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MONO-AMNIOTIC TWINS: DANGER TO THE LIFE OF AT LEAST ONE TWIN

(First Case Report in the Philippines)

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Twin pregnancy is not an uncommon occurrence. Of the 93,734 admissions in the maternity ward of the Philippine General Hospital from 1921 until 1943, there were 661 twin pregnancies giving an incidence of 1 per 141.

Since the babies are usually small, their deliveries are relatively easy. Their survival of course depends on their maturity, absence of maternal complications such as toxemia and placenta previa, fetal injuries incident to labor, and sufficiency of the mother's milk for their nourishment.

We speak of double ovum and single ovum twins. In the former, the twins come from different ova and are separated from each other by a partitioning wall composed of two layers of amnion and two layers of chorion. In the latter, the partitioning wall is composed only of two layers of amnion. It is unfortunate that our records do not distinguish between single- and double-ovum twins. However, all the twins (except one acardiacus twin having the size and shape of a goose egg) had partitions between them, so that each baby had its own amniotic compartment independent of the other. The advantage of this natural arrangement is that there cannot occur any danger of the interlacement of the cords as often occurs when there is no partition between the two, or in what is called monoamniotic twins, an example of which is here reported for the first time in the Philippines.

A monoamniotic sac containing more than one fetus is of great practical interest because of the grave danger it presents to the life of one if not of both twins. By the free movement of both fetuses, the cords become interlaced and knotted several times so that the circulation of one or of both may stop either during pregnancy or during the delivery of either one. The life of the second twin is especially en-

dangered because the birth of the first twin usually has the tendency to pull down the interlaced cords before the second twin, thus causing asphyxia of the latter during its birth.

Quigley[1] who reviewed the obstetrical literature up to March 1935 said that monoamniotic twins are extremely rare, there being only 109 cases published up to that date. Since then until 1940, two additional cases have been added, those reported independently by Sol Litt[7] and Parks[8]. Such authors as Ahlfeld[2], Rosenberg[3], Jeannin[4], Caseaux[5], and Rosinelli[6] independently agree in the extreme rarity and dangerousness of monoamniotic twins. Fortunately, though De Foe's quintuplets had only one placenta, there were five amniotic sacs, one for each quintuplet.

According to Quigley[1], of 109 authentic cases published in the medical literature, both twins survived only in 17 cases or 15 2/3 per cent chance. Both twins died in 41 cases and one baby died in 20 pregnancies. Eight of these babies were monsters. Eight resulted in abortions. Viardel[7] was the first to describe the condition in 1671. Quigley[1] reported the first case of monoamniotic twins in America that reached full term and where one baby was born alive. The second baby was stillborn because of the prolapse of the knotted interlaced cords.

Sol Litt[8] *et al* reported a case of monoamniotic twins, both born macerated as a result of the knotting and plaiting of the cords. One twin was anencephalic. Monoamniotic twins show a high incidence of abnormalities in one or both fetuses. One of the twins here reported had dactylism consisting of an extra thumb in one hand. According to Streeter, such anomalies are due to the disparity of the vitality of the different tissues of the body, the underlying factor being the constitution of the germ plasm; and the deformity dates back to the laying of the germ disc.

In 1940, Parks and Epstein[9] reported the first case of monoamniotic pregnancy in America where both twins, though premature (8 mos.), were born alive. These babies lived because there was not much interlacement between the two cords. Moreover, immediately after the birth of the first baby, the second twin was at once extracted by podalic version and breech extraction, because its hand prolapsed. This immediate delivery of the second twin saved its life.

As to Etiology, two theories have been presented; namely, primitive duality and primitive unity. Kleinwachter[10], Leishman[11], and Ahlfeld[2] favor the primitive duality wherein originally there were two amnions; but, because of the movements of the two fetuses, or the pulsation of the two closely lying cords, the amniotic partition had been torn. In support of this theory, mention is made of a small remnant of the partition between the cords seen in some cases.

The primitive unity theory was proposed by Schultze[12] and Bumm[13] who argued that, if tearing of the partition is to be believed in, it should also occur in biovular pregnancies. The fact that 5 of the cases have a common bifurcated cord argues against primitive duality. And we should like to add that connected twins or diplopogi, such as the Siamese or the Yangco twins; and the asymmetrical twins consisting of the autosite and parasite are clear proofs of primitive unity.

Both theories may be correct. But what we are most concerned in is the fact that whichever theory obtains, eventually, both fetuses lie in one amniotic sac and the life of one if not of both fetuses become endangered. And this is due to the knotting of the cords which occurred in 53.2 per cent in the collected series of Quigley.[1]

The cases reported by Dietrich,[14] Hammerschlag,[15] Newman,[16] and Quigley[1] gave similar findings as the one here reported where the cord of the second twin was caught in a knot of the cord of the first and the circulation was cut off by the birth of the first twin.

The following case report is the first one to be published in the Philippines among 661 twins delivered in the Philippine General Hospital from 1921 to 1943.

Case Report—S.A.L., 24 years, primipara, was admitted in the private service of one of us (H.A.S.) in the Philippine General Hospital in the morning of November 23, 1943, because of slight labor pains. She had been diagnosed to have twins since the fifth month of pregnancy, both fetuses being in cephalic presentation. She had good prenatal care. Nothing abnormal was noted in her condition. Her large abdomen was considered natural for her twin pregnancy. She was an intelligent patient who readily followed instructions. The blood pressure and urinalysis were normal throughout.

At nine p.m. or 9 hours after her admission to the hospital she had profuse flow of amniotic fluid, amounting to about 500 cc. Vaginal examination at this time showed the cervix to be 5 fingers dilated, but at 10:30 p.m., the cervix was completely dilated. The pains were somewhat weak but the first baby was born spontaneously after an injection of 1/6 cc. of pitocin at 1:04 a.m., November 24, 1943. No second amniotic bag was ruptured. In thirty minutes, the head of the second child became engaged pushing before it a palm-sized plait of knotted cord, which, on further examination, was found also to be connected with the cord of the second baby. Though the second baby was delivered soon afterwards, it was stillborn as expected. Both babies were of the same sex and looked very much alike. The first baby weighed 2640 grams and the second baby 2440 grams. The second baby was a case of polydactylism. It had an extra thumb on the left hand. There was only one placenta which weighed 1000 grams. There was no partition between the babies and the distance of the insertion of the cords was only 5 centimeters.

COMMENT: The short distance between the insertion of the cords and especially the absence of an amniotic partition between the fetuses, which gave them freedom of movement in any direction, explains the interlacement of the cords and the formation of true knots, which as shown in some cases reported, may cause the death of one or both twins before full term is reached. The intrauterine death of one or both twins may cause miscarriage or premature labor.

The lesson to be derived from this case is that the presence of monoamniotic twins should be suspected when there is no bag of water to be ruptured or which ruptured spontaneously after the delivery of the first child and the presenting part of the second baby is felt directly with the examining fingers without any intervention of the membranes. In such a case, to prevent the prolapse of the plait of interlacement of the cords, the cord of the first baby should be ligated, cut short, and pushed up beyond the presenting part of the second child before the latter is delivered. In case the plait of the cords descends before it, and cannot be pushed upward, measures should be taken for the immediate delivery of the second child to save it from asphyxia as the result of the prolonged compression of its cord.

After the preparation of the above article on April 6, 1945, the senior author of this paper (H.A.S.) cesareanized a case of severe eclampsia, 18 yrs. old, to save the babies. They happened to be of monoamniotic twins with broad interlacement

and true knotting of the cords. Had these babies been delivered per vaginam even though the mother were in normal condition, the life of at least one of the babies would have been endangered. The babies were asphyxiated at birth and had to be fed by the dropper for the first few days, but they finally survived and were discharged in good condition at the age of over one month.

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RADIOLOGICAL FINDING IN SYPHILIS OF THE RECTUM

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Syphilis of the rectum is very rare or seldom thought of. This accounts for the meagerness of the discussion about it in radiological literature. Good illustrations of typical cases are lacking. Because of this, this article may be of service to the reader.

This case is that of a 46-year-old Filipino female patient admitted to the hospital on May 19, 1939, because of frequent, scanty, and bloody bowel movements and of the presence of masses in the anus. According to her history, her second husband had a strong history of venereal infection and one of her pregnancies had resulted in miscarriage.

This particular illness had started 3 years before as a painful and bloody defecation accompanied by formation of soft masses in the anal region with blood on defecation especially upon straining. Six months before admission, her B. M. became frequent—10-20 times a day—and was accompanied by tenesmus but not with fever. Stools were always soft, flattened and tinged with blood.

She had lost weight since onset. The only important physical findings were in the abdomen and rectum. The abdomen showed a palpable and elongated mass in the left iliac and hypogastric regions which probably was an indurated and enlarged sigmoid colon. The anus showed external hemorrhoids; and, on rectal examination, a distinct fibrous stricture could be appreciated about 1 inch from the anal margin. The examining finger met a rather firm and dense surface all around the rectum, which gave felt like a wart. The rectal lumen was so very much narrowed that it hardly admitted the tip of the examining finger. The vaginal examination showed that the rectum could be felt as a hard tube. A moderate amount of foul brownish pus was passed per rectum.

With this information and these findings, the case was referred for radiography of the colon. The picture distinctly showed the uniform tube-like narrowing of the whole portion of the rectum, sigmoid, and a small portion of the descending colon (Fig. 1). Even the double contrast method gave distinctly the same finding and showed the mucosa to be smooth with the disappearance of the normal folds.

With these X-ray findings, the first consideration that comes to the mind of the radiologist is of course the luetic pathology. Although clinically the symptoms may appear to be those of malignancy, yet the radiological finding is not the same as that usually found in rectal or sigmoidal cancer. Malignancy, to be sure, shows also stricture or narrowing of the involved gut; but the narrowing is often irregular and not symmetrical as in this case. In cancerous growth, the extent of the lesion cannot be as extensive as is presented in this case which involves not only the rectum but also

the sigmoid and portion of the descending colon. This is seldom if ever seen in the case of malignancy. The patient would probably die before cancer attains this stage. Then, too, as in Charcot's joint, the patient is relatively healthy in spite of these marked pathological changes.

This radiologic impression is further supported by other laboratory findings. The blood Wassermann, for instance, has been persistently strongly positive, 4 plus. The spinal fluid also shows positive reaction. The histological examination of a piece of rectal tissue shows chronic and subacute inflammatory process, with tendency to round-cell perivascular infiltration but no evidence of malignancy. The possibility that the case may be that of lymphogranulomatous pathology is ruled out by the Frei test which is negative.

This case clearly shows the importance of X-ray examinations in diagnosis. The clinical symptom—namely, the painful and bloody defecation, which becomes frequent as the disease advances and is accompanied by tenesmus and the formation of flattened stools—this may be found in malignancy and in a variety of granulomatous condition as well as in syphilis. In fact, Stokes claims that there is no sign of diagnostic criteria which may be considered distinctive of this disease. The claim of others that exacerbation of heat and tenesmus at night is characteristic of this disease is not true in this case. The patient never showed such symptoms. The venereal history of the patient's second husband and the positive Wassermann in the blood and spinal fluid are important data in the diagnosis of the case. But such findings alone cannot eliminate the possibility of malignancy, because a syphilitic patient may also have a rectal or sigmoidal cancer. Biopsy is of course very important, but there are instances where proctoscopic examinations cannot reach the site of pathology to enable one to get a piece of tissue for section. Neither can rectoscopic examination alone give the extent of the lesion. Hence, a radiological examination of the colon is of utmost importance. If it reveals extensive narrowing of the lumen of the gut, it would help greatly in the formulation of a course of treatment; provided, of course, it is interpreted in the light of clinical data and pertinent serological findings.

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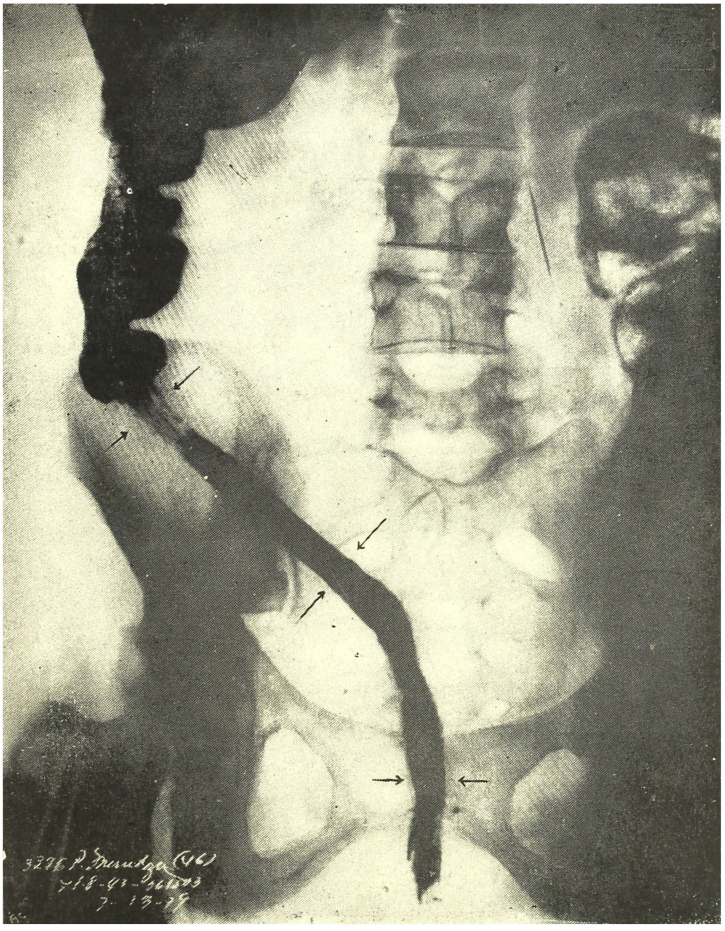

FIG. 1.—*The picture shows distinctly the uniform tube-like narrowing of the whole portion of the rectum, sigmoid, and a small part of the descending colon.*

SIXTY-TWO CONSECUTIVE CASES OF SYMPHYSEOTOMY

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In the Journal of the Philippine Islands Medical Association, v. XIX, March, 1939, No. 3, is a report by Drs. A. Baens and N. Espinola on ten consecutive cases of symphyseotomy. Up to date, I have had a total of sixty-four cases.

The results on the whole have been so encouraging that I have not hesitated to section the symphyseal joint whenever indications and conditions for its use arise. Sound and good obstetrical judgment must always be exercised in weighing the pros and cons of any obstetrical problem and is always a determining factor in the prognosis; but the obstetrician, too, must be proficient and skillful in the different modes of intervention belonging to his art, if he will serve the interest of both mother and child through the hazards of childbirth. Proficiency and skill in symphyseotomy would so add to the obstetrician's scope of action that, in dealing with cases of cephalo-pelvic disproportion where the test of labor is pushed to the limit, he can meet the problem with self confidence and equanimity.

Local conditions and peculiarities provide a rich field in symphyseotomy. The Filipino pelvis has an average Baudelocque's diameter of only 17 cm. as against that of the Americans which is 21 cm. The average weight of the Filipino baby is not very far from that of Americans, 3000 grams against 3200 grams. There are, however, many Filipino babies weighing around 3500 grams and a smaller number reaching 4000 to 4500 grams. A few weigh as much as 5000-grams or more. According to Williams, "actual dystocia is rarely encountered, unless the weight exceeds 5000 grams, provided, of course, that the pelvis and fetal presentation are normal." In my experience, the reserve capacity of the Filipino pelvis with average measurements is so small that, when the weight of the baby ranges from 3,500 grams to 3,700 grams, we frequently have mechanical difficulties. Extreme dystocia are encountered with babies weighing from 4500 to 5000 grams, unless the pelvis is distinctly above the average size. Then, too, we have quite a number of cases with the external conjugate measuring from 15 to 16 centimeters found in our women of smallish stature.

We have many patients, particularly common in the indigent class, who come to the specialist only after very protracted labor, potentially or actually infected, having passed through doubtful hands, and therefore poor risks for the abdominal route of delivery.

REGIONAL ANATOMY

A good understanding of the regional anatomy, to my mind, is an absolute requisite to good technic of operation and to full appreciation of its dangers. A reading knowledge is not enough. There should be a thorough study of anatomical rela-

tions in the fresh cadaver to minimize, if not to avoid totally, injuries to neighboring structures.

Whether the symphysis pubis is a true joint or not is still a disputed question. In the mass of fibrocartilage interposed between the pubic bones, Luschka claims the presence of a synovial membrane and therefore would classify the symphysis pubis as a true joint. Joessel and Loeschke deny the existence of a synovial membrane and think that the fluid in the interior is only a product of degeneration and liquefaction. Superiorly, the joint is held by the superior ligament; and, inferiorly, by a very much stronger band of fibrous tissue, the ligamentum arcuatum. Behind is a thin layer of fibrous capsule; and, in front, the anterior ligament with deccussating connective tissue fibers.

In the non-pregnant state, the average separation of the pubic bones as reported by D. Abramson *et al,* from extensive X-ray studies, is 4.6 mm. During pregnancy, all the pelvic joints suffer subluxation in response to the combined action of estrin and relaxin. This is a favorable change, as this allows a physiological increase in the available diameter during parturition.. Partridge calculates that a total luxation of six millimeters at the joints of the pelvic girdle around a tightly fitting head would produce a millimeter clearance on every respect of the fetal head. One millimeter clearance is not to be despised, as it may mean a living child. The average seperation at the symphysis pubis during pregnancy is 7.7 mm. I have observed in two of my patients a maximum luxation of about 2 cm. at the joint interferring with locomotion and producing sharp pains on slight motion at the symphysis and sacroiliac joints with radiation to the lower extremities. One of these patients had to get hold of a chair for a prop and had to slide sidewise without lifting the legs in moving from one place to another in the house. In old primiparas, the separation at the symphysis during gestation may be so minimal that its location with the point of the knife is made somewhat difficult. Also, in some cases, the cleft is tortuous, sickle or S-shaped — a fact to be borne in mind during sectioning of the joint.

Just behind the symphysis pubis is the cavum Retzii, filled with adipose tissue. Next is the lower portion of the urinary bladder and the urethra. In cases with protracted second stage of labor, the bladder is carried with retroceding lower segment of the uterus, assuming a suprapubic position, so that only the lengthened urethra remains behind the joint.

Attached to the rami of the pubic and ischial bones forming the pubic arc, behind and somewhat inferiorly, are the crura of the clitoris, each about four centimeters long, uniting medially to form the body of the clitoris. Body and crura are made up of intricate, plexiform, vascular channels confined in definite masses of fibrous tunics. Injury to these cavernous channels would lead to hematoma formation between and behind the cut ends of the pubic bones.

Below and posterior to the pubic arc are ill-defined strands of fibrous connective tissue, the pubo-vesical ligament, which is the main supporting structure holding the bladder and urethra close to the posterior surface of symphysis pubis and chiefly responsible for good continence of the urine. Severance of these fibrous strands would lead to cystocele and urethrocele with probable incontinence.

The diameters of the pelvis are greatly increased with the gaping of the bones. There is relatively greater increase towards the transverse and oblique diameters

than towards the antero-posterior diameters. The general rule is for every centimeter separation, there is a gain of 2 mm. at the obstetrical conjugate.

Galabin gives the following changes accordingly:

Separation in Symphysis	Increase in True Conjugate	Increase in Transverse Diameter
2 cm.	0.25 cm.	1.00 cm.
3 cm.	0.50 cm.	1.50 cm.
4 cm.	0.65 cm.	2.00 cm.
5 cm.	0.83 cm.	2.25 cm.
6 cm.	1.10 cm.	3.00 cm.

Doderline has calculated that, when the pubic bones gape by six to seven centimeters, the area of the superior straight is increased by one-half.

When the conjugate vera is less than 7.5 cm., or when the head of the fetus is too large for a pelvis nearly or entirely normal, or when the presenting diameter is long because of error of attitude of the head of the child, one should be careful in deciding for symphyseotomy, lest the bones gape beyond the maximum and impair the sacroiliac joints.

INDICATIONS

In this series, the indication were all secondary to failed forceps application and extraction. Persistence in the use of brutal force in tight forceps extraction means the great probability of intracranial injuries leading to stillbirths or to disabilities of varying degrees if the babies survived. One indication was for failure to extract the aftercoming head in breech extraction.

All the cases were with cephalo-pelvic disproportion. Quite a number belonging to the indigent class, came to the hospital after a protracted labor, bags of water ruptured for many hours, actually with definite signs of infection and precluding the abdominal route of delivery. Most of the cases were my private pay patients who were given the full test of labor and who required forceps application with failure to extract the baby. In cases with marked cephalo-pelvic disproportion, I instituted elective or early cesarean section.

The radical cesarean section often advised for infected cases gives a mortality rate of from 20% to 30%. In cases of failed forceps extraction, De Lee would not hesitate to sacrifice the baby by craniotomy; but in so doing the obstetrician acts as "judge, jury and executioner."

Zarate of Buenos Aires has broadened the indications of his so-called "partial symphyseotomy" by sectioning the joint early in labor upon the discovery of an existing cephalo-pelvic disproportion and then allowing the patient to follow the natural course of delivery. When one treads on grounds like those of Zarate — that is, elective and primary symphyseotomy — one encroaches on the field of cesarean section.

Technic

The position of the patient is that of advanced lithotomy with the legs in partial abduction held by assistants or by leg supports.

The urinary bladder is carefuly emptied. The applied forceps is not withdrawn.

If the anterior blade is on the way, as it may be when the application is for a transverse position of the head, it is glided to one side and rotated back to its correct place after the joint has been cut.

In sectioning the joint, I have followed the subcutaneous approach, avoiding the rather extensive dissection of Farabeuf and of Bourne of England.

To achieve precision, I have practiced on the fresh cadaver many times before doing it on the living. I see to it that the point of the knife does not penetrate beyond the space of Retzius to avoid injury to the urinary bladder and urethra.

The left index finger is inserted into the vagina, posterior to the symphysis pubis to push the urethra towards the right side, very much facilitated by inserting a catheter into the urethra to give it volume and solidity. A straight, narrow bladed knife is held firmly and perpendicularly to the anterior surface of the joint and is made to pierce the skin and subcutaneous tissue one-half centimeter below the superior border — thus respecting the superior ligament. One hits the correct starting place when the point of the knife feels the gristly fibro-cartilage.

With the point of entrance of the knife as the fulcrum, the blade is oscillated downwards and forwards, increasing the reach of the knife as the ligamentum arcuatum is approached. This ligament offers a tough fibrous resistance to the edge of the knife. This is cut completely, care being taken not to cut the periurethral tissue where the pubo-vesical ligaments are situated.

A slight traction of the head with the forceps completes the separation of the pubic bones accompanied by a snap. If the separation is not effected by slight traction, the knife is reinserted and the superior ligament is cut. Traction again will easily bring about gaping of the bones. The section of the joint is usually done within a minute.

The soft parts of a multiparous patient stand the strain of distention with better tolerance than those of primiparas. In the latter, to lessen the strain on the soft parts proximal to the symphysis pubis during the gaping of the bones, a deep episiotomy incision is made. The traction and rotation of the head of the child is done gently to avoid laceration of the soft parts.

After delivery, the soft parts are inspected for injuries. The episiotomy wound in primiparas, any lacerations, and the skin puncture are sutured. A permanent catheter is inserted into the urinary bladder, and removed three to four days after birth. The anterior half of the pelvic girdle is strapped with adhesive plaster to approximate and keep the bones together.

REPORT OF CASES

The series comprises a total of 64 cases. Thirty-eight of these belonged to the paying class; the rest were admitted in the charity ward of the Philippine General Hospital under my service.

There were 53 primiparas, three of whom I had cesareanized with the first pregnancies for cephalo-pelvic disproportion. These three cases expressed the wish to have a vaginal delivery notwithstanding the warning that delivery per vaginam might be with symphyseotomy.

Eight of the primiparas were above 30 years in age. One was 36; two were 37.

There were eleven multiparas with definite history of dystocia in the previous deliveries.

All were given very much more than the adequate test of labor: "a couple of hours of second stage of labor after the rupture of the bag of water and in the presence of good uterine contractions." The head of the child was given plenty of time for moulding. Only a change in the fetal heart rate, and a stretching, thinning lower segment cut the test of labor. Five had 48 hours of labor, one, 55 hours; one, 60 hours; four, 72 hours; one, 80 hours; one, 85 hours; and one, 96 hours. Many had the second stage lasting from six to eight hours.

Two cases were with intrapartum eclampsia. Twenty-one were cases of right occipito posterior. There were two cases of face presentation.

High forceps application preceded the symphyseotomy in 28 cases, and mid-forceps, in 34 cases.

Eleven had the average Baudelocque's diameter of 17 centimeters (for Filipinos). Thirteen had below 17 centimeters. Seventeen cases were accompanied by three-centimeter separation of the pubic bones; three had five-centimeter separation; and one, with six-centimeter separation. The last was a case of face presentation, with a Baudelocque's diameter of 17.5 cm.; and the baby weighed 3500 grams.

Puerperal morbidity was rather high. Definite puerperal infection was evident in 17 cases. This is to be expected by the very nature of the cases. Five developed pyelitis. One case developed an intraligamentary abscess of the left side after about two weeks of low grade fever. This patient came from outside with history of prolonged labor, having chills and a high temperature of 39.5 degrees centigrade. The amniotic fluid was foul. I emptied the pus through the extraperitoneal route. It amounted to about 400 cc. The patient made a rapid recovery after the pus had been drained.

There were four cases that developed partial loss of control of urination. These patients had some drippling when the bladder became full. All have been corrected by plastic restoration of the pubo-vesical ligaments to bring the relaxed urethra close to the symphysis pubis again. In one the repair was done after about three weeks of puerperium; in three, immediately after delivery in the second parturition.

The average stay in the hospital was two weeks.

Ten cases have returned for succeeding deliveries. Five of these had spontaneous deliveries with their second pregnancies. Four have delivered twice since the symphyseotomy operation—one, requiring two successive midforceps; one by midforceps once, and the rest spontaneously. In all these cases, there was noticed a separation of the bones by from one and a half to three centimeters during the passage of the head. Thus the symphyseotomy operation had conferred on the pelvis a permanent enlargement for succeeding deliveries. One exception to the rule, in which the patient does not seem to have derived any benifit from the first symphyseotomy operation is in the case of a woman, para IX, with history of instrumental deliveries in many of her confinements. Baudelocque's diameter is only 16.7 cm. In the last three deliveries, she had three successive symphyseotomies for failed high forceps application.

MORTALITY

There was only one maternal death, but this can not be ascribed to the symphyseotomy itself. It was the case of a primipara, 22 years old, with a failed attempt

at high forceps application when the cervix was only five centimeters dilated. As a consultant, I was not informed about the attempted operation; and I pushed the test of labor for many hours more, until the cervix became fully dilated and until the fetus revealed signs of distress. During the hours of further waiting, there was observed a tender tumefaction at the region of the lower abdomen, which was not alleviated by catheterization of the urinary bladder. A living baby was extracted by forceps with symphyseotomy. One hour after delivery, the patient collapsed and died. The autopsy showed that the anterior wall of the lower segment had divided into two flaps between which about 300 cc. of black, clotted blood had collected. The dissection of the anterior wall of the lower segment into two flaps was produced by the second blade of the forceps during the first attempt at intervention. The careful autopsy did not show any penetration by the knife of the space of Retzius, nor of the urinary bladder, nor of the anterior flap of the dissected wall of the lower segment. From the autopsy, one can explain the presence of the tender tumefaction in the lower abdomen after the first attempt at high forceps application. Were the consultant properly informed of the first attempt at intervention, the diagnosis of rupture of the uterus would have been thought of and the line of treatment adopted would have been immediate radical cesarean section.

The mortality in this series is one out of 64 or 1.56%. Any form of cesarean section after failed forceps application or in the presence of frank infection would give a mortality rate of from 10% to 30%, according to foreign figures. From 1927 to 1940, there were 364 cases of cesarean section performed by different operators in the Philippine General Hospital. Seventeen were cases of radical cesarean section with a mortality rate of 35.28%.

Morisani of Naples, using the open method of symphyseotomy, lost 10 out of 50 cases—a mortality rate of 20%. Schwartz, employing the subcutaneous approach, had three maternal deaths out of 113 cases—a mortality rate of 2.65%.

There were two stillbirths. One was due to the inability to extract the aftercoming head in breech extraction; the symphyseotomy was done too late. The other case was one where the resident on duty used strong traction with the forceps for about thirty minutes before the consultant was called. Heart beats were still audible, and the operation was done to give the fetus the benefit of the doubt.

There were three neonatal deaths. One had diarrhea of the newborn; another was from a mother with eclamptic convulsions; the third was in a case where the mother had been neglected outside for two days and the heart beats on admission was around 190 per minute.

DISCUSSION

The results in this series would justify the use of symphyseotomy. The arguments against it cannot hold if no other obstetrical operations can be employed to cover the class of patients given, with the aim of saving the life of the fetus and at the same time exposing the mother to minimal risks.

No very definite and clear-cut procedure can be chosen for the cases of relative cephalo-pelvic disproportion. Before or early in labor, one cannot say which case shall be delivered by the abdominal route; and which, by the vaginal route. The physical means of evaluating the degree of cephalo-pelvic disproportion, including X-ray cephalometry and pelvimetry, are of valuable aid; but again the clinical test

of labor remains to be the fairest test for a final decision. Other factors than mere determination of the size of the head and mensuration of the capacity of the pelvis, the last accurate to the millimeter when the X-ray method is used, enter into the chances of delivery per vaginam—factors, like the malleability of the fetal head, the quality of uterine contractions, and the degree of elasticity of the pelvic joints. When the clinical test of labor fails, forceps applied and traction would not effect descent of the head, child still living, skill in symphyseotomy would serve as a good operation in reserve.

Based on bacteriological studies of the intraovular space during cesarean section, Douglas concludes that twelve hours after labor the risk of infection increases definitely and progressively with each hour of labor. He therefore, proposes the radical form of cesarean section to take care of cases belonging to this type. If we follow this dictum, we would encourage many early cesarean section and deprive many women of the chance to deliver spontaneously, which probability in relative disproportion amounts to from 75% to 80%. And if the twelve hours limit is passed, the uterus is to be sacrificed.

In the treatment of infected cases, one of the operations in use is the Gottschalk-Portes cesarean section. The exteriorized uterus after a long-drawn postoperative course to get rid of the infection, requires another operation to put back the uterus in its usual place. At its best, the operation is attended with 10% maternal mortality.

CONCLUSIONS

The following advantages of symphyseotomy are very evident:

1. It can prevent craniotomy on the living child in failed forceps extraction, when delivery through the abdominal route offer greater hazards to the mother.
2. With proper skill, the dangers attending the mother in symphyseotomy can be minimal.
3. It is done in quick time and in a very simple way and therefore would contribute the least shock to a patient subjected to a very long test of labor.
4. There is no invasion of the abdominal cavity, no exposure of the abdominal viscera, no spill into the abdominal cavity of infected uterine seepage.
5. Postoperative courses, despite the very bad nature of the cases, are often smooth.
6. There is no scar which will serve as a point of weakness in the uterine wall and therefore there is no fear of rupture in the succeeding pregnancies and labor.
7. There is improvement in the capacity of the pelvis, thus enabling the patient to meet future requirements towards more natural delivery.

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RECENT EXPERIENCES WITH TRANSURETHRAL UROLOGICAL SURGERY *

LUIS F. TORRES, Jr., M.D.
Department of Surgery, College of Medicine, University of the Philippines, and the Philippine General Hospital.

The object of this paper is to acquaint the medical profession of the Philippines with the newest phase of urological surgery. Transurethral urological procedures comprise all of those operative procedures performed on the urethra, prostate, and bladder through the cystoscope. The instrument used differs from the standard cystoscopic appliance in that it has a straight sheath and a foroblique telescope, while the standard cystoscope has a sheath with a curved tip and a right-angled telescope. The difference between the foroblique and the right-angled telescope will be made clear by the following example. To an observer standing in front of a building (foroblique telescope) the building will appear in profile, all contours being appreciable, including its height; to the same observer from an airplane flying over (right-angled telescope) the building will appear flat and squat. It will therefore be evident that the ordinary cystoscopic experience with the standard right-angled lens will not be sufficient as a background for transurethral surgery. Routine cystoscopies must be performed with the foroblique lens in order to familiarize the transurethral surgeon with the profile, the landmarks, and the contour of the prostatic urethra and bladder, so that at the time of operation there need be no time lost in orientating the mental image. The transurethral work on which this report is based, and which covers the period from January 1941 to December 1945, is founded on a background of 681 cystoscopies performed with the foroblique telescope of the McCarthy panendoscope.

Transurethral Prostatic Resection

The obstructing prostate gland is the prime objective of transurethral surgery. There were 80 patients with obstruction in the prostatic urethra, 22 of which were due to fibrous median bar, 5 to cancer of the prostate, and the rest to benign prostatic hypertrophy. Of these 80 patients, 36 were operated on by perineal prostatectomy, 12 by suprapubic prostatectomy, and 32 by transurethral surgery. Thus it is seen that while I have employed all the 3 methods of surgical approach to the prostrate, I have used the closed transurethral method in roughly about 40%. I believe with Lowsley and other urologists that the urological surgeon should be able to attack the obstructing prostate by any of the 3 accepted routes—suprapubic, perineal, or transurethral—as the case may demand. It is merely a question of selecting the operation that suits the patient rather than forcing all patients to suit one operation to the exclusion of all others. I have heretofore reserved the transurethral route for those cases of small enlargements of the prostate or small fibrous prostates producing the so-called median bar obstruction. In my transurethral resection cases I have removed

* Read at the Manila Medical Society, Feb. 12, 1946.

an average of 20 grams of prostatic tissue using the pistol-grip type of resectoscope and the technique of Dr. Reed M. Nesbit of Michigan. For the purely fibrous prostate with median-bar formation, I have used the Collings Knife Electrode through the panendoscope. There were 2 deaths from acute fulminating pyelonephritis at a time when urinary antiseptics such as sulfa drugs and penicillin were not available. That was in 1943, the middle of the Japanese period of occupation.

Transurethral Resection of Bladder Tumors

Eight cases of papillary carcinoma of the urinary bladder were submitted to resection per urethram followed by deep x-ray therapy. There were no deaths in this group attributable to the operative procedure, but one patient died two weeks postoperatively of cerebral embolism. He had been suffering for years from chronic pulmonary tuberculosis and generalized arteriosclerosis.

Cystoscopic Fulguration

By connecting the bladder electrode to the coagulating current of the high-frequency generator, one can destroy by electric sparking ("fulguration") cysts or newgrowths inside the bladder. This was the method introduced in 1910 by Edwin Beer. Nineteen patients were fulgurated 26 times cystocopically without a single death. All of them are known to be alive during this period of observation.

Transurethral Crushing of Bladder Stones or Litholapaxy

The operation of crushing bladder stones, which is an old one, is again coming to the fore. Henry Jacob Bigelow's stone crusher, combined with cystoscopic control by means of the McCarthy Foroblique Panendoscope, offers an ideal means of extirpating bladder stones of not more than one inch in diameter. Provided the stone is freely movable in the bladder and within the required diameter in size, crushing can be performed with the blind Bigelow Lithotrite. The instrument is then removed and the fragments evacuated through the large panendoscope sheath by means of an Ellik evacuator. Before withdrawing the panendoscope sheath, the foroblique telescope is inserted to check up on any fragments left. The process of crushing can then be repeated until the last speck of stone is evacuated. Out of 52 patients with bladder stones, 13 qualified under the conditions noted above and were submitted to litholapaxy. There was one fatality a few days postoperatively due to acute fulminating pyelonephritis. This also happened in 1943, and probably the same reasons may be adduced to explain it.

Conclusions

From these observations, one may conclude that:

1. Transurethral prostatic resection has a definite place in prostatic surgery, but it should be tried only by those with the necessary training in cystoscopic vision with the foroblique lens. (I have purposely not mentioned the cold punch technique of resection, which is more difficult to master and requires as a background cystoscopic experience with the direct vision cystoscope).

2. The resectoscope extends further our therapeutic armamentarium against

bladder newgrowths; for, with the movable loop of the instrument, one can extirpate tumors from the bladder as easily and as efficiently as through the open bladder.

3. Cystoscopic fulguration of bladder tumors and crushing of bladder stones may also be accomplished through urologic surgery that makes use of the natural route.

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Editorial

Regarding the Proposed Principles of Medical Ethics for the Medical Profession in the Philippines

Article 3 of the Constitution of the American Medical Association defines "constituent associations" as "those state and territorial medical associations which are, or which may hereafter be, federated to form the American Medical Association, in accordance with this Constitution and By-Laws." As one of these constituent associations, the Philippine Medical Association is governed by the *Principles of Medical Ethics* of the American Medical Association. These Principles, which were adopted by the Board of Medical Examiners on September 19, 1929; approved by the Honorable the Secretary of the Interior on January 9, 1930; and made effective on November 15, 1930; have

guided the Board of Medical Examiners in enforcing the rules governing the professional conduct of all licentiates.

Authoritative and official pronouncements of the Governments of both the United States and of the Commonwealth of the Philippines, however, assure the granting of our independence next July 4th. If this comes to pass and we become an independent Republic, the Philippine Medical Association will automatically surrender all the privileges and benefits derived from its affiliation with the American Medical Association. It also means that the Philippine Medical Association will no longer be governed by the *Principles of Medical Ethics* of the American Medical Association, that the Philippine Medical Association will have to formulate its own *Principles of Medical Ethics.*

In anticipation of our forthcoming political independence, therefore, the Council of the Philippine Medical Association has adopted the *Proposed Principles of Medical Ethics.* This document is the embodiment of Resolution No. 24 of the Board of Medical Examiners, approved on June 26, 1940, to adopt a "slightly modified Code of Medical Ethics," based on the proposal of the Philippine Medical Association and of the Manila Medical Society, that would be "suitable to local conditions, customs, and traditions"—a code that would supersede the *Principles of Medical Ethics* of the American Medical Association.

The *Proposed Principles of Medical Ethics* have been carefully studied by the Chairman of the Judicial Council of the American Medical Association, and his suggestions are to be found in his letter printed elsewhere in this issue. The attention of all the members of the Association is invited to this letter as well as to the *Proposed Principles of Medical Ethics* itself, which also appears elsewhere in this issue. The members are urged to submit, through their representatives, to the House of Delegates, such amendments to the *Principles of Medical Ethics* as they deem desirable or necessary. These amendments will be taken up and acted upon by the House of Delegates when it convenes in May.—A.S.F.

Miscellaneous

ABSTRACTS FROM CURRENT LITERATURE

ABSTRACTORS

Isabelo Concepcion, M.D.
Walfrido de Leon, M.D.
Felisa Nicolas-Fernando, M.D.
Carmelo Reyes, M.D.

And the Deaf Shall Hear, by Lois Mattox Miller. Hygeia, Feb. 1945.

Fenestration operation already has been performed in more than 2,000 cases, some as long as 7 years ago. In 1944, a committee of the American Academy of Ophthalmology and Otolaryngology conducted investigation of fenestration technique and results. Dr. Maurin Jones said: "Recently I have seen patients whose hearing, before operation 5 years ago, was below the useful range and who now can hear low whispers". There are 15,000,000 deaf or partially deaf in the U. S. A. A large percentage of these was due to otosclerosis. Symptoms: tinnitus, progressive loss of hearing.

In 1876 Kessel (German) made first attempt to loosen stapes from the closed window and hearing improved, but deafness came back as window closed again. Holmgreen (Swedish) sought to keep window open by inserting a plastic peg—it was also a failure. Sourdille (Frenchman) folded a thin flap of skin over the *new* window; then operated repeatedly to keep window open until "regenerating process of bone becomes gradually exhausted". Other surgeons discovered that bone growth started around microscopic splinters made while drilling the window; also slightest trace of blood encouraged growth of new tissue.

In 1938, Julius Lempert, New York City, after 12 years of study reported in the Archives of Otolaryngology (July 1938 issue) a successful technique. He approached directly into aural cavity (less inflammation and less infection, as there is less cutting of tissue). Then made an oval opening just above oval window with a tiny dental burr; used a fine gold burr to smooth and polish the opening—an important factor in preventing bone regeneration. He cleared away every last fragment of bone splinter. He used the shrapnell's membrane to cover new window. In 1941, Lempert reported a new location for the new window. By 1943, he had operated on 800 patients; in 70%, practical hearing was reported. By 1945 (Arch. of Otolaryngology Jan. issue), he introduced an important change in technique: A small piece of cartilage taken from outer ear, is inserted in a new window, then shrapnel's membrane is drawn over and made fast. The cartilage serves as a new stapes, capable of transmitting sound vibrations, prevents bone formation and possible damage to VIII N.

The perfected fenestration, applied in about 50 cases, resulted in restoration of almost practically normal hearing in all of them. During the past 7 years Lempert has trained about 30 surgeons to do this operation.

They stress these points: (1) proper selection of cases; (2) hearing nerve must be normal; (3) only surgeons who had received thorough instruction of technique from competent specialists can achieve good results (98% can be improved). Thus otosclerosis ceases to condemn its victims to the world of silence.—*F. N. F.*

Medical Research in Australia, Journal of the American Medical Association (as Foreign letters) 127:290 (Feb. 3) 1945.

J. V. Connolly in in his article "Some Australians Take Stock" published by Longmans, Green and Co., commented thus: The usual story is that a University graduate visits overseas countries in order to gain experience and to meet other scientists eminent in their respective

fields. When such men are asked subsequently why they do not return to Australia, the usual answer is "The facilities are not enough."

In Australia there is 0.74 medical graduate (as compared with 0.85) per 1,000 in England. Bearing the factor of non-concentration of population, it is not overcrowded. It is the normal thing for general practitioners in a town, to do his own surgical work. Thus consulting surgeons in the city receive nothing like the same amount of general surgery that is sent to surgeons in English city, where the general practitioner practices almost exclusively as a physician. Fees of consulting surgeons are small naturally. There is reluctance to give to the man who has moved to the top of the profession the formal recognition that is accorded to him elsewhere. Influences affecting the standards of the profession tend toward the production of a fairly uniform level. There is little encouragement of special aptitude and no particularly high reward for ambition. Attention to this problem has been revived recently as an aftermath of the visit of Sir Howard Florey of Oxford University, co-discoverer of penicillin and now professor of bacteriology at the University of Oxford. He said Australian graduates seek overseas field for their work because the facilities in Australia were not good enough. Professors and others were overburdened with teaching and a good deal of outside work. They had no time to pursue research, and without research universities were lowered to the level of technical schools. (Sir Howard is a graduate of the University of Adelaide, Australia).

Oxford and the Medical Research Council of Great Britain are heavily subsidized by the Government. They are controlled by scientists and protected from direct political interference. It is unfortunate that scientists, altho strong in brain powers, are weak in voting powers. The result is that ministers of the government have a habit of expressing fervid agreement with their views and doing nothing.—*F. N. F.*

Medicine's Newest Wonder Drug, Hygeia, Nov. 1945. Streptomycin is the name of a new drug, which may prove to be another wonder drug. It is being studied and improved by several bodies of research workers. It will be at least a year before it can be generally available. Preliminary tests showed it to be effective where penicillin and the sulfas fail: in typhoid and undulant fevers, cholera, tuleramia, possibly tuberculosis.

Streptomycin was discovered by Dr. S. A. Waksman of the New Jersey Agricultural Experiment Station, a microbiologist.

It has been found that soil microbes kill disease bacteria. Dr. Rene J. Dubas of the Rockefeller Institute for Medical Research had discovered a soil microbe which would kill the bacteria that cause pneumonia and streptococcus infections, and from it extracted the drug *tyrothricin*. This set the Oxford group of research men to studying a green mold, which led to the discovery of penicillin.

In 1943, Waksman and a young assistant, Dr. Albert Schatz, found Actinomyces griseus which attacked several disease bacteria, including typhoid fever. The substance extracted was named streptomycin. He asked men of Merck & Company laboratories to assist him (Drs. Randolph Major, Hans Molitor and James Carlisle).

In Toronto, 66 soldiers who were suffering from urinary tract infections were given streptomycin. Result was satisfactory in 24 hours.

Drs. Hobart A. Reimann, William F. Elias and Alison H. Price (all of Philadelphia) tried it on a patient sick of typhoid for 3 weeks. Small doses of the drug given by hypo every 3 hours—prompt recovery. Treatment of subsequent patients, had the same result.

Other Philadelphia group of workers tried it on a patient with salmonella infection. They gave the drug by mouth: unlike penicillin streptomycin is highly resistant to acid stomach juices. Within 4 days, the patient was cured.

The Mayo Clinic group of workers tried it on tuleramia, or rabbit fever, and good results were obtained. Now, it has been found good in human tuleramia.

Streptomycin also holds promise against tuberculosis. The result of the work of Drs. W. H. Feldman and H. C. Hinshaw of the Mayo Foundation on tuberculosis in guinea pigs was satisfactory.

Streptomycin seems to be an excellent supplement for penicillin. Since penicillin is an

acid and streptomycin a base, the two may perhaps be combined to make a salt—penicillin streptomycinate,—penicillin working against one set of microbes, streptomycin against another.

An indication of the faith in streptomycin is the fact that Merck & Company is building a $3,000,000 plant to produce the drug.

The microbes are grown in big tanks or in glass bottles, where they feed on a shallow layer of nutrient broth. As they grow, they drop their drug, streptomycin, into the liquid. It is then extracted by laborious chemical processes.—*F. N. F.*

Suppressive Treatment of Malaria in Military Forces, by O. R. McCoy. Journal National Malaria Society, Tallahasse, Fla. 4:9 March, 1945. According to the author, atabrine has proved much more effective than quinine for suppression of malaria, and in general is better tolerated and preferred by the troops. When atabrine is taken in doses of 0.6 or 0.7 Gm. per week during and for several weeks following exposure to falciparum infection, appearance of symptoms is consistently prevented not only during suppressive treatment but also after medication is discontinued. Suppressive doses of atabrine apparently act as curative doses in this type of malaria. In this respect, atabrine is far superior to quinine. Because of this falciparum malaria has been much less a problem in the military forces.

Vivax malaria, on the other hand, is suppressed but not cured by atabrine. Relapse of vivax malaria experienced after the cessation of suppressive medication constitutes a major portion of the Army's malaria problem. In units heavily seeded with vivax malaria it may be necessary to continue suppressive treatment in order to maintain military effectiveness even though no further exposure to infection occurs.—F.N.F.

SOCIETY ACTIVITIES

PHILIPPINE OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL SOCIETY

PROCEEDINGS OF THE INAUGURAL MEETING

held January 26, 1946 at the

Guazon Memorial Hall, Philippine General Hospital at 2:30 p.m.

I. Dr. Fernando: I take great pleasure in introducing to you the President of the Philippine Medical Association, who will give the Opening Remarks.

REMARKS BY THE PRESIDENT OF THE PHILIPPINE MEDICAL ASSOCIATION, DR. VICTORINO DE DIOS

Mr. Chairman, dear Colleagues:

About a month ago, a group of physicians gave birth to a new medical society known as the Philippine Ophthalmological and Otolaryngological Society. We are today inaugurating its existence. I consider this first meeting a historical event, as it marks the beginning of a closer relationship and better understanding among the physicians dedicated to the practice of E.E.N.T. specialty. These physicians have grouped themselves for the sake of mutual cooperation and of expanding their scientific activities.

The Society is national in its scope, and it has a long-range scientific program. In this, it will help, in great measure, the Philippine Medical Association. The organizers of this Society should be congratulated for their initiative, efforts, and sacrifices. It will serve as an incentive to other doctors of the Philippine Medical Association to create other sections on their respective specialties.

Several years ago there was felt a need of creating sections on different specialties to raise the standard of our medical practice and to extend our medical training. In fact, sections on E.E.N.T., Surgery, Obstetrics, and Gynecology were in the process of organization when the war broke out.

It is very fortunate that we have a leader in the medical profession who has shown interest in and who has exerted effort towards promoting medical knowledge among our physicians by adopting a policy of holding regular medical conferences in which interesting cases are thoroughly discussed. These discussions enlighten us on certain medical problems. This gentleman is no other than our Guest of Honor, Dean Sison. The creation of sections on different branches of medicine will push further the development of medical knowledge among our physicians.

In other countries like America, sections on different specialties of medicine are well organized and are producing invaluable scientific works. I can say that these are the fountains of medical knowledge, which enable America to discover scientific wonders for the benefits of mankind, and which has made America a leader in medical scientific progress. In our country, we need similar organizations by means of which our prominent doctors in the different lines of practice can further their medical knowledge, so that they may acquire skill and technic in performing the most delicate

operations, so that they may acquire new methods of approach to the diagnosis and treatment of diseases, and so that our patients need not go to the Mayo Clinic or to Vienna for the tumor of the brain, for the diseases of the larynx, or for other serious ailments. These sections on different specialties should receive encouragement and help from the Government as well as from private institutions.

By July 4, 1946, we shall have our independence; and one of the requisites of independence is self-sufficiently in every respect. Let us make our profession as self-sufficient as possible.

The war just passed definitely proved the importance of the well-organized activities in various fields of medicine in time of grave emergency. Medical men found themselves face to face with new problems, in the home front as well as on the battle front. These problems taxed their ingenuity to the utmost, but they were promptly solved, because they were properly endorsed for solution to the corresponding organized groups of specialties. Even now that the war is over, we need the services of these organized groups, for the reconstruction and rehabilitation of our devastated country, so that the people may enjoy good health, physically and mentally. Thus alone can we attain peace, happiness, and prosperity.

II. Dr. Fernando: The next number in the program is the induction to office of the officers-elect by Dr. Victorino de Dios, consisting of the following: President, Antonio S. Fernando, M.D.; Vice-President, Edmundo Reyes, M.D.; Secretary-Treasurer, Jose N. Cruz, M.D.; Directors, Geminiano de Ocampo, M.D.; Tomas Ilano, M.D.; Jesus Eusebio, M.D.; Gregorio Farrales, M.D.

III. After his induction into office, the new President of the Society, Dr. Antonio S. Fernando, delivered the following address:

ADVANCING THE PRACTICE OF OPHTHALMOLOGY AND OTOLARYNGOLOGY IN THE PHILIPPINES *

ANTONIO S. FERNANDO, M.D.

Mr. President of the Philippine Medical Association,
distinguished Guests, and Colleagues:

I am deeply touched by the honor you have bestowed upon me by electing me President of this newly organized Society, and I am taking this opportunity to voice my gratitude publicly. I am also deeply conscious of the enormous responsibility that my new office entails, and I am assailed by doubts as to my ability to discharge my obligations and to live up to your expectations.

My courage, however, has been buttressed by the thought that, despite the wreckage, the poverty, and the confusion engendered by the most widespread and devastating war the world has ever witnessed; despite the difficulties in transportation and communication, zealous members of our profession managed to meet on November 25, 1945, and to found this Society "to promote the science and the art of ophthalmology and otorhinolaryngology and the betterment of public health as well as to promote the

* Inaugural Address delivered immediately after his induction to office of President of the Philippine Ophthalmological and Otolaryngological Society, January 26, 1946, at the Philippine General Hospital.

practice of those specialties in the Philippines." With such enthusiasm and determination, I feel confident that I can count on the full support and cooperation of all the members; that, together, we cannot but succeed in our enterprise. For I believe that the greater the share we have in an undertaking, the more deeply we are concerned with its success.

The Officers-Elect have just taken the oath to uphold the provisions of our Constitution and By-Laws to the best of their ability. Those provisions we should know by heart and bear in mind all the time. For thus alone can we map out policies to attain our objectives. These policies should dovetail with the larger program of reconstruction and rehabilitation of health activities that our country has to undertake, if it is to be on its feet again.

Our Constitution calls for the holding of scientific meetings; the building of a library; the giving of short post-graduate courses; the encouragement of research and the awarding of honor to distinguished service and/or outstanding scientific contributions to our particular branches of medicine; the enforcement of medical ethics; the promotion of the spirit of *camaraderie* among the members; the establishment of international scientific relations; etc. The purpose of the Society is, clearly, to encourage the formation in the Philippines of a group of specialists—adequate in number, up-to-date in their medical knowledge, highly trained in techniques, cultured, conscientious, cordial and ethical in their dealings with one another—the older specialists sharing their experiences with the younger ones; the research workers, the fruit of their labors and discoveries with their colleagues. Such a group of specialists cannot but be a boon to the public, whose health they are duty-bound to protect and whose ills they should cure or alleviate.

What surprises me is that it had never occured to us to establish a society of this sort years before. The explanation lies, perhaps, in the smallness of our group at the beginning. And I cannot help wondering why specialization has taken root so slowly in this country. It is now about 50 years since Dr. José Rizal performed what is even now considered a very delicate operation—cataract extraction. His success, despite the great difficulties under which he operated, showed his skill and ability. How many competent specialists have we had in that long period?

According to our 1938 statistics, 680 physicians were employed by the Bureau of Health; but not a single one of these was strictly an E.E.N.T. specialist. By the end of 1939, 4,700 physicians were in active practice throughout the country; but only a handful were E.E.N.T. specialists, and most of these were in Manila.

At the same time, E.E.N.T. cases have gained in frequency. In the twelve-year period from 1918 until 1927 inclusive, 537,218 first visits (excluding dental cases) were registered in the out-patient department of the P.G.H. Of this number, 114,199 or 21% consulted the E.E.N.T. department. In 1929, this percentage rose to 24; and in 1944, to 26.4. 7.4% of the total hospital admissions in 1939 were E.E.N.T. cases. The P.G.H. average for the period September-December 1945 was 21% of the total 10,669 first visits. It was 33% out of a total 10,286 visits in the latter part of 1945 (Nov.-Dec.) in the North General Hospital.

The figures for the provinces cannot differ much from those for Manila. Yet there has not been a corresponding increase in the number of E.E.N.T. specialists. Although many of the cases are minor and may be treated by general practitioners, it

should be obvious to everyone that they can be handled better by specialists. And is it not our obligation to give the public the best possible medical care?

The most effective way to achieve this end is by the so-called "group practice." In the Philippine General Hospital, for example, patients are grouped as surgical, medical, obstetrical, pediatric, E.E.N.T., etc.—each group under the care of specialists. There are also laboratory, X-Ray, and pathology departments, which attend to biopsy work, laboratory and post-mortem examinations, etc. If, in government provincial hospitals, this system cannot be followed because of alleged lack of funds, specialists should be employed on part time basis.

The advantages of group practice are universally accepted. "No one scientist," Alexis Carrel has pointed out, "is capable to master all the techniques indispensable in the study of a simple human problem. Therefore, progress in knowledge of ourselves requires simultaneous efforts of various specialists. Each specialist confines himself to one part of the body, or consciousness or of their relations with the environment . . . Such a division of work has made possible the development of the particular sciences. Specialization is imperative." And, as André Maurois said, "A man's power and intelligence are limited. He who wants to do everything will never do anything."

The Mayo Clinic in Rochester, Minnesota, is an outstanding example of group practice in America. Incidentally, it is also followed in this hospital. Let us create a demand for group practice, and the supply is bound to follow.

Fortunately for the cause of group practice, we have, as our Guest of Honor at this Inaugural Meeting, a man whom I consider to be the strongest and the most enthusiastic exponent of post-graduate work in this country. Through his dynamic leadership, the Government established a post-graduate school before the war. Refresher courses were started, and definite plans for real graduate courses in the different specialties were mapped out. But the outbreak of the war suspended all these activities. I hope that their revival would be given priority in the rehabilitation program.

So important in the estimation of our Society are post-graduate courses that it has already created a Standing Committee to study ways and means by which the subject could be brought to the attention of the Philippine Medical Association at its next Annual Meeting in May. In the development of the specialties, we should create as many opportunities as possible for study and improvement, instead of imposing too stiff requirements at the very start, which might only serve to retard that development so devoutly to be desired. Examining boards could later be created when regular graduate courses are already functioning smoothly.

I had occasion to mention this phase of the program of our Society to Dr. Olin West, Secretary of the American Medical Association; and his reply dated December 17, 1945, is very encouraging. He said that Dr. William L. Benedict of the Mayo Clinic, to whom he referred our plan, is willing to help us carry it out. Dr. Benedict is very active in the educational activities of the American Academy of Ophthalmology and Otolaryngology, which has a splendid post-graduate program.

This, I would like to think, is a concrete step towards maintaining close relations with famous E.E.N.T. clinics abroad, especially with those in the United States, which is another aim of our Society. And perhaps we may consider the gracious presence in this Inaugural Meeting of a prominent representative of the American specialists

as a tangible manifestation of these relations. European clinics, likewise, developed some of our well-known specialists.

These close relations with America have, of course, been of long duration. Modern medicine in the Philippines, as a matter of fact, had its beginning with the coming of the Americans. The first dean of the College of Medicine, University of the Philippines, was an American. The College itself is a member of the Association of the American Medical Colleges; and its prominent professors are graduates of, or trained in, American medical colleges. The late Dr. V. C. Alcantara, our pioneer in broncho-esophagology, whose loss we deeply mourn, was trained in Chevalier Jackson's Clinic. The Philippine Medical Association is affiliated with the American Medical Association; and, through this important connection, it and its official organ, *The Journal of the Philippine Medical Association,* have eraned renown in the scientific world. At the outbreak of the war, the *Journal* was sent on an exchange basis to 126 well known medical institutions all over the world.

It is our hope that, through our affiliation with the P.M.A. as a distinct section, we may likewise win recognition abroad. We should be particularly interested in other E.E.N.T. clinics in the tropics. In Egypt, a small country like ours, for example, ophthalmology has made comparatively rapid progress. Through government efforts, research and post-graduate work in this specialty has been assiduously carried on in the Giza Memorial Ophthalmic Laboratory and Hospital in Cairo; and with the aid of the Egyptian Ophthalmic Society succeeded in inviting the XVth International Congress of Ophthalmology to hold its meeting in Cairo in 1937. Likewise, the eye hospital in Madras, India, where Robert H. Elliot, the author of *Tropical Ophthalmology,* earned world fame, should serve as an inspiration for our initial efforts.

The success of this Society, its achievements will depend upon the sustained and synchronized efforts of its officers and members. I am aware that pioneering work is always beset with difficulties and obstacles; but, if we act with prudence and determination, intelligence and vision, nothing can stop us from attaining our ends.

I thank you.

IV. Dr. Fernando: We are highly honored at this, our Inaugural Meeting, by the presence of a worthy representative of the American specialists. He has been kind enough to accept our invitation to be our Guest Speaker. I take great pleasure in introducing to you Lieutenant Colonel Donald E. Tinkess of the Medical Corps, United States Army, Chief of the Department of Eye, Ear, Nose and Throat, 4th General Hospital, Fort William McKinley.

ADDRESS BY LT. COL. DONALD E. TINKESS, GUEST SPEAKER AT THE INAUGURAL MEETING OF THE PHILIPPINE OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL SOCIETY

Mr. President, honored Guests, Members of the Society, and Friends: It is a real pleasure for me to join you in this, your first society meeting. I am distressed, as I know you all are, by the considerable loss of life, the widespread suffering and destitution, and the great destruction of property. But it is very reassuring to see the fine people of the Philippines rallying to rebuild their splendid country. Your new society is an excellent example of the progressive spirit so necessary for success; and it will serve as an inspiration for others.

When your Committee asked me to speak to you, I accepted with the understanding that it would be an informal talk about the practice of ophthalmology and otolaryngology as carried on in several American institutions with which I have been associated.

I shall first outline how eye, ear, nose and throat work is practiced at the Mayo Clinic. This is the outstanding example in the United States of group practice, where a number of physicians join together, each taking some part in the medical care of the patient, and pooling their knowledge and abilities for his benefit.

The Mayo Clinic was founded about fifty years ago by two brothers, William J. and Charles H. Mayo, in the small city of Rochester, Minnesota (population 26,000), situated between Chicago and Minneapolis. It has steadily grown into a huge organization with a 14 story clinic building, some smaller buildings, several large hospitals, and several hundred physicians and surgeons. About 100,000 patients attend the Clinic each year and most of these are examined in the EENT Section.

The Section of Ophthalmology can be said to consist of four subsections with chiefs, assistants, and residents (fellows). Dr. William L. Benedict is Director of the Department, and he supervises external diseases and the operative work. Dr. Avery de Prangen handles refraction and muscle cases. Dr. Henry Wagener looks after all the fundus work (ophthalmoscopy). He has been doing this for about 25 years, has undoubtedly had more experience in this particular field than anyone else in the world, and is an outstanding example of specialization. A fourth section deals with neurological ophthalmology, muscle paralyses, diplopia, diseases of the optic nerves, visual field studies. This is also an exceedingly busy department because a great number of neurological cases are always in attendance at the Clinic.

Dr. Gordon B. New heads the Section of Laryngology, Oral and Plastic Surgery, which is concerned with diseases and injuries of the face and neck, including the larynx. Many malignant and benign tumors are treated; those on the surface by excision or diathermy with radium and X-ray therapy given when indicated. Epitheliomas of the larynx are removed by laryngofissure or laryngectomy. Papillomata of the vocal cords are destroyed by diathermy with suspension (Lynch type) laryngoscopy. Since deformities often result from the procedures for malignant disease, considerable plastic surgery is done. Faciomaxillary surgery, treatment of dental fractures, and infections are handled in this department. Alcohol injections of the mandibular and maxillary divisions of the fifth nerve are given for trifacial neuralgia.

Dr. Harold I. Lillie is chief of Otolaryngology. It is this section which takes care of ear diseases, nose and sinus conditions, pharyngeal disease, and tonsillectomies. Radical mastoidectomies are done for chronic aural disease. The new fenestration operation for deafness is now being performed. All tonsil operations in adults are done with local anesthesia, scissors-dissection with snare being the favorite method. The intranasal antrum window is the operation of choice in chronic suppurative maxillary sinusitis with the Denker Radical sinusotomy occasionally used. All work in this department is carried out with the doctor standing, the patient sitting in a hydraulic dental type chair. Sprays are not used, since Dr. Lillie has always disliked them.

The endoscopic work is cared for by internists from the Chest Section. Dr. Porter P. Vinson for many years was in charge; Dr. Herman Moersch has been chief in recent years. Dr. Vinson always favored the German Bruening proximally lighted

scopes, because most of the work was diagnostic. Practically all other American bronchoscopists use the distally lighted Jackson type scopes.

Cancer of the oesophagus causing obstruction is treated by dilatation with bougies on a string guide. This treatment is only paliative, and it occasionally causes rupture with fatal outcome; but it is considered preferable to gastrostomy.

Everyone attending the Clinic is treated as a private patient. The fee charged often varies according to the patient's financial status. All physicians are on a salary, and any profits are used to further medical research and investigation.

The New York Eye and Ear Infirmary in New York City is a very different type of Medical Institution. Only eye, ear, nose, and throat patients are admitted. All patients attending the hospital are charity cases, except emergencies and some private cases sent to the private pavilion for hospital care. The attending physicians have their office hours in their private offices in the morning, and they come to the Infirmary three afternoons a week.

Free clinics are held each afternoon. There are six eye services and six ear, nose, throat services, each with a chief, assistants, residents, and internes; and each service holds clinics three times a week. With so many different chiefs, there are bound to be numerous different ways of doing things, so that a resident during his stay at the Infirmary spends time on each service and learns many varied methods.

The Eye Institute is a part of the Columbia Presbyterian Medical Center, located in New York City. It is housed in a modern eight-story building especially designed for clinical work, research, and teaching. Dr. John Wheeler was its Director and was Professor of Ophthalmology until his death shortly before the war. Charity eye patients are examined at the Vanderbilt Clinic in the main Medical Center building; and, if hospitalization or special investigation is necessary, they are sent to the Institute. As at the Infirmary, clinics are held in the afternoons, and the attending specialists give their time and work without payment other than the experience gained and the opportunity to work and exchange ideas with leaders in their specialty. Students of the College of Physicians and Surgeons of Columbia University receive their eye training there. There are a number of full time research workers carrying on the work. One of the few eikonometers in the country is used for measuring and studying aneisokonia. Dr. John Dunnington is the Senior Ophthalmologist. Dr. Algernon Reese is one of the Senior attending oculists and is the pathologist. Dr. Ramon Castroviejo does his corneal transplants at this hospital.

The Institute accepts both charity and private patients, the latter being sent in by the attending members of the staff. Because it is a part of the Medical Center, there is considerable referred work from other departments of the hospital and there is the further advantage of close association with a teaching institution, the medical school.

I hope that this short outline of eye, ear, nose and throat practice in three American medical institutions has been of interest to you and that at some time in the near future many of you will have an opportunity to visit us in the United States and see the places I have described. A warm welcome awaits you.

V. Dr. Fernando: Our Guest of Honor needs no introduction. He is generally considered an outstanding leader of the medical profession, a famed clinician, and an inspiring teacher. Ladies and Gentlemen: Dean Sison.

ADDRESS OF THE GUEST OF HONOR

DEAN ANTONIO G. SISON, M.D.
College of Medicine, U.P.

President of the Association, distinguished Guest, Colleagues, and Friends:

First of all, allow me to extend my sincere congratulations to the members of this new association and to the officers they have chosen. As I see the names of the officers of this Association, I feel very gratified in the good selection of the men who will direct the future policies of the Philippine Ophthalmological and Otolaryngological Society, especially your President who is not satisfied with mere routine work, and who it has been my fortune and privilege to know since his student days. He has made contributions to medical knowledge which are well known even outside of our country; and certainly the medical school and the medical profession can be proud of him.

As I look at the constitution and by-laws of your newly organized Society, I find among other things that "The purposes of this Society shall be to promote the science and the art of Ophthalmology and Otorhinolaryngology and the betterment of public health as well as to promote the practice of these specialties in the Philippines." This article of your by-laws shows very lofty and praiseworthy ideals.

In the remarks of your President, he decried that such a society has not been organized earlier. I am rather glad it was organized later, because the gradual development of ophthalmology and otorhinolaryngology paved the way for the organization of the society. I still recall the early days of the College of Medicine, University of the Philippines, when it did not have a well qualified specialist in the diseases of the eye, ear, nose and throat; and it gives me pleasure to mention here the name of the man who is responsible for the growth of the knowledge of these specialties. The first Dean of the College of Medicine, Paul Gaspar Freer, a real scientist, was at that time also the Director of the Bureau of Science. He was the one who, through his foresight, brought a specialist from Chicago, Dr. Reinhart Rembe, whose services were contracted by the University of the Philippines to take charge of the Department of Eye, Ear, Nose and Throat.

I do not want to be understood, however, as saying that before that time of Rembe there was no specialist in the E.E.N.T. of any kind. You all have heard of Rizal, our greatest hero, who about half a century ago performed the first operation on cataract. While he was in Europe, after finishing his study of medicine, he specialized on the eye; and evidently the knowledge he obtained in his preparation gave him enough confidence and skill to operate successfully on the father of the woman whom he later married, a short time before he was shot on Bagumbayan.

Ambitious young physicians have also, through their own initiative, gone abroad. These are the pioneers. One of them is the present Head of the Department of E.E.N. & T. who became assistant of Dr. Rembe when the Department of E.E.N. & T. was organized in the College of Medicine, University of the Philippines. Without them, the departments of E.E.N. & T. in the College of Medicine, University of the Philippines, and in the Santo Tomas Faculty of Medicine could not have been organized. I wonder if, without them, the progress and growth of these specialties could have advanced in the right direction it has taken from the very

beginning. Now it is no longer possible for a general practitioner to take care of his practice adequately without counting on the help of the different specialists.

Dr. Donald Tinkess, the guest speaker, has mentioned the Mayo Clinic which is one of the pioneering institutions of group practice in the United States. Permit me to say a few words about specialization. Whether one should specialize in just looking through the ophthalmoscope as Col. Tinkess has mentioned or on only one of these four specialties of the E.E.N.T., we have to admit that the growth and the progress of medical science are due to these men who try to know more and more about less and less.

In connection with specialization in different branches of clinical medicine, it must be mentioned that one can never acquire the true knowledge of whatever specialty, unless one is willing to observe the three important fundamental conditions before making a diagnosis: a very careful history-taking, a very thorough physical examination, and the indicated laboratory examinations.

I do not care what specialty you want to practice; you can never get away from these three important fundamental conditions, coupled with a thorough knowledge of anatomy, physiology, and pathology of the organs of your specialty and their relations with the rest of the whole body. You have to have the necessary preparation in general medicine which you can use as a point of vantage. There is no specialty of any kind that can be followed without realizing the relation of one organ to the whole body. It is always a part of the whole. Even in dentistry which is now considered as a branch of medicine, it is not just tooth-filling or tooth-pulling, as wrongly considered by many.

Inasmuch as it is of general knowledge among educators, that the best educator is the one who continually carries on research work, there is nothing that gives me more satisfaction and hope in the bright future of your Society than the article in your Constitution and By-Laws providing for the promotion of the art and science of Ophthalmology and Otorhinolaryngology; and I hope that it will be carried out. With the present officers, it is safe to anticipate what this Association can accomplish within a few years.

With the approaching independence of the Philippines, everyone of us should feel the responsibility and share the task in the rehabilitation of our country. We have to depend on ourselves. Self-reliance and self-confidence should be the motto that everyone should have in any undertaking. I am, therefore, glad that this Association has been organized. There is a great need for the services of specialists throughout the Philippines. These services the members of this Association can render. That is the task. That is their sacred trust.

Allow me once more to congratulate the members of this Association, its officers, and especially those who are responsible for its organization.

VI. Dr. Fernando: In behalf of the Society as well as my own, I should like to thank our distinguished guests and all those whose presence has graced this our Inaugural Meeting, and whom we now invite to partake of the modest refreshments we have prepared. After the refreshment, we shall hold our business meeting, which I would like to request all the members to attend. I thank you all!

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BUSINESS MEETING

The following is an abstract of the minutes of the business meeting of the Society at 4:50 p.m.:

1. The meeting approved the minutes of the Organization Meeting held November 26, 1945, at the North General Hospital.

2. The President announced the appointment of the Standing and Special Committees, as approved by the Board of Directors.

3. The Meeting unanimously approved the final draft of the Constitution and By-Laws of the Society (see page 76).

4. A Special Committee was created to study ways and means of establishing a Manila Eye, Ear, Nose and Throat Infirmary for both private and charity patients and to submit a comprehensive recommendation pertaining to its organization and functions at the next business meeting of the Society.

5. The meeting adjourned at 6:50 p.m.

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CONSTITUTION AND BY-LAWS
of the
PHILIPPINE OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL SOCIETY

CONSTITUTION

Article I — Name of the Society

The name of this organization shall be the Philippine Ophthalmological and Otolaryngological Society. It shall also constitute the Section of Ophthalmology and Otolaryngology of the Philippine Medical Association after due action to that effect shall have been taken by the Philippine Medical Association.

Article II — Purposes

The purposes of this Society shall be to promote the science and art of Ophthalmology and Otorhinolaryngology and the betterment of public health as well as to promote the practice of these specialties in the Philippines. No new provisions of this Constitution and By-Laws shall be approved that shall conflict with those of the Philippine Medical Association.

Article III — Membership

Sec. 1.—This Society shall be composed of (1) Associate members, (2) Active members and (3) Fellows, who are members in good standing of the Philippine Medical Association.

Sec. 2.—Associate members are those general practitioners who have been practicing ophthalmology and otorhinolaryngology continuously for at least two years in preference to other branches of medical science.

Sec. 3.—Active members are those who have limited their practice to these specialties for a period of not less than two years but not more than five consecutive years.

Sec. 4.—Fellows are those who limit their practice to these specialties and who have practised them continuously for a period of more than five years immediately preceding their application for membership in this Society.

Sec. 5.—Honorary Fellowship. Any eminent ophthalmologist or otolaryngologist not a resident of the Philippines, who has been an invited guest of the Society, may be accorded an Honorary Fellwship upon recommendation by the Board of Directors and approved by the Society.

Article IV — Guests

Sec. 1.—Any outstanding physician or scientist may be invited by the Board of Directors as Guest to address the Society.

Sec. 2.—Any high government official or renowned citizen of the Philippines, may be invited by the Board of Directors as a Guest of Honor of the Society.

Article V — Officers

Sec. 1.—The officers of the Society shall be a President, a Vice-President, a Secretary-Treasurer, and four Directors.

Sec. 2.—These officers shall be elected at the annual session and shall serve for a term of one year or until their successors are duly elected and installed.

Sec. 3.—Only Fellows in good standing are eligible to be officers of the Society.

Sec. 4.—When acting as officers of the Section of Ophthalmology and Otolaryngology of the Philippine Medical Association, the President, Vice-President, and the Board of Directors of the Society may be called Chairman, Vice-Chairman and Executive Committee respectively, in accordance with the provision of the Constitution of said Association.

Article VI — Board of Directors

Sec. 1.—The President, the Vice-President, the Secretary-Treasurer and the four Directors shall constitute the Board of Directors. The President, the Vice-President, and the Secretary-Treasurer of the Society shall also be the officers of the Board. A majority of the members of the Board shall constitute a quorum. Besides the duties mentioned in the By-Laws, the Board shall have the following duties:

(1) It shall have charge of the property and financial affairs of the Society;
(2) Upon nomination by the President, it shall appoint Committees that are not otherwise provided for;
(3) It shall submit to the Society annual reports of its proceedings and transactions, and of the financial status of the Society;
(4) It shall fill temporarily any vacancies occurring *ad interim* between annual sessions in the offices of the elective officers;
(5) It shall approve an annual program of major activities of the Society; and
(6) It shall determine the status of members of the Society in accordance with Article III and other rules promulgated by the Society.

Article VII — Meetings

The Society shall meet regularly in January, March, May, July, September, and November; the time and place of the meeting to be decided by the Board of Directors. At the January meeting, the officers-elect shall be installed, and the new President shall deliver his inaugural address. The November meeting shall be considered the annual session, and the order of business shall be as follows:

1.—Call to order by the President
2.—Roll call
3.—Reading of minutes
4.—Report of the Secretary-Treasurer
5.—Report of the Board of Directors
6.—Reports of the different Committees

of ideas, and in order that he may contribute, hi stime, energy, and means towards making

7.—Election of officers
8.—Unfinished and new business
9.—Closing address by the President

10.—Adjournment; to be immediately followed by the Annual Dinner to which Fellows who have reached the age of sixty years or over and the past presidents shall be invited as Guests.

Article VIII — Funds and Expenses

The annual dues of the members shall be decided by the Society. Funds may also be raised by voluntary contributions. Fund may be appropriated by the Board of Directors based on the income, and approved by the Society. All resolutions appropriating funds must be referred to the Board of Directors before action by the Society is taken thereon.

Article IX — Medical Ethics

The Principles of Medical Ethics of the Philippine Medical Association shall govern the conduct of the members of the Society. All questions of ethical nature brought up at the business meeting shall be referred to the Board of Directors without discussion.

Article X — Seal

The Society shall have its own official seal.

Article XI — Amendments

The Society may amend at the annual session any article of this Constitution by a two-thirds vote of the members present, provided such amendment shall have been sent officially to the Secretary-Treasurer who shall distribute copies of said proposed amendment to the members one month before the annual session.

BY-LAWS

Chapter I — Membership

Sec. 1.—Any member in good standing of the Philippine Medical Association who has been practicing ophthalmology and otorhinolaryngology for at least two years may apply for membership in the Society.

Sec. 2.—The Board of Directors shall consider all applications for membership; and, on the personal data submitted and other pertinent information in possession of the Board, the latter shall classify the applicants as associate members or active members or Fellows, in accordance with Article III of the Constitution. If the application is approved by the Board, a recommendation to that effect shall be submitted to the Society for final approval.

Sec. 3.—The expression "members of this Society" as used in the Constitution and its By-Laws shall be interpreted as including the associate members, the active members, and the fellows of the Society.

Sec. 4.—A member of the Society shall be considered in good standing if he has paid his dues to the Philippine Medical Association and to the Society for the current year.

Sec. 5.—Each member in attendance at the annual session of the Society shall enter his name at the Registration Book, and if in good standing, shall receive a regis-

tration card which shall be evidence of his right to all the privileges of membership and the right to vote.

Chapter II — Meetings

Sec. 1.—The regular meeting of the Society shall consist of a scientific meeting, followed by a bussines meeting, except the annual session when there shall be no scientific meeting.

Sce. 2.—Any menber of the Society may participate in the discussion during these meetings.

Chapter III — Election of Officers

Sec. 1.—All elections of officers shall be by secret ballot, and a majority of the votes cast shall be necessary to elect an officer, except the Directors, the first four of whom obtaining the highest vote, are to be considered elected. In case no nominee receives a majority of the votes in the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one nominee receives the majority of the votes.

Chapter IV — Duties of the Officers

Sec. 1.—The President shall preside at all meetings of the Society and of the Board of Directors, and shall perform such other duties not specified in this Constitution and By-Laws as custom and parliamentary usage require.

Sec. 2.—The Vice-President shall assist the President in the discharge of his duties. In the event of his death, resignation, or removal, the Vice-President shall succeed him.

Sec. 3.—The Secretary-Treasurer shall issue the programs of meetings as approved by the Board of Directors; keep the minutes of the proceedings; and be the custodian of all records, papers and property belonging to the Society. He shall keep a card-index register of all members of the Society.

As Treasurer, he shall demand and receive all funds due the Society, together with bequests, voluntary contributions, and donations. He shall disburse funds in accordance with duly authorized vouchers, deposit in the Philippine National Bank the money received; and withdraw warrants from said bank with the approval of the President. He shall render an annual report of his activities —giving a detailed statement of membership and of funds received and disbursed, and a summary of the finances and property of the Society.

Chapter V — Duties of the Board of Directors

Sec. 1.—The Board shall meet upon the call of the President or on petition of two of its members. In addition to its duties already enumerated in the Constitution, the Board shall consider all questions involving the rights and standing of the members of the Society, hear and decide all questions of their discipline, or refer them to the Council of the Philippine Medical Association for final action. The Board shall audit the accounts of the Secretary-Treasurer and present, in its annual report, a statement of the same as well as of the property of the Society with such suggestions as it may deem necessary as well as full in-

formation concerning the management of all affairs of the Society which the Board is charged to administer.

Chapter VI — Committees

Sec. 1.—There shall be standing committees, to be announced in the January meeting. They shall be:

1.—The Committee on Scientific Meetings
2.—The Committee on Publications and Library
3.—The Committee on Postgraduate Courses

These committees shall report annually in writing to the Society.

Sec. 2.—Committee on Scientific Meetings.—This Committee shall consist of three members, one of whom shall be the Secretary-Treasurer; and it shall prepare the scientific programs. Each program shall be submitted to the Board of Directors for approval and then distributed to the members by the Secretary-Treasurer at least one week before the meeting. This Committee shall also prepare a scientific program and submit it to the Board of Directors for incorporation with the Scientific Program of annual meeting of the Philippine Medical Association.

Sec. 3.—Committee on Publications and Library.—This Committee shall consist of three members. No paper shall be published as having been read before the Society unless it has actually been read. It shall endorse for publication only those that are of scientific or practical value, and which will reflect credit on the Society. This Committee shall also be in charge of the Society's library, recommend ways and means of enlarging it, and be responsible for making efficient a "package library" service for the benefit of the members.

Sec. 4.—Committee on Postgraduate Courses.—This Committee shall consist of three members, and shall prepare and arrange, with approval of the Board of Directors, a short practical course in certain subjects in ophthalmology and otorhinolaryngology for the benefit of the members of the Society. Clinical materials shall be freely used in these courses. These courses should be given immediately before, during, or after the Annual Meeting of the Philippine Medical Association, if that meeting is held in Manila.

Chapter VII — Dues

Sec. 1.—Four pesos per annum shall be assessed on each associate member; six pesos, on each active member; and eight pesos, on each fellow. These dues shall be payable in the month of January.

Sec. 2.—Any member of the Society failing to pay his dues for one year shall lose his privileges and prerogatives until he pays his back accounts. Any member who fails to pay his dues for a period of two consecutive years shall be automatically dropped from the roll, but can be re-instated upon payment of his accounts.

Chapter VIII — Expulsion or Suspension

Any member expelled or suspended by the Philippine Medical Association shall automatically be expelled or suspended by the Society. Any member accused of unethical conduct shall be investigated by the Board of Directors, which shall submit

specific recommendations to the Council of the Philippine Medical Association, whose decision shall be final.

Chapter IX — Rules of Order

This Society shall be governed by Robert's Rules of Order when not in conflict with the rules of the Society.

Chapter X — Miscellaneous

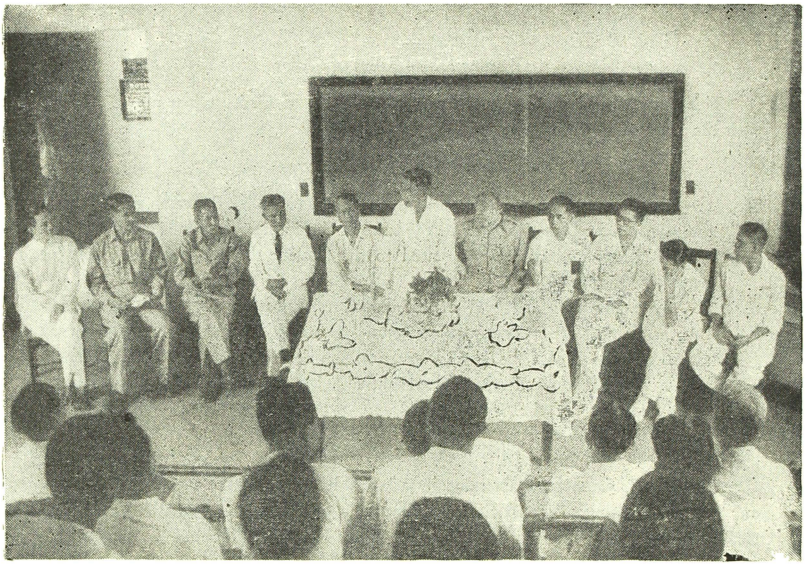
Sec. 1.—The reading and publication of papers shall be under the same rules as promulgated in the Constitution and By-Laws of the Philippine Medical Association.

Sec. 2.—All papers and reports presented to the Society shall become the exclusive property of the Society.

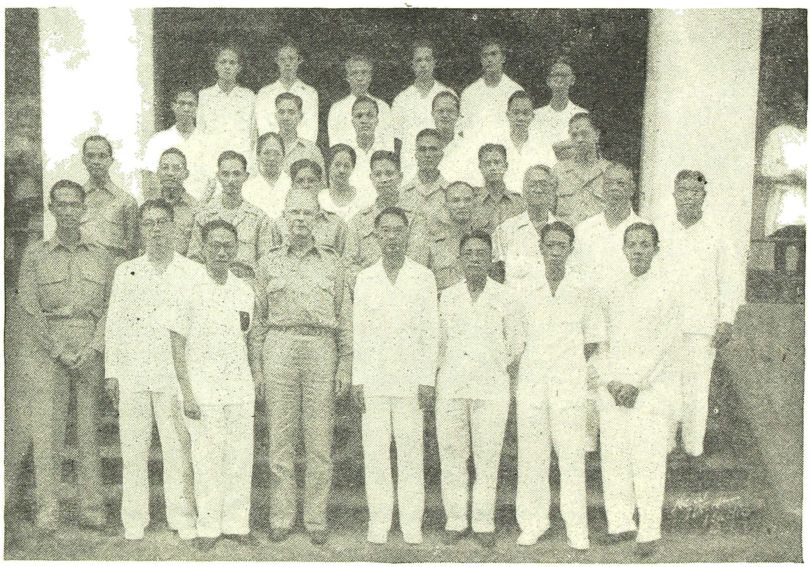
Sec. 3.—By unanimous approval of the Board of Directors and with the three-fourths votes of the Society at its annual meeting, the Society may grant an award consisting of a medal and/or a citation for outstanding scientific contribution or distinguished service to Ophthalmology and/or Otorhinolaryngology to any member of the Society.

Chapter XI — Amendments

These By-Laws may be amended by a two-thirds vote of the members present at any business meeting of the Society, provided the proposed amendment has been properly submitted to the Board of Directors at least fifteen days before the meeting.



Officers and Guests at the Inaugural Meeting of the P. O. & O. S. January 26, 1946.



Members and the guest speaker who attended the Inaugural Meeting.

PROPOSED PRINCIPLES OF MEDICAL ETHICS OF THE MEDICAL PROFESSION IN THE PHILIPPINES *

ARTICLE I

The Physician's Responsibilities in General

Section 1.—The practice of medicine is a profession whose prime object is the service it can render to humanity. In its practice, reward or financial gain should be a subordinate consideration.

Section 2.—On entering his profession, a physician assumes the obligation of maintaining the honorable tradition that confers upon him the well deserved title of "friend of man". He should cherish a proper pride in his calling, conduct himself as a gentleman, and endeavor to exalt the standard and extend the sphere of usefulness of his profession.

Section 3.—In his relation to his patients, he should serve their interest with the greatest solicitude, giving them always his best talent and skill.

Section 4.—In his relations to the State and to the Community, a physician should fulfill his civic duties as a good citizen, conform to the laws, and endeavor to cooperate with the proper authorities in the due application of medical knowledge for the promotion of the common welfare.

Section 5.—With respect to the relation of the physician to his colleagues, he should safeguard their legitimate interests, reputation, and dignity—bearing always in mind the golden rule, "whatever ye would that men should do unto you, do ye even so to them."

Section 6.—The ethical principles actuating and governing a clinic or a group of physicians are exactly the same as those applicable to the individual physician.

ARTICLE II

Duties of Physicians to their Patients

Section 1.—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 obligations to his patients is, in most cases, his own conscience, any violation of this rule on his part is discreditable and inexcusable.

Section 2.—A physician is free to choose whom he will serve. He may refuse calls, or other medical service for reasons satisfactory to his professional conscience. He should, however, always respond to any request for his assistance in an emergency. Once he undertakes a case, he should not abandon or neglect it. If for any reason he wants to be released from it, he should announce his desire previously, giving sufficient time or opportunity to the patient or his family to secure another medical attendant.

*This embodies the suggestions of the Chairman of the Judicial Council, A. M. A., in his letter of January 21, 1938, which appears eslsewhere in this issue of the Journal. It was approved by the Council of the P. M. A. on February 20, 1946, and it will be submitted to the House of Delegates for final approval at the Annual Meeting of the P. M. A. next May, if and when the Philippines is granted independence by the United States of America. Then, it will be submitted, through the Board of Medical Examiners, to the Honorable the Secretary of Health and Welfare, for official adoption by the Board and for the guidance of the Medical Profession in the Philippines.—A. S. Fernando, *Secretary-Treasurer*.

Section 3.—In serious cases which are difficult to diagnose and treat, or when the circumstances of the patient or of the family so demand or justify, the physician should seek the assistance of his colleagues in consultation.

Section 4.—A physician must exercise good faith and strict honesty in expressing his opinion as to the diagnosis, prognosis, and treatment of the case under his care. Timely notice of the serious tendency of the disease should be given to the family or friends of the patient, and even to the patient himself if such information will serve the best interest of the patient and his family. It is highly unprofessional to conceal the gravity of the patient's condition, or to pretend to cure or alleviate a disease for the purpose of persuading the patient to take or to continue a course of treatment, knowing that such assurance is without accepted basis.

Section 5.—The medical practitioner should guard as a sacred trust anything that is confidential or private in nature that he may discover or that may be communicated to him in his professional relations with his patients, even after their death. He should never divulge this confidential information, or anything that may reflect upon the moral character of the person involved, except when it is required in the interest of justice, public health, or public safety.

ARTICLE III

Duties of Physicians to the Public

Section 1.—Physicians should cooperate with the proper authorities in the enforcement of sanitary laws and regulations and in the education of the masses on matters relating to the promotion of individual as well as community health. They should enlighten the public on the dangers of communicable diseases and other preventable diseases, and on all the measures for their prevention and cure, particularly in times of epidemic or public calamity. On such occasions, it is their duty to attend the needs of the sufferers, even at the risk of their own lives and without regard to financial returns.

Section 2.—It is the duty of every physician, when called upon by judicial authorities, to assist in the administration of justice on matters which are medico-legal in character.

Section 3.—It is the duty of physicians to warn the public against the dangerous and false pretensions of charlatans and quacks, since their deceitful practices may cause injury to health and even loss of life.

Section 4.—Humanity requires every physician to render his services gratuitously to poor and indigent persons who are in need of his attendance. However, institutions endowed privately or publicly should not be granted this privilege.

ARTICLE IV

Duties of Physicians to Each Other

Section 1.—Physicians should labor together in harmony, each giving freely to others whatever advantage he may have to contribute.

Section 2.—It is not advisable for a physician to treat members of his family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician or of the immediate family dependents of physicians.

Section 3.—When a physician is called to a distant place by a sick colleague who is in easy financial circumstances, compensation that will at least meet the traveling expenses of the visiting physician should be proferred.

Section 4.—In order to protect his own reputation, the attending physician should be the first to suggest a consultation. He should not wait until the patient becomes dissatisfied or begins to think he is not improving.

Section 5.—In consultation, no insincerity, rivalry, or envy should exist between the consultants. Every participant should be frank, candid, and respectful with the patient and

his family, and with one another. In every consultation, the benefit to be derived by the patient is of first importance.

Section 6.—Out of consideration for the object of consultation and for the physician's duty to uphold the honor and dignity of his profession, no physician should meet in consultation any one who is not qualified by law to practice medicine. In arranging for a consultation the attending physician should fix the hour of the meeting. However, it is his duty to make the appointment in a way satisfactory to the consultant.

Section 7.—Every physician participating in a consultation should endeavor to observe punctuality. Unless the cause of delay is known, if the attending physician does not arrive within a reasonable time after the appointed hour, the consultant should, according to the circumstances attending the case, be at liberty either to regard the consultation as postponed or to see the patient alone. In the latter case, he should leave his conclusions in writing in a sealed envelope. On the other hand, if the consultant does not appear at the fixed time, the attending physician, after a reasonable period of waiting, and with the consent of the patient or his family, may either arrange for another consultation or give permission for the consultant to examine the patient and forward to him a written statement of his opinion. In giving such written opinion, the consultant must see to it that the opinion is under seal and that his statements are courteously worded.

Section 8.—The attending physician should give the consultant all necessary information relating to the case. This should be done in a place away from the patient and his family. After this the consultant should be brought in and introduced to the patient by the attending physician, who may examine the patient again, if he thinks it necessary, to note any possible change before turning his patient over to the consultant. The latter then should proceed to make a thorough examination. During the examination, the attending physician may make pertinent remarks or observation. While in the presence of the patient or of his family, the consultant should not make any remarks about the diagnosis, etiology, prognosis, or treatment, or hint at any possible error of the attending physician.

Section 9.—In a secluded place away from the patient, the physicians should discuss the case and determine the course of treatment to be followed. Neither statement nor discussion of the case should take place before the patient or his family or friend, not only to save the attending physician from possible embarrassment, but also to prevent all possible misapprehensions which susceptible lay persons might easily derive from the plain discussion usually unavoidable in such cases.

Section 10.—Once the discussion is terminated, the result of the deliberations should be announced. The duty of announcing it to the patient's family or friends should be mutually arranged between the attending physician and the consultant, and no opinion or informaiton should be announced without previous deliberation and concurrence.

Section 11.—Differences of opinion should not be divulged; but, when there is an irreconcilable disagreement, the circumstances should be frankly, courteously, and impartially explained to the patient's family or friends.

Section 12.—When a consultation is over and the physician in charge is designated, the latter shall be responsible for the care and treatment of the patient. He may, however, suggest calling in any other physician whom he regards as competent to help or to advise. He may at any time change or abandon the course of treatment outlined and agreed upon at the consultation, if and when, in his opinion, such action is required by the condition of the patient. If he does this, he should at the next consultation state his reasons for departing from the course previously agreed upon, because it is his duty to follow the treatment outlined and refrain from changing it for trivial motives. If an emergency occurs and the physician in charge is not available, the consultant should attend to the case until the arrival of his colleague; but he should not take further charge of it except with the consent of the attending physician.

Section 13.—Cases which appear to be out of the proper line of practice of the physician in charge, or refractory in spite of the usual clinical treatment, or with a grave prognosis, and particularly if the patient cannot pay the expenses of a consultation—these cases should be

referred to those who specialize in that class of ailments. It is desirable that the patient bring with him a letter of introduction giving the history of the case, its diagnosis and treatment, and all the details that may be of service to the consultant. The latter should, in turn reply in writing to the physician in charge, giving his opinion of the case together with the course of treatment he recommends. These opinions or suggestions must be regarded as strictly confidential.

Section 14.—A physician should observe utmost caution, tact, and prudence, both in words and in action, as regards the professional conduct of another physician, particularly when it concerns a patient previously treated by the latter or actually under his care. In his dealings with patients not under his care, he should not say or do anything that might lessen the patient's confidence reposed in the attending physician.

Section 15.—Whenever a physician is compelled to make a social or business call on patients under the professional care of another physician, he should not make inquiries or comments as to the etiology, diagnosis, treatment, or prognosis of the case. The most that should be mentioned is the general physical condition of the patient or other topics foreign to the case.

Section 16.—A physician should not take charge of or prescribe for, a patient already under the care of another physician, unless the case is one of emergency, or the physician in attendance has relinquished the case, or the services of the attending physician has been dispensed with.

Section 17.—A physician called upon to attend a patient of another physician—either because of an emergency, or because the family physician asks for it, or is not available—should attend only to the patient's immediate need. His attendance ceases when the emergency is over or on the arrival of the physician in charge after he has reported the condition found and treatment administered; and he should not charge the patient for his services without the knowledge of the attending physician.

Section 18.—Whenever, in the absence of the family physician, several physicians have been simultaneously called in an emergency case because of the alarm and anxiety of the family or friends, the first to arrive should be considered the physician in charge, unless the patient or his family has special preference for some other one among those who are present. As a matter of courtesy, the acting physician-in-charge should request, at the start, that the family physician be called. When the patient is taken to a hospital, the attending physician of the hospital, likewise, should communicate with the family physician so as to give him option of attending the case.

Section 19.—Public interest demands that the relation between government and private physicians should be friendly and cordial, for the promotion and protection of public health depend greatly upon the cooperation of private physicians.

Section 20.—The physician should carefully refrain from making unfair and unwarranted criticism of other physicians; and, even in justified circumstances, criticisms should be made in a constructive way and only directly and privately to the physicians involved. Whenever there is an irreconcilable difference of opinion, or conflict of interests between physicians, which cannot be adjusted by both sides alone, the matter should be referred to a committee of impartial physicians or other competent bodies for arbitration.

ARTICLE V

Duties of Physicians to the Profession

Section 1.—A true physician does not base his practice on exclusive dogma or sectarian system, for medicine is a liberal profession. It has no creed, no party, no master. Neither is it subject to any bond except that of truth. A physician should keep abreast of the advancement of medical science: contribute to its progress; and associate with his colleagues in any of the recognized medical societies, so that he may broaden his horizon through the exchange of ideas, and in order that he may contribute, his time, energy, and means towards making these societies represent the ideals of the profession.

Section 2.—A physician should be upright, deligent, sober, modest, and well-versed in

both the science and the art of his profession. Extravagance, intemperance, and superstition are most destructive to professional reputation, influence, and confidence; and they are not only morally but also financially disastrous.

Section 3.—Advertising by means of untruthful or improbable statements in newspapers or other publications, or exaggerated announcements on shingles and signboards, calculated to mislead or deceive the public, or made in a manner not consistent with good morals and right professional dealings with patients, is unprofessional. Announcements in newspapers, or on signboards or shingles, should be restricted to the facts about the location of clinics, office hours, and limitation of practice. It is equally incompatible with honorable standing in the profession to solicit patients by circulars, by advertisements, or by personal communications or interviews not warranted by personal relations, or to procure patients indirectly through solicitors or agents.

Section 4.—It is unprofessional for a physician to help or to employ unqualified persons for the purpose of evading the legal restrictions governing the practice of medicine. It is equally degrading to the good name of the medical profession to prescribe, dispense or manufacture secret remedies or to promote their use in any way. It is likewise unprofessional to promise or boast of radical cures or to exhibit publicly testimonial of success in the treatment of diseases.

Section 5.—It is degrading to professional character for physicians deliberately to prolong the progress of treatment of disease for questionable motives, or to establish an unjust competition among physicians in a community by unwarranted lowering of fees.

Section 6.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unprofessional to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever. It is unprofessional for a physician to pay or offer to pay, or to receive or solicit commission for the purpose of gaining patients, or for recommending professional service.

Seciton 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals, in executive sessions, or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because of deficiency in moral character or education.

Section 8.—It is unprofessional for a physician to enter into agreement or contract with an organization to furnish medical services to a group of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita under conditions that make it impossible to render adequate service to them, or which interferes with reasonable competition among physicians of a community.

ARTICLE VI

Duties of Physicians Towards their Allied Professionals

Section 1.—Physicians should cooperate with, and safeguard the interest, reputation, and dignity of, every pharmacist, dentist, and nurse; because all of them have as their objective the amelioration of human suffering. But, should they violate their respective professional ethics, they thereby forfeit all claims to favorable consideration of the public and of physicians.

Section 2,—It is unprofessional for a physician to recommend or approve for the care of the sick any medicine or appliance of doubtful utility, when his recommendation can be used by a lay body to promote its sale, its services, or its use.

Section 3.—It is unethical to receive remuneration from patents for surgical instruments

and apparatuses or medicines; to accept rebates on prescriptions or surgical or medical appliances, or perquisites from attendants who aid in the care of patients.

Adopted on October 15, 1937, by
The Special Committee on Medical Ethics of
The Philippine Islands Medical Association

(Sgd.) ANTONIO S. FERNANDO, *Chairman*
" CANDIDO AFRICA, *Member*
" E. D. AGUILAR, *Member*
" G. GARCIA, *Member*
" E. M. PANIS, *Member*

AMERICAN MEDICAL ASSOCIATION
JUDICIAL COUNCIL

629 Euclid Ave., CLEVELAND, OHIO, January 21, 1938

Dr. A. S. Fernando, *Secretary*
Philippine Islands Medical Association
Manila, Philippine Islands.

Dear Doctor Fernando:

I have taken some time and have given careful consideration to the copy of the Code of Medical Ethics of the Philippine Islands Medical Association. I suppose that this was sent to me for such criticism as might occur to me rather than with a primary object of telling how good it is. This code impresses me very much and in some respects I believe it to be superior to the Principles of Medical Ethics of the American Medical Association. I like its general layout better and the way the ideas included in it are grouped together.

Taking up the code by pages I have no suggestions to make on Page 1, with the exception that in Section 4, at the end of the second line, it might be well to include the phrase "conform to the laws." This comes to my mind because of the fact that where a law governs the practice of medicine, it supersedes the Principles of Ethics if there is any conflict. Such cases have arisen in the United States, particularly in contract practice, almost all forms of which have some feature or features which, according to the Principles of Ethics, make that practice unethical; but, because of the laws of those states where this condition exists, the laws necessarily supersede the principles.

PAGE 2. I am quite in agreement with the last sentence of Section 4, Article II. It occurs to me that if some occasion arises for discipline under that section, there might be great difficulty in proving that a man knew that "such assurance is false." I would therefore make the suggestion for your consideration, to substitute for the word *false* the phrase *without accepted basis*. It is my opinion that the difficulty of disciplining would be much easier.

PAGE 3.—*Section 6. Third line.* The word *shall* in this connection is a positive prohibition for any physician to meet in consultation anyone with a lower qualification than what is required to practice medicine, which of course, includes all the means of caring for the sick. I can conceive of a situation arising such as the following: A man might be taken suddenly ill and even unconscious, when everyone might run to his assistance. Among them might be an osteopath or someone else with a lower degree than that of M. D., who may be doing what he knows to relieve the victim, but who might recognize that the seriousness of the case was beyond his capacity and ask for a physician. In such a case the osteopath should of course retire when the physician arrives, but naturally the physician would desire to know so much about the history of the case as the osteopath might give to him. This meeting under such circumstances as this would be a consultation. If the physician coming to the aid of the osteopath in the emergency should absolutely refuse to have anything to do with the osteopath, he would hardly be following the ideals of our profession to care for those in need of our services as best we can. It would also bring discredit on the medical profession as a whole for a physician to refuse his services because of his prejudice, for one doing his particular best, although not with the same efficiency as the physician might do himself. I should therefore suggest that *shall* be changed to *should*. I note the word *shall* in a few places throughout the code and it would seem advisable to change the

word all the way through. Unless we are setting up a definite system of laws to cover all contingencies which may arise, the positive prohibition of certain things is less advisable than the statement of the principles which should govern action. *The Principles of Medical Ethics of the A. M. A.* was definitely written and has been in operation for a number of years, with the idea of establishing the right principles that should govern the actions of medical practitioners in their dealings with the public and with their patients as well as with one another. It has carefully avoided definite prohibitions for particular instances, and this policy has enabled us better to control the actions of those who need control. We find in all cases of appeal brought to the Judicial Council that there is sophisticated reasoning back of the claims under which the appellant asks for reversal of the preceding court. There is an effort by such sophisticated reasoning to evade or circumvent the pronouncements in the principles under which they are disciplined. Laws may be evaded by sophisticated reasoning and by other shrewd means; but the principles are basic, broad, and inclusive, and cannot be evaded by any such measures. From experience I would commend these remarks to your careful attention.

PAGE 5. Line 3. The word *must* in this line is open to the same suggestion that I have just made in respect the word *shall*.

PAGE 7. Section 2. This section impresses me as not being comprehensive enough. Commercial concerns, in order to sell their wares to the public, are eager to obtain endorsements from physicians. The section as written is rather restricted in its statement as to why or when it is improper to recommend a certain product. The word *accommodating* somewhat removes those restrictions, but it seems to me the object of the section should be to make it unprofessional for a physician to recommend or approve any medicine or appliance used for the care of the sick when his recommendation can be used by a lay body to promote its sale, its services, or its use. I would think that the publicity connected with the doctor's name makes the action unethical as being a type of unethical advertising as well as the unethical feature of the recommendation by a doctor of treatment or remedy to a lay person for self treatment.

PAGE 7. Section 6. I note in this section that the matter of a division of fees is covered in practically the same terms as the *Principles of Medical Ethics of the American Medical Association once used*. The American College of Surgeons has a statement in their obligation on entering the College, that the candidate will not under any conditions divide a fee with another physician. Both the American Medical Association and the American College of Surgeons have numerous violations of the principles underlying the division of a fee, and many of those who were inclined to split fees have found satisfactory methods of getting around the direct act of splitting a fee. Because it was simply the division of the fee which was prohibited, disciplinary action has been difficult to take. The offending member assumes that the division of the fee is the reprehensible thing which is prohibited. Of course, this is sophisticated reasoning; but, because of the wording of the *Principles of Ethics* and the obligation of the American College of Surgeons, nothing can be done about it. For this reason, the American Medical Association a few years ago revised its principles, making no mention of the division of fees but making it unethical to receive a commission. No matter how a commission is paid, it is unethical; and the centering of the attention on the act of splitting a fee confuses the situation and those desiring to do so will take advantage of that confusion. Furthermore there are many instances in which a fee very justifiably may be divided between a referring doctor and a specialist to whom the patient is referred. There is nothing essentially wrong with the practice in many instances. For example, a patient with limited income but requiring much service from both the referring doctor and the specialist cannot afford to pay both. The two, then, may consult with the patient as to the total cost of the service and the proper division of that cost between hospitalization and the fees of the specialist and of the family doctor. There may be no commission involved in that transaction: and, because there is none involved, there is nothing wrong with it. The American College of Surgeons still retains the clause concerning division of fees in its oath. The A. M. A., however, has found that it can bring the reprehensible practice of dividing

fees much more satisfactorily under its control by the present pronouncement against the giving or receiving of a commission. I offer this experience for your careful consideration.

PAGE 7. Section 3. This section as written is specific enough to cover rebates on prescriptions and sale of surgical appliances, the receiving of perquisites from attendants, and the general idea of "unethical combination with a pharmacist and manager or the proprietor of a pharmacy." It seems to me, though, that singling these things out from the other clauses referring to commissions, opens the door to the possible interpretation that these particular acts are different from the receipt of commission in another way. For this reason, it might add to the difficulties of applying the principle underlying them.

I note that the title is *Code of Medical Ethics*. Although the Principles of Medical Ethics are commonly and ordinarily spoken of as the Code of Medical Ethics, the real title of the American Medical Association's statements is the *Principles of Medical Ethics*. We make every effort to stress that the ethics of the profession are based upon principles which are broad in their application and are in fact principles and not laws. A code is defined as "a systematized body of laws "or" a system of rules and regulations." It seems to us that when we try to cover the contact of a doctor with his patients, with the public, and with one another, it is impossible to include in such laws, rules, or regulations, all the circumstances under which the doctor has to deal with others. But if the statements are made simply as principles, all of the situations will be covered and there can then be no evasion or circumvention of our pronouncements.

I note that there are many situations which we in the United States have found in late years necessary to be covered by additional statements in our principles. The trend of the times in general in this country has become so commercialized that new ideas and new practices have sprung up, on which there might be a very definite and honest difference of opinion. So many cases of this character have arisen and have come to the Judical Council of the A. M. A. for opinion and in some cases on appeal from actions of state societies, that the House of Delegates, at the instance of the Judical Council, has covered these situations through their general principles without making specific application by stating the acts which come under those principles. I enclose herewith the latest revision of the *American Medical Association's Principles of Ethics*, in which these particular circumstances are marked in red pencil for your consideration as to the advisibility of their adoption in your *Code of Ethics*. It may possibly be that the condition of medical practice in the Philippines has not come to the unfortunate situation that it has in the United States and there may be no need of such pronouncements at present. It might, however, be well to consider whether, if you do not have the abuses in the Philippines that we have in the United States, it may not be well to guard against their development in this changing age and increasingly growing emphasis on the economics of medicine in the minds of the profession.

Please consider that all of the remarks herein made are based on the experience of the medical profession in the United States and are offered for your consideration only as suggestive and for such use you may in your own judgment consider advisable. I shall be glad to be of any further use that I can be to you in the problems that you have before you and feel greatly complimented by your request for the opinion of the American Medical Association in your establishment of principles under which the profession in the Philippines should work.

Sincerely yours,

(Sgd.) GEORGE EDWARD FOLLANSBEE
Chairman

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