



**Journal**  
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1976 PMA ANNUAL CONVENTION  
APRIL 28 TO MAY 1, 1976  
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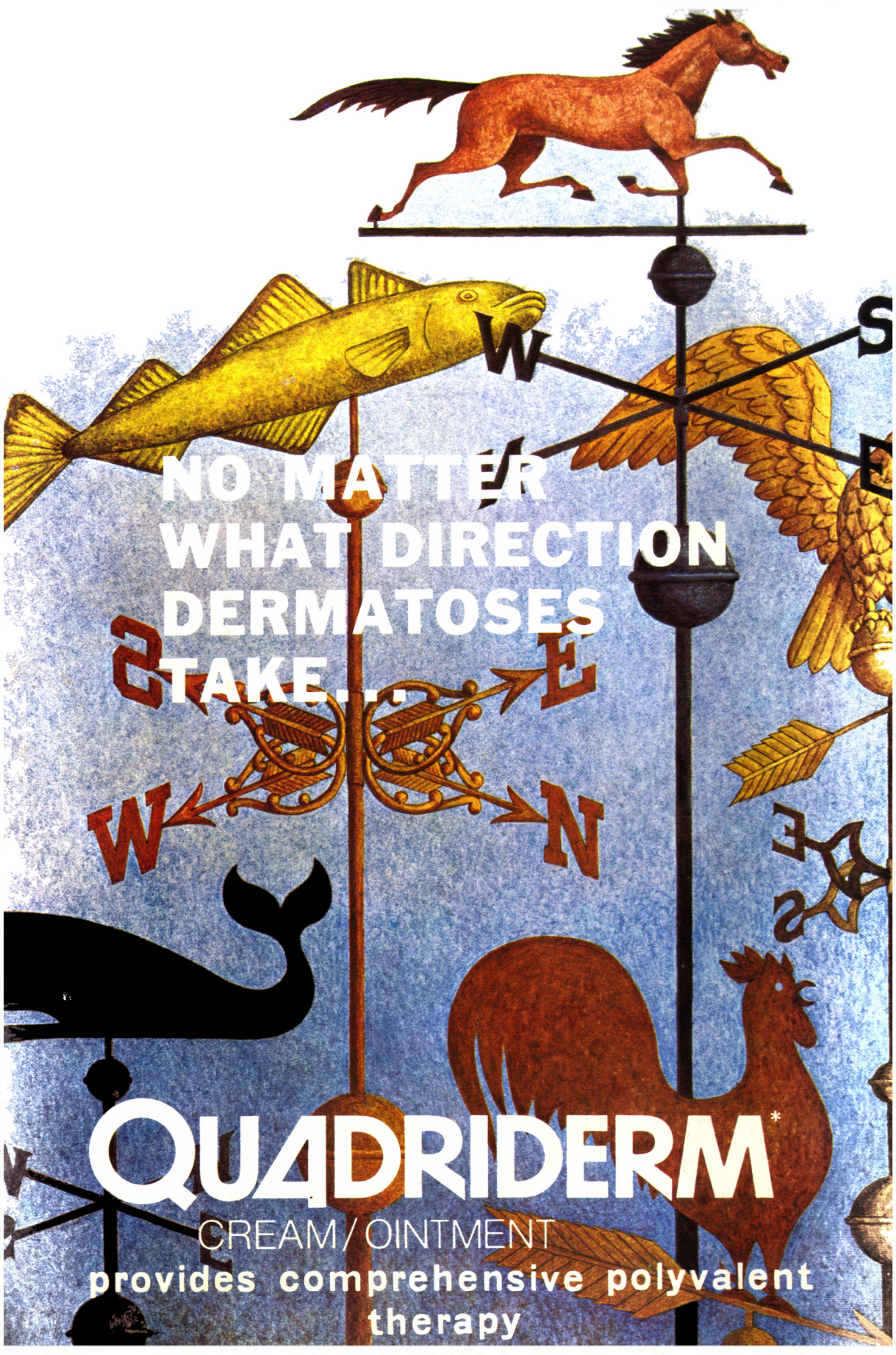
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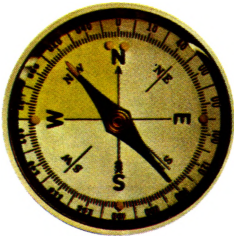
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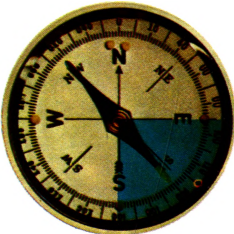
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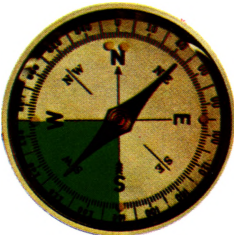
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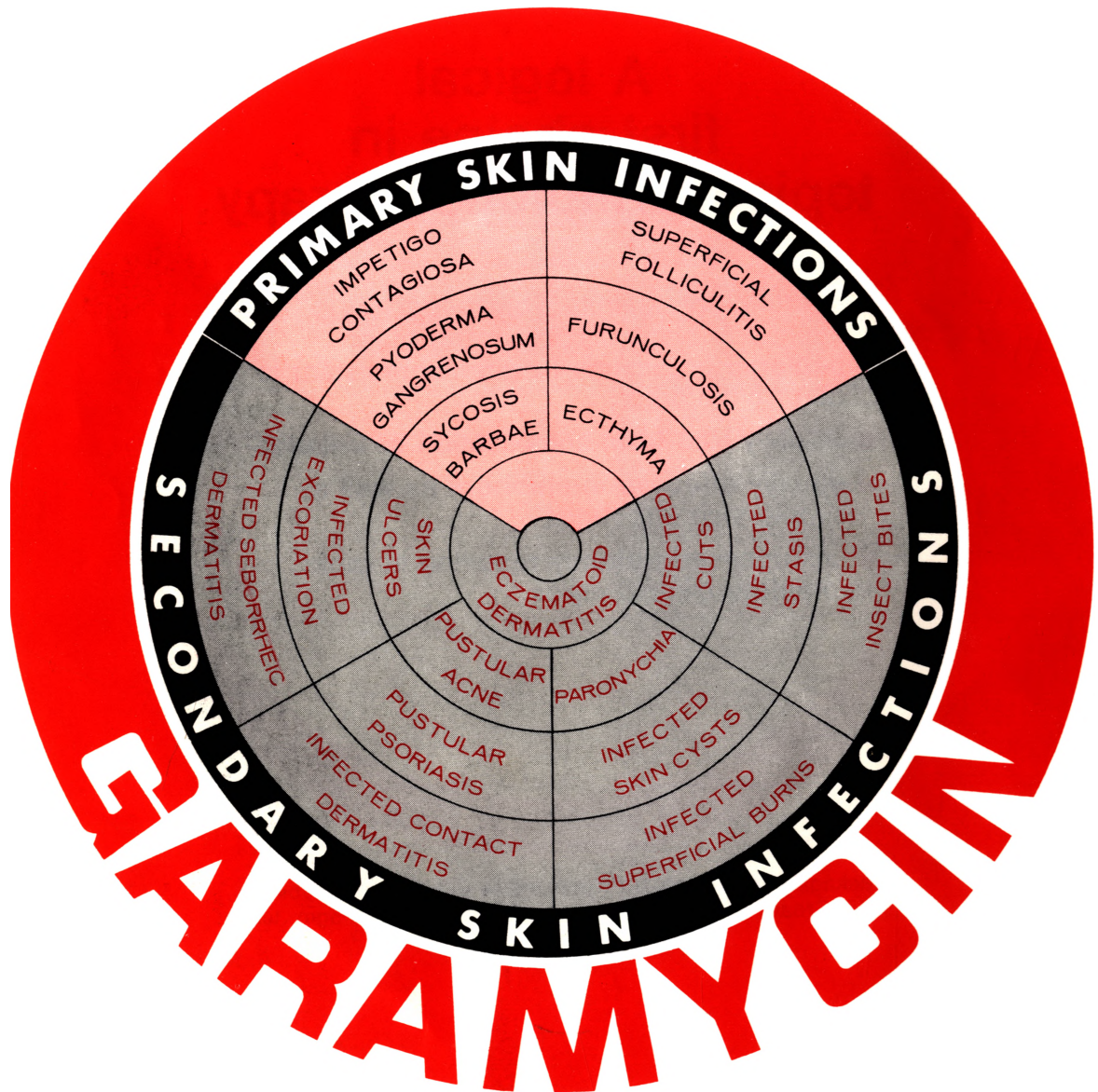
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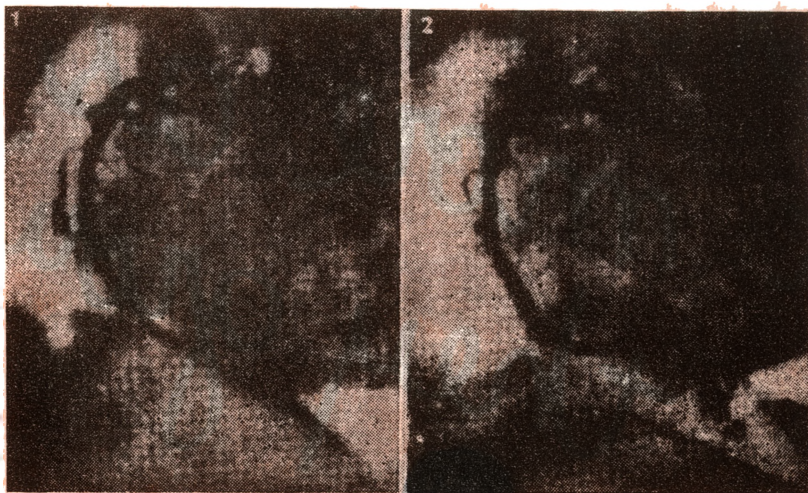


Figure 1 was taken before and Fig. 2 was taken after the administration of 5-mg. ISORDIL sublingually. Significantly, the artery is filled slightly more distally, and its diameter is increased after administration of the drug. (Sewell, W.H.: The Medical and Surgical Management of Coronary Insufficiency, a motion picture, on file at Ayerst.)

Current investigations suggest that the symptoms of coronary insufficiency (angina pectoris in particular) result from inadequate oxygen supplies to the heart. The disparity between oxygen required and oxygen available can be resolved by improving coronary artery flow and by reducing myocardial oxygen requirements.

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SERIOUS BACTERIAL INFECTION**

Delay can be critical

get the 24 hour head start

*....while the culture is being plated*

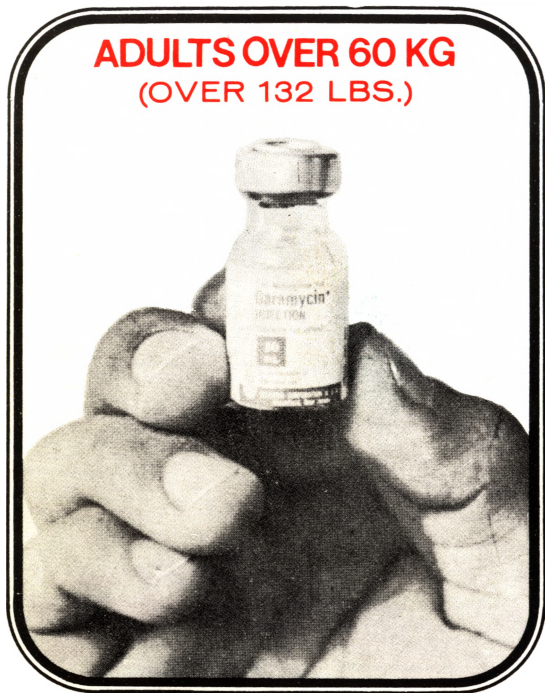
**GARAMYCIN<sup>\*</sup>  
INJECTION**



# Simplified Dosage Guidelines for Garamycin\* Injection

(For Intramuscular Administration)  
PATIENTS WITH NORMAL RENAL FUNCTION

**ADULTS OVER 60 KG**  
(OVER 132 LBS.)



**DOSAGE**  
ONE 80 mg. VIAL  
3 times daily

**ADULTS 60 KG or LESS**  
(132 LBS. or LESS)



**DOSAGE**  
ONE 60 mg. AMPULE  
3 times daily

If calculated on an individual weight basis, the recommended dosage of GARAMYCIN Injection for adult patients with *serious infections* is 3 mg/Kg/day, in three equal doses; *life-threatening infections*, up to 5 mg/Kg/day in three or four equal doses. CHILDREN, in moderate or severe infections, 3 to 6 mg/Kg/day, in three equal doses. INFANTS AND NEONATES (premature and full-term neonates, one week of age or less), 6 mg/Kg/day, in two equal doses; INFANTS OLDER THAN ONE WEEK, 6 mg/Kg/day, in two or three equal doses.

## FOR INTRAVENOUS ADMINISTRATION

A single dose of GARAMYCIN Injection may be diluted in sterile isotonic saline solution or sterile 5% dextrose solution and may be infused over a period of up to 2 hours.

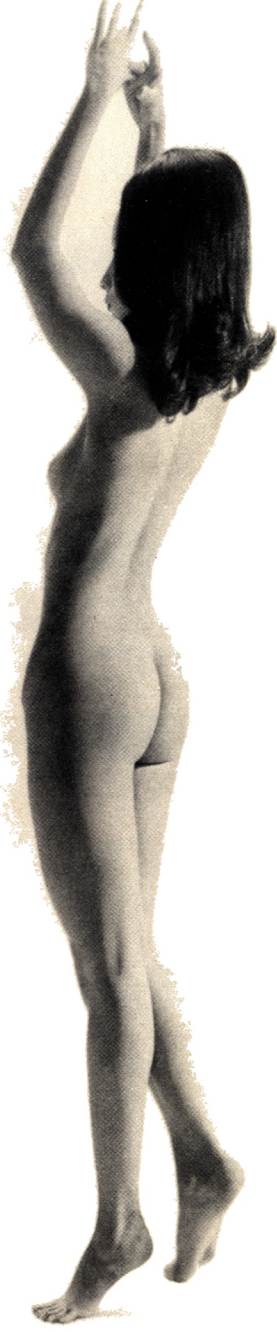
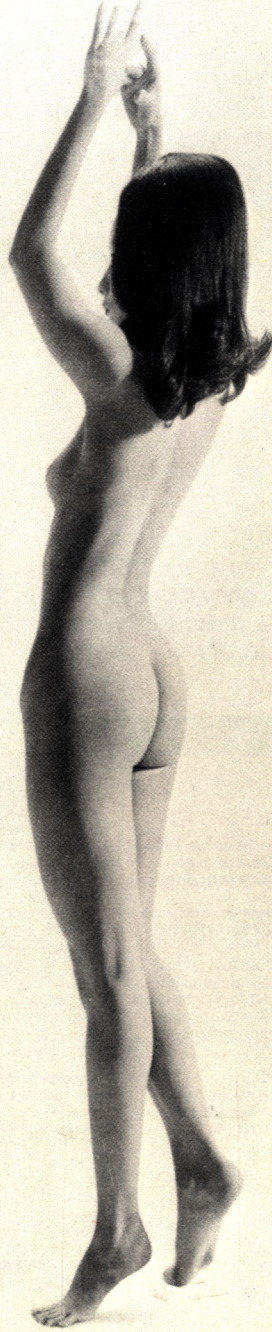
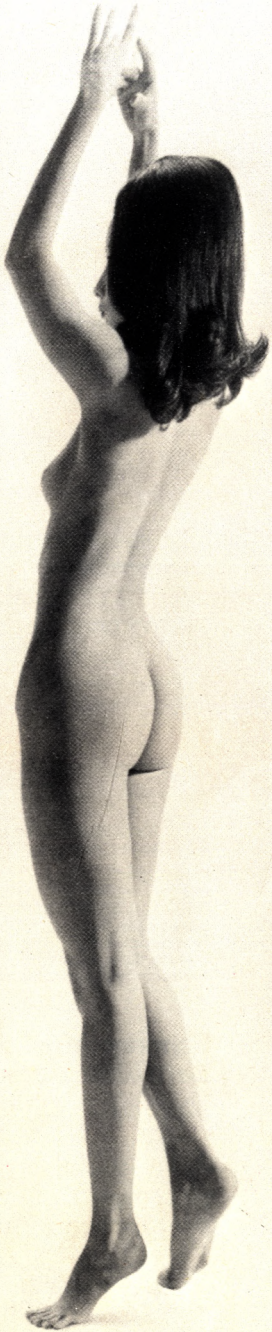
A single dose of GARAMYCIN Injection undiluted may also be given directly into a vein or I.V. tubing slowly over a period of 2 to 3 minutes and may, if necessary, be repeated every 8 hours.

USUAL DURATION OF TREATMENT, ALL CONDITIONS: 7 to 10 days.





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# In allergic and inflammatory dermatoses three simple distinctions for logical therapy with Ultralan

Weeping skin conditions need a base with a high water content



**Ultralan  
Cream**

This base allows exudate to flow off freely so speeding up the drying out of the skin and helping the healing process.

Skin conditions which are neither weeping nor very dry need a base with a balanced fat/water content



**Ultralan  
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This base protects the skin from drying out and lightly lubricates it without clogging warmth or moisture.

Very dry skin conditions need an anhydrous fat base



**Ultralan  
Fatty Ointment**  
*new*

This base keeps moisture in the epidermis and facilitates the penetration of the active principle.

**Indication**  
Ultralan cream - fatty ointment  
effective corticoid preparation for the topical treatment of allergic and allergic skin conditions

**Composition**  
Ultralan ointment:  
contains 2.5 mg fluocortolone and 2.5 mg fluocortolone acetate.

**Ultralan cream:**  
contains 2.5 mg fluocortolone and 2.5 mg fluocortolone caproate.

**Ultralan fatty ointment:**  
contains 2.5 mg fluocortolone and 2.5 mg fluocortolone acetate.

**Indications**  
The Ultralan preparations are indicated for virtually the complete range of inflammatory and allergic skin conditions:  
Ultralan ointment with its universal base for nearly all types of skin disorders.  
Ultralan cream with its low fat content especially for acute and subacute processes and for application on visible skin areas, e. g. on face.  
Ultralan fatty ointment with its water-free base for dry skin.

**Contra-indications**  
Tuberculous processes in the region under treatment; vaccinia, smallpox and chickenpox.

**Possible side-effects**  
When large quantities of Ultralan are used or when extensive skin areas are covered with an occlusive dressing, systemic absorption may occur. In rare cases, the skin might become atrophic after long-term and high-dose application of Ultralan or other fluorinated corticoids.

**Special notes**  
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In mycosis, locally acting antimycotic agents are indicated.  
When Ultralan is applied in cases of secondarily infected processes, additional administration of locally acting chemotherapeutic agents is indicated.

**Dosage and administration**  
In general, initially twice or three times daily in a thin layer. After recession of the acute symptoms, one daily application is sufficient.  
In case the skin should dry too much under treatment with Ultralan cream, transfer to Ultralan ointment is recommended.  
Ultralan fatty ointment must not be used in weeping processes.  
When Ultralan is used on the face it should not get in contact with the eye.

For further details please consult our scientific literature.

**Presentation**  
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## EDITORIAL

### MEDICAL ALUMNI SOCIETIES

Alumni Societies of Schools particularly those of higher learning play an important role in shaping the future of the various professions and eventually of the country. They provide the leadership that could effectively influence and accomplish this role. Recognition of such leadership brings alumni to the stewardship of local or national medical organizations, specialty societies, medical institutions, and government health services where they distinguish themselves further. There are also the greater number of alumni that assume prominence in the ever challenging field of medical practice. From all these, the people and the country benefit.

It is therefore, always a happy occasion for alumni groups to look forward meeting every year during our PMA National Conventions, Regional or Component Society Annual Meetings, and Medical School Homecomings. To renew acquaintanceships, to reminisce, to greet old friends, and to make new ones. Indeed, it is a source of great pride to belong to a Medical School that has nurtured worthy and successful alumni.

Alumni Societies are grateful and have responded quite generously to the needs of their mother institutions and occasionally, certain individual alumni have given philanthropically. However, our Alumni Societies can still do more. May I suggest that endowments for professorial chairs, grants for research, continuing scholarships for deserving medical stu-

**dents, donations for laboratory instruments and equipment, and teaching aids be given priority.**

**There is something unique that the PMA has made actually possible which the Medical Schools have not. It has provided the numerous occasions where alumni meet other alumni and more importantly, alumni work with other alumni. This is the PMA!**

**A. J. RAMOS, M.D.**



**Greetings:**

**to the**

**DELEGATES AND MEMBERS**

**69th PMA ANNUAL CONVENTION**

**APRIL 28 TO MAY 1, 1976**

**BAGUIO CITY**

# THE FUNGI KILLERS



# Tinactin\*

(Tolnaftate)

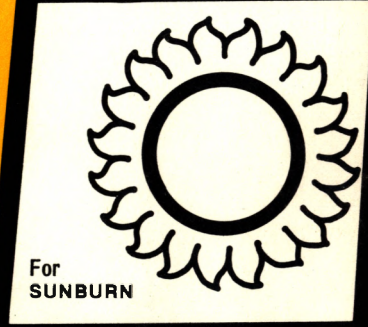
CREAM, 5 Gm./SOLUTION, 10 ml.

The first truly fungicidal  
drug for topical use

# VANDOL\*

## OINTMENT

### the ideal soothing ointment for family use



# VANDOL\*

## OINTMENT



# A Two Year Experience with Vasectomy in the Philippines\*

PEDRO M. REYES, JR., M.D., F.A.C.S., F.A.A.P.

## INTRODUCTION

VASECTOMY is of maximum usefulness in the male whose desired family size has been attained and whose marital partner is still young and unwilling to undergo the inconveniences and uncertainties of conventional contraceptive practices. The sterilization counterpart in the female, no matter what technic is used, involves entry into the peritoneal cavity and therefore carries a potentially serious risk. Vasectomy, as has been developed in this program, is a short, painless, low cost, procedure with a high success rate (100% of all patients returning for semen examination), low complication rate, and virtually without side effects. There have been a total of 690 acceptors during the last 2 years of the program and a review of our experiences will serve to crystallize some thoughts on how the program can be rendered more effective, particularly in relation to the overall program of the government towards population growth rate control.

## Inertia of the Initial Acceptance of Vasectomy.

Educational, cultural, and religious factors have, in the past, limited the acceptance of vasectomy in the Philippines as a family planning technic. The program was intended to gain entry into a heretofore poorly tapped source of fertility control — the male half of the marriage partnership — representing 50% of all actively reproductive individuals. Although the program had been planned months before, its operation started only on November 1, 1973. The venue of the vasectomy program was a suite on the third floor of the Institute of Maternal and Child Health Building of the Children's Medical Center at 11 Banawe, Quezon City. Partitioning of the allotted space created a waiting room — reception room, an office for interviewing prospective acceptors, and an operating room complete with an operating table and overhead operating lamp. Actually, the Vasectomy Clinic was part of an Advanced Family Planning Technology Clinic (an euphemistic name for Voluntary Sterilization Clinic) in which the female counterpart was assigned to Dr. Restituto Buenviaje, who did the female sterilization by transva-

\*A Program Supported by Pathfinder Fund, Inc., Boston, Massachusetts.

ginal tubal resection. The office staff of the whole clinic consisted, initially of only one nurse, later re-enforced by the addition of a licensed midwife. The Project Director of the Program initially at its most difficult first year was Dr. Fe del Mundo.

The vasectomy program was given a quota of 200 acceptors for the first year. Optimism rode high at the start of the program, since the Institute of Maternal and Child Health had over 300 Family Planning Clinics all over the Philippines with 144 of these in the Greater Manila Area and surrounding provinces, all of which were potentially large sources of acceptors. Disappointingly, only 2 patients came for vasectomy during the first 4 months of operation of the clinic.

Realizing that acceptors were not forthcoming from the Family Planning Clinics, the clinic staff and some concerned staff members of the I.M.C.H. began their own motivational campaign. Sorties were made into different quarters for informational seminars. The first targets were the municipal councils of the suburban towns of San Juan, Rizal; Quezon City; Pasay City; Caloocan City; and Mandaluyong, Rizal. Abruptly, in March, 1974, 6 acceptors came. Each month since then, the number of acceptors increased progressively (See Chart), so that by the end of the project year on October 30, 1974, there were 37 acceptors more than the quota of 200 allotted to the vasectomy clinic.

### The Importance of a Continuous Motivational Campaign.

The second year of operation of the Vasectomy Clinic was allotted 450 acceptors. During the first month (November, 1974) 59 acceptors came. Subsequent months showed regular fluctuations in the number of acceptors. Each month showing a decline in acceptors was followed by a motivational campaign, causing an increase in the subsequent months. During the latter half of the 2nd year of operation, a precipitous drop in the number of acceptors had to be countered with informational seminars conducted by Mrs. Alice Arca, the Clinic Nurse, mostly in industrial firms with a high male population. This experience during the second year convinced us that a continuing motivational campaign is necessary for a steady stream of acceptors.

### Spreading the Popularity of Vasectomy

During the first year of operation of the Vasectomy Clinic, a visit was made to Gasan, Marinduque, on the invitation of the town mayor and his wife, so that interest in vasectomy may be awakened in the area. During this visit, which was on the last week-end of August, 1974, 13 acceptors submitted for vasectomy, and a local health officer was trained in the technic so that continuity of the program in the area would not be disrupted. This pattern of itinerant surgery and concomittant training of a physician in the area has been repeated more often during the second year of operation, when visits were carried out in the following places:

1. Bacolod City	November 23-24, 1974	— 27 cases
2. Angono, Rizal	April 2, 1975	6 cases
3. Angono, Rizal	August 4, 1975	9 cases
4. Pasig, Rizal	August 9, 1975	11 cases
5. Novaliches, Rizal	August 30, 1975	7 cases
6. Angono, Rizal	September 24, 1975	1 case



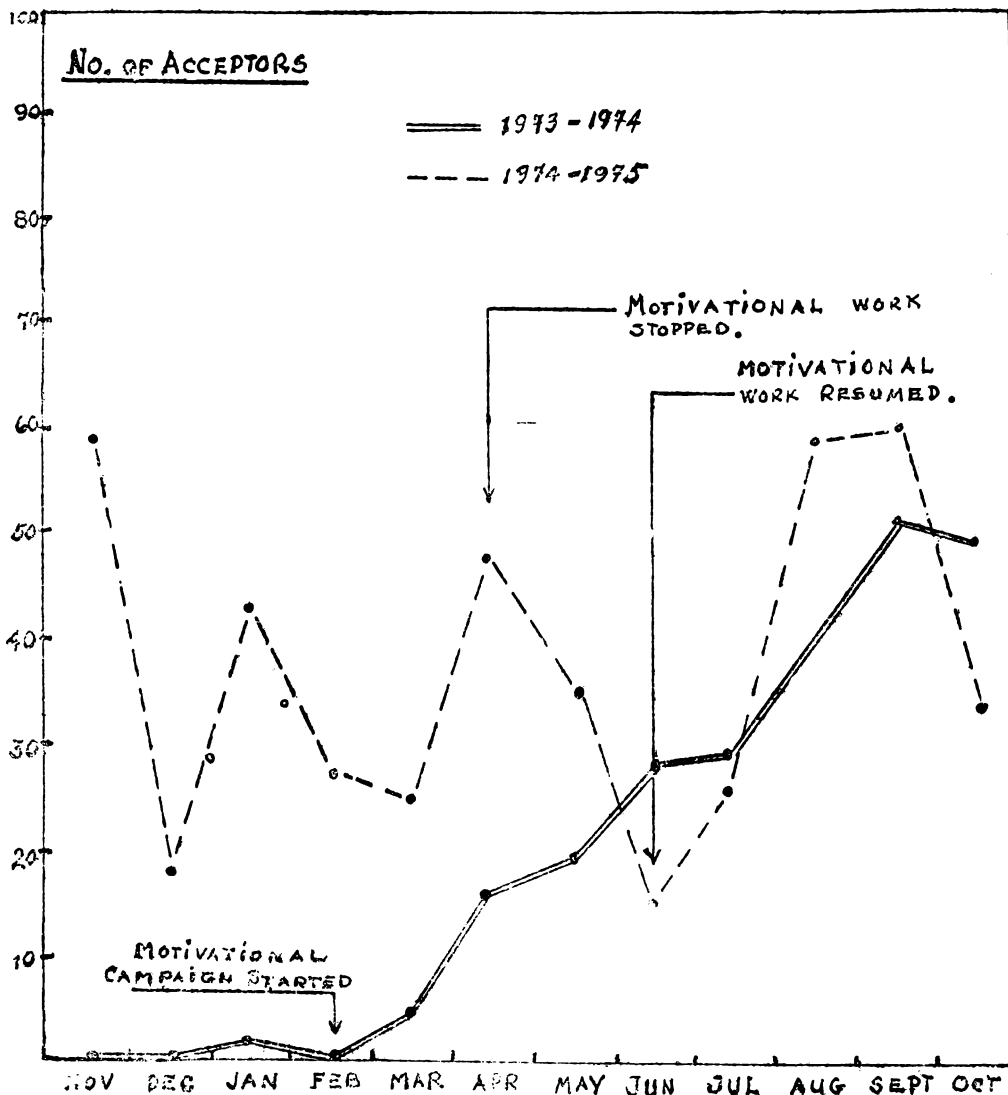


Fig. 1. Graph shows difficulty of initial operation and need for continuous motivational efforts to insure success of the program.

In each of these places one or more trainees were on hand to utilize the patients for training. In each place, care was exercised so that the initial experience of the community with vasectomy was pleasant. The procedure had to be fully accepted and not discredited by incurring unpleasant complications.

**The Vasectomy Clinic as Training Center.**

The Institute of Maternal and Child Health, recognizing the potentialities of vasectomy as an effective fertility con-

trol tool, entered into a program of training rural physicians to do vasectomy, with the Vasectomy Clinic as its primary training center. Groups of 2 or more physicians were sent to the Vasectomy Clinic for practical training in the operation. A minimum of 5 assisted vasectomies and 5 actually performed operations were required of each trainee and at the end of the training schedule, a certificate was awarded.

Physicians trained in vasectomy at the Clinic sponsored by the I.M.C.H. are listed below:

**LIST OF PHYSICIANS TRAINED ON VASECTOMY**  
**1st Quarter: July, Aug. Sept. '75**  
**F.Y. — 1975-76**

**July 7-11, 1975**

1. Dr. Antonio F. Dioneda (C)  
Dioneda Family Planning Clinic  
Balogo, Sorsogon

**July 14-18, 1975**

1. Dr. Sotero A. Escarilla, Jr.  
Iriga City Puericulture & Family  
Planning Center, Iriga City
2. Dr. Eduardo C. Enojado  
Naga City Puericulture  
& Family Planning Center  
Naga City

**July 21-25, 1975**

1. Dr. Dominador N. Braganza (C)  
Guinobatan Puericulture  
& Family Planning Center  
Guinobatan, Albay
2. Dr. Vicente E. Borre (C)  
Virac Puericulture & Family  
Planning Center  
Virac, Catanduanes
3. Dr. Ernesto S. Antolin (C)  
Balanga Puericulture & Family  
Planning Center  
Balanga, Bataan

**August 4-8, 1975**

1. Dr. Tadeo D. Cortez (C)  
Nueva Ecija Doctor's Hospital

**& Family Planning Clinic**  
Cabanatuan City

2. Dr. Tiburcio S. Macias (C)  
Mayor Joaquin Macias Medical/  
Surgical & FP Clinic  
Sindangan, Zamboanga del Norte
3. Dr. Lolita R. Tudayan (C)  
Training Division  
Institute of Maternal & Child  
Health, 11 Banawe, Quezon City

**August 11-15, 1975**

1. Dr. Apollo Q. Duque (C)  
San Fernando Norte Puericulture  
& Family Planning Center  
Cabiao, Nueva Ecija
2. Dr. Roque C. Alba (C)  
Santiago Puericulture & Family  
Planning Center  
Santiago, Isabela

**August 18-22, 1975**

1. Agerico L. Tecson  
Candaba Puericulture & Family  
Planning Center  
Candaba, Pampanga
2. Dr. Aida M. Gatchalian (C)  
Bo. Kapitolyo Puericulture  
& Family Planning Center  
Pasig, Rizal

**August 26-30, 1975**

1. Dr. Virgilio L. Morales (C)  
Naguilian Puericulture & Family  
Planning Center  
Naguilian, La Union

**September 2-6, 1975**

1. Dr. Estrellita M. Fullantes (C)  
Juan Sumulong Memorial Puericul-  
ture & Family Planning Center  
Tanay, Rizal

**September 9-13, 1975**

- \*1. Dr. Magdalena V. Catalan (C)  
Family Planning Physician  
E. Rodriguez Memorial Hospital  
& Family Planning Clinic  
Marikina, Rizal
- \*2. Dr. Ma. Eliza Tech Veloso (C)  
Family Planning Physician  
Pasig Puericulture & Family  
Planning Center  
Pasig, Rizal
- \*3. Dr. Rosalinda V. Viado (C)  
Family Planning Physician  
Baranca-Ibaba Puericulture  
& Family Planning Center  
Mandaluyong, Rizal

**September 22-26, 1975**

1. Dr. Virgilio M. Orillo (C)  
Family Planning Physician  
Bo. Washington Family Planning  
Clinic  
Surigao City
2. Dr. Maximo D. Soliman (C)  
Family Planning Physician  
Tanza Puericulture & Family

c — Certified

— Trained in the field by itinerant team (Dr. Oscar Estrada & Dr. Lolita Tudayan)

The vasectomy clinic has also trained 2 physicians of the I.M.C.H. for itinerant vasectomy visits to various cities and towns of the Philippines. These physicians are Dr. Oscar Estrada and Dr. Lolita Tudayan. Dr. Estrada has since done over 600 vasectomies in over 30 cities and towns. Dr. Tudayan was recruited primarily to train I.M.C.H. Fa-

**Planning Center**

**Tanza, Iloilo City**

**2nd Quarter: October, November  
and December 1975**

**October 6-10, 1975**

1. Dr. Samuel J. Babol (C)  
Babol's Family Planning Clinic  
Matalam, North Cotabato
2. Ramon V. Blanca, M.D. (C)  
Blanca Hospital & Family Planning  
Clinic  
Molave, Zamboanga del Sur

3. Dr. Rene S. Sison (C)  
Sison's Medical & Family  
Planning Clinic  
Valencia, Bukidnon

**October 6-10, 1975 (continuation)**

- \*1. Dr. Diosdado C. Asuncion (C)  
Municipal Health Officer  
Zambales (Masinloc)
- \*2. Dr. Salvador V. Fune (C)  
Municipal Health Officer  
Sta. Cruz, Zambales
- \*3. Dr. Lauro B. de Jesus (C)  
Municipal Health Officer  
Castillejos, Zambales
- \*4. Dr. Bulan F. Roste (C)  
Municipal Health Officer  
Cabangan, Zambales

**October 21-25, 1975**

1. Dr. Isabel O. Henares  
City Health Officer  
Bacolod City
2. Dr. Pedro S. de Guzman  
St. Jude's Hospital  
Dimasalang, Sampaloc, Manila

mily Planning Clinic Physicians and Municipal health officers in the provinces. To date, she has trained 4 municipal health physicians in Zambales province and 3 I.M.C.H. physicians in the Pasig Puericulture and Family Planning Center in Pasig, Rizal. She next expects to go to train 10 physicians in Isabela Province very shortly.

### **An Improved Vasectomy Technic**

Early in the first year of the Program, a standardized vasectomy technic that would enhance the acceptability of the operation was devised. The technic utilized 2 incisions, was virtually bloodless and painless, and accomplished in 3 to 5 minutes. Standardization of the procedure made it possible to train doctors adequately after assisting 5 and actually performing 5 vasectomies.

This technic of vasectomy was depicted in photographs, which together with the text of the first year experience with the program, was presented as a scientific exhibit at the Annual Convention of the Philippine College of Surgeons, held at the Pines Hotel in Baguio City in December, 1974 and at the Annual Convention of the Philippine Pediatric Society held at the Hotel Intercontinental in May, 1975. Slides have also been made of the technic and these are projected during informational seminars and lectures of the Clinic Staff. Motivational campaigns are also rendered interesting and convincing by showing these slides.

The details of the technic of vasectomy as done in this clinic are as follows:

1. The whole scrotum and penis are rendered aseptic with Povidone Iodine (Betadine Solution).
2. Drapes are placed so that only the scrotum is exposed.
3. The left vas deferens is grasped firmly so that the tip of the index finger is beneath the vas and the thumb over it.
4. Xylocaine 1% solution is injected into the scrotal skin directly over the vas. Infiltration is continued into the tissues around the vas to avoid reflex pain in the abdomen when the vas is exposed.

5. A piece of gauze is used to press on the skin swollen by the injection until the vas is easily discerned under the skin.

6. A small 3/4 centimeter transverse incision is made over the skin overlying the vas, making sure that the incision is made at the exact site of the infiltration of anesthesia.

7. A small towel clip with the jaws open just enough to accommodate the vas is used to pick it up and deliver it out of the scrotal skin.

8. The sheath of the vas is then incised cleanly to expose the vas as a naked tube.

9. The vas is then picked up with the tip of a straight iris scissor.

10. A small straight mosquito clamp is then inserted beneath the vas so that 2 centimeters of it is fully exposed by pushing the clamp beneath the vas almost to the handle.

11. Two mosquito clamps are applied on both extremities of the exposed vas and at least 1 centimeter of vas is excised.

12. The cut exposed ends of the vas are ligated with 4-0 silk and the sutures cut short.

13. The vas is then allowed to slip back into the scrotal sac.

14. No sutures are necessary for the skin. Sutures cause pain and abet infection.

15. The opposite side is similarly treated.

16. Compression on the operated area is applied by the patient's right hand over a gauze dressing for 2 minutes to establish hemostasis.

The simplicity and ease of execution of the operation as devised have resulted in a low morbidity. There were only

6 complications out of 690 vasectomies done, representing a complication rate of 0.8 of one percent. These complications were:

1. Hematoma .....	2
2. Swelling (edema) .....	1
3. Oozing .....	1
4. Spermatic cyst .....	1
5. Decreased libido .....	1
<b>TOTAL</b>	<u>6</u>

There were 337 patients out of 690 acceptors who returned for semen examination. All these showed no sperms in the semen after 30 ejaculations or 60 days following vasectomy. The success rate of the vasectomy based wholly on 337 patients who returned for semen examination is 100%.

### ACCEPTOR PROFILE

The largest number of acceptors (50%) were in the age group 31-40 years.

#### FIRST YEAR ACCEPTORS

November 1, 1973 — October 31, 1974

A g e	W i f e	H u s b a n d
20 — 25	18	11
26 — 30	48	38
31 — 35	64	71
36 — 40	51	69
41 — 45	8	31
46 — 50	1	13
51 +	0	3
Unknown	47	1
<b>TOTAL</b>	<u>237</u>	<u>237</u>

#### SECOND YEAR ACCEPTORS

November 1, 1974 to October 31, 1975

A g e	W i f e	H u s b a n d
15 — 19	0	0
20 — 24	44	12
25 — 29	108	71
30 — 34	163	123
35 — 39	111	151
40 — 44	20	73
45 — 49	4	14
50 +	2	9
Unknown	1	0
<b>TOTAL</b>	<u>453</u>	<u>453</u>

The largest group of acceptors had 4-6 children (over 50%).

### FIRST YEAR ACCEPTORS

November 1, 1973 to October 31, 1974

Number of Children:

0 — 1 .....	0
2 — 3 .....	65
4 — 6 .....	142
7 — 9 .....	25
10 + .....	5
	<hr/>
	237

### SECOND YEAR ACCEPTORS

November 1, 1974 — October 31, 1975

Number of Children:

0 — 1 .....	0
2 — 3 .....	129
4 — 6 .....	265
7 — 9 .....	49
10 + .....	10
	<hr/>
	453

### The occupation profile of the acceptors

#### FIRST YEAR

November 1, 1973 to October 31, 1974

Occupation:

Privately employed .....	90	Jobless .....	7
Laborers .....	42	Vendors .....	5
Drivers .....	33	U. S. Navy .....	5
Gov't employees .....	15	Janitors .....	4
Businessman .....	10	Self-employed .....	3
Fishermen .....	7	Pastors .....	2
Salesmen .....	7	Unknown .....	2
Farmers .....	4	Student .....	1

**SECOND YEAR**

November 1, 1974 — October 31, 1975

**Occupation:**

Laborers .....	134	Jobless .....	11
Privately employed .....	91	Restaurant workers .....	9
Drivers .....	68	Unknown .....	6
Gov't employees .....	34	Security guards .....	5
Self-employed .....	25	Janitors .....	4
Farmers .....	19	Hospital workers .....	3
Vendors .....	13	Students .....	3
Salesmen .....	13	Pastors .....	3
Fishermen .....	12		

Almost 2/3 of the patients came from the Greater Manila area and 1/3 came from the surrounding provinces. Some of the latter were done at visits to the provinces.

**FIRST YEAR**

November 1, 1973 — October 31, 1974

**Patient's Address:**

Patients from Manila & Greater Manila area .....	169
Patients from the provinces .....	68

**SECOND YEAR**

November 1, 1974 — October 31, 1975

**Patient's Address:**

Patients from Manila & Greater Manila area .....	337
Patients from the Province .....	116

**SUMMARY**

The vasectomy program of the Children's Medical Center as funded by the Pathfinder Fund Inc. of Boston, Massachusetts, has just completed its second year of operation. A total of 690 vasectomies have been accumulated

with a success rate of 100% (based on acceptors who returned for semen examination) the complication rate is 0.8 of one per cent. The acceptability of the program, which took 5 long months before taking off, was to a large extent due to the technic of operation which has made the procedure a short, virtual-

ly painless, bloodless one, with a low complication rate. The clinic has developed from one initially geared purely for service to one with a training orientation. Trainees come from rural areas and this augurs well for the adoption of vasectomy as a practical method of fertility control in the provinces.

Vasectomy, however, has not yet reached the stage of acceptability that female sterilization now enjoys, and motivational efforts have to be maintained unrelentingly if the movement for vasectomy is to maintain its momentum. Therefore, a certain amount of the funds for vasectomy programs should go to this particular item.

The acceptor profile reveals that the majority of those who submit to the procedure are in the age group 30-40 years. The large majority have over 4 children at the time of sterilization. This trend is still not too favorable for population growth rate control. Motivation should therefore be directed towards those with three children or less.

The class of present acceptors is on the side of the more educated segment

of the population with a relatively high income level. The informational, educational and motivational thrusts of any program for vasectomy must therefore be more vigorously directed at the economically poorer and less educated segment of the population who in the long run are the ones who most need vasectomy for fertility control.

The movement to popularize vasectomy as a fertility control measure should emphasize its effectiveness, its low cost, its simplicity of execution with the minimum of instruments, and the feasibility of its widespread implementation without sophisticated training of those who do it in a rural setting. When withdrawal of support from foreign fundings deprive the country of what now is abundantly available contraceptive materials and devices, we may have to lay more emphasis on vasectomy as a practical solution to the problem of fertility control. This program which we are undertaking has given us an insight into the problems of this sterilization movement in males, but at the same time, it has broken down some of the barriers that had heretofore prevented its acceptance.



# Stauts of Pediatric Education in the Philippines\*

FE DEL MUNDO, M.A., M.D.\*\*

MEDICAL AUTHORITIES and educators in the Philippines have in recent years been more encouragingly responsive than in the past, to the increasing requirements of Pediatrics in the medical curriculum. It has taken time and effort to attain these aspirations for Pediatrics but now favorable and encouraging trends are evident.

In this country, four important conferences have favorably influenced the teaching of Pediatrics: namely, the Pediatric Education Seminar of the Western Pacific Region, WHO, in February 1967 the First and Second National Conference on Medical Education under the auspices of the Association of Philippine Medical Colleges (APMC) in 1968 and 1972 respectively, with logistic support from the Josiah Macy Foundation; and the Nutrition Seminar for Medical Educators in 1973, also under the auspices of APMC. These conferences have, directly or indirectly, accelerated revision and changes in pediatric education, with

fruitful and far-reaching effects.

An outstanding factor in the progress of Philippine pediatric education has been the Philippine Pediatric Society, with its annual conventions, its Qualifying Board, and its varied activities to upgrade the teaching and practice of pediatrics.

Social awareness and involvement in communities now pervade all disciplines. Medical education in general, but pediatrics in particular, has been very much influenced by this trend. Concern for the rural population has increased, although implementation of measures in their behalf has not been as fruitful as desired and hoped.

In the Philippines, noteworthy is the fact that the nine medical schools (two were opened in 1975), collectively and individually have taken valuable measures and formulated revisions and recommendations to upgrade pediatric education.

## BACKGROUND

Significant in justifying changes in pediatric education in the Philippine are day to day observations on trends in the country as well as information obtained from current Philippine Health Statistics and Demographic Data thus:

\*\*Medical Director, Children's Medical Center Philippines.

\*Read in the Conference on Pediatric Problems in Tropical Countries sponsored by South Asian Regional Seminar on Tropical Medicine and Public Health (SEAMEO), Bangkok, Thailand, November 27, 1975.

**Table I. HEALTH AND DEMOGRAPHIC DATA  
PHILIPPINES, 1973**

Total Population	40,219,000
Total children under 15 (43% of the total population)	17,385,000
Registered Births	1,049,290
Ave. birth rate (1963-73)	26.1/100 live-births
Crude death rate	7.0
Growth rate	2.8%
Fertility rate	119.9%
Infant Mortality rate	64.7/1000 live-births

The latest statistics show a total of 17,385,000 children under 15 years or 43% of the total population, as compared to 25% in developed countries.

The average birth rate for the past 10 years (1963-1973) is 26.1 per 1000 population. The figure 1,049,290 represents the total number of births registered in 1973. Of this number, 49.6% did not have the benefits of medical attendance. Among those who were medically attended 45.4% were delivered by physicians; 6.2% by nurses and 48.4% by midwives. In 1973, 23.3% were delivered

in hospitals while 76.7% were home deliveries.

The neonatal mortality rate is 32.5 per 1000 (Table II) which is 2 to 3 times that of developed countries. It has also been noted that pre-school mortality rate in the Philippines is 60 to 80 times that of Australia and New Zealand. It is accepted that pre-school mortality rates are more sensitive indices of the socio-economic status of a country and the efficiency and organization of child health services than the infant mortality rates.

**Table II. NATALITY STATISTICS, PHILIPPINES 1973**

Neonatal Mortality Rate	30.3/1000
Maternal death rate	1.4%
Birth attendance	57.3% of births
Assisted by	
Physicians	45.4%
Nurses	3.9%
Midwives	24.3%
Place of birth	
In hospitals	23.3%
Home deliveries	76.7%

Although the present maternal death rate of 1.3% was reduced by 83.3% in the past 50 years, this rate is still three times that of progressive countries.

**Medical Manpower**

There are approximately 13,600 active physicians in the Philippines today. More than half are based in the cities. One-third are concentrated in Metropolitan Manila.

Overall ratio in 1970 was approximately 1 physician per 2,800 population. Maldistribution continues to be a serious

problem and the solution to medical manpower loss is far from satisfactory. A compulsory six-month service in rural areas before granting medical licensure may to some extent help our masses.

The bulk of pediatric practice in the Philippines is in the hands of the general practitioner. The majority of those who limit their practice to pediatrics or who spend considerable time to children, are registered in the Philippine Pediatric Society and so the membership of this Society may well be taken as representing the pediatric manpower supply of the country.

**Table III. PHILIPPINE PEDIATRIC SOCIETY MEMBERSHIP 1975**

<b>Total Members</b>		<b>564</b>
<b>Classification:</b>		
Fellows	111	
Specialists	109	
Active	266	
Affiliate fellows	8	
Associates	70	
<b>Distribution</b>		
Greater Manila	435	
Provinces	129	

The maldistribution of physicians who have had additional training in Pediatrics and Child Health is evident. Thus 4/5 of pediatricians are in and around Manila while 1/5 are spread in the rest of the

country. Some countries have reported a ratio of 1 pediatrician to 1000 children. In the Philippines the average proportion is approximately 1:30,000 children.

**Table IV. RATIO OF REGISTERED PEDIATRICIANS TO CHILDREN, PHILIPPINES (1975)**

	<b>Number of</b>	<b>Pediatricians</b>	<b>Ratio</b>
		<b>Registered in PPS</b>	
Greater Manila	2,602,200	435	1:6000
Provinces	14,200,000	129	1:110,000
<b>Total Average</b>	<b>16,802,200</b>	<b>564</b>	<b>1: 29,800</b>

## UNDERGRADUATE PEDIATRIC EDUCATION

In recent years both the status and hours allocated to Pediatrics in the medical curriculum have improved significantly (Tables VI, VII, and VIII). To a large extent these have resulted from recommendations of medical education seminars and conference previously mentioned.

### Fundamental Principles

One of the guiding principles in the preparation of the pediatric curriculum in the nine medical schools of the country, is the basic objective of a medical school in the Philippines as defined in the First National Conference on Medical Education, thus:

"The basic objective of a medical school is the production of a basic physician, that is, one who is well rounded in all aspects of medicine, who can take care

of his patients adequately in general practice in his particular environment, and who is all prepared to take up any branch of medical science after graduation."

Another fundamental principle is the realization of a need for comprehensive and continuing care of a growing and developing subject, highly sensitive and vulnerable to the environment. We subscribe to the central concept of pediatrics and child health as a concern for normal child development; that the student should be introduced to the study of growth and development (physical, intellectual, emotional and social) and those factors which cause significant deviations from the accepted norms.

### Apportionment of Clinic Hours

It is encouraging to note that presently Pediatrics ranks third (Table VII) in the apportioning of total clinic hours and this comes close to Surgery.

Table V. \*HOURS IN MEDICAL SCHOOLS, PHILIPPINES (1974)

Total hours	4,000**
Apportioned into	
Basic	1/3
Clinical	2/3
Apportionment of Clinic Hours	
Medicine	30 — 32 %
Surgery	20 — 22 %
Pediatrics	15 — 18 %
OB-Gyn	12 — 15 %
Psychiatry & Neurology	10 — 12 %
E E N T	5 — 8 %

\*From the Association of Philippine Medical Colleges (APMC)

\*\*Excluding the 2 months of full clinical clerkship in Pediatrics and the duties at night, also Sundays and holidays.

It is also an observation that a good portion of Community Medicine is taken up by Pediatrics since children constitute about 47% of the population in most

communities. Further as recommended by the WHO Pediatric Education Seminar, Pediatrics is integrated with the other clinical disciplines.

**Table VI. IVTH YEAR 10-12 MONTHS ROTATING FULL-TIME CLERKSHIP\***

Medicine	3 months
Surgical	2 — 2 1/2 months
Pediatrics	2 months
OB-Gyn	1 — 1 1/2 months
Psychiatry	1 month
Community Medicine	1 month (extramural)
EENT	1/2 — 1 month

\*From the Association of Philippine Medical Colleges (APMC)

The number of hours allotted to undergraduate pediatric teaching as recommended by different pediatric education seminars are 300 to 400 hours excluding of the internship period. The 1963 conference in Manila suggested a minimum

program schedule as follows:

All the medical schools presently give much more than the recommended 300 hours; some have more than doubled the time for Pediatrics, which also is started earlier, with the basic subjects.

**Table VIII. TIME ALLOTTED TO PEDIATRIC (1973-75)**

	MCU	FEU	UP	CIM	UE	UST	SWU
First 3 years	204	169	137	170	168	197	94
Fourth Year (Clerkship)	2 mo.	2 mo.	2 mo.	1 1/2 mo.	2 mo.	2 mo.	2 mo.
Total Pediatric hours		650	432			549	
Total hours medical curric.		4815	5468			4104	

**Students and Faculty members**

The student enrollment in medical schools has been reduced in recent years so that classes are now less congested

than in the past. Nevertheless there are still more students than abroad, so that three sections per year with 40 to 50 students each, are still observed.

**Table IX. ENROLLMENT IN MEDICAL SCHOOLS, PHILIPPINES**

Medical School	Ave. Undergraduate Med. Students Per Academic Year 1968-73	Freshmen Quota
Univ. of Sto. Tomas	1,250	300
Univ. of the Philippines	400	None; usually 85-100
Manila Central Univ.	825	200 but will admit 100 in 1974-75
Far Eastern Univ.	1,150	300
Southwestern Univ.	950	100 beginning 1974-75
Univ. of the East	850	300 but admits 250-270
Cebu Inst. of Med.	725	200

The proportion of faculty to students is still unsatisfactory. To some extent this had been improved by affiliating with some accredited teaching hospitals and providing pediatric supervisors from the medical school. This has also increased bed capacity for teaching purposes. Full time staff have been appointed in 4 schools while in 3 schools all teaching staff are on part time basis.

The salaries of the staff leave much to be desired and in fact are unrealistic to current cost of living; hence it is not easy to obtain full time staff.

#### **Topics, Time allotted, and methods**

The departments of Pediatrics of the seven medical schools have availed of a list of topics and time per topic as recommended by a Committee of the APMC in its First National Conference on Medical Education (Annex A). Details as to methods and on what year to take them up have been left to each school. Topics that have been allocated more hours are as follows:

Characteristics and Problems of Various Age Periods (up to 14 hrs.)

Growth and Development (6 to 14 hours)

Physiology and diseases of the newborn (6 to 16 hours)

Communicable Diseases (20 to 30 hours)

Digestive System (4 to 15 hours)

The trend is to introduce Pediatrics earlier in the second year, starting with such topics as Growth and Development, Genetics, Nutrition and Social and Preventive Pediatrics. Steps have been taken to integrate Pediatrics into some of the basic subjects and other clinical disciplines.

Didactic lectures have been reduced in

favour of bedside and extramural activities. Preceptorship of small groups is commonly observed. Assignment with pay patients has been started in at least one school.

Health education of parents and teaching them some procedures in the care of sick children are activities of medical students in the hospital or in community projects.

Family planning and maternal and child health have been emphasized both in urban and rural setting so that medical students now have opportunities to do motivational work and give family planning services.

A health center in an urban poor locality or in a rural area is now under a medical school and child care in such a center is under a staff of the Department of Pediatrics.

Although the past three years have been years of adjustment and revisions to meet the new 4 year medical curriculum (Annex B), it may be said that there have been aggressive and positive steps to tailor pediatric curriculum to Philippine needs.

#### **Research**

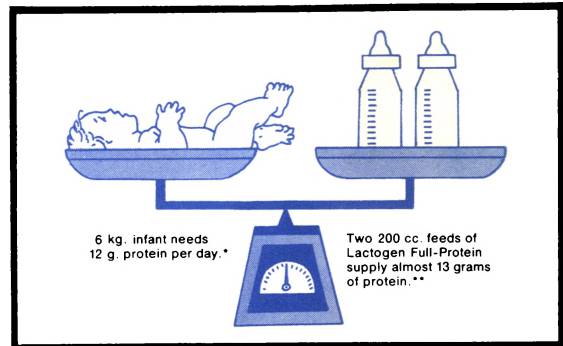
A deplorable aspect in medical education in the Philippines is the lack of incentives for students or faculty to do commendable research work. Student research is encouraged in 3 schools and the students themselves have taken the initiative of developing a research fund. The Philippine Pediatric Society during its annual convention offers research contents, a motivating factor to do research. One company awards a yearly research fellowship per school which may be for Pediatrics.

# Lactogen Full-Protein. The ideal follow-on formula.

Protein needs increase in relation to a baby's age and weight. And because the non-milk part of the diet is usually a most unreliable source of protein, the milk given to growing babies should compensate with an adequate supply of protein.

This is why Lactogen Full-Protein is the ideal formula during follow-on time . . . when the number of baby's milk feeds are gradually reduced and weaning foods are introduced into his diet. At full strength, Lactogen Full-Protein contains 3.24 g. of cow's milk protein per 100 cc. By contrast, most humanized formulas provide only 1.5 to 1.7 grams of cow's milk protein per 100 cc.

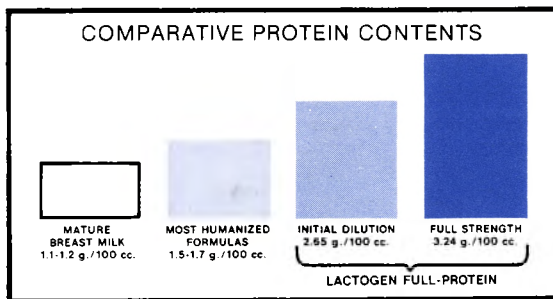
The protein content of Lactogen Full-Protein is above that of most milks suggested for routine infant feeding and meets a baby's daily protein needs in only two feeds. Take the example of a 6 kg. infant, likely to be 4 to 6 months old. Such a baby will need approximately 12 g. of protein a day. With two 200 cc. feeds of Lactogen Full-Protein, these needs are covered.



\* Based on the U.S. RDA (1968) for infants of 2 to 6 months.

\*\* Considering cow's milk protein to be equivalent in quality to breast milk protein.

It is clear that the protein supply from the other feeds can thus be minimal without harm to the child.

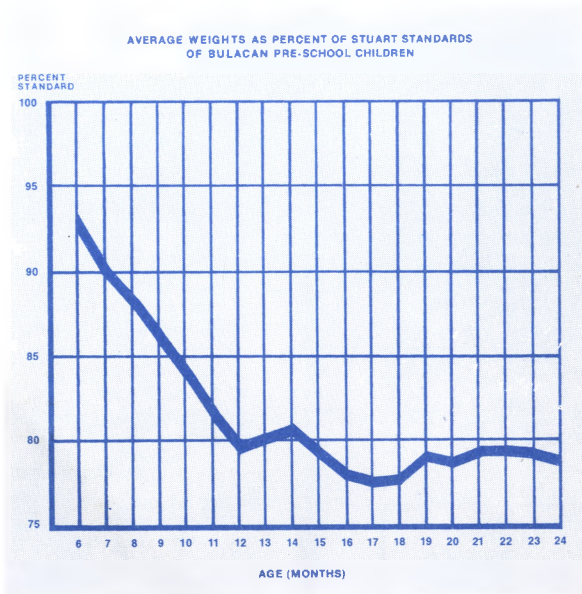


So when a mother starts baby on weaning foods, make sure he gets the protein he needs at his age. Prescribe Lactogen Full-Protein. The ideal follow-on formula.

Complete — with a full range of vitamins and iron in physiologically appropriate quantities.



# What's all this about protein-calorie malnutrition?



A local study by the USAID\* revealed that nutritional deterioration occurs during the first 6 to 11 months of an infant's life, and is caused mainly by poor weaning practices. While weaning foods, like "lugao", can supplement a baby's diet, they are often relatively low in protein — particularly good-quality protein.

Monthly data from the same study (see graph above) suggest that the child grows satisfactorily while he is being breast-fed and the supply of mother's milk is adequate. But after the sixth month, mother's milk alone, or mixed feeding with rice-based weaning foods like "lugao", is not enough to support the rapidly-growing infant. What is needed is a guaranteed daily protein supply when such weaning foods could represent 3 out of 5 of the day's feeds.



**It is for situations like this that Nestlé has come up with an ideal supplement or follow-on formula to breast milk and to humanized formulas. . .**

\*Report of the Bulacan Province Nutrition and Family Planning Program, December 1972, in manuscript form, Nutrition Division, USAID, Manila, Philippines.



### Evaluation of Students

There has been very little change in the evaluation of medical students; we still depend to a large extent on examinations and recitations and at times evaluation of preceptors.

In the clinical years, presentation of cases, participation in conferences and performance in patient care are assessed.

A final qualifying examination is given at the end of clerkship. Oral examinations have been discontinued.

The Medical Board Examination to some extent allows individual evaluation of students and a comparison of students from the different schools.

A Pediatric Residency Training Program usually consists of 3 to 4 years training in the Department of Pediatrics of a University hospital or in some accredited training center or hospital under a certified Fellow in Pediatrics. As formal residency programs are limited to teaching hospitals in bigger cities, there are not enough opening for all graduates who wish to specialize in Pediatrics. Therefore, a big number of graduates start a year or two in any local hospital but subsequently leave for abroad. In fact even residents in university and teaching hospitals seldom remain longer than one or two years in the country. Pediatrics is one of the most popular fields among graduates who leave. Unfortunately those who return to practice can be counted with the fingers.

Some information on residencies in the seven Philippine medical schools are summarized in Table X.

An example of a residency training program leading to a specialist certificate of the Philippine Pediatric Society

is summarized in Table XI and the distribution of residents' assignments in the 3 or 4 years residency program is shown in Annex C. It is gratifying to note that those who complete 3 to 4 years under a residency training program in the country succeed as pediatricians wherever they practice, particularly when the practice is outside of Greater Manila.

### POST-GRADUATE AND CONTINUING PEDIATRIC EDUCATION

During the one-year rotating internship after the M.D. degree is conferred, a two-month assignment in Pediatrics may be considered as a post-graduate course before licensure of practice. This prepares the physician for general practice, of which 40% to 60% is pediatrics.

Since 1968 the University of the Philippines has given 2 to 3 week annual courses in Pediatrics for practitioners. The University of Sto. Tomas has also given such courses since 1971; the FEU started a Community Pediatrics Course with Community Obstetrics last year. The other schools give annually short courses for their own alumni.

Medical societies have offered half to one-day courses in pediatrics for practitioners. In fact pediatric refresher courses are popularly requested by practitioners and the Philippine Pediatric Society has annual courses in different regions of the country.

### SUMMARY AND CONCLUSIONS

While Pediatrics or Child Health has been recognized as an autonomous department in all the medical schools in the Philippines for about 50 years now, significant gains have been attained only in the past eight years, following a Pe-

Table X. PEDIATRIC RESIDENCY TRAINING PROGRAMS IN UNIVERSITY HOSPITALS, PHILIPPINES 1974

	UST	UP	MCU	SWU	FEU	UE	CIM
1. Bed Capacity	40	120	20 (charity)	50		20	20
a. Pediatric			30 Semi-charity				
b. Nursery	60	60 (charity) 80 Pay	20 (Charity) 30 Semi-charity	20	20 (Charity)	25 (charity) 10 Pay	25
2. OPD Load							
General Pediatric	150	80-100	30-40 daily	60	65-30	25-30	10
Child Health (Preventive)	20 daily	40/day	25/week	50/week once	20/week		
3. No. of Residents	8	22	5	3 reg. 2 adj.	6 reg. 6 adj.	1 PT 4 reg.	7
4. Duration Resi- dency Program	3 years	3 years	3 years	3 years	4 years	4 years	3 years
5. Affiliation with other teachings hospitals				Yes	Yes	Yes	Yes
6. Staff Time							
— Part Time	9	8	6	8	11	9	7
— Full Time	17	2	0	0	6	2	0
Total —	26	10	6	8	17	11	7

**Table XI. A PEDIATRIC RESIDENCY TRAINING PROGRAM\*  
(3 or 4 YEARS)**

**I. Clinical Training**

**A. General Pediatrics**

- |                 |             |
|-----------------|-------------|
| 1. In-Patients  | (a. Service |
|                 | (b. Pay     |
| 2. Out-Patients | (a. Service |
|                 | (b. Pay     |

**B. Care of Newborn Infants**

General Nursery  
Neonatal Intensive Care Unit (NICU)

**C. Preventive Pediatrics**

Child Health Clinic  
School Health Service

**D. Outpatient Subspecialty Clinics**

- |                    |           |
|--------------------|-----------|
| 1. In the hospital |           |
| Neurology          | Radiology |
| Hematology         | Surgery   |
| Allergy            | Pathology |
| Cardiology         |           |

**II. Clinical Laboratory for Pediatric Procedures**

**III. Community Pediatrics**

- Attend a 3-week Course at the Institute of Maternal and Child Health for training in Maternal and Child Health and Family Planning, prior to
- Community Health and Medical service (outside headquarters).

1. San Luis, Pampanga	55 Km.
2. Niugan, Malabon	10 Km.

**IV. Research and/or Case Report**

**V. Teaching: Tutoring of affiliate medical students**

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\*At the Children's Medical Center Philippines.

diatric Education Seminar in the Region under the auspices of World Health Organization in 1968, two National Conferences on Medical Education in 1968 and 1972, and a Conference on the teaching of Nutrition in Medical Schools, the last three assisted by the Josiah Macy Jr. Foundation, through the Association of Philippine Medical Colleges. Worthy of mention among recent changes in **undergraduate pediatric education** are:

- More teaching hours for Pediatrics/Child Health, above the recommended 300 or 400 hours so that some schools are giving up to 800 or more hours.
- Introduction of the subject earlier in the medical curriculum, mostly in the second year or even in the first year.
- Full time staff so that only two schools have none; before 1968 practically there were no full time staff in any of the schools.
- Classes are small and more manageable as a result of a reduction of total enrollment for purposes of accreditation. Whereas there were 200 to 250 students taking up pediatrics per year, the number has diminished to less than half so that there are only 2 or at most 3 sections instead of 5 or 6 sections per class.
- Closer relations and integration in the basic subjects as well as clinical departments are now implemented.
- Community pediatrics is very much emphasized so that extramural teaching and community involvement have increased strikingly. In

this connection:

- \* Medical schools have community projects both in urban poor and rural areas with one center under its charge and a pediatrician staff supervising child care.
- \* Maternal and Child Health and Family Planning have received special attention with the students and residents actively participating.
- \* Nutrition is now taught with greater emphasis and more attention given to practical aspects and current problems.
- Almost all of the Pediatric faculty members have undergone teacher training courses including live-in and sensitivity training.
- Evaluation methods have been devised which include minimum pass level and quartile deviation; student counselling by faculty advisers concerning problems on scholastic performance and related contributory factors; the use of standard performance evaluation sheets, feedback evaluators of the services and staff by the students and periodic assessment of the senior students totality of knowledge in clinical pediatrics though an oral and written exams at the end of their pediatric training.

In the **residency training programs**, there are more systematic programs. Extramural activities constitute an important part of the program. Residents have been increased stipends are slightly more reasonable. Evaluation methods have been improved.

As regards **post-graduate and continu-**

**ANNEX A**

**PEDIATRIC TOPICS AND TIME ALLOTTED**

Subject Matter	Time Allotment in Different Schools							
	Rec. by APMC*	MCU	FEU	UP	CIM	UE	UST	SWU
Characteristics & Problems of Various Age Periods	4	12	1	1	9	2	14	2
Physiology & Dis. of Newborn	12	16	11	9	13	6	16	8
Social Pediatrics Including Family Planning	3	2	8	3	0	4	5	4
Preventive Pediatrics	2	3	2	4	3		5	2
Growth & Development	10	11	9	10	6	13	14	6
Genetics	3	2	1	5		3		2
History Taking & P. E.	4	2	12	3	6	1		4
Therapeutics & Pediatric Procedures	3	8		5	3	1		3
Infant Feeding & Problems	6	5	6	3	6	12	6	6
Nutrition & Its Disturbances	6	7	6	2	7	12	6	8
Psychopathologic Problems	3	4		2	4	3		2
Fluid & Electrolyte	5	7	5	3	7	7	4	8
Communicable Diseases	25	20	30					
Respiratory System	6	15	13	5	11	1	3	4
Digestive System	5	15	10	4	6	9	7	6
Genito-Urinary	5	9	7	4	4	1	3	4
Nervous System & Convulsive Disorders	10	10	6	5	10	1	3	6
Cardiovascular Disease	8	10	9	11	6	8	3	4
Blood & Blood Forming Organs	6	10	6	5	6	4	3	5
Inborn Errors of Metabolism	2	2	5	2	7	2	0	3
Collagen Diseases	2	6	2	3	0	0	3	2
The Skin	2	4	0	2	4	0		1
Musculoskeletal System	2	2	0	3	6	0		2
Neoplasms	2	4	0	6	1	2		2
Pediatric Emergencies		5	2	3	1	1		1
Allergy Immunology	4	0	5	7	4	0		1
Endocrine Glands	5	8	5	7	14	3	3	2
Spleen, Thymus, & R-E System	4	2	5	1	7	1	3	2
Unclassified Diseases	2	2		9				
<b>Total Hours</b>		<b>203</b>	<b>161</b>	<b>132</b>	<b>162</b>	<b>101</b>	<b>100</b>	<b>114</b>

\*First National Conference on Medical Education. Association of Philippine Medical Colleges 1968.

## ANNEX B

## REQUIREMENTS FOR M.D. IN THE PHILIPPINES (1972)

- Baccalaureate Degree: 4 years AB or BS
- Four years in a recognized Medical School, the 4th year of which is 10 to 12 months full clerkship with 24 hour duties, including Sundays and holidays.
- M.D. degree is conferred
- One year rotating internship in a hospital or medical center accredited by the Board of Medical Education.
- Licensure Examination to qualify for practice
- Six months of service in rural areas under the auspices of the Department of Health before the Certificate of Licensure is awarded.

ing education, the rotating internship after the M.D. degree has added to the practice and experience of the new graduate before practice.

A rural assignment of 6 months by the Department of Health exposes the new graduate to community medicine and public health, both for service and gaining experience on practice in less privileged areas.

The problems encountered show that there are still many steps and measures to take before reaching close to satisfactory pediatric education, the principal problems of which are logistics, materials and teaching aids; large classes; lack of full time and more staff resulting in inadequate supervision; and implementation of satisfactory evaluation of students, staff, and school.

## ACKNOWLEDGEMENT

The author acknowledges with deep appreciation the help extended by Dr. Jose Cuyegkeng, Executive Director of the Association of Philippine Medical Colleges (APMC) for valuable data, in-

formation and APMC reference books on Medical Education in the country.

Dr. Leticia S. Cordero of the Far Eastern University and Dr. Juanita Yadao of the Children's Medical Center Philippines, helped gather data from medical schools and some teaching hospitals. Dr. Franz Rosa, MCH Adviser of WHO Western Pacific Region made available some WHO references on medical education.

This paper would not have been possible without the valuable cooperation of the chairmen and assistants of Pediatrics of the seven medical schools; namely: Dr. R. G. Arellano of the University of Sto. Tomas; Drs. L. Mabilangan and R. Mendoza of the University of the Philippines; Dr. Pablo Abella of the Southwestern University in Cebu City; Dr. S. Alikpala of the University of the East; Dr. L. Cordero of Far Eastern University; and Dr. Purificacion Espinosa of the Cebu Institute of Medicine, and Dr. Rosita C. Brillantes of the Manila Central University.

ANNEX C

THE CHILDREN' MEDICAL CENTER PHIL. INC.

\* Outline of Services for Residents (1974)

First Year	Second Year	Third & Fourth Year
1. Memorial (Service) Ward	1. Memorial (Service) Ward	1. Memorial (Service) Ward
2. Memorial (Service) OPD	2. Memorial (Service) OPD	2. Memorial (Service) OPD
3. II Floor Pay	3. II Floor Pay	3. II Floor Pay
4. III Floor Pay	4. III Floor Pay	4. III Floor Pay
5. General Nursery -- IV Floor	5. Neonatal Intensive Care Unit (NICU) IV Floor	5. General Nursery & NICU --- IV Floor*
6. OPD Pay	6. OPD Pay	6. OPD Pay
7. Preventive Pediatrics ((Child Health Clinic)	7. Preventive Pediatrics (Child Health Clinic)	7. Emergency Room
8. Family Planning Course at INCH	8. Community Pediatrics in the Is. of Marinduque (2 months)	8. Preventive Pediatrics (Child Health Clinic)
9. School Health	9. Surgical Pathology	9. Subspecialty Clinic Hematology Cardiology Surgery Radiology Allergy-PGH (2 weeks) Neurology-JE or PGH (2 weeks)

ANNEX C (Continued)

- 10. Clinical Laboratory
- 10. Subspecialty Clinics
  - Hematology
  - Cardiology
  - Surgery
  - Radiology
  - Allergy-PGH (2 weeks)
  - Neurology-UE or PGH (2 weeks)
- 10. Elective (1 month)
  - Infectious Diseases
  - SLH (2 weeks)
  - Tuberculosis
  - QI (2 weeks)
- 11. Clinical Laboratory
- 11. Elective (1 month)
  - Infectious Diseases
  - SLH (2 weeks)
  - Tuberculosis
  - QI (2 weeks)
- 11. Research
- 12. Radiology Conferences
- 12. Tutoring of Medical Students
- 12. Organizing Conferences and Reports
- 13. Research and/or Case Report
- 13. Research
- 13. Tutoring Medical Students

\*Others assignments as deemed necessary

Prepared by:

Attested by:

(Sgd.) FE DEL MUNDO, M.D.

(Sgd.) ROSALINDA B. SORIANO, M.D.

April, 1974



ANNEX D

PEDIATRIC RESIDENCY TRAINING PROGRAM (TEACHING HOSPITALS)

	C.M.C. Hospital	National Children's	St. Luke's Hospital	Jose Reyes Hospital	Mary Johnston Hospital	Fabella Mem. Hospital
1. Date Started	: 1957	: 1962	: 1960	: 1957	: 1952	: 1957
2. Type of hospital:	Children and women	Children	General	General	General	Women and children
3. Bed Capacity	: 95 total	: 150 total	: 750 total	: 450 total	: 192 total	: 700 total
a. Pediatric	: 55	: all	: 75	: 43	: 41	: 110
b. Nursery	: 20	: Premature bas sinets Isolettes	: 35	: 25	: 32	: 200
4. OPD Load	:	:	:	:	:	:
General	: 52/day 16,857/year	: 73/day 90,600/year	: 41/day 16,212/year	: 24/day 9,996/year	: 9/day 27,600/year	: 94/day 32,850/year
Child Health	: 1,116/year	: 3/day	: 3/day	: 4/day	: 10/day	
Specialty	:	:	:	:	:	:
1.	: Cardiology	: Cardiovascular	: Cardiology --- 88	: Cardiology	: ER --- 4,500	: Cardiology 5/mo.

2. : Surgery : Neurology — 54 : Surgery : Dental — 1,500 : Surgery 10/mo.  
 3. : Hematology : Allergy — 150 : Hematology : Sterilization : Hematology 10/  
 4. : Neurology : Allergy : Psychiatry — 10 : Neurology 555 mo.  
 5. Family Planning : Neonatology 100/  
 6,890 : mo.

5. Number of :  
 Pediatric resi- : 18 : 4 : 7 : 3 : 17  
 dents : : : : : :  
 6. Classification & :  
 Stipend : : : : : :

1. 1st Year : P325.00/mo. : (Plus Board & : P603.00/mo. : P350.00/mo. : P603.00/mo.  
 2. 2nd Year : 375.00/mo. : + 60 subsistence: Lodging--P90.00) : Subsistence 400.00/mo. : Subsistence  
 3. 3rd Year : 400.00/mo. : + 8.00 Laundry : Senior-P440.00 : 8.00 Laundry/ 450.00/mo. : Laundry 8/mo.  
 4. 4th Year : 450.00/mo. : : Asst. Residents : mo. : 500.00/mo. :  
 All meals on : (Same for all) : P350.00 : : :  
 duty otherwise : Junior Res.- : (Same for all) : : (Same for all)  
 once daily : P260.00/mo. : : : :  
 7. Duration : : : : : :  
 Residency : 4 years : 3 years : 3 years : 4 years : 3 years

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# ANNUAL REPORT OF THE PMA NATIONAL TREASURER

February 15, 1976

To the House of Delegates:

As I am about to end my third year in office as PMA National Treasurer, it is my pleasure to report the following:

1. **PMA FUNDS** — Our Association is now in a very good financial position. Our Cash on Hand, in Banks, and short term investments have reached the million peso mark.

2. **PMA LOT** — The total contract price of the 5,019.8 sq. m. PMA lot acquired from the PHHC was ₱612,405.40. As of December, 1975, the total payment made for the lot was ₱486,058.74. The balance payable in 48 monthly installments of ₱2,940.62 would be ₱126,446.66 to be completed within 3 years and 7 months. However, upon the approval of the Executive Council, we have paid the balance of the loan in FULL on January 15, 1976 in the amount of ₱166,338.81 saving for our Association more than ₱17,000.00 in interest.

3. **PMA BUILDING** — As we have previously reported, all indebtedness to the United Construction Co., Children's Medical Center, and to Cuasay Suarez Plumbing Services in the construction of the PMA Building were fully liquidated including personal loans without interest from Dr. Jesus V. Tamesis, Dr. Fe del Mundo, and Dr. Rosita Rivera-Ramirez. The total expenditures incurred for the construction of the PMA Multipurpose Pavillon was ₱1,002,413.69.

4. **MATEF & DBP FUNDS** — Our total disbursement from March 16, 1975 to January 31, 1976 was ₱162,883.77. Upon the approval of the Executive Council, we have increased the Matef Benefit from ₱3,000.00 to ₱4,000.00 starting January 1, 1976. In my opinion, we can further increase the Matef Benefit in the next fiscal year 1976-77. As of January 31, 1976, the total Matef & DBP Fund is ₱539,736.51.

5. **PMA JOURNAL** — We have separated the Journal Fund from the Operating Fund upon the suggestion of our Editor. As of January 31, 1976, the total reserved fund for the Journal is ₱38,812.62.

6. **PHYSICIANS FUND** — As of January 31, 1976, the amount of ₱165,321.61 of our Physicians Fund are all invested in the money market securities.

7. **DOLLAR DEPOSIT** — Our dollar deposit in the Bank of America as of January 31, 1976 is \$5,573.80 recorded in the books at the conversion rate of ₱6.00 to U.S. \$1.00. At the current exchange rate of ₱7.30 to U.S. \$1.00, this deposit would amount to ₱40,688.74.

8. **DUES to the WORLD MEDICAL ASSOCIATION** — Due to restrictions on dollar exchange, we were unable to pay in due time our obligation for dues to the World Medical Association. Our total unpaid dues after condoning some of the previous years, is 15,148 Swiss Francs or approximately ₱35,535.92. It was suggested by the World Medical Association that during this period of currency transfer difficulties, we can pay our dues by opening an account for the World Medical Association in one of our local banks. We sent follow up letters informing them to submit the necessary papers required by the bank duly authenticated by a Notary Public at the Philippine Consular Office. Unfortunately, up to this time, the requirements were not fully complied with by the WMA. In the meantime, we have opened a separate bank account in the CBTC on January 14, 1976 in the amount of ₱35,535.82 under the name of PMA-WMA.

9. **INVESTMENT PORTFOLIO** — With the approval of the Executive Council, we have invested a greater portion of the funds in higher interest earning and safe investments. As of January 31, 1976, the total fund in money market placement is ₱728,505.00. Of this amount, ₱428,505.00 is MATEF & DBP Fund.

10. **SALARIES OF PMA PERSONNEL** — Due to the high cost of living, we have increased gradually the salaries of our PMA employees including the 10% across the board salary increase, the ₱50.00 emergency allowance, and Christmas Bonus (1 month salary).

1. **Other REPORTS** —

a) Attended all the Executive Council meetings and submitted in detail, monthly statement of receipts and disbursements with comparative figures of previous months, and monthly balances of cash in banks and short term investments.

b) Published in the bi-monthly issue of the PMA Journal, the Treasurer's Report to keep members informed on the PMA Finances.

c) Remitted regularly component societies' share in membership dues.

d) Acknowledged promptly all remittances received from component medical societies.

e) And lastly, I would like to put on record the invaluable support and cooperation rendered by the Accounting, MATEF & DBP, Membership Record, and the Journal Sections in the PMA Staff.

(SGD.) HILARION C. DE DIOS, M.D.  
PMA National Treasurer

**Republic of the Philippines**  
**Department of Public Works and Communications**  
**BUREAU OF POSTS**  
**Manila**

**SWORN STATEMENT**  
**(Required by Act 2580)**

The undersigned, HILARION C. DE DIOS, M.D., Business Manager of the JOURNAL OF THE PHILIPPINE MEDICAL ASSOCIATION (title of publication), published Bi-monthly (frequency of issue), in English (language in which printed), at Quezon City (office of publication), after having been duly sworn in accordance with law, hereby submits the following statement of ownership, management, circulation, etc., which is required by Act 2580, as amended by Commonwealth Act No. 201,

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In case of publication other than daily, total number of copies printed and circulated of the last issue dated, January-February, 1976.

1. Sent to paid subscribers .....	10,000
2. Sent to others than paid subscribers .....	200
<b>Total .....</b>	<b>10,200</b>

(SGD.) HILARION C. DE DIOS, M.D.  
 Business Manager

SUBSCRIBED AND SWORN to before me this 6th day of April, 1976 at Manila, the affiant exhibiting his/her Residence Certificate No. A-3876454 issued at Quezon City on Jan. 13, 1976.

(SGD.) RODRIGO C. MANAOG  
 Postal Inspector

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