The PHAN staff visited her home in Quezon City for the traditional interview with the PHA president and got a touch of Tes as homemaker to husband Bartolome “Mel” and their three children who are totally bonded into each other. Seeing them sing together accompanied by their own music on piano, flute and guitar is simply heavenly. Small wonder why she moves with a distinctly soothing calm in the workplace that commands respect from her colleagues.

She was born and raised in Quezon City, along with her only younger sibling Carmencita, by loving parents, Engr. Carmino Bacnis and Dr. Avelina Bacnis. As an obedient daughter, Tes followed on the footsteps of her mom who she claims to be very influential in her career path. “My mom who is such a benevolent generous allergologist, trained in the US but came back to be one of the first allergologists in RP, always brought my sister and me with her to her clinic on Saturdays, and in the summertime. I would see how she genuinely would like to help her patients” she reminisces. “I think, as young as grade 4, there seemed to be no question that becoming a doctor was the vocation I was going to take”.

Her only sibling, Carmencita Bacnis-Verayo is a radiologist at the Makati Medical Center. “Menchu and I have always had a harmonious relationship, mostly centered on our parents, as we help each other take care of them! My mom had a heart attack a decade ago while my dad, I had to do CPR on two times at home; providently, I was home early in the evening during those times. They are both acceptably healthy and look younger than their 83 years! Professionally, my sister and I become each other’s consultant adviser when we need opinions regarding
our respective fields of practice," she says. In her early teens, Tes was diagnosed to have Nephrotic Syndrome and was on steroids for over six years. “I knew and felt how it was to be a PATIENT. It did not “traumatize” me and alienate me away from “doctors” she recalls. “My mom’s example as a model physician influenced me more strongly. This was a very difficult period in my life and in my parents’ lives. My dad was quite ill from a neurologic disorder, and I, with this kidney problem, for several years. Our faith in God was even strengthened more by this challenging phase in our lives. I should say God has allowed me the opportunity to serve and become a doctor by healing me”.

Being a doctor is her backbone and fiber, which she claims was reinforced when she witnessed her favorite Uncle succumb to a fatal heart attack at the Philippine Heart Center. She chose cardiology because she finds it to be the most dynamic and promising field to match her energy and passion. “As I was going through my Cardio training at the PHC, I noticed that the patients with peripheral vascular disease were only “second-class citizens”, as far as priorities for treatment. These patients were being managed by the cardiovascular surgeons who prioritized open heart cases and were referred to cardio only for cardiac clearance. I decided I wanted to help these patients. I researched on medical care that can be provided these patients and I stumbled on this article in the NEJM entitled The Time for Vascular Medicine Has Come. That formally started it all.”

Now, Tes is a multifaceted gem for the PHA. An eternal student who wants to keep learning new things, yearning to keep honing selected skills, she gets especially challenged with teaching and mentoring roles. “This is the most demanding role and sphere of responsibility, I suppose. Soon after coming back from US training, I started teaching at the PHC and PGH, started training technicians to do vascular ultrasound scanning to help start up vascular laboratories at the PGH, Chinese General Hospital, Medical Center Manila, Manila Doctors’ Hospital, Asian Hospital, and help strengthen the technical staff at the PHC, and Medical City. At the end of the day, I feel the great sense of fulfillment it leaves me, after teaching young doctors, or caring for patients. I take pride also in having participated in the education and training of our future cardiovascular specialists, especially our vascular medicine specialists, as I see them become very active physicians in their respective areas or regions”.

Born to lead, she balances her life by her out of cardiology passions. “I dream of formal education or training in other fields like Health Economics, or Podiatric Medicine, or Music/Voice. I almost auditioned for the UP Concert Chorus. I knew that I might get in, and thought if I really wanted that to be my chosen career…”

Dream on Tes for you have realized many. "God has allowed me the opportunity to serve and become a doctor by healing me... We do not have to wait for a crisis to work. We can work for change, now... Cardiology is the most dynamic and promising field.” Above all her accomplishments, she finds her being a mom the most challenging and best role to play. “I can say I have a healthy and happy relationship with my children; I delivered my children, one at each stage of my training—the eldest, Regina Isabel, 20, was born during my Internal Med training years, the second, Ana Karina, 19, was born during my Cardiology training years , and Miko or Juan Miguel Carlos, 15, was born just after my vascular training in PHC and just before I left for my training at the Cleveland Clinic Foundation. Regina is preparing to get into Medicine proper training. Karina is in an A8 Psych course which she says can prepare her for anything—teaching children, or fashion design. Miko dreamed of becoming a game creator, but recently, has been asking about neurosurgery. Through this all, my husband, Mel, has been very supportive of my vocation, through undergraduate premed, Medicine proper, residency, fellowship, and now this, the PHA.

One magnificent woman, so accomplished and so family-oriented still dreams for more quality time with her family amidst all her duties and responsibilities “I have always made it a point to keep doing and enjoying things together, have quality time together, be there in the most important events of my husband’s and my children’s lives. Still am dreaming to have more quality time for my family... I believe that will soon come true”.

For the year ahead, Tes still has the PHA to lead as she stands to bring relevance of the PHA to its members, stakeholders and the Filipino people by stressing on the mission and the broad objectives of the PHA to be a proactive organization. “For our members and we have to plan how we can all contribute to the PHA. Not just reactionary but proactive. We don’t have to have to wait for a crisis to work. We can work for change. We want to see more members and we can get them by reaching out to them through more opportunities to dialogue with them”.

How many years have you been serving the PHA? in what capacity?
I had begun working for the PHA very early in my medical training. "I graduated in 1996, a premed, Medicine proper, residency, fellowship, and now this, the PHA.

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in my professional career, becoming an active member of the Council of Stroke and PVD soon after training, and later, Council Chair. Vascular Medicine is one of my greatest passions. So, I guess, I have been working for the PHA since circa 1997... I came home from training mid 1995. So, virtually my entire professional career has almost entirely been intertwined with the PHA, teaching and training.

When did you first feel you were called to serve the PHA that eventually would lead you to the top post of this elite organization?

It was Dr. Paul Garcia and Dr. Fatima Collado who enticed me into the world of PVD. I would sit in and watch over their shoulders as I sat amazed at how much more dynamic the peripheral circulation was, than what was taught in medical school. I realized early on, by being a PHA member, we could do much more to concretely improve cardiovascular education and care.

Having been working for the PHA for many years now, can you describe the PHA culture? The PHA as a conglomerate of people? As an organization with a mission?

The PHA culture? Because of the many talented, renowned, accomplished leaders and members before me, I suppose, there is always this drive to be better, to aim for excellence, to be innovative.

Conglomerate of people--- members who have achieved a certain degree of professionalism in order to be members, there are certain academic and professional requirements that have to be fulfilled before one is admitted—in that sense, you can say it is an elite organization. And the PHA would like to keep providing opportunities for continuing medical education and excellence in cardiovascular care practices through its many programs and activities.

You are known to be a lady of many ideas and initiatives that you always see to completion. Do you think a one-year presidency is enough for you?

One year may not be enough to see most of the projects to completion, or to see most ideas become realities. But one doesn’t need to become a president to contribute such ideas or participate in such projects, or work hard to see them to completion.

Being the president means being the leader of the group—the Board and the members—who oversees all the plans to fruition, who opens up opportunities for new ideas to effect change where needed, any member of the PHA has that equal opportunity to contribute to Philippine Cardiology.

What are your priority plans?

I would say, I want to first engage the PHA and its members to a deeper commitment and a strengthening of the PHA from within. Building up what we already have and equipping our members and staff through human resource development projects. Then, reach out to new frontiers and link up with new partners. Ever since I got into the PHA Board, when as the newest Board member, we handle advocacy, I have dreamed of partnering with wellness groups and other potential stakeholders in advertising and marketing who have the same advocacy as the PHA. We plan to pursue the “Wellness in the Workplace” advocacy with the Department of Labor and Employment (DOLE) and the Employee Compensation Commission (ECC). For the first time, PHA will join the Advertisers Congress on Nov. 18-21, 2009 in Subic, Olongapo City. This is a great opportunity for PHA. We will have a booth near the entrance where we can showcase our advocacy and programs. We can distribute our modules, infomercials and brochures, etc. The PHA Central Luzon and Northern Luzon Chapters will definitely be involved. We can tap food companies with health foods. These are companies who may need cardiovascular wellness program/ they will know that we are there through word of mouth.

Member activation is always priority, to be more relevant to our members. What is it that will make our members value his or her membership in the PHA, what will make the members “look up” to the PHA for guidance

Light moments with President Tes (l-r) PHAN staff Supe, Banez & Demerre
as far as cardiovascular care standards are concerned, as far as providing opportunities for new learning in cardiovascular care, as far as contributing to the tangible improvement in the cardiovascular health of the Filipino people?

I seek answers to these and will do so by opening up more channels of communication beyond how we had been doing before. I would like to communicate with the members more regularly, more often, to hear about how they think the PHA can be more relevant and proactive. Through the sponsorship of MSD, I was able to arrange for web-based meetings with the chapters so the PHA Board can meet them en banc and more than the once-a-year meetings that we usually have. The answers I get I hope will help us encourage more member participation and activation. I would like to see more members actively participating in the activities of the PHA, not just our hardworking council members and board members. I plan to meet representatives of the different alumni associations of the different cardio training programs to get some feedback and suggestions.

How can the PHA be a staunch advocate of anti smoking knowing that 7 of the top 10 causes of deaths are smoking related?

We can work together with the Philippine College of Physicians (PCP) and Philippine College of Chest Physicians (PCCP) and harness our efforts and resources towards this goal.

How can the cardiologists with their brilliance and eloquence be proactive advocates of healthcare reforms?

Issue LOUDER messages of cardiovascular prevention, partner with government agencies who may be responsive. Dr. Ma. Adelaida “Leni” Iboleon-Dy, the new director who has always been supportive of my programs, through the years is now the Advocacy Committee chair and with her connections, we hope PHA can have a greater reach and impact.

How can you and the PHA’s past leaders influence Congress and Senate to do relevant healthcare reforms? Do you think the PHA should and would go as far as impacting legislations?

Being able to effect change in cardiovascular healthcare by having bills made into law will be one of the most tangible outcomes—for example, if we are able to convince the Philhealth to reimburse health care that has been shown to be aligned with evidence-based practice guidelines may be reinforcement enough. I have delegated Dr. Saturnino “Bong” Javier as chair of the Legislative Affairs Committee. We can work together with the PCP in the healthcare reforms they will support. But we can also prioritize those that impact cardiovascular health like the “food supplements”. Hopefully, this year we will really be able to make a stand.

By the way, Senator Antonio Trillanes IV called the PHA because he is pushing through with his bill for the government to make a national registry for heart diseases. We are now mandated to make a registry through this Bill. In actuality, this is really the mandate of the PHA on the councils, to come up with a registry. When this bill is put into law, then we would surely get the Department of Health to support. I am definitely thinking about looking into other Bills that we can support and use.

What do you think of our current healthcare system in the country? What flaws do you see? How can the PHA help to improve the flaws? What are our strengths?

Our strength is in cardiovascular education for prevention of cardiovascular disease.

In your inaugural speech, you mentioned your agenda by way of challenges. TO BE STRONGLY RELEVANT (to stakeholders/members/Filipino people); ENCOURAGE, INITIATE AND SUPPORT RESEARCH; STRENGTHEN THE PROFESSIONALISM OF THE ASSOCIATION; ENSURE SUSTAINABILITY AND FISCAL VIABILITY OF THE ASSOCIATION. They are indeed colossal tasks. Realistically, do you think you can achieve your goals in one year or are you preparing for a continuity scheme to achieve your goals?

Each President, or any Board member for that matter, hopes that any project he or she proposes will be espoused by the Board, and likewise the succeeding terms, to ensure its success. In the first place, these goals should be aligned with the PHA Mission and Vision. We shouldn’t think parochial. We don’t just plan just so we have projects for the term of office. We dream of a vision and we work towards that. We acknowledge the limitations, the realities, but we aim to overcome them so we can achieve our mission and attain our vision. We
Historic... From page 30

84,105 Balangueños in 14,065 households in Balanga. Practicing Internal Medicine and Cardiology claim that their work is very much different from that of Manila and they take pride in their closely knit, harmonious rather than competitive clinical practice to less-demanding patients distributed among the three secondary hospitals, namely, Bataan Doctors Hospital, ICMC (Isaac Catalina Medical Center) and Women's Hospital and one tertiary hospital the St. Joseph Hospital, all within a one-kilometer radius. As such, even with the bulk of patients that each of these three doctors have, they have the luxury of time to attend to their passions outside cardiology and live by what they preach on healthy lifestyle for cardiovascular disease prevention.

“We thank the PHA CPR council for allowing and helping us in facilitating BLS and ACLS training for our doctors and nurses, especially those assigned in special areas like ICU and ER. These trainings made a great impact in our practice of Cardiology here in the province and I can say that BLS and ACLS really save lives!” remarks Bugarin.

“My only frustration is maybe the lack of facilities for specialized cardiovascular interventions here like emergency pacing, vascular surgeries, etc. We need to send patients to Manila,” laments del Rosario. “We don’t have training residents and fellows here. All moonlighters” he adds.

According to del Rosario, he sees 30-50 patients a day, 50% with hypertension, 40% with chest pain, 60% with CAD, 20% with diabetes and more than 60% are likewise dyslipidemic. Peripheral arterial diseases are seldom seen. “Balanga is a small city, we have simple needs and we can go around town with no money in our pockets. If we need gas, we can load up and pay later” exclaims Bautista.

They share a bond with the rest of the Balanga doctors, made solid by their strong faith in God. They take time to meet every Friday to pray the rosary together as well as socialize. Their strong sense of “giving back” is seen by the many fund-raising activities they have done so far.

These three PHA members share the same hope that someday, they can organize a cardiology training program and expand quality medical care to neighboring towns, with the help of the PHA. God will surely honor their desire. ED

PHA singers... From page 15

Joining a group especially a choir entails a lot of sacrifice and this is a commitment. I compose songs (the melody at least). I play the piano and guitar. I sing in the car when I am alone or with the family.

“Singing, especially with a group (like a choir), is also a stress buster for me. The harmony of the human voices put together always amazes me. Someone told me it’s a way of giving the glory back to the Father,” she said.

It is her mom’s side whose talent leans toward music. My eldest son Gelo is showing interest in singing and playing instruments, she said.

Asked which is her favorite song? She said I used to sing classical, gospel and folk songs with the glee club; I sing contemporary and ballad. I like, “I’ll never say goodbye” the theme song from the movie “The Promise” (with my husband as the singer).

MARIO JOSELITO D. GARCIA, MD
UST Hospital
Angeles University Foundation Medical Center
World Citi Medical Center
Sacred Heart Medical Center

Dr. Mario Garcia vividly remembers telling his parents that he wanted to sing when he was in grade 4 at the San Juan Elementary School.

Although his mother, who used to be a campus queen, is musically gifted, she never had the chance to teach him sing. He never complained because he knew that raising five kids was tough.

He was a popular figure being one of the brightest and handsomest students. One Friday afternoon, their class adviser conducted an impromptu singing contest that intimidated the entire class. As class president, he was mandated to start the program, so he had no choice. He sang Let Me Try Again, a Frank Sinatra hit. “The class gave me a 60-second standing ovation. I don’t know if they really loved my voice or they were just amused by my style. Since then I tried to learn more songs and would sing during my spare time,” he said.

Singing as a profession was not on his mind because he was sure he will do better as a doctor.

During his sophomore and junior years as a training Fellow in cardiology, he was part of the UST group that placed second prize in the PHA-sponsored inter-Hospital Choir contests. Their coach was a medical clerk, who later on made it to the famous Julliard School of Music in London. He had both a funny and humbling experience with him. “One time, while he was classifying our voice range, he asked me if I was alto. I insisted, alto...then he said if you’re not going to follow me, you are base. I insisted, alto...then he said if you’re not going to follow me, you better leave the group... I stayed. We won, 1st place. “

Singing as a profession was not on his mind because he was sure he will do better as a doctor.

Whenever he has the chance, he is on the videoke. His genre includes pop rock, alternative music, middle of the road and lately he’s been into ballads, with partiality to Martin Nievera selections. He said “singing makes me feel good. I often sing his Kahit Isang Saglit because I love the lyrics.

He also prefers the repertoire of Mark Bautista and Christian Bautista. Whenever I sing Ang Bayan Ko, I get teary eyed.

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Drs. Bugarin, Ramirez & Lavapie & Grande in front of the scenic La Vista resort
When putting meaning to results in clinical trial, researchers compare the number of people who experience the same clinical outcome against those prevented; from two differing exposures, from the experimental drug and controls. A 2 x 2 table usually summarizes these results though most of the time, this table is not presented in published articles.

Risk is measured as a proportion of number of volunteers who developed the clinical outcome over the total number of patients enrolled in each group. These are straightforward percentages that speaks of the bad outcomes e.g. Scenario 1, 40% risk of death amongst controls and 20% risk of death amongst experimental group. Relative Risk Reduction (RRR) is the difference between the two risks as a percentage of the risk those not exposed to the therapy. In the example above, the relative risk reduction would be (40% - 20%) / 40% or RRR of 50%. Interpretation, relative to the current standard of care, as determined by the control, the experimental drug reduced the risk by 50%, that is from 40% to 20%. On the other hand we likewise compute for Absolute Risk Reduction (ARR), which is simply the difference between the two risks. In the above example, the absolute risk reduction is computed as 40% - 20% which is equal to 20% of 40% = 0.2. These two expressions of risk reduction mean the same thing, in some respects, but looks at data from different perspectives. Both are important information in decision making and has its biggest impact in program development. Its application is also best illustrated between rare and prevalent disease. Let’s apply the same risk reduction formulas in a rare scenario, e.g. Scenario 2, control risk of 4% and experimental risk of 2%. The RRR will be computed as 4% - 2% /4% which is equal to 50% [100% - 2/4% = 50]. ARR of 4% - 2% which is equal to 2% / 4% = 0.5. In both scenario 1 and 2, the RRR is 50%, but the ARR in scenario 1 is 20% and scenario 2, at 2%. RRR does not take into account the size of the initial risk and the actual reduction. In the given example, while the ARR vary greatly, the RRR remains the same. While ARR may give a more accurate report of the effect of the intervention, sometimes people have difficulty understanding the distinction between the two. So, the Number Needed to Treat (NNT) was conceived. The Number Needed to Treat (NNT) is the reciprocal of the Absolute Risk Reduction. If the ARR is expressed as a decimal, the Number Needed to Treat is 1/ARR; if the ARR is expressed as a percentage, the Number Needed to Treat is 100/ARR. In the above example, the Number Needed to Treat is 100/20% or 5. The Number Needed to Treat tells how many people you need to treat in order to see the desired outcome in one additional patient. In this example, you would need to treat 2 patients to prevent one additional patient from dying at 12 months. The NNT gives you a clear number to use to balance benefits against risks. If you only need to treat 2 patients to see a benefit, you may feel comfortable ignoring extremely mild side effects. However, if you need to treat 2000 patients to see a benefit with a drug that has very severe side effects, you may not feel comfortable recommending this treatment.

The other important numerical expression we frequently encounter in published literature is the 95% confidence interval (95% CI).

Results can be clinically significant without being statistically significant. While this is interesting to biostatisticians, medical practitioners are more interested in results that are clinically significant. Results can be clinically significant without being statistically significant. A negative confidence interval tells us that the results were opposite the expected outcome. While there is a mean probability of 45% reduction in mortality and no greater than a 53% chance, it is also true that for some subset of the population studied, there is a 2% chance of an increase in mortality.

By Raul Martin A. Conching, MD
The present era of medical practice is characterized by increasing culture of litigation, so much so that a physician is left with no choice but to arm himself with legal knowledge, lest he wakes up one day with a lawsuit on his breakfast table. People have become more aware of their legal rights, and, with the increasing intrusion of third parties in the once exclusive physician-doctor relationship, much has changed.

The fiduciary nature of the physician-doctor relationship, characterized by mutual trust and confidence, has slowly but definitely been eroded. We physicians trust and know ourselves. Except perhaps for a very few, if any, we only do what in our medical judgment is best for our patients, with the ultimate aim in mind to at least provide them comfort and ease their pains, if not totally cure them. We physicians are non-legal conscious by nature, forgetting or even unaware of the legal technicalities demanded of us while treating our patients, all in good faith. But good faith is not a defense against the violation of this legal mandates. In this issue, I thought it best to discuss the rights of patients first. Subsequent issues will deal with their obligations and rights and obligations of physicians as well.

There are 13 rights the law provides for the protection of patients and these are: right to appropriate medical care and humane treatment, right to informed consent, right to privacy and confidentiality, right to information, the right to choose health care provider and facility, right to self—determination, right to religious belief, right to medical records, right to leave, right to refuse participation in medical research, right to correspondence and to receive visitors, right to express grievances and right to be informed of his rights and obligations as patient.

Right to appropriate medical care and humane treatment means that a patient is entitled to a medical care corresponding to his state of health without any discrimination as to age, gender, religious belief or financial capacity. The limitations to this right are the available resources, manpower and competence available at the time. If treatment could not be immediately given, the patient should be directed to wait for care or referred or sent for treatment elsewhere. But always, the patient should be informed of the reason for the delay, transfer or referral. In emergency cases, immediate medical care and treatment without any deposit, pledge, mortgage or any form of advance payment, must be given. When a physician is sued for violation of this right, the burden lies on him to prove that the appropriate medical care was not given due to the above limitations, otherwise, he will be held liable.

The patient has the right to informed consent. When a patient seeks admission, the physician is not automatically authorized to do whatever he likes to him. He is entitled to a clear, truthful and substantial explanation in a manner and language understandable to him of ALL proposed procedures - diagnostic, preventive, curative, rehabilitative or therapeutic. The person who will perform such procedure must provide his name and credentials, inform the patient of possibilities of risks of mortality or serious side effects, problems related to recuperation and probability of success of such procedure. The physician is liable for the performance of these procedures without consent regardless of the outcome, even if it has been applied with due care and diligence, the patient sustained no injury or the physician is a specialist and competent in doing the procedure. The cause of action here is the lack of consent, not the consequent damage or injury. However, a consent is not necessary in the following cases: a) in emergency cases where a patient is unconscious or incapable of giving a consent AND no one is with him to give the consent in his behalf. In these cases, the consent is implied by law and the physician is privileged to act in assumption that consent has been given, PROVIDED, he acts as what the occasion demands in conformity with the usual practice of physicians in the same locality; b) when the health of the population is dependent on the adoption of a mass health program to control epidemic like compulsory immunization of children; c) when the law makes it compulsory for everyone to submit to a procedure (as routine chest radiography of all teachers every three years); d) when the patient is either a minor or legally incompetent in which case consent of a third party is required; e) when disclosure of material information will jeopardize success of treatment in which third party disclosure shall be done; and f) when the patient waives this right in writing.

In case of a minor or legally incapacitated patient, third party consent is given in the order of priority, not just any adult present at the time: spouse, son or daughter of legal age (oldest), either parent (father is prioritized over the mother), grandparents (paternal prioritized over the maternal), brother or sister of legal age and guardian. If the above persons do not give consent and the physician or medical director of the institution believes that the procedure is beneficial to the patient, the court, upon petition by the physician or any interested party, may give the consent or appoint a guardian to give it.

In case of a married person, his or her consent alone is sufficient. But there is nothing wrong if the consent of the spouse is likewise taken for the preservation of marital harmony and especially when the procedure has a high mortality and the death of the patient will deprive the spouse of marital consortium, impairment of sexual function and destruction of the unborn product of conception. The quantum of information necessary to obtain informed consent has no fixed or standard rule and primarily is a question of medical judgment.
Milestones in medicine are often but mere footnotes in world history and world politics, and yet it is common knowledge that poisons and potions have been pivotal in the survival of monarchs and political figures, and that diseases have been known to wipe out armies long before they reach the battlefield. Political misfortunes have been attributed to bad or tragic destiny, but the footnotes of medicine shed light on these events, often posing a question of what if.

When Franklin D. Roosevelt (FDR), was elected to an unprecedented fourth term in 1944, the strain of leading America through World War II had taken its toll. Not only was he stricken with polio, FDR was suffering from malignant hypertension and heart failure. A Bethesda cardiologist recommended that FDR be given digitalis, put on a diet, and bed rest. FDR's blood pressure during 1944 reached dangerously high levels, up to 210/120 but a more senior presidential physician insisted that the FDR’s health was good, that and such blood pressure was normal for a man his age! More concerned with FDR’s bronchitis, this physician prescribed vasoconstrictor nose drops and sinus sprays which, of course, did little to alleviate his breathlessness, and probably further worsened his hypertension. In February 1945, FDR attended the Yalta summit with Winston Churchill and Joseph Stalin. It was a strenuous trip for the ailing president. Most in his entourage, including Harry Truman, saw him tired and worn out. The big three Allied leaders met together only twice during World War II, but when they did conference, their decisions changed the course of history. The question of whether FDR’s health compromised his bargaining power with Stalin has been debated. FDR’s ill health was apparent to Stalin and the Soviets, and the poker faced Stalin bargained hard and got, among others, Soviet control of the Baltic countries of Latvia, Lithuania and Estonia. On April 12, 1945, FDR died suddenly while working at his desk, after complaining of a “terrific pain” in the back of his head. It was a fatal stroke.

It was only in the 1950s when Rauwolfia was introduced as an antihypertensive agent and when epidemiologic studies had started to infer that elevation of blood pressure played a critical role, even in the asymptomatic, in causing death and disability. The Framingham Heart Study was launched not long after FDR succumbed to a massive hypertensive stroke, at a time when cardiologists in the United States numbered fewer than 400 and heart disease was already the nation’s leading cause of death. One wonders had FDR been under a different doctor, someone more maverick and with early access to Rauwolfia, and if FDR took his digitalis as was prescribed in Bethesda, would he lived longer, and or at least been stronger at the bargaining table at Yalta and how much of the course of world history would have been changed. What if?

During World War II, Ferdinand Marcos escaped a Japanese prison camp and ran to the hills where he became a commando guerilla. The rigors of guerilla life took its toll, and he ends with blackwater fever. He treks down to Manila and collapses into the arms of his mother. Moribund, his physician brother brings him to Philippine General Hospital where he convinces the hospital director to have him admitted under covert circumstances. No one in the staff knew who this guerilla was or what he had done, but everyone cooperated in hiding him behind bookshelves, changing his location, shielding him from Japanese doctors and sentries. Only the brilliant internist ABM Sison was in direct contact, and he gave the soldier every ounce of medical genius he had. He sent his intern to the streets of Azcarraga to fetch quinine in the blackmarket. From the brink of death, Ferdinand Marcos was saved by his sheer will to live and to fulfill his destiny (with the aid of course of a brilliant internist who knew quinine could cure malaria, and the intrepid intern who knew where to procure it).

Forty years later, news leaked that President Marcos had rejected his first kidney transplant and was in uremic coma, the word spread quickly to Boston and to Ninoy Aquino. The news goaded Ninoy to make his move. It was not really known then how Marcos was, and those that knew and talked too loud were silenced. Marcos eventually survived his second transplant, thanks to the expertise of transplant surgeons miracle changed the course of Philippine history, or at least extended the lease on life of an ailing dictatorship. But it came too late to stop the assassination attempt on Ninoy.

Nineteen-eighty-three was about two years after Ninoy’s bypass surgery. At that time although bypass surgery was a well-established therapeutic modality, the common perception in the 1980s was that having bypass surgery was like a diagnosis of cancer, such that one is but on extended lease on life and that death was due anytime. So perhaps to Ninoy’s mind, better to die a hero’s death than to die of obscurity in a foreign land because of an ailing heart. But nobody really knows how bad his heart was, or how he perceived his heart condition. His father, Benigno Sr., died suddenly of a heart attack while watching a boxing match in Rizal Memorial Coliseum. Such a family history of sudden death has a large impact on one’s psyche, maybe just maybe these were workings of his political mindset: a win–win gambit but with high stakes, go home and fulfill his destiny either to succeed Marcos or die a hero for his country.

But that was 1983, and what we knew about the medical therapy of coronary disease was but a fraction of what we know today. We know of course that in the best of hands and in the best of situations, bypass surgery has been known to prolong life significantly. A few more years, medications now known to modify the natural
What is the status of coronary CT angiography in local-cardiovascular practice today?

Cardiovascular computed tomography has evolved rapidly over the past decade expanding its indications for the non-invasive assessment of the heart, great vessels and peripheral vasculature. In our local setting, the use of coronary CT angiography (CTA) for the non-invasive assessment of the coronary arteries and left ventricular function is slowly gaining ground. Its utilization is not as widespread as I would like it to be, but with the availability of more advanced CT scanners in various medical centers, more clinicians are now appreciative of its important role in the care of patients with probable and established coronary artery disease.

Which set of patients benefit most from this technology? Does it have a role in patients presenting with chest pain in the ER?

A multi-society document outlining appropriateness criteria for cardiac CT (CCT) was published in 2006. Since then, CCT has shown rapid growth in technological advances and clinical use.

An International Multidisciplinary Update of the 2006 Appropriateness criteria for Cardiac Computed Tomography was published in the July-August 2009 issue of the Journal of Cardiovascular Computed Tomography. There was a significant change in appropriateness of indications. Five of the 12 originally uncertain indications shifted to appropriate and a total of 10 originally inappropriate indications shifted to uncertain. All 13 original appropriate indications remained so. Interested readers may refer to the complete report for more details. In general, coronary CTA is indicated in patients with suspected CAD with symptoms, more so if the stress test is equivocal. The other important indication is in the evaluation of bypass grafts in the setting of chest pain syndrome.

It is now appropriate to perform coronary CTA for the assessment of acute chest pain in patients with low pretest probability for CAD and no EKG changes and negative serial cardiac enzymes. It is also appropriate in the use of “triple rule out” to exclude obstructive CAD, pulmonary embolism and aortic dissection in the acute setting. These clinical presentations are frequently encountered in the emergency room. The judicious use of coronary CTA results in early therapeutic intervention when needed as well as early hospital discharge when test results are negative improving cost-cutting measures.

Should there be any concern regarding exposure to higher dose of radiation during coronary CT angiogram?

(Pls. comment on supposed increase in cancer risk especially breast cancer in women)

Radiation exposure is considered an important risk of various cardiac imaging modalities including coronary CTA. It is assumed that there is no amount of safe radiation and that any radiation exposure is potentially harmful. Radiation doses vary greatly depending on the image acquisition protocol (prospective gating significantly lowers radiation exposure compared to retrospective EKG gating), settings, the type of scanner, gender and body habitus of the patient. Women receive more radiation because of breast tissue and because of higher sensitivity of breast tissue to radiation, radiation risk of coronary CTA are higher for women than for men. Obesity also increases exposure to radiation.

What are the limitations of coronary CT angiography? Does the 256-slice CT scanner attenuate these limitations?

The presence of extensive coronary calcification can lead to high levels of signal attenuation and cause artifacts. As such there is a greater likelihood that coronary evaluation for lumen stenosis will be non-diagnostic in these calcified segments. Accordingly, some centers do not proceed with coronary CTA in the presence of coronary calcium score of 600 to 1,000. However, such approaches have not been thoroughly studied or validated.

Fast heart rates (> 80 beats/min) and irregular rhythm (atrial fibrillation) used to represent relative contraindications for coronary CTA because of high incidence of motion artifacts. With the advent of the 256-slice scanner, it is now possible to obtain good images even with heart rates of 80 to 100 beats per minute.

Consideration should also be given to increased body weight. Patients with BMI > = 30 kg/m2 tend to produce grainy or blurry images. Tube voltage and current are therefore correspondingly increased to achieve good image quality. An appropriate balance should then be established between acquisition of quality images and the potential risk to increased radiation exposure.

How do you see the future of this technology in cardiovascular medicine?

It has always been emphasized that the prognosis of patients with coronary artery disease depends mainly on two important factors, namely, the severity of coronary artery lesions and the status of left ventricular function. Coronary CTA is the only non-invasive diagnostic modality at present that can give us this information with a high degree of accuracy. Coronary CTA can also be performed together with other diagnostic tests like Positron Emission Tomography (PET), so-called “hybrid” examination. The coronary CTA can delineate coronary vessels with significant lesions and PET can pinpoint the segments with increased FDG uptake denoting the presence of unstable plaque due to accumulation of inflammatory cells. This information would be useful to the interventionalist and clinical cardiologist in the care of patients who will undergo transcatheter revascularization. Other uses currently under study is its utility in mapping out the pulmonary venous and left atrial anatomy to guide electrophysiologists in their ablation procedures among patients with atrial fibrillation.

As the temporal and spatial resolutions and image acquisition techniques continue to improve, the utilization of coronary CTA will undoubtedly expand. This bodes well for all of us who continue to search for ways on how to improve the lives of our patients.
The pharmaceutical industry in the Philippines figured prominently on the national headlines a few months ago because of the alleged bribery attempt by Pfizer Philippines of Malacanang with five million drug discount cards called Sultit Cards. To many Filipino cardiologists, the surfacing of an innocuous pharmaceutical enticement in the national consciousness after being linked with politics and bribery was, at the very least, surprising.

Unmasking drug discount cards

Discount cards are industry-initiated outpatient instruments handed out to patients to cushion the impact of the high price of medicines. How these discount cards came about allegedly as tools to stave off the signing of an executive order by the President that would impose a mandatory 50-percent maximum reduction in the retail price of 22 medicines (of which the majority of the drugs belong to the implicated company) is unclear. Pfizer has since denied that the offer of the cards is in any way connected to the implementation of the Cheap Medicines Act.

But many physicians will surely (and expectedly) ask. Will a company that makes billions out of medicines whose prices stand to be slashed resort to such machinations to protect its huge profits? Will a company that has spent millions to launch a discount card technology, unleash a huge field force and forge partnerships with drugstores, think twice protecting a system that will be nullified and thrown away if the mandatory price reduction is effected? Well, I leave you with your own answers to these questions.

So, what are these discount cards? To unmask them will require some direct exposure to their actual use in the clinic, as well as access to first-hand information from people who directly handled them—who understandably shall remain incognito.

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At the outset, a discount card is a veritable testimony to the high price of a drug and is thus a necessity to make the product accessible to the paying consumer. “Designed to help you understand your health condition better and guide you through the path of improved health”—proclaims its medical director on the Astra–Zeneca card for its Up with the Good, Down with the Bad patient support program. Pfizer’s Sultit Card emphasizes that this “can mean better outcomes which help you avoid the greater expense of disease like hospitalization… complications and diminished quality of life … indeed sulit (worth it)!” Novartis’ Kaagapay Card declares it is meant “to assist you in achieving the best quality healthcare we both aspire for”. Glaxo Smith Kline Value Care card cites its aim “to help you manage your health condition so you can do more, feel better and live longer”.

All cards will only apply the discount for a maximum purchase for the month, e.g. for once-a-day tablet, it is usually for 30-35 tablets only. The next discount comes when the purchase is made for the next month. If the card has not been used for a long time, the card is automatically deactivated. Fortunately, the card user can have it activated again when he makes another purchase (meaning he is back on the drug). To their credit, the cards will allow a discount even for purchases less than the monthly ceiling. This means a patient does not have to buy a month’s supply to avail of the discount.

These cards, seen through the eyes of the issuing parties, the pharmaceutical companies, are undoubtedly portrayed as a generous support to the community for its pharmacologic needs. Charitable at 20%, benevolent at 30%, magnanimous at 50%. One can only ask in a muted tone— are they really?

This is clearly a relevant issue that begs to be answered. Is the benevolence depicted in the discount scheme beyond reproach? Well, the loftiness of an act must always be weighed against what the cards stand for, aim for and build at. Many of them have been in the market for so long that one can intuitively conclude that whatever expenses were incurred during the research and manufacture of these drugs have already been earned back a hundred fold a long time ago. Should discount cards then be considered a form of rollback? Go figure.

All the five discount cards are pre-activated cards which the patients can use immediately with a doctor’s prescription. They require some enrolment to maintain an active status—which means some contact numbers and information are entered into the company databank. This means the company knows who uses what and therefore can follow them up if their cards become inactive. The patients are likewise provided medical bulletins, updates and support through the hotline numbers identified on the cards. Clearly, all these are intervention points.

Even more importantly, can these cards be used to track prescribing habits of doctors? Ever wondered why these cards that leave your clinics have codes? Can these codes be used to track which doctors use which drugs? Go figure again

So do I believe in these cards? Of course, I encourage my patients to use them. Better with a 50%-discount than none at all—especially before the price reductions took effect. These discount cards surely provide some level of support to the purchasing patient. But let us not make any false notions about them. They are also marketing tools necessary to maintain good business. If a discount can be given, the discount should necessarily still fall within a tolerable margin at which the company does not stand to lose profit from the product.

Which is why the biggest objection posed by some sectors to these cards is—if you can allow a 50%-discount on a drug, which means you are willing to slash 50% off its purchase price, why don’t you just drop the price 50% in total? Then everyone is happy—with or without a card.

After all, the most benevolent scheme is one where a discount card is never needed at all since the price has been made affordable enough.
The Emperor’s new clothes

The wide QRS tachycardia depicted in the 12-lead ECG and rhythm strip shown below is unmistakably ventricular tachycardia (VT). These tracings recorded from a 63-year old male with ischemic cardiomyopathy and 40% ejection fraction shows almost all of the known criteria as well as a probably unheard-of criterion for VT.

AV dissociation is demonstrable in the rhythm strip. There is negative QRS concordance across the precordium. The bundle branch block (BBB) morphology showing an rS pattern with a slurred S upstroke in lead V1 and a QS pattern in lead V6 is atypical for left BBB. An equiphasic QR complex in lead I and a negative QS complex in lead AVF inscribe an axis of (-) 90°. The QRS complex is quite wide measuring 0.16 sec. The tachycardia rate exceeds the arbitrary cut-off rate set for VT at 150 bpm.

The highlight of this ECG, however, is the abrupt diminution of the QRS voltages and shortening of the cycle lengths (marked by a green arrow) sustained for several consecutive beats at 175 bpm. Subsequently, a transitional rhythm composed of QRS complexes with alternating heights simulating electrical alternans at a slower rate of 170 bpm appeared before the restoration of the original rhythm at a rate of 166 bpm (marked by a red arrow). The abrupt change from one form to another form of wide QRS tachycardia, referred here as “the emperor’s new clothes,” is a rare observation which could also indicate that the tachyarrhythmia is of ventricular origin (Prystowsky’s Cardiac Arrhythmias: An Integrated Approach for the Clinician, McGraw-Hill 1994).

Sustained monomorphic VT in the setting of chronic myocardial ischemia is generally believed to be due to a re-entrant mechanism. Variable conduction times around functionally dissociated (figure A) or anatomically discrete (figure B) re-entry circuits could explain the presence of two or more distinct QRS configurations and R-R intervals during a supposedly monomorphic VT.

The direction of impulse propagation through potential re-entry sites is determined by the conduction velocity and refractory periods of the downstream fibers which are, in turn, influenced by the prevailing autonomic tone, state of myocardial perfusion, and electrolyte-acid-base balance. Conduction through a fast pathway or a small circuit alternating with conduction through a slow pathway or a big circuit could account for an electrical alternans-like QRS morphology.

The changing QRS patterns and cycle lengths during VT do not denote the development of a different tachyarhythmia but only amplify the underlying re-entrant mechanism. Similarly, the emperor’s new clothes do not change the man, but they reveal what he is.

By Edgardo S. Timbol, MD
In this ultra IT-driven world where websites are complementing and at the same time, competing with publications for news delivery, 80% go for PHAN hard copy.

98 percent say: **PHAN is relevant and is gaining headway**

By Gynna P. Gagelonia

TAGAYTAY CITY, July 25, 2009 -- In recent years, the Philippine Heart Association (PHA) NewsBriefs has metamorphosed into a mini magazine that springs a surprise, coming up with something “new” every issue.

Its evolution has gone beyond its editorial content. Its readership and circulation have expanded from PHA members, health professionals, members of the pharmaceutical fold to lay people from multi sectors. Pharmaceutical firms make up the bulk of advertisers, players outside of the pharmaceutical realm have placed advertisements, though.

PHA's makeover has generated diverse comments and feedbacks, most of which are positive. The negative reviews are rare but PHAN takes them constructively and equally crucial in its goal to come up and come out with better issues.

Wanting validation from the PHA hierarchy, a brief survey was conducted during the “PHA Outcome Assessment Towards the PHA Mission-Vision 2009”

Here is the general impression of the 42 respondents.

Forty or 97.56% look forward to receiving their copy which has an attractive cover and a superb layout.

It is a relevant piece of publication in the book of 40 respondents, thus 79% claimed they are proud to have a bi-monthly publication.

In this ultra IT-driven world where websites are complementing and at the same time, competing with publications for news delivery, 35 or 80% believe that the PHA should still continue to have PHAN in circulation and the members receive their hard copies by mail. Twenty-nine or 69% answered a big “no” to the question “would you want the PHAN to shift to issues to be purely web-based, while five replied “yes”.

Each issue carries well-balanced news and features (23) complemented by columns that are relevant (23). On the contrary, six think at times, the news and features are self-serving.

Twenty-eight can’t get enough of editorial content as they prefer to see snippets on late-breaking news on common medical issues discussed in international conferences; 26 prefer more current medical news; while a sub-specialty column featuring subspecialties or latest news on various sub-specialties was favored by 28 respondents.

The way the “informative” news are being delivered were hailed by 61.73%.

A big majority (31) agree to the magazine format PHAN has evolved into, find time and enjoy reading the issue. Six or 14.29% shelved it after seeing the cover.

The question “is 32 pages enough reading for you” got the following answers: Majority or 22 answered “yes”, 15 abstained, two said “no” while one said “too much.”

Almost all prefer the number of pictures used per issue. The suggestions/observations were: include more Chapter activity. Sometimes there are pictures that I don’t like. Only eight or 19.05% said they want less pictures.

Twenty-four or 57.14% get their copies regularly, while 18 or 42.86 don’t receive the PHA issues regularly.

PHAN has always been financially dependent on revenues generated from pharmaceutical ads. Twenty-six think PHAN should be funded by PHA, 32 maintain that PHAN should be self-sustaining through ads. A good number agree that PHAN should be an income-generating publication, while 10 don’t agree.

Sixty-nine percent or 29 are amenable to opening the PHAN to multi-agency ads and not just to the PHA’s pharmaceutical allies.

The names of possible advertisers that cropped up according to popularity were: fitness centers, schools, diagnostic centers, healthy options, country clubs/golf clubs, consumer products, medical centers, real estate companies and milk products. There is no place or space for supplements in PHAN.

More suggestions that were collated were: Circulate the PHAN on time, in the Features section include the names and birthdays of celebrators, let us be ethical and profound; does PHAN have to be glossy; in clued news about ASEAN heart societies; news/issues on legislative concerns on cardiovascular disease; please include a list of international/local symposia; include more chapter/provincial news.

E. Cabral leafs thru the PHAN pages, while R. Abarquez looks on

F. Dizon is happy with his to-go, a copy of PHAN

Physicians from different disciplines: “PHAN is a stand out”
A Japanese scientist in 1971, but came out commercially in the late 1980’s. Indeed statins and renin angiotensin system blockers have made a big dent on the natural history of coronary heart disease. But they came too late to avert the fate of a man who gambled with his life, there was no doctor who could talk him out his will to die a hero's death. None of these could have stopped an assassin's bullet.

In hindsight there are many what ifs. If Ninoy knew that medical treatment can make him live longer would he have gambled or would he have waited for Marcos to die, and then come back. What if he came back in 1986 when Marcos conceded to have a snap elections, would Ninoy have brokered a peaceful transition? Among Asia’s elite of leaders, Ninoy was not the only one with heart disease, Malaysia’s Mahathir already had two bypass surgeries, and Lee Kwan Yew has had an angioplasty and recently suffered bouts of atrial fibrillation, but he continues to do well and influence Singaporean politics. Of course it is different matter with men in power, I remember when I was in training in Connecticut, then President Bush collapsed while having dinner in Tokyo. It was atrial fibrillation — was it after saki or sushi that did it? — and it resolved quite quickly; but boy, the prospect of Dan Quayle assuming the presidency scared the heck out of my professor. Bush's successor, the well-loved Bill Clinton, had his quadruple bypass after his incumency in 2004, but it still made the front pages. And everyone knows how active he still is, campaigning for his wife and later on for Barack Obama, and even posing for a picture with our own Manny Pacquiao.

It is unfortunate that milestones in medicine are picked up slowly and the public perception about disease takes time to change, and medical advances, even those that win Nobel prizes, are but footnotes in the histories of nations and world politics. As far as the press is concerned, political stories far outsell the advances in science and medicine; only the erudite physician and the wily venture capitalist know better.

First step we will make is be part of the advertising congress where we may get to interact with big companies who themselves may have cardiovascular health promotion needs, or who may be interested in preparing with us, after we “advertise” to them about our organization.

You stressed in your Inaugural Speech that under your term the PHA will be quite conservative and cautious with its budget and expenses. Please elaborate.

Times are now more difficult nowadays, it has been increasingly difficult to find sponsors for our many projects. We have to assess which projects are most relevant and effective and then prioritize them for funding; we have to look for new partners as sponsors; we have to tighten up our spending, especially that we have three major conventions next year.

At what rung in the hierarchy of the PHA board did you start thinking like a president. Meaning did you start any program that you knew you would pick up or pursue when you are president?

Most of what I had planned to do this term, I had begun proposing early on. This is now the opportunity to carry them out.

Aside from conducting a survey to measure the impact of the PHA programs, what kind of monitoring system that measure outcome of PHA projects do you have in mind? Who will make up the Task Force on Performance and Outcome Measure Monitoring?

This will centrally involve the VP or the chair of the Committee on Councils and Chapters and the board members who chair committees like research, advocacy and community service.

Do you think there is a need to revisit the PHA constitution and by-laws?

Yes, I have asked Dr. Norbert Lingling Uy to convene his group and start taking a look at certain provisions already.

What do you think will be your legacy to the PHA?

Internal strengthening (membership activation and good governance) and opening up new horizons and finding new partners.

Do you have any acknowledgements or wish list for the PHA?

I have mentioned most of it, my parents who influenced me positively towards this career path, and my husband who supported me through most of my professional life.
Photography (from the Greek Word “photos” which means light, and “graphos” for painting or recording) is all about the use of light to record images.

Photography is an art when it is utilized to emphasize the subject/theme and the mood to add drama. The choice of lighting is crucial in coming out with a good picture.

In this issue are photos that were made more dramatic and engaging with the conscious use of the Direction of Light.

Email your contributions to nickmcruzmd@yahoo.com; cc: gynnagagel@yahoo.com.

The Direction of Light

Quiet Moments by Dr. Rodney Jimenez, UERM and St. Luke’s Heart Institute. This is a proof that form and volume can take shape with sidelighting. The subject is a medical resident whose laptop becomes a source of light that betrays his contemplative mood and highlights the book, another strong element. Using black and white further enhances the setting because it eliminates clutter.

Sunset after the Storm by Dr. Nick Cruz, St. Luke’s Medical Center. After a heavy downpour, sunset at Manila Bay can still exude a refreshing mood. While making its graceful exit, the sun provides linear reflection on the bay that is interrupted by the waves formed by a passing banca.

Panglao Sunset by Dr. Edgar Tan of Cebu Doctors’ Hospital. A perfect example of a great photo even if the sun has slipped off the horizon. The silhouettes of the boat and the trees complement an equally interesting background.

Una Chica en Barcelona

by Dr. Nick Cruz

This is called spotlighting. The sun’s side-lighting the subject and the wall generates shadows on the girl’s face. Harsh side-lighting is another strategic approach to give a picture a striking element.

Twins by Dr. Nick Cruz. Doing it against the light creates highlights on the twins’ curly hair. Backlighting does not always result in silhouettes. The trick is to illuminate the subject’s front, usually the face, using flash or reflectors. Reflectors do not have to be expensive. You may improve by using any white illustration board or even the sunshade on our car’s windshield.
Today, Bataan is a haven for the adventure and culture buffs who go for history or a taste of the natives’ way of life, of pristine clear waters springs, white-sand, charming accommodations and many a mouth-watering fare and convivial townsfolk.

It is also a Mecca for war veterans who have lived to tell their story about the infamous Death March during the famous Battle of Bataan which goes down in history as the last stand of the American and Filipino soldiers, fighting side by side before they were defeated by the Japanese forces in World War II. What remains of this significant part of Philippine history is etched in the memory of the War Vets and their descendants, enshrined in historical landmarks like the Flaming Sword and the Shrine of Valor (Dambana ng Kagitingan) in Pilar town.

Orion, Bataan is the birthplace of Francisco Balagtas, greatest Filipino poet and author of the renowned “Florante at Laura”, and Don Cayetano Arellano, the first chief justice of the Supreme Court.

To top that, Bataan takes pride in having raised seven cardiologists namely --Drs. Honesto Del Rosario, Irma Claire Bautista, Elsa Apostol and Roberto Anastacio from Balanga, Dr. Ramoncito Tria from Samal, PHA Secretary Isabelo Ongtengco from Morong and Eduardo Dela Cruz from Orani.

Balanga City, the capital stands out to have cradled four of Bataan’s seven cardiologists. While Anastacio and Apostol have been called to other shores (Manila and Australia, respectively), the two doctors -- Del Rosario and Bautista are joined in by Dr. Orlando Bugarin, a native of Pangasinan whose heart was won by a Balanguena pediatrician.

By bus or car, Balanga is a two-and-a-half hour drive from Manila. By ferry, it will take you an hour of sea voyage from the Cultural Center of the Philippines terminal to Mt. Samat. This once quaint residential-agricultural city now teems with tourism and restaurant trade establishments, including the Nico’s Terrace Grill owned by Dr. Nesty Del Rosario. This four-year-old resto is a favorite hub for the Balanga doctors who unwind after clinic and rounds to listen to the band with Dr. Nesty on the lead guitar while singing various tunes that could surely mend a broken heart. Singing and healing is indeed becoming a universal theme for the PHA.

The Crown Royale Hotel and the La Vista Island Resort, owned by the family of Dr. Banzon-Bugarin, are also contributors to the city’s tourism receipts and a generator of jobs for the Balanga folk.

The hotel and the resort played host to the CPR Workshop conducted by Dr. Marcellus Francis Ramirez on Aug. 25, 2009.

The bayanihan spirit is prevalent in Balanga.

Bugarin says “the practice of our profession is harmonious rather than competitive”.

According to Del Rosario, “what is rewarding here is we have a very healthy working relationship with our colleagues. We enjoy a good referral system.”

The mother PHA, along with its Central Luzon Chapter, headed by Dr. Angelito Medina of Pampanga, applaud these three PHA members who have chosen to serve the See page 20