

DR. IDOL L. BONDOC, PETITIONER, VS. MARILOU R. MANTALA, RESPONDENT.

G.R. No. 203080. November 12, 2014

Ponente: VILLARAMA, JR., J.

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VILLARAMA, JR., J.:

Before us is a petition for review on certiorari assailing the Decision[1] dated May 24, 2012 and Resolution[2] dated August 14, 2012 of the Court of Appeals (CA) in CA-G.R. SP No. 120563. The CA affirmed the Decision[3] dated August 12, 2010 and Order[4] dated February 28, 2011 of the Office of the Deputy Ombudsman for Luzon in OMB-L-A-09-0681-K.

The Facts

On November 6, 2009, Marilou R. Mantala (respondent) filed a complaint for grave misconduct against Dr. Idol L. Bondoc (petitioner), Medical Officer III at the Oriental Mindoro Provincial Hospital (OMPH).

Respondent was admitted at the OMPH on April 3, 2009, at around 11:00 in the morning, with referral[5] from the Bansud Municipal Health Office (BMHO). She was due to deliver her fifth child and was advised by the BMHO for a cesarean section because her baby was big and there was excessive amniotic fluid in her womb. She started to labor at 7:00 in the morning and was initially brought to the Bongabon Health Center. However, said health center also told her to proceed directly to the hospital.

In her complaint-affidavit,[6] respondent alleged that inside the delivery room of OMPH, she was attended to by petitioner who instructed the midwife and two younger assistants to press down on respondent's abdomen and even demonstrated to them how to insert their fingers into her vagina. Thereafter, petitioner went out of the delivery room and later, his assistants also left. As she labored in pain, she felt the movement of her baby inside her womb and the intermittent stiffening of her abdomen.

At about 4:00 in the afternoon, petitioner returned to the delivery room and asked her, "Hindi ka pa nanganganak?" Since she could no longer bear the pain, she requested petitioner to perform a cesarean section but this was not done. The midwife arrived and berated her for not yet sleeping and holding on to the steel bar. The midwife and the younger assistants again pressed down on her abdomen causing excruciating pain on her ribs and made her very weak. They repeatedly did this pressing until the baby and placenta came out. When she regained consciousness, she was already at the recovery room. She learned that an operation was performed on her by petitioner to remove her ruptured uterus but what depressed her most was her stillborn baby and the loss of her reproductive capacity. The next day, she was transferred to a ward. She noticed her very swollen vulva and her surgical wound open with liquid squirting from it. Her wound was regularly cleaned by a nurse. On April 9, 2009, she was discharged notwithstanding that the suture on her wound needs to be fixed and she still has a cough. At home, she took the antibiotics, cough medicine and multivitamins prescribed by petitioner.

After two days, the opening in her wound widened. Her husband brought her to the Bongabon Community

Hospital but they were advised to have her wound re-stitched by the same surgeon (petitioner) who operated on her. Thus, on April 14, 2009, they went back to OMPH. She was attended to by a certain Dr. Gonzales who cleaned her wound which now has a lot of pus, and the said doctor commented that "problema ito ni Bondoc." On April 18, 2009, after she was given blood transfusion, petitioner re-stitched her wound. Thereafter, it was Dr. Gonzales who regularly checked on her condition.

On April 27, 2009, petitioner removed the sutures but still left open three of them. She wondered then why petitioner suddenly showed kindness towards her. In the evening of April 28, 2009, petitioner talked to her and said in a threatening tone "Ikaw ang sadyang ayaw magpa-cs" and also told her that he just came from Pinamalayan and Bansud and already talked to Dr. Atienza and Dr. Sales. Petitioner then told the nurse on duty, "Papirmahin mo si Mantala, pauuwiin ko na 'yan bukas. Tanggalin mo na rin ang tahi." He further said, "huwag sana akong idemanda ni Mantala kasi kaya ko siyang baligtarin" The following day, she was discharged after the nurse had removed the remaining sutures. At home, it was her sister who cleaned the still open wound.

Joel F. Mantala, respondent's husband, and her sisters Mylen R. Amistad and Lucia Rala, executed their respective affidavits[7] to corroborate her story. In addition, respondent submitted the affidavit of Dr. Rosinico F. Fabon, the anesthesiologist on duty during the operation performed by petitioner on April 3, 2009.

Joel Mantala claimed that at the OMPH at around 2:30 in the afternoon when her wife was still laboring, petitioner talked to him and told her that the baby is too big and if it comes out alive it will probably be abnormal so that it would be better if the baby is stillborn. He further averred that despite the pleas of her wife for a cesarean operation, petitioner insisted on a normal delivery during which she almost died.[8]

On the other hand, Dr. Fabon narrated that in the afternoon of April 3, 2009, he was attending to a patient being operated on by petitioner when he heard the latter saying that "meron pa nga kami sa DR macrosomia, polyhydramnios pa, pero paanakin na lang 'yon, abnormal din naman ang bata kahit mabuhay, kawawa lang siya" After the operation, petitioner went out of the Operating Room (OR) and proceeded towards the direction of the OB ward. At 5:35 in the afternoon, a Request for Surgery[9] was forwarded to the OR for Emergency Pelvic Laparotomy of respondent with a diagnosis of T/C Ruptured Uterus.

When respondent was brought to the OR at 8:15 p.m., Dr. Fabon found her conscious but very weak and pale, with abdominal pain and tenderness on very slight palpation. He then heard from petitioner himself that it was the same patient he was referring to earlier with a diagnosis of macrosomia, polyhydramnios. Petitioner volunteered that respondent had just delivered her baby but that her uterus probably ruptured in the process of childbirth. "Pinilit no 'ng tatlong ungas, ayon lumusot pero patay ang bata, tapos Ho, mukhang pumutok" petitioner said.

Dr. Fabon immediately prepared respondent for General Anesthesia; respondent was inducted at 8:35 p.m. while surgery began at 8:45 p.m. He continued to narrate what transpired next and his observations, as follows:

That right after induction - when patient was asleep already and don't feel any pain at all - her blood pressure suddenly dropped to 70/40 mmHg;

That after opening the abdomen, I saw massive hemoperitonium and the ruptured uterus with bleeding from various directions. I immediately requested for additional blood to be used intra-operatively while at the same time I established another intravenous line so as to cope with on-going surgical blood loss. I had now three big-bore fast-dripping IV lines.

That in spite of this measure, blood pressure dropped to 50/30 mmHg. There was an instance wherein I cannot even appreciate the blood pressure of the patient, her pulse hardly noticeable on palpation and she was very pale that necessitates turning the anesthetic gas off so as to keep her alive. She was given a dose of Atropine after patient did not respond to two 10mg doses of Ephedrine. I prescribed Dobutamine and Dopamine drips to

help improve her blood pressure and maintain adequate urine output. Unfortunately, only Dopamine was available. I had to use 100% Oxygen at 3L/minute without mixture of volatile gas for several minutes. She was maintained using muscle relaxants alone on controlled ventilation.

That Dr. Bondoc operated on the patient all by himself without the help of a consultant or an assistant surgeon. Nowhere in the patient chart will show that he referred this case to his consultant; one thing that I was wondering why he was doing the surgery alone. He utilized the scrub nurse to assist him making a delicate and bloody surgery more bloody and difficult.

That after Dr. Bondoc had removed the ruptured uterus and the bleeding was controlled, he made intra-operative referral to Dr. Ariel Tria, a resident surgeon, to check on the urinary bladder and the ureters.

That the operation performed was Subtotal Hysterectomy with Unilateral Salpingoophorectomy. I noticed that the operation technique was different from that which Dr. Bondoc had written in the Surgical Memo and that the patient did not tolerate the procedure well.

That the patient was very pale after the procedure with low blood pressure due to massive blood loss. That her blood pressure started to improve at the Recovery Room but the pulse rate remained considerably high for several hours. Her urine output was inadequate and that it had to be maintained using Dopamine.

That when Leo Reyes, the Recovery Room nurse, referred the patient to me and I checked the urinary catheter, I noticed her vagina to be massively swollen with hematomas all over.

That the patient had to be referred to Internal Medicine for co-management[.]

That Marilou Mantala stayed in the Recovery Room for almost eleven (11) hours. She was transferred to Gyne Ward at 9:20 AM the following day.[10]

In his counter-affidavit,[11] petitioner averred that when respondent was brought to OMPH with referral form from BMHO, she had been in labor for more than twelve (12) hours at home. He submitted his admitting diagnosis of the patient, "Gravida 5 Parity 4 (4004) Pregnancy Uterine 38 to 39 Weeks Age of Gestation by Last Menstrual Period Cephalic in Labor; Macrosomia; Fetal Death in Utero."

Petitioner alleged that during his interview with respondent, the latter admitted to him that she doesn't want to be confined at any hospital because she was afraid to be handled by medical doctors. Instead, she went to a traditional birth attendant (TBA) or "hilot which she voluntarily named as Apolonia Salcedo, residing at Dalapian, Labasan, Bongabon, Oriental Mindoro. Respondent clearly defied the advice of Drs. Theresa Atienza and Mario Sales not to give birth at home. As to her swollen vulvar hematoma which was noticed by Dr. Fabon, it was the result of prolonged labor.

As to the charge that he abandoned the respondent to his assistants, petitioner claimed that between 12 noon and 2:00 o'clock in the afternoon, he was busy checking on pregnant patients at the out-patient department (OPD) of OMPH until he was called for his first cesarean section (CS). Later at 4:00 o'clock, without resting and having lunch, he visited respondent and other admitted patients at the delivery room. Together with the nurse on duty, Mrs. Evelyn D. Morales, petitioner said he explained to respondent her and her baby's condition based on the referral from BMHO (polyhydramnios) and initial findings that her abdomen and baby were big and the baby's heartbeat is not appreciated. He presented the respondent with two options: have a normal delivery or undergo cesarean section, and the consequences of each choice. Respondent chose the former believing that she can handle this childbirth at home, and petitioner respected her decision.

After seeing other patients at the delivery room, petitioner was called for his second CS that day. Thus, he was obliged to proceed to the OR and left the respondent under the care of three assistants, one of whom is an

experienced midwife. That he was not the one who attended to the respondent during her delivery is confirmed by the statements of respondent herself, Dr. Fabon and Mrs. Morales. Further, petitioner claimed it has been a long-time practice at OMPH that whenever the doctor is at the OR, the experienced midwives will take over the delivery of laboring patients.

Petitioner blamed respondent for risking her own life in not seeking immediately a higher level of medical care and instead preferring a TBA who is prohibited under a 2006 provincial circular to handle deliveries at home. He emphasized that upon admission the fetal heart tone is no longer appreciated and maintained that diligent care was extended to respondent during her stay at OMPH. As to the complications like cough and wound dehiscence, he explained that these were the effects of anesthesia and surgery (loss of blood, massive blood transfusion and intravenous fluid infusion), and also poor compliance with prescribed medication. He further asserted that he had referred the patient to other co-doctors on duty like Dr. Romy Lomio (Internal Medicine) for co-management.

On April 23, 2010, petitioner submitted a manifestation that he had resigned as Medical Officer of OMPH effective March 5, 2010. He thus posited that the administrative case is now rendered moot and academic.

On August 12, 2010, the Office of the Deputy Ombudsman for Luzon rendered a Decision finding the petitioner administratively liable. It held that by fully entrusting to his subordinates the task of handling respondent's complicated delivery, petitioner exhibited an improper or wrongful conduct and dereliction of duty as medical practitioner. Being the most competent person who should have rendered the appropriate medical service to respondent, petitioner should have personally attended to the latter. Such action or inaction of his part amounts to intentional or willful neglect in discharging his sworn duty as a government physician which is also equivalent to misconduct in office. The administrative case filed against the respondent is also not rendered moot by his subsequent resignation in office.

The Decision of the OMB thus decreed:

WHEREFORE, judgment is hereby rendered finding respondent Medical Officer Idol L. Bondoc of Oriental Mindoro Provincial Hospital (OMPH), Barangay Ilaya, Calapan City, Oriental Mindoro, guilty of Grave Misconduct.

Respondent Idol L. Bondoc is hereby meted the penalty of DISMISSAL in the Government Service pursuant to Section 10, Rule III, Administrative Order No. 07, as amended by Administrative Order No. 17, in relation to Section 25 of Republic Act No. 6770. The penalty of dismissal shall carry with it that of cancellation of eligibility, forfeiture of the retirement benefits, and the perpetual disqualification for reemployment in the government service pursuant to Section 58, Rule IV of the Uniform Rules on Administrative Cases in the Civil Service.

The Honorable Governor of the Province of Oriental Mindoro, is hereby directed to implement this DECISION immediately upon receipt thereof pursuant to Section 7, Rule III of Administrative Order No. 7, as amended by Administrative Order No. 17 (Ombudsman Rules of Procedure) in relation to Memorandum Circular No. 1, series of 2006 dated 11 April 2006 and to promptly inform this Office of the action taken hereon.

SO DECIDED.[12]

The foregoing ruling was affirmed by the CA and petitioner's motion for reconsideration was denied.

The CA concurred that petitioner should have chosen to stay in the delivery room and personally attend to the patient as he is the most competent person to render medical service in view of respondent's critical condition. It likewise faulted the petitioner for deliberately leaving the laboring and unstable respondent to the care of his inexperienced subordinates at the time she was about to give birth. As to petitioner's excuse that he had to attend

to an equally important cesarean operation, the CA said there was no sufficient showing of the latter's urgency and assuming it to be true, still, petitioner should have exerted efforts to refer respondent's case to another competent doctor or one of his consultants.

Petitioner is now before this Court arguing that the CA erred in affirming the Ombudsman's ruling that he is guilty of grave misconduct and imposing on him the penalty of dismissal from the service. He reiterates that his failure to attend to respondent was not without justification and that in the seven years he had been a medical officer of OMPH, he has dutifully observed the sworn duties of the medical profession and would not neglect his responsibilities nor commit misconduct at the risk of his medical career which he had nurtured through the years.

The petition has no merit.

Misconduct is defined as a transgression of some established and definite rule of action, more particularly, unlawful behavior or gross negligence by a public officer,[13] a forbidden act, a dereliction of duty, willful in character, and implies wrongful intent and not mere error in judgment.[14] It generally means wrongful, improper or unlawful conduct motivated by a premeditated, obstinate or intentional purpose. The term, however, does not necessarily imply corruption or criminal intent. To constitute an administrative offense, misconduct should relate to or be connected with the performance of the official functions and duties of a public officer. On the other hand, when the elements of corruption, clear intent to violate the law or flagrant disregard of established rule are manifest, the public officer shall be liable for grave misconduct.[15]

In this case, both the Ombudsman and CA found the petitioner guilty of grave misconduct in failing to attend to respondent when she was having prolonged difficult labor and vaginal delivery after being diagnosed with macrosamia and polyhydramnios.

Polyhydramnios is an abnormal condition occurring in pregnancy, characterized by excessive amniotic fluid (the fluid surrounding the baby in the uterus). Apart from protecting the baby from any external impact by providing a cushioning effect, the clear or slightly yellowish fluid plays a vital role in proper fetal development as well. However, increased levels of the fluid can cause various complications during different stages of pregnancy and childbirth.[16] Intra-amniotic pressure is markedly elevated in most patients with severe hydramnios. The incidence of cesarean section is also increased as a result of unstable lie and placental abruption, which may occur with the rapid decrease in intrauterine pressure that accompanies membrane rupture.[17]

One of the known causes and risk factors of polyhydramnios is fetal macrosomia (having a baby too large for the gestational age).[18]

According to medical authorities, a macrosomic infant poses a different set of complications. The incidences of shoulder dystocia,[19] birth injuries, perinatal death, and low Apgar scores are increased in macrosomic infants.[20] In these cases, careful attention to the patient, potential risk factors, clinical progress, and fetal size should allow obstetricians to reduce the occurrence of maternal and neonatal morbidity.[21] Vaginal delivery of the macrosomic infant is associated with an increased incidence of birth trauma. The question whether to perform cesarean section thus arises.[22]

If the estimated fetal weight is 4000 to 4500 g by ultrasonography and the patient has a clinically adequate pelvis, labor may be allowed. If labor is protracted or the second stage is prolonged, a cesarean section would avoid the possible trauma of a difficult vaginal delivery. Because of the greater morbidity associated with infants who weigh more than 4500 g, elective cesarean section is warranted.[23]

On the other hand, prolonged labor may culminate in obstructed labor, and is associated with maternal infection, uterine rupture and postpartum hemorrhage.[24]

As per the admitting diagnosis[25] submitted by petitioner, the latter was aware of macrosomia and the fetal heartbeat not appreciated. He also maintains that respondent's baby was already dead due to prolonged labor but she had insisted on having a normal delivery. However, this claim is belied by the sworn statements of respondent, her husband and her sisters, all of whom averred that they requested for a cesarean section as per the advice given by Dr. Atienza who examined her in March 2009, and as confirmed at the Bansud Health Center where she was told that it would be risky for her to have a normal delivery. Moreover, Joel Mantala asserted that what petitioner said to him was that the baby was too big and if born alive it would probably have abnormalities so it would be better that the baby is stillborn.

The Court is more inclined to believe respondent's version which was duly corroborated by Dr. Fabon who heard petitioner saying that: "Meron pa nga kami sa DR macrosomnia, polyhydramnios pa, pero paanakin na long 'yon. Abnormal din naman ang bata kahit mabuhay." This puts into doubt petitioner's supposed finding that the baby was already dead upon respondent's admission at OMPH and that it was respondent who insisted on a normal delivery. Even assuming that petitioner had actually confirmed intrauterine fetal death, this only aggravates the patient's condition and it was incumbent upon petitioner as the obstetrician on duty to personally attend to her and render appropriate management or treatment.

In deliberately leaving the respondent to a midwife and two inexperienced assistants despite knowing that she was under prolonged painful labor and about to give birth to a macrosomic baby by vaginal delivery, petitioner clearly committed a dereliction of duty and a breach of his professional obligations. The gravity of respondent's condition is highlighted by the expected complications she suffered - her stillborn baby, a ruptured uterus that necessitated immediate surgery and blood transfusion, and vulvar hematomas.

Article II, Section 1 of the Code of Medical Ethics of the Medical Profession in the Philippines states:

A physician should attend to his patients faithfully and conscientiously. He should secure for them all possible benefits that may depend upon his professional skill and care. As the sole tribunal to adjudge the physician's failure to fulfill his obligation to his patients is, in most cases, his own conscience, violation of this rule on his part is discreditable and inexcusable.[26]

A doctor's duty to his patient is not required to be extraordinary. The standard contemplated for doctors is simply the reasonable average merit among ordinarily good physicians, i.e. reasonable skill and competence.[27] Even by this standard, petitioner fell short when he routinely delegated an important task that requires his professional skill and competence to his subordinates who have no requisite training and capability to make crucial decisions in difficult childbirths.

Petitioner's proffered excuse that it was the practice in OMPH to allow midwives to administer to patients during deliveries, is unacceptable. No proof of such alleged hospital practice such as an official written directive was presented. Besides, it is doubtful whether hospital administrators would remedy personnel shortage by permitting inexperienced staff, by themselves, to handle laboring patients with high-risk pregnancies and maternal/fetal complications.

As to the two other scheduled CS performed by petitioner on the same day, this will not exculpate him from administrative liability. As correctly pointed out by the CA, there was no showing of similar urgency in the said operations, and petitioner could have referred respondent to another competent physician. He could have likewise arranged for adjustment in the operation schedules considering that his personal attention and management is urgently needed in respondent's difficult and complicated delivery. But there is no indication in the records that petitioner duly informed or referred the matter to the other doctors or the administrators of OMPH.

We therefore hold that the CA correctly affirmed the Ombudsman in finding the petitioner guilty of grave

misconduct. His violation of the sworn duty to attend to his patients faithfully and conscientiously is inexcusable. Such flagrant disregard of established rule and improper conduct were proven by substantial evidence.

Not only did petitioner routinely delegate his responsibility to his subordinates, he casually instructed them to press down repeatedly on respondent's abdomen, unmindful of her critical condition as borne out by his very own findings. Worse, petitioner haughtily and callously spoke of respondent's case to the other doctors and medical staff while performing a CS after he had briefly attended to her at the delivery room "...paanakin na long 'yon, abnormal din naman ang bata kahit mabuhay, kawawa lang siya." Such insensitive and derisive language was again heard from the petitioner when he referred for the second time to respondent's traumatic delivery, saying that: "Pinilit no 'ng tatlong ungas, ayon lumusot pero patay ang bata, tapos ito, mukhang pumutok" As a government physician, petitioner's demeanor is unbecoming and bespeaks of his indifference to the well-being of his patients.

Petitioner thus not only committed a dereliction of duty, but also transgressed the ethical norms of his profession when he failed to render competent medical care with compassion and respect for his patient's dignity.

A physician should be dedicated to provide competent medical care with full professional skill in accordance with the current standards of care, compassion, independence and respect for human dignity.[28] (*Italics supplied.*)

Finally, we find no merit in petitioner's argument that the CA should have at least considered as mitigating circumstances his being a first offender,[29] his 16 years in government service, and that he had not acted in bad faith and with clear intent to violate the law and established rules.

Jurisprudence is replete with cases declaring that a grave offense cannot be mitigated by the fact that the accused is a first time offender or by the length of service of the accused.[30] While in most cases, length of service is considered in favor of the respondent, it is not considered where the offense committed is found to be serious or grave.[31] In *Medina v. Commission on Audit*,[32] the Court stressed that dishonesty and grave misconduct have always been and should remain anathema in the civil service. They inevitably reflect on the fitness of a civil servant to continue in office. When an officer or employee is disciplined, the object sought is not the punishment of such officer or employee but the improvement of the public service and the preservation of the public's faith and confidence in the government.

WHEREFORE, the petition is DENIED for lack of merit. The Decision dated May 24, 2012 and Resolution dated August 14, 2012 of the Court of Appeals in CA-G.R. SP No. 120563 are AFFIRMED and UPHELD.

With costs against the petitioner.

SO ORDERED.

Velasco, Jr., (Chairperson), Reyes, Perlas-Bernabe, and Jardeleza, JJ., concur.

November 20, 2014

NOTICE OF JUDGMENT

Sirs/Mesdames:

Please take notice that on ____November 12, 2014____ a Decision, copy attached herewith, was rendered by the Supreme Court in the above-entitled case, the original of which was received by this Office on November 20,

2014 at 10:13 a.m.

Very truly yours,

(SGD)

WILFREDO V. LAPITAN

Division Clerk of Court

[*] Designated as Acting Member per Special Order No. 1866 dated November 4, 2014,

[1] Rollo, pp. 33-48. Penned by Associate Justice Ramon R. Garcia with Associate Justices Amelita G. Tolentino and Samuel H. Gaerlan concurring.

[2] Id at 50-51.

[3] Id. at 52-69.

[4] Id. at 70-75.

[5] Id. at 135.

[7] Id. at 5-13.

[8] Id. at 5.

[9] Id. at 40.

[10] Id. at 7-8.

[11] Id. at 21-25.

[12] Rollo, pp. 67-68.

[13] Civil Service Commission v. Ledesma, 508 Phil. 569, 579 (2005), citing Bureau of Internal Revenue v. Organo, 468 Phil. 111,118 (2004) and Castelo v. Florendo, 459 Phil. 581, 597-598 (2003).

[14] Office of the Ombudsman v. Magno, 592 Phil. 636, 658 (2008), citing Estarija v. Ranada, 525 Phil. 718, 728(2006).

[15] Civil Service Commission v. Ledesma, supra note 13.

[16] (visited October 16, 2014).

[17] "Hydramnios, oligohydramnios" by Tiong Ghee Teoh/Nicholas M. Fisk, High Risk Pregnancy Management Options edited by D K James, P J Steer, C P Weiner and B Gonik, published by W. B. Saunders, Second Edition 1999, p. 310.

[18] Supra note 16.

[19] Shoulder dystocia occurs when, after delivery of the fetal head, the baby's anterior shoulder gets stuck behind the mother's pubic bone. Sourced at (visited October 16, 2014).

[20] "Cesarean Section: History, Incidence, and Indications" by Karen A. Raimer and Mary J. O'Sullivan, Surgical Obstetrics edited by Warren C. Plauche, John C. Morrison and Mary J. O'Sullivan, published by Saunders, 1992, p. 412.

[21] "Identification and Delivery of the Macrosomic Infant" by Joseph M. Miller, Jr., Surgical Obstetrics, id. at

321.

[22] Id. at 318.

[23] "Cesarean Section: History, Incidence and Indications" by Karen A. Raimer and Mary J. O'Sullivan, Surgical Obstetrics, supra note 19.

[24] "Poor progress in labor, including augmentation, malpositions and malpresentations" by Selina Chua/Sabaratnam Arulkumaran, High Risk Pregnancy Management Options edited by D K James, P J Steer, C P Weiner and B Gonik, published by W. B. Saunders, Second Edition 1999, p. 1106.

[25] Rollo, p. 136.

[26] Cited in *Runez, Jr. v. Jurado*, 513 Phil. 101, 106 (2005).

[27] *Ruhez, Jr. v. Jurado*, id., citing *Cooper v. McMurry*, 149 Pac. (2d) 330 and *Reyes v. Sisters of Mercy Hospital*, 396 Phil. 87, 107 (2000).

[28] Art. II, Sec. 1, Code of Ethics of the Philippine Medical Association (2008).

[29] While petitioner had been the subject of a previous administrative complaint lodged before the Provincial Legal Office, it was dismissed under Resolution dated February 19, 2010 of the said office for lack of evidence. See CA rollo, pp. 132-133.

[30] *Medina v. Commission on Audit*, 567 Phil. 649, 664 (2008).

[31] *Duque III v. Veloso*, G.R. No. 196201, June 19, 2012, 673 SCRA 676, 684, citing *Civil Service Commission v. Cortez*, G.R. No. 155732, June 3, 2004, 430 SCRA 593, 605.

[32] Supra note 30, at 665, citing *Civil Service Commission v. Cortez*, id.

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