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*Title page: London School of Tropical Medicine and Hygiene, London U.K. Photo courtesy of LSTMH. Top view: front of the present building. Bottom view: Headstone and window. This prestigious and internationally recognised centre of excellence in all aspects of international health, health policy and public health, was founded in 1899 by Sir Robert Manson, as the London School of Tropical Medicine This became the London School of Hygiene and Tropical Medicine (LSHTM) in 1924, formally opened by the Prince of Wales in 1929.*

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## World Medical Association International Code of Medical Ethics

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006.

### Duties of Physician in General

- A PHYSICIAN SHALL always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.
- A PHYSICIAN SHALL respect a competent patient's right to accept or refuse treatment.
- A PHYSICIAN SHALL not allow his/her judgment to be influenced by personal profit or unfair discrimination.
- A PHYSICIAN SHALL be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.
- A PHYSICIAN SHALL deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.
- A PHYSICIAN SHALL not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.
- A PHYSICIAN SHALL respect the rights and preferences of patients, colleagues, and other health professionals.
- A PHYSICIAN SHALL recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.
- A PHYSICIAN SHALL certify only that which he/she has personally verified.
- A PHYSICIAN SHALL strive to use health care resources in the best way to benefit patients and their community.
- A PHYSICIAN SHALL seek appropriate care and attention if he/she suffers from mental or physical illness.
- A PHYSICIAN SHALL respect the local and national codes of ethics.

### Duties of Physician to Patients

- A PHYSICIAN SHALL always bear in mind the obligation to respect human life.
- A PHYSICIAN SHALL act in the patient's best interest when providing medical care.
- A PHYSICIAN SHALL owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.
- A PHYSICIAN SHALL respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.
- A PHYSICIAN SHALL give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.
- A PHYSICIAN SHALL in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.
- A PHYSICIAN SHALL not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

### Duties of Physician to Colleagues

- A PHYSICIAN SHALL behave towards colleagues as he/she would have them behave towards him/her.
- A PHYSICIAN SHALL NOT undermine the patient-physician relationship of colleagues in order to attract patients.
- A PHYSICIAN SHALL when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information



*Editorial*

## Regulation and Self-Regulation of the medical profession

At the General Assembly of the WMA, held in Pilansberg, South Africa, NMAs gave expression to their concerns on a number of topics of which they felt WMA should be aware. Two NMAs opened the discussions by expressing their disquiet at the increasing intrusion of governmental and healthcare authorities in the self regulation of the medical profession.

This trend has most recently been led notably by the English speaking countries, as, for example, by the United Kingdom in the development of its body regulating the medical profession. In the UK, this is the General Medical Council, in which, for many years the Chief Medical Officers England, Northern Ireland and Scotland and Wales, as government officials, were ex-officio members of the Council (\*). Over the past few decades however, initially a small number of Lay members were appointed to the Council. Then, in the more recent reforms, the number of these has been increased and it has been suggested that there should not be a majority of the medical profession in the regulating body. Appointed Lay members, as well as the physicians elected by the profession, all play their part in the activities of the Council, including disciplinary hearings. The fundamental argument for all of this is the concern that the views of the consumers of healthcare professional services should be represented in the regulation of the professional providers of medical services.

Self-regulation was commented on in the World Health Organisation Report 2006 on Human Health Resources in which, while recognising that self-regulation could and had worked well in a number of Member States and also setting out reasons why it had not worked well in others, the author(s) did not recommend that self-regulation of the profession be further developed. Commenting on changing trends in the role of governments, led by pressures for universal access and financial protection in relation to healthcare services, they write "Rather than relying on one single regulatory monopoly, national health workforce strategies should insist on cooperative governing e.g. between professional organisations-self-regulatory professional organisations" indicating professional organisations dealing with entry to the professions, ethics, sanctions and training; institutional regulators (social health insurance/state managed employment contracts etc.) and civil organisations (relating to protecting the interests of citizens), and the behaviour of healthcare institutions, all as players influencing the behaviour of healthcare institutions and workers. (1)

It should be noted that, whilst in a number of countries regulation is not delegated by Ministers to self-regulating bodies such as the elected Medical Orders or Councils, in such countries the internal disciplinary determinations of the Medical Orders, Councils etc comprising elected professional peers (commonly with legal advisers), frequently tend to play some role in disciplinary and regulatory procedures. Indeed in some cases, decisions, other than withdrawing the licence to practice (although in a number of countries including suspension or withdrawal of the licence) rest with these bodies. In others, where the jurisdiction lies with special courts, the profession is present in a statutory role as advisers to the judge considering the matter. (2)

There is little doubt that, in future, the age of absolute autonomy of the physician who is licensed to provide medical services to the public (which through social security/healthcare systems consume a considerable part of GNP) will be modified, to permit lay representation in the regulating and licensing bodies.. In the age of consumerism there is a demand that the voice of consumers should play a role in the regulation of the standards of those

providing professional services to them through whatever healthcare system is provided. What is disturbing the profession is the potential risk that the non-medical members appointed by government to "represent the consumer interest" may be influenced by the views of the governments who appoint them or by their appointed advisers, thus diluting the professional voice of the main body of physicians, whose **ethical and professional duty** is to ensure that impartial informed clinical and not political considerations are the basis of advice and action by physicians in the best interests of their patients. This would be of particular concern if the balance between professional and lay members were at or near parity and a deciding vote rested with a President, whose independence might be compromised through his appointment by one of the parties or by government, rather than one appointed through the expressed wishes of the majority of both elements of the Regulating Body, professional and lay, e.g. a senior member of the judiciary..

Whilst these concerns may appear to be unwarranted, they are very real and are not reflections of opposition to any reform of long established traditions. Indeed, physicians are increasingly aware of the need to ensure that professional competence should ensure that the best possible quality of medical care provided by physicians is maintained throughout active professional life, reaffirmed from time to time by continuing professional development, re-accreditation and licensing, as appropriate. Such trends are actively being pursued in a number of countries. What is essential is that necessary appropriate change is achieved through open transparent productive dialogue between the medical profession and the other interested parties, be they consumers or healthcare providing agencies, both governmental or non-governmental. In this way the primary role of physicians, in preventive, diagnostic, therapeutic, advisory roles or as advocates of the healthcare interests of individual patients and communities, can be maintained by appropriate regulatory bodies established for this purpose.

As already indicated, it is just and proper for the views of the community (who use and finance health care services), through



## WHO new Director General

**Dr. Margaret Chan has been appointed as the new Director General of the World Health Organisation. Dr. Chan was earlier Director of Health for Hong Kong and she joined WHO in 2003. Prior to her appointment as Director General she was Assistant Director General for Communicable Diseases and Representative of the Director General for Pandemic Influenza. (for further details see page 110)**



appropriate government or other lay members of the public, to play some part in approving the standards of care and behaviour of those providing medical services. But once these have been approved, the judgement of whether or not these standards have been breached or abused should properly be left to the judgement of professional peers and judged strictly by the agreed standards of conduct, having regard to all the relevant circumstances.

In a paper on “The teaching of medicine as a service of healing”, (3) the authors write “The profession’s desire for autonomy is predicated on its promise to police itself in the public interest. These legal measures (laws governing registration and licensing in UK, USA and other English speaking countries) granted medicine a broad monopoly over healthcare – along with the understanding that in return, medicine would concern itself with the health problems of the society it served and would place the welfare of society above its own.”. They continue “The primary obligation as a physician is to act as a “healer”, but society has chosen professional status as the way to organise the activities required from medicine and entrusted to the profession”.

In the changing modern world, where advances in knowledge and the ability to intervene in both life-threatening and chronic diseases has hugely increased, (with consequent changes in management and treatment now requiring substantial teamwork with other professionals rather than individual action), some change in the regulation of the profession is inevitable. Nevertheless, the concerns expressed above which are “in the best interests of patients” need to be met, not substantially jettisoned

in an enthusiastic rapid “politically correct” response to the changing circumstances of the 21st century.

In order to face up to these challenges the medical profession needs to inform the general public not only of nature of the problems, but also of the threat to the freedom of physicians to provide them with independent impartial best advice, uninfluenced by the constraints imposed by political considerations or the perceived need for instant reactions to particular circumstances. At the

same time the responsibilities outlined above, on which clinical autonomy and the right to give the best advice in the interest of the patient is granted, must be seen to be properly governed by the regulating body, if the “self-disciplining” of the profession is to be retained.

*Alan Rowe*

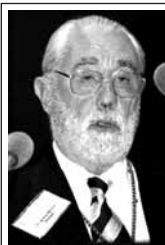
\* The National Chief Medical Officers (CMOs) were represented by the Chief Medical Officer of England plus the CMO of either Scotland, Northern Ireland or Wales in alternation.

(1) Working together for Health. World Health Report 2006, 121-124 Geneva

(2) Rowe A, Garcia-Barbero M, Regulation and Licensing of Physicians in the European Region, WHO (2005) p. 21-22. WHO Copenhagen. WHOLIS number EUR/05/5051794

(3) Creuss R and S “Teaching medicine as a profession in the service of Healing” Acad. Med. 1997,72,941-52.

*(See also page 106)*



## Dr. André Wynen honoured

**The World Medical Association’s Secretary-General Emeritus, Dr. André Wynen has been honoured by his appointment as Grand Officier de l’Ordre de Leopold, in recognition of his work and role as Founder and Former President of the Chambres Syndicales des Médecins Belges, Secretary General of the World Medical Association and President of the Groupe Memoire.**

## Libyan Court Decision on Bulgarian Doctor and Nurses

Despite the huge international outcry and the accumulated scientific evidence following the original outrageous decision concerning the accused during their first trial, in a second trial, in what has been described as “a highly politicised retrial and a grotesque miscarriage of justice” the death sentence has been imposed by a Libyan Judge.

The overwhelming scientific evidence, not only of Montagnier – the discoverer of the HIV – who stated that the virus was active in the hospital before those accused started to work there, and the most recent report of the Oxford Team on the Genetic history of the genetic subtype of the HIV virus from the infected children, has been disregarded by the court.





## Medical Ethics and Human Rights

In a joint statement about the decision by the Libyan court, the International Council of Nurses and the World Medical Association said:

“We are appalled by the decision of the Libyan court to sentence the five Bulgarian nurses and the Palestinian doctor to death. Today’s decision turns a blind eye to the science and evidence that points clearly to the fact that these children were infected well before the medical workers arrived at the hospital.

How many children will go on dying in Libyan hospitals while the Government ignores the root of the problem?

If there is any hope of justice for these nurses and this doctor, we appeal to the Supreme Court to again quash these death sentences.”

As indicated above an appeal is to be lodged once again and the Libyan Justice of

Minister, has been reported as saying “There could be a complete revision of the case”. From the comments emanating from the rest of the world notably in the West, the outcome of such review is likely to be more diplomatic or political rather than ensuring justice to the accused and a verdict, based on all the evidence.

The whole medical profession and the rest of the civilised world must surely be horrified at this barbaric decision which clearly flies in the face of the evidence and transparent impartial administration of justice.

(see also *Secretary General’s comment p. 106*)

### **WMA Policy Revision**

Whilst it has not previously been our custom to reproduce all WMA Statements and Declaration in the Journal, readers will have noted that we have recently published revisions to such document as the Geneva Declaration which have achieved general international acceptance as setting out fundamental principles relating to human rights and medical ethics. The WMA approved the result of the fundamental review of WMA Policy document which has been taking place over the past two years at its General Assembly in South Africa (see page 93). As a result we have decided to publish some of the other important documents in their revised form in addition to listing all the documents revised or archived, in addition to the new policy adopted at this General Assembly. (all policy documents are, of course, accessible at [www.wma.net](http://www.wma.net)) – Editor

## Medical Ethics and Human Rights

### **World Medical Association Declaration on Hunger Strikers**

Adopted by the 43rd World Medical Assembly Malta, November 1991 and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006

#### **Preamble**

1. Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are often a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term or feigned food refusals

rarely raise ethical problems. Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual’s true intention, especially in collective strikes or situations where peer pressure may be a factor. An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker’s advance

instructions were made voluntarily and with appropriate information about the consequences. These guidelines and the background paper address such difficult situations.

#### **Principles**

2. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.
3. Respect for autonomy. Physicians should respect individuals’ autonomy. This can involve difficult assessments as hunger strikers’ true wishes may not be as clear as they appear. Any decisions lack moral force if made involun-





tarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

4. 'Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or *primum non nocere*. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.
5. Balancing dual loyalties. Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.
6. Clinical independence. Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.
7. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.

8. Gaining trust. Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

### Guidelines For The Management Of Hunger Strikers

9. Physicians must assess individuals' mental capacity. This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.
10. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.

11. A thorough examination of the hunger striker should be made at the start of the fast. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.
12. Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.
13. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.
14. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.
15. If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.
16. Continuing communication between physician and hunger strikers is critical. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want



## Medical Ethics and Human Rights

to be done when they are no longer able to communicate meaningfully. These findings must be appropriately recorded.

17. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.
18. If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.
19. Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.
20. Artificial feeding can be ethically appropriate if competent hunger strikers

agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.

21. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coer-

cion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting. ■

## WHO announces new standards for registration of all human medical research

The World Health Organization was urged research institutions and companies to register all medical studies that test treatments on human beings, including the earliest studies, whether they involve patients or healthy volunteers. As part of the International Clinical Trials Registry Platform, a major initiative aimed at standardizing the way information on medical studies is made available to the public through a process called registration, WHO is also recommending that 20 key details be disclosed at the time studies are begun.

The initiative seeks to respond to growing public demands for transparency regarding all studies applying interventions to human participants, known as clinical trials. Before making the recommendations, the Registry Platform initiative consulted with all concerned stakeholders, including representatives from the pharmaceutical, biotechnology and device industries, patient and consumer groups, governments, medical journal editors, ethics committees, and academia over a period of nearly two years.

"Registration of all clinical trials and full disclosure of key information at the time of registration are fundamental to ensuring transparency in medical research and fulfilling ethical responsibilities to patients and study participants," said Dr Timothy Evans, Assistant Director-General of the World Health Organization.

Although registration is voluntary, there is a groundswell of policies aimed at spurring registration of all clinical trials. In July 2005, for example, the International Committee of Medical Journal Editors, a group representing 11 prestigious medical journals, instituted a policy whereby a scientific paper on clinical trial results cannot be published unless the trial had been recorded in a publicly-accessible registry at its outset.

Some groups have raised concerns that these new requirements could jeopardize academic or commercial competitive advantage if they apply to preliminary trials of new interventions. Similar concerns have been voiced about the requirement to disclose certain items--such as the scientific title of the study, the name of the treatment being tested and the outcomes expected from the study--at the time of registration.

"Our aim is to make clinical research transparent and enhance public trust in science, but we are engaged in a fair and open process with all stakeholders. We look forward to continued dialogue about trial registration and results reporting as we move forward with the Registry Platform," said Dr Ida Sim, Associate Director for Medical Informatics at the University of California, San Francisco and coordinator of the Registry Platform initiative.



The planned Registry Platform will not be a register itself, but rather will provide a set of standards for all registers. It has not only standardized what must be reported to register a trial but is creating a global trial identification system that will confer a unique reference number on every qualified trial.

Currently, there are several hundred registers of clinical trials around the world but little coordination among them. The Registry Platform seeks to bring participating registers together in a global network to provide a single point of access to the information stored in them.

The WHO Registry Platform will launch a web-based search portal where scientists, patients, doctors and anyone else who is interested can search among participating registers for clinical trials taking place or completed throughout the world. ■

## WMA Statement On Professional Responsibility For Standards Of Medical Care

Adopted by the 48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996, and editorially revised at the 174th Council Session, Pilanesberg, South Africa, October 2006.

### Recognising that:

1. The physician has an obligation to provide his or her patients with competent medical service and to report to the appropriate authorities those physicians who practice unethically and incompetently or who engage in fraud or deception (International Code of Medical Ethics); and
2. The physician should be free to make clinical and ethical judgements without inappropriate outside interference; and
3. Ethics committees, credentials committees and other forms of peer review have been long established, recognised and accepted by organised medicine to scrutinise physicians' professional conduct and, where appropriate, impose reasonable restrictions on the absolute professional freedom of physicians; and

### Reaffirming that:

4. Professional autonomy and the duty to engage in vigilant self-regulation are essential requirements for high quality care and therefore are patient benefits that must be preserved;
5. And, as a corollary, the medical profession has a continuing responsibility to support, participate in, and accept appro-

priate peer review activity that is conducted in good faith;

### Position

6. A physician's professional service should be considered distinct from commercial goods and services, not least because a physician is bound by specific ethical duties, which include the dedication to provide competent medical practice (International Code of Medical Ethics).
7. Whatever judicial or regulatory process a country has established, any judgement

on a physician's professional conduct or performance must incorporate evaluation by the physician's professional peers who, by their training and experience, understand the complexity of the medical issues involved.

8. Any procedure for considering complaints from patients which fails to be based upon good faith evaluation of the physician's actions or omissions by the physician's peers is unacceptable. Such a procedure would undermine the overall quality of medical care provided to all patients. ■

### World Medical Association

## World Medical Association 57th General Assembly, Pilanesberg, South Africa, 13–14 October 2006

### General Assembly Ceremonial Session

The General Assembly Ceremonial Session was opened by the Chair of Council, Dr. Yoram Blachar, following which the official delegates from member states were introduced to the President by the Secretary General.

The President of the South African Medical Association, Dr. J.P. Niekerk, in welcoming

participants, made reference to a statement made by Archbishop Tutu that, while the Church must not be an organ of the State it must be the conscience of the State, likewise, National Medical Associations must serve as the medical conscience of the State.

Hon. Edna Molewa, Premier of the North West Province was then introduced by the President, Dr. Letlape. Welcoming delegates to South Africa, she made reference to



the final report of the outgoing Secretary General of the United Nations, Kofi Anan, in which he emphasized the need for global partnerships and improved coordination and cooperation between nations. She said that the WMA was exactly the kind of organisation needed to achieve this goal. The world has an ambitious agenda in the Millennium Development Goals. The health profession must lead the way, helping governments to understand that investing in health is critical. NMAs must be partners with governments in this regard, so that budgets, policies and programmes adequately prioritise the health of citizens. Alongside this priority must be a concerted effort to address the complex and multidimensional problems of poverty. The relationship between poverty and disease means that meeting this challenge is a matter of life and death. The Premier encouraged the General Assembly to examine specifically the problems created by medical migration, noting that Africa was suffering the effects of aggressive recruitment of physicians from wealthy countries. She concluded by stating that there is no investment more important than the investment in health and that the world's physicians must work with decision makers to ensure its high placement in national agendas.

#### **Presentation of Past-President's Medal**

The Chair of Council, Dr. Blachar, paying tribute to the outgoing President of the WMA, Dr. Kgosi Letlape said:

"It is with great admiration that I look back upon Dr. Letlape's career and various achievements. Graduating MB., ChB at the University of Natal and then pursuing his specialist training in Ophthalmology in Edinburgh, Scotland, Dr. Letlape became the first black South African ophthalmologist in 1988, at a troubling time for the nation of South Africa which was at the height of its Apartheid era.

Since being elected chairperson of the South African Medical Association in 2001, a position he still holds today, he has diligently worked towards providing public healthcare for the 38 million South Africans who cannot afford private funding.

In his attempts to address the HIV/AIDS epidemic and erase the stigma attached to the disease, he spearheaded the establishment of the Tschepang Trust in 2002, together with the Nelson Mandela Foundation. The trust facilitates the treatment of HIV-positive patients at specific centres all over South Africa. Dr. Letlape has also been outspoken on the issue of the so-called "Brain Drain" phenomenon, advocating the improvement of working conditions in order to retain doctors, particularly those working in public health systems.

As part of the WMA, he served on the working group for one of the WMA's most renowned documents, the Declaration of Helsinki. Along with former WMA Secretary General Dr. Delon Human, he has made tremendous headway in the founding of the African Regional WMA offices, which will be holding their first annual meeting next January. Dr. Letlape has relentlessly worked to bring together the various African Medical Associations, for the purpose of getting Africa's endemic health problems placed on the international health agenda. The grave disparities in healthcare can now be addressed at international level. As President of the WMA he has been vocal in his support for including Taiwan in the WHO, in order to forge a global health system that can bypass politics and help countries around the world prepare for and cope with pandemics. He has been equally outspoken on the topic of medical professionalism whereby he maintains that physicians should always work in the best interests of their patients, as well as training doctors to be good leaders in their communities."

Dr. Blachar formally thanking Dr. Letlape on behalf of the World Medical Association, then presented Dr. Letlape with a Past President's Medal and invited him to deliver his Valedictory Address.

#### **Valedictory Address Of Dr. K. Letlape**

In his Valedictory Address, Dr. Letlape first expressed his gratitude to the organisation

and its members for the privilege of serving them. Continuing, he asserted that the WMA must be the global champion of basic health care for all, free at the point of delivery and called for an increased emphasis on public health globally. Physicians must engage in social and community affairs, directly influencing policy to the greatest extent possible. This includes involvement in areas such as working to prevent armed conflict, which is within the portfolio of the health profession because of the devastating effect of war on human health and on national health systems. The profession must not accept limited health care resources as an unfortunate fact of human life. Dr. Letlape stated that "We must bake a bigger cake and ensure that it is shared equitably". This will require resourcefulness and leadership across medical disciplines. There must be commitment by everyone to be part of the solution to the global medical human resources problem. Modern medicine must represent progress across all boundaries, engaging stakeholders at all levels, from national governments to patients.

#### **Installation of President**

Dr. N. Aragaman of the Malaysian Medical Association, who had been elected by the 2005 General Assembly, then took the Presidential Oath and was installed as the 58th President of the World Medical Association.

#### **Presidential Address Of The New President, Dr. N. Arumugam**

"It is a great honour and privilege to be elected as the President of the World Medical Association. I would like to thank you for electing me and giving me the opportunity to serve as the president of the association.

The WMA in its mission statement clearly states the objective to provide a forum for its member associations to communicate freely, to co-operate actively, to achieve consensus on high standards of medical ethics and professional competence, and to promote the professional freedom of physi-





cians worldwide. The WMA is committed to serve humanity by endeavouring to achieve the highest international standards in Medical Education, Medical Science, Medical Art, Medical Ethics, and Health Care for all people in the world.

The Association has been led by a series of distinguished presidents who have promoted the ideals of the WMA. Dr. Kgosi Letlappe has continued in this tradition and on his visits to numerous national medical association meetings, he has in his fervent speeches appealed to the membership for strong commitment to the profession and emphasised the importance of being united and proactive. Dr. Yank Coble the immediate past president over the last couple of years, has through the "Caring Physicians of the World" initiative organised regional meetings in different parts of the world to bring the different associations of the various regions together to communicate and learn from one another. I would like to thank The South African Medical Association, especially the organising committee, for having successfully organised this year's meetings and social events. I would also like to thank Dr. Otmar Kloiber the Secretary General and the WMA secretariat for their committed service and smooth running of the General Assembly.

The World Medical Association which was established after the Second World War by twenty seven national medical associations, now has a membership of over eighty national medical associations. Recognising the need to draw more of the many non-member nations, the council, after much deliberation, has revamped and streamlined the subscriptions payable by member organisations depending on economic status of the country. It is earnestly hoped that this will help to draw more national associations to join the WMA in the coming years, and boost the strength of the WMA and help to enhance the cause of medicine.

In any large organisation generally, the bigger and more vocal members will tend to dominate discussion and influence. The establishment of the recent regional meetings should provide opportunities and impetus for the smaller member national associations to play a more active role in the

affairs of the WMA. As universal participation is a necessity for any healthy organisation in the coming year, I will work with council to find ways to stimulate contribution of some of the dormant and smaller members of the association.

Many National Medical Associations are unable to allot sufficient time to the concerns and activities of the WMA as they have their own demanding schedules and activities. Many individual physicians of National Medical Associations (NMAs) are not aware of the workings and the significance of the WMA. Physicians nowadays belong to many different medical societies, especially specialist/subspecialty societies related directly to their work and they do not see the immediate relevance of the WMA. It is important for the development and the importance of the WMA that national associations highlight the activities of the WMA in their newsletters, their websites and in their activities whenever possible. It is also necessary to have prominent visible links to the WMA website in the homepages of member organisations. I therefore strongly urge all of you to incorporate the activities of the WMA in as many ways as possible in the activities of your national associations, thus making the WMA more visible to the physicians of the world.

Ethics derived from a basic view of humanity, has been part of medical practice from the beginning. Ethical medical practice refers to the appropriate treatment of a patient, maintaining a high standard of medical ability and skills with a caring and moral obligation. Doctors are taught to be dedicated to the service of humanity and subscribe to the caring spirit when entering the profession of medicine. Medical practice has attracted much criticism about unsympathetic personal uncaring attitudes and inappropriate treatments. That this probably applies to a small minority of doctors compared with the huge number of doctor-patient contacts each day, gets overlooked and the profession as a whole is discredited.

The WMA has emphasized the core values of the profession of caring, ethics, science, compassion and universal accessibility.

Over the years the association has achieved reasonable success in promoting these values not only to the profession but also to the public and relevant authorities. During the last two years under the Caring Physicians of the World initiatives doctors from various countries were nominated, selected, and recognised. A book published in conjunction with the initiative highlighted their contribution to society. This was a worthy project as it highlighted the caring aspect of the profession. To continue this initiative and to motivate more doctors to follow these exemplary footsteps and to recognize those who have dedicated their life to the care of the needy it is time we institute a World Physicians/Doctors Day. On this day the WMA should honour a doctor from each of the five regions of the world for their care, compassion and contribution to society. The day will help to emphasize, promote, develop and help to maintain the tradition of caring.

Since the end of the Second World War, more than half a century ago there have been remarkable discoveries and inventions in medicine, which have led to unparalleled improvement in the health of the world population. We are able to control and treat deadly infectious diseases, which were causing fatalities and unthinkable suffering around the world, with newly discovered medications. Through innovative procedures and operations we are also able to correct congenital abnormalities and acquired disabilities. The medications and treatment modalities have helped relieve suffering, improve the quality of life of the individual, the family and the nation. Changes in the living standards of many countries in the world further contributed to healthier populations. Eradication of polio and the discovery of medicines to treat deadly infections gave hope and optimism to the people of the world that they were going to enjoy uninterrupted improving good health.

These achievements and improvements seem to have been short lived and the world is again faced with new epidemics and challenges. The health of the population of the world seems more vulnerable and more hazardous than ever before in recent history. The last decade has not only seen emer-



gence of deadly infections like AIDS (Acquired Immunodeficiency Syndrome) and SARS (Severe Acute Respiratory Syndrome) but also of a chronic serious epidemic commonly termed as “life style diseases”. The number of patients afflicted with Obesity, Hypertension, Diabetes Mellitus, Dyslipidaemia and related diseases has been increasing at an alarming rate the world over. This surge in life style diseases has not been confined to the wealthier and more developed countries but has been spreading at an alarming rate in the developing and poorer countries. The current epidemic affecting people in the prime of life, causes untold misery to individuals, families and countries. The immense drain on the financial resources of families and nations has jeopardised the development of sustainable health care systems in many countries.

As life style diseases are chronic in nature and progression insidious, patient’s attention to the problem is delayed and awareness is only drawn to the disease at a late stage, making it complex and expensive to treat. In many countries life style diseases affect about 30% of the population, while in some it affects almost 60% of the population and is rising incessantly. Researchers and pharmaceutical companies are trying to develop new therapeutic medicinal compounds to control and treat these conditions.

Though new medicines are necessary to treat those already afflicted, the only sustainable solution in overcoming this epidemic will be by concerted lifestyle changes and instituting preventive measures. The WMA should through its various member organisations lobby relevant authorities and governments to emphasize the necessity for change, as governments are not doing enough. They have either not recognised the enormity of the problem or have been reluctant to face reality.

While many organisations have highlighted the problem there have only been limited results. It is now time for the WMA with the National Medical Associations to launch a rigorous effort to stress the importance, to both the people and governments of the world, of the need for global action. Advocacy for diet modification, encourag-

ing physical activity, anti-smoking measures and regular medical examination aimed at early preventive actions may look daunting but without the immediate institution of these measures the world will within the next decade or two face such an enormous problem that it will not be able to handle it.

The new millennium was awaited with eagerness and globalisation was the buzz word of the new century. Newer technologies especially electronic communication, the internet, the media and air travel have all contributed to shrinking the world at a staggering pace. Nations were being more connected and interdependent than ever before. International business was thriving and there was high expectation for improvement of international understanding, cooperation and unity in the world. Increasing pace of international travel, liberalisation of national borders and increasing changing migration patterns were moving the world towards to a more homogenous society.

Suddenly the world was shattered by events never seen before, turmoil set in and now terror reigns. Ideological differences, religious extremism, racial confrontations, economic disagreements have resulted in extreme provocation and excessive retaliations. These actions have divided the world and ushered in an era of anguish and unpredictability which has affected all of us in many ways.

South Africa, which has probably experienced one of the most traumatic periods in modern history under the apartheid regime, was liberated after a long and protracted struggle. The liberation of South Africa and the transition to a prosperous and successful democracy gives hope that old differences can be put aside and a new beginning benefiting all can be established. The Centenary celebration of the start of the civil rights struggle, started by one of the pioneers in the liberation struggles in South Africa Mohandas Karamchand Gandhi, was held a few weeks ago here in South Africa. Mahatma Gandhi, as he has now come to be known, was the pioneer of Satyagraha – resistance through mass civil disobedience, strongly founded upon ahimsa – non-violence, becoming one of the strongest

philosophies of freedom struggles worldwide. It has been noted that Gandhi remained committed to non-violence and truth, even in the most extreme situations.

Numerous medical groups through the years have served in areas of disasters and conflicts to help the needy and suffering, irrespective of their allegiance to any political or religious grouping. The events of the last few years should make the profession reflect on its role as curing the sick and use its unique position to explore the greater possibility of helping to re-establish unity and harmony in the world and thus healing wounds of the people, both physical and mental.

Emergencies and crisis are a part of medical practice and intermittent outbreaks of epidemics have occurred through out history. What was new in the recent emergencies was the scale and ferocity. The world in general and the Asia Pacific region in particular, has experienced unprecedented calamities over the last five years. Natural disasters – Tsunami and Katrina, the epidemics of Severe Acute Respiratory Syndrome (SARS), Avian Flu, and man made environmental disasters of flood and haze – are continually threatening the health of the world. Doctors and healthcare workers have always been in the frontline treating and combating diseases with all the inherent dangers. These disasters in general and SARS in particular have startled and alarmed the doctors and healthcare workers, as many of them were struck by the illness.

Affected and battered countries around the world urgently announced measures to reduce the health consequences after each episode. As of today, forests are being destroyed and burned blatantly contrary to international agreements; the haze is choking regions of the world, avian flu is smouldering, and raging floods are causing havoc in many areas. All these have not only caused major damage and hardship but have exposed huge populations to a myriad of diseases. Environmental degradation in the name of progress must be halted and health must be given the rightful priority it deserves.

These are challenging times to practice medicine as the widening gap between what

medicine can do today and what the individual or the society can afford has shaken up the fundamentals of medical practice. The changes in the last few decades especially in the mode of health care delivery, commercialisation of medicine and the growing disparity of medicine in populations, due to the staggering cost of new developments, all put the doctor in an unenviable position between the patient and the systems. Increasing public demand for medical services with counter demands by payers to control costs, has put tremendous pressure on doctors and healthcare professionals.

The patient's quest for perfect results, often not fathoming the unpredictability of medical procedures, has put further tension on the doctors while escalating medical indemnity costs. The increasing control of the profession by administrators, regulatory authorities, governments and third party payers, has caused much annoyance and uneasiness. Private hospitals are generally managed by commercial interests and the difference between commercial values and professional values often leads to conflicts. It is important for doctors to be objective, balanced and keep the interest of the patients foremost at all times.

In spite of the uphill tasks and emerging challenges, the profession must stand and work together to achieve the best working conditions for the profession while delivering efficient and caring treatments to patients."

The Chair of Council, then formally adjourned the session.

## **General Assembly, Adjourned Plenary Session**

The Session was formally opened by the Chair of Council, Dr. Y. Blachar. Apologies were received from Drs. Wynen and Odenbach.

The Credentials committee reported that 42 NMAs were registered, recognised and in good standing with full voting rights, the collective number of votes being 93.

After the adoption of Standing Orders, the Minutes of the General Assembly in Santiago, Chile 2005 were adopted.

There were three nominations for the post of President 2007-2008 and Dr. J. Snaedel (Icelandic Medical Association) was elected to this office.

Dr. Y.D. Coble, Past President, presented an update of the Caring Physicians of the World initiative. He reported that WMA regional meetings had been held in Africa, Latin America, Europe, North America and the Asian and Pacific regions, under the auspices of the project. He introduced Dr. Malegapuru Makgoba, a South African physician chosen for inclusion in the CPW book and presented him with a copy of the book.

The Assembly then received the Report of Council. Under the reports of matters from the Socio-Medical Affairs and of the Medical Ethics Committees the recommendations arising from the huge review of WMA statements, recommendations and policies occupied much of the time. The decisions on the recommendations for revision adopted are listed below. Some recommendations involved rescinding and archiving of previous statements. Details of the recommended changes adopted are available on the WMA website ([www.wma.net](http://www.wma.net)) or from the WMA office.

New proposals adopted are shown in bold below and the texts appear elsewhere in this issue of the journal or the next issue. (*See also page 100-106*)

### Socio-Medical

Statement on Obesity – **new** (*see page 107*)  
 Statement on Medical Education –revision  
 Statement on Adolescent Suicide –revision  
 Statement on Traffic Injury – revision  
 Resolution on Tuberculosis – **new**  
 Resolution on Medical Assistance in Air Travel – **new**  
 Statement on the Role of Physicians in Environmental Issues – revision  
 Statement on Physicians and Public Health – revision  
 Statement on Injury Control – revision  
 Statement on Access to Health Care – revision

Statement on Responsibilities of Physicians in Preventing and Treating Opiate and Psychotropic Drug Abuse – revision  
 Statement on Alcohol and Road Safety – revision)

Resolution on Child Safety in Airline Travel – **new**

Statement on Avian and Pandemic Influenza – **new**

### Medical Ethics

Statement on HIV/AIDS and the Medical Profession – revision

Resolution on Combating HIV/AIDS – **new**  
 Declaration of Venice on Terminal Illness – revision

Statement on Human Organ Donation and Transplantation – revision

Statement on Ethical Issues Concerning Patients with Mental Illness Statement of Sydney – revision

Declaration of Sydney on determination of Death and the recovery of Organs – revision  
 Declaration of Oslo on Therapeutic Abortion – revision

Statement on Assisted reproductive Technologies – **new**

Statement on Animal Use in Biomedical research – revision

Statement on Medical Ethics in the event of Disasters – revision

Statement on Child Abuse and Neglect – revision

Statement on Patient Advocacy and Confidentiality – revision

International Code of Ethics – revision (*see page 87*)

Declaration of Malta on Hunger Strikers – revision (*see page 90*)

The Secretary General noted that there had been no discernable consensus among NMAs concerning rescinding the WMA Resolution concerning Dr. Radovan Karacic. The German Medical Association informed the Assembly that the original reasons for adopting the resolution had not changed, Dr. Karacic had not surrendered nor been captured and there had been no justice for the crimes he is alleged to have committed. The recommendation to rescind and archive the Resolution concerning Dr. Radovan Karacic was not accepted by the Assembly



**The following resolutions were rescinded/archived:**

Education: the Declaration of Rancho Mirage on Medical Education; Statement on Drug Treatment of Tuberculosis; the Twelve principles of Healthcare in any National healthcare system; Use and misuse of Psychotropic drugs and on the prescription of substitute drugs in the outpatient treatment of Addicts to opiate drugs.

After the Chair of Ethics had explained that a new document on telemedicine was being prepared, the documents on Statements etc. rescinded and/or archived including the Fifth World Conference in Medical Use of computer in Medicine; Statement on Accountability, Responsibilities and Ethical Guidelines in the Practice of Telemedicine and the Statement on Home Medical Monitoring, Telemedicine and Medical Ethics, were rescinded and archived.

Finance and Planning

In matters relating to Finance and Planning the Assembly adopted recommendations relating to future General Assemblies

- that the theme for the Scientific Session of the 2007 Assembly to be held in Copenhagen should be "Information Technology in Health Care"
- that the 2009 General Assembly be held in India.

The applications for membership from the **Medical Association of Namibia**, the **Samoa Medical Association** and that of the **Somali Medical Association** were approved.

Following a detailed overview of the 2005 Financial Statement and the 2007 Budget, both the 2005 Statement and the 2007 Proposed Budget were approved.

The proposed amendment of the Bylaws to allow a new differentiated dues structure accepted in principle in 2005 in Santiago, were formally adopted and the Secretary General reported that the new system would be reviewed annually by Council and every five years by the General Assembly.

Despite some discussion as to whether the proposal to impose a six year limit on the number of consecutive years an individual

can serve as Chair or Vice-Chair of Council or as Treasurer should be reduced to four years, the six year proposal was adopted.

The following Resolution introduced by the Japan Medical Association on North Korean Nuclear Testing was adopted by the Assembly

**World Medical Association  
Resolution On North  
Korean Nuclear Testing**

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

"RECALLING the WMA Declaration on Nuclear Weapons adopted at the WMA General Assembly in Ottawa, Canada, in October 1998; the WMA:

Denounces North Korean nuclear testing conducted at a time of heightened global vigilance on nuclear testing and arsenals;

- 1) Calls for the immediate abandonment of the testing of nuclear weapons; and
- 2) Requests all member National Medical Associations to urge their governments to understand the adverse health and environmental consequences of the testing and use of nuclear weapons."

Following this, the rest of the Council Report was adopted.  
*(for Resolutions adopted by the Council see page 99)*

Associate Members

The Associates' members report presented by Dr. Dumont, reported that in the absence of Dr. Franzblau whose apologies were received, the motions he had submitted were deferred. No new proposals from Associate members had been received. The Associates noted that their proposal for a statement on "Child Safety in Airline Travel" had been forwarded to the Assembly for adoption. Drs. Fuchs and Mot were elected as the two representatives. The report of the Associate Members' meeting was received.

Open Session

During this session when delegates were invited to present matters of importance to the medical profession which needed to be brought to the attention of the WMA, NMAs made the following points:

The Hong Kong Medical Association expressed concern about the trend for governments to encroach on self-regulation by the medical profession. This they considered presents a serious threat to professional autonomy. These concerns were shared by the Australian Medical Association who offered to cooperate with WMA activity to defend medical professionalism.

The Bolivian Medical Association reported concerns about the by-passing of standard accrediting processes as a consequence of an agreement between the Bolivian and Cuban governments. This was supported by the Spanish and Uruguayan Medical Associations. The American Medical Association announced its intention to submit an emergency resolution on this topic to the Council meeting immediately following the General Assembly (*see page 99*).

The New Zealand Medical Association, in relation to the harvesting of organs and transplantation in China, expressed concern that the core issue, namely that informed consent cannot be obtained from condemned prisoners, was being lost in the WMA's diplomatic approach to the problem. It felt that the Chinese Medical Association should publicise the position taken that condemned prisoners are in no position to give informed consent, and provide evidence of its efforts to educate its members of this fact. The Chair of Council informed the Assembly that a WMA delegation will meet with members of the Chinese Medical Association to discuss many subjects, with the hope that the outcome of the meeting would be a documented mutual agreement or memorandum, which would be presented to Council at its next session.

The Phillipine Medical Association informed the General Assembly that the present health care budget in their country was less than 1% of GDP. This underinvest-





ment was compromising patient care. It has resulted in massive unemployment of health professionals, causing some physicians to leave the country to work as nurses elsewhere.

The Canadian Medical Association expressed support for the establishment of an annual "World Doctors' Day" an idea raised in the WMA President's speech.

The Secretary General referred to the fact that the American Medical Association (AMA) had provided important assistance to the WMA for many years through offering the services of various staff members to serve as the WMA Legal Advisor. While they would continue to provide corporate legal services to the WMA, especially on issues arising from WMA's corporate status as a US corporation, they would no longer provide a legal adviser during WMA meetings. The Secretary General in thanking the AMA for its invaluable contribution referred in particular to the work of the most recent WMA Legal Adviser, Sharon Ostrowski, who was no longer with the AMA. The General Assembly agreed a note of appreciation to Ms Ostrowski which the Secretary General will convey to her. He also thanked Ms Leah Wapner of the Israel Medical Association for serving as the Legal adviser during this Assembly.

He also announced that that Dr. Alan Rowe who had served as Editor of the World Medical Journal had retired and that a search for his replacement was almost completed.

It was noted that Dr. Rowe could not attend the meeting for health reasons. The General Assembly thanked Dr. Rowe for his engagement and dedication to the WMA and his excellent work in developing the WMJ. The General Assembly agreed a note of warm appreciation to Dr. Rowe which the Secretary General agreed to convey to him.

Informing the General Assembly that Dr. John Williams, WMA Ethics Adviser would end his tenure as a staff member at Ferney-Voltaire in December, although he would continue to advise the WMA on ethical issues. Paying tribute to Dr. William's, he said that Dr. William's excellent work had

helped WMA to clarify its approach to policy development, strengthening WMA policy. The Secretary General expressed his hope that continuing to work together would assist in eventually growing the Ethics Unit into a WMA Ethics Institute. The Assembly joined in a Standing ovation to Dr. Williams for his tireless efforts and outstanding contributions.

## 175th WMA Council Meeting Pilansberg, South Africa 2006

During the meeting of the 175th Council in Pilansberg, October 2006, the following two Council resolutions were adopted:

### Council Resolution In Support Of The Bolivian Medical Association

"There are credible reports that arrangements between the Cuban government and the Bolivian government to supply Cuban physicians to Bolivia are bypassing systems established to protect patients that have been set up to verify physicians' credentials and competence.

The World Medical Association is significantly concerned that patients are put at risk by unregulated medical practices, including the provision of drugs and medical supplies that are improperly labelled and of uncertain origin.

There already exists a duly constituted and legally authorized Bolivian Medical Association, which is charged with the registration of physicians and which is required to be consulted by the Bolivian Ministry of Health.

Therefore, the WMA:

1) Condemns any collusion of two countries in policies and practices that disrupt the accepted standards of medical credentialing and medical care;

Closing the 2006 WMA General Assembly the Chair of Council thanked the South African Medical Association for its generous hospitality. He also recognised the work of the Secretary General, the staff and the interpreters.

2) Calls upon the Bolivian government to work with the Bolivian Medical Association on all matters related to physician certification and the practice of medicine and to respect the role and rights of the Bolivian Medical Association;

3) Urges, as a matter of utmost concern, that the Bolivian government respect the WMA International Code of Medical Ethics that guides the medical practice of physicians all over the world."

### Council Resolution On Legislation Banning Smoking In Public Places

"Recognizing the abundant evidence linking adverse health outcomes and exposure to second-hand smoke; and

Nothing that despite this new evidence, many countries still allow smoking in public places

The World Medical Association:

Congratulates the French government and French physicians on the introduction of legislation that would ban smoking in public areas; and

Urges other National Medical Associations to advocate for similar legislative changes in their own countries if such legislation does not exist."



## WMA New Statements

# WMA Statement on avian and pandemic influenza

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

1. This statement provides guidance to National Medical Associations and physicians on how they should be involved in their respective country's pandemic planning process. It also encourages governments to involve their National Medical Associations when planning for pandemic influenza. Finally, it provides broadly stated recommendations about activities that physicians should consider in preparing themselves for pandemic influenza.

## Avian Influenza versus Pandemic Influenza

2. Avian influenza (bird flu) is a contagious common viral infection of birds and, less commonly, pigs. Two forms have been identified: less pathogenic avian influenza (LPAI) and highly pathogenic avian influenza (HPAI), which is extremely contagious and has nearly a 100% mortality rate in birds. Avian influenza viruses differ from human influenza viruses. While avian influenza viruses do not normally infect humans, since 1997 several cases of human infection have been documented.

3. The current H5N1 HPAI virus is a subtype of influenza type A viruses and was first isolated from South African terns in 1961. The current outbreak started in late 2003 and early 2004 in eight countries in Asia. While originally reported as controlled, since June 2004 new outbreaks of H5N1 have reappeared. Migratory and smuggled birds are likely to be responsible for the spread of H5N1. The infected birds shed large quantities of virus in their faeces, and exposure to infected droppings or to environments contaminated by the virus

is common. It is anticipated that H5N1 will continue to spread along the migratory pathways of wild birds. Most human infections have occurred in rural areas where freely-roaming small poultry flocks are kept.

4. HPAI is controlled by rapidly destroying all infected and/or exposed birds, by proper disposal of the carcasses, and by quarantining and rigorous disinfection of farms. In order to contain an outbreak, aggressive measures are needed immediately after the outbreak is detected.

5. Human pandemic influenza occurs three to four times a century and can take place in any season, not just winter. Pandemic influenza results from the emergence of a new human influenza strain to which no human immunity exists. This new human pandemic strain can arise from either avian influenza strains or from influenza viruses infecting swine and potentially other mammalian species. It is usually associated with a higher severity of illness and, consequently, a higher risk of death. All age groups may be at risk, and experts predict an infection rate of 25-50% of the population, depending on the severity of the strain. Since the virus strain cannot be accurately predicted, a vaccine against pandemic flu may not be available until several months after the pandemic begins. A major factor in protecting populations will be the time from emergence of a new strain to the development and manufacture of vaccine. It is hypothesized that use of antivirals may control the progression of a pandemic following its emergence, so adequate supplies of anti-virals are important. At all phases of a pandemic outbreak, but especially during the period when vaccine is unavailable, infection control is critical.

6. Health officials are concerned that avian influenza, if given the right opportunities, could mutate to form a new strain of human influenza virus against which humans have no immunity or existing vaccine – a pandemic strain. It is apparent that H5N1 has the capacity to directly jump the species barrier and cause serious disease in humans but thus far, H5N1 has demonstrated very limited, if any, human transmission potential. A new pandemic virus could develop if a human became simultaneously infected with H5N1 and a human influenza virus, resulting in gene swapping. Also, the H5N1 virus could mutate on its own. With this new virus strain, direct human-to-human transmission could result, and if the virus remains highly pathogenic, a pandemic with high mortality rates could occur. This is believed to have happened in the worst pandemic of the 20th century, the "Spanish Flu" of 1918, that killed 50 million people worldwide.

7. Even though the H5N1 virus is not easily transmitted to humans, any H5N1 human infection provides an opportunity for co-existence with a human influenza virus. Consequently, the World Health Organization (WHO) and other health organizations recommend that any person coming in contact with infected poultry receive the current annual flu vaccine. Since it is not yet known whether residual immunity to the N1 component of the annual vaccine provides any immunity to H5N1, there is no way to accurately predict the severity of the next pandemic. It is important to recognize that while there is current concern surrounding H5N1, a pandemic influenza strain may not arise from H5N1 but may come from another HPAI strain. Regardless of this, the odds are great that another pandemic will occur.

## Principles of Pandemic Influenza Planning

### *The Role of Governments*

8. The WHO has responsibility for coordinating the international response to



an influenza pandemic. It has defined phases in the evolution of a pandemic that allow an escalating approach to preparedness planning and response leading up to a declaration of onset of a pandemic.

9. The development of a national pandemic plan, will, by necessity, be led by the national government, but physicians should be involved at all stages. While each nation will have unique situations to address, the following pandemic preparedness principles apply:

- a) Define key preparedness issues, needs, and goals.
  - i. The prioritization of one or two goals for the nation's pandemic planning is essential. Depending on these goals, the prioritization and use of vaccines and antivirals will vary. For example, a goal of reducing morbidity and mortality due to influenza will have very different planning criteria from a goal of preserving societal infrastructure.
  - ii. Defining the nation's needs in the event of a pandemic will require making some basic assumptions about the severity of the pandemic in the nation. Based upon that assumption, it will then be possible to make some predictions about the issues and needs facing the country. It will be useful to consult with other nations that have prepared pandemic plans to see what challenges they faced in identifying their needs and issues.
- b) In countries where there is a substantial presence of healthcare professionals in the private sector, involve those in the private sector who will be managing the pandemic on the ground, particularly physicians, in the decision-making process.
  - i. The administration of millions of doses of antivirals and vaccine to the management of surge capacity and hospital beds will all require specific participation of those most knowledgeable and involved in the process.

- c) Prepare risk communication and crisis communication strategies and messages in anticipation of public and media fear and anxiety.
- d) Provide guidance and timely information to regional health departments, health care organizations, and physicians. Utilize physicians as spokespeople to explain the medical and ethical issues to the public. Ensure that communications mechanisms and infrastructure continue to function efficiently.
  - i. As planning proceeds, timely and clear information not only of the plan, but also of the rationale behind decisions, needs to be made available to public health authorities and the medical establishment as well as to the public. Physician leaders in a community are well-respected and frequently can serve as excellent spokespersons to educate the public about the issues surrounding pandemic planning. Public feedback into important decisions that may have moral and ethical implications will help secure public acceptance of the plan. For example, holding a public engagement process to assess the public's opinion about rationing of vaccine during a pandemic can be useful.
  - ii. It is important that government representatives and physicians speak with one voice in order to avoid confusion and panic during a pandemic event.
- e) Identify the legal issues and authorities for pandemic responses, e.g. liability, quarantine, closing borders.
  - i. Authorities will need to make decisions that range in complexity from local decisions to close public areas, to national decisions regarding border closings and/or quarantine/isolation of exposed/infected citizens. The legal and ethical issues surrounding these decisions need to be in place prior to a pandemic.
- f) Determine the order of importance for use of scarce resources such as vaccines and antivirals, based on

pandemic response goals. Priority groups chosen for vaccine should be those that help maintain essential community services and those at highest risk.

- g) Do not put physicians in the position of being responsible for decisions regarding the rationing of vaccine, antivirals and other scarce resources during a pandemic. Those decisions must be made by the government.
- h) Outline coordination and implementation of a response by stages of the pandemic.
  - i. Depending on the size of a country, this response may be at a national level or at a regional level. Large countries may see the pandemic occur in waves in which case affected regions will need to have their own response ready to be implemented.
- i) Consider the surge capacity of hospitals, laboratories, and the public health infrastructure and improve them if necessary. Prepare for absences of key staff and the need to maintain health services for conditions other than influenza.
- j) Prepare for the psychosocial impact on health care workers in managing the waves of a pandemic.
- k) Consider whether the safety of those in facilities managing the pandemic must be ensured, such as police protection of the supply chain for vaccines and antivirals. Address what might be needed to control a pandemic in the absence of a vaccine.
- l) Assess whether there is sufficient funding available to adequately prepare for pandemic influenza.
  - i. Political will to fund public health preparedness is essential. Resources spent on pandemic planning should be framed in the context of general preparedness; pandemic preparedness and public health preparedness share many of the same issues.
- m) Identify key issues that remain to be resolved, which may include management of patients in the community, triage in hospitals, ventilation management, safe handling of bodies, and death investigations and reports.



*The Role of the National Medical Association (NMA)*

10. In any disaster situation or infectious disease outbreak, physicians and their professional organisations will be challenged to continue to provide needed care to the vulnerable and sick, as well as to aid in the emergency response called for in the specific situation. The following issues should be considered in this regard:
- a) NMAs should have their own organization-specific business contingency plan in place to ensure continued support of their members.
    - i. Many existing plans anticipate disruptions such as fires, earthquakes, and floods that are geographically restricted and have fairly well defined timeframes. However, pandemic influenza planning requires assumptions that the influenza will be widely dispersed geographically and will potentially last many months.
  - b) NMAs should clearly identify their responsibilities during a pandemic.
    - i. The NMA should actively seek participation in the nation's pandemic planning process. If this is achieved, the NMA's responsibilities will also be clearly defined both to its physicians as well as to the government.
  - c) For effective global pandemic influenza planning, NMAs should collaborate and network with NMAs from other countries.
    - i. Many NMAs have already been involved in their countries' pandemic planning process. Challenges and key roles for the NMA that have been identified should be shared.
  - d) NMAs should have an essential role in communicating vital information:
    - i. to the public. As the authoritative medical voice, an NMA engenders public trust and should use that trust to communicate accurate and timely information regarding pandemic planning and the current state of the pandemic to the public;

- ii. between authorities and physicians, and between physicians in affected areas and their colleagues elsewhere;
  - iii. Between health care professionals. NMAs should work with other health care provider organizations (e.g., nurses, hospital groups) to identify common issues and congruent policies and messages regarding pandemic preparedness and response.
- e) NMAs should offer training seminars and clinical support tools, such as online and e-published self-help training materials, for physicians and regional medical associations.
    - i. Such training/tools should consider how, in a worst-case pandemic scenario, physicians will manage respiratory crises without intensive or critical care facilities. Training should also be given in triage strategies and how infected patients should be counselled.
  - f) NMAs should consider what new programs and services they might offer during a pandemic, such as coordination or provision of mental health crisis support programs for affected members and their families, facilitation of health emergency response teams, emergency locum relief, and facilitation of equipment supply lines.
  - g) NMAs should be involved in and support the development and implementation of government plans while still considering their own professional code of ethics. They should monitor and assess the implementation of said plans to ensure that as pandemic outbreaks cycle through their natural history, health interests remain paramount.
  - h) NMAs should advocate for adequate government funding to prepare for pandemic influenza.
  - i) NMAs should anticipate the different practice environments that may evolve during pandemic conditions and be prepared to discuss liability and related issues with health authorities and advise members on such issues.

- j) NMAs should be prepared to advocate on behalf of members who, during a pandemic, will have rapidly emerging professional needs that must be met, and on behalf of patients and the public who will be affected by the unfolding events.

*The Role of the Physician*

11. Physicians will be the first point of contact and source for advice for many as a pandemic evolves. The following are broad issues that physicians should consider in the event of a pandemic:
- a) Be sufficiently educated about pandemic influenza and transmission risks.
    - i. Communication about the actual risks of pandemic influenza is important to impart a sense of urgency without creating undue public alarm. Consider active physician participation in the media response to a pandemic.
  - b) Be vigilant for the possibility of severe or emerging respiratory diseases, especially in patients who have recently travelled internationally.
    - i. As with any emerging infection, the astute physician is one of the important surveillance tools for detecting and managing an outbreak.
  - c) Plan for how to manage high-risk patients in the office/clinic setting and communicate the plan to clinic staff.
    - i. Isolation and infection control plans must be available and staff should be well-versed in them. Be aware of what regional public health authorities are requesting be done with potential patients and their exposed contacts.
  - d) Plan how to concurrently manage patients with chronic illnesses who require routine medical management.
  - e) Plan accordingly for possible interruptions of essential services like sanitation, water, power, and disruptions to the food supply. Plan for the possibility of staff shortages because





of personal illness and/or the care of next-of-kin who are ill.

- i. It is vital to have contingency plans in place to deal with possible societal disruption. Recognize that the usual sources of these essential services may not be functioning so that identifying alternative sources for these essentials may be necessary.
- f) Prepare educational materials for patients and staff, including recommendations for proper infection control.
  - i. An educated patient/public that recognizes the necessity for stringent measures such as quarantine and isolation will make a physician's job easier should s/he have to utilize such procedures when a pandemic occurs.
- g) Remain involved in local pandemic planning efforts and understand how the plan will affect the physician. Participate in local simulation exercises.
  - i. Since physicians will be on the frontlines of monitoring, reporting, and eventually managing pandemic influenza patients, they must be closely involved in the planning process. They must continuously provide feedback as to what is logistically possible regarding physicians' efforts on the ground when a pandemic arrives.
- h) Physicians have an ethical responsibility to provide services to the injured or ill. They should have resources in place in the event they and/or their own families become infected.
  - i. A physician will have a strong public health duty in the time of a pandemic and his/her services will be critical at a time when surge capacity will be stressed. Physicians should make arrangements for the care of their families and dependents in the event of a pandemic.
  - ii. Physicians should take all measures necessary to protect their own health and the health of their staff.

iii. Physicians can also consult the WMA Statement on Medical Ethics in the Event of Disasters for additional guidance.

- i) Develop a clinic plan to decrease potential for contact including isolation areas for infected patients, use of close-fitting surgical masks, designating separate blocks of time for non-influenza-related patient care, and postponing non-essential medical visits.
- j) Review staff infection control procedures and train staff in the use of personal protective equipment. Provide signage in the office instructing patients on respiratory hygiene practices; provide tissues, receptacles for their disposal, and hand hygiene materials in waiting areas and examination rooms.
- k) Get vaccinated against annual influenza each year and urge all staff to be vaccinated.
  - i. Annual influenza readiness goes a long way for pandemic preparedness. Additionally, it is possible that components in the annual vaccine (e.g., N1) may provide some immunity against H5N1.
- l) Work to ensure that the office/clinic has access to adequate supplies of antibiotic and antiviral medications as well as commonly prescribed drugs such as insulin or warfarin, in case the pharmaceutical supply line is disrupted.

## Recommendations

12. That the WMA increase its collaboration with the WHO on pandemic planning and commit itself to becoming an important participant in the decision-making process.
13. That the WMA communicate to the WHO its capabilities and the capabilities of its NMA members to provide a credible voice that can efficiently reach many practising physicians.
14. That the WMA acknowledge that although pandemic planning is a country-specific task, it can provide general principles for guidance. Additionally, the WMA can provide basic advice that can be given by its member NMAs to practising physicians.
15. That the WMA establish an operational capacity to develop and maintain emergency communication channels between the WMA and NMAs during a pandemic.
16. That the WMA provide timely evidence-based control measures to countries with no or limited or no up-dated information about pandemics.
17. That NMAs be actively involved in the national pandemic planning process.
18. That physicians participate in local pandemic planning efforts and be involved in communicating vital information to the public.

## WMA Resolution on tuberculosis

**Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006**

### Preamble

1. According to the World Health Organization, tuberculosis is a problem affecting over 9 million people every

year and ranks among the leading infectious diseases with an annual incidence rate of 1%. The Eastern European region is particularly affected.

2. In developing countries, the incidence of tuberculosis has risen dramatically due mainly to its prevalence in areas with a high rate of HIV/AIDS. The



increased movement of populations has also exacerbated the problem.

3. The multi-resistant forms of tuberculosis, a by-product of original bacilli resistant to the action of the main tuberculosis medicines, also present great difficulties in controlling the disease.
4. Radiological detection and sputum examination targeted at high-risk subjects continues to be an essential element of tuberculosis prevention.
5. Among migrants, the homeless, prisoners and other high risk groups, such a strategy is particularly efficient in preventing epidemics.
6. The reactivation of screening and follow-up programmes and the application on a large scale of rapid and strictly supervised daily treatment should help address the epidemic.
7. The vaccination policy for BCG (bacille Calmette-Guérin) should be targeted at children from their first vaccination.

## Resolutions

8. The World Medical Association, in consultation with the WHO and national and international health authorities and organisations, will continue to work for the improvement of tuberculosis treatment and surveillance and will also promote surveys of individual cases, the reactivation of screening and surveillance programs, and the large-scale application of daily care delivery and treatment supervision.
9. The WMA supports calls for adequate financial, material and human resources for tuberculosis and HIV/AIDS prevention, including adequately trained health care providers and adequate public health infrastructure, and will participate with health professionals in providing information on tuberculosis and its treatment.
10. The WMA encourages continuing professional development for healthcare professionals in the field of tuberculo-

sis. Specialized courses on multi-drug-resistant TB are particularly important.

11. The WMA calls on its National Member Associations to support the WHO in its

DOTS strategy and in other work to promote the more effective management of tuberculosis. ■

## WMA Resolution on medical assistance in air travel

### Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

1. Air travel is the preferred mode of long distance transportation for people across the world. The growing convenience and affordability of air travel has led to an increase in the number of air passengers, including older passengers and other individuals at increased risk for health emergencies. In addition, long-duration flights are common, increasing the risk of in-flight medical emergencies.
2. The environment in normal passenger planes is not conducive to the provision of quality medical care, especially in the case of medical emergencies. Noise and movement of the plane, a very confined space, the presence of other passengers who may be experiencing stress or fear as a result of the situation, the insufficiency or complete lack of diagnostic and therapeutic materials and other factors create extremely difficult conditions for diagnosis and treatment. Even the most experienced medical professional is likely to be challenged by these circumstances.
3. Most airlines require flight personnel to be trained in basic first aid. In addition, many provide some degree of training beyond this minimum level and may also carry certain emergency medicines and equipment on board. Some carriers even have the capacity to provide remote ECG reading and medical counselling services.

4. Even well-trained flight personnel are limited in their knowledge and experience and cannot offer the same assistance as a physician or other certified health professional. Currently, continuing medical education courses are available to physicians to train them specifically for in-flight emergencies.
5. Physicians are often concerned about providing assistance due to uncertainty regarding legal liability, especially on international flights or flights within the United States. While numerous airlines provide some kind of liability insurance for medical professionals and lay persons who will provide voluntary assistance during flight, this is not always the case and even where it does exist, the terms of the insurance cannot always be adequately explained and understood in a sudden medical crisis. The financial and professional consequences of litigation against physicians who offer assistance can be very costly.
6. Some important steps have been taken to protect the life and health of airline passengers, yet the situation is far from ideal and needs improvement. Many of the major problems could be mitigated by simple actions taken by both airlines and national legislatures, ideally in cooperation with one another and with the International Air Transport Association (IATA) to arrive at coordinated and consensus-based international policies and programs.
7. National Medical Associations have an important leadership role to play in pro-



moting measures to improve the availability and efficacy of in-flight medical care.

8. Therefore the World Medical Association calls on its members to encourage national airlines providing medium and long range passenger flights to take the following actions:

a) Equip their airplanes with a sufficient and standardised set of medical emergency materials and drugs that:

- are packaged in a standardised and easy to identify manner;
- are accompanied by information and instructions in English as well the main languages of the countries of departure and arrival; and
- include Automated External Defibrillators, which are considered essential equipment in non-professional settings.

b) Provide stand-by medical assistance that can be contacted by radio or telephone to help either the flight attendants or to support a volunteering health professional, if one is on board and available to assist.

c) Develop medical emergency plans to guide personnel in responding to the medical needs of passengers.

d) Provide sufficient medical and organisational instruction to flight personnel, beyond basic first aid training, to enable them to better attend to passenger needs and to assist medical professionals who volunteer their services during emergencies.

e) Provide insurance for medical professionals and assisting lay personnel to protect them from damages and liabilities (material and non-material) resulting from in-flight diagnosis and treatment.

9. The World Medical Association calls on its members to encourage their national aviation authorities to provide yearly summarised reports of in-flight medical incidents based on mandatory standardised incident reports for every medical incident requiring the administration of first aid or other medical assistance and/or causing a change of the flight.

10. The World Medical Association calls on its members to encourage their legislators to enact legislation to provide immunity from legal action to physicians who provide emergency assistance in in-flight medical incidents.

11. In the absence of legal immunity, the airline must accept all legal and financial consequences of providing assistance by a physician.

12. The World Medical Association calls on its members to:

a) educate physicians about the problems of in-flight medical emergencies;

b) inform physicians of training opportunities or provide or promote the development of training programs where they do not exist; and encour-

age physicians to discuss potential problems with patients at high risk for requiring in-flight medical attention prior to their flight.

13. The World Medical Association calls on IATA to further develop precise standards in the following areas and, where appropriate, work with governments to implement these standards as legal requirements:

a) medical equipment and drugs on board medium and long range flights;

b) packaging and information materials standards, including multilingual descriptions and instructions in appropriate languages;

c) medical emergency organisation procedures and training programs for medical personal. ■

## WMA Resolution on child safety in air travel

**Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006**

1. Whereas air travel is a common mode of transportation and is used by people of all ages every day;

2. Whereas high standards of safety for adult passengers in air travel have been achieved;

3. Whereas strict safety procedures are being followed in air travel that greatly increase the chance of survival during emergency situations for properly secured adults;

4. Whereas infants and children are not always guaranteed adequate and appropriate safety measures during emergency situations in aircraft;

5. Whereas restraint and safety systems for infants and children have been successfully tested to reduce the risk of suffering injuries during emergency situations in aircraft;

6. Whereas child restraint systems have been approved for usage in standard passenger aircrafts and successfully introduced by several airlines;

Therefore, the World Medical Association

7. Expresses grave concern regarding the fact that adequate safety systems for infants and children have not been generally implemented;

8. Calls on all airline companies to take immediate steps to introduce safe, thoroughly tested and standardized child restraint systems;

9. Calls on all airline companies to train their staff in the appropriate handling and usage of child restraint systems;

10. Calls for the establishment of a universal standard or specification for the testing and manufacturing of child restraint systems; and

11. Calls on national legislators and air transportation safety authorities to:



## From the Secretary General

- a) require for infants and children, as a matter of law, safe individual child restraint systems that are approved for use in standard passenger aircraft;
- b) ensure that airlines provide child restraint systems or welcome passengers using their own systems, if the equipment is qualified and approved for the specific aircraft;
- c) ban the usage of inappropriate “Loop Belts” frequently used to secure infants and children in passenger aircraft;
- d) provide appropriate information about infant and child safety on board of aircraft to all airline passengers. ■

## From the Secretary General

### Self-governmental Structures are endangered in many countries

Regardless whether your understanding of a just state is based on Magna Carta or on Montesquieu, sharing power is an essential element. The horizontal separation of power results in the classical split into a legislative, executive and juridical branch. But there is – less visibly and often less regulated – also a vertical separation of power.

We have associations and parties, groups and families, which all have their formal or informal power of regulation. In modern language this is called “subsidiarity” and it gives way to allocation of power by social or decisive factors. Issues are being dealt with on the level of competence, in the family in the group, in the profession.

This vertical power sharing is now being silently reduced in many countries of the world. With an amazing synchronicity, governments in the different parts of the world dismantle the self-governments of our profession. In Germany, Great Britain, New Zealand, in Romania or Hong Kong, all over the world and regardless of the political system, changes or attempts have been made or are underway to disrupt the democratic representation of our interest through our self-governments. Medical Councils which formerly were freely elected by the

profession, are watered down to lay bodies, or governments determine the members of institutions.

In this way the respect for democratic processes and the sharing of powers gets lost on a large scale. In history this is not a new political development, but the precedents are truly scaring. In the thirties the German Reichsregierung stopped any democratic decision making process within the physicians’ self-government and substituted the formerly professionally elected body by a government nominated “Reichs-Ärzteführer”. The communist governments in Europe dissolved, prohibited self-government and/or seized their properties after World War II. A democratic mandated, but yet extra-parliamentarian power – not to say “opposition” – was unwanted then and it seems to be becoming increasingly unpopular with governments around the world now.

These changes do not affect us alone: other partners in the health care systems are affected as well. All groups enjoying the right of self-regulation are being faced with the same problem. For some liberal professions, this may not be a first line item as they may find their self-regulation to be a more technical process. However for those

health professions enjoying some degree of freedom for self-regulation the same danger of dismantlement exists.

The argument for doing so is always the same: Self-governing regulatory bodies are not capable of doing the things necessary to regulate the profession and to protect the public.

And indeed, we often are desperate about our (in-)capabilities of self-regulation. We know where we failed and we sometimes feel helpless ourselves. We tend to narrow regulation, to install systems of recertification, validation and assessment, we review and sometimes punish. But even so, all this seems not to be enough.

As medicine gets more effective and efficient every day, the degree of complications and the concomitant dangers grow as well. While everybody accepts new treatments and new approaches to prevention as the natural course of events, the concomitant dangers need someone be blame for them.

Certainly complexity is no waiver of responsibility and difficulties are no excuse for a lack of professionalism. On the other hand blaming every risk and wrong development on individual health professionals is neither fair nor appropriate. To attribute individual or system failures to the self-government is only fair if it has violated its own responsibility. Self-government should not be charged with deficits in health care financing caused by legal regulations or a shortage of resources. Parliaments and governments are responsible for that. Self-governments should not be charged for their incapacity of dealing with criminal misbehavior of professionals. This is a job for the law-enforcement agencies

The inclusion of patients in medical self-government is one option for cooperation. However government manipulations water-down self-government by installing representatives who have neither the competence nor a mandate from those to be regulated, is neither democratic nor helpful. But indeed, the achievement of more democracy or competence may not be intended in the first place, the real aim may be just another way to silence a very active and critical part of society.





We tend to take democracy and freedom for granted, but they are not! Actually, hard as they were to obtain, we have no right to give them up. Democracy and freedom are not ours: they belong first to the generations to come. If we give them up, their chances

to get them back are extremely unlikely. Therefore it is our strict obligation and moral imperative to fight for our democratic rights and freedom.

Otmar Kloiber

## Obesity – A Growing Problem

*This WMA statement has already provoked the following comment from Sir Alexander Macara. (ed.)*

Do others share my cynicism about the value of worthy statements emanating from gatherings of the “good and great” held in some salubrious resort?

Even the most hardened sceptic would concede that there are occasions when a major health threat demands personal and collective action. The pandemic of obesity evokes a guilt reaction – it seems to have taken the medical world by surprise. We should be chastened to realise that in our preoccupation with rescuing patients from individual lethal diseases like cardiovascular disease, cancer and diabetes, we have neglected the root causes of such afflictions, of which obesity reigns supreme. Ironically, its domain extends to the developing world where under-nutrition, at the opposite end of the spectrum of malnutrition, remains prevalent.

Of course, there are genetic causes of obesity including the mercifully uncommon Alstrom and Prader-Willi syndromes, as well as the more common endocrine causes such as hypothyroidism, whose victims are obviously exempt from the approbrium attached to the typical obese individuals whose plight is no less self-inflicted than those in thrall to tobacco or alcohol.

What then, can or should physicians and other health professionals do about obesity? The World Medical Association’s Statement is terse and clear. How then is Europe – where over 50% of adults and nearly 25% of children are already overweight and obesity in adults accounts for up to 6% of direct health costs and 12% of indirect costs of disease(2) – responding to the challenge ?

Individual countries, with support from National Medical Associations (NMAs) are taking specific and commendable initiatives such as promoting healthy catering in schools and encouraging physical activity by prescribing exercise. Physicians are act-

### Medical Science and Professional Practice

## WMA Statement on the Physician’s role in Obesity

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

### Preamble

1. Obesity is one of the single most important health issues facing the world in the twenty-first century, affecting all countries and socio-economic groups and representing a serious drain on health care resources.
2. Obesity has complex origins linked to economic and social changes in society including the obesogenic environment within which much of the population lives.
3. Therefore the WMA urges physicians to use their roles as leaders to advocate for recognition by national health authorities that reduction in obesity should be a priority, with culturally appropriate policies involving physicians and other key stakeholders.

### The WMA recommends that physicians:

4. Lead the development of societal changes that emphasize environments which support healthy food choices and regular exercise or physical activity for all people;
5. Individually and through medical associations, express concern that excessive

television viewing and video game playing are impediments to physical activity among children and adolescents in many countries;

6. Encourage individuals to make healthy choices;
7. Recognise the role of personal decision making and the adverse influences exerted by current environments;
8. Recognise that collection and evaluation of data can contribute to evidence based management, and should be part of routine medical screening and evaluation throughout life;
9. Encourage the development of life skills that contribute to a healthy lifestyle in all persons and to better public knowledge of healthy diets, exercise and the dangers of smoking and excess alcohol consumption;
10. Contribute to the development of better assessment tools and databases to enable better targeted and evaluated interventions;
11. Ensure that obesity, its causes and management remain part of continuing professional development programmes for health care workers, including physicians;
12. Use pharmacotherapy and bariatric surgery consistent with evidence-based guidelines and an assessment of the risks and benefits associated with such therapies.



ing on points 6 to 12 of the WMA manifesto, but we also need to take political action on points 4 and 5. Reassuringly, opinion polls show that physicians are still the most trusted professionals in society and our collective activity in collating and presenting evidence underpins our advocacy of communal action and governmental responsibility.

The medical profession in Europe is intimately involved in initiatives by both the European Union (EU) Commission through DG Sanco and the European Region of the World Health Organisation (WHO). In December 2006, the EU adopted a "Green Paper" signalling its intention to promote healthy diets and physical activity, following advice from a network of experts from Member states which had been set up two years previously. Contemporaneously in March 2005, it set up a "Platform" on Diet, Physical Activity and Health, involving European medical and consumer associations including the Standing Committee of Doctors in the EU (the CPME) and the European Heart Network, the Food Industry, Non-governmental organisations (NGO's) such as the International Obesity Task Force (IOTF) and individual experts "united by a common determination to play their part in the fight against obesity" (3) To quote the spokesman for the World Federation of Advertisers, "the Platform has changed the terms in which the stakeholders – the NGO's and Industry among others – are talking" (4). Intergovernmental organisations are also involved, including the WHO and the European Food Safety Authority as observers. The Platform's chairman, Robert Madelin, who is the European Commission's Director General for Health and Consumer Protection, is on record as saying "We are giving industry the chance to show that it is committed to the fight. We propose to start by avoiding regulation". (5) A robust framework has been constructed for monitoring and evaluating efforts and outcomes. Commissioner Markos Kyprianou has identified projects on reformulation, portion sizes and consumer communication, especially to children, as key issues (6) and has declared his intention to legislate if voluntary measures fail. Given the reluctance of industry to

agree upon a clear system of labelling of the levels of salt in cereals or to refrain from advertising junk food to children, the author, representing the COME in the Platform fears that Kyprianou will be obliged to act.

The EU also jointly organised with the WHO's European Regional Office, a Ministerial Conference, held in Istanbul in November 2006, in which Health Ministers were joined by colleagues from other sectors including Education, Transport, Agriculture and Environment and Sport. As in the EU Platform, relevant NGOs participated and public-private partners were included (7). The outcome was a "European Charter on counteracting Obesity", endorsed enthusiastically by all 53 Member States. Preventive actions, including the promotion of breast feeding, a reduction in the levels of salt, sugar and fat in processed foods, and the design of environments which will facilitate physical activity, were agreed. Follow-up will involve a detailed "action plan" and triennial reviews of progress.

Is it realistic to expect meaningful evidence of success? A leading article in the British Medical Journal has identified sources of guidance which might deliver such evidence, but comments "the first people to seduce are Europe's finance ministers" (8). There speaks the voice of reality!

Alexander Macara

### Obesity

## **Obesity – a condition of excess body fat; not excess weight**

Most of your patients will be able to tell you their weight, albeit a little reluctantly! However, very few of these people will be making any clear distinction in their minds between 'weight' and 'fat'. This confusion has contributed to the plethora of diet plans which focus on different measures of success. Through this misconception, unhealthy patterns of eating have devel-

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oped, resulting in often long-term unhappiness as a consequence of unstable and seemingly uncontrollable weight fluctuations, not to mention health risks.

Obesity is a condition of excess body fat and successful weight reduction must involve a sustained decrease in fat and not just weight. Dr Susan Jebb, Head of



Nutrition and Health at MRC Human Nutrition Research in Cambridge, has conducted research into body composition and obesity for many years. “The difficulty is that it requires a reduction of 9,000 calories to remove 1kg of fat, whereas you can lose 1kg of water without any calorie deficit at all. Changes in body fat occur much more slowly than changes in weight”.

Unfortunately the popular and easy measurement of body mass index (BMI) only gives a measure of relative weight-for-height and does not make any specific measurement of body fat. The most accurate methods to measure fat (such as underwater weighing or scanning techniques) are difficult and expensive to use.

Simple, rapid and relatively cheap methods of examining body composition (e.g. using calipers to measure the thickness of subcutaneous fat, or the newer method of bioelectrical impedance analysis (BIA)) can give a better estimate of fatness than BMI alone. However, until recently these procedures have needed the input of a health professional, restricting the measure of body fat outside the clinical setting.

In recent years there has been a breakthrough in impedance technology, led by the electronic manufacturers Tanita. All BIA operates on the principle that body fat acts as an insulator, whereas lean tissue, with its salt and water content, is an effective conductor. Hence, the body impedance gives a measure of relative fatness. Traditional impedance measuring devices involve attaching four electrodes to the patient on the hand and foot on one side of the body and measuring the voltage drop across the body when a small battery driven electric current is applied. In contrast, the Tanita Body Fat monitor, resembles a set of bathroom scales. It calculates an individual's percentage of body fat by passing a safe, low level electrical current through the bare feet and gives an immediate digital display of the body fat percentage. This simple procedure allows patients to regularly monitor their own body composition at home.

The Tanita Body Fat Monitor can also be used by health professionals to identify patients with excess body fat and more importantly to monitor the impact of treat-

ment programmes to reduce health risks. Excess fat is associated with an increased risk of many conditions, notably CHD and diabetes. Sustained reductions in body fat lead to reductions in disease-related risk factors.

By placing the emphasis on the measurement of body fat, health professionals can

help to encourage the public away from ‘crash diets’ which promise rapid weight losses and towards permanent changes in their eating and exercise habits which will help them to achieve and maintain a healthy body composition. ■

## The Hajj and Influenza risk – The threat can no longer be ignored

In an editorial entitled “Hajj and the risk of influenza” (Gatrad et al., *BMJ* 303, 1182-3) attention is drawn to the major risk of a rampant spread of the influenza virus and a global pandemic “a potentially devastating prospect that has been inadequately prepared for”.

Recalling that the Hajj attracts more than 2 million pilgrims from almost every country on earth – “the largest annual gathering in the world” (1) (2) – to this deeply spiritual journey which follows months or years of preparation. Nevertheless, it is stated “that from a public health point of view such a gathering makes possible rampant spread of the influenza virus and a global epidemic”.

The authors, while noting that the Saudi authorities currently recommend vaccination against influenza for pilgrims with high risk chronic illnesses, quote data from a UK pilgrim survey indicating that many remained unimmunised (3). They comment that probably this picture is far worse

amongst pilgrims coming from the economically developing world. Further, recalling that following a previous epidemic meningococcal immunisation is already mandatory for all pilgrims, they suggest that mandatory influenza immunisation for all pilgrims should be considered. Calling on WHO, which is still developing its strategy to prevent an influenza pandemic, to work with the Saudi authorities, they state that a “coherent international response will be needed to ensure that resources and logistics are in place so that strategies can be implemented”.

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WHO

## Dr. Margaret Chan to be WHO's next Director-General

9 NOVEMBER 2006 | GENEVA – Dr. Margaret Chan of China will be the next Director-General of the World Health Organization (WHO).

In her acceptance speech, Dr. Chan said: “what matters most to me is people. And two specific groups of people in particular. I want us to be judged by the impact we have on the health of the people of Africa, and the health of women. ... Improvements in the health of the people of Africa and the health of women are key indicators of the performance of WHO.”

“All regions, all countries, all people are equally important. This is a health organization for the whole world. Our work must touch on the lives of everyone, everywhere“. “But we must focus our attention on the people in greatest need.“

Dr. Chan was nominated as Director-General on Wednesday by the WHO Executive Board and her appointment was confirmed by the World Health Assembly. The Director-General is WHO's chief technical and administrative officer. She was previously WHO Assistant Director-General for Communicable Diseases and Representative of the Director-General for Pandemic Influenza.

Dr. Chan obtained her Medical Degree from the University of Western Ontario in Canada and also has a degree in public health from the National University of Singapore. She joined the Hong Kong Department of Health in 1978, and was appointed as Director of Health in 1994. As Director, she launched new services focusing on prevention of disease and promotion of health. She also introduced new initiatives to improve communicable disease surveillance and response, enhance training for public health professionals, and to establish better local and international collaboration. She has effectively managed outbreaks of avian influenza and the world's first out-

break of severe acute respiratory syndrome (SARS).

Dr. Chan paid tribute to her predecessor. “We are all here because of the untimely death of Dr. LEE Jong-wook. We are also all here because of many millions of untimely deaths. I know Dr. Lee would have wanted me to make this point. He will always be remembered for his 3by5 initiative. That was all about preventing untimely deaths on the grandest scale possible.“

Dr. Chan told the Assembly that as Director-General she would focus on six key issues for WHO: health development, security, capacity, information and knowledge, partnership, and performance.

She emphasized the importance of global health security in her vision of the Organization's role: “Health security brings benefits at both the global and community levels. New diseases are global threats to health that also bring shocks to economies and societies. Defence against these threats enhances our collective security.“

Underlining the importance of strong systems to deliver health care to the people who need it, she said: “All the donated drugs in the world won't do any good without an infrastructure for their delivery. You cannot deliver health care if the staff you trained at home are working abroad.“

She especially praised the people who deliver health care. “The true heroes these days are the health workers with their healing, caring ethic. They are determined to save lives and relieve suffering, and they work with impressive dedication, often under difficult conditions. The world needs many, many more of them.“

Dr. Chan underlined the diverse approaches needed to strengthen health and health care in different parts of the world. “Many countries in Africa face the challenge of rebuilding social support systems. Others in central

Asia and Eastern Europe are undergoing transition from planned to market economies. They want WHO support. They want to make sure that equitable and accessible systems built on primary health care are not sacrificed in the process.“

She said she would strengthen WHO's commitment to gather, analyse and build recommendations based on evidence: “I plan to set up a global health observatory to collect, collate and disseminate data on priority health problems. I will integrate WHO's research activities to more strategically address a common health research agenda.“

There is a growing number of initiatives and players in the field of global health. Dr. Chan said she would work strategically with partners to deliver the best possible results for global health. “Today, collaboration to achieve public health goals is no longer simply an asset. It is a critical necessity. WHO needs to develop an approach to collaboration that emphasizes management of diversity and complexity.“

Turning her attention to the internal management of WHO, Dr. Chan said: “I will also accelerate human resource reform to build a work ethic within WHO that is based on competence, and pride in achieving results for health.“

She also addressed the challenges ahead of the Organization: “As we know, not all of the problems faced by WHO in its efforts to improve world health are subject to scientific scrutiny, or yield their secrets under a microscope. You know the ones I mean: lack of resources and too little political commitment. These are often the true ‘killers’.“

Ending her address, Dr. Chan repeated her pledge to work hard to improve the health of people around the world. “The work we do together saves lives and relieves suffering. I will work with you tirelessly to make this world a healthier place.“

Dr. Anders Nordström, appointed by the Executive Board as Acting Director-General of WHO in May, will continue in this role until a new Director-General takes office.



## Global polio eradication now hinges on four countries

### Polio-free countries seek to protect themselves

GENEVA, 12 OCTOBER 2006 — The world's success in eradicating polio now depends on four countries – Afghanistan, India, Nigeria, and Pakistan – according to the Advisory Committee on Polio Eradication (ACPE), the independent oversight body of the eradication effort.

With a targeted vaccine and faster ways of tracking the virus, most countries that recently suffered outbreaks are again polio-free. In parts of the four endemic countries, however, there is a persistent failure to vaccinate all children, and polio-free countries are considering new measures to help protect themselves from future outbreaks.

“With a more effective monovalent vaccine and accelerated lab processes for identifying poliovirus, these countries have the best tools we’ve ever had,” noted Dr Stephen Cochi, Chair of the ACPE and Senior Adviser to the Director of the Global Immunization Division at the US Centers for Disease Control and Prevention. “Eradicating polio is no longer a technical issue alone. Success is now more a question of the political will to ensure effective administration *at all levels* so that all children get vaccine.” As an illustration, the office of Afghan President Hamid Karzai has already taken direct oversight of polio vaccinations, following the sharp increase in cases in the Southern Region of Afghanistan.

Given that all children paralysed by polio in the world this year were infected by virus originating in one of the four endemic countries, polio-free countries are now taking new measures to protect themselves. The Ministry of Health of Saudi Arabia, for example, will be enforcing stringent polio immunization requirements for the upcoming pilgrimage to Mecca.

“Polio eradication hinges on vaccine supply, community acceptance, funding and

political will. The first three are in place. The last will make the difference,” said Dr Robert Scott, Chair of Rotary International’s PolioPlus Committee, speaking on behalf of the spearheading partners of the Global Polio Eradication Initiative. Rotary is the top private-sector contributor and volunteer arm of the Initiative, having contributed US\$600 million and countless volunteer hours in the field since 1985.

The ACPE advised the four polio-endemic countries to set realistic target dates for stopping transmission, noting that improvements in reaching all children in these areas have been only incremental, and that these

### Stop TB

## WHO Global Task Force outlines measures to combat XDR-TB worldwide

### Countries, WHO and partners to mobilize response teams to confront extensively drug-resistant tuberculosis

GENEVA, 17 OCTOBER 2006 - Health experts have confirmed that the emergence of extensively drug-resistant tuberculosis (XDR-TB) poses a serious threat to public health, particularly when associated with HIV. At its first meeting, the World Health Organization (WHO) Global Task Force on XDR-TB also outlined a series of measures that countries must put in place to effectively combat XDR-TB. In addition, the Task Force will help mobilize teams that can respond to requests for technical assistance

countries will take more than 12 months to end polio.

**Circulation of wild poliovirus:** Since 1988, global polio eradication efforts reduced the number of polio cases from 350,000 annually to 1403 in 2006 (as at 10 October 2006), of which 1300 are in the four endemic countries (where poliovirus transmission has never been stopped): Nigeria, India, Afghanistan and Pakistan. This is the lowest number of endemic countries in history.

**Funding:** In addition to strengthened political ownership in the remaining endemic countries, key to success is the ongoing commitment of the international donor community. For 2006, a further US\$50 million is urgently needed, to ensure planned immunization activities through to the rest of the year can proceed. Additional funding of US\$390 million is needed for 2007-2008, of which US\$100 million is needed for activities in the first half of 2007.

from countries, and be deployed at short notice to XDR-TB risk areas.

These were among a series of outcomes issued by the Global Task Force meeting held on 9 and 10 October in Geneva. The meeting was urgently convened to review the latest available evidence on the impact of highly resistant tuberculosis, including when associated with HIV.

Addressing the Task Force, Acting Director-General of WHO, Dr Anders Nordström, said the Organization was “absolutely committed” to supporting country efforts to fight TB in all forms.



“It is critical that urgent steps are taken to address XDR-TB, especially in areas of high HIV prevalence,” said Dr Nordström. “At the same time we should not lose sight of the need to make long-standing improvements to strengthen TB control, and build the necessary capacity in health services to respond to drug-resistant tuberculosis.”

Along with a call for countries to strengthen TB control – the key to preventing TB drug resistance – consensus was reached on an

XDR-TB case definition (see below). In high HIV prevalence settings, there was also agreement that control of XDR-TB will not be possible without close coordination of TB and HIV programmes and interventions.

The Task Force also made specific recommendations on drug-resistant TB surveillance methods and laboratory capacity measures; implementing infection control measures to protect patients, health care workers and visitors (particularly those who are

HIV infected); access to second-line anti-TB and antiretroviral drugs for countries; communication and information-sharing strategies related to XDR-TB prevention, control, and treatment including co-management with antiretroviral therapy; and research and development of new TB drugs, vaccines and diagnostic tests.

WHO and Task Force members will now coordinate with national and international partners involved in TB as well as HIV pre-

## WHO Global Task Force on XDR-TB, October 2006

### Outcomes and Recommendations

#### **Preventing XDR-TB through strengthening TB and HIV control**

To prevent the appearance and spread of drug-resistant TB, the Task Force underlined as a priority the need for the immediate strengthening of TB control in countries, as detailed in the new Stop TB Strategy and Global Plan to Stop TB 2006-2015. This should be done in coordination with scaling up universal access to HIV treatment and care. WHO and Task Force members will help mobilize teams of experts that can be deployed in the field, at the request of countries, to assist in strengthening TB control, and where relevant HIV control.

There were also specific recommendations on:

#### **Management of XDR-TB suspects in high and low HIV prevalence settings:**

Accelerate access to rapid tests for rifampicin resistance, to improve case detection of all patients suspected of multidrug-resistant TB (MDR-TB) so that they can be given treatment that is as effective as possible. Rapid diagnosis is potentially life saving to those who are HIV positive.

#### **Programme management of XDR-TB and treatment design in HIV negative and positive people:**

- Adhere to WHO Guidelines for the Programmatic Management of Drug Resistant TB;
- Improve MDR-TB management conditions;
- Enable access to all MDR-TB second-line drugs, under proper conditions;
- Ensure all patients with HIV are adequately treated for TB and started on appropriate antiretroviral therapy.

#### **Laboratory XDR-TB definition:**

XDR-TB is defined as resistance to at least rifampicin and isoniazid from among the first line anti-TB drugs (which is the definition of MDR-TB) in addition to resistance to any fluoroquinolone, and to at least one of three injectable second-line anti-TB drugs used in TB treatment (capreomycin, kanamycin, and amikacin).

#### **Infection control and protection of health care workers with emphasis on high HIV prevalence settings:**

Accelerate wide implementation of recommended infection control measures in health care settings and other risk areas in order to reduce the ongoing transmission of drug-resistant TB, especially among those who are HIV positive.

#### **Immediate XDR-TB surveillance activities and needs:**

Strengthen laboratory capacity to diagnose, manage and survey drug resistance; Commence rapid surveys of drug-resistant TB so that the extent and size of the XDR-TB epidemic, and its association with HIV, can be determined.

#### **Advocacy, communication and social mobilization:**

- Initiate information-sharing strategies that promote effective prevention, treatment, control of XDR-TB at global and national levels and also in high HIV prevalence settings;
- Strengthen communication with affected communities and individuals;
- Develop a fully-budgeted plan with the resources and funding required to address XDR-TB, including through necessary improvements in overall TB control and HIV care in the immediate and medium term;
- Initiate resource mobilization.

Planning is also underway for a focused meeting in the near future on research and development issues relating to TB, including promoting the development of the new diagnostics, drugs and vaccines that are urgently needed. A meeting on antiretroviral therapy and XDR-TB is also planned.



vention, care and treatment to take the recommendations forward. They will also develop a plan that identifies the resources required to implement these outcomes and the overall emergency response.

Drug-resistant TB has emerged as an increasing threat to TB control but a WHO / US Centers for Disease Control and Prevention study, published earlier this year, documented for the first time cases of tuberculosis that were extensively resistant to current drug treatments. XDR-TB was identified in all regions of the world, though it is still thought to be relatively uncommon.

Last month, concerns about the emergence of XDR-TB were heightened by reports and

studies from KwaZulu-Natal province in South Africa of high mortality rates in HIV-positive people with XDR-TB. This led to warnings that XDR-TB could seriously threaten the considerable progress being made in countries on TB control and the scaling up of universal access to HIV treatment and prevention.

Among the first countries to request assistance to strengthen its national emergency XDR-TB response, and the extra challenges posed by HIV, is South Africa. The South African Department of Health is to host an XDR-TB meeting on 17 and 18 October, with participation from WHO and representatives from other affected southern African countries.

## **WMA Asian-Pacific Regional Conference: Day 1**

The first day of the Asian-Pacific Regional Conference, held at Chinzan-so in Tokyo, began with an Open Session attended by Dr. Yank Coble, Chair of the Caring Physicians of the World Initiative; Dr. Yoshihito Karasawa, President of the JMA; Dr. Kgosi Letlape, President of the WMA; and Dr. Yoram Blachar, WMA Chair of Council. This session included addresses by Dr. Shigeru Omi, Regional Director of the WHO Regional Office for the Western Pacific, who spoke on "Current Situation of Pandemic Influenza", and by Dr. Jorge Puente, Vice President of Medical and Regulatory Affairs for Japan and Asia at Pfizer, who spoke on "The State of the Profession in the World Today". Dr. Ross Boswell, Vice-Chair of Council of CMAAO and Dr. Otmar Kloiber, WMA Secretary General, both then reported on the state of the medical profession in their respective countries.

Dr. Omi, who has a tremendous track record in the eradication of polio and containment of SARS, explained in his presentation the current situation concerning highly-pathogenic avian influenza, the threat of a pandemic, and measures to prevent the occurrence of such a pandemic. He explained that migratory birds were not the only carriers of the infection, as was commonly believed, but that factors such as the export of domestic poultry were also extremely critical.

Giving the example of Vietnam and Thailand, which were successful in containing the spread of highly-pathogenic influenza, Dr. Omi emphasized the importance of measures such as the identification of early symptoms of infectious disease and the swift reporting of accurate information to the WHO; precise evaluation of the situation and decision-making; and a systematic response that includes monetary compensation for the disposal of domestic poultry. He particularly emphasized the problem of losing opportunities to contain infectious disease due to failure to promptly release and share information.

Following their keynote speeches, a welcome reception also attended by Mr. Jiro

## ***Regional and NMA News***

### **Asian Pacific Regional Conference**

#### ***How to cope with Natural Disasters and Infectious Diseases – Caring Physicians of the World: 1<sup>st</sup> WMA Asian-Pacific Regional Conference***

**Dr. Masami Ishii**

Secretary General, CMAAO Executive Board Member, Japan Medical Association

#### **Special Public Lecture**

The 1<sup>st</sup> WMA Asian-Pacific Regional Conference, held jointly by the World Medical Association (WMA) and the Japan Medical Association (JMA), opened auspiciously on the warm and sunny afternoon of September 10, 2006 in Tokyo. The conference brought together participants from 18 countries to discuss the themes of natural disasters such as earthquakes and tsunamis, which occur virtually yearly in the Asian region; infectious diseases, which pose an increasing risk of a pandemic beginning in Asia and spreading throughout the world; and the state of the medical profession and medical associations.

Preceding the conference, in the early afternoon of September 10, a public lecture held by the JMA and supported by the WMA was held on the same themes as the conference. Two lectures were presented: "Crisis Management for Infectious Diseases", by Dr. Takeshi Kasai, WHO Regional Adviser in Communicable Disease Surveillance and Response for the Western Pacific; and "Disaster Preparedness and Response", by Dr. Yasuhiro Yamamoto, Professor, Department of Emergency and Critical Care Medicine, Nippon Medical School. Held at the JMA Auditorium as a satellite event attended by nearly 700 people. President of the WMA, Dr. Kgosi Letlape and Chair of Council Dr. Yoram Blachar addressed the lecture.



Kawasaki, Minister of Health, Labour, and Welfare, as well as several parliament members was held, allowing participants to deepen their friendships.

### Asian-Pacific Regional Conference: Day 2

September 11 dawned with thunder showers but cleared to a sunny day. The program for Day 2 of the conference covered three themes.

Session 1: Disaster Preparedness and Response – Earthquake and Tsunami;

Session 2: Disaster Preparedness and Response – Infectious Disease; and

Session 3: The State of the Profession.

Session 1 began with an explanation by Dr. Yoshinobu Tsuji, Associate Professor at the Earthquake Research Institute at the University of Tokyo, that the Asian-Pacific region, collectively known as the Pacific Rim, is prone to earthquake and tsunami disasters due to plate tectonics. Reviewing the history of past earthquakes and tsunami up until the present, he also briefly described the tsunami warning systems and evacuation measures that have been used to date.

This presentation was followed by keynote speeches by Dr. Yasuhiro Yamamoto and Dr. Takeshi Kasai, who had both also spoken at the public lecture held the previous day. Dr. Yamamoto presented results of analysis of the case of the Great Hanshin-Awaji Earthquake in Japan in 1995 that showed that in the 72 hours following the earthquake, over 80% of rescues were performed or assisted by family members or neighbors of trapped people or by trapped people themselves; less than 20% of rescues were performed by professional rescue workers in the line of duty.

Dr. Yamamoto also reported that with the passage of time, the need for medical care for chronic disease as well as psychological care increases. This highlights the need for pre-hospital care and synchronization with rescue measures in other countries that pro-

mote training workshops on AED and other resuscitation methods. Japan and the other developed countries are all expected to have increasingly aging populations. With the importance of elderly people themselves taking measures to prevent falls and keep with them at all times a medical history and list of their medications, as well as bystanders to an incident having learned how to respond to an emergency, not only cross-border responses to major disasters but also the further promotion of safety education and training in the future is vital.

Dr. Kasai spoke about measures against a new, highly infectious influenza strain, saying that there were three levels of response: measures against avian influenza; early containment of a new human influenza virus; and measures against a pandemic. Unlike in natural disasters, support from neighboring countries or regions cannot be anticipated in the case of a pandemic, and so preparedness is the cornerstone of risk control. It is vital that each region is as prepared as possible for a pandemic and that information sharing is prompt.

Dr. Dongchun Shin of the Korean Medical Association reported on the prompt rescue activities of that medical association in cooperation with Indonesian Medical Association in the aftermath of the Sumatra Earthquake, and it was proposed that networks such as the WMA and CMAAO could play a useful role in international disaster relief activities.

In Session 3, on the state of the medical profession and medical associations, there was a free discussion about the future direction of medical association activities based on reports of the current situation for each national medical association and reports presented in this session.

In conclusion, Dr. Kazuo Iwasa, Vice-President of JMA and Vice-Chair of Council of WMA, spoke about the significance of this conference and of medical activities that overcome national boundaries and differences of race and religion under the enduring values laid down in the WMA Declaration of Geneva and the Oath of Hippocrates, the fundamental principles of all medical practitioners.

### Conclusion

In enabling the sharing and discussion of information about medical response to the extremely relevant themes of natural disasters, which are a very real risk in this region, and outbreaks of infectious disease, international regional meetings such as this are deeply significant. Health care essentially should not be limited to healthcare services provided by health insurance based on assessments and agreements, but should comprehensively involve all aspects of the health and lives of members of the public as well as seek and find directions for problems that cross national boundaries.

Looking at the unexpectedly great response to the public lecture held in conjunction with this conference, it is clear that members of the public feel tremendous uncertainty about responses to major natural disasters and have even greater needs. Moreover, changing our perspective, the two themes of this conference – natural disasters and infectious diseases – both occur across national and social boundaries and require a collective response by human and organizational networks when they occur.

For this reason also, it is highly significant that the results of this regional conference will be announced widely through the Asian-Pacific areas. We should note that this kind of conference is strongly needed by the NMAs which lack of national resources to cope with the natural disasters and infectious diseases. Information sharing will be more increasingly required among the regional NMAs.



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