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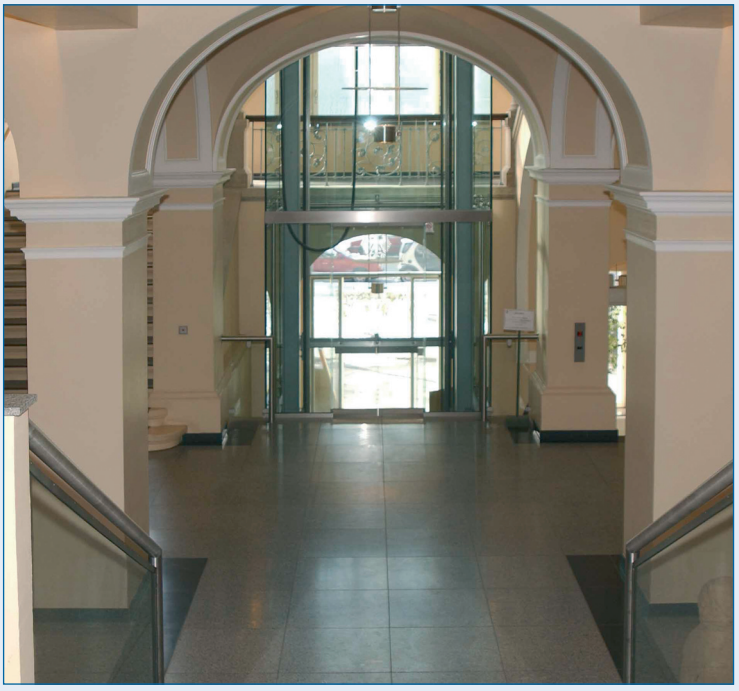
WORLD MEDICAL JOURNAL

VOL. 52

No. 2, JUNE 2006

173RD WMA COUNCIL MEETING



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Titlepage: *Title page: Robert Koch Institute, Berlin, Germany. Photo courtesy of Robert Koch Institute. On top: RKI aerial view (Source: RKI / Ossenbrink). At the bottom: Foyer of the Robert Koch Institute (Source: RKI / Schnartendorff)*

This was founded as the "Prussian Institute for Infections Diseases" of which Koch was the Director. His name was added to the title in 1912 and the Institute finally re-titled the "Robert Koch Institute" in 1942.

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50670 Köln, No. 015 13330.
At present rate-card No. 3 a is valid.

The magazine is published quarterly.

Subscriptions will be accepted by Deutscher Ärzte-Verlag or the World Medical Association.

Subscription fee € 22,80 per annum (incl. 7 % MwSt.). For members of the World Medical Association and for Associate members the subscription fee is settled by the membership or associate payment. Details of Associate Membership may be found at the World Medical Association website www.wma.net

Printed by
Deutscher Ärzte-Verlag
Köln – Germany

ISSN: 0049-8122

DECLARATION OF GENEVA

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

Editorial

Human health resources

Over the past two years we have drawn attention to the increasing problems facing not only the medical profession but also all the health professions. These have related both to the changes and expectations of society globally and the remarkable increases in scientific knowledge and technological developments which have increased the potential and actual ability to control and treat many diseases. At the same time the journal has reported the other side of the picture, the continuing existence of poverty and the inequity in access to even the most basic, let alone the more sophisticated medical advances which result from it. Over the past few years these issues have been placed on the international agenda and we have witnessed increasing public acknowledgement of the need to reduce the gap between economically successful developed countries and developed or under developing countries. This has been acknowledged by summits such as those of the G7 and individual governmental aid programmes, by generous non-governmental donors, and by worldwide fund raising movements directed towards specific major diseases or natural disasters such as we have witnessed in the past few months. Nevertheless these international aid contributions still fall far short of the estimated need.

However attention is now being drawn to another major threat to healthcare, the relief of suffering and the reduction of morbidity and mortality from major diseases and this at a time when there is increasing concern and awareness of the risk of a new global pandemic. The WHO World Health Report 2006 launched in April 2006 is entitled "Working together for Health"(1) and marks the beginning of the WHO year of "Human Health Resources", to be followed by a decade of action to deal with the global shortage of health workers. This shortage applies to most groups of personnel working in the health sector and calls for a radical reappraisal of the activities of the recognised main stream health professions, doctors, nurses and midwives, pharmacists and dentists etc and for assessment of the potential for limited training for carrying out specific tasks for some professionals and others, as opposed to the wider basic and specialist knowledge and skills training considered essential for certain professionals to practice in health care professions.

While the report highlights the compelling and urgent need in some of the world's poorest countries, where the WHO estimates that some 57 countries (36 in Africa alone) have a deficit of 2.4 million doctors, nurses and midwives, reflecting the problems of AIDS, skills drain, rural/urban drain etc. in addition to the factors mentioned above, developed countries are also experiencing or anticipating a shortage in these professions. The latter is exemplified by a suggestion made in a recent meeting that the anticipated needs of the USA for physicians in 2020, will be for 200,000 new doctors (half the current estimated global number of physicians available in the year 2020).

In another part of the WHO report, emphasis is also placed on the need for strong leadership - an issue which is being addressed by the World Health Professions Alliance of which the World Medical Association is a member. The late Director General Dr. LEE Jong wook's opening overview of the Report referred to "Acquiring critical capacities by strengthening core institutions for sound workforce development. Leadership and management development in health and other related sectors such as education and finance is essential for strategic planning and implementation of workforce policies. Standard setting, accreditation and licensing must be effectively established to improve the work of worker unions, educational institutions, professional associations and civil society".

Later the report calls, amongst other things, for increased licensing and accreditation and examination of cost and labour efficiency of health professionals, pointing out the evidence of the better rates of immunisation in the population when using nurses rather than doctors in countries where most of the immunisations are normally given by nurses. In this context the report cites three "Cochrane" reviews (2) of the results of substituting nurses for doctors in primary care. These showed no difference in quality of care and outcomes between appropriately trained nurses and doctors and showed the nurses giving more health care advice. While on the other hand nurses ordered more tests and used more other services than doctors, thus reducing cost saving. In another review of 85 randomised controlled trials, 10 of which were considered to be of high methodological quality), while it was concluded that audit and feedback can improve professional practice. the effects were variable, "small to moderate". It concludes "results of the trials do not provide support for mandatory use of audit and or unevaluated feedback".

Commenting on self-regulation, while acknowledging that this can be effective and that medical associations etc. can regulate the behaviour of the profession and maintain technical competence, the report states "Self-regulation by professional associations is not always effective" and comments on the difference between the east and west. In the latter, notably Europe and America, "the majority of organisations are at least more than 110 years old, whereas in low income countries 4 out of 10 are less than 25 years old." Even more importantly, it comments on the strain on self regulation resulting substantially from employers increasingly overriding it, Whilst acknowledging this to be the case where the state is the traditional employer of health workers, it points out that increasingly the previously self-employed autonomous health workers are now working in an employer-employee situation. "The employer, whether the state, a non-governmental non-profit making organisation, financial corporation or international organisation tends to have the most influence on professional behaviour, concluding that associations by themselves can no longer claim to provide coherent governance, in the public interest, of the health workforce as a whole." This acknowledges important concerns which

have already been increasingly occupying the profession for some time past. However, while the report does not specifically recommend the abolition of self- regulation, it urges the creation (where necessary) of the technical bodies for licensing, accreditation etc. and also suggests the inclusion of all stake holders in forums which would permit interaction between all organisations affecting the behaviour of health workers and the health institutions, well illustrated in a diagram showing interaction between professional organisations, institutional regulators and civil society organisations. (3)

Nevertheless, the report quotations above reinforce the urgent need for reflection, and if need be action by the medical profession and its medical associations, in particular those with regulating powers. The reflection must take into account not only the need to adapt the functions for which the special training of physicians is required but also the needs of the globalised society in which we live.

The World Health Assembly this year, in its decision addressing the problems of shortage of human health resources and also the challenges of international migration of health personnel in six recommendations in its resolution (4), urged Member States to affirm their commitment by:

„Giving consideration to establishing mechanisms to mitigate the adverse impact on developing countries of loss of health personnel through migration including means of receiving developed countries supporting health systems, especially in human resources development, in the countries of origin;

promoting training in accredited institutions of a full spectrum of quality professionals and also community health workers, public health workers and professionals;

promoting training partnerships between schools in industrialised developing countries involving faculty and student exchange:

encouraging financial support by global health partners donors etc. of health training institutions in developing countries;

promoting planning teams in each country facing health-worker shortages drawing on stake holders including professional bodies, public and private sectors and non-governmental organisations to formulate comprehensive strategy for the health workforce, including consideration of effective mechanisms for utilisation of trained volunteers using innovative approaches to teaching in developed and developing countries with state-of-the-art teaching materials and continuing education through the innovative use for information and communications technology."

It is clear from this that the crisis in Human Health Resources is one which National Medical Associations will neglect at their peril and need to address, not only in their own national context but also in the international global context. The WMA has addressed the issue of physician migration and also referred to countries' bilateral agreement to effect meaningful co-operation in health care delivery in its statement of Helsinki 2003 "Ethical Guidelines for the International Recruitment of Physicians." However, the issues raised in the WHO Report, the decade of action and the global alliance set up to address these issues (6), call for serious consideration and leadership if the profession is to influence policy initiatives proposed by governments to deal with this serious threat to future health care.

Alan Rowe

(1) The World Health Report 2006 "Working together for Health", WHO Geneva
(2) ibid p. 138
(3) Ibid p. 214
(4) WHO,WHA59.23
(5) WMA statement accessible on www.wma.net
(6) Global Health Workforce Alliance

Trust in Physicians

Abundance of Medical Information – Shortage of Medical Orientation

by Peter Atteslander, Professor emeritus, University of Augsburg, Director, INAST Research Univ., Inst. Sociology, University of Neuchatel

Would you trust a machine? Probably you do not. You might rely on its functioning. Trust however has a quite clear intrinsic meaning: trust is a psychic and social process based on firm beliefs. You definitely will not trust a medical system as such but specific persons playing an important role in its institutions. It is above all the medical doctor on the daily front interacting with the patient before him that you trust, sometimes you have to trust. In many existential situations the patient lays his life in doctors' hands. He is confident about the physician's professional abilities, judgements and increasingly about medical orientation which only the physician is a master of. Many of us are lost before the growing amount of all kinds of public health advice, leaving us over-informed but under-oriented.

Can one measure trust in physicians? Indeed: since many decades, numerous surveys show that medical doctors are constantly granted one of the highest prestige statuses amongst all professions. There is no marked decline of trust in physicians, their general acceptance in spite of the fact that medicine is increasingly experiencing all kinds of pressure, economic, bureaucratic and stressful through the increasing velocity of medical technology development, inevitably leading to more specialisation. General anxieties are felt and unspecified critique finds its public. Mass media seem to be more interested in either sensationally reporting cases of malfunctions in our health systems, creating wrong hopes or propagating

new therapies not yet applicable. They fail to adequate orientate the citizen.

Nevertheless, a traditional image of doctor's role still seems to persist today. This in spite of magnificent medical technologies, new organization and miracles of medical practice. It is human empathy with the patient that the lone horse- and buggy doctor lived with centuries ago. Compared to our days, he had rather little to offer but himself and a handful of medicaments and instruments to use.What has changed since then? Do we not still talk of the physician himself as 'the most efficient medicament', and of his practice as being an art? Until today, the interaction between patient and doctor remains the most important source of trust.The more complex health structures become, the more important it is to safeguard the physician's role to offer medical and mental orientation to patients. Even those expert in using the internet are essentially in danger of getting lost in a labyrinth of information they are unable to interpret. Since trust is a social and mental process, it can neither be ordered, regulated or even administrated. Without orientation, patients will comply less with medical prescriptions. Compliance is amongst many other aspects predominantly the result of trust in the prescriptions and advice of the physician.

There are however many factors that endanger this (fortunately still persisting) common trust. The World Health Organisation (WHO) stated long ago that governments are responsible for the health of their citizens and can only discharge that responsibility by taking adequate measures in the health care and social spheres. To ensure fair distribution of medical services most so called OECD-states, representing modern rather wealthy societies, have introduced so-called cost-moderating laws. This results in wide spread fears that increased state intervention will further undermine the necessary state-free area of doctor- patient relations. Experience shows that more administration does not in itself lead to greater control over rising costs. States cannot be made responsible for individual health conditions. On the other hand it can be expected that they safeguard general policies which permit the best possible individual medical actions by all concerned. Adequate health care and social measures, however, always imply greater control and planning. It is not advisable to implement too strict bureaucratic norms at the cost of impeding doctor-patient relations. Individual behaviour is all too often influenced by state action, but it cannot be planned in detail, certainly not where health is involved.

The health care systems are highly complex. Today we do not know exactly how they function. At best we still find areas where it does not function. In future it will be impossible to satisfy every conceivable need. The total sum of individual needs as expressed, does not necessarily represent the need of a society at large on which state interventions (based on data from social epidemiological surveys, that rarely meet methodological expertise), are decided. General expectations of the kind aroused by too comprehensive WHO-postulates which interpret health as a state of "complete physical, mental and social well-being and not merely the absence of illness", cannot be transposed into legally effective entitlements for the individual. The inadequacy of a health care system which is widely perceived today, does not in itself point to the goals which should be set.

There is an increasing pressure not only to economise in healthcare systems, and also to harmonize procedures independent of cultural differences, leading to different social behaviour. This provokes ever more new regulation of health reporting. Warnings by many scientists have evidently not reached politicians and bureaucrats. Large sums have been wrongly invested trying to measure qualitative health matters with quantitative instruments. Of course health care has material and economic aspects, but all other predominantly qualitative processes cannot be measured by purely quantitative methods. Healing.requires more than a functioning human body,and the physician more than a technician. It was an illusion that the highly dynamic structures of the health care systems could be regulated, finally controlled by simple material indices. It is an essential error to believe that the role of physicians can be standardized. There is no such thing as a standard patient, just as there is no statistically determined average health situation. Beware of statistical artefacts when dealing with sick human beings.

Complex systems tend to be self relevant and hard to grasp. They are even harder to govern. In health systems responsibilities are often nebulous and poorly defined. Combined with economic restrictions and bureaucratic standardisation, more and more non medically trained agents tend to restrict physicians' traditional as well as prospective role. Their indispensable moral and ethical identity is thereby severely menaced.

The progress of modern medicine highlights in addition another problem, which may be described as the concept of pressure for 'positivisation':, especially in medical technology, surgery and pharmacology, where the quick and obvious successes and immediate effects are so apparent, experienced as "relief" and verifiable. Such pressure for their broad and instant application arises that it, in turn, increases demand leading to new problems of distribution, both of human resources and costs. This happens irrespective of the dangers of interactions with other medicaments, often only recognised only later.

There is growing hedonisme regarding health: Eat the pills today, pay tomorrow, often with illness !

The progress in modern medicine is in many senses of the word, fantastic. One is tempted to say that as in other fields of technology we are offered more answers than we have questions for. In medicine this means that there are more investigation alleys and more therapies at hand than we can pay for. Ethical problems are not anticipated ; adequate and fair distribution of medical services remains largely unsolved, rationing wide spread. Even rationalization, as the step before restricted distribution of medical services is declared, should rely on systematic, optimized action. In practice, rationing often fails to meet these criteria. The discussion, as to when it is necessary to omit certain therapy which has questionable perspectives, has only just begun. We are only starting to comprehend that the effects of modern medicine may also have important societal implications.

Illness must no longer be understood solely as the dysfunction of a biological organism. We have to learn and to understand it as a typical social attitude. This changes also the interaction between physician and patient. This aspect has been largely disregarded by medicine up to now since the manifest successes of modern medicine conceals this weak point.

Illnesses which can be precisely defined in scientific terms and the disorders, for which clear forms of therapy exist, are increasing. Nobody would deny this success. Their relative importance measured against the general requirements placed on the medical system, is however rapidly declining. New and hard to define syndromes of illness are spreading. We see modern medicine as being caught in a dangerous trap between the growing availability of technical and medical expertise and the increasingly manifest and perceived lack of social health orientation.

Trust in physicians is in principal a qualitative property of highest importance. This holds true especially when we speak of healing processes. The question is pertinent, as to whether in future the precious asset of a free and humane doctor-patient interaction can be safeguarded against the strong influence of growing economization, bureaucratization (above all) , in view of a growing non steered quantitative regulation in the health system.

One of the leading medical social scientists wrote decades ago "Medicine as a social institution has extremely broad functions. Not only does medicine deal with the prevention and treatment of pain, disease, disability, and impairment, but it also provides an acceptable excuse for relief from ordinary obligations and responsibilities, and may be used to justify behaviours and interventions not ordinarily tolerated by the social system without significant sanctions. The definition of illness may also be used as a mechanism of social control to contain deviance, to remove misfits from particular social roles, or to encourage continued social functioning and productive activity. Thus, the locus of control for medical decision making is a key variable in examining the implications of medical care for social life more generally".

Physicians have rapidly to overcome the manifold effects of the further growing specialization. More time will be demanded for interdisciplinary actions. Managing relevant information from different sources applicable in specific cases has yet to be learned. Most important, the uniqueness and intimacy in which human trust in the patient-doctor relationship can only grow, has to be defended with all appropriate means. We follow Mechanic[I] in as far as we now witness the increasing velocity of bureaucratisation of medicine as having the effect of diluting the personal responsibility of physicians, making it more likely that interests other than those of the patient will prevail in the future." By segmenting responsibility for patient care, medical bureaucracy relieves the physician of direct continuing responsibility. If the patient cannot reach a physician at night or on weekends, obtain responsive care, have inquiries answered or whatever, the problem is no longer focused on the failure of an individual physician, but on the failures of the organization. It is far easier for patients to locate and deal with individual failures where responsibility is clear, than to confront a diffuse organizational structure where responsibility is often hazy and the buck is easily passed. To the extent that the physician knows that a patient is his or her charge, the physician feels a certain responsibility to protect the patient's interests against organizational roadblocks and requests that may not be fully appropriate. But when responsibility is less clear it is easier to make decisions in the name of other interests such as research, teaching, demonstration, or the "public welfare," whatever that might be" (p. 415).

Trust, as we said before, is based on firm belief. Belief in the the doctor-patient relationship is often nurtured by hope, even if it is unrealistic and not to be granted. The more pressures of all kinds exist in this hybris of health systems,. the more pressing is the question of what to do. My proposition is that the physician has always to be in the centre of information. We forsee that doctors will depend to a greater extent on other specialised experts and technical systems, will have to be the centre of information , and will not be able to carry the personal full responsibility for their patients. The physician may need assistance for the interpretation of relevant data, but he alone is in charge of the ultimate decisions. This entitles him to ask for all means and measures to live up to his responsibility for the good of his patient who trusts him. It is high time that the physician's role has to be widely understood, honoured and enforced.

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[I] David Mechanic, The Growth of Medical Technology and Bureaucracy: Implications for Medical Care, in: Patients, Physicians, and Illness, E.Gartly Jaco, London, New York, 1979, p. 415)

Dr. LEE Jong-wook

We very much regret the sudden death of the Dr. LEE Jong-wook, Director General of the World Health Organisation, on the eve of the World Health Assembly. His ambitious project 3 by 5 to tackle HIV/AIDS thought by many to be unrealistic, nevertheless was a real attempt to unite agencies in a common goal. His promotion of partnerships in dealing with AIDS, Tuberculosis and Malaria, the agreement on stockpiling Tamiflu and his efforts to stimulate countries to recognise the real threat of pandemic influenza, were indications of his determination to engage governments in the fight against the threats posed by these diseases. Dr. LEE died on 22 May 2006. He was 61.

The World Medical Association Declaration of Tokyo. Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment

Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 ***and the 173rd Council Session, Divonne-les-Bains, France, May 2006***

Preamble

It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.
   The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.
4. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.
5. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.
7. The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

* *the latest revisions are shown underline. See also WMA Council report page 46*

The World Medical Association regulations in times of armed conflict

Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957, amended by the 35th World Medical Assembly, Venice, Italy, October 1983 and the WMA General Assembly, Tokyo 2004, and

editorially revised at the 173rd Council Session, Divonne-les-Bains, France, May 2006

1. Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.
2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:
   a. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care.
   b. Weaken the physical or mental strength of a human being without therapeutic justification.
   c. Employ scientific knowledge to imperil health or destroy life.
   d. Employ personal health information to facilitate interrogation.
   e. Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.
3. During times of armed conflict, standard ethical norms apply, not only in regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.
4. The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the required care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion.
5. Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict. This obligation includes a requirement to protect health care personnel.
6. As in peacetime, medical confidentiality must be preserved by the physician. Also as in peacetime, however, there may be circumstances in which a patient poses a significant risk to other people and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.
7. Privileges and facilities afforded to physicians and other health care professionals in times of armed conflict must never be used for other than health care purposes.
8. Physicians have a clear duty to care for the sick and injured. Provision of such care should not be impeded or regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.
9. Physicians have a duty to press governments and other authorities for the provision of the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.
10. Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the repair of the public health infrastructure in the immediate post-conflict period.
11. In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.
12. Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.
13. In fulfilling their duties, physicians and other health care professionals shall usually be identified by internationally recognized symbols such as the Red Cross and Red Crescent.
14. Hospitals and health care facilities situated in war regions must be respected by combatants and media personnel. Health care given to the sick and wounded, civilians or combatants, cannot be used for morbid publicity or propaganda. The privacy of the sick, wounded and dead must always be respected.

* *The latest changes in text are shown underline. See also WMA Council report page 46*

WMA Declaration of Malta

A background paper on the ethical management of hunger strikes

The following background paper and glossary of terms were prepared by the British Medical Association in association with the revision of the Malta Declaration currently being considered by WMA Council and National Medical Associations.
See also „glossary of themes", p. 41-42.

Introduction

Physicians need to understand the background to the guidance given in the World Medical Association's Declaration of Malta. This paper aims to set out that background and some authentic case examples are included to illustrate how complex this area of practice can be. These cases are taken from field experience in widely differing contexts and countries. They have been simplified and anonymised to protect individuals' confidentiality and they reflect how very different strategies may have to be adopted by physicians according to the circumstances of the case.

Although the Malta Declaration sets broad international standards for managing hunger strikes in custodial settings, physicians still need to use their own moral judgement in particularly complex situations. To do this, they should be aware of the various different forms of fasting which stem from differing intentions on the protesters' part and which require different handling. Hunger strikers' motivations and their perseverance in a particular kind of hunger strike can differ greatly. Gaining their trust can be difficult but is crucial for doctors, who must be able to act independently from the detaining authorities. Physicians also need to be alert to the pressures which can be exerted on hunger strikers in custodial settings - not only by the authorities but also by peer group hierarchies and sometimes even by physicians themselves. For example, if doctors ask hunger strikers to give advance instructions at the start of a fast saying whether or not they would refuse resuscitation at a later stage, it may be difficult for the hunger strikers to do anything other than refuse artificial feeding, without losing face with their peer group. This may not be a truly valid and informed choice unless physicians can discuss it in private with the hunger striker. Physicians need to understand the clinical and moral criteria concerning when to resuscitate a protester and when to abide by such a refusal of treatment. The crucial differences between "artificial" and "force" feeding need to be understood. Physicians also need to be aware of the symptoms and the clinical physiology of the different stages of fasting in order to give accurate medical counselling to patients about what to expect. (Such advice can be found in the 'Course for prison doctors', chapter 5, by the World Medical Association, Norwegian Medical Association and International Committee of the Red Cross at http://lupin-nma.net). Health professionals often act as mediators between patients, authorities and other people such as patients' families. They can be in a position to facilitate face-saving opportunities which could bring the hunger strike to an end for the benefit of all involved. This paper seeks to help them do that.

Definition of "hunger strike"

As explained in the glossary, a "hunger strike" involves food refusal as a form of protest or demand. Such fasting is particularly undertaken by people in custodial settings who lack alternative means to gain attention and bring pressure to bear to obtain some goal. Short-term rejection of food rarely gives rise to ethical dilemmas as health is generally not permanently damaged as long as fluids are accepted. It is important, however, for physicians to have a clear frame of reference on how to define a serious "hunger strike".

Excluded here are short-lived fasts which peter out within 72 hours. If hunger strikers continue to refuse both nutrition and hydration for more than 48 hours, however, they risk significant harm. Dry fasting without any fluid intake which persists for more than a few days would fall within the definition of "hunger strike" used here but, fortunately, this is rare. As the body cannot survive more than a few days without fluid, death would occur within the first week which, from the protesters' perspective, is too short a period for negotiation to be effective. In short, the term "hunger strike" as discussed here refers to protest fasting without any intake of food but with ingestion of adequate quantities of water.

In the first days of fasting, the body uses its stores of glycogen in the liver and muscles. Ketosis occurs and is discernible clinically on the breath or by laboratory test in the urine. It subdues the voracious sensation of hunger experienced during the first days of fasting. It can be argued that total fasting (taking water only) for longer than 48 - 72 hours is the clearest definition on metabolic grounds for the term "hunger strike". Glycogen stores are exhausted by about day 10-14 and certain amino acids take over as the substrate for gluconeogenesis. Muscle, including heart muscle is gradually lost. Close medical monitoring is recommended after a weight loss of 10% in lean healthy individuals and major problems arise at a weight loss of about 18%. Hunger strikers need to be aware that dehydration is a risk as they lose their sensations of hunger and thirst.

1. The medical duty to establish competence and motivation

Assessing patient competence and gaining an understanding of the purpose of the fast is crucial for physicians. Good communication and trust are essential here. Fasting as a symptom or manifestation of a psychiatric disorder such as anorexia or depression requires a totally different approach, so assessing patients' mental health must be a first step for physicians. People suffering from any serious psychiatric or mental disorder likely to undermine their judgement need medical attention for their disorder and cannot be permitted to fast in a way that damages their health. Fasting for religious reasons should also not be confused with

protest fasting but should be respected. It is generally not health threatening and does not raise dilemmas when undertaken by an otherwise healthy person.

Two main categories of individuals embark on hunger strikes with quite different intentions and motivation. In potentially coercive contexts, (which include any situation of detention) it is important for physicians always to determine for themselves what are the exact motives for refusing nourishment.

Some food refusers fast to gain publicity to achieve their goal, but have no intention of permanently damaging their health. Their goal may seem relatively petty or it may involve reasons of principle. As they do not wish to die, these protesters often agree to artificial feeding being provided at some stage and may actually request medical assistance in monitoring their fast. Those who repeatedly make this type of protest can come to be seen as exercising a form of blackmail by the authorities, who then let strikes continue to test protesters' resolve. Physicians need to clarify privately with protesters, at regular intervals, how far they are willing to go and when they expect and desire medical interventions to be made to prevent lasting harm to their health.

The other very different category consists of what might be seen as very determined hunger strikers who are not prepared to back down unless their goal is actually attained. Individually or in groups, they may differ in their mode of fasting but they share a determination to risk their health or their lives for a cause. Political hunger strikers often fall into this category. Unlike the food refusers who rely on medical help to prevent serious harm, this category of protesters often mistrust physicians, whom they see as belonging to the detaining system. Such protesters pose a serious challenge to medical ethics, as their willingness to take fasting to the extreme inevitably raises difficult questions about whether and when to intervene and the thorny ethical question of whether feeding contrary to patients' expressed wish can ever be justified. In this paper, we have rejected the term "death fast" which is sometimes used to describe a determined hunger strike. The term is unfortunate in that it appears to assume death is the inevitable outcome. By perceiving death as the objective of the fast, opportunities for constructive dialogue may be lost from the outset. It is seen by the authorities as establishing an unacceptable ultimatum with no leeway for discussion. This can deter doctors from even attempting to mediate.

2. The medical duty to attempt to establish "voluntariness"

"Voluntary total fasting" is a term often used, but fasts in detention are seldom total. Most protesters accept fluids and sometimes the rejection of food too is less than total. Participation can also be more coerced than voluntary, particularly in long collective hunger strikes. The authorities may want to stop protests by finding acceptable compromises but pressures may come inadvertently from staff, such as guards, whose taunts and derision of protesters can lead to a hardening of positions. Detainees may also suffer coercion from peer groups in subtle as well as obvious ways. These often complex situations can lead to the point where it becomes virtually impossible for a protester to cease fasting voluntarily. The informed and voluntary nature of individuals' food refusal are key aspects that physicians need to ascertain once mental competence has been established. Physicians must do their utmost to speak to each patient privately, out of earshot of all other people but with an interpreter if necessary. It is important that interpreters are not connected with the detaining authorities or the patient's peer group and that they are aware of the confidentiality expected of them. Those orchestrating collective hunger strikes are often reluctant to allow such talks, as this undermines their authority. This is possibly the most complex situation to deal with in determining whether hunger strikers are indeed genuine volunteers. The subsequent extent to which medical confidentiality can be guaranteed in custodial settings needs to be discussed with the patient. Physicians should do everything in their power to engage in frank discussion with patients and gain their trust. Where protesters appear to be fasting under duress, a solution may be to separate those individuals in hospital on a medical pretext, thereby extracting them from the influence of others and allowing them, if they agree, to resume nourishment on medical grounds. Pressure may still come from relatives or the media. Families often alert the media, hoping this will heighten the pressure on the authorities to make concessions but it can also increase pressure on the protester not to give way.

Physicians sometimes cannot gain the trust of patients. In such situations, it may be possible to bring in an external physician unconnected with the detaining authority or one nominated by the patient to ascertain whether the fast is truly voluntary. If the "voluntariness" of the decision appears to be established, protestors' decisions should be respected. It is likely that some cases of coercion go undetected, even if all reasonable precautions are taken, but in the absence of evidence to that effect, physicians must listen to and abide by what patients say.

Physicians can discuss with patients the flaws or lack of logic in their expressed wishes without exercising undue pressure. Experience shows that particularly in highly political hunger strikes, decision-making is far from simple. There may be situations where physicians need to challenge the patient rather than accept that person's views at face value. It is here that the importance of trust and the confidentiality of the individual interview become of paramount importance. There are cases in which physicians, confronted with an apparently fanatical hunger striker, can use their position of trust and medical authority to try to bring the protestor to reason.

Case example 1 – Difficulties of establishing a hunger striker's real wishes

A physician, visiting a collective hunger strike involving many politically motivated prisoners, listened carefully to the story of a female protestor. She had suffered many hardships, including rape and the loss of family members. She was barely 20 years old and appeared politically motivated almost to the point of fanaticism. Her intention, she said, was to fast unto death to protest against oppression. The physician decided to test her determination as he was

not convinced her words reflected her real wishes. He took a firm stance, arguing that her apparent choice to die seemed wrong after all she had already endured and survived. In his view, her decision was ill thought out and he said that, as a doctor, he was unwilling to let her waste her life but wanted her to reconsider. The young woman was shocked as nobody – not even she herself - had questioned her intention previously. She burst into tears but, on reflection, agreed that she did not want to die. As they talked, the doctor's careful reasoning and analysis of her situation helped her to identify her real wishes. The conversation between them was kept confidential but the woman agreed to accept nourishment which was given on a medical pretext to avoid pressure being brought to bear upon her by her peer group. The doctor's willingness to probe deeper than the woman's superficial statements allowed him to test whether her statements really were an autonomous expression of her views. Her readiness to hear his arguments made the hunger striker re-evaluate her intentions and realize that she had suppressed her true feelings. The example shows how complex such issues can be and the risks of accepting an individual's views without any question.

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3. The duty to provide accurate information to patients

Physicians need to explain to each protester the implications of fasting for that person. This entails first taking a detailed medical history and conducting an examination so that existing medical conditions are identified and discussed. They should objectively warn patients who suffer from ailments that are incompatible with prolonged fasting, not to embark on a hunger strike or to restrict themselves to a limited form of fasting. Conditions such as diabetes, gastritis, gastric or duodenal ulcer and many metabolic diseases are contra-indications to total fasting. Only if fully informed, can protesters make a truly voluntary and informed decision on whether to embark on a hunger strike. They only have a chance of obtaining their goals if there is enough time for the authorities under pressure to react. The likely duration of their fast is therefore of paramount importance to hunger strikers, especially if they have difficulties in making their plight known to those outside who can try to exercise influence. It will be essential for hunger strikers to know as accurately as possible how long they personally could fast. The fatal outcomes of total fasting were first documented during the 1980 and 1981 hunger strikes in Northern Ireland where death generally occurred between 55 and 75 days. Similar experiences have confirmed this wide time bracket. The three-week interval is due to differences in initial physical constitution and individual adaptation. It is not possible to predict any time span more precisely. Protesters need to be advised that death occurs some time after six full weeks of fasting and survival after ten weeks of total fasting is practically impossible. They also need to know that in the final clinical stages of fasting, they will no longer be capable of discernment and need to make clear in advance what they expect physicians to do for them then.

4. The duty to give counselling

Medical counselling may often be a key element in determining the duration of a hunger strike. Physicians often find that some patients do not believe them, even when they try to give objective counselling. Some people who are detained understandably mistrust physicians, whom they see as working for the authorities. Doctors can have a difficult task convincing hunger-strikers that they are acting on their behalf, partly because in many cases doctors are unable to show that they are neutral. In such situations, there is a role for outside physicians, not only to give medical advice, but also to act as neutral intermediaries in negotiations with the authorities. Doctors are often able to play a crucial role, but only if they obtain the trust of the patient. In some cases, transferring a hunger striker to hospital on the pretext of performing further tests may serve a humanitarian purpose, allowing the protester to resume nourishment on the doctor's orders. Detainees, however, confide in the physician only if they are convinced that medical confidentiality will be respected. The element of trust is here all-important.

To give accurate advice and counselling, physicians need to clarify the type of hunger strike that will occur. Most so-called "total fasts" involve protesters accepting water but abstaining from all foodstuffs. Different cultures, however, have different notions of how fasting should be defined. Salt (either NaCl alone or a combination of minerals) is often added to the water and possibly sugar or other sweet substances such as honey. Some cultures define fasting in terms of abstaining from solid food (substances that need to be chewed) or from food that is cooked or heated. They may discount the ingestion of milk, honey or even nutrients such as eggs but the duration of the fast remains the crucial element. Physicians need to make clear to hunger strikers that non-total or partial strikes, if prolonged, lead to death but at a much later stage than a total fast.

Some forms of partial fasting are considered as "cheating" by the authorities. This can lead to controversy about the seriousness of the protest. Prolongation of the period for potential negotiation, however, is often beneficial to the final outcome and helps avoid deaths. Therefore physicians can find themselves in an apparently counter-intuitive situation. They may see more advantages in terms of life-saving opportunities in a longer hunger strike which allows more time for negotiation rather than a short fast which is more restrictive in terms of what can be ingested and therefore more lethal. Physicians need to avoid implying to protesters or the authorities that non-total fasting is not serious or lacks credibility. They should not challenge partial hunger strikers on the non-total quality of their protest fast. Physicians need to understand that partial fasting for a lengthy period of time can be a legitimate form of protest which could provide more time to find a face-saving solution for all involved and thus be instrumental in avoiding fatal outcomes. They must not, however, let themselves be manipulated by either the authorities or the hunger strikers. Physicians must not give erroneous clinical testimony or advice. Prison doctors, for example, have been known to threaten hunger strikers with grave medical sequelae that are fictitious. In one example, doctors

told hunger strikers that fasting caused impotence, with the sole purpose of frightening them into giving up their fasting. This sort of action is completely unethical and undermines any trust that hunger strikers may have in the medical profession.

5. The duty to maintain confidentiality

The duty of confidentiality is as strong in custodial situations as in the community. It is never an absolute requirement in either context if serious harm would result from non-disclosure and physicians need to make an evaluation about where the best balance lies. In situations where physicians are unable to maintain some aspects of a patient's confidentiality, this should ideally be made clear at the start of the consultation. Wherever possible, however, physicians should respect patient confidentiality as the maintenance of trust depends upon it. This applies to non-medical information given to physicians by patients. For example, physicians interviewing hunger strikers might learn the names of the ringleaders of the protest, but they would lose patients' trust and may put them at risk of reprisals if they disclosed that information to the authorities.

Case example 2 – Challenges in maintaining confidentiality

In a collective hunger strike, the physician realised that the hunger strikers needed to prolong their protest to allow time for the negotiation of their goals but none wished actually to risk their lives. As the protest was the focus of media attention, however, they could not be seen to be lacking in commitment and so while ostensibly refusing normal food, they privately agreed with the doctor to accept some nutrition and hydration intravenously. The physician maintained the trust and confidentiality of the prisoners by not disclosing the full situation to the prison authorities who, recognising that normal food was still being rejected, eventually threatened to end the strike by force feeding. The physician intervened and explained that he had the situation under control without force. Both sides in the protest were engaged in a drama where neither was willing to be seen to concede. The doctor's ability to agree privately with the prisoners to provide artificial feeding allowed time for both sides to reach an acceptable compromise without publicly losing face.

Hunger strikers also need to be aware that requiring a doctor to maintain their confidentiality can in some cases have potential disadvantages for them. Such aspects need to be discussed at an early stage.

Case example 3 - Challenges in maintaining confidentiality

A political prisoner on hunger strike complained to a visiting physician that he had been forcibly fed while semi-conscious contrary to his verbal advance instructions. The prisoner wished to register a formal complaint. Having listened carefully to the prisoner's story, however, the doctor had doubts as to whether the prisoner had indeed been fed against his will since although semi-comatose, he was a strong man who could have exhibited some signs of resistance. In fact the prisoner had made no effort to resist and later, in private, he confided in the physician that he was relieved to have been resuscitated but that these facts had to be kept confidential both from other prisoners and from the prison authorities. The doctor, therefore, was obliged to continue the pretence of taking the complaint seriously but in cases such as this, physicians also need to explain to hunger strikers the risks of such a deception since in future situations, it would be assumed that the hunger strikers did not want to be resuscitated unless they had made their real views plain. A hunger striker in this situation would have a particularly difficult dilemma if asked to sign a formal advance directive refusing future resuscitation since this would either force him to expose his real views or it would mean that he risked being allowed to die in future if evidence were lacking of his real feelings. In this case, as a last resort, the confidentiality of the prisoner's discussion with the visiting physician could arguably be breached to avoid that harm but this would really need to be discussed in advance with him.

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6. The advantages and disadvantages of communicating with families

Families may support detainees' fasting or try to get the authorities to intervene to save the prisoner's life regardless of that individual's views. Given, however, that people in custodial settings often have only limited ways of making their own genuine views known, physicians attending them can find it useful to communicate with their relatives. Direct contact with them may provide crucial background information allowing them to make the best decision. Cases also arise where physicians find themselves at odds with a family demanding intervention which the patient refuses. In many countries, the family of a prisoner on hunger strike has the legal right to require medical intervention. While keeping this in mind, physicians should never forget that their primary professional commitment is to the patient. Where families support the hunger striker or openly lobby for media attention, the authorities may be reluctant to allow family visits and physicians may have an important role as intermediary. Although pressures on hunger strikers should obviously be kept to a minimum, this should not be an excuse to suppress family visits.

7. Is there a duty to act as mediator?

The role of mediator is outside physicians' obligations in most circumstances but in the context of hunger strikes, they can be particularly influential in saving life if they are willing to do so and have the trust of both sides. They also need an objective view of the true situation. They may then be in a position to negotiate and possibly obtain concessions from both sides. They have to decide from the start, however, whether they can act as a medical intermediary between hunger strikers and the authorities and if they cannot, they need to make that clear to patients and not pretend to play the role. Prison doctors are likely to be in a privileged position if they have the trust of the prisoners and the confidence of the prison authorities. If hunger strikers trust and confide in them, physicians are able to evaluate how urgent is the need for mediation. Most hunger strikers desperately want to find a way out of the confrontation and

often stop fasting if they obtain some minor form of concession from the authorities. In such cases physicians may be in the best position to negotiate some compromise between the two parties. When the demands of hunger strikers are very obviously out of reach, prison doctors must not fall into the trap of pretending otherwise or insinuating that a solution is achievable through mediation. They should make clear that they are outside the negotiations but the crucial role of providing accurate information to patients about their medical condition should continue.

8. The duty to remain objective and independent

Medicalisation of hunger strikes often occurs and can threaten physicians' ability to act independently. Local law may require medical monitoring of the hunger strike and the status of a particular hunger striker can also influence the attention given to that person. Physicians may have to balance objective medical observations with pragmatic face-saving situations, in order to buy time for essential negotiations to produce results. They must avoid pandering to any particular interest group by giving medical information or advice that is scientifically questionable or inaccurate.

Physicians working for prison administrations or other detaining authorities sometimes cannot be really independent. Even if they are fully aware of the ethical implications of a terminal hunger strike, without external support they are often powerless to oppose administrative decisions imposed on them by the authorities. Medical associations have a duty to inform physicians of international ethical guidelines that should be respected at all times and to provide support for them. Independent physicians ideally should be permitted to counsel hunger strikers in the interest of all involved and in order to try to avoid any fatal outcome. Some countries do allow this, and these physicians' independent status ensures their credibility as acceptable intermediaries for all parties concerned.

9. Management of medical conditions during a hunger strike

The WMA's training module on prison health care contains a detailed account of the clinical stages undergone by hunger strikers between the first days of fasting and the final stage between 45 to 75 days later when death occurs from cardiovascular collapse or severe arrhythmias. As well as the physical aspects, physicians need to be aware of patients' mental and psychological disruptions. Refusal to take sustenance leads to a clinical syndrome that resembles, but is not equivalent to starvation. In the latter case, body depletion is a dragged-out process, with little caloric intake, but still minimum absorption of vital elements such as vitamins or proteins. It is this intake that differentiates total fasting in a hunger strike situation (taking just water) with starvation in concentration camps. Among the symptoms experienced by long term hunger strikers are significant gaps in memory and inability to concentrate. They live for the moment. Total fasting forces the body to find substitute sources of glucose, essential for providing energy, to the brain in particular. Lack of calorie intake disrupts the usual pathways, and complex mechanisms kick in to replace the external energy source. The body begins to digest itself, breaking down the various tissues so as to have a constant supply of glucose. If the fasting leads to medical complications, it is the duty of physicians to do more than merely take notes and monitor vital signs. There is need for them to enter into a serious discussion with each hunger striker. It cannot be stressed enough that the privacy of the medical consultation is of paramount importance, so as to avoid any meddling or coercion, from any side, and for physicians to be able to play their role.

10. Artificial feeding, force-feeding and resuscitation

It is important that physicians understand the moral and practical distinctions between forcible feeding, artificial feeding and resuscitation. The WMA Malta Declaration gives some leeway to the treating physician, who should have the final word in deciding what is best for the patient, all factors being taken into consideration. Force-feeding, however, is out of the question. If the protester's intent is to extend the fasting as long as possible, there should be advance discussion between the physician and hunger striker to clarify the expectations on either side. In particular, physicians need to be clear what actions they have patient consent for once the fasting has clouded the patient's mind and coherent communication becomes impossible. Physicians must discuss the crucial issue of artificial feeding and resuscitation before that stage. In some countries, patients' known wishes dictate what the physician does after consciousness is lost. In others, this is not an option and physicians may be prosecuted if they fail to intervene to save the hunger striker's life. Physicians need to know clearly what attitude to adopt and also make this clear to the hunger striker, so that they can reach a decision in common. If, for personal reasons, physicians cannot accept the patient's decision, they should say so and step aside so that another physician can act according to the informed decision of the hunger striker.

Artificial feeding should not involve coercion. It may be prescribed by a physician or be imposed by a judicial authority. This occurs usually at a stage when the hunger striker is no longer fully conscious and too weak to express a view. Artificial feeding involves administering nutriments and liquids parenterally or through a naso-gastric tube. Even when physicians agree to respect patients' advance refusals, some circumstances may justify a decision to resuscitate or artificially feed a hunger striker who has lost competence. A justification would be for example, that the situation has changed after the patient lost awareness so that the advance refusal may be considered inapplicable to the new scenario. If, however, when competence is regained, the hunger striker persists in the refusal of feeding or treatment, the physician should allow the person to die in dignity, without repeated resuscitations.

Physicians should never condone or participate in forcible feeding or any other enforced measures which may amount to cruel, inhuman and degrading treatment. When hunger strikes have a political component, the authority in charge may decide to end them by force and order the forcible artificial feeding of protesters. This may be decided very early on in the fasting, when there is no actual medical need to administer nutrition. It should be realized in this

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Declaration of Malta Glossary **To be read in conjunction with the background discussion paper on management of hunger strikes.**	
Advance instructions/advance directive	Mentally competent patients can give consent or refusal in advance for future medical interventions, in order for their wishes to be known if later mental impairment leaves them unable to express a view. Advance instructions are a useful indicator of an individual's views but only if the person making them is aware of the implications and not pressured to make a certain choice. These criteria can be hard to meet in custodial settings but are not invariably absent. Physicians need to be aware that at the start of hunger strikes, there can be pressure for hunger strikers to prove that their intentions are serious which may push them into making an ill-considered advance refusal of resuscitation. Where possible, physicians need to discuss this privately with hunger strikers and ascertain their real intention. Some advance instructions truly reflect the individual's wishes but others do not. Physicians need to assess the evidence. Advance instructions can be written or verbal but have no value if made under duress. They may also be invalid if the situation has undergone significant change since the individual lost competence and it is no longer what he or she expected it to be. (See WMA statement on advance directives, Helsinki 2003).
Artificial feeding	Although often seen as synonymous, artificial feeding is not the same as forcible feeding. All force-feeding is artificial but not all artificial feeding is forced. Artificial feeding in hunger strikes can be a solution for hunger strikers who do not want to endanger their health but who refuse to take nourishment normally for reasons of their own. Artificial feeding is acceptable if hunger strikers make known their agreement to it by any means or, if incompetent, they have not refused it in advance.
Force feeding	Force feeding not acceptable. It involves use of force and physical restraints to immobilise the hunger striker. Although described as life saving, it is sometimes implemented as a coercive measure to break a hunger strike
Autonomy	Physicians should respect patients' autonomy by not overriding their voluntary, informed and competent decisions. In the case of hunger strikes, this means physicians should respect patients' refusal of feeding. It is important for physicians to explain accurately to hunger strikers the potential health impact of prolonged fasting and to advise them on how to minimise the harmful consequences by for example, increasing fluid and vitamin intake. Consent and refusal are invalid if the result of coercion. Autonomy is one of four key principles that are frequently portrayed as core to modern medical ethics.
Beneficence & Non-maleficence	The duty to benefit (beneficence) and not harm (non-maleficence) are also part of the four key principles but need to be interpreted holistically. Imposing treatment in the face of valid patient refusal is seen as a harm not a benefit. In custodial settings, this raises questions about whether prisoners or detainees can make such free choices.
Best interests	Physicians are morally obliged to act in patients' best interests but this does not mean prolonging life at all costs. An assessment of best interests must be a balance between seeking the best medical outcome and a consideration of the patient's own views, values and preferences. Physicians do not act in patients' best interests by overriding patients' strongly held wishes.
Confidentiality	All patients, including detainees, have rights of confidentiality but these are not absolute rights. Consent to disclosure should generally be sought from competent individuals. Information about incapacitated individuals can be disclosed if it is in their best interests. For all patients, disclosure is also permitted if it prevents serious harm to others. In hunger strikes, information about the patients' views and medical condition should be shared among health professionals providing care. Information can be given to other people such as relatives and lawyers with hunger strikers' consent.

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Dual loyalties	Physicians supervising the management of hunger strikers often have contractual duties and obligations to other agencies, such as prison authorities. The WMA strongly emphasises that medicine is a privilege that invariably carries certain responsibilities. All medically qualified individuals must demonstrate the professional duties of beneficence and non-maleficence even when they have dual loyalties and even if their work does not involve the actual provision of care. This means that all people who have been trained as care givers have the same ethical duties of care givers even when not employed to provide care.
Eating/fasting	Good communication depends on all parties understanding common terms in the same way. Different cultures have very differing views on what constitutes fasting or accepting nutrition. This is addressed in the WMA background paper and also in chapter 5 of the WMA's Internet course for prison doctors on www.lupin.nma.net.
Hunger strike and „Voluntary Total Fasting“	Refusing nutrition takes different forms. The terms "hunger strike" and "voluntary total fasting“ are sometimes used inter-changeably even though fasting may be neither voluntary nor total. The" voluntariness" of the individual's decision is a key issue for physicians in assessing whether to abide by it. Partial or short-term food refusal rarely raises ethical dilemmas. The most accepted definition of a hunger strike is total fasting (taking only water) for over 48-72 hours. Salt, minerals or sugar may be added to water. Dry fasting where all nutrition and hydration are refused is uncommon and leads to death within a week. A hunger strike is not equivalent to suicide. Individuals who embark on hunger strikes aim to achieve goals important to them but generally hope and intend to survive.
Justice	Justice is another of the commonly cited four key principles of medical ethics. In this context, it is the requirement for physicians to treat hunger strikers fairly, by listening to their views and trying to minimise undue coercion from any source.
Physician/physician assistant	The WMA primarily addresses its guidance to physicians but in the context of hunger strike management, other health professionals are likely to be involved and should be encouraged to abide by the Malta Declaration. Professional guidance for other groups such as nurses and paramedics, for example, generally reflects the same principles.
Undue pressure/coersion	Informing hunger strikers of the implications of their decisions and encouraging them to reflect are essential and do not constitute undue pressure. Attempting to dissuade them from fasting by threats, including the threat of forcible feeding, is not acceptable.

respect that the authorities often have specific agendas when ordering doctors to artificially feed (or force-feed) hunger strikers. While claiming to want to save lives, some coercive authorities clearly intend to repress the principle of protest. For example, the authority may decide to force-feed hunger strikers after two weeks of fasting, when there is no immediate medical need to intervene. It may also be decided to feed prisoners who resist by brute force, tying down their limbs and forcibly inserting a naso-gastric tube. This coercion is what defines force-feeding. It is not necessarily carried out by medical staff but may involve medical orderlies if doctors refuse.

Case example 4

In a collective hunger strike, the degree of commitment to the fast varied considerably among the hunger strikers. It was clear to the visiting physician that some prisoners were absolutely determined to fast until they died. These prisoners not only refused all nourishment and drank only water but they resisted all attempts to provide nutrition by naso-gastric tube. If tubes were inserted against their will, they used them to suck out any nourishment that had gone into their stomach. Other prisoners in the same strike however, told the doctor privately that they were willing to accept an intravenous line or naso-gastric tube as long as they could maintain the pretence publicly that these interventions were done against their will. Since all the prisoners were saying publicly that they were unwilling to be artificially fed (even though privately some were saying the opposite), the first task for the doctor was to separate the

prisoners from each other without in any way indicating that some were willingly accepting nutrition. Eventually, however, it was bound to become clear which prisoners were determined to fast to death since the physician recognised that it would be unethical to force feed those who were genuinely resistant. He hoped that by separating them, each of the prisoners would have some opportunity to reconsider their decision away from the influence of the peer group in a situation of privacy. For those who maintained their fast, their decisions were respected.

11. Gaining support from professional associations

Physicians can themselves in difficult situations if they want to comply with the international guidelines which are in conflict with local legislation. They may face the dilemma of whether to do everything to save a person's life or respect the right of individuals to dispose of their bodies as they please. This question is often further complicated by religious or legal issues. Local law may require physicians to intervene, even against their will, if a hunger striker's life is at stake. On the other hand, international ethics guidelines focus on the rights of individuals to determine what is done to them. Where individual rights are respected, hunger strikers have a chance to have their decisions respected. Physicians encountering difficult dilemmas should appeal to their national associations or directly to the World Medical Association for guidance and support. It may also sometimes be necessary to have help from a perceived neutral organization, such as doctors from the ICRC (International Committee of the Red Cross), Council of Europe CPT (Committee for Prevention of Torture and Inhuman Degrading Treatment and Punishment) or similar organizations.

From the Secretary General's Desk

"What do we expect from the next WHO Director General?"

On the day he was supposed to open the 59th World Health Assembly on May 22nd this year, the Director General of the World Health Organization (WHO) tragically died following a sudden illness. The World Health Assembly decided to hold an extraordinary session later this year to determine the next Director General (DG).

Dr. Lee was committed to give more power to the regional organizations of WHO. Certainly all health care is local and coming closer to place of need was logical and necessary. He headed a difficult institution, because a political organisation is struggling between opposing political interests, increasing challenges for health and an always inadequa te budget. This task is like squaring a the circle – there is no final solution.

Geneva is the home of the Red Cross, the United Nations Commission on Human Rights, the first assembly place of a supranational organization preceding the United Nations. The Conventions regulating minimal human behavior in wars have the name of this city and what ever is connected with it has the bonus of being of high moral standing. But that is an illusion. The WHO is a good example of an institution which many people believe it to be a moral authority for health care. Something it never was, and most likely never will be.

The organization was build right in the middle of a political minefield between the east and the west. In times of cold war it was one of the green tables where leaders of the political blocks could meet and discuss, without pretending to like each other. The old demarcation lines have gone. In time of globalisation, trade determines the rules. But the borders and frontiers are not gone. They are now more complex, sometimes invisible and often blurry. Players in the globalisation game often don't know whether they are friends or foes. And all may be different tomorrow. The problem is: "the old mines are still hot".

The WHO is a governmental organization and it is only as good as the governments it represents. No government of this world is made of Saints, no government is without mistakes, yet many deserve our respect. But many others have no democratic background – they are not elected leaders of their people. Many governments of this world deny their people basic rights, the freedom of speech, the right to work, the right to move, the right to build coalitions. Many governments deny their people even the right to live, they torture and abuse their own people. Yet they sit in the World Health Assembly, the highest deliberative body of the WHO.

WHO has driven many health campaigns: The fight against small pox and polio are wonderful success stories, much of it Dr. Lee's achievement. The WHO works successfully on tobacco control and fights tuberculosis world wide, it has programmes on injury prevention and disaster relief, it supports medical reference centres and provides administrative guidance for the recognition of education and training. In other words there are many, many things the WHO has to be praised for. If it wasn't there, we would have to build it.

But then it is a political organisation with the parameters described above, excluding many people from cooperation just for political reasons: Taiwan is a good example of this. Its basis of work are the decisions of the World Health Assembly and reports, facts and figures provided by the countries – or better their governments. How much do we trust reports from countries without

free press, without the freedom of expression? Large parts of the WHO work are ideologically biased, they are neither the reflection of high morals nor of good science but just of political powers.

Whoever goes there to be the new DG has an uphill battle before him. Organisational reform like with the rest of the UN-Institutions is urgently needed. So what can we realistically expect? The political problems will remain. However, a re-focusing on true health issues and a closer cooperation with the health care community would be a good start. There is a strong alliance out there for health care, but WHO is going in another direction. The revitalization of bare-foot-doctor concepts in the recent discussion on "human resources for health" is just one example of the misled attempts to tackle one of the worst current problems in global health care: the global shortage of health professionals.

To take out politics will be the biggest political challenge for the new DG. To orient WHO towards health and not political problems will help to shift resources in the right direction. More transparency to and cooperation with the health community is high on our wish list.

At WHO many people work as staff and as volunteers who care for health. They deserve our cooperation and support. They also deserve a powerful DG who is able to free their way. WHO doesn't need a compromise candidate, it needs a strong and courageous leader. WHO needs a leader who knows that the Organization is there to serve the people of the world – and governments only if they do exactly the same.

WMA

173rd WMA Council Meeting held in Divonne

The 173rd Council met in Divonne les Bain, France 18-20th May 2006 under the chairmanship of Dr. Yoram Blachar.

After welcoming new members the first item of business was to elect a new Vice Chairman to replace Dr. Hashimoto, who had resigned. Following nomination Dr. K. Iwasa (Japan) was elected as Vice-Chairman of Council.

Following the approval of the minutes of the 171st and 172nd meetings, the President, Dr. Kgnosi Letlape reported on his activities since the last meeting. He had just visited Finland where he participated in a very productive WHO meeting on "Health as a bridge for Peace". Turning to Africa he reported that the establishment of an African Regional meeting was progressing very well. This should be formalised at a meeting in July and it was anticipated that it would meet later in the year. HIV/AIDS remained a major problem and he felt that actions of WMA needed to become more open in this area. Priorities were preventing the extension of HIV/AIDS and increasing access to treatment. In this connection he stressed that the unavailability of medicines was aggravated by problems with patent systems.

Dr. K. Iwasa

He was also concerned about those infectious diseases which were not adequately covered and welcomed the role of the Health Protection Agency He was very disturbed by the lack of disaster plans and preparations still in many countries. NMAs could assist with these, but there was a lack of appropriate mechanisms for mobilisation of the profession.

On a different note he stressed the need for coordination of those health professionals who rapidly respond to the need for assistance in major disasters.

He paid a special tribute to Dr. Yank Coble for his work in inspiring the "Caring Physicians of the World" project, especially in promoting and supporting regional meetings. These had permitted real dialogues on major issues relating to medicine.

He felt that WMA needed to become more engaged in policy decisions in the health-field, particularly with WHO. It also needed to promote leadership within the profession.

Concluding by referring again to the problems of Africa he said that while the "3 in 5" initiative was a most welcome one, unfortuntely the target was not being achieved. Only 1.3 of the three million target had been achieved by the programme. At the same time he paid tribute to the work of the catholic missions who quietly got on with work providing care, particularly in the most remote areas.They were one of the biggest providers of help globally and in Africa provided 10% of the aid for HIV/AIDS care.

The Secretary General invited to speak to his written report, (*see **49 for the full report***), said that the first part concerned the Caring Physicians of the World Initiatative and it was appropriate therefore that Dr. Yank Coble should present this.

Dr. Coble, referring to the World Medical Journal (WMJ 2006, **52**, (1), 11) said that the start of this project was in Helsinki. The book had been launched in Santiago, had been sent to NMAs and will go to all Ministries of Health. It had been distributed to Ministers in Bangkok, Taiwan, India, to the President of the United States of America and also to many international bodies. The programme had been expanded through regional meetings in Johannisburg, Bangkok, Prague, North and South America. He was delighted that these meeting provided firm evidence that people would agree on the enduring traditions of Caring, Ethics and Science in medicine.

The Secretary General, Dr. Otmar Kloiber, expressed his pleasure at being part of these activities which also increased the visibility of the WMA, especially for those members who cannot get to global meetings such as those of the Council and the General Assembly. Returning to his report he said that much of the work had concentrated on governance, statutory reform, finance and balancing the budget. Referring to problems of getting NMA subscriptions, he reminded NMAs of the need to pay both in time, and in full.

There had been continuing discussion on finance and partnerships and he pointed out that engagement in new activites could not be done without forming partnerships.

Turning to the World Health Professions' Alliance (WHPA), he reported that cooperation had been very positive, although possible points of critical discussion had still to be faced by the Alliance, such as shared competences and the limits of each profession. The Alliance was in agreement that the World Health Report (WHR) on the work force was distorted. There was an emphasis in this WHO report on training lay people, but while some of this emphasis had been modified during the preparation of the report, there were still statements about self regulation and a preference for a "command and control" style. The so called "Global Alliance for the Workforce for Health" had prepared its work without the Health Professions. The WHPA had asked for a discussion on the World Health Report with the Director General. As it was not possible to see him about their concerns before World Health Day, the Health Professions Organizations did not participate in this.

There was a need to cope with the problem of representation at WHO. This would be a core part of the strategic development of the WMA.

Both Dr. Blachar and Dr. Letlape concurred in their concern that the WHR possibly downgrades the profession.

Dr. Blachar thanked Dr. Kloiber, in particular for his work in taking over WMA at a difficult time and in fulfilling the Council's expectations.

In response to a question about the obligation of the Chinese Medical Association to include a member of the government amongst the senior officers of the Association, Dr Coble observed that at the time of the SARS epidemic, the Vice President of the Chinese Medical Association was a Minister, the executive Vice President and executive staff were politically determined.

Council then adjourned for the Meeting of the

Finance and Planning Committee

This meeting was opened by the Chairman, Dr. John Nelson and the minutes of the last meeting in Santiago were approved.

Dues

The committee considered various reports concerning NMAs' dues and actual dues payment; also the status of council members and officers during their term of office in the event of irregularities in payment of dues by their NMA. Legal counsel confirmed that NMAs who are represented on Council are required to pay their dues on schedule, or have a written agreement with the Secretary General that they will be regularised before the General Assembly. The Secretary General outlined the process of dealing with non dues payment, a process which now leads to the termination of single membership.

Financial statement 2005

After further discussion on the issue of non dues payment, the committee considered the financial statement for 2005, presented by Mr. Adi Häallmayr who gave a particularly clear transparent presentation of the situation. The Council noted the remarkable achievement of "turn round" in the financial position which had taken place, achieving a balanced budget for the first time in years. This was thought to be impossible in the space of a year and the Secretary General was congratulated on this achievement. This, Dr. Kloiber reported had been largely due to strict budgetary constraints on activities and a number of other factors which were included in Mr Häallmayr's report.

In response to a question as to whether this improvement was sustainable, the Secretary General responded positively, but only if the WMA confined itself to its Core business. Any extra activity would call for extra financing. Concerning any advantage to be gained by moving from Ferney Voltaire to Geneva, he referred to a relevant study currently being undertaken by the World Dental Federation.

The committee recommended that the preliminary financial statement for 2005 be approved, also by council later.

Governance changes

The Finance and Planning Committee dealt with the Governance changes that had been developed over the last year. These recommended changes in the Bye laws including a limitation of the terms of officers to a maximum time of six years, during which a council member could hold a specific function. Furthermore the Executive Committee consisting of the chairpersons of Council, the Committees and the Treasurer, was enlarged to include the President as a non-voting member. The executive committee will serve at the request of the Council Chair and will advise the Chair of Council, Council and the Secretary General. The amendments to the Bye-Laws were recommended for approval and submission to the General Assembly. *This was subsequently approved by Council*.

Business development Group

An oral report from the Business development Group was considered. Eight options were identified and the group sought to identify two for initial consideration. A survey of the views of participants present at the council meeting on the options was distributed.

Strategic Plan

The Secretary General presented the Strategic Plan for 2006-2010. He commented that during the Caring Physicians of the World Initiative and the Strategic survey they had learnt that there was a need for clear advocacy work called for by most NMAs, an issue which was also discussed in parallel by the Business Group. Referring to the document he indicated that before the

committee there were three areas reflecting NMAs needs, namely, Ethics Guidance including Social- Medical Questions, Advocacy Representation and Service and Outreach.

Dr. Kloiber said that outreach services needed to be developed, as did Advocacy. The Ethics Unit needed to be strengthened and this was the way forward to maintain the high reputation of WMA, as exemplified by Helsinki, Geneva and Tokyo. He paid tribute to the outstanding work of Dr. John Williams both in the unit and his other contributions in the representational work. Speaking generally about ethics, he felt that more attention needed to be given to beginning and end of life issues, many of which may not lead easily to consensus agreements. Issues of cloning, of stem cells and of the use of modern technology and its problems need equal attention. We also have our own problems. NMAs should be challenged to report back if WMA guidance was not acceptable. Prison Medicine and multi-drug resistant tuberculosis need to be tackled. Awareness of the problems of young physicians and young students must be strengthened and WMA needs to advocate for them. Referring to the importance of the location of the Office near to Geneva, he outlined the opportunities this provided for discussions with the UN, WHO, ILO, the Commission on Human Rights etc.. There was however some limit on how much the Secretary General and Dr. Williams could do. Asking NMAs to sit in on some meetings was difficult as meetings were often at short notice and air fares costly. Nevertheless in order to avoid lost opportunities, there is a need for more involvement of NMAs.

Services and support to NMAs also need to be strengthened. In this connection he was glad to respond to NMAs who ask for help, but this had to be within the limits imposed by shortage of staff.

The services to individual associate members need to be broadened. The web portal and other projects should to be part of the outreach to associates. The benefits of associate membership need to be strengthened beyond receipt of the WMJ and insurance. The Journal now has a new image, is now more orientated to WMA work and offers a platform for discussion.

Dr. Haddad welcomed the Secretary General's plan. The three areas highlighted were absolutely right and should be used to build upon. He agreed with the emphasis on Advocacy, but more resources were needed.

The committee recommended that the Chair of the committee and the Secretary General convene a working party to develop an implementation plan proposing specific objectives, deliverables and time tables, with cost estimates for the actions proposed in the Strategic Plan.

In further discussion the committee considered the financial implications of expanding the advocacy role, the manpower needs to develop the Ethics Unit, to deal with Documentation and the development of the www portal etc.

Future General Assemblies

The arrangements for the 2006 WMA General Assembly in South Africa were reported. The Danish Medical Association proposed "Health Care Information Technology" as the theme of the Scientific Session in Copenhagen in 2007, but the final decision on the theme would be for the 2006 General Assembly to decide.

Associate members

The report on Associate membership was received.

Public relations

The Committee received the report of the Public Relations consultant and thanked Mr. Nigel Duncan for his work.

World Medical Journal

The committee received the report of the Editor of the World Medical Journal and the Hon Editor stressed that a successor had not yet been identified. The Chair recognised the need to identify a successor to Dr. Alan Rowe soon and thanked him for his considerable efforts.

The Ethics Committee

Dr. Eva Bagenholm, opening the meeting welcomed new members, following which the minutes of the last meeting in Santiago 2006 were approved.

Ethics Unit

Dr. Williams, who will be leaving the WMA Ethics Unit at the end of the year, presenting the report of the Ethics Unit, informed the committee that the Ethics Manual had now been translated into Macedonian, Albanian, Taiwanese, Indonesian and Chinese, French and Spanish. It was hoped to produce the manual as a CD ROM in three languages. The Bulgarians had also offered to translate it, bringing the total translations to 19 languages. An online version in Norwegian will soon be available as well as Arabic, if funds are available.

Policy review

The committee then considered proposed changes to policy and NMAs comments on them.

The *Declarations of Geneva, of Tokyo and the Regulations in Times of Armed Conflict* which had undergone minor revision (see pages 29, 34, 35 for the revised texts), were recommended for approval and were later **approved by council**.

The committee then considered policies classified as requiring major amendment.

In the list of amended documents recommended for approval (*see list below*), notable points raised included the removal of Human Tissue from the proposed revised *Statement on Human Organ Donation and Transplantation*. This was requested in order to distinguish between organs and tissues, which were subject to different legal treatment in European Community legislation. The German Medical association agreed to develop a new proposal for a statement on Human Tissue Donation. Other amendments to the original text were adopted.

The proposed revision of the *International Code of Medical Ethics* led to considerable discussion which substantially focused as much on the concepts underlying proposed phrasing, as on individual words. After agreement on some word changes, it was agreed that a new working group would fur-

ther consider the revision, the group to be led by the Icelandic Medical Association and includes members from the Medical Associations of Canada, Israel, Slovakia and the United Kingdom.

After some discussion of the 1996 *Policy Statement on Weapons and their relation to Life and Health Issues* which had been recommended for minor revision, following NMAs' expression of views, it was agreed that the BMA would do a revision for consideration at the next meeting.

Concerning those WMA policies undergoing major revision the committee recommended and, **with some changes in the Declaration of Oslo, the Council later approved the following**:

- That the *Proposed Revision of the International Code of Medical Ethics* be assigned to a new working group led by the Icelandic Medical Association and including the NMAs from Canada, Israel, Slovakia and the United Kingdom;
  the *Proposed WMA Statement on HIV/AIDS and the Medical Profession* be approved and forwarded to the 2006 General Assembly for adoption and that the
  Interim Statement on AIDS, Statement on the Professional Responsibility of Physicians in Treating AIDS Patients, and the Statement on Issues Raised by the HIV Epidemic be rescinded and archived.
- That the *Proposed Revision of the Declaration of Venice on Terminal Illness* be approved and forwarded to the 2006 General Assembly for adoption and that the *Statement on the Care of Patients with Severe Chronic Pain in Terminal Illness* be rescinded and archived;
  the *Proposed Revision of the Statement on Human Organ Donation and Transplantation*, as revised, be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Statement on Ethical Issues Concerning Patients with Mental Illness*, as revised be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Declaration of Sydney on the Determination of Death and the Recovery of Organs* as re-titled, be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Declaration of Oslo on Therapeutic Abortion*, as revised and amended by Council, be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Statement on Assisted Reproductive Technologies* be approved and forwarded to the 2006 General Assembly for adoption; and that the *Statement on In-vitro Fertilisation and Embryo Transplantation and the Statement on Ethical Aspects of Embryonic Reduction* be rescinded and archived.
- That the *Proposed Revision of the Statement on Animal Use in Biomedical Research* be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Statement on Medical Ethics in the Event of Disasters*, as revised be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Statement on Child Abuse and Neglect*, as revised, be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Statement on Patient Advocacy and Confidentiality*, be approved and forwarded to the 2006 General Assembly for adoption; and
  the *Statement on Foetal Tissue Transplantation* be rescinded and archived.
- That the *Proposed Revision of the Declaration of Malta on Hunger Strikers* be referred to NMAs for comment, along with a background paper and glossary of terms prepared by the BMA.(*see pxxx*)

The recommendations were later approved by council.

Human Rights

The Secretary General reporting on Human Rights matters, said that the CD ROM Course for Prison Doctors was completed in English and Spanish, Mr. Hernan Reyes (ICRC) added that the French version was virtually complete and the CD ROM would then be in English, French and Spanish. Dr. Terje Vigen (Norway) stated that a Chinese version was under discussion. Dr. Kloiber resuming his report reminded the committee of WMA's participation in the teaching project in relation to the Istanbul Protocol. The number of countries who would permit this to take place was unfortunately limited.

Speaking of problems which had come to the WMA, he spoke first about Guantanamo Bay. The American Medical Associations in their discussions with the USA government had made WMA policy on this issue very clear and the AMA continued to be very helpful.

Referring to Cuba he reminded the committee that two years ago doctors were imprisoned for speaking among other issues about problems of health care and of preferential treatment for some parts of the population. The WMA had appealed for better conditions and for the release of those doctors imprisoned. Dr. Parsa-Parsi had attended a meeting on Medical Apartheid in Cuba which was held in Germany. Dr. Parsa-Parsi said that medical care was available for Tourists and High Officials in reasonable conditions but there were few facilities for the rest of the population. There was a high abortion rate in the absence of birth control, especially amongst the younger population. He also spoke of the suffering of doctors imprisoned in inhuman conditions whose families had evidence of their bad physical state. Dr. Kloiber urged NMAs to pick up this issue and support these doctors.

China

The Secretary General then addressed the subject of China. He reminded the committee that they had asked him to write to the Chinese Medical Association about the harvesting of organs from executed Chinese prisoners. This matter had already been discussed at a time when China applied to be a member of WMA in 1997. Last year the Times newspaper had reported that the Deputy Minister of Health admitted that this activity had taken place but stated that regulations would deal with this. Nevertheless advertisements still appeared

from hospitals offering kidney transplants obtained from this source. Since then there have been reports that Chinese doctors have participated in removing organs from executed prisoners, and allegations have even been made that vivisection is taking place.

The Secretary General wrote to the Chinese Medical Association as instructed and had had no reply. Likewise there had been no reply to a second letter in December 2005, requesting that the association confirm its support of WMA policy on this matter as for all other policies, in accordance with the WMA conditions of membership.

In view of the consistent failure to reply not only to letters but also to e-mails and faxes etc, the Council now had to consider further action.

In the ensuing discussion, speakers sought clarification that the policy referred to was that prisoners were in no position to give informed consent and that physicians should not participate when organs were removed from prisoners after execution. This was confirmed and it was further indicated that China was a fully paid up member of WMA in 2004.

Following extensive discussions during which very deep concern was widely expressed, it was proposed and agreed that the secretariat prepare a document with all the evidence of these practices, for information and use by NMAs. The following Resolution was **later adopted unanimously by the Council** after further discussion.

The committee also recommended and **council later approved:**

"That the Secretary General forward the Resolution on Organ donation in China to the Chinese Medical Association with a letter expressing the council's grave concerns. The letter will indicate that the Council had discussed future possible actions with respect to the Chinese Medical Association in the event that it did not respond to WMA with an express condemnation of this practice and its support of WMA policy on this issue."

Taiwan

The committee also reviewed its concerns about WHO denial of participation of Taiwan in the World Health Assembly and other technical meetings and adopted the following recommendation which **Council later endorsed**:

"That the WMA issue a press release reaffirming its position on the status of Taiwan as an observer at the World Health Assembly, the importance of the meaningful participation of Taiwan in technical meetings of the World Health Organisation and urging that Taiwan's status and participation not be hindered by excessive bureaucratic or administrative requirements."

Council Resolution on Organ Donation in China

Whereas, the WMA Statement on Human Organ and Tissue Donation and Transplantation stresses the importance of free and informed choice in organ donation, and
Whereas, the statement explicitly states that prisoners and other individuals in custody are not in a position to give consent freely, and therefore their organs must not be used for transplantation, and
Whereas, there have been reports of Chinese prisoners being executed and their organs harvested for donation,
Therefore, the WMA reiterates its position that organ donation be achieved through the free and informed consent of the potential donor.

The WMA demands that the Chinese Medical Association condemn any practice in violation of these ethical principles and basic human rights and ensure that Chinese doctors are not involved in the removal or transplantation of organs from executed Chinese prisoners.

The WMA demands that China immediately cease the practice of using prisoners as organ donors. *20.05.06*

Socio-Medical Committee

The Socio-Medical Affairs committee met under the Chairmanship of Dr. Henry Haddad and approved the minutes of the meeting in Santiago 2006.

Policy Revision

The committee proceeded to consider comments from NMAs on policies requiring major revision, using the consent agenda procedure (*the final recommendations of the committee are set out below*). Under this procedure, which agrees all items other than those identified by committee members as indicating a need for discussion, following short discussion, the *Statement on Medical Education* was approved, as was that on *Adolescent Suicide and Traffic Injury*.

There was some discussion on the *Role of Physicians in Environmental Issues* in which the importance of the environment in disease was stressed It was pointed out that the European Union had addressed this topic, but that this was ,of course, a worldwide issue. The document was drawn up in 1997 and it was suggested that the document needed to be expanded. It was recommended that a working group be established (*see below*)

The committee's recommendations, **later agreed by Council**, were

- That the *Proposed Statement on Medical Education* be approved and forwarded to the 2006 General Assembly for adoption;
  the *Fifth World Conference on Medical Education* and the *Declaration of Rancho Mirage on Medical Education* be rescinded and archived;
  the *Proposed Revision of the Statement on Adolescent Suicide*, (as revised), be approved and forwarded to the 2006 General Assembly for adoption;
  the *Proposed Revision of the Statement on Traffic Injury*, as revised be approved and forwarded to the 2006 General Assembly for adoption.
- That a Working Group be established to address the topic of the *Role of Physicians in Environmental Issues*.
- The Working Group, composed of the NMAs from France, Brazil, South Africa and the United States, will review all of the proposed documents developed to date on this subject.
- That the P*roposed Revision of the Statement on Health Promotion* be referred to NMAs for comment;
  the *Proposed Revision of the Statement on Injury Control* be referred to NMAs for comment;

the *Proposed Revision of the Statement on Access to Health Care* be referred to NMAs for comment;
the *Proposed Revision of the Statement on the Twelve Principles of Provision of Health Care in Any National Health Care System* be referred to NMAs for comment;
the *Proposed Statement on the Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse* be referred to NMAs for comment and
the *Proposed Revision of the Statement on Alcohol and Road Safety* be referred to NMAs for comment.

After considering NMAs' suggestions for classifying the five Socio-Medical Affairs policies adopted in 1996 the committee recommended and **Council later agreed**

- that the S*tatement on Family Planning and the Right of a Woman to Contraception* undergo major revision by the British Medical Association and the *Statement on Resistance to Antimicrobial Drugs* undergo major revision by the American Medical Association;
- That the *Declaration on Family Violence* and the *Statement on Professional Responsibility for Standards of Medical Care* undergo minor revision.
- That the *Resolution concerning Dr. Radovan Karadzic* be rescinded and archived.

Tuberculosis

During the consideration of NMAs' comments on a proposed Statement on Tuberculosis, the committee proposed that the Resolution on Tuberculosis as revised, be approved and forwarded to the 2006 General Assembly for adoption and that the 1997 *Statement on Drug treatment of Tuberculosis* be rescinded and archived. This was subsequently **agreed by Council**

In an oral report by the Secretariat on progress in the development of the on-line course on the treatment of drug-resistant TB, reference was made to the success of the Geneva Press conference, that a chapter on Tuberculosis in prisons had been added by ICRC, that the text material would be tested in South Africa and then be translated into other languages.

Medical Assistance in Air Travel

There was considerable discussion on a Resolution, originally proposed in the Associates' meeting, on *Medical Assistance in Air Travel*. The Secretary General pointed out that this dealt with the problems and the risk of physicians' liability when responding to calls for medical assistance in the air. He considered that this needed to be regulated internationally. While in some legislation there was a limit on the financial liability in these circumstances, a speaker called for the enactment of legislation to provide immunity from liability action to those physicians who provide emergency assistance in in-flight incidents. A further speaker pointed out that the request for assistance came from the airline and it could be that the Aviation Authority should accept the liability. It was also suggested that the Airlines should regard the doctor as an employee in these circumstances. Several speakers observed that there could be no immunity from criminal liability and a suggestion was made that in the absence of immunity from legal liability, airlines must "accept all legal and financial consequences of asking for assistance".

Dr Kloiber said that there were differences in legal responsibilities in different countries. After amendment, the committee recommended "that the *Resolution on Medical assistance in Air Travel*, as revised, be recommended for approval and forwarding to the 2006 General Assembly for adoption. This was subsequently **approved by Council**.

Discussion of a proposed *Resolution on Child Safety in Airline Travel* was deferred, pending a review of this topic by the German Medical Association

Avian and Pandemic Influenza

Finally, the committee recommended that in view of the importance and urgency of this issue:

"The Proposed WMA Resolution on Avian and Pandemic Influenza, be sent without delay to NMAs, and that NMAs be urged to use the recommendations in the document in their policy and advocacy activities, in advance of further consideration of this topic at the 2006 General Assembly".

Further Council discussion

In addition to the decisions of Council in the second part of its meeting set out above, the Russian Medical Society made a statement about the situation of physicians in Russia clarifying that the Pirogov Conferences were called by the Health Minister. They were not meetings of National Medical Associations. The Chairman of Council took note of this.

Secretary General's Report to the 173rd WMA Council Session

(October 2005 – April 2006)

Consolidation

The year 2005 was determined by the serious financial situation of the WMA. The years before the operation of the WMA ended with deficits, thus consuming significant parts of its assets. It therefore was the first priority to maintain strict control over the WMA finances. This has been successfully achieved by

- Consulting with the executive treasurer, who immediately reorganized our investments and cash management and thereby stopped financial losses.
- Quarterly financial reports, allowing better control over the financial and economic situation.
- Priority setting: The World Medical Association has been involved in a variety of fields which certainly are related to medicine and the work of physicians, however we were not able to provide a useful and sustainable service. Those activities were terminated or reduced and will only be revived, if an idealistic or material net value can be obtained for the association or its members.
- Reviewing contracts and business relations. We examined all contracts for necessity and price-worthiness. In many cases we achieved better prices for the same service or better service for the same price. We reduced spending for travel and representational expenses to an absolute minimum.
- Outsourcing. After the resignation of our French translator the position has not been refilled. French translations are now being done by an outside translator at lower cost to the association with no loss in quality and speed.
- Application of rules. Consulting with the executive committee, the financial officers or the Sponsorship advisory committee leed to clear governance and financially sustainable partnerships and sponsorship arrangements, thus reducing the risk of financially non-sustainable engagements or ethically questionable liaisons.

The strict application of these methods helped to achieve a balanced budget for 2005 much earlier than anticipated. However, this does not mean that the WMA is in a financially comfortable situation:

- The income from dues is still unstable. Again in 2006 some major dues did not come in time or as agreed, some did not come in full.
- Some member associations pay only nominal dues, some because clearly their financial situation does not allow other, some which have obviously other reasons.
- Even with a complete income from dues this would not allow extra activities, which increase our visibility, presence at international organization or own activities providing service to our members or the general public.
- Revenue from sponsorship is problematic as it may produce dependency we do not wish and as it is of course in the hands of a partner whether to engage or not.
- With the opening of the borders between Switzerland and the European Union consumer prices and labour costs adapted to the level of the dominating Swiss neighborhood,.the once very cheap French area "Pays de Gex" west of Geneva has become one of the most expensive areas in Europe.

Caring Physicians of the World Initiative

Prior to our General Assembly in Santiago de Chile, October 2006 we organized a regional conference with the Latin American Confederation of Medical Associations CONFEMEL in Santiago on 10/11 October 2006 and we publicly launched the Caring Physicians of the World-Book on October 12th. Since then the distribution of the Caring Physicians of the World-Book has continued and its reception is overwhelmingly positive. We have not received a single negative comment on the book, but a great deal of support and interest in it.

The campaign is about values, dedication and pride and upholding our traditions of caring, ethics and science. At the same time in our conferences we are addressing the current needs of the member associations on a very practical level. With own conferences in Europe and North America and the participation of WMA leaders in regional or national meetings in various places, we are continuing the CPW campaign.

Regional Leadership Conferences

Latin America

Together with the Confederation of Medical Associations in Latin-America CONFEMEL the World Medical Association held a regional conference prior to our General Assembly in Santiago de Chile, October 9th and 10th. The Cooperation with CONFEMEL allowed us to meet not only with our regional member associations, but also other medical associations which exist either in parallel with our members in some of the countries or which are from countries having no association with WMA member status. The conference dealt with issues of health system reform and continuing professional development.

Europe

The heads of the European Medical Associations in the WMA met in Prague, December 9th and 10th. The leadership seminar focused on:

- Health and Human Resources, analysing the global trends of migration from south to north and in the European region from east to west. In general the migration follows an economic gradient from poorer to richer countries, from less favorable to better working conditions. Concerning the situation in Africa it was noted that for many countries there, the loss of health professionals is catastrophic. In some of the European countries it already leads to a significant shortage of professionals endangering continuation of care especially in rural areas. Among the factors that make professionals migrate are not only payment issues but also too high workloads, inadequate working circumstances and overburdening democracies. In European countries the loss by migration into other countries is even exceeded by loss to other occupations of young physicians and the choosing of early retirement by established physicians.
- In Germany, Belgium and France, strikes and demonstrations of doctors were the apparent signs of a deep dissatisfaction with the conditions doctors have to work

under in many European Countries. A presentation on the perception of the current protest actions taken by doctors especially in Belgium and Germany showed an overwhelming support by the public for the strikes and demonstrations of the doctors.

- A second session dealt with pandemic preparedness and the threat of the avian flu outbreak turning into a human pandemic. Although in all of the countries represented pandemic plans were already prepared or under preparation, the overall preparedness was not seen to be sufficient. Questions of management, resource allocation but also preventive strategies remained still open. The represented leadership felt it necessary that the National Medical Associations should be more strongly involved in the discussion of and preparation for a possible pandemic. Finding a fine line and appropriate risk communication that on the one hand explains the threats and necessity for preparation, but on the other hand does not trigger panic, seems to be the challenge in which the organisations of physicians can help most.

It was mentioned by some of those present that regional conferences like the one in Prague would offer possibilities for participation

North Americas

Leaders of the Canadian, American and Mexican Medical Associations met on Amelia Island, Florida, March 24th and 25th to discuss – for the first time in this group – emerging health topics for the region with leading experts from academic institutions and the industry.

- The development of the profession, its new challenges through rapid changes in technology, demography and patient demands meet in North America with a sharp deficit of health professionals. Currently the health care markets in Canada and the United States are the strongest magnets for health professionals. This stimulates a global migration as it has been described in our preceeding European conference (see above). New technologies but also better planning for the health work force may counteract the problems of human resources.
- For many years now counterfeit drugs have been observed and registered as a serious threat to the developing nations. However the notion that this is a problem of developing countries is a mistake. Counterfeit drugs probably occur in all countries, certainly in the rich countries of the northern hemisphere. This poses multiple dangers:
  - Counterfeits are theft of intellectual property. They reduce the return on investments others have made and reduce the resources for new developments.
  - Counterfeits are of uncontrolled quality. They may or may not contain the active substance, they may or may not be dosed correctly, they may or may not carry other poisonous substances, and they may deteriorate faster than described on the package
  - Counterfeits destroy trust. The occurrence of counterfeits severely endangers patients' compliance.

  It will be challenge for us to help to detect counterfeits (by just considering them), but at the same time not to diminish the compliance of our patients.
- Although North America has been spared from infection with the avian influenza virus H5N1, the threat of a global health pandemic exists for the Americas as for any other region in the world. Although our knowledge about the pandemic development and the medication options, both those for prevention (vaccines), therapy (anti-virals) and the treatment of opportunistic infections (antibiotics) have strongly improved, the risk has grown as well. A century ago pandemic spread was somewhat limited by the slowness and low density of transportation. At that time traveling around the world took weeks, but now it takes only hours and before a serious virus may be diagnosed, it most likely to have already landed on another continent. Our awareness of this threat has to be increased and our resources, communications structures and our regulations, have to be tested in the preparedness for a global pandemic.

The three North American Medical Associations agreed to work on a common action plan.

World Health Professions Alliance (WHPA)

(www.whpa.org)

In 1999 the International Council of Nurses (www.icn.ch), the International Pharmaceutical Federation (FIP) (www.fip.org) and the WMA founded the World Health Professions Alliance. The alliance aims are to foster the cooperation of the professional organizations and to augment our advocacy work with the international organizations, especially the WHO and the public. Last year the World Dental Federation (FDI) (www.fdiworldental.org) joined the alliance.

Since its inauguration the WHPA has taken an active role in the anti-tobacco initiative, in the fight to protect human rights, the recognition of the HIV/AIDS pandemic and against discrimination of the mentally ill. It promoted awareness on issues such as antimicrobial resistance, nutrition and health care for the elderly. The WHPA has engaged in leadership issues and has often overcome objections of officials who prefer to speak with a "single" health profession.

During the last year WHPA has cooperated with the International Alliance of Patient Organisations, IAPO (www.iapo.org). On the occasion of its second annual meeting in February 2006 the WMA President, Dr. Kgosi Letlape, represented the World Health Professions Alliance and spoke on their behalf on patient safety.

The WHPA serves as a platform for various discussions and initiatives in health care.

- it cooperates closely with the WHO and the Industry to combat counterfeit drugs and materials,
- it develops guidelines for the competence of international health care consultants,
- it discusses overlapping educational issues and

- it serves as a common platform on health professional issues with WHO.

The latter point has led to a personal discussion with the Director General of WHO, Dr. Lee Jong-wook. Dr. Lee met with the Secretaries of the four WHPA Associations on April 3rd, 2006. In the meeting the Associations documented their interest and need for a closer relationship with WHO and their preparedness for a stronger cooperation especially on human resource related issues. The secretaries' expressed their opinion that there is a need to further discuss some aspects of the World Health Report 2006 in common. It was agreed that the relative status of the health professions associations be revised and that common work on human resources issues with a focus on regulation should start as soon as possible. We were not able to achieve a significant role in the "Alliance for the workforce for health" under preparation by WHO.

The WHPA Leadership Symposium

In May 2004 the WHPA staged its first WHPA leadership symposium. The symposium aimed to strengthen the bond and encourage collaboration between the three health professions at the country level.

The second biennial WHPA Leaders' Forum will be held on May 20-21, 2006 in Geneva, Switzerland. The main focus of this forum is patient safety, highlighting the critical role of health professionals. Daniel Ford of the National Patient Safety Foundation Patient and Family Advisory Council will lead a discussion on building blame-free, responsible health care environments. The ways in which health professionals can combat counterfeit medicines will also be discussed, along with the importance of health professionals working together.

The European Forum of Medical Associations and WHO (EFMA)

Budapest 21-22 April 2006

The EFMA is a common forum of Medical Associations of the WHO-Region "Europe" and the WHO EURO in Copenhagen. Although existing now for nearly a quarter of a century WHO has lost interest in the Forum during the last years under the leadership of the current director, Dr. Marc Danzon in the year 2000. This year the deputy director of WHO EURO, Dr. Nata Menabde, joined the Forum in lieu of the Regional Director who was unable to attend because of illness. This was the first participation of WHO leadership since the year 2000.

The current leadership made it clear that the support formerly given to this Forum could not be reestablished. However, the WHO offered partnerships for the establishment of common projects.

The Forum discussed among others topics

- National patients' records databases, and stressing the importance of having the users of these systems, patients and health professional included in the planning of the systems.
- Collaboration between the medical profession and the pharmaceutical industry, including the guidance given by the Standing Committee of European Doctors (CPME).
- Threats to health and pandemic preparedness
- Patient safety and "no blame" approaches were discussed using the example of the legally regulated blame free reporting system in Denmark, and
- Health policy reforms in Europe. The Forum received reports on the current situation in Albania, Germany, Kazakhstan, Croatia, United Kingdom, Byelorussia and Azerbaijan. It was apparent that in most of the countries the governments, while on one hand talking about more competition, on the other they are more and more regulating the health care systems directly and by that doing just the opposite of what they are preaching. Professional autonomy and self-regulation are under pressure. A presentation on the perception of the current industrial actions taken by doctors especially in Belgium (last year) and Germany (ongoing) showed an overwhelming support by the public for the strikes and demonstrations of the doctors.

Other national or regional meetings

WMA officers or the Secretary General attended national meetings of the following WMA member associations or their regional groups:

- Colegio Médico de México
- Indian Medical Association
- Medical Associations of the South East Asian Nations (MASEAN)
- Standing Committee of European Doctors (CPME),

On-line Course on treatment of multi-drug resistant tuberculosis (MDR-TB)

Following the success of the online course for prison medicine,WMA decided to translate the new WHO guidelines for the treatment of multi-drug-resistant tuberculosis into a course that would help doctors who treat patients with MDR-TB. The guidelines were finally published with a considerable delay in the fall of last year.

The development of an online course on the treatment of multi-drug-resistant tuberculosis has been nearly completed. The final product will be launched in mid-June. The project is a cooperation with the Foundation for Professional Development of the South African Medical Association and the Norwegian Medical Association. It was made possible by a grant from Eli Lilly, Inc.

Assignment to regions

The **Indonesian Medical Association** has been reassigned to the **Pacific Region** on their own request. This assignment is effective from the beginning of 2006.

The new member, the **Singapore Medical Association**, has been assigned to the **Pacific Region**.

WHO

Health workforce crisis is having a deadly impact on many countries' ability to fight disease and improve health

World Health Report outlines need for more investment in health workforce to improve working conditions, revitalize training institutions and anticipate future challenges

GENEVA/LUSAKA/LONDON – A serious shortage of health workers in 57 countries is impairing provision of essential, life-saving interventions such as childhood immunization, safe pregnancy and delivery services for mothers, and access to treatment for HIV/AIDS, malaria and tuberculosis. This shortage, combined with a lack of training and knowledge, is also a major obstacle for health systems as they attempt to respond effectively to chronic diseases, avian influenza and other health challenges, according to The World Health Report 2006 - Working together for health, published by the World Health Organization.

More than four million additional doctors, nurses, midwives, managers and public health workers are urgently needed to fill the gap in these 57 countries, 36 of which are in sub-Saharan Africa, says the Report, which is highlighted by events in many cities around the world to mark World Health Day. Every country needs to improve the way it plans for, educates and employs the doctors, nurses and support staff who make up the health workforce and provide them with better working conditions, it concludes.

"The global population is growing, but the number of health workers is stagnating or even falling in many of the places where they are needed most," said WHO Director-General Dr LEE Jong-wook. "Across the developing world, health workers face economic hardship, deteriorating infrastructure and social unrest. In many countries, the HIV/AIDS epidemic has also destroyed the health and lives of health workers."

The World Health Report sets out a 10-year plan to address the crisis. It calls for national leadership to urgently formulate and implement country strategies for the health workforce. These need to be backed by international donor assistance.

Infectious diseases and complications of pregnancy and delivery cause at least 10 million deaths each year. Better access to health workers could prevent many of those deaths. There is clear evidence that as the ratio of health workers to population increases, so in turn does infant, child and maternal survival.

"Not enough health workers are being trained or recruited where they are most needed, and increasing numbers are joining a brain drain of qualified professionals who are migrating to better-paid jobs in richer countries, whether those countries are near neighbours or wealthy industrialized nations. Such countries are likely to attract even more foreign staff because of their ageing populations, who will need more long-term, chronic care," said WHO Assistant Director-General Dr Timothy Evans.

To tackle this crisis, more direct investment in the training and support of health workers is needed now. Initial costs will be for the training of more health workers. As they graduate and enter the workforce, funds will be needed to pay their salaries. Health budgets will have to increase by at least US$10 per person per year in the 57 countries with severe shortages to educate and pay the salaries of the four million health workers needed to fill the gap. To meet that target within 20 years is an ambitious but reasonable goal, the Report concludes.

Financing this gap will require significant, dedicated and predictable funding from national sources, as well as from international development partners. The Report recommends that of all new donor funds for health, 50% should be dedicated to strengthening health systems, of which 50% should be dedicated specifically to training, retaining and sustaining the health workforce.

At least 1.3 billion people worldwide lack access to the most basic healthcare, often because there is no health worker. The shortage is global, but the burden is greatest in countries overwhelmed by poverty and disease where these health workers are needed most. Shortages are most severe in sub-Saharan Africa, which has 11% of the world's population and 24% of the global burden of disease but only 3% of the world's health workers.

The Report calls for prompt and innovative initiatives to improve efficiency. For example, HIV/AIDS, TB and other priority disease programmes have implemented ways for health workers with limited formal training to successfully carry out specific health tasks. These experiences should be drawn upon to develop national health workforce strategies.

The World Health Report recommends that in order to achieve the goal of getting "the right workers with the right skills in the right place doing the right things," countries should develop plans that include the following:

- Acting now for workforce productivity: better working conditions for health workers, improved safety, better access to treatment and care;
- Anticipating what lies ahead: a well-developed plan to train the health workforce of the future;
- Acquiring critical capacity: workforce planning; development of leadership and management; standard setting, accreditation and licensing as drivers for quality improvement.

Beyond the national strategies the report urges global cooperation:

- Joint investment in research and information systems;

- Agreements on ethical recruitment of and working conditions for migrant health workers and international planning on the health workforce for humanitarian emergencies or global health threats such as an influenza pandemic;
- Commitment from donor countries to assist crisis countries with their efforts to improve and support the health workforce.

Global Access to HIV Therapy Tripled in Past Two Years, But Significant Challenges Remain

1.3 Million People Now Receiving Treatment in Low- and Middle-income Countries; Sub-Saharan Africa Leads in Treatment Scale-up. Lessons learned in "3 by 5" should guide efforts to move towards Universal Access to Treatment by 2010

GENEVA, 28 MARCH 2006 – A new report by the World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS) shows that the number of people on HIV antiretroviral treatment (ART) in low- and middle-income countries more than tripled to 1.3 million in December 2005 from 400 000 in December 2003. Charting the final progress of the "3 by 5" strategy to expand access to HIV therapy in the developing world, the report also says that the lessons learned in the last two years provide a foundation for global efforts now underway to provide universal access to HIV treatment by 2010.

Progress in treatment scale-up, while substantial, was less than initially hoped. The report notes, however, that treatment access expanded in every region of the world during the "3 by 5" initiative, with approximately 50 000 additional people beginning ART every month in the past year. Sub-Saharan Africa, the region most severely impacted, led the scale-up effort, with the number of people receiving HIV treatment there increasing more than eight-fold to 810 000 from 100 000 in the two-year period. By the end of 2005, more than half of all people receiving HIV treatment in low- and middle-income countries resided in sub-Saharan Africa, up from one-quarter two years earlier.

"Two years ago, political support and resources for the rapid scale-up of HIV treatment were very limited," said WHO Director-General, Dr LEE Jong-wook. "Today "3 by 5" has helped to mobilize political and financial commitment to achieving much broader access to treatment. This fundamental change in expectations is transforming our hopes of tackling not just HIV/AIDS, but other diseases as well."

In July 2005, the G8 nations endorsed a goal of working with WHO and UNAIDS to develop an essential package of HIV prevention, treatment and care, with the aim of moving as close as possible to universal access to treatment by 2010, a target subsequently endorsed by the United Nations General Assembly in September 2005. The new WHO/UNAIDS report outlines a number of steps that must be taken to continue and expand treatment scale-up toward achieving this goal.

Substantial increases in HIV treatment access

Countries in every region of the world made substantial gains during the "3 by 5" period in closing the gap between those in need of treatment and those receiving it. The number of public sector treatment sites in low- and middle-income countries increased from fewer than 500 providing ART to more than 5100 operational treatment sites by the end of 2005. A recent survey showed for example that the number of treatment sites in Malawi increased from three in early 2003 to 60, and in Zambia increased from three to more than 110 facilities in just over two years.

Globally, 18 developing countries met the "3 by 5" target of providing treatment to at least half of those in need by the end of 2005, and are now concentrating their efforts on moving towards universal access to treatment. While other countries fell short of this target, lessons learned in expanding treatment access and overcoming critical weaknesses in health systems are informing new initiatives to further scale-up HIV prevention, treatment and care services. Increased availability of ART averted an estimated 250 000 to 350 000 premature deaths in the developing world in 2005 alone.

Launched by WHO and UNAIDS on World AIDS Day, 1 December 2003, "3 by 5" aimed to provide treatment to 3 million people in low- and middle-income countries by the end of 2005. This ambitious target was based on a 2001 analysis of what could be accomplished with an optimal combination of funding, technical capacity building, health systems strengthening and political will and cooperation. The initiative confirmed that HIV treatment can be delivered effectively in a wide variety of health systems, including those in poor countries and rural settings, and that large-scale ART access is both achievable and increasingly affordable.

Between 2003 and 2005, global expenditure on AIDS increased from US$ 4.7 billion to an estimated US$ 8.3 billion. Significant proportions of this funding were provided by the US President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria and the World Bank. During the same period, the price of first-line treatment decreased by between 37% and 53%, depending on the regimen used.

Progress: Treatment Access by Region

Between end-2003 and 2005, HIV treatment access expanded in every region of the world. Sub-Saharan Africa and East, South

and Southeast Asia, the regions most heavily affected by the epidemic, achieved the most rapid and sustained progress.

- More than 810 000 people in sub-Saharan Africa, or 17% of those in need of ART, had accessed treatment by the end of 2005. Well over half the people on ART in the developing world live in this region. This substantial increase in ART availability in sub-Saharan Africa occurred despite considerable regional challenges: the region is home to over 20 of the world's 25 poorest countries, and suffers a shortage of some 1 million professional health workers, with an additional 20 000 trained staff lost each year to emigration.
- East, South and Southeast Asia recorded significant gains in ART access from end-2003 (70 000 people) to 2005 (180 000 people), with coverage in the region expanding more than 75% in 2005. Thailand was a major driver of this increase, particularly during 2004 and the first half of 2005.
- Latin America and the Caribbean, with more than 315 000 people on ART (up from 210 000 at the end of 2003), is providing treatment to approximately 68% of its population in need – the highest coverage of any region in the developing world. Thirteen countries in this region provide treatment to more than half of the population in need.
- Despite gains in overall numbers on treatment, ART access in low- and middle-income countries in Eastern Europe, Central Asia, the Middle East and North Africa was lower than in other regions, with just 21 000 people in Eastern Europe and Central Asia and 4000 in the Middle East and North Africa receiving treatment as compared to 15 000 and 1000 respectively at the end of 2003. Virtually all countries in these regions are experiencing low-level epidemics that involve difficult-to-reach populations such as injecting drug users (IDUs) and sex workers.

Reaching Women, Children and Vulnerable Populations

While the new report found no systematic bias against women in ART access, rates of coverage for women varied. In some countries, more women receive treatment; in others, more men. One notable area of concern is access to therapy to prevent mother-to-child HIV transmission, which remains unacceptably low. Between 2003 and 2005, fewer than 10% of HIV-positive pregnant women received antiretroviral prophylaxis before or during childbirth. As a result, 1800 infants were born with HIV every day. Each year, over 570 000 children under the age of 15 die of AIDS, most having acquired HIV from their mothers. In 2005, 660 000 children under the age of 15 were in need of immediate ART, representing more than 10% of unmet global need. Nine out of ten children needing treatment live in sub-Saharan Africa.

While an estimated 36 000 injecting drug users (IDUs) were receiving ART by the end of 2005, more than 80% (30 000) of these are in Brazil. The remaining 6000 patients were distributed among 45 other countries. These figures suggest a large unmet need, particularly in Eastern Europe and Central Asia, where IDUs represent 70% of HIV cases, but just 24% of patients currently on treatment.

"Misinformation about the disease and stigma against people living with HIV still hamper prevention, care and treatment efforts everywhere," said Dr Peter Piot, UNAIDS Executive Director. "If we are to get ahead of the AIDS epidemic, we must tackle stigma, ensure that the available funds are spent effectively to scale-up HIV prevention, care and treatment programmes, and mobilize more resources."

Moving toward universal access

While important advances in HIV treatment access have been achieved in the past two years, the report also acknowledges that, despite the efforts of many partners and significant funding from a number of donors, the "3 by 5" strategy fell short of its ambitions. Obstacles to scaling up HIV treatment and prevention highlighted in the report include poorly harmonized partnerships; constraints on the procurement and supply of drugs, diagnostics and other commodities; strained human resources capacity and other critical weaknesses in health systems; difficulties in ensuring equitable access; and lack of standardized systems for the management of programmes and monitoring progress.

"The past two years have provided a wealth of experience and information on which we must now continue to build," said Kevin De Cock, Director, HIV/AIDS Department at the World Health Organization. "We intend to utilize this knowledge to focus future efforts on overcoming persistent challenges and obstacles. It is particularly important that scaling-up HIV prevention, treatment and care services contributes to strengthening of health systems overall."

A number of lessons learned in treatment scale-up efforts and outlined in the new report provide a valuable roadmap for efforts to achieve universal access to treatment. Among these are:

- The positive impact of targets in creating and sustaining momentum for action and in increasing accountability among stakeholders. A key element of the "3 by 5" strategy was developing bold country-level targets that encouraged national governments to expand capacity beyond what was previously considered possible. Moving forward, targets for treatment must be complemented by achievable targets for other elements of a comprehensive response to AIDS, including prevention and mitigating impact.
- The need to strengthen health systems. Building universal access to HIV treatment will require significant ongoing efforts to re-build, reinforce and expand under-staffed and under-funded health care systems that are already severely challenged in many countries.
- Promoting a 'public health approach' to health care delivery that emphasizes service decentralization, community mobilisation and education, team-based approaches and the delegation of routine tasks to trained nurses and health workers. The approach also promotes use of mechanisms to ensure the consistency and quality of supplies of drugs and diagnostics as

well as the routine offer of voluntary testing and counselling to increase knowledge of HIV status in settings where there is high HIV prevalence.

- The ongoing need to intensify prevention efforts and to integrate prevention and treatment scale-up, using all effective approaches and paying particular attention to the needs of vulnerable groups. Epidemiological modelling consistently shows that more deaths can be averted with a comprehensive response including both prevention and treatment, than by focusing on treatment or prevention alone.
- The need for substantial increases in resources and sustainable financing. UNAIDS estimates that the gap between available resources and those needed is US$18 billion for the period 2005-2007, and that at least US$22 billion per year will be needed by 2008 to fund comprehensive national HIV prevention, treatment and care programmes.
- Long-term donor commitments are essential to ensuring sustainable treatment scale-up, as placing large numbers of people on ART is impractical for many countries without firm funding. The report encourages the use of innovative financing mechanisms to fund increased resources for AIDS. These include a proposal by France to introduce an airline solidarity contribution and the UK's International Finance Facility, which aims to "front-load" additional funds leveraged from international capital markets to make them immediately available for sustainable investments that support the achievement of the Millennium Development Goals.

The new report emphasizes that WHO and UNAIDS will continue to build upon these lessons learned, as well as on the priorities, strategies and partnerships of "3 by 5" in accelerating the AIDS response. UNAIDS is currently facilitating the development of nationally agreed plans and targets to move towards universal access to HIV prevention, treatment, care and support. WHO's contribution to realizing the goal of universal access will be based on a set of priority interventions in the following five strategic directions known to be able to significantly influence the epidemic in different epidemiological contexts:

- enabling people to know their HIV status through HIV testing and counselling;
- accelerating the scale-up of treatment and care;
- maximizing the health sector's contribution to HIV prevention;
- investing in strategic information to guide a more effective response; and
- strengthening and expanding health systems.

Intellectual property rights, Innovation and Public Health Commission

Developing country access needed to existing and new medicines and vaccines

GENEVA. The independent Commission on Intellectual Property Rights, Innovation and Public Health has presented its report to the World Health Organization. The report recommends key actions needed to ensure that poor people in developing countries have access to existing and new products to diagnose, treat and prevent the diseases which most affect them.

Over half of the people in the poorest parts of Africa and Asia lack regular access to existing essential medicines because they cannot afford them, or because the health system in their country is too weak. Apart from access to existing medicines, some health products specifically for diseases which disproportionately affect developing countries are simply not developed at all due to the lack of a sustainable market. The relationship between intellectual property rights, innovation and public health has been at the heart of debate on these issues.

The report of the Commission: "Public Health, Innovation and Intellectual Property Rights" is the result of two years' analysis of how governments, industry, scientists, international law and financing mechanisms can work best to overcome the challenges.

"There is now global momentum to address these issues, and we have a unique opportunity to build on this. There is more awareness, more money potentially available, more utilization of scientific capacity in developing countries and new institutions such as public–private partnerships. The Commission report is clear that we must build on all of these to ensure that poor people in developing countries have sustainable access to the medicines, vaccines and diagnostics they need now, and critically, in the future. The report maps out the ways this can be done," said Mme Ruth Dreifuss, the Chair of the Commission.

The report was commissioned by the World Health Assembly and WHO's Director-General, Dr LEE Jong-wook, established the Commission on Intellectual Property Rights, Innovation and Public Health in February 2004 meeting first in April (as reported in WMJ 50(2), 50).

"We are grateful to the Commissioners for undertaking this difficult task. With this report, the Commission has built a solid foundation from which countries can move forward. I encourage all countries to give serious consideration to their role in addressing these critical issues," said Dr LEE Jong-wook, today as Mme Dreifuss presented the report, which contains more than 50 recommendations which serve as a road map for tackling the issues in different country settings. The report after consideration by the Executive Board, goes to the World Health Assembly. *(see next issue)*

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