of the profit system is a strong conflict between profit and care. They both compete for the available healthcare money. The more restricted the care, the greater the profit (Wynne 2000).

Payment Systems (Item-of-Service and Capped Payments). In the item-of-service (IOS) system, where the provider sets the fee, the problems in care are less acute. Fees are increased to cover service and profit. In NFP services, ethical systems have generally withstood the pressures to misuse patients for profit (Wynne 2000). The ethic to provide the best possible care for the patient pushes up costs in all systems. A strong emphasis on profits does generate overservicing and the misuse of the sick for profit. This has occurred particularly in those under most pressure to generate profits, i.e., the FP corporate systems. Corporate groups did not hesitate to exploit the most vulnerable sectors of society to increase profits and create vast empires (Wynne 2000).

On the other hand, capped payment systems are where patient care dilemmas occur principally. NFP systems, for instance, are able to respond by stretching the resources as far as they can and result in a form of concerned and humanitarian rationing. FP systems, in contrast, have to balance the interests of the patient against the profit interest of the provider.

Probity and Cost-Containment. Systems that cap fees do so in order to contain costs and reduce the money spent on care. A minimum amount is paid. The profits generated are consequently a question of conscience—the extent to which the care provider becomes profit- oriented and compromises care as a result (Wynne 2000). Much of this will depend on the pressures for

profit and on the type of care provider. To Wynne, the cultural and psychological aspect of the care provider is best encompassed by the word "probity"—the old worldly idea of being "fit and proper," someone who will behave responsibly in dealing with society.

An important question is the extent to which the market culture has generated patterns of encouragement to those providing care to circumvent the pressures of conscience. In studying the market healthcare transaction, it is important to examine the ways in which a strongly competitive marketplace has made it legitimate for excessive profit-taking at the expense of patient-care. It is also important to understand how the patients as customers are reacting (even rebelling) against this market-driven proposition in the context of the postmodern society.

The Customer in Capped Systems. Market proponents claim that the "customer" exerts market pressures to prevent the provider from taking out excess profit and striking a balance which protects the customer. This view is in line with Adam Smith's classical capitalist view of an "invisible hand" which brings ultimate equilibrium to the market; however, this balance will depend on the strength of the opposing forces. Patients now want empowerment, which is further reinforced by a megatrend in healthcare consumerism (Coile 1998). Hospitals, physicians and healthcare providers are now beginning to listen to the marketplace, and consumers are telling them they want choice, service and healthy outcomes. Yet, for the patient-consumers, when was the last time they had freedom of choice in, of all places, a hospital? Either they have no choice or they have no access; and if they have such, it is not a genuine choice at all, making them not only frustrated but also powerless.

Unfortunately, the healthcare customer may not be capable of actually exerting pressure on the market situation. The only way perhaps for the customer's role to manifest is indirectly via government; thus, the way in which governments have fulfilled their responsibilities in this situation must be also examined. Often, probity requirements are largely ignored and the oversight function of government fails to protect patients (Wynne 2000).

From the foregoing discussions, it can be appreciated that the evolution of healthcare from a traditional humanitarian enterprise into a more profit-oriented market commodity left patients alienated, isolated, disenchanted and disadvantaged. The postmodern aspirations may give them back their voices; but how the postmodern theories can be translated into structures and tools for a more patient-centered delivery of healthcare services is another matter.

Modern versus Postmodern Medicine Theories and Practice

According to Wallace Sampson, M.D. editor of the *Scientific Review of Alternative Medicine*, the postmodernist philosophy "includes the concepts that all views of the subject may be of equal value, reality is relative to the observer, and reality is molded by culture and social influences" (2000: http://www.cfs.purdue.edu/extension/efr/efr11-03.htm) The culture's (and so is the subject's) need may not be necessarily the same as those followed by current scientific or medical standards of the "Western" world. Postmodernists argue that modern medicine is unfeeling, dominated by Western thought and focused on the physiological aspects of health. The postmodernist approach advocates personal experience over objective experimentation as the real basis for the value of therapy (Evers 2001).

Nevertheless, science is still valuable in determining the efficacy and safety of treatment. Why is it then that despite the advances in medicine that brought alleviation of pain and suffering due to human diseases, patients continue to feel dissatisfied, alienated and isolated from the very system that is supposed to bring them relief? The void needs to be defined. Again, as Muir Gray said, "Postmodern health will not only have to retain, and improve, the achievements of the modern era, but also respond to the priorities of postmodern society, namely: concern about values as well as evidence; preoccupation with risk rather than benefits; the rise of the well informed patient" (Muir Gray 1999: 1550). Indeed, although patients would complain about waiting lines and waiting lists, professional attitudes, and poor communications, few would question the enterprise of medicine itself. Thus, while faith in the ability of science and technology to resolve all human and social problems is diminishing, postmodernity is definitely providing us with a golden opportunity to question the theories that underlie our approaches to (and beliefs in) the medical enterprise.

The Importance of Theories in Healthcare and How They Shaped the Ways Practitioners Collect and Interpret Evidence

Theories are at the heart of medical practice, planning and research. "The choice of a theory, although often unacknowledged, shapes the way practitioners and researchers collect and interpret evidence" (Alderson 1998: 1007). It is therefore important to recognize theories as they powerfully influence understanding of healthcare. There are three theoretical frameworks about facts and reality that are important in medical practice, namely, positivism, social construction, and postmodernism (Alderson 1998).

Positivism. In positivism, the detached scientist examines parts isolated from their context and searches for universal laws. In medicine, the emphasis on specific body parts, conditions and treatments assumes that these are

universally constant and replicable facts. It aims to discover general laws about relations between phenomena, particularly cause and effect. Experiments are designed to measure and explain associations and to test whether a law can be disproved.

Beaumont (2003) calls this the "Quantitative Research Approach," while Littlejohn (2002) refers to it as "Worldview I." Both assert the belief that there exists a real objective reality. Beaumont noted that this classic quantitative paradigm goes back to Plato (truth by reflective thought) and Aristotle (knowledge through observation and classification). This is the tradition embodied in randomized clinical trials (RCTs), which is the bedrock design of all medical research, which evidence about treatment is based on. Table 1 lists the five premises that embody Worldview I.

Table 1. Five Premises of Worldview I

Aspect	*Description*
Synchrony	Stability over time exists in contrast to change (diachrony), therefore it is valid to develop causal laws.
Objective Measure	It is possible to objectively measure an independent reality.
Independent Reality	There exists a single reality. The reality is objective and not value-laden. Our experiences are just reflections/interpretations of it. Because our perceptions are merely reflections of this reality, we should mistrust concepts such as "subjectivity," "consciousness" and creative reflection in helping to understand this reality.
Dualism	Objects (i.e., the world) and symbols (i.e., language) are separate. Language is just a tool for description and the world would exist without it.
Correspondence	Language deos correspond to reality (to a degree).

Source: Adapted from Littlejohn 1995: 13.

Alderson (1998), a social scientist writing in the *British Medical Journal*, aptly provided insights on this theory by selecting pain management as an example. Citing one randomized trial of babies (Anand *et al.* 1987), physiological tests showed "massive shock reaction" in babies not given analgesia. This evidence questioned the then standard treatment of withholding analgesia and the theories that babies cannot experience pain.

The positivist's concentration on the body and brain sees real pain as neurological reactions to visibly damaged tissue. This is "like Descartes' view of a mechanism of impulses traveling from the damaged site to the brain, as when 'pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end' " (Alderson 1998: 1007). Consequently, pain management had been refined through rigorous experiment and the cautious insistence on firm evidence.

However, it must be noted that pain is a paradox because it is an intense personal sensation providing no direct, reliable evidence for the observer. Therefore, positivism's strength in precise observation can be a limitation when pain is assessed. Concern about overestimating pain and over-prescribing analgesics deters clinicians from treating pain adequately (Royal College of Surgeons of England 1990). To understand pain better, it might be necessary for clinicians to think partly in non-positivist ways, i.e., to accept the patients' subjective views and see pain as more than physical, involving the mind as well as the body (Alderson 1998).

While it is true that positivist theories in social medicine may take some account of context, however they still tend to see the social in physical terms (e.g., how people's estimation and expression of pain differ by age, sex or race). Alderson (1998) aptly described this in her commentary, thus, "...children with behavioral difficulties are given Ritalin. Treatment tends to deal with the individual rather than the context; causes for behavior are sought within the child's body, rather than in family relationships, education policies, or town planning. Although they originate from personal accounts, medical records of reported pain and distress tend to be treated as firm facts and as grounds for treatment and research processes—rather like a solid road that supports traffic" (Alderson 1998: 1008).

Social Construction. A contrasting approach to positivism is to believe "that there is not a single view or truth, and that a range of views can be valid in different ways" (Alderson 1998: 1008). It is then possible to attend to different voices. "People construct evidence through their own experience, and observers inevitably join in this activity whether they try to take a surface or a submerged view" (Alderson 1998: 1008). There is therefore no neutral, or objective perspective. The experience and the observers' responses are deeply personal whatever the origins of the pain; thus, the complex meanings of pain and disease can be seen as questions or problems, rather than as given facts.

The alternative paradigm of Beaumont and Littlejohn rejects the assumptions listed in Table 1 and replaces them with the five axioms of qualitative research (Beaumont 2003):

1) Simple cause and effect is a simplistic illusion.

2) Knowledge is contextual and can only be described as a working framework.

3) The inquirer and the object of inquiry interact with each other so they are inseparable.

4) Reality consists of multiple constructed realities that can be understood to some extent, but cannot be predicted or controlled.

5) All inquiry is value-laden.

In trying to take nothing for granted and to see reality in a new light, phenomenology (one of the range of social construction theories) takes the view of a questioning outsider rather than an accustomed insider (Alderson 1998). The aim is to see how actors make sense of their experiences, and how they try to rationalize and cope with pain. Their reported intentions and motives are seen as more relevant to explanations than are external causes. Clinicians, for instance, would discuss with patients their views on possible causes and cures for their suffering. Concepts of individual pain threshold acknowledge pain as more than physical. The mind's organization of perceptions, and emotions of fear and hope, affects physical pain in ways that positivism's separation of body from mind cannot address.

Within social construction theories, researchers' and practitioners' relationships with patients, instead of being ignored or being controlled to reduce bias (as in the randomized clinical trial situation), are seen as areas worth researching in their own right. In clinical research, they would then strive to be as close to the conditions of an actual clinical experience in the doctors' clinics, rather than a contrived and artificially controlled clinical scenario that does not happen in reality. The words and the gestures during interactions are investigated for how they symbolize larger issues. For instance, the patients may also influence doctors through spoken and unspoken signals about their health, their understanding of their disease, and their social background. Guided by their interpretation of these signals from patients, doctors tend to adapt their behavior and language, which in turn alters the patients' responses in mutually changing and evolving perceptions and behaviors. In contrast, the positivist blind and double-blind trials acknowledge these interactions, and then try to cancel them out as unwanted variables, such as placebo effects.

Social construction theories consider how doctors construct and reconstruct their patients (as "informed and articulate" or as "difficult elderly woman"), whereas patients in the same way reconstruct their doctors (as

"caring," "arrogant" or "vague"), and also themselves (when they accept or resist becoming the kind of person the doctor supposes them to be). Research within the social construction framework takes account of the expectations and values, backgrounds, and roles of the main groups in the medical transaction. It likewise takes into account the organization of the clinic or the ward; the time, space, and funding allowed; and professional and political influences on how meanings of pain and anxiety are expressed, perceived, and reconstructed (Alderson et al. 1994).

Postmodernism. In postmodernism, boundaries are broken down. Three centuries of modern science are founded on sharp dichotomies: the binary system used in computers, life-death and mother-child. Yet life-death certainties are challenged by concepts of persistent vegetative state (or the "living dead" kept physiologically functioning by artificial life-support systems), and reproductive medicine creates new meanings of motherhood (e.g., surrogate pregnancies and test tube babies). It can be said, therefore, that doctors have been described as being among the first to create postmodern society in practice, but among the last to acknowledge it in theory (Hodgkin 1996). The greater use of postmodern thinking, excitingly however, could clarify current medical uncertainties (Alderson 1998). Postmodernists are skeptical about what truth is, what counts as knowledge, and who can determine the validity or worth of any enterprise. This attention to different voices, like those of the "deviant" patient with intractable pain, can help practitioners give more informed and emphatic care.

To Beaumont (2003), on the other hand, postmodernism combines the Quantitative and Qualitative views. Although they are based on opposing assumptions, to him there are still appropriate ways of combining the two but this needs to be done in a very careful manner, taking into account the underlying assumptions as fundamental aspects to consider and not something that can be ignored.

Disenchanment in Modern Healthcare: Individual Options versus Science as the only Option. It must be noted that postmodernism has roots in the "flower-power" and "personal development" subcultures that proliferated in the 1960s as reactions to the perceived failure of intellectual reasoning (in the shape of politics, science and technology) to provide authentic well being for individuals and communities. It then blossomed into the generalized, self-expressive and self-validating "me" culture in the late 20th century. Postmodern thinking then crept into health care services that are dominated by the authority of professional expertise (often contradictory), and into Science (socially insensitive) that are in progressive stages of deconstruction (loss of faith in their authoritativeness).

The loss of, or more often diminution of, faith in health professionals and medical science arises from two common sources (Meredith 2002):

(1) The most important is the failure of these authorities to provide an adequate solution to a health problem. Examples are the failure of veterinary authorities to halt the world's worst foot and mouth disease epidemic, or the spread of mad cow disease that threatens humans. These failures do not have to be some kind of error. It could be also that medical authorities do not yet have an "answer" to the problem being presented.

(2) Access of people to vast resources of information, which may lead them to question the authority or the validity of information and advice offered them. This also arises from the increased level of education, networking and personal development of many patients of today's generation.

Suspicion of science lies at the heart of postmodernism (Muir Gray 1999); for instance, fear of prions in meat and altered genes in plants are signals of reduced trust in science and, by association, in medicine and in healthcare (Medical Network 2003). Patients are shifting their gaze from benefits towards risk. Now, since children are no longer infected by polio, parents question the risk of their children contracting the disease due to the side effect of the polio immunization itself. People with hypertension dwell on the risk of stroke and the side effects of their tablets, rather than on the modest chance of health gain. The criticism on too much emphasis on technology extended to complaints about iatrogenic illnesses (e.g., adverse drug reactions, or complications from surgery). A more Marxist view is the belief that commercialization of healthcare (i.e., for profit) in capitalist society has caused an increase in doctor-caused diseases.

Postmodern Perspective in Healthcare: The "Art" of Medicine versus the "Science" of Medicine

Postmodernism moves on from doctor-centered decisions made on evidence, to decisions balanced by the preferences and beliefs of the patients informed by evidence, i.e., a more human and patient-centered opinion. Confident and educated patients can learn about their condition from electronic knowledge banks. It is this recognition of the multiple realities existing in the different world of patients, which clinicians often see as homogeneous, that will inform future clinical decisionmaking.

First of all, doctors have maintained power in the biomedical model. They have done this by exclusively sequestering all of the information and

knowledge about technical medicine. This means that the patient may have to give total control of their body to the doctor. The postmodernists explore this power ratio and then give some control back to the patients. As Foucault (1965) said, the choice of words and phrases could affect the way people think. Doctors who have the reputation and influence can then gain power over their patients' bodies. This use of language to affect thinking is the so-called discourse in postmodernism.

The postmodernist dislikes the present state of medical discourse because one theory (the doctor being the dominant one) has more prestige that it should be considered the only truth. They do not believe that science should have as much dominance over what people believe about their health, as there are other options. They believe in a *pastiche* (pick and mix) of healthcare so that patients can choose some parts from the biomedical view of health that work for them, and some from complementary medicine (Meredith 2000).

A major problem in the biomedical model is the way that it fails to explain the cultural differences in health. It cannot account for people in different cultures that use a different model to deal with their health and yet it appears to work for them. Postmodernists believe that members of society should be able to choose their own methods of health care, complementary medicine included. The care is more patient-centered, putting value on patient narratives, and on the building of a genuine doctor-patient relationship based on mutual trust and respect.

The postmodernist doctor is one who has evolved from the role of an "authoritative figure" via "client educator" to the role of "client facilitator" (also known as healer) offering the client timely experiences in self-awareness, self-discovery, self-education, self-empowerment and self-discipline (Meredith 2002).

Healing and scientific medicine overlap in some areas but also have some fundamental differences in approach (Meredith 2002). They can often be used together, either in complementary or contemporaneous alternative ways. Both systems can make significant contributions to healthcare and both are also open to abuse, error and inconsistency. Healthcare workers have the opportunity to be scientists and healers simultaneously, thus practicing both science and the art of medicine.

Complementary and Alternative Medicine: Postmodern Manifestation in Healthcare

Complementary and Alternative Medicine (CAM) is a multibillion-dollar industry globally (MacLennan et al. 1996; Eisenburg et al. 1998). In

Australia, for example, there is an increasing demand for CAM and General Practitioners (GPs) are right in the forefront of this demand (Pirotta 2000; Lewith 2000; Bensoussan 1999). In fact, one in five to six GPs in the State of Victoria is using CAM in their practice (Pirotta 2000; Royal Australian College of General Practitioners 1996). Furthermore, one in seven GPs in Australia uses acupuncture (Easthope et al. 1999).

Pragmatism, among consumers seeking cure and among the general GPs seeking more patients and better clinical results, is not a complete explanation of the burgeoning of CAM. Instead, this growth is substantially a result of pervasive and rapid social change, alternatively termed "globalization" and "postmodernization" (Eastwood 2000). Globalization and postmodernization are creating a new social reality, of which a prominent characteristic is the proliferation of consumer choice. Bensoussan (1999) noted that one does not have to adopt postmodern values to use CAM, but rather to live in an age in which people shop around for healthcare services. This could be true, but it has to be noted that increased consumer choice, and the ability to shop around, are themselves also postmodern values. The GPs and the family physicians are in the forefront of this postmodern practice. On one hand, they are reacting to a social change as "economic pragmatists," responding to consumers' increasing demand for CAM (Eastwood 2000). On the other hand, they themselves are acting as agents of social change by acknowledging the limitations of orthodox biomedical treatments and promoting CAM as part of their service delivery. In fact, a surprising number of GPs are openly critical of their biomedical training and their perceived role in general practice as "technocrats" rather than "healers" (Eastwood 2000).

Even the relatively limited scientific validation of CAM has not prevented their use of such therapies. The postmodern movement facilitated among GPs their search for new avenues of specialization and professional development.

Reasons for GPs' Use of CAM. There are three broad categories on why CAM is increasingly being incorporated into the clinical practices of GPs (Eastwood 2000):

(1) Last Resort – the use of or referral to practitioners of CAM to treat patients with chronic conditions unresponsive to orthodox therapies.

(2) Integrated Approach – a considered choice to regularly incorporate CAM, in addition to orthodox biomedical therapies.

(3) Ideological Conversion – the adoption of CAM as the main treatment practice. GPs who fall into this category also tend to use diagnostic techniques similar to that of alternative practice.

The last two seemed contradictory to the observation of Bensoussan (1999) that simple pragmatism among patients and doctors adequately accounts for the dramatic increase in the use of CAM. Data from the study of Eastwood (2000), in fact, indicate that GPs acknowledge that regardless of the deficit of scientific evidence for how or why, CAM does achieve clinical results. Many of the GPs recognize the limitations of biomedical and synthetic pharmaceutical treatments, often legitimizing their use of CAM (clinical legitimacy) by citing the history and tradition underlying these treatments (Eastwood 2000). This return to tradition, history and roots is a prominent aspect of postmodernization (Crook et al. 1992). It is therefore of considerable interest that the Australian Therapeutic Goods Administration has specified two major categories of acceptable evidence for complementary therapies: (1) scientific evidence, and (2) evidence based on traditional use of a substance or product (Complementary Medicines Evaluation Committee 2000).

On the other hand, the following factors were responsible for GPs' decisions to incorporate CAM into their treatment armamentarium (Eastwood 2000):

(1) Competition in the healthcare market;
(2) Personal dissatisfaction with general practice;
(3) Personal satisfaction gained through the clinical effectiveness of CAM;
(4) Resistance to becoming "technocrats" rather than "healers";
(5) Recognition of the limitations of orthodox biomedical treatments; and
(6) Concern, genuinely shared with patients, about overreliance on synthetic drugs and invasive surgery.

GPs note that in addition to being pragmatic, their patients want healthcare options. Some are indeed ideological in their increasing demand for "natural" therapies and are concomitantly mistrustful of pharmaceuticals and invasive surgery. Similarly, these GPs are often ideological in their own motivations. Many are genuinely disillusioned with their biomedical training and with the reality of their practice; thus seeking a more rewarding approach to primary care for themselves and their patients, through the incorporation of CAM into their biomedical practice.

Globalization and Postmodernism in Creating New Social Realities

The pastiche approach to healthcare, together with the postmodern way of thinking, is aided by the phenomenon of globalization (Eastwood 2000). This is a theory which states that the world gets smaller because of media. As a consequence, one can simply search on the Internet the different types of

healthcare from around the world (e.g., traditional Chinese medicine). This gives patients more options and means other than what is traditionally prescribed—orthodox biomedical medicine.

Social scientists incorporate globalization processes in postmodernism to designate fundamental changes occurring within Western societies, of which the inclusion of CAM into mainstream healthcare is a part (Eastwood 2000). Factors in the globalization processes include (1) increasing public access to information; (2) increasing sensitivity towards traditional cultural practices; and (3) increasing openness to traditional medicine, for example traditional Chinese medicine (Bensoussan 1999).

Another aspect of globalization is concern about the ecological crisis, which has contributed to a "return to nature" within Western societies. Postmodernization theorists point to this trend as a key determinant in the historical shift from modernity to postmodernity. The return to "natural" medicines is a part of this trend and of the globalization processes generally (Crook et al. 1992). The effects of globalization processes and postmodernism are contributing to a new relativistic, postmodernist worldview whereby both doctors and consumers see biomedicine as only one road to health and well-being (Eastwood 2000), among other equally acceptable array of options, CAM included.

Postmodernism in Philippine Medicine

Postmodern approaches in healthcare may have actually antedated formal modern medical practice in the Philippines. Even before the colonial period, there was already the widespread use of herbal medicine in the country, and the practice of traditional ways to manage diseases. When the Spaniards came, the traditional and indigenous methods of healing just effortlessly blended with the rituals of the Catholic religion. It even made room for the coming of the public health and Western health system introduced by the Americans in the Philippines, blending all into one happy co-existence. Nevertheless, the traditional and indigenous methods were eventually relegated into the inferior category, remaining strong and popular mainly among the poor and the uneducated. This was aided by the predominance of Western medicine in the country, the rise of organized mainstream medical professionals who eventually held power and influence, and the establishment of pharmaceutical business in the country based on Western models.

Foundations for Postmodern Healthcare Practices in the Philippines

Philippine culture in itself is already sensitive and responsive to postmodern inclinations as it pertains to health and diseases. Remnants of its

precolonial past are the beliefs in the spirit world that makes its presence felt by sometimes causing illnesses to humans, and the use of natural and herbal methods in the healing processes. Likewise, a dominant force in the Filipino psyche is faith in God invoked during times of life-threatening diseases, reinforced by the introduction of the Catholic religion. To be noted in all of these are the following: (1) the folkloric ways coexisted and were blended with Western biomedical approaches, and (2) the patient is almost always surrounded by family members who are actively involved in the patient's healing process.

Philippine Culture and Social Milieu. Before the coming of Magellan in 1521, Filipinos were animists by religion. Four hundred years of Christianity have not really eliminated this deep belief in the spirit world. Roman Catholicism's spirits, angels, saints and devils were simply added to the already existing paranormal elements—*aswang, tikbalang,* and *lamang-lupa*; thus, when biomedical medicine fails to cure a patient, the Filipino could quickly resort to the folkloric ways without necessarily losing faith altogether in Western medicine.

The noted clinical psychologist, Jaime Bulatao (1992: 310), in his article, talks about the study and teaching of psychology in the Philippines which suggested that it should expand beyond the concept of psychology only as a science. He said, "...psychology is a science, as rational as any science can be. This psychology corresponds to man treated as object. But besides being an object, man is also a subject, a person, and in this regard psychology's content differs from that of physics or other sciences. Hence, psychology to fulfill the subjective needs of man must be more than merely rational. Besides objective facts, it must teach empathy. Besides objective ways of knowing, it must teach processes of identification. Besides ratiocination, it must teach insight. Besides behavior, it must study mind. Besides objective truths, it must teach what Maslow calls B-values, values of being. Besides being intrapersonal and interpersonal, it must also be transpersonal" (Bulatao 1992: 310). These statements are in fact his recognition that Filipino values, in order to be understood well, when expressed in such conditions such as sickness and disease would need more than just the orthodox rational scientific approach. "Where meditation for instance could only be studied in its physiological and biochemical effects, it can be studied for the underlying myth that gives substance and meaning to the Filipino identity.... A study of the Filipino values, experientially absorbed and then expressed in local concepts, then becomes a valid and relevant approach to a study of the Filipino" (Bulatao 1992: 310).

Indeed, healing not only of the body, but also of the mind and the spirit pervades the Filipino's focus in times of health crisis. It is thus a fact, that when it comes to health and its maintenance, prayers play an important role.

Faith healing through prayers may be either for physical or non-physical maladies. Additionally, while a Filipino consults a medical doctor for an ailment, he or she (or upon the insistence of some members of his family) may also consult the *albularyo or* herb doctor, on the side and will find no contradiction in this approach. Indeed, the Filipino culture today, according to Bulatao is a "strange mixture: on top is a European and American layer of science, language and religion; underneath is a deep layer of human relations, a closeness to nature, and a deep belief in a surrounding world of spirits" (Bulatao 1992: 160).

Thus, in Philippine culture, two types of traditional folkloric healing prevail: (1) the albularyo dispensing herbal medicine, or the *hilot* directly rearranging bones and muscles, and (2) the faith healers (the *manggagamot* or faith healer, charismatic, *espirista* or spiritual healer) and the psychic healers. In the local culture, the relationship between the healer and the patient is one built on faith and trust. As Bulatao (1992: 138) stressed, Filipinos do not necessarily conceptualize sickness according to the categories of *Materia Medica*[2], but can manifest it as "possession of evil spirits," which could only be symbols of deep unease in a person lying beyond the reach and control of conscious reason but could also be a source of mental and physical torment to the person. In healing, communicating their inner experiences, their subjective world to be acknowledged and not to be separated from their objective reality, is important to Filipinos. Such a process requires discourse and investment in time to relate the patient to healer. Even in the practice of modern biomedical medicine, doctors who devote time (even in light talk) relate well with their patients. They are also well-liked to the extent that a patient would exclaim, thus, "I am alright already doctor just by seeing you!"

In that regard, holistic healing requires acceptance of the patient's belief system and in his reality. To Bulatao (1992: 141), "... the act of being healed must be a deep emotional experience in which the patient is deeply committed to removing the barrier to health, no matter in what conceptual framework it is perceived." Coming from a deeply animistic background, the worlds of objective reality and subjective reality tend to fuse for the Filipino (Bulatao 1992: 146).

The Health-Seeking Patterns of Filipinos. If one now looks at some objective insights provided by the Department of Health (DOH) Household Survey (DOH Health Sector Reform Agenda 1998), it will definitely give one some thoughts on the contemporary health-seeking behavior of Filipinos as a manifestation of their deeper social and cultural values; for instance, Table 2 gives the responses to health complaints by the different income groups by quartile. First of all, it shows that when it comes to health concerns, mainstream doctors are not the only sources of relief for Filipinos. While doctors are consulted the least by the poorest quartile (only ¼ of them), the

traditional healers are consulted 60 percent by the poor, and even by ten percent of the richest quartile. Self-care, which includes both biomedical pharmaceuticals and herbal preparations, is prevalent in all socioeconomic groups (50-64 percent). The poorest quartile is also much more inclined to consult non-physician health professionals (usually midwives). While much of this behavior can be due to economic reasons, a simple way of looking at it is to see it as the only reason; particularly when even ten percent of the rich consult traditional healers, and 50 percent of them self-medicate. While this dimension was no longer amplified in the study, it would have been interesting to examine the reasons why this particular option was taken. Because of this, it is safe to state that a significant number of the population indeed caters not only to orthodox biomedical medicine, but also to traditional and complementary healing practices because of practicality and effectiveness.

Table 2. Health-Seeking Patterns of Filipinos by Income Group

Response to Health Complaint	*Poorest Quartile*	*Quartile 2*	*Quartile 3*	*Richest Quartile*
Consulted Doctor	25%	36%	37%	48%
Consulted Other Health Professional	50%	30%	10%	10%
Consulted Traditional Healer	60%	20%	20%	10%
Self-Care	64%	59%	60%	50%
Total	100%	100%	100%	100%

Source: DOH-PIDS Household Survey (1993) from the Health Sector Reform Agenda Philippines 1999-2000.

From the World Bank (2001) study entitled, *Filipino Report Card on Pro-Poor Services*, which was based on the survey conducted by the Social Weather Station (SWS), the utilization of health facilities by the bottom 30 percent (and also by the middle 30 percent) and rural population is more skewed not only towards the local health stations and government hospitals but also to the traditional healers (Table 3). Again, a portion of the top 40 percent (16 percent of them) and 20 percent of the urban population also consults traditional healers.

Table 3. Utilization of Health Facilities by Location and Expenditure Class (Percentage Usage)

Area / Group	*Barangay Health Station*	*Health Center*	*Government Hospital*	*Private Clinic / Hospital*	*Non-Profit Clinic*	*Traditional Healer*
Urban	24	19	36	56	4	20
Rural	37	28	43	38	3	39
Bottom 30%	37	28	37	28	3	40
Middle 30%	34	27	48	42	4	31
Top 40%	21	16	34	68	4	16

Note: The row total adds up to significantly > 100% due to multiple uses of the facilities by many households.
Source: WB 2001.

Across regions, Visayas and Mindanao depend more on traditional healers than the other regions (See Table 4).

Table 4. Utilization of Health Facilities by Region (Percentage Usage by Facility)

Area / Group	*Barangay Health Station*	*Health Center*	*Government Hospital*	*Private Clinic / Hospital*	*Non-Profit Clinic*	*Traditional Healer*
RP	29	22	39	49	4	27
NCR	13	20	30	59	4	7
Balance Luzon	14	17	45	49	2	11
Visayas	43	19	42	46	4	42
Mindanao	51	34	32	46	5	51

Note: The row total adds up to significantly > 100% due to multiple uses of the facilities by many households.
Source: WB 2001.

Table 5 shows people's overall net satisfaction rating of the various health facilities. It is clear from this survey that all income groups were satisfied with the traditional healers, who in fact, sometimes even rated better than others.

Table 5. Overall Net Satisfaction Rating of Most Frequently Used Health Facility

Poverty Group	*Barangay Health Station*	*Health Center*	*Government Hospital*	*Private Clinic / Hospital*	*Non-Profit Clinic*	*Traditional Healer*
RP	1.14	1.22	1.19	1.55	1.57	1.55
Bottom 30%	1.24	1.16	1.17	1.69	1.60	1.52
Middle 30%	1.02	1.20	1.32	1.44	1.14	1.80
Top 40%	1.17	1.35	1.09	1.57	1.82	1.40

Note: Very Satisfied = 2; Somewhat Satisfied = 1; Undecided = 0; Somewhat Dissatisfied = -1; Very Dissatisfied = -2.
Source: WB 2001.

Table 6 gives the net satisfaction rating of different types of health facilities according to type of service received. Although it is expected that the traditional healers will be rated fairly low in terms of equipment and supplies according to the modern concept of a biomedical facility, it must be noted that the government facilities were rated badly as well due to the general disenchantment with the mainstream system. On the other hand, in terms of convenience of schedule, the attitude of the healthcare givers, and understanding of the patients' health issues, the traditional healers were rated either as good as (versus private clinics) or sometimes even better than the government hospitals. This gives us the impression that traditional healing practices are strong in this country, and that it could answer patients' needs that are not currently addressed. While it is true that the choice could be because of economic reasons, it could be more than this especially when the patients are satisfied with the services provided them. The areas where traditional healing showed a strong rating (e.g., understanding of the patients' health issues, attitudes of the caregivers) are dimensions that could be further pursued as they reveal the Filipino patients' longing for a more personal, holistic and, therefore, probably postmodernistic aspirations.

Health Governance and the Health Sector Reform Agenda. DOH is the government's principal health agency. It ensures access to basic health services for all Filipinos through the provision of quality healthcare, and the regulation of providers of health goods and services. Its current mandate calls for it to be both a stakeholder in the health sector, and a policy and regulatory body for health. As a major player in the health sector, the DOH acts as a technical resource, a catalyzer of health policies, and an advocate for health issues. Its departmental vision calls for it to be the leader of health in the Philippines, through its mission of guaranteeing equitable, sustained and quality health for all Filipinos, especially the poor, and to lead the quest for excellence in health.

Table 6. Overall Net Satisfaction Rating of Most Frequently Used Health Facility

Aspects of Service	*Barangay Health Station*	*Health Center*	*Government Hospital*	*Private Clinic/ Hospital*	*Non-Profit Clinic*	*Traditional Healer*
Treatment Received	1.06	1.09	1.16	1.46	1.22	1.53
Medical Facilities	0.20	0.39	0.93	1.37	1.41	0.67
Non-Medical Facilities	0.57	0.73	0.63	1.31	1.35	1.11
Waiting Time	0.63	0.50	0.62	1.14	1.09	1.49
Paperwork Requirements	0.83	0.78	0.92	1.23	1.00	0.33
Convenience of Schedule	0.90	0.98	1.03	1.33	1.26	1.27
Attitude of Health Personnel	1.05	1.10	0.99	1.48	1.5	1.50
Number of Health Personnel	0.90	0.90	0.98	1.38	1.26	0.96
Availability of Health Personnel	1.00	0.86	0.99	1.39	1.30	1.47
Competence of Health Personnel	1.02	0.96	1.07	1.5	1.43	1.05
Understanding of Your Health Issues	0.88	1.09	1.06	1.41	1.3	1.24
Availability of Medicines and Supplies	0.62	0.45	0.63	1.42	1.35	0.84
Quality of Medicines and Supplies	0.83	0.73	0.85	1.48	1.35	1.13
Cost of Medicines and Supplies	0.98	0.88	0.80	0.61	0.57	1.55
Cost of Treatment	1.21	1.20	1.17	0.77	0.48	1.59
Flexibility of Payment	1.11	1.09	1.10	0.91	0.74	1.36
Convenience of Location	1.41	1.46	0.85	1.08	1.04	1.60

Note: Very Satisfied = 2; Somewhat Satisfied = 1; Undecided = 0; Somewhat Dissatisfied = -1; Very Dissatisfied = -2.
Source: WB 2001.

In 1992, with the full implementation of Republic Act (RA) 7160 (the Local Government Code), the DOH had to change its role from implementation of healthcare services to that of governance. In 1999, Executive Order (EO) 102 redirected the functions and operations of the DOH, giving birth to the Health Sector Reform Agenda (HSRA), which was the Estrada administration's strategy for a pro-poor healthcare thrust. It transformed the DOH from sole provider of health services to provider of technical assistance. And because of devolution of basic services to local government units (LGUs), DOH was likewise transformed to a technical authority on health (http://www.doh.gov.ph/).

Also, in 1999 through EO 205, the Inter-Local Health Zones (ILHZs) were created (1) to promote, encourage and ensure the full integration of delivery and development of healthcare services throughout the country, and (2) to provide for the participation, involvement and collaboration of all LGUs with major stakeholders (DOH and DILG). This now provided the direct framework for DOH assistance to LGUs, people's organizations and other members of civil society. This is consistent with its governance mandate in health.

The concept of health governance within the DOH Health Sector Reform Agenda carries with it some indications and personality of a postmodernistic approach. While the structure of the public health system is still basically biomedical in its configuration, health governance is infusing it with a different character. It now implies that the other sectors of society (other than the medical professional groups and the mainstream medical establishment) are equally important in decisionmaking in healthcare. This somehow distributed the power which once was solely held by the biomedical establishment. Knowledge, as well as the delivery of services, could now flow in both directions, e.g., top-down and bottom-up. The structure that could later develop at the grassroots or local level could be one which is infused with dynamic discourse. The public energy field and the intentions are clear. With constitutional and statutory mandates, people are now given back their voices, empowering them to contribute in the decisionmaking and planning in areas like healthcare that once was not their domain.

When HRSA was planned in 1999, the DOH aimed to achieve nationwide implementation of the health reform program by 2004. This required a massive public investment of around 111 billion pesos. Lack of funds and the political turmoil that ensued with former President Estrada's removal from office delayed effective and sustained implementation; thus, DOH decided that instead of aiming for nationwide implementation of HSRA by 2004, it would just be providing the momentum for reform that will be difficult to reverse. This then gave birth to the Convergence Strategy.

The DOH Convergence Strategy. The Convergence Strategy calls for gradual implementation of the reform package in selected implementation or convergence sites. These sites (provincial or city) are called convergence sites (also synonymous with the ILHZs), not only because all major health reform components are being implemented in an integrated fashion, but also because all the major stakeholders such as DOH, Philhealth, the local government, civil society groups, and the beneficiaries themselves come together and pool their efforts and resources to make health reforms succeed. The Convergence Strategy aims to generate sufficient improvements in health delivery and financing in the local sites that are easily discernible by the residents. A strong support base of satisfied residents and their political representatives would make HSRA implementation irreversible. DOH targeted the implementation of the health reform package in 64 convergence sites by 2004 (HSRTAP 2003).

The Health Sector Reform Technical Assistance Project (HSRTAP) will assist in 16 of the 64 sites. This was later reduced to eight sites after recognizing the enormity of the effort and the resources needed to launch a convergence site. The HSRTAP developed the methodology, processes, procedures and tools for implementing the convergence strategy, which are being applied in the eight LGU sites (also called the ILHZs). These methodology and tools are constantly refined as experiential knowledge accumulates, and are shared with the central and regional DOH offices, which are responsible for attaining targets of establishing 64 sites by 2004.

Public Policy and Mandate. In 1991, the passage of RA 7160 devolved the responsibility of managing health services to the LGUs. Under the new setup, the LGUs took over the management of local hospitals while DOH provided the technical support. Despite the imperfections in implementation, the intention was clear, i.e., empowering communities to make decisions for themselves in healthcare. This is an indication of a postmodernistic view. Section 102 of the Code even mandates the creation of Local Health Boards in every province, city or municipality with membership that includes representatives from the private sector or nongovernment organizations (NGOs) involved in health services (Rodriguez 1999). Although much of the functions of this Board are on allocation of resources, it is not necessarily limited to that. Nevertheless, controlling resource allocation is an effective strategy where the citizens themselves can influence the character of their healthcare systems.

RA 7160 is the statutory vehicle in implementing the constitutional mandate. Article 13, Sections 11 and 12 of the 1987 Philippine Constitution call for the State to adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and other social services available to all people at affordable cost. It must be

noted likewise that the 1987 Constitution is a product of the 1986 People Power Revolution, thus is strong in people empowerment and civil society participation in many aspects of national life and development. This national aspiration as enshrined in our Constitution is very much postmodernistic in my view.

Healthcare Programs: The DOH Inter-Local Health System. The system is a district health system wherein the local government units, together with the NGOs, communities, and the private sector in a well-defined geographical area come into partnership through a memorandum of agreement to develop commitments to a shared vision and goals in providing accessible, equitable and quality health services. The ILHZ is usually composed of but not limited to one core referral hospital, catchment rural health units, and barangay health stations (Pinero and Dorotan 2002).

The World Health Organization (1986) defines the District Health System (DHS) as more or less a self-contained segment of a national health system, which comprises a well-defined administrative and geographic area either rural or urban, and all institutions and sectors whose activities contribute to improve health. DHS has been applied to many developed and developing countries where responsibility for health services has been devolved to local health authorities.

The purpose of the ILHZs is to integrate the hospital and the public health services for a more efficient and holistic delivery of health services. It draws upon the communitarian orientation of the stakeholders, complementing each other in the delivery of health services, such as the provincial and municipal LGUs, the DOH, Philhealth, NGOs, private sector and the community in general. It lends itself to a decentralized scheme in which decisionmaking power about the health of the community and the individual members is not concentrated in the DOH but is shared among the many sectors of society. It can then lend itself to a multisectoral and pluralistic point of view, with many discourses within the framework of a democratic model.

The experiences in eight pilot sites show that ILHZ objectives have not yet been fully attained. Nevertheless, considering the time of active implementation of about two to three years now, the gains in ILHZ development are already quite impressive (Pinero and Dorotan 2002). The pace of ILHZ development heavily depended on the response of the concerned LGUs, which in general were dynamic and community-driven. If the community is enthusiastic about the presence of the ILHZ concept in their healthcare, then it must be stimulating some responsive chords in their inner aspirations.

Taking Advantage of Postmodern Healthcare Trends: Implications for Philippine Public Health Administrative System

The devolution of healthcare management to the local communities is an opportunity to invent a new design for the healthcare system. In fact, healthcare enjoys a special privilege in this regard because health is a common denominator in any society. Health and well-being are solid foundations for the creation of constructive human enterprise. Human habitats can be redesigned according to the framework of healthier communities.

Empowered local communities, as envisioned by our Constitution and the statutory laws that followed (i.e., the Local Government Code), are beginning to assume responsibility for their health, welfare, education and economic well-being. Reform from the top-down must be accompanied by the more powerful bottom-up approach. The communities must assert their voices and demand participation, while the political leaders must be ready to share this power in a constitutive manner, rather than a distributive one.

It is only when the ILHZ Board or the LGU Local Health Board owns the disease in its community that it can begin the task of transformation. One can transform only what one owns. An empowered community that feels accountable and responsible for its own disease, criminality, and ignorance will be likewise self-empowered to transform these society's maladies into something positive like health, solidarity, moral citizenship, economic progress, peace and order, etc. Problems must be solved right at the level where they are generated, and that is at the local level.

Community Solidarity and Integration: The Neural Network as a Model for Human Connectivity

The natural human biological system can be a framework for redesigning the healthcare system. The key elements would be connectivity and integration. What would happen if a human community is structured the way the human body would be structured? The workings of the human organism entail coordination; for instance, the human brain can be "alive" and can have consciousness when it succeeds in connecting the different cells of the body through the neural circuitry. One can then begin to imagine if building a community based on the model of the neural network will succeed. There will be community-based hospitals that are connected to families and to all human organizations in order to create self-directed, self-conscious and healthy communities. One is only conscious of one's own humanness if one's brain cells and the other cells of one's body are connected.

In nature, forms of life are organized from the bottom up. Groups of cells are organized into tissues, and tissues into organs. Groups of organs communicate with one another to perform one important systemic function (e.g., digestion, absorption and assimilation of food). Systems (e.g., muscular, skeletal) make one organic whole in the same manner that health organizations can communicate with one another and can decide to do something. Some groups with specific strengths to offer would then join other groups. The weakness of one group will find strength in another, until one strong integrated network is born. There will be diversity, but in diversity springs forth unity like the different cells in the human body. It is paramount in this model that communities must learn to network with one another, to not only harmonize their needs and aspirations, but also synergize their resources by sharing capital and information.

The perception on the present setup of the government's ILHZs is that of an integrated network of different groups coming together to create something. While it is believed that this is a move in the right direction, the concern at the moment is the lack of "self-consciousness" in the community enterprise. While this effort is shedding energy fields, it is still fragmented, unable therefore to use that energy to explode into one fine shining moment that would make the community discover it as wondrously and consciously alive. This is probably akin to one defining moment in the history of life itself, when the organic chemical prototypes suddenly convulses into that explosive moment that gives birth to life itself. But who or what would be the catalyst for that crucial "convulsion" to happen?

Physicians in the Postmodern World:
Redefining the Ultimate Role

Physicians have long held the scepter of power that controls much of the healthcare system for centuries. They must now be ready to adapt to a changing reality. There is now a new opportunity for them to redefine the concepts and values of their profession. Sure, the technical expertise will still be there, but it will be only one of the other roles the physicians must necessarily play.

For a long time in Philippine society, the concept of a successful physician is one who builds a solid reputation for being a good clinician or a practitioner of the discipline. Others would specialize in the theories and find success in the academic environment as a teacher, while equally successful are those who are good in the field of discovery and research. In whatever field of medical specialization, one will find the physician—successful clinical practitioner, the venerable medical professor, or the intense scientist. The community still needs them for sure. But one may wonder why, despite their

proliferation, large sectors of the society still feel unhealthy and disenchanted with the present healthcare system.

When the delivery of healthcare needs to be organized in a systematic fashion, a medical bureaucracy has to be developed to cater to the needs of healthcare organizations and systems. In this setting, a different type of physician called the physician-executive types emerged. They can be seen at the helm as administrators running hospitals, corporate health organizations, group practice, pharmaceutical firms and public institutions. They are managers who ensure that clinical and research work of health professionals is done in a cost-effective manner. They are also very much comfortable in the capitalist market setting, although many are in these roles even in non-democratic systems.

The next wave of physicians will be more attuned to the needs of the postmodern aspirations. They will be community organizers and builders. They will not only be masters of knowledge but also of communication. They will be facilitators. In this role, they will be logical architects of and for healthier communities. They will be in the forefront building not only healthy individuals, families, neighborhoods, villages, and healthy cities, which are all the building blocks of a healthy nation. From treating sick patients, they will also be treating sick human organizations, human networks, and human communities.

Self-Consciousness in Value Formation

The insights of postmodernism will allow one to consider that social reality is a human invention. From this social consciousness will arise renewal of values. Empowering communities will be in itself the new politics. New economics comes through sharing of abundance. Then, it will be possible to invent it the desired way. With this new consciousness come new intentional people, families, neighborhoods, organizations, and an intentional nation. It is actually a creation of a new consciousness of developing intentional convergent communities. The DOH, in this regard, wants to start a momentum to initiate intentional communities that have their own consciousness which will later catch "fire" and would be irreversible—developing into one national consciousness of connected people. What it seeks is a sort of "community plunge" so that "attention shifting" will occur. More than beholding would be needed, there will be change.

Forecast

Diseases in all their forms (e.g., physical, emotional, social, political) can be designed out of the population by inviting the conversation in all

communities, and invoking the possibility. As our healthcare system is decentralizing, so is the redesigning of the habitat. Health is an outcome behavior. It happens when everything else is working in the community. In this redesign of the communitarian healthcare, here are the following possibilities:

"Hospitals" Without Walls. It is not hard to imagine that in the future, healthcare will be available not only in hospitals' and clinics but also in workplaces, churches, schools, parks, in fact, anywhere. Thus, a hospital can be imagined not as a place but a geographic area. The services can, in fact, be brought to where the people are rather than the other way around. The architecture of the places for healing will be redesigned to capture this virtual dimension. The bureaucracy will be changed as well to adapt to this phenomenon.

Centers of Wellness. The virtual clinics will become centers of health rather than of diseases. People will consult about health rather than about diseases. The customers are healthy people rather than sick patients. People who are not actually sick will consult the doctors. This is because intervention will move upstream. This is a departure from the usual situation when damage is already irreversible. Signs of this phenomenon are already around us. Healthy people taking Vitamin E to prevent tissue degeneration and taking anti-cholesterol agents even when blood cholesterol level is still normal. To do this, administration of public health will shift more towards promotion of longevity—promoting life itself. One can even call it "prolongevity."

The Need for Electronic Integration. The virtual clinic, as a result of not only decentralization but also deinstitutionalization to some extent, will not be possible without electronic integration. Information networks and the running of these under a redesigned bureaucracy will be unprecedented, requiring an integrated way of keeping universal medical records.

Volunteered Citizenship. The financial requirement to run this type of scenario will be mind-boggling. It might be necessary to think of the framework as building blocks that shall be built in incremental steps. This article would like to propose the mobilization of thousands of volunteers for this purpose. The capacity of youth and retired sectors is not yet studied. Not only does the author think about retired doctors, dentists, pharmacists and even nurses, but also retired teachers, professors, engineers and other professionals. Existing and dormant talents will be identified, pooled, and retooled if necessary. Senior citizens will find a new lifework plan that will be designed to generate vigor and vitality.

Integrated Health Approaches. People will seek an integrated way of healing. This should be welcomed as one of the answers to alleviate the

pressures of costs, by including alternative and complementary medicine alongside orthodox medicine. Noting the high prevalence of self-medication among the population, the person will be made primarily accountable for his own self-care. This will likewise require a new way of approaching healthcare administration and bureaucracy. The cadre of midwives can be strengthened to be transformed into case managers assigned to families and sectors of the population. Wellness centers (or health design centers) and self-care will play a prominent role in this scenario.

This new system will be population-driven rather than patient-driven. Health will be viewed holistically as a habitat problem that cannot be divorced from the socioeconomic problems for example. Physicians and all healthcare professionals and bureaucrats need to have additional training in population medicine, community development, management of wellness centers, self-care, complementary medicine, and electronic and information/ communication technology, and in demand reduction.

Conclusion

Postmodernity is providing us an opportunity to redesign the present healthcare concepts and paradigm. This is not to say that it will completely negate and replace the advantages that are still present in orthodox modern medicine. Rather, this is but the recognition that it is no longer adequate to answer the new shifts in meaning of how it is to be really healthy in its all-encompassing view. Physicians are still in a unique position to be architects of this new design. However, for them to be such would require retooling, which includes training in leadership and community development.

The Philippines has an enduring culture and belief system that is not alien to the holistic postmodern concept of healing. At the same time, present trends in health governance call for a communitarian and self-empowered approach that is already enshrined in the constitutional aspirations of the people. These are the primordial signs that will continue to grow to a level that all intentions and energies will converge into one cataclysmic focus. When the time comes, it will not only be irreversible, but also explosive. The forecasts just proposed are the early "writings on the wall."

Endnotes

[1] From paper read at the First National Congress for Health Research, 20 November 1981, Philippine Plaza Hotel Manila.

[2] Also called pharmacognosy, the science dealing with the sources, physical characteristics, uses and doses of drugs.

References

Alderson, Priscilla
1998 The Importance of Theories in Health Care. *British Medical Journal,* 317: 1007-1010.

Alderson, P., M. Madden, A. Oakley, R. Wilkins
1994 *Women's Views of Breast Cancer Treatment and Research.* Institute of Education, London.

Anand, K., W. Sippel, A. Aynsley-Green
1987 A Randomized Trial of Fentalyn Anesthesia. *Lancet,* I: 243-248

Arbuckle, G.A.
2001 Ministry and Postmodernism. *Health Progress* 82 (2): 14 Available at http://www.findarticles.com/p/articles/mi_qa3859/is_200103/ai_n8944193/pg_2 [Accessed 8 December 2003].

1990 *Healthcare Ministry: Refounding the Mission in Tumultuous Times.* Collegeville, MN: Liturgical Press.

Beauchamp, T.L.
2002 Biomedical Ethics. *Future – The Aventis Magazine.* January

Beaumont, R.
2003 *Quantitative/Qualitative Research Fundamental Propositions* [Internet] Applied Theories of Human Communications. Available at http://www.robin2.free-online.co.uk/virtualclassroom/chap5/s5/comm_theories/qual_quan1.pdf [Accessed 08 December 2003].

Bensoussan, A.
1999 Complementary Medicine – Where Lies its Appeal? *The Medical Journal of Australia,* 170: 247-248.

British Department of Health
1999 *Modern Standards and Service Models: Mental Health.* Stationery Office, London.

Bulatao, J.C.
1992 *Phenomena and Their Interpretations, Landmark Essays 1957-1989.* Quezon City, Philippines: Ateneo de Manila University Press.

Chan, J.J. and J.E. Chan
2000 Medicine for the Millennium: The Challenge of Postmodernism. *Medical Journal of Australia* 172: 332-334, April 03. Available at http://www.mja.com.au/public/issues/172_07_030400/chan/chan.html [Accessed 8 December 2003].

Coile, R.C., Jr.
1998 *Millennium Management: Better, Faster, Cheaper Strategies for Managing 21st Century Healthcare Organizations.* Chicago: Health Administration Press.

Complementary Medicines Evaluation Committee
2000 *Guide to Levels and Kinds of Evidence to Support Claims* [Internet]. Canberra, Commonwealth Department of Health and Aged Care. Available at

http://www.health.gov.au/tga/docs/pdf/tgaccevi.pdf [Accessed on 08 December 2003].

Crook, S., J. Pakulski, M. Waters
1992 *Postmodernization: Changes in Advanced Society.* London: Sage Publications.

Department of Health (DOH)
1998 *Health Sector Reform Agenda Philippines 1999-2004.* Manila: Department of Health.

Easthope, G., J. Beilby, G. Gill, B. Tranter
1999 Acupuncture in Australian General Practice: Practitioner Characteristics. *The Medical Journal of Australia,* 169: 197-200

Eastwood, H.L.
2000 Complementary Therapies: The Appeal to General Practitioners. *The Medical Journal of Australia,* 173: 95-98.

Eisenburg, D.M., R.B. Davis, S.L. Ettner et al.
1998 Trends in Alternative Medicine Use in the United States, 1990-1997. *Journal of the American Medical Association,* 280(18) (November): 1569-1575.

Evers, W.D.
2001 *Postmodernism and Medicine* [Internet] eFood RAP, Volume 11, Number 3, 02 February. Available at http://www.cfs.purdue.edu/extension/efr/efr11-03.htm [Accessed 08 December 2003]

Fisher, P., Ward, A.
1994 Complementary Medicine in Europe. *British Medical Journal,* 309(6947) (July): 107-11.

Foucault, M
1965 *Madness and Civilization: The History of Insanity in the Age of Reason.* New York: Random House.

Hodgkin, Paul
1996 Medicine, Postmodernism, and the End of Certainty. *British Medical Journal,* 313(7072) (December): 1568-1569.

HSRATP
2003 The Philippines Health Sector Reform [Internet] *Management Sciences for Health* TechnicalReports. Available at http://www.The%20Philippines%20Health%20Sector%20Reform%20Agenda.htm [Accessed 8 December 2003].

Hsu-Ming Teo
2000 Those Who Can, Do. *The Australian.* 1 January: 30.

Illich, I.
1990 *Limits to Medicine: Medical Nemesis – The Expropriation of Health.* London: Penguin.

Lewith, G.
2000 Complementary and Alternative Medicine: An Educational, Attitudinal and Research Challenge. *Medical Journal of Australia,* 172: 102-103.

Littlejohn, S.W.
1996 *Theories of Human Communication* (5th edition). London: Wadsworth Publishing Company.

Lyotard, Jean-Francois
1994 The Postmodern Condition. In S. Seidman, ed. *The Postmodern Turn: New Perspectives on Social Theory*. Cambridge, England: Cambridge University Press.

Maclennan, A.H., D.H. Wilson, A.W. Taylor
1996 Prevalence and Cost of Alternative Medicine in Australia. *Lancet,* 347: 569-573.

Medical Network
2003 Medical Governance in Primary Care. [Internet] Available at http://www.themedicalnetwork.org/articles/april_articles_governance.htm [Accessed 08 December 2003].

Meredith, M.
2002 *Healing Compared to Evidence-Based Medicine* [Internet] Path of Health, Sunflower Health. Available at http://www.lovehealth.org/info/healing1.htm [Accessed 08 December 2003].

Mitroff I. and E. Denton
1999 *A Spiritual Audit of Corporate America*. San Francisco: Jossey-Bass.

Muir Gray, J.A.
1999 Postmodern Medicine. *Lancet* 354: 1550-1553.

Pinero, A.A., E. Dorotan
2002 *Local Health Systems: Inter-Local Health Zones, A New Approach to Reform*. Department of Health, Manila.

Pirotta, M.V., M.M. Cohen, V. Kotsirilos, S.J. Farish
2000 Complementary Therapies: Have They Become Accepted in General Practice? *Medical Journal of Australia* 172: 105-109.

Rodriguez, R.
1999 *The Local Government Code of 1991 Annotated,* 4th edition. Manila: Rex Bookstore.

Royal Australian College of General Practitioners, Services Division
1996 *Directory of RACGP Members and Their Interests*. Surry Hills: New Litho Pty Ltd.

Royal College of Surgeons of England, College of Anesthetists
1990 *Report of the Working Party on Pain After Surgery*. RCS, London

Sampson, W.
2000 Postmodernism and Medicine [Internet] *The Scientific Review of Alternative Medicine*, 40(1) (Spring/Summer): 18-55. Available at http://www.cfs.purdue.edu/extension/efr/efr11-03.htm [Accessed 08 December 2003]

Wheatley, M.
1992 *Leadership and the New Science: Learning About Organizations from an Orderly Universe*. San Francisco: Berret-Koehler.

Winckler, M.
2002 The Good Doctor. *Future – The Aventis Magazine*. January.

World Bank (WB)
2001 *Filipino Report Card on Pro-Poor Services*. Washington D.C.: World Bank.

Wynne, M.
2000 *Different Medical Systems* [Internet] Medical Services. Available at http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/health/medical_services.html [Accessed 08 December 2003].