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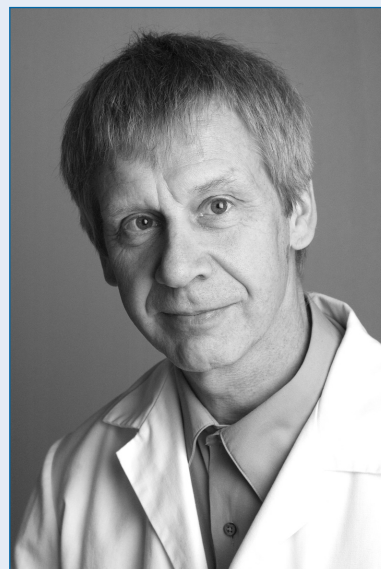
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WMA-PRESIDENT 2007-2008



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## Editorial

# The challenge to medical care

The Tobacco Control Resource Centre, a resource supported by the British Medical Association, the European Commission and the European Regional Office of the World Health Organisation, published in 2000 a report in the context of Tobacco Control Programme under the title "Tobacco – Medicine's Big Challenge." Now at the end of 2007, while Tobacco remains a problem and the great scourges of disease still challenge medicine, a huge challenge (possibly "**The Challenge**" for the medical profession) faces the health professionals providing medical care, namely the problem of the supply and distribution of health care workers. The 2006 World Health Report of WHO\* highlighted the problem, notably the huge discrepancies in the distribution of Physicians, Dentists, Nurses, Midwives and other Health care workers, not only within countries but more significantly between countries. Scientific advances have made great contributions in our knowledge of the nature and causes of many diseases, accompanied by discovery and development of many new drugs to cure or ameliorate the effects of disease. All of these call for increasing skills and increased demands on all sectors of the medical workforce in developed countries. It places increased demands on the sparse, sometimes almost non-existent supply of health care workers in underdeveloped countries, where healthcare was already minimal, obstructing any implementation of advances in healthcare available elsewhere.

Hitherto the limited attempts to address manpower problems in the healthcare workforce had, unsurprisingly, concentrated on workforce problems within national health care systems, substantially disregarding the huge disparities between countries, regions and even continents. At the same time concern has been expressed by both the profession and by some other authorities about the recruiting of physicians in developed countries from developing countries who are already under-doctored, Codes of practice and statements of policy to change this have been issued by the World Medical Association\*\* and by some governments and authorities.

While a great tribute should be paid to those organisations and governments who, in one way or another have, over many years, encouraged the provision of doctors, nurses and other medical assistance to those countries in need, and to those health professionals who undertook to meet the needs, it was effectively only with the arrival of HIV/AIDS and, more recently the risk of pandemic disease, coupled with increasing political awareness of the need to deal with poverty, inequity and human rights, that the need to address the problems associated with the global health workforce have been forced to the forefront of discussion.

In previous editorials in the World Medical Journal, *WMJ 52 (1) and (2)* we have drawn attention to emerging trends not only in the changing or expanding role of individual health professions, but also to problems of training, mobility and availability of health professionals. Further problems complicating the whole issue relate to the changes in role and functions of health professionals, reflecting not only the increasing aspirations of the individual health professional, but also the increasing specialisation within individual health professions.

In the first part of 2008 at least two conferences will address some of the issues involved. The first is a World Health Organisation Global Conference to be held in Addis Ababa Ethiopia in January 2008, when the conference will address the topic of Task Shifting (*see p. 90*). "Task Shifting" is defined in a number of WHO documents as "the name given to a

\* "Working together for health" The World Health Report 2006 WHO, Geneva, ISBN 92 4 156317 6

\*\* WMA Statement on Ethical Guidelines for the Recruitment of Physicians, Helsinki 2003



process of delegation whereby tasks are moved, where appropriate, to less specialised health workers”.

The second conference, organised by the World Health Professions Alliance in the week preceding the WHO Assembly, is the First World Conference the Role and Regulation of Health Professions which will be held in Geneva (*see p. 90*). Both Conferences are of huge importance in relation to the provision of health care across the globe in both developed and developing countries.

The conferences have great relevance to the future role and functions of the Medical Profession. Whereas previously, physicians, when recognised for full registration as a medical practitioner, held the sole licence to carry out certain specific acts such as the right to prescribe and to engage in the practice of medicine, in an increasingly sophisticated and technical world it is clear that some of these reserved functions can be carried out by other health professionals under regulation, after appropriate technical specialist training. This has substantial implications for changes in the protected role that physicians have previously held in certain areas, while possibly calling for new roles in other areas, essentially calling for a reassessment of the role and functions of physicians in society. In some countries such changes have already occurred in areas such as the extension of limited prescribing rights to other health professionals such as nurses, and extending the acts carried out by other health professionals. By enhancing the role of some health professionals, such changes increase the provision of certain health services to a much wider population in both developed and developing countries.

Nevertheless, as indicated earlier, if there is a basic shortage of health care workers in all the health professions, the world is faced with a major problem. This shortage does not only apply to underdeveloped countries. In more developed countries as scientific and technical knowledge and development have increased there is also increased demand for the implementation of these discoveries and a consequent demand for more health workers. Thus the USA estimates that by 2020 they will require at least

200,000 physicians to meet their needs, more than the current need of the rest of the world!

The WMA Secretary General in his column refers to another problem associated with the changes in role and functions of physicians, namely the need for clarity in identifying the roles of health professionals and the titles used to identify them to the public. The differences in titles used for physicians across the world are illustrated in an article by Dr. Doren, to which Dr. Kloiber refers. (*see p. 97*).

The Health Workforce problem which the 2006 World Health Report highlighted is now being actively pursued and it is essential that, as indicated in the editorials referred to above, both individual physicians and their representative organisations actively address these issues. The distribution of certain diseases has been radically changed as a result of greatly increased international travel, with the potential for wider dissemination of communicable diseases including newly emerging diseases, and the risk of major pandemics need to be balanced with attention to the global problems of inequitable distribution of physicians, with such huge disproportions in

their distribution. With the calls for “task shifting” as part of the solution, this may also call for radical changes in the career cycle of physicians, nurses, pharmacists, including professional practice in foreign countries as a normal part of the professional career structure. All of these considerations require urgent attention at a time when the very nature of the regulation of the health professions is also under review, including the question of the degree to which the professions themselves should play a role in regulation, a matter of major concern to those professions whose proud role has for millennia been that of “Caring Professions”. It is to this end that the medical profession defends its position in self-regulation of standards of care and its ethical code of conduct in the interests of both patients and profession. All of this must be urgently considered both in discussions at individual, at national level and in the global conferences referred to above. There is no time to be lost. Just as the profession has taken a stand on Tobacco so it must face up to this Big Challenge to the profession itself. Both individual physicians and their leaders must act. Time waits for no man!

Alan Rowe

## Make medicines child size

On 6. December 2007, the WHO launched a five years initiative to raise awareness and accelerate action on medicines for children. This project is based on a document which was accepted at the 60th World Health Assembly in May 2007. At the same time the WHO released the first international List of Essential Medicines for Children (WMJ 53(2), 50). The list contains 206 medicines that are deemed safe for children and address priority conditions. On this list a number of existing medicines are however lacking because they have not been adapted for childrens use.

It has been known for a long time that there is a substantial gap between the availability

of childrens medicines and the actual need and that this gap is global even if it is most evident in poor income countries. In industrialized societies more than half of the children are prescribed medicines authorised and dosed for adults but not authorized or dosed for children. In developing countries, the problem is compounded by lower access.

In this project there are three main priorities.

1. To improve access where proper medicines for children exist but they are not reaching those in need due to cost and inefficient distribution systems.





2. To increase development of medicines which exist for adults but are either in unsuitable forms for children or have not been developed for children taken into account the different pharmacokinetics in children of various ages.
3. To facilitate research into areas where there are very few or even no medicines and where the efficacy of existing medicines is unknown. This applies specially to medicines for various infectious, tropical disease.

This project has received a wide acceptance and backup from many stakeholders such as UNICEF, the pharmaceutical industry, regulatory agencies and various NGO's such as Save the children. WMA most certainly will do its utmost to facilitate this project. The project starts at a time when WMA is addressing the special situation of children in two areas. One is the upcoming revision of the existing document on Health of Children since 1998, by many considered one of the best documents of the WMA.

This issue should also be kept in mind during the process of revision of the Declaration of Helsinki and in conjunction to that a new document on research of children which has been circulated to NMA's for comments. Lastly we should take this opportunity to work closely with the WHO as this is one of many topics where it is of obvious value that these International organisations join forces.

Jon Snaedal

President of the WMA

**Editorial note:**

*The text of many of the statements etc. adopted by the WMA General Assembly, while referred to in the Report (see p. 103) have been printed in the appropriate sections e.g. Ethics. Due to constraints on available space, those on Noise and Family Planning will appear in the next issue. They can also be accessed at [www.wma.net](http://www.wma.net).*

## China affirms its commitment to WMA Transplantation policy

Following the visit of a WMA delegation earlier this year (see report in *WMJ* 53,2), the Chinese Medical Association, in a letter from the Secretary General, Dr. Wang affirmed its commitment to WMA policy and wrote as follows:

"... after discussions in the Chinese Medical Association, a consensus has been reached, that is, the Chinese Medical Association agrees to the World Medical Association Statement on Human Organ Transplantation, which states that organs of prisoners and other individuals in custody must not be used for transplantation except for members of their immediate family. The Chinese Medical Association will, through its influence, further promote the strengthening of the management of human organ transplantation and prevent possible violations of the regulations made by the Chinese Government. We also hope to work more closely with the WMA and exchange information and views on the management of human organ transplantation".

## Medical Ethics and Human Rights

### Medical Research on Child Subjects

**Dr. James Appleyard, MD, FRCPCH, Past President WMA**  
(see also pp. 86 and 109)

Children worldwide bear the greatest burden of disease. Medical research on child subjects is essential to identify effective and sustainable action that will lead to improvements in child health (1,2). There is a natural reluctance to involve children in any risk associated with such research. Testing in adults has rightly to precede any trial of new approaches to treatment amongst children.

Children, however, have been subject to research studies in residential institutions prior to any independent ethical review

being introduced. The most public and controversial research study on children during the second half of the 20<sup>th</sup> century was the 'Willowbrook Hepatitis Study' started in 1956 at a New York State Institution for mentally defective persons. (3,4) Such examples led to the persistence of a predominantly protective approach towards research in children. So much so that, with the increasing number of medications available to adults in the last half century, children were increasingly being 'left behind'. The market for new drugs amongst children was much smaller and that a combination of the inherent protective environment with the increased cost of clinical trials meant that pharmaceutical companies did not

undertake the relevant trials in children. Practicing pediatricians faced the dilemma of knowing how effective a new chemical substance has been found in adult studies and feeling duty bound to try them on their child patients 'off label'

In the 90's this had reached such a proportion that pediatricians were pressing for changes in the system. (5,6) The 'Children's rule, evolved in the USA, has had a positive effect on promoting children's research. (7, 12) and Europe has followed with the E.U. Directive 2001/20/EC Both the Food and Drug Administration and the E.U. Commission have been consulting further on their existing regulations



Regulations are important within the legal framework of each country. Medical research is increasingly a global imperative and the relevant common ethical standards need to be international. (6)

The WMA's **Declaration of Helsinki** (9) has underpinned the guidelines from the Council for International Organisations of Medical Sciences (CIOMS) (7) and ICH GCP (8) It has also been the reference document for many national pediatric guidelines. (5) The paragraphs specifically related to children are paras. 24 and 25, regarding consent and/or assent of 'minors'

"24 For a research subject who is legally incompetent, physically or mentally incapable of giving consent or is a **legally incompetent minor**, the investigator must obtain informed consent from the legally authorized representative in accordance with applicable law. These groups should not be included in research unless the research is necessary to promote the health of the population represented and this research cannot instead be performed on legally competent persons".

"25 When a subject deemed legally incompetent, **such as a minor child**, is able to give assent to decisions about participation in research, the investigator must obtain that assent in addition to the consent of the legally authorized representative."

In the WMA's Declaration of Ottawa on the Right of a Child to Healthcare, a precautionary protective approach to research is adopted as one of the General Principles:

Para 4 V1 states "In particular every effort 'should be made to protect every child from unnecessary diagnostic procedures, treatment and research";

We need to change the emphasis about the need for research on children for their own benefit while maintaining full protection The WMA should provide leadership for the benefit of children worldwide. Most of the burden of disease affecting children is outside the rich countries of the USA, Europe and Japan, where regulations and guidelines have moved to a more positive approach to research in children. Principles recognizing the importance of research and the growing maturity of chil-

dren to assent and consent to the process, their need for special protection with the avoidance of harm, are essential. These are of particular importance in relation to matters referred to ethical review committees, which must include in their membership specialist paediatric expertise in study design when considering paediatric research.

It is difficult to incorporate all these essential points within the Declaration of Helsinki even though there is an opportunity to do so now that revisions are being considered. The WMA has already accepted the special needs of Children in their previous agreement to a separate Declaration on the Right of a Child to Health Care, in addition to the general rights of all patients. The Associate Members Meeting at the General Assembly of the WMA, with the particular support of representatives from the USA, Germany and Nigeria, recommended that a separate Statement on Medical Research on Child Subjects be considered by the WMA Assembly in Copenhagen with a view to its being circulated for comment by national medical associations (NMAs). The Assembly agreed and the Statement has been sent out to nmas by the WMA Secretariat.

The Statement has been drafted from the principles underlying the key guidelines on pediatric research in Europe (10, 12) United States (11) and Japan (13) and relates directly to the Declaration of Helsinki. The Statement should form a template for the development of local national guidelines in each country to provide both a positive and protective environment for the promotion of child health and welfare

The Preamble summaries the importance of medical research for children and the need to protect them from harm. The five main paragraphs highlight issues which are either specific to children or must be considered in the context of childhood. Each statement underlines a principle and each sentence is both self standing and to be taken in context. Further clarification of these principles need to be expanded in local national guidelines. Thus the document has been constructed to be a succinct as possible

## Draft Proposed Statement

### Preamble

Advances in medical care are based on the scientific evaluation of preventative, diagnostic and therapeutic measures.

Children should share in the benefits from scientific research relevant to their individual age related health needs.

Research on children is essential for the development of scientifically based medical knowledge that will ensure the effective promotion of child health and the well being of children worldwide.

Children involved in research need special protection. They differ from adults biologically. —with their increased vulnerability, age specific needs and growth and development potential.

Children must be subject to the safeguards applicable to all research subjects in the Declaration of Helsinki, together with paragraphs 24 and 25 concerning legally incompetent minors.

The Declaration of Ottawa defines the right of a child to health care, which includes the principles of consent and self determination amongst children in paragraphs 9-13.

Physicians should respect international and national professional guidelines on research in children which conform to these principles.

### Need for Protection

Biomedical studies involving children as research subjects should be focused on the knowledge of epidemiology, pathogenesis, diagnosis and treatment of diseases or conditions of childhood.

A child should not be involved in research that can be carried out on laboratory models, animal subjects or adult persons, or that serves only a scientific interest The knowledge to be gained from the research must form a necessary contribution to the health-care of children.

Different physiological, psychological and pathogenic features occur at the different



ages and stages of the growth ,development, sex and ethnicity in childhood. from the premature newborn infant through adolescence.

There is a need to balance the potential benefits to children against any risk involved in the research.

Physicians must respect the integrity and relative autonomy of a child and strive to attain the maximal achievable benefit, with the avoidance of unnecessary risks, discomfort and stress.

### **Avoidance of harm**

Risks should be minimised and potential harm leading to physical, psychological, social, spiritual impairment should be avoided

Minimal risk involves procedures, questionnaires, observation and measurements even being carried out in a child sensitive way.

Greater than minimal risk is can be associated with invasive procedures or therapies. These should be carried out only when the research is concerned with diagnosis and treatment and the expected benefits to the child participant outweigh the known or anticipated risks involved where the research is likely to yield justifiable generalisable knowledge of vital importance about the child's disorder or condition and research that provides the only opportunity to identify, prevent or alleviate a rare disease confined to childhood

### **Study Designs**

Study protocols and study designs must be child specific. In addition to including the safeguards for adult subjects , they should justify the necessity of the research on children

Preclinical safety and efficacy data are pre-conditions for the start of paediatric clinical trials.

The selection of children to participate in a biomedical research project should not depend upon the child's race, nationality,

gender or religion, except in cases where one or more of these attributes relate to the objective of the research

The performance of a study must be guaranteed to be conducted by experts competent in childhood diseases and disorders, empathetic and truly conversant with children, parents, and all legal requirements where the interests of the child are paramount

Child specific protocols should be drawn up by experienced experts and the study should be carried out under the supervision of paediatricians

Age specific informed consent/assent forms need to be available for child subjects, their parents and legal representatives.

The study protocols should be evaluated by independent research ethics committees on which there are paediatric health professionals.

### **Consent/Assent**

Children are minors who have not reached the age for self responsible consent.

Informed consent means the approval of the child's parents or legal representative for the participation of the child in a research study, following sufficient information to enable them to make an informed judgment.

Informed Assent means the acquiescence of the child to participate in the research following information being provided in a form understandable to their age group.

The consent of both parents should be sought prior to enrolling a child in a biomedical research project.

There must be no forced or undue influence, financial or otherwise, on the child's decision to participate in the research or on the parents/legal representative's consent.

The refusal to participate in the research by an informed child must be respected .

### **Privacy**

The privacy if the child must be fully assured throughout the research project.

All personal and health related information about the child and the family, collected and stored, must remain confidential.

### **Research Ethics Committees**

The interests of children should always be represented on independent research ethics committees when research on children is being considered. The membership must include children's physicians experienced in paediatric research and trained in the special needs of children. Other members should be well acquainted with the needs of children .

### **Further work on this Statement**

A detailed scrutiny by national medical associations and other interested 'stakeholders' is welcomed. The W.M.A has set up an electronic working group to receive comments and suggestions both on the need for a document such as this which is specific for children and on the core principles in the statement which can be used to develop both international and local national guidelines.

Please send your comments to your National Medical Association or as individuals to the WMA office [secretariat@wma.net](mailto:secretariat@wma.net)

James Appleyard MD FRCPCH  
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November 2007

### **References**

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### World Health Professions Alliance Conference on Regulation of Health Professions display

The World Medical Association will join with its partners in the World Health Professions Alliance (WHPA)\* and the World Confederation for Physical Therapy in hosting a conference in the Regulation of Health Professions.

The Conference will be held in Geneva, Switzerland on May 17-18 2008 and discuss the role and future of health professions' regulation. It will focus on models of health professions' regulation, examples of best practice in regulatory body governance and a discussion of trade in services and its implications for regulation.

The Conference, intended to bring together regulators, leaders of health professions, policy makers, health system managers and administrators; researchers and scientists and other interested parties, will take place prior to the World Health Assembly (19-23 May 2008).

For full details of speakers, programme, registration and submission of abstracts visit: [www.whpa.org/reg/index.htm](http://www.whpa.org/reg/index.htm)

\*The World Health Professions Alliance is a unique alliance of dentistry, medicine, nursing and pharmacy aiming to address global health issues and striving to help deliver cost effective quality health care worldwide. The WHPA member organisations are: the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP), the World Dental federation (FDI) and the World Medical Association (WMA). WHPA will be joined by the World Confederation for Physical Therapy (WPTC).





## WMA Statement On The Ethics Of Telemedicine

Adopted by the WMA General Assembly, Copenhagen, Denmark, October 2007

### DEFINITION

Telemedicine is the practice of medicine over a distance, in which interventions, diagnostic and treatment decisions and recommendations are based on data, documents and other information transmitted through telecommunication systems.

### PREAMBLE

The development and implementation of information and communication technology are creating new modalities for providing care for patients. These enabling tools offer different ways of practising medicine. The adoption of telemedicine is justified because of its speed and its capacity to reach patients with limited access to medical assistance, in addition to its power to improve health care.

Physicians must respect the following ethical guidelines when practising telemedicine.

### PRINCIPLES

Patient-physician relationship and confidentiality

The patient-physician relationship should be based on a personal encounter and sufficient knowledge of the patient's personal history. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period.

The patient-physician relationship must be based on mutual trust and respect. It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed.

Ideally, telemedicine should be employed only in cases in which a prior in-person relationship exists between the patient and the physician involved in arranging or providing the telemedicine service.

The physician must aim to ensure that patient confidentiality and data integrity are not compromised. Data obtained during a telemedical consultation must be secured through encryption and other security precautions must be taken to prevent access by unauthorized persons.

Responsibilities of the physician

A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based.

It is the obligation of the physician to ensure that the patient and the health professionals or family members caring for the patient are able to use the necessary telecommunication system and necessary instruments. The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and that the continuity of care is guaranteed.

The physician asking for another physician's advice or second opinion remains

responsible for treatment and other decisions and recommendations given to the patient.

A physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of telecommunication. A physician must be prepared to recommend direct patient-doctor contact when he/she feels that the situation calls for it.

Quality of care

Quality assessment measures must be used regularly to ensure the best possible diagnostic and treatment practices in telemedicine.

The possibilities and weaknesses of telemedicine in emergencies must be acknowledged. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the level of threat to the patient and the know-how and capacity of the persons who are with the patient.

### RECOMMENDATION

The WMA and National Medical Associations should encourage the development of national legislation and international agreements on subjects related to the practise of telemedicine, such as e-prescribing, physician registration, liability and the legal status of electronic medical records.



# WMA resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment

**Initiated: September 2002, Adopted by the WMA General Assembly, Helsinki 2003 and amended by the WMA General Assembly, Copenhagen, Denmark, October 2007**

The World Medical Association,

1. Considering the Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, the dignity and value of the human person,
2. Considering the Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind,
3. Considering Article 5 of that Declaration which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment,
4. Considering the American Convention on Human Rights, which was adopted by the Organization of American States on 22 November 1969 and entered into force on 18 July 1978, and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987,
5. Considering the Declaration of Tokyo, adopted by the World Medical Association in 1975, which reaffirms the prohibition of any form of medical involvement or presence of a physician during torture or inhuman or degrading treatment,
6. Considering the Declaration of Hawaii, adopted by the World Psychiatric Association in 1977,
7. Considering the Declaration of Kuwait, adopted by the International Conference of Islamic Medical Associations in 1981,

8. Considering the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "It is a gross contravention of medical ethics... for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment...",
9. Considering the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the United Nations General Assembly on December 1984 and entered into force on 26 June, 1987,
10. Considering the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989,
11. Considering the Resolution on Human Rights adopted by the World Medical Association in Rancho Mirage, in October 1990 during the 42nd General Assembly and amended by the 45th, 46th and 47th General Assemblies,
12. Considering the Declaration of Hamburg, adopted by the World

Medical Association in November 1997 during the 49th General Assembly, calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions,

13. Considering the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000,
14. Considering the Convention on the Rights of the Child, which was adopted by the United Nations on 20 November 1989 and entered into force on 2 September 1990, and
15. Considering the World Medical Association Declaration of Malta on Hunger Strikers, adopted by the 43rd World Medical Assembly Malta, November 1991 and amended by the WMA General Assembly, Pilanesberg, South Africa, October, 2006,

## Recognizing

16. That careful and consistent documentation and denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity,



17. That physicians, by ascertaining the sequelae and treating the victims of torture, either early or late after the event, are privileged witnesses of this violation of human rights,
18. That the victims, because of the psychological sequelae from which they suffer or the pressures brought on them, are often unable to formulate by themselves complaints against those responsible for the ill-treatment they have undergone,
19. That the absence of documenting and denouncing acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims,
20. That nevertheless there is no consistent and explicit reference in the professional codes of medical ethics and legislative texts of the obligation upon physicians to document, report or denounce acts of torture or inhuman or degrading treatment of which they are aware,

### Recommends that National Medical Associations

1. Attempt to ensure that detainees or victims of torture or cruelty or mistreatment have access to immediate and independent health care. Attempt to ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.
2. Promote awareness of the Istanbul Protocol and its Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment. This should be done at country level using different methods of information dissemination; including trainings, publications and web documents.
3. Disseminate to physicians the Istanbul Protocol.

4. Promote training of physicians on the identification of different modes of torture, in recognizing physical and psychological symptoms following specific forms of torture and in using the documentation techniques foreseen in the Istanbul Protocol to create documentation that can be used as evidence in legal or administrative proceedings.
5. Promote awareness of the correlation between the examination findings, understanding torture methods and the patients' allegations of abuse;
6. Facilitate the production of high-quality medical reports on torture victims for submission to judicial and administrative bodies;
7. Attempt to ensure that physicians observe informed consent and avoid putting individuals in danger while assessing or documenting signs of torture and ill-treatment;
8. Attempt to ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.
9. Support the adoption in their country of ethical rules and legislative provisions:
  - 9.1 aimed at affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware; depending on the circumstances, the report or denunciation would be addressed to medical, legal, national or international authorities, to non-governmental organizations or to the International Criminal Court. Doctors should use their discretion in this matter, bearing in mind paragraph 68 of the Istanbul Protocol.
  - 9.2 establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible

with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.

- 9.3 cautioning physicians to avoid putting individuals in danger by reporting on a named basis a victim who is deprived of freedom, subjected to constraint or threat or in a compromised psychological situation
10. Place at their disposal all useful information on reporting procedures, particularly to the national authorities, non-governmental organizations and the International Criminal Court.

Istanbul Protocol, paragraph 68: "In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters."



# WMA Resolution On Health And Human Rights Abuses In Zimbabwe

Adopted by the WMA General Assembly, Copenhagen, Denmark, October 2007

## PREAMBLE

Noting information and reports of systematic and repeated violations of human rights, interference with the right to health in Zimbabwe, failure to provide resources essential for provision of basic health care, declining health status of Zimbabweans, dual loyalties and threats to health care workers striving to maintain clinical independence, denial of access to health care for persons deemed to be associated with opposition political parties and escalating state torture, the WMA wishes to confirm its support of, and commitment to:

- Attaining the World Health Organization principle that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"
- Defending the fundamental purpose of physicians to alleviate distress of patients and not to let personal, collective or political will prevail against such purpose
- Supporting the role of physicians in upholding the human rights of their patients as central to their professional obligations

- Supporting physicians who are persecuted because of their adherence to medical ethics

## RECOMMENDATION

Therefore, the World Medical Association, recognizing the collapsing health care system and public health crisis in Zimbabwe, calls on its affiliated national medical associations to:

1. Publicly denounce all human rights abuses and violations of the right to health in Zimbabwe
2. Actively protect physicians who are threatened or intimidated for actions which are part of their ethical and professional obligations
3. Engage with the Zimbabwean Medical Association (ZiMA) to ensure the autonomy of the medical profession in Zimbabwe
4. Urge and support ZiMA to invite an international fact finding mission to Zimbabwe as a means for urgent action to address the health and health needs of Zimbabweans

In addition, the WMA encourages ZiMA, as a member organization of the WMA, to:

5. Uphold its commitment to the WMA Declarations of Tokyo, Hamburg and Madrid as well as the WMA Statement on Access to Health Care
6. Facilitate an environment where all Zimbabweans have equal access to quality health care and medical treatment, irrespective of their political affiliations
7. Commit to eradicating torture and inhumane, degrading treatment of citizens in Zimbabwe
8. Reaffirm their support for the clinical independence of physicians treating any citizen of Zimbabwe
9. Obtain and publicize accurate and necessary information on the state of health services in Zimbabwe
10. Advocate for inclusion in medical curricula, teachings on human rights and the ethical obligations of physicians to maintain full and clinical independence when dealing with patients in vulnerable situations

The WMA encourages ZiMA to seek assistance in achieving the above by engaging with the WMA, the Commonwealth Medical Association and the NMAs of neighboring countries and to report on its progress from time to time.





## WMA Statement on Health Hazards of Tobacco Products

**Adopted by the 40th World Medical Assembly, Vienna, Austria, September 1988 amended by the 49th WMA General Assembly, Hamburg, Germany, November 1997 and the WMA General Assembly, Copenhagen, Denmark, October 2007**

### PREAMBLE

More than one in three adults worldwide (more than 1.1 billion people) smokes, 80 percent of whom live in low- and middle-income countries. Smoking and other forms of tobacco use affect every organ system in the body, and are major causes of cancer, heart disease, stroke, chronic obstructive pulmonary disease, fetal damage, and many other conditions. Five million deaths occur worldwide each year due to tobacco use. If current smoking patterns continue, it will cause some 10 million deaths each year by 2020 and 70 percent of these will occur in developing countries. Tobacco use was responsible for 100 million deaths in the 20th century and will kill one billion people in the 21st century unless effective interventions are implemented. Furthermore, secondhand smoke - which contains more than 4000 chemicals, including more than 50 carcinogens and many other toxins - causes lung cancer, heart disease, and other illnesses in nonsmokers.

The global public health community, through the World Health Organization (WHO), has expressed increasing concern about the alarming trends in tobacco use and tobacco-attributable disease. As of 20 September 2007, 150 countries had ratified the Framework Convention on Tobacco Control (FCTC), whose provisions call for ratifying countries to take strong action against tobacco use by increasing tobacco taxation, banning tobacco advertising and promotion, prohibiting smoking in public places and worksites, implementing effective health warnings on tobacco packaging, improving access to tobacco cessation treatment services and medications, regulating the contents and emissions of tobacco prod-

ucts, and eliminating illegal trade in tobacco products.

Exposure to secondhand smoke occurs anywhere smoking is permitted: homes, workplaces, and other public places. According to the WHO, some 200,000 workers die each year due to exposure to smoke at work, while about 700 million children, around half the world's total, breathe air polluted by tobacco smoke, particularly in the home. Based on the evidence of three recent comprehensive reports (the International Agency for Research on Cancer's Monograph 83, Tobacco Smoke and Involuntary Smoking; the United States Surgeon General's Report on The Health Consequences of Involuntary Exposure to Tobacco Smoke; and the California Environmental Protection Agency's Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant), on May 29, 2007, the WHO called for a global ban on smoking at work and in enclosed public places.

The tobacco industry claims that it is committed to determining the scientific truth about the health effects of tobacco, both by conducting internal research and by funding external research through jointly funded industry programs. However, the industry has consistently denied, withheld, and suppressed information concerning the deleterious effects of tobacco smoking. For many years the industry claimed that there was no conclusive proof that smoking tobacco causes diseases such as cancer and heart disease. It has also claimed that nicotine is not addictive. These claims have been repeatedly refuted by the global medical profession, which because of this is also resolutely opposed to the massive advertising campaigns mounted by the industry

and believes strongly that the medical associations themselves must provide a firm leadership role in the campaign against tobacco.

The tobacco industry and its subsidiaries have for many years supported research and the preparation of reports on various aspects of tobacco and health. By being involved in such activities, individual researchers and/or their organizations give the tobacco industry an appearance of credibility even in cases where the industry is not able to use the results directly in its marketing. Such involvement also raises major conflicts of interest with the goals of health promotion.

### RECOMMENDATIONS

The WMA urges the national medical associations and all physicians to take the following actions to help reduce the health hazards related to tobacco use:

1. Adopt a policy position opposing smoking and the use of tobacco products, and publicize the policy so adopted.
2. Prohibit smoking at all business, social, scientific, and ceremonial meetings of the National Medical Association, in line with the decision of the World Medical Association to impose a similar ban at all its own such meetings.
3. Develop, support, and participate in programs to educate the profession and the public about the health hazards of tobacco use (including addiction) and exposure to secondhand smoke. Programs aimed at convincing and helping smokers and smokeless tobacco users to cease the use of tobacco



products and programs for non-smokers and non-users of smokeless tobacco products aimed at avoidance are both important.

4. Encourage individual physicians to be role models (by not using tobacco products) and spokespersons for the campaign to educate the public about the deleterious health effects of tobacco use and the benefits of tobacco-use cessation. Ask all medical schools, biomedical research institutions, hospitals, and other health care facilities to prohibit smoking on their premises.
5. Introduce or strengthen educational programs for medical students and physicians to prepare them to identify and treat tobacco dependence in their patients.
6. Support widespread access to evidence-based treatment for tobacco dependence - including counseling and pharmacotherapy - through individual patient encounters, cessation classes, telephone quit-lines, web-based cessation services, and other appropriate means.
7. Develop or endorse a clinical practice guideline on the treatment of tobacco use and dependence.
8. Join the WMA in urging the World Health Organization to add tobacco cessation medications with established efficacy to the WHO's Model List of Essential Medicines.
9. Refrain from accepting any funding or educational materials from the tobacco industry, and to urge medical schools, research institutions, and individual

researchers to do the same, in order to avoid giving any credibility to that industry.

10. Urge national governments to ratify and fully implement the Framework Convention on Tobacco Control in order to protect public health.
11. Speak out against the shift in focus of tobacco marketing from developed to less developed nations and urge national governments to do the same.
12. Advocate the enactment and enforcement of laws that:
  - a. provide for comprehensive regulation of the manufacture, sale, distribution, and promotion of tobacco products, including the specific provisions listed below.
  - b. require written and pictorial warnings about health hazards to be printed on all packages in which tobacco products are sold and in all advertising and promotional materials for tobacco products. Such warnings should be prominent and should refer those interested in quitting to available telephone quit-lines, websites, or other sources of assistance.
  - c. prohibit smoking in all enclosed public places (including health care facilities, schools, and education facilities), workplaces (including restaurants, bars and nightclubs) and public transport. Mental health and chemical dependence treatment centers should also be smoke-free. Smoking in prisons should not be permitted.

d. ban all advertising and promotion of tobacco products.

- e. prohibit the sale, distribution, and accessibility of cigarettes and other tobacco products to children and adolescents.
- f. prohibit smoking on all commercial airline flights within national borders and on all international commercial airline flights, and prohibit the sale of tax-free tobacco products at airports and all other locations.
- g. prohibit all government subsidies for tobacco and tobacco products.
- h. provide for research into the prevalence of tobacco use and the effects of tobacco products on the health status of the population.
- i. prohibit the promotion, distribution, and sale of any new forms of tobacco products that are not currently available.
- j. increase taxation of tobacco products, using the increased revenues for prevention programs, evidence-based cessation programs and services, and other health care measures.
- k. curtail or eliminate illegal trade in tobacco products and the sale of smuggled tobacco products.
- l. help tobacco farmers switch to alternative crops.
- m. urge governments to exclude tobacco products from international trade agreements.



## Education

### Avicenna Directories to replace World Directory of Medical Schools

Discussions have been taking place between WHO and the University of Copenhagen with a view to replacing the World Directory of Medical Schools with the establishment of a Global database of health professions. It is planned to include other academic health institutions relating to the other health professions such as dentistry, midwifery, nursing, pharmacy, public health and will include information

on schools' accreditation, number of admissions, students, graduates, Faculty, educational resources, address, and national official recognition. The database will be run by the University of Copenhagen in collaboration with WHO, the World Federation for Medical Education (WFME), the Foundation for the Advancement of International Medical Education and Research (FAIMER), the International

Pharmaceutical Federation and other partners.

The database will be based in the Faculty of Health Sciences in the University of Copenhagen with the close collaboration of WFME. These electronic resources will be called the **Avicenna Directories**. It is understood that the work has already started.

### Global Standards for Quality Improvement in Medical Education

The World Federation of Medical Education has published European Specifications for Basic and Postgraduate Medical Education and Continuing Professional Development.

These have been developed by a WFMA/AMSE international task force set up by MEDINE, chaired by WFME and ASME, sponsored by the European Commission, and provides a valuable tool adapting the global standards in medical education to the

European Region of WHO. It is directed towards national and international authorities, institutions and organisations with responsibility for medical education and represents a valuable tool in planning quality improvement in medical education, setting out the essential elements which need to be considered in planning necessary reforms in medical education. While this is an essential tool for authorities and institutions concerned with medical education it is

of value to all physicians who have responsibilities in medical education,

WFME Global Standards for Quality Improvement in Medical Education  
European Specifications.  
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## Point of view

### A Worldwide Tour of Medical Degrees and Qualifications

#### **Dr. Denis Doran MD**

In recent years, attempting to recognise a medical degree or qualification can be challenging. With the reunification of East and West Germany, the opening of the European Community to several new member states, the break-up of the Soviet Union and the fragmentation of Yugoslavia into several individual nations, medical degrees and qualifications which were not familiar before are now more commonly seen.

Another problem that Boards, Medical Councils and Colleges have had to deal with for many years, is to differentiate and recognise which degrees relate to clinical practice, which ones are linked to academic careers and which ones are honorary. The increase in international migration has made this problem even more pressing.

This article will review the broad range of medical degrees and evidence of qualification presented nowadays to licensing bod-

ies, dental committees and residency programme applications. It is not intended to provide an official or exhaustive list of medical qualifications but merely to reflect on the great variety of titles for medical diplomas and qualifications.

#### **EUROPE**

In Europe, the medical degrees awarded vary from country to country (and also



## Point of view

within countries), of which the following are examples.

In Belgium, the French university diploma is *Docteur en Médecine, Chirurgie et Accouchement*. The Flemish university degree is *Aerts, Arts (Physician)*.

In the countries of the former Soviet Union Russia, Ukraine, Moldova, Armenia and Estonia all issue a *Doctor in Medicine Diploma*; Uzbekistan awards a *General Practitioner diploma* and the rest of the 15 republics award a *Vrach (Physician) diploma*.

In the nations of the former Yugoslavia, Croatia and Macedonia award a *Doctor of Medicine diploma*, while Bosnia-Herzegovina, Serbia and Slovenia formerly issued a *Lekar (or Zdravnik) diploma* - now a *Doctor of Medicine diploma*.

The graduates from medical schools in Austria, The Czech Republic and Slovakia receive a *Medicinae Universae Doctor Diploma*.

In Scandinavia, Norwegian and Danish medical schools award a *Candidatus Medicinae diploma*; Iceland - a *Candidatus Medicinae et Chirurgiae diploma*; Sweden - a *Lakaexamen diploma* and in Finland - a "*Lisensiat* (*Licence in Medicine*). The degree *Laaketieteen Tohtori (Doctor of Medicine)* is a traditional university doctorate, the highest degree and is a requirement for the position of Professor.

In the Netherlands an *Arts (or Artsexamen) diploma* is awarded, in Luxembourg a *Bachelor Academique en Sciences de la Vie-Médecine*, and in Bulgaria, a *Master's/Physician or State Examination certificate* is awarded

A few degrees have unusual sounding names: in Albania *Mjek I Prerjithshem*; in Greece, *Psycho Iatrikes*; Belarus currently *Kvaliifi Kaciya (Physician diploma)* formerly a *Vrach*.)

Romania awards a *Doctor-Medic diploma*; Poland, a *Lekarz diploma*; Hungary - an *Orvos doctor or MD diploma*, and Turkey - a *Doctor of Medicine diploma*.

In the United Kingdom, the basic British medical degree is the *MB, BCh, (Medicinae Baccalaureus, Baccalaureus Chirurgiae)*.

Varieties of the same degree exist throughout Britain and the rest of the Commonwealth. These are *BM BCh, MB ChB, MB BChir, MB, BS*. In the UK, an MD could be awarded to one who does research and submits a thesis in the field of medicine, or as an honorary degree, to a senior or academic physician. Throughout the world, many countries with former educational associations with Britain award degrees reflecting the British type of medical degree.

The Conjoint Diploma *LRCP, MRCS*, and the *LMSSA (Licentiate of the Royal College of Physicians of London, Member of the Royal College of Surgeons of England, and the Licentiate in Medicine, Surgery of the Society of Apothecaries)* were registrable qualifications with the General Medical Council (where all practising physicians have to be registered if they wish to practice) until 1999. The Scottish Triple Conjoint Diplomas, *LRCPE, LRCSE, LRCPSG* are similar qualifications which were registrable with the GMC until 1999.

In Ireland, the basic medical degree is *MB, ChB, BAO (Baccalaureus in Arte Obstetrician)*. The *LRCPI, LRCSI* diplomas, unlike England and Scotland are still registrable with the Irish Medical Council. Also recognised is the *LM (Licence in Midwifery)*

For Germany there is a *State Examination Certificate*, either on passing a three part State exam (*Dritter Abschnitt Certificate*) or a two part State exam, (*Zweiter Abschnitt Certificate*) which are recognised for basic licensing purposes. Italy awards a *Laurea in Medicina e Chirurgia diploma (Bachelor of Medicine and Surgery)*, Portugal awards a *Licenciatura em Medicina diploma* and Spain, a *Licenciado en Medicina y Cirurgia*.

Switzerland awards a *Diploma Federal*.

## LATIN AMERICA

Brazil awards a *Medico (or MD) diploma*; Bolivia a *Titulo en Provision Nacional de Medico Cirujano*; Costa Rica, Venezuela and Chile, a *Medico Cirujano diploma*; Ecuador, Honduras and Nicaragua, a *Doctor en Medicina y Cirugia*; Mexico

and Peru, a *Titulo de Medico Cirujano*. Surinam awards an *Arts or Geneesheren diploma*.

## NORTH AMERICA

In Canada, francophone universities award a *Docteur/ Doctorat en Médecine diploma*:

Anglophone universities offer the MD diploma. In the USA, most graduates of medical schools receive an MD. Another medical degree awarded by 19 medical schools is the *Doctor of Osteopathy or DO diploma*.

## ASIA

China and Taiwan offer a *Bachelor of Medicine degree*. China also offers a *Bachelor of Traditional Medicine* and Japan offers an *Igaku (Bachelor of Medicine)*. In Malaysia following the British system the *MB,BS or MB,ChB* are awarded as well as the *Doctor "Perubatan"*. North Korea offers a *Doctor diploma* and South Korea, earlier a *Hak Sa diploma* and now a *Bachelor of Medicine*; Indonesia awards a *Doktor diploma* and Mongolia a *Physician diploma*.

## AFRICA

Angola and Mozambique ex-Portuguese colonies offer the same diplomas as Portugal; the Democratic Republic of Congo, an ex-Belgian colony, awards a *Docteur en Med., Chir et Accouchement diploma*, as well as a number of others, which are accepted for basic medical licensing purposes. Gabon, Benin and Ivory Coast have a *Doctorat d'Etat en Médecine*.

Most other countries of the world issue either an MD, *Doctorat en Médecine* or *MBBS/MB ChB degree*.

## NON-MEDICAL QUALIFICATIONS

The PhD is a university awarded research Doctorate, not necessarily associated with clinical practice, awarded after supervised academic research and the submission of a





thesis. (Often Clinical Psychologists, who unlike Psychiatrists cannot prescribe medications have a PhD.).

## MEMBERSHIP/FELLOWSHIP OF COLLEGES AND OTHER SPECIALIST INSTITUTIONS

Medical Colleges and Academic Institutions, many of which have existed many or for hundreds of years, award fellowships. The Colleges are normally concerned with specialties, although, as, mentioned above, some conduct examinations related to their own specialty which are recognised for basic licensing purposes to practice medicine e.g. LRCPI, LRCPI. Fellowships, on the other hand normally require the passing of a higher examination or assessment and election by the College as Fellows. Honorary Fellowships are mostly awarded for exceptional and distinguished practice in medicine. Such Colleges have as their aim the development of the specialty and the maintenance of high standards and excellence, a condition which their members are bound to fulfil as a condition of Membership or Fellowship. The use of titles varies greatly between countries and institutions.

## MEMBERSHIP

e.g. MCCFP Membership of Canadian College of Family Physicians;

MACP Membership of American College of Physicians;

MRCGP Membership of the Royal College of General Practitioners.

Membership of these bodies, while not obligatory in some countries, often marks the end point of specialist training and is awarded after an examination. This type of Membership is, in certain countries, recognised as achieving formal specialist qualification, notably in the UK where for example, the MRCP is the recognised basic specialist qualification in medicine, whereas the FRCS is the basic specialist qualification for surgery.

## FELLOWSHIP

e.g. FAAP Fellow of the American Academy of Paediatrics.

FRCP Fellow of the Royal College of Physicians.

Fellowships require a much higher distinction and status. They are usually awarded after passing a very difficult examination or are elected for distinction in the relevant branch of medicine.

In many countries of Europe and to a certain extent throughout the world, physicians appointed as Professors prefer to be called Professor rather than Doctor and in England, Fellows of the Royal College of Surgeons are referred to as Mister. In fact all surgeons are called Mister but "Obstetric and Gynaecologist" specialists if they hold an MD, may use the title Doctor.

## CONCLUSION

It is not the purpose of this article to discuss the details of qualifications associated with the great variety of medical degrees listed above.

Nevertheless, licensing bodies have the role of recognising (or not) these medical degrees and qualifications and to suggest, when necessary, updates to qualify for a licence to practice.

Accordingly, the public at large need to accept the fact that physicians qualified to practice in their region may not necessarily have the usual MD after their name.

*Address for communication*

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## From the WMA Secretary General

## Trust me, I'm a Doctor!

Although you never should say this to your patients – you often will enjoy exactly the desired high degree of confidence in what you do and what you are – a physician. However, we are about to lose this!

No, I am not referring to the sermon-like repeated "doctor bashing" of politicians and media, I am referring to what may be thought to be advertising, but may be largely a lack of precision and carelessness in communication, with which we are endangering our image.

More and more people are reaching out their hands to patients saying „Hallo! I am your doctor.“ But what kind of doctors are they? At best they may be scientifically

trained persons but they may well be doctors of podology. This not a joke! There is an economic war and we are about to lose it, because as it looks as if we have not even understood that it is going on.

The battles our associations are fighting about scope of practice and task shifting, are not an academic entertainment. Politicians and economists are trying to de-professionalize medicine and make it a cheap commodity for the masses.

Why? Is it – at least partially – our fault because we have produced the confusion, or at least we let it happen? . Not only does a normal person already have a hard time to understand what an Endocrinologist is and



## From the WMA Secretary General / WMA

does, we even top-up this non-communication with academic degrees, titles and abbreviations that are cryptic, confusing and worst of all – misleading.

Appendices of titles, consisting of dozens of apparently randomly combined letters make us look like amateurs rather than serious professionals. Yes, we may be proud to be a fellow of a college or society and why not talk about it. Yes, it is more than correct to display specialist qualifications. But titles that even our colleagues can only decipher when they hold exactly the same title could be considered vain advertising. Whom are medical titles good for? Should they not serve our patients to find the right physician, to find the right treatment from a qualified physician?

In this issue, Denis Doren, MD, from Ontario (Canada) has taken a look at the medical degrees, qualifications and titles that are being awarded and used around the world. One might attribute the wide variety

he found as a sign of pluralism, cultural diversity and tradition. But let's face it, for our patients it is simply a mess. To make this more transparent, at least to the consumer (the patient), is there not some justification for simplifying the whole thing to "Licensed Medical Practitioner", with the addition "and Licensed xxxxx Specialist", where appropriate. If then, the letters indicating qualifications degrees e.g. MD, and Fellowships of Colleges etc are added, they will be less confusing.

In this day and age, access to the computer surely permits patients to find the meaning and significance of the letters.

And of course there are others who welcome our own confusion. While we don't deliver clarity – they do it by simply classifying us as "service providers" or "health workers". Separating us from our patients is made easy by our use of terms and abbreviations and making physicians accede to the generic group of "service providers" in

health care, neglecting the additional qualities implicit in a practicing profession.

Do we want to maintain a special role in health care? Do we want to remain advocates for our patients? Do we want to keep our leadership role in healthcare teams? If the answer is "yes" we should avoid the ridiculous variety of titles and acronyms we are currently using and should make sure that patients can identify us as what we are: physicians. This still permits the nomination of a speciality, provided the qualification has been earned and awarded, but we should do it with the degree of transparency and clarity we owe our patients and the public.

Only then we will be able to protect our titles. This will not be enough as a sufficient strategy to protect our scope of practice, but we have to realize that it is a necessary requirement.

Trust me, I'm a doctor!

## WMA General Assembly

**The General Assembly of the World Medical Association was held in the Marriott Hotel, Copenhagen on 5<sup>th</sup> and 6<sup>th</sup> October 2007**

### **Ceremonial Session 5<sup>th</sup> October 2007**

The President, Dr. N. Arumugam formally opened the Session.

The Secretary General Dr. Otmar Kloiher reported the death on 10<sup>th</sup> of June of Dr. André Wynen, former Chair of Council and Secretary General. Paying a tribute, he said "André Wynen was our friend, teacher and leader, serving the World Medical Association and the whole medical profession with dedication and passion.

### **The meeting stood in silent tribute.**

The Secretary General, then took the Roll Call, introducing the Delegates and the Observers of other organisations present which included the International

Committee of the Red Cross, CIOMS, Confemmel, the Danish Nursing Association, the Federal Council of Brazilian Doctors, the International Dental Federation, the International Federation of Medical Students, the International Federation of Pharmaceutical Manufacturers and Associations, the Medical Women's International Association, the Standing Committee of European Doctors, the World Federation of Medical Education, the World Psychiatric Association, the International Rehabilitation Council for Torture Victims and the World Self-Medication Industry.

Dr. Jensen, President of the Danish Medical Association welcomed World Medical Association and all the participants to

Copenhagen. He congratulated Dr. Snædel, the incoming President on his election and paid tribute to his work, notably for his contribution in the revision of the International Code of Ethics. He thanked the outgoing President Dr. Arumugam for all his work over the past year.

The Chair of Council Dr. Hill warmly thanked Dr. Jensen and the Danish Medical Association for the invitation to return to Copenhagen for this year's Assembly and for the hospitality, which was greatly appreciated. Proposing a vote of thanks to the President, he reminded the meeting that Dr. Arumugam, a cardiologist in Malaysia, was a champion of Public Health, had played a major role in the introduction of Tobacco Legislation in that country.

## Retiring President's Address

Dr. Arumugam said that it had been a terrific year in which it had been an honour and a privilege to represent the World Medical Association. He had tried to advance the views of WMA, had witnessed the challenges facing Health Care Services and Medicine in different countries and met fellow doctors across the world. He expressed his thanks both to Council and to his fellow Officers for their work and support during the past year. His main task had been to emphasise the work of the WMA and improve its visibility. He had visited and attended the Annual meetings of many National Medical Associations and referred to the problems of the profession such as increasing regulation reducing the time for professional work. Focusing on Continuing Professional Development, he noted that this had been a special problem over the past 10 years where there were many hurdles in developing countries. Addressing the problems in South East Asia in particular, he referred to the development of a points system for CPD in that region.

Patient Safety was also an important problem especially in hospitals. This had been addressed by the Hospitals Association in Malta which had recognised the WMA Statement on this issue. A Conference of Medical Associations in SEA had included CME on Ethics in Medicine and Clinical Practice. Dr. Arugunam also referred to the increasing problem of medical litigation.

Turning to China he reported that the seven persons in the delegation had discussed the problems of Organ Transplants and harvesting organs from prisoners, the shortage of organs and other problems with the Chinese Medical Association and the Minister of Health. At the end of the meeting it was concluded that Trade in Organs must stop. He was encouraged by the recent acceptance of the WMA Code on Transplantation of Organs by the Chinese Medical Association. He commented that the problems of transplantation, including ethical and legislative aspects had been discussed by the German Medical Association whose meeting he had addressed.

Obesity was a major problem and the looming epidemic needed addressing with a preventive healthy diet and food labelling.

The problems of tobacco continue. While the Framework Convention on Tobacco Control was welcomed, he felt that it so far had had a limited effect and the World Medical Association must continue its efforts to encourage Tobacco Control activities.

Turning to the World Health Professions Alliance he commented that the Presidents of these professions met to discuss the problem of Health Personnel Migration and Task shifting, where areas of difference still need to be addressed.

The President referred to his presence in India, the Philippines and most recently at a meeting of CONFEMEL, finally commenting that at the recent AMA meeting there was concern over the development of clinics in supermarkets and that in Australia there was a need for vigilance over the issue of what is being called "Task Shifting". He closed by stating that the most unforgettable event for him had been the reading and affirmation of the WMA Oath of the Medical Profession.

The Assembly rose in a Standing Ovation.

## Installation of the new President

Dr. Hill in thanking Dr. Arumugam for all his work for the profession referred to the wisdom, care and understanding he had shown as President. He then presented Dr. Arumugam with the Past President's medal.

Introducing Dr. Snædel as the new President, Dr. Hill said he had been elected in recognition of his many services to the profession and the WMA. Dr. Snædel took the oath on assuming the office of President and was invested with the Presidents Badge of Office.

## Presidential Address by Dr. Jon Snædel

"Dear colleagues, distinguished guests.

During the last decades new discoveries in clinical research as well as in basic research have been stretching the ethical boundaries of medicine. The World Medical Association has managed to be at the forefront of this evolution and during the past

few years the WMA has revised many of its old documents in ethics as well as in other fields. It has been a privilege to participate in the solution of many of these dilemmas, not least when the International Code of Medical Ethics was revised after a process of 2 years and finally finished in South-Africa last year. To take an example of how new thoughts are integrated in such a document I will mention one paragraph of the Code.

One of the paragraphs has been unchanged since its earliest version in 1949: "*A PHYSICIAN SHALL always bear in mind the obligation to **preserve** human life.*" In the last revision one word was changed and the word preserve was replaced by the word respect and now it reads: "*A PHYSICIAN SHALL always bear in mind the obligation to **respect** human life.*" The change of just one word reflects a fundamental change in our way of thinking of our duties. Our abilities to treat our fellow human beings have vastly increased as we are now able to preserve live for a long time even if this life is without any obvious quality. There is a saying that life is a disease with 100% mortality, a saying that medicalises life itself. We have to acknowledge the fact that death is inevitable and that in its last phases it is of more value to the person to treat the symptoms rather than the disease. In this phase of life our obligation is thus to **respect** the patient rather than to preserve his life.

There are many other ethical questions we have to address and the WMA is working constantly on these. Just to mention two issues we are dealing with in the coming months – a revision of the Helsinki declaration on research involving human subjects and a new document on stem cell research. Every now and then we are faced with ethical dilemmas we did not foresee. I will give you an example of such an issue which unfolded in my country just 3 weeks ago. A private company in genetic research has now offered those who wish for and are willing to pay, an analysis of their genetic makeup. The whole genome is analyzed by half a million markers and the person will get a report on his chances of getting a number of diseases. But is it not just wonderful that we have a technique that can provide us with such information of your health and



health risks? In our view there are, however, obvious problems with this type of information. One is clearly that you are not able to change your genes, which means that if you know that your chances of getting say a certain type of cancer; you will not be able to affect that chance. Another is that this technique will obviously be very interesting to insurance companies who could then insist that you will go through such a test whether you like or not. There are even more obstacles to this idea than I have accounted for and this is just one example of many of what medical ethics is about.

During my year of presidency of the World Medical Association my main concerns will therefore be medical ethics and its manifold tasks. I will build on the traditions of our Association and work in harmony with the Council and the Secretariat, as it is of great importance that we work together for our mutual cause even if I have chosen this specific part of work of our Association for my mission. There are many means to achieve our goals. At this Assembly we will discuss the future of the World Medical Journal. I would like to see this Journal, and thereby the WMA itself, have a much greater role in medical ethics and public health than it has had up to now. When I asked the librarian in my University hospital to take a look into the accessible Journals of Medical Ethics it became clear to me that there is a place for one more. The Journals are far less in number than in many specific fields of medicine, even subspecialties, and the distribution of most of them seems to be confined to the society they are published for. This can be seen by their limited impact factor. A new international journal on medical ethics and public health published by the WMA will in my mind not only be an asset to the association but more importantly, of clear benefit to the clinical doctor which this new journal should be aimed at.

Closely linked to ethics are human rights. I feel that the WMA is on the right track in its

collaboration with very important organisations in this field such as the Red Cross, Amnesty International and not least the International Council for Torture Victims which actually have their main office here in Copenhagen. The important task of preventing torture by using a tool called the Istanbul Protocol in ten countries has now been underway during the last 4 years. It is my hope that the WMA will continue to work for this important human rights issue in all possible ways during the coming years.

The WMA has during the last years discussed advocacy because that is the means by which the association will have effect. The WMA aims its work mainly towards three types of receivers, the individual doctor, the association of doctors, mainly the NMA's of the WMA, and towards international organisations. The main receivers of the work of the WMA throughout the years have been the NMA's. That is of course good, but to have a real effect on health issues, ethics and international politics of medicine our Association needs more visibility. By revamping the WMJ we will increase our visibility towards the individual doctor. Doctors will hopefully go to our new Journal for advice and inspiration and we will reach out with a printed version as well as an electronic one to all parts of the world in spite of language barriers. Another important and imminent task is to increase our presence and influence in international organisations. One specific task will be to work to preserve our education and training because it has been on the agenda of the WHO to solve the problem of shortage of doctors by proposing a shorter training, some kind of technical doctor trained for limited purposes. Even if we can understand that some countries need to address this difficult problem urgently, we feel that in the long run this method will undermine the health service in these countries. I would therefore like to

echo the words of our past president, Kgosi Letlape, when he said in his address in South-Africa that the solution to this problem is to "keep the pastures green in our countries."

Doctors are not working alone. Team work is an increasing issue in our daily routine and we are accustomed to work alongside other health professionals, most often nurses and pharmacists. The WMA participates in an international collaboration with the respective organisations of these two professions as well as the dentists. However, we need to address the collaboration of these professionals on the ground better. Another task of mine will be to work on that in a task looking specifically at collaboration for better pharmacological treatment. More tasks of this kind are obvious and will most likely be looked at in the near future.

Lastly I will mention the specific group of patients I care for and treat in my daily work as a geriatrician, persons with dementia, more specifically Alzheimer's disease. Even if I feel some urge to place their problems on the agenda I realize that the problems of specific group of patients are not an issue for the WMA. We work for all of them. However I will use this opportunity to correct a prevalent misunderstanding, that this is a specific problem for the developed world. In fact most demented persons are found today in the developing world and the greatest increase of this patient group is without question in Asia and Africa.

During the coming year I hope to bring some benefit to the WMA but I acknowledge that one person will not be able to achieve much. It is therefore my sincere hope that I will be able to collaborate with as many of you as possible during my presidency. May the WMA continue to thrive and prosper for many years."

The President then thanked the Assembly members and their guests for attending and formally closed the Ceremonial Session.





## Plenary Session of the Assembly 6<sup>th</sup> October 2007

Dr. Hill, Chair of Council, opened the meeting and the Secretary General, Dr. Kloiber referred to the sad death of Dr. André Wynen and informed the Assembly that a Memorial Book was open for signature.

He also reminded the Assembly that the World Health Professions Association's Leadership would take place in November. There were 30 places on the course and 24 applications had so far been received and approved. There were still six vacancies and he invited applications for these places, preferably female candidates.

Dr. Hill, after listing the apologies for absence, stated that there were three nominations for the Presidency of the World Medical Association for 1908-9 and opened the floor for further nominations. In the absence of any other proposals he declared the three candidates to be Drs. Blachar (Israel), Desai (India) and Boswell (New Zealand).

Dr. Hill then referred to the presence as an observer of the President of the International Dental Federation (FDI), Dr. Michèle Aerden, and invited her to address the meeting.

Dr. Aerden referring to the FDI as one of the partners in the World Health Professions' Alliance (WHPA), said that it was the third oldest health professional organisation in the world. As a worldwide independent organisation representing 140 Dental Associations FDI it was the voice of dentistry and was represented at the UN, WHO and ISO. Recognising that Health was a fundamental human right she pointed out that this included the need for Oral Health. In 1981 WHO recognised the goal of global oral health. In 2007 Oral Health was on the Agenda of the World Health Assembly and the important role of prevention in Oral Health was recognised, including the role of Fluoride.

Dr. Aerden said that it was important to collect data on oral health because of its value, particularly in developing countries where projects had been set up.

Turning to the importance of ethics she stressed that this was also true of Dentistry. She spoke of the importance of defending the position of the profession in recognising the dignity of individual and the well-being of patients. Speaking of the effects of oral disease on morbidity and mortality, she referred the effects of pain on the quality of life and to the link between oral disease and the rest of the body.

A proposal was being made in WHPA for action to make things HAPPEN. There was a "Health in Africa" Vision. In Africa, where there were major gaps in health care, conferences were planned in Africa in 2007 and in America in 2008, to address the problems of health access policy and also education in health promotion and disease prevention. Action by the WHPA would make a difference.

Dr. Hill thanked Dr. Aerden and reminded the meeting that Dr. Letlape had been sitting on the working group in WHPA for the past year.

Dr. Haikerwald presented the report of the Credentials Committee. 45 Delegations were present of which 43 had the right to vote.

The Standing Orders and the Minutes of the Pilanesberg meeting were both adopted, following which each of the three candidates in the presidential election addressed the meeting. At the conclusion of these presentations delegations proceeded to a formal ballot for the electing the President-elect 2008-2009.

### President-elect

The Secretary General declared the result of the ballot was that **Dr. Yoram Blachar** had

been elected to the office of President-elect for the year 2008-2009.

Dr. Blachar, responding to this said that he was deeply touched by the trust placed in him and thanked those who had elected him, expressing in particular his thanks to his wife and to Ms. Leah Wapner for their great continuing support and help.

## Report of Council

*(Much of the written report of Council circulated before the November meeting appears in the report of the 176<sup>th</sup> Council meeting in WMJ52(2): matters other than the statements and resolutions adopted by the Assembly which are set out below, are set out in the account of the 178<sup>th</sup> Council meeting (see page 107).*

### Finance and Planning

Dr. Hill presenting the report, turned first to recommendations arising from the **Finance and Planning Committee** business.

### Cabo Verde

The application for constituent membership of the Ordem dos Medical de Capo Verde was approved.

### Scientific Session, Seoul 2008

The theme of "Health and Human Rights" was **approved** for the 2008 scientific meeting in Seoul.

### Treasurer's Report

The Treasurer, Dr. J.D. Hoppe presenting his report reviewing the period 2005-2006, referred to the Financial Statement prepared with Mr. Hallmayr which had been approved by the auditors KPMG, and then spoke to the document in some detail. He reported that the net balance, reversing the deficit of the years 2004-5 which had been overcome through the efforts and actions of the Secretary General, had continued to



improve, both from Dr Kloiber's continuing actions, from the improvement in income from members dues and other financial earnings.

The Financial Statement for 2006 was unanimously **approved**.

Dr. Hoppe then presented the Budget for 2008 which, in the absence of any questions from the floor, was **approved** unanimously.

Dr. Hill expressed his thanks both to Dr. Hoppe and to Mr Hallmayr for their work during the year. He reminded delegates that

the new dues categories had been approved and sent to delegations.

Before turning to Medical Ethics Dr. Hill put to the Assembly the following Council Resolution which was **adopted** unanimously by the Assembly.

## Resolution in Support of the Medical Associations in Latin America and the Caribbean

*Adopted by the WMA General Assembly, Copenhagen, Denmark, October 2007*

There are credible reports that arrangements between the Cuban government and certain Latin American and Caribbean governments to supply Cuban health workers as physicians to these countries 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.

There exist already duly constituted and legally authorized medical associations within this region that are charged with the registration of physicians and which should be consulted by their respective Ministries of Health.

Therefore, the WMA:

1) Condemns any actions by governments in policies and practices that subvert or bypass the accepted standards of medical credentialing and medical care;

2) Calls upon the governments in Latin America and the Caribbean to work

with the medical associations on all matters related to physician certification and the practice of medicine and to respect the role and rights of these medical associations and the autonomy of the medical profession.

3) Urges, as a matter of utmost concern, that the governments in Latin America and the Caribbean respect the WMA International Code of Medical Ethics and the Declaration of Madrid that guide the medical practice of physicians all over the world.

## Medical Ethics and Human Rights

Dr. Hill then put to the Assembly the following statements and resolutions arising from **Medical Ethics Committee** business.

### Telemedicine

A proposed Statement on the Ethics of Telemedicine (see medical ethics page 91) was unanimously **approved**.

### Human Tissue for Transplantations.

A proposed Statement on Human Tissue for Transplantation was **approved** unanimously.

### Documentation and Denunciation of Acts of Torture

Dr. Hill asked Britte Sydhoff, Secretary General of the International Rehabilitation

Council for Torture Victims (IRCTV) to address the meeting.

Britte Sydhoff, introducing the IRCTV as an international NGO said that it was a pleasure to stand before the WMA and thank them for their support. She explained that the ICRTV had 130 rehabilitation centres in 78 countries.

She was very pleased with the WMA stand on Torture, as exemplified by the Tokyo and Hamburg Statements. The proposed improvements in the Statement on Documentation of Torture constituted a strong supplement to the existing statement. The need for proof of torture is vital and specific training in how to note and provide such documentation is important, as physicians do not know how to do this. She commented that often victims are detained until the evidence is gone.

The Istanbul Protocol and Guidelines help in producing good reports to be used in court. IRCTV is carrying out advocacy and training activities and she stressed that Prevention through documentation can help both the Health and Legal professions. The collaboration of National Medical Associations has been a real part of the success of the training about the Istanbul Protocol.

Dr. Hill thanked the IRCTV for its work and cooperation, in which Dr. Snaedel had been deeply involved.

The proposed revision of the WMA **Resolution** on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (*see Medical Ethics p. 92*) was **approved** unanimously.



## Socio-Medical Affairs

Dr. Hill put to the Assembly the following recommendations arising from the **Socio-Medical committee** business:

### Noise Pollution

The proposed revision of the WMA Statement on Noise Pollution was **adopted** unanimously.

### Family Planning and Right to Contraception

The WMA Statement on Family Planning and the Right of a woman to Contraception was **adopted**.

### Health Hazards of Tobacco Products

The proposed Statement on Health Hazards of Tobacco Products (*see page 95*) was **adopted** unanimously.

Dr. Hill announced that in the Spring, an exciting new project on Tobacco will be announced.

### Health and Human Rights Abuses in Zimbabwe

The proposed **Resolution** on Health and Human Rights Abuses in Zimbabwe (*see page 94*).

The rest of the Council report was **approved**.

## Associates Meeting

In the absence of the Chair, Dr. DuMont, Dr. D. Johnson gave the report of the Associate's meeting. He indicated that there were very spirited discussions although only one Resolution was adopted. This was a Statement on "Ethical Principles for Research on Child Subjects" which, it requested, should be referred to Council for processing.

Dr. J. Appleyard who had made the original proposal said he appreciated the support of the Associates' meeting in referring it to the Assembly with the suggestion of referral to Council. He also urged the Assembly and NMAs to take this matter forward. It was parallel to Helsinki and reflected the concern about child subjects and research in America, Europe and Japan.

The Chair drew attention again to the recommendation that this be referred to Council and Dr. Kloiber commented that it could be considered by Council at its post-Assembly meeting and then be processed.

The proposal that the Statement be referred to Council for processing was **approved**.

Dr. Johnson further reported that the Associates meeting had appointed two representatives and deputies to the Assembly expressed the hope that this would be to the advantage of the Associates, requesting that their role be examined when the analysis Associates' Membership is considered. The report was **adopted**.

## Open session

Dr. Siguero wished to propose a resolution that the writing of prescriptions must be limited to physicians. He was concerned that with pending elections in Spain the nurses asked that they might prescribe. Currently there was a fear of a nurses strike and Dr. Siguero pointed out that the International Council of Nurses supported the concept of nurse prescribing. He considers that prescribing must be limited to physicians exclusively, as only physicians, because of their education, can diagnose and ensure the quality of the appropriate drug prescription. Only the qualified physician has the knowledge of both the appropriate drug and of the risks associated with their prescription. He appealed to the WMA to defend the right to prescribe for physicians. There was a need to appeal to health authorities to ensure this through appropriate legislation. Dr. Nathansen (UK) said that a number of physician's support nurse prescribing from a *Limited List* and that the UK is about to move to nurse prescribing from the National Formulary. The BMA is opposed to this. There is a need for very great care in the drafting of legislation to ensure that the intended nurse prescribing is restricted to a Limited Formulary. There are many problems which are related to "Task Shifting". Prescribing by non-physicians is a world wide trend. WMA must express its position, we have generally enough physicians to deal with prescribing needs.

Dr. Letlape considered the matter to be very complex. It would be difficult to produce a resolution to cover the whole area of needs for prescribing, as we have to consider the challenges of areas in which there are no qualified physicians and patients need care there; people are specially trained to diagnose and prescribe in such areas.

The responsibilities which go with prescribing need to be included in the training. The President, Dr. Snædel, thanked the Spanish Medical Association for raising this issue. While Dr. Nathansen had indicated that "the ball was lost", he felt that it was not lost – we can dialogue with the professions and relevant authorities. The International Federation of Pharmacists was looking at this issue and we must dialogue with them. The matter would be on the agenda of Council.

Dr. Haikerwal (Aust) expressed sympathy for Spain, stating, however, that "the train has moved on". In Australia physicians, nurses and optometrists are moving in this direction. Dialogue is vital. Task substitution must be avoided and medical supervision was essential in any such job substitution. Dr. Mckie (Canada) reported that in Alberta and some other provinces, allied health professionals have the right to prescribe. The Alberta Medical Association set out generic guidelines for allied health professionals including provisions on conflict of interest. There was a need to ensure adequate records. Collaborative care was based on the skills of the provider. The CMA would provide further information to the WMA. A speaker from the Japanese delegation agreed with others that this was a fundamental issue. Dr. Montgomery (Germany) agreed with others that the train had left. He felt that the Ministry of Health was using this concept as a means of breaking down physicians' domination. While he understood the situation in some countries he felt that a Council Working group should be set up. The Administrators think that by using this mechanism they will save money. Dr. Lemye (Belg.) also agreed that "the train had left". Such extension of the right to prescribe could be useful in, for example, Disaster Medicine, but these powers should be provided by the use of exemption mechanisms. Governments, however, do not only



consider the lack of qualified physicians as the problem, but also look at curtailing the prerogatives of physicians. Dr. Figueredo (Uruguay) supported this. There was no lack of qualified physicians in South America but nevertheless the other health professionals were being used to treat some sections of the population even where patently there were enough physicians, and he proceeded to quote a case illustrating this situation.

Dr. Blachar (IMA and President-elect) felt the situation to be both fundamental and threatening. He strongly supported setting up a Working Group to produce a paper for the May meeting of Council.

Dr. Siguero (Spain) thanked contributors for their support and said that he supported Dr. Montgomery's proposal. He had a feeling that some physicians were helping the train to leave! There was no lack of qualified physicians in Spain, politics and some professionals were behind this move. WHO should not be promoting it.

Dr. Hill said this had been a good debate and the issue would be placed on the Council agenda.

Dr. Sabilli (Philippines) referred to a recent television broadcast in which comments were made about Philippine doctors in derogatory chauvinistic terms. He pointed out that his country was spending its own money training physicians who then went abroad to assist in providing healthcare. At the same time, he thanked those countries who had assisted his country with secondary care. However he appealed to other NMAs to assist in stopping the derogatory remarks being made suggesting that diplomas of Philippine physicians could not be checked etc. Such remarks were deplorable. Philippine physicians are asking for an apology from those who do this.

Dr. Hill assured the speaker that the AMA had found the TV statement distasteful. Yesterday the AMA had approached the TV programme supporting the Philippine Doctors in their desire for an apology.

Dr. Chan (Hong Kong) thanked Dr. Kloiber for supporting a small survey on the regulation of the Profession in South East Asia and welcomed the article on Medical Professional in the WMJ. He would like it to be translated into other languages, notably Chinese, and would also like it to be followed up by a survey, perhaps by other NMAs, concerning the right to prescribe. He also felt that it would be most helpful if we could see the results of follow-up of Resolutions and Statements issued by WMA. Finally he suggested that the effects of air pollution should be studied in the profession, both in developed and developing countries considering that this would also need both mid and long term surveys.

The Secretary General commented that there were strict limitations on what WMA, with a limited staff of seven could do. Speaking of Resolutions and Statements etc, he said that implementation was in the hands of NMAs. Developing this he said would like feedback, giving as examples:

- a) Work on Task-shifting. (He had been asked by WHPA to seek this.)
- b) Discussion of the White Paper on Regulation (*WMJ* 53(3) p. 58).

Dr. Kloiber then referred to the forthcoming WHPA conference next year on International Regulation of Health Professions. It was essential that we achieve a common understanding on Self Regulation. Some of the problems he had reported to the WHO. NMAs must also take up this issue. At the Chief Executive Officer's conference concerns over issues of regulation and licensing were expressed and he was looking to NMAs to act on this.

Dr. Hill, closing the session, thanked all those who had contributed to what had been a very valuable session.

#### **General Assembly – 2008**

Dr. Shin then presented a film on Korea and the forthcoming General Assembly, 15-18 October 2008, thanking WMA for agreeing

to come to Seoul and extending a warm invitation to delegates to go to Korea.

#### **Closure**

There being no other business the Secretary General, Dr. Otmar Kloiber, expressed his appreciation of the support received from NMAs, notably in paying their Dues on time. He said that the change in the Dues structure had gone smoothly. We have never had such strong representation from some parts of the world. We need to continue to strengthen this. In thanking NMAs, he particularly mentioned the outstanding commitments of Japan and of India in responding to the increases in dues. He expressed warm thanks to all NMAs who had supported projects on Advocacy including the AMA and the BAK, also the DMA for acting as hosts to the Assembly – observing that this imposes costs on the host NMAs. He reminded the Assembly that the WMA office was a small one and had to depend on members for support.

Turning to direct support, he particularly mentioned the CMA's engagement in Advocacy, Information Technology, and Ethics. He continued that, while it was not possible to identify all contributions, he had to mention the Officers, Chairs of committees etc and the Chair of Council – all of whom contribute a great deal. The BMA, Norwegian MA, SAMA and BAK had all supported projects or given technical support, such as the legal advice provided by the Israel MA. Finally, he thanked most warmly Dr. Jensen and his Vice Chair Dr. Buhl, the DMA and its staff for the splendid organisation, arrangements and hospitality we had experienced during the meeting in Copenhagen.

Dr. Hill finally gave a warm thanks to the interpreters and to delegates for all their enthusiasm and hard work and formally closed the Assembly.



## 178<sup>th</sup> WMA Council Meeting

178<sup>th</sup> Council took place in the Marriott Hotel, Copenhagen on 6<sup>th</sup> October 2007

The Chairman, Dr. Hill opened the meeting with business arising from the General Assembly and sought the views of Council on the subject of “task shifting” which was a matter of major concern to NMAs. He said that there were considerable differences in the degree to which this was occurring in different parts of the world and called for expressions of interest in membership of a working group on this topic.

Prof. Nathanson was interested, in particular because this was a matter of special importance in the UK and members from Canada, Israel, Belgium, Germany, Norway, Brazil, Korea, Spain, Iceland indicated an interest. After the Chair pointed out that working groups were limited to six members and it was **agreed** that the Chair would select the group of six.

Dr. Davis (AMA) wondered whether it was too late to set up a working group. Had the train not already left the station?

Council considered a proposed Statement on “Research and Children” from the Associates’ group, referred to the Council by the Assembly. Dr. Kloiber pointed out that the Assembly’s wish was that this be referred to NMAs, was there a need for a working group? Dr. Nathanson said that this was an important area, it overlapped Helsinki. She wondered whether there should be a self-standing group or that this be included in the Helsinki group remit. Dr. Appleyard, a Past President, who had made the original proposition agreed that this was important -a feeling which was reflected at the Associates’ meeting. Helsinki was an “umbrella” declaration. The concerns about children were difficult to incorporate in Helsinki. The proposal was specifically geared to the needs of children it would not interfere with Helsinki. He would welcome this going to NMAs for their comments and

also for them to take this forward”. Dr. Bagenholm, Chair of Ethics, thought that this should be a separate statement, although it might eventually be part of Helsinki. She supported its referral to NMAs for their comments.

The Council **agreed** that the proposed statement should be circulated to NMAs for their views and that the Helsinki working group should co-ordinate the comments of NMAs for the next Council meeting. Amongst the views expressed there appeared to be a consensus that the statement should be a separate one but should be linked to the Helsinki Declaration.

Dr. Williams (Ethics consultant) said that the issue had not been dealt with adequately in Helsinki up to the present. Now there was a new interest in research ethics. Helsinki set out the principles but WMA did not want to go any further than that. It was a question of why stop here with children? Suggestions had been received which included vulnerable populations, concerns about women etc – would we not be asked to include the aged and deprived populations? Dr. Hill expressed his personal view that the issues relating to children were really different. Dr. Kloiber pointed out that the request before Council was whether to include something, exclude it or include other areas. The Working Group could come back with a considered view, taking into account the views of NMAs.

Mr Tholl pointed out that the Canadian Medical Association already had a statement. The issue could go into Helsinki or, as in Canada, be a separate document. It should be left to the working group to come forward with a suggestion.

Dr. Bagenholm felt that it might be better to have separate working groups rather than

making Helsinki larger while Dr. Vilmar considered that we should concentrate on children first. We “lack knowledge about research in children. It might in the end have to be taken up in the general review”.

In response to a call by Dr. Hill, expressions of interest in working on this were made by Israel, Brazil, Canada, South Africa and the UK.

Under Any Other Business, Dr. Hakerwal (Aust) raised the issue of corporate governance. He asked who were directors – which countries? Dr. Hill said that WMA was a USA state registered organisation and that Council members are directors.

Dr. Plested (AMA) referred to the new advocacy adviser’s contract needed for the new Advocacy position, which would have to be in France. He pointed out that if the person was hired in another country this might be illegal in France. He wondered whether it would be possible for a third member association to do the hiring or if he could be made a 90 day adviser, as we have to use French rules. Dr. Davies queried whether he could be hired in Geneva, or an NMA could second someone.

Dr. Kloiber indicated that similar problems would arise in Geneva as in France and that he had sought legal advice on how to deal with the employment in the most efficient and legal manner

Finally the Council considered how the WMA in its activities could be more inclusive and how the Associate members could participate in a more productive way. The Chair said that he would look into all issues concerning the Associates, and referred to the valuable Open Session of the Assembly which we had experienced earlier. In the absence of any other business the meeting was closed.



## Inter-professional training seminar on infection control in South Africa

### Health care workers safety in the context of drug resistant TB in low and middle-income countries

The World Medical Association (WMA) initiated together with the International Council of Nurses (ICN), the International Hospital Federation (IHF) and the International Federation of Red Cross and Red Crescent Societies (IFRC)/South African Red Cross Society, members of the Lilly MDR-TB Partnership, a workshop in Cape Town, South Africa, on health care worker safety and infection control, in the context of drug-resistant TB in low and middle income countries. The 2-day workshop, 12-13 November 2007, brought

together South African community support workers, hospital managers, nurses and physicians working in the context of drug-resistant TB to jointly examine and address these issues. This common seminar for all four health care professions was the first one held in South Africa.

Given the already critical shortage of health providers and the generally weak health systems in the regions most affected by XDR-TB and MDR-TB, particularly in southern Africa, anxiety about safety in the health care environment runs high and can dis-

suaude health providers from accepting assignments in these settings. The workshop programme, therefore addressed administrative, environmental and personal respiratory protection with the objective of identifying good practices and challenges to the implementation of joint recommendations for facilities and health workers. It drew up recommendations for implementing guidelines in their hospitals and suggested establishing a common working group with a plan of action to communicate the identified practices and recommendations.

## WHO publishes new standard for documenting the health of children and youth

GENEVA/VENICE – WHO published the first internationally agreed upon classification code for assessing the health of children and youth in the context of their stages of development and the environments in which they live.

*The International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY)* confirms the importance of precise descriptions of children's health status through a methodology that has long been standard for adults. Viewing children and youth within the context of their environment and development continuum, the ICF-CY applies classification codes to hundreds of bodily functions and structures, activities and participation, and various environmental factors that restrict or allow young people to function in an array of every day activities.

The rapid growth and changes that occur in first two decades of life were not sufficiently captured in the International

Classification of Functioning, Disability and Health (ICF), the precursor to the ICF-CY. The launch of the ICF-CY addresses this important developmental period with greater detail. Its new standardized coding system will assist clinicians, educators, researchers, administrators, policy makers and parents to document and measure the important growth, health and development characteristics of children and youth.

Children who are chronically hungry, thirsty or insecure, for example, are often not healthy and have trouble learning and developing normally. This classification provides a way to capture the impacts of the physical and social environment so that these can be addressed through social policy, health care and education systems to improve children's well-being.

"The ICF-CY will help us get past simple diagnostic labels. It will ground the picture of children and youth functioning and dis-

ability on a continuum within the context of their everyday life and activities. In this way it enables the accurate and constructive description of children's health and identifies the areas where care, assistance and policy change are most needed," said Ros Madden, Australian Commission on Safety and Quality in Health Care, and, Chair of the Functioning and Disability Reference Group of the WHO Family of International Classifications (WHO-FIC) Network.

The ICF-CY has important implications globally for research, standard setting and mobilizing resources. "For the first time, we now have a tool that enables us to track and compare the health of children and youth between countries and over time," said Nenad Kostanjsek of WHO's Measurement and Health Information team. "The ICF-CY will allow countries and the international community to take informed action to improve children's health, education and rights, by treating their health as a function of the environment that adults provide."

The classification also covers developmental delay. Children who achieve certain milestones later than their peers may be at increased risk of disability. Using this classification, health practitioners, parents and teachers can describe these delays precisely in order to plan for health and educational needs and frame policy debates. The children and youth version of the *International Classification of Functioning, Disability*

and Health (ICF-CY) was launched in Venice, with international praise:

“The publication of the ICF-CY by the WHO provides, for the first time, a standard language to unify health, education and social services for children,” said Dr. Margaret Giannini, Director of the Office of Disability, U.S. Department of Health and Human Services.

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## First List of Essential Medicines for Children released – WHO increases efforts to ensure appropriate medicines for children

WHO launched a new research and development campaign entitled “Make Medicines Child Size”, launched in London intensifies efforts to ensure that children have better access to medicines which are appropriate for them.

The campaign also coincided with the release by WHO of the first International List of Essential Medicines for Children. The List contains 206 medicines deemed safe for children and addresses priority con-

ditions. More than half of the medicines prescribed for children in industrialised countries are medicines prescribed and dosed for adults and are not authorised for children. Lower access to medicines in developing countries adds to the problems there.

Dr. Hans Hogerzeil, Director of Medicines Policy and Standards at WHO emphasized this saying “A lot more needs to be done. There are priority medicines that have not

been adapted for childrens’ use or are not available when needed”.

WHO will also work with governments to promote changes in their legal and regulation requirements for childrens’ medicines.

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## Projected supply of pandemic influenza vaccine sharply increases

23 OCTOBER 2007 | GENEVA – Recent scientific advances and increased vaccine manufacturing capacity have prompted experts to increase their projections of how many pandemic influenza vaccine courses can be made available in the coming years.

Last spring, the World Health Organization (WHO) and vaccine manufacturers said that about 100 million courses of pandemic influenza vaccine based on the H5N1 avian influenza strain could be produced immediately with standard technology. Experts now anticipate that global production capacity will rise to 4.5 billion pandemic immunization courses per year in 2010.

“With influenza vaccine production capacity on the rise, we are beginning to be in a much better position vis-à-vis the threat of an influenza pandemic,” Dr Marie-Paule Kieny, Director of the Initiative for Vaccine Research at WHO, said today. „However, although this is significant progress, it is still far from the 6.7 billion immunization courses that would be needed in a six month period to protect the whole world.“ “Accelerated preparedness activities must continue, backed by political impetus and financial support, to further bridge the still substantial gap between supply and demand,” she said.

This year, manufacturers have been able to step up production capacity of trivalent (three viral strains) seasonal influenza vaccines to an estimated 565 million doses, from 350 million doses produced in 2006, according to the International Federation of Pharmaceutical Manufacturers & Associations. According to experts working in this field, the yearly production capacity for seasonal influenza vaccine is expected to rise to 1 billion doses in 2010, provided corresponding demand exists.

This would help manufacturers to be able to deliver around 4.5 billion pandemic influenza vaccine courses because a pan-



demic vaccine would need about eight times less antigen, the substance that stimulates an immune response. Vaccine production capacity is linked to the amount of antigen that has to be used to make each dose of the vaccine. Scientists have recently discovered they can reduce the amount of antigen used to produce pandemic influenza vaccines by using water-in-oil substances that enhance the immune response.

The progress was reported at the first meeting of a WHO Advisory Group on pandemic influenza vaccine production and supply. The Global Action Plan Advisory Group, an independent, international committee of 10 members, met at WHO headquarters one year after eight new strategies to increase pandemic influenza vaccine were identified and pub-

lished in the WHO *Global pandemic influenza action plan to increase vaccine supply*.

At the Advisory Group meeting, other progress on the Global Action Plan was discussed. WHO reported it is setting up a training hub that would serve as a source of technology transfer to developing countries.

The Advisory Group also discussed a new business plan which assessed options for further increasing vaccine production capacity and reviewed priority next steps. The three most valuable options include continuing to promote seasonal influenza vaccine programmes, supporting the industry to sustain production capacity beyond seasonal demand and enabling some vaccine production facilities to change, at the onset of a pandemic, from producing inacti-

vated vaccines to live attenuated vaccines. Due to the higher yields obtained with live attenuated influenza vaccine technology, facility conversion could, by 2012, bridge the expected supply-demand gap and produce enough vaccine to protect the global population within six months of the declaration of a pandemic.

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## Protecting health from climate change – World Health Day 2008

WHO has announced that the topic for World Health Day 2008 will be “Protecting Health from climate change”. Sixty years ago WHO was founded as part of the international commitment to build global security and peace. In the same spirit of universal solidarity, WHO is seeking to unite the nations of the world in combating the threat to public health safety from climate change.

In parallel with the increasing international emphasis on the need to place the reduction of environmental climate change high on the international agenda to maintain sustainable development, the need to also address the environmental effects on public

health is essential. Dr. Chan, Director General of WHO comments “Health professionals are on the front line in dealing with the impacts of climate change. The most vulnerable populations are those who live in countries where the health sector already struggles to prevent, detect, control and treat diseases and health conditions including malaria, malnutrition and diarrhoea. Climate change will highlight and exacerbate these weaknesses by bringing new pressures on public health, with greater frequency.”

She added “We need to put public health at the heart of the climate change agenda. This includes mobilising governments and stake-

holders to collaborate on strengthening surveillance and control of infectious diseases, safer use of diminishing water supplies, and health action in emergencies”.

On World Health Day, 7<sup>th</sup> April 2008, marking the Sixtieth anniversary of the World Health Organisation, communities and organisations around the world will host activities to create greater awareness and public understanding of the health consequences of climate change and the impact and interdependency of health with other measures taken to reduce and control the effects of climate change in policy decisions and policies taken at national and international level.





## New Internet course on multidrug-resistant tuberculosis MDR-TB

Multi Drug Resistant Tuberculosis is difficult to treat and knowledge about it is scattered around the world. Thanks to WHO there is not only a strategy to treat tuberculosis the “DOT Strategy” but now there are also WHO guidelines on how to prevent and treat MDR-TB using the existing evidence in the world.

Guidelines however are theoretical knowledge that doesn't easily transfer into practice in the real world. The WMA therefore volunteered, together with its member organizations, the South African Medical Association, the Norwegian Medical Association, to produce a learning programme for the MDR-TB Guidelines and offer it electronically through the Internet.

This course is a free self-learning tool allowing physicians in all parts of the world to learn and test their knowledge about MDR-TB using the Internet. The Foundation for Professional Development of South Africa wrote the learning programme, which subsequently has been reviewed by an international advisory committee and then transformed into an Internet-based course by the Norwegian Medical Association. A first testing phase with an evaluation was implemented in South Africa. The CME accredited MDR-TB online training course is now accessible from the WMA web page [www.wma.net](http://www.wma.net).

The course is free of charge and is available in English. Soon it will be translated into French, Spanish, Chinese and Russian.

### Review \*

## Human Rights and Prisons – a training programme on human rights for prison officials

Professional Training Series No. 11, UN Publications, UN New York and Geneva 2005, ISBN 92-1-15416-3

Prisons are places where a higher proportion of people with significant physical and mental health problems are incarcerated, but also where the health care they receive is likely to be substandard. Pressures on medical staff, lack of funding, uncertainty about the ethical duties of doctors and the potentially restrictive attitude of prison governors can all reduce access to good quality and impartial healthcare.

Although the rights of prisoners, and the duties of those who supervise them are well established, and comprehensively set out in a variety of declarations, treaties, covenants and conventions, these are often poorly understood by prison officials. Either they are not seen as applicable to a particular institution, or inflexible procedures that

undermine human rights are not reviewed or changed.

It is therefore welcome that the European Regional Office of WHO has published a modular course on human rights training for people who have a responsibility for detainee care. While its focus is prison detention, it is equally applicable to other forms of custody, such as police stations and detention centres. It has direct relevance to doctors, but unfortunately does not suggest that prison medical staff, who are often as much in need of human rights and ethics teaching, should be exposed to the principles that the document promotes.

Designed in modular form, and backed by a manual, listing standards, sources and systems, a compilation of relevant human rights instruments, and a condensed pocket guide, the training is designed to be delivered over a period of five days. While aspiring to a variety of aims, a key purpose is to equip students with a broad knowledge of human rights practice in relation to prisons,

and to relate these to their day-to-day experience. An important and measurable outcome must be to change attitudes, so that prejudice is replaced with an understanding of the need to protect the dignity of the vulnerable.

Much of the success of the courses that are based on these documents will depend on the quality of those delivering the training. It is not suggested that these should include doctors, and this is a gap that should be filled, since the relationship between doctor, prisoner and institution is fertile ground for highlighting human rights and ethical dilemmas that are real and practical. Through their relevance and familiarity they can provide a good basis for the group discussions that form a major part of the training.

The section on health is adequate, but not fully complete. There is little reference to assessment of self-harm risk – a major cause of death in custody being suicide – and the monitoring of prisoners with psy-

\* This is the first of two reviews on *Prison Health*. The second will review a recent publication by the WHO European Office on *Health in Prisons* and will appear in the next issue WMJ 54 (1).



chiatric problems. In any prison in the world, there will be a relatively high proportion of inmates with alcohol and/or drug dependence, and a range of psychiatric disorders. Prison staff can be very influential in helping patients to develop a willingness to address their addiction, and more could be taught on the often simple and accessible services that prisons can provide. Alcohol and drug misuse are common causes of recurrent, often petty crime, and more understanding about the nature of the disease of addiction, and the capacity for the addict to change, would be welcome. The sections on drug misuse are written in disciplinary, rather than therapeutic terms.

Backed by high-level declarations, and written in the language of rights, the starting point for the training module on health is that prisoners, like other members of their society, deserve access to the highest available standard of health. Given that a prison population is disproportionately unhealthy, and that resources, particularly in secondary care are limited, the realisation of that right is often a distant aspiration. Prison staff who carry an attitude that equates a loss of liberty with a removal of basic rights, add fuel to the fires of resentment and stigmatisation, thereby increasing a sense of helplessness in those for whom they are responsible. An institution run on principles that acknowledges rights is more likely to be one in which staff have a higher level of work satisfaction and esteem. Training in human rights may not turn them into advocates for change, but may help them to operate in a way that promotes decency and dignity.

For doctors who access the training manual, there is much to challenge attitudes that in my experience have developed more as a result of a lack of knowledge than through outright discrimination. Prison medical staff frequently assume that the "dual relationship" that exists in their specialty (and in others), implies a reduction in their fundamental medical ethical duties. While the need to consider the interests of the prison is ever-present in the doctor's mind, it should only rarely lead to breaches of consent and confidentiality. A relationship of trust between the detained patient and the doctor has therapeutic value, allowing the

doctor more opportunities to provide care, along with reassurance that confidentiality will usually be kept.

Welcome elements in the training package are the need for prisoners to undergo a medical examination as soon as possible after arrival, respect for cultural beliefs, and the risks that HIV/AIDS sufferers will be isolated through ignorance and fear of infection. However, more could be said about the need to be alert to signs of abuse and inappropriate restraint measures, and on the duty of medical staff to report abuse. Doctors have the benefit of independence and an ethical duty to report abuse, so are well-placed to speak out when they encounter abusive behaviour. They also have an obligation to record, not just the nature of the abuse and the injuries sustained, but also the action they take as a result.

The training manual will not help doctors looking for more certainty on the issue of gross abuse. Definitions of torture and degrading treatment are not sufficiently robust or clear, leaving the student in some doubt as to where the involvement of a doc-

tor begins and ends. While there is a clear condemnation of physician involvement in torture, current examples such as force-feeding and the provision of advice on interrogation should be illustrated. At a time when the ethical duties of doctors have been redefined in the interests of national security, these contemporary situations deserve more reflection.

An essential part of training is evaluating its effect, and the course recognises that this should be built in over the long-term, using attitudes and system change as key markers of progress. As the manual states, there is a lot more to the teaching of human rights than a "lecture and a wave". Participants need to be challenged, and their attitudes and behaviour changed, if our prisons are to become more humane places.

*Michael Wilks*

Michael Wilks is a forensic physician, and Chairman of the Rehabilitation of Addicted Prisoners Trust in the UK. He is President of the Standing Committee of European Doctors (CPME) for 2008/9.

## Letter

Correspondence  
Hon. Editor  
World Medical Journal

Sir,

The September 7<sup>th</sup>, 2007 issue of the Medical Journal of the World Medical Association is carrying a story about "presumed Consent" for the removal of organs from dead for transplantation.

The U.K. Chief Medical Officer, Sir Liam Donaldson is quoted as saying that the practice of "presumed Consent" would increase the number of organs available for transplantation to the betterment of the health of the recipients.

I am troubled by the apparent violation of the first tenet of the Nuremberg Code of Medica Ethics which clearly states that

"Freely Given Informed Consent" is the sine quo non of all activities by physicians in dealing with patients.

I would suggest that this practice be stopped immediately.

I would also suggest that physicians all over the world should sign the donor card and carry it in their wallets and stipulate to their loved ones that they want their organs harvested for transplantation.

Unless we, physicians show by example the importance of the donation of organs there is little chance that there will ever be enough organs available to help the living.

Michael J. Franzblau MD, FAAD  
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