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## Dear colleagues throughout the world!

It is a great honor to address you as the new editor of the World Medical Journal. The World Medical Journal reflects the thoughts and ideas of physicians from all parts of the world. I invite you to not only read the Journal, but to be a part of the Journal by filling it with your manuscripts, illustrations, reviews and opinions. Your contributions are the heart and soul of the Journal.

First, I would like to take this opportunity to thank Dr. Alan Rowe and pay special tribute to his longstanding Editorship of the World Medical Journal. Dr. Rowe's global perspective of medicine, strong sense of ethics, wisdom and brilliant literary skills have shaped this Journal into a truly outstanding publication. His tireless efforts have left a unique impact on the global medical community and I will do my best to continue the work he has begun. We are truly grateful to Dr. Rowe for his long-standing and altruistic work.

As the new editor, I will have the opportunity to communicate with leaders of medical associations from all parts of the world. However, I will do more than speak to the leaders of our member organizations. I will encourage these organizations to use our Journal as a means of expressing their views and the concerns of their members. The national medical organizations in small and developing countries may not have the resources to pay dues and attend WMA meetings and conferences. However, they are in our brotherhood – *gens una sumus*. I will work with medical organizations in all countries to engage their active participation in our Journal.

I will also work directly with physicians throughout the world to try to make the WMJ more personal. I would like to see the Journal become a voice for our colleagues in all countries. Of course, in order to converse with someone, it is best to be able to see the person's face and to look him or her in the eyes. Global organizations can rarely do this, so I will try to do the next best thing. I will ask you to write about who you are, what you feel and what you think. What urgent issues do you face? What are the pressing medical needs in your country? We will continue our discussions of social, medical, and ethical issues on national and international levels, but also expand the discussions to the personal physician level.

Every country has unique medical problems, but often similar issues exist elsewhere. For example, in Latvia we currently face the predicament that the government is reluctant to increase the excise-tax for tobacco. Cigarettes can be bought cheaply in Latvia and many tourists come from other countries in order to buy large quantities of cigarettes. The low price of cigarettes also affects the Latvian people

because there is little financial incentive to stop smoking. The Latvian Medical Association has taken a stand against smoking and has urged the government to ban smoking while driving. I would like to know more about your experiences in the struggle to eliminate smoking.

I will also ask you to write about your national medical association, organizations and your personal experiences. Each story may be an etude, opus, or masterpiece. I would like you to send me pictures so that along with your publication we can show who you are. This is a good way to get to know one another. Physicians from Somalia and Vietnam have already answered my first call. Thank you! In our very next edition we would like to have stories from many other countries and their medical organizations. Please don't hesitate to communicate with me.

As Editor of the WMJ, I will communicate with editors of medical journals in countries throughout the world. Large countries with thousands of physicians have multiple weekly and monthly medical journals which are readily available. Many journals are supported by advertising and are provided free of charge to every physician. On the other hand, in small countries where the health-care budget is constrained, scanty journals are published infrequently and often are not accessible to every physician. Most of these medical journals are edited by physicians who are well aware of the problems facing physicians and patients in their own country. I will pay particular attention to physician editors and communications from smaller countries to help highlight local issues. This may help find common solutions. I will work to provide a forum for a global perspective on issues that are important to all.

The World Medical Journal is a global publication and as such I plan to dedicate each issue to one of our member countries. The cover will depict a symbol or work of art from that country. As you can see, I have taken the Editor's prerogative and begun with my country, Latvia. Our cover shows a panoramic view of Riga, the capital of Latvia and a painting „Physician and Apothecary” painted by Latvian artist, Miervaldis Polis. The painting depicts the medical environment of Riga in the 15<sup>th</sup> century. Our next cover will be from Norway and the following from Somalia.

Dear colleagues! Thank you for allowing me to serve as your editor. Please join me in working to improve our common bond: the World Medical Journal.

*Sincerely yours –  
Pēteris Apinis, M.D.  
President of the Latvian Medical Association,  
Editor-in-Chief of the World Medical Journal*



## From the Secretary General's desk

### The global Shortage of Health Professionals must concern all of us



**Dr. Otmar Kloiber**  
Secretary-General  
(Germany)

Most countries of the world experience a shortage of health professionals. This has led to migration – more or less – along a wealth or payment gradient from East to West, from North to South. Countries like the United States Canada or the Scandinavian countries are now long time net importers of physicians and other health professionals (graph 1), while countries in Asia, like India, China and the Philippines as well as Sub-Saharan African countries are net providers of physicians (graph 2). A third group lies in the middle: immigration and emigration are strong and in a few cases even balanced like Germany, the United Kingdom or the Czech Republic.

While the rich countries report shortages especially in rural practice, countries in Sub-Saharan Africa are factually depleted from physicians. Comparing the density of physicians in counties of Sub-Saharan Africa to the density in Europe or North America makes it clear that the rich countries suffer from a relative, if not a luxury problem, when compared to the poorest countries in

the world. But does that mean they don't have to worry?

Indeed the shortage of physicians especially in the European Countries and North America is harmless only on the first look. Internally the undersupply of health services can produce severe tension within the countries and regions. But more important, although the relative numbers of physicians in demand is comparatively low, it translates into a high absolute number on a global scale. This produces a pull to the physicians in poorer countries. What we find is a significant percentage of physicians trained in Africa or Asia showing up to work in the United States, Canada, West and Central Europe. The relative shortage of physicians in the rich countries leads to an absolute deficit in the poor countries.

However special migration is by far not the only problem as money is not the only driving force. When we look to the reasons for migration (see graph 3) we find remuneration as the first argument, but closely followed by a group of other reasons, which can be summarized under working and living conditions. And indeed some migrations streams e.g. from Germany to Scandinavia are not being driven by money, but by chances for a better and more satisfying work environment, more time for patient care, more time for the family.

The quantitatively biggest loss to the work force in Central Europe occurs because of its demographic shift combined with a set of recent health reforms that are driving the traditionally long working physicians into early retirement. Loss of professional autonomy, clinical independence, a ridiculous and still growing amount of bureaucracy and financial disincentives make many physicians to give

up early, if they are not young enough to go away.

Counteracting this by just producing more physicians doesn't work either. Germany produces more physicians than it need. Yet during the last decade not only the dropout rate of medical students increased dramatically, even worse, successful graduates don't show up in clinical practice. More than a fifth of those completing medicine either seek directly positions abroad or go to other professions.

What can be an answer: The rich health care systems developed three strategies that can be summarized under the terms

- **Hotlines:** don't provide care – just talk about it! Certainly people in western countries want to be served immediately, hotlines are a demand of our times. But they are also used to keep patients away from their physicians.
- **Rationing:** pretending that higher quality requires concentration. Disinvestment strategies usually come with arguments of quality. Services have to be concentrated to get higher numbers and more proficiency, drugs have to be intensively tested and evaluated over and over again. Sometimes these arguments are true, sometimes this is nothing but a hidden rationing.
- **Substitution:** "You don't need a physician!" More and more medical tasks are shifted to nurses, midwives, pharmacists and other health professionals. Indeed many automated and standardized procedures can be done by others than physicians and delegation may be a reasonable way to discharge physician. In a number of cases even complex procedures can be done by specially trained nurses or other professionals. However, what we currently see in charging nurse practitioners, pharmacists and others is nothing else but to downgrade primary care to a non-professional, because of non – educated level.

To a certain extent it works. People feel satisfied, because they are immediately taken care of. What they don't realize is that doing just something often is not enough and sometimes even dangerous.

When we turn our look to the poorest countries of the world, it becomes clear that the substitution of physician and often nurse capacity is unavoidable. With physician/population ratios as low as 1/50000 there is no way that physicians will be available for all medical services. Task shifting, as the WHO calls the provision of medical and nursing services by laypersons, is necessary. However, as clear as a necessary and unavoidable emergency measure WHO wants to call it first class care.

Laypersons can be trained and guided to valuable and often high quality care. The best example of that is the Red Cross/Red Crescent workforce, which for most of it is a voluntary lay structure. They do undoubtedly a terrific job. However, they are embedded in a well-structured organization providing continuous training, guidance, support and supervision and most of all they work with clear and strict limits.

For some specific tasks this may be possible and actually is already being deployed in several countries. Often with specific programs and limited to certain tasks. Unfortunately people in those countries don't only get the diseases for which there are programs i.e. for HIV/AIDS, tuberculosis, malaria and river blindness, they get all the other problems people get: heart infarcts, mental disorders, rheumatism, injuries and so on. How lay community workers should provide a first class care for all those illnesses and injuries probably will remain a secret. But worse: If not combined with measures to invest and strengthen the remaining professional workforce Task Shifting will even drive out the last health professionals.

Of course all those programs are supposed to be evaluated. But in the past those evaluations have served as justifications tools looking to exactly what they wanted to

## Doctors and nurses trained abroad working in OECD countries

| OECD country   | Doctors trained abroad |                     | Nurses trained abroad |                     |
|----------------|------------------------|---------------------|-----------------------|---------------------|
|                | Number                 | Percentage of total | Number                | Percentage of total |
| Australia      | 11 122                 | 21                  | NA                    | NA                  |
| Canada         | 13 620                 | 23                  | 19 061                | 6                   |
| Finland        | 1 003                  | 9                   | 140                   | 0                   |
| France         | 11 269                 | 6                   | NA                    | NA                  |
| Germany        | 17 318                 | 6                   | 26 284                | 3                   |
| Ireland        | NA                     | NA                  | 8 758                 | 14                  |
| New Zealand    | 2 832                  | 34                  | 10 616                | 21                  |
| Portugal       | 1 258                  | 4                   | NA                    | NA                  |
| United Kingdom | 69 813                 | 33                  | 65 000                | 10                  |
| United States  | 213 331                | 27                  | 99 456                | 5                   |

NA, not applicable.

**Graph 1:** The health care systems of the rich nations are strongly depending on immigrant physicians. (World Health Report 2006)

## Doctors trained in sub-Saharan Africa working in OECD countries

| Source country              | Total doctors in home country | Doctors working in eight OECD recipient countries* |                                      |
|-----------------------------|-------------------------------|--|--------------------------------------|
|                             |                               | Number   | Percentage of home country workforce |
| Angola                      | 881                           | 168  | 19                                   |
| Cameroon                    | 3 124                         | 109  | 3                                    |
| Ethiopia                    | 1 936                         | 335  | 17                                   |
| Ghana                       | 3 240                         | 926  | 29                                   |
| Mozambique                  | 514                           | 22   | 4                                    |
| Nigeria                     | 34 923                        | 4 261  | 12                                   |
| South Africa                | 32 973                        | 12 136   | 37                                   |
| Uganda                      | 1 918                         | 316  | 16                                   |
| United Republic of Tanzania | 822                           | 46   | 6                                    |
| Zimbabwe                    | 2 086                         | 237  | 11                                   |
| <b>Total</b>                | <b>82 417</b>                 | <b>18 556</b>                                      | <b>Average 23</b>                    |

\* Recipient countries: Australia, Canada, Finland, France, Germany, Portugal, United Kingdom, United States of America.

**Graph 2:** Many African countries have lost significant parts of their workforce to the rich countries of the world. (World Health Report 2006)

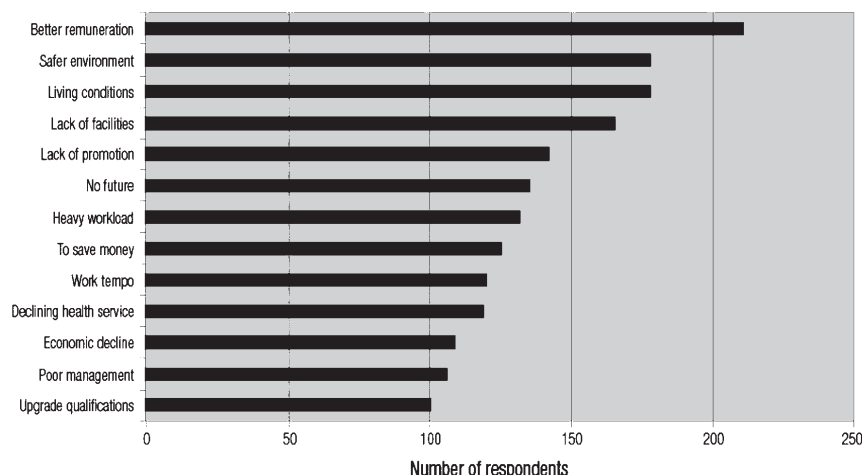
see. No doubt, as long as there is external money for a task-shifting project on HIV/AIDS care you will see a decline of mortality from AIDS. But what happens to all the other medical needs that can't no longer be served. What happens to the surrounding communities, which may have nothing left? How sustainable will be a non-paid lay force when outside support will be gone?

Now, we already see a huge problem in rise of Multi-Drug-Resistant Tuberculosis (MDR-TB) and even worse Extended-Drug-Resistant TB (XDR-TB). And as a WHO officer correctly analysed: XDR-TB is nothing else than badly managed MDR-TB, and MDR-TB is nothing else than

badly managed TB. This gives us a glimpse preview on what may happen with resistance development to anti-retroviral drugs in non-professionally structured treatment programs.

Health care is highly depending on hope and trust. For patients and those who work in the system. If hope and trust is missing, development will not happen. The health care systems of many countries of this world are living proof of this. Task shifting without strengthening the existing health professional workforce will down-spiral the health care systems of the poorest countries even more leading to the exodus of even the last health professionals.

### Health workers' reasons to migrate in four African countries (Cameroon, South Africa, Uganda and Zimbabwe)



**Graph 3:** Payment is an important reason for health professionals to migrate, but working and living conditions are likewise important. (World Health Report 2006)

Unfortunately, the rich countries installing the programs for task shifting in the poor countries are at the same time the magnets for migrant physicians. Bringing the workforce situation of the rich countries in order, which means in the first place improving the work and life conditions for the health professionals is a necessary prerequisite to help the health care systems of the poor countries of this world.

Training sufficient numbers of health professionals, but also providing well enough work and living conditions for them is an urgent demand in rich and poor countries. And just because of the strong attraction the rich countries produce, fixing their workforce problem is no luxury item but a question of survival for many nations.

## WHO Executive Board, 122<sup>nd</sup> session, 21– 26 January 2008

Between the yearly sessions of the World Health Assembly, the “Executive Board” is the highest steering body of the World Health Organisation (WHO). From January 21<sup>st</sup> to 26<sup>th</sup>, 2008 it met in Geneva for its 122<sup>nd</sup> session. The Executive Board dealt with many technical and health matters ranging from the pandemic influenza preparedness, or the Poliomyelitis to the strategies to reduce the harmful use of alcohol and the monitoring of health-related Millennium Development Goals<sup>1</sup>. Some of which the Health Professions, admitted as observers to the Session, took a common stand on. The board recognized the international discussion about climate change and iterated on its effects on human health.

### Developing effective health responses to climate changes

Of particular interest is the **resolution on climate change and health** that was adopted by

the Board for submission to the World Health Assembly. The resolution namely recognizes that “the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably strengthened”<sup>2</sup> and that “reinforcing health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health”<sup>3</sup>.

The Board therefore recommends the World Health Assembly to take several actions, such as for WHO Director General to draw to the attention of the public and policy-makers of the serious risk of climate change to global health security and to the achievement of the health-related Millennium Development Goals, and, to work with appropriate UN organisations and other agencies in order to develop capacity to assess the risks from climate change for human health and to implement effective responses. Dr

Margaret Chan, the Director General of WHO, is also encouraged to consult Member States on the preparation of a work plan for scaling up WHO’s technical support to Member States in that area.

### Voicing health professions’ concerns to the Executive Board

The World Medical Association’s secretariat followed closely the Board session and took an active role together with the other partners in the **World Health Professional Alliance**<sup>4</sup>. The WHPA is a unique alliance of dentists, nurses, pharmacists and physicians addressing global health issues and striving to help deliver cost effective quality health care worldwide. The World Medical Association represents the physicians in this Alliance.

The WHPA identified three key themes out of the WHO Board agenda, on which it

1 The working documents and adopted resolution of WHO Executive Board can be downloaded from: <http://www.who.int/gb/>

2 Preamble, indent 6

3 Preamble, last indent

4 FDI World Dental Federation, International Council of Nurses, International Pharmaceutical Federation, and the World Medical Association - <http://www.whpa.org/>

addressed the Executive Board with joint statements.

- Female genital mutilation, a severe violation of women's human rights

In its statement, the Alliance welcomes the report by WHO secretariat on female genital mutilation (FGM), noting the slow rate of decline of these practices, and praises the draft resolution submitted to the Board for adoption. Because of its serious detrimental impact on the physical and mental health of women and girls, female genital mutilation is a matter of deep concern to health professionals. The WHPA therefore urges Medical and Nursing Associations, and invites the support of other health professions associations, to develop educational programs that would:

- Include adequate information on the acute dangers of female genital mutilation for women and girls;
- Raise awareness on such practices as a severe violation of women's human rights that physicians or other health professionals should never practice under any circumstances,
- Encourage physicians and nurses to inform women, men and children about FGM and discourage them from performing or promoting such practices.

In the end –the members of the Executive Board could not find a compromise on several controversial amendments put forward by the US delegation. The text will therefore be submitted – in its current version - to the World Health Assembly in May.

On the 6<sup>th</sup> of February, in a statement to mark the international day of zero tolerance to FGM, the WMA repeated its strong condemnation of this practice and expressed serious concern about the increasing tendency for female genital mutilation to be carried out by medical personnel.

- Addressing the health of migrants from a human rights' perspective

While welcoming the initiative from WHO secretariat in this area, the WHPA emphasizes in its statement some key issues that should be addressed by the Board in its resolution:

- The **legal status of migrants**, whether documented or undocumented, constitutes an important health determinant. Although all migrants are exposed to the particular trauma of the migration process, the situation is even more acute for undocumented migrants in particular when accessing health care. In addition, the Alliance deplores the practice in some destination countries whereby health professionals are encouraged or even constrained to denounce or give personal details to the authorities on undocumented migrants. This blatantly violates the fundamental principle of patient confidentiality, threatens the patient/health care professional relationship and, inappropriately, introduces law enforcement responsibilities within health professionals' scope of practice.
- **Children of undocumented** migrants start their lives disadvantaged because they may not be registered at birth. The WHPA is deeply concerned that unregistered and undocumented children face exclusion from access to health services, such as immunization, and to schooling
- The Alliance deplores as well the discrimination often faced by **migrant health professionals** in accessing social and health services in receiving countries. Other forms of discriminations include lower pay, job insecurity, less favourable assignments and heavier workload. Health professions organizations therefore support a code of ethical recruitment, including a focus on equal opportunity, and its full implementation by employers and other authorities.
- The WHPA emphasizes that the resolution should address the particular needs of **migrant women**. Many are particularly exposed to gender-based violence and other forms of abuse, due to their

precarious economic, social and legal status. They encounter difficulties in accessing health care, including sexual and reproductive health services, leading – amongst other things - to inadequate antenatal care, high rate of stillborn children and a higher incidence of unplanned pregnancies amongst the migrant communities.

In conclusion of the statement, the Alliance recommends that the countries facing migration challenges develop comprehensive **human rights impact assessments** and **monitoring mechanisms** that take into consideration the right of all migrants, women and men, to the highest attainable standard of health, regardless of their legal or social status.

- The strengthening of efficient health systems as a key determinant of international migration of health personnel

The health professions readdressed the challenges resulting from international migration of health personnel and is pleased to note that since its foundation, the Global Health Workforce Alliance<sup>5</sup> has developed into a facilitating body that drives and shapes the global agenda in this context. However, despite major effort, the realities of health personnel migration have not yet changed significantly. Reminding that migration is a symptom of a dysfunctional health system, the World Health Professions Alliance stresses the urgent need to translate international policies, guidelines and codes into tangible national action, as much as sharing of best practices and successes. It calls upon all governments, WHO and other stakeholders to seriously address the strengthening of functional health systems, as well as the reinforcement of infrastructures and training capacity of countries worldwide in order to reach the goal of self-sufficiency in health human resources.

5 The Global Health Workforce Alliance is a partnership dedicated to identifying and implementing solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations. The Alliance is hosted and administered by WHO - <http://www.who.int/workforcealliance/en/>



## Non-communicable diseases are in the focus of a new WHO action plan

Non-communicable diseases are not the beloved children of public health. Although WHO deals with them now for a long time they never have gotten the clear and programmatic approach infectious diseases have received. This, of course, has something to do with the clear aetiology of infectious diseases. Second traditional public health was heavily focused to infectious diseases as the leverage for public or political action was impediment, while it seemed that non-communicable diseases were a matter of fate or personal behaviour.

However, huge progress has been made when looking on non-communicable diseases from the risk side. Analyzing factors that lead to non-communicable diseases is an established and successful strategy. Starting with the work of Bernardino Ramazzini inaugurating occupational and environmental medicine more than 200 years ago coming to the multinational Frame Work Convention on Tobacco Control as the most recent major achievement effective and often very cheap methods have been found to combat a large number of non-communicable diseases and injuries.

Risk factors are a key to combating non-communicable diseases: The draft action plan especially stresses tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. But looking to the poorest countries of the world childhood and maternal underweight, high blood pressure, unsafe water, indoor smoke from solid fuels, illicit drug use, traffic related injuries, environmental and occupational risks, unsafe health care practices, abuse, violence, poverty and poor housing are certainly likewise important and preventable risk factors for non-communicable diseases and injuries.

The overall purpose of the draft action plan is to

- “map the emerging epidemics of non-communicable diseases and analysing their technical, social, economic, behavioural and political determinants [...]
- reduce the level of exposure of individuals and populations to the common risk factors for non-communicable diseases [...]
- strengthen health care for people with non-communicable diseases [...]

The new draft action plan develops 5 objectives (see box) each with action items for member states, the WHO secretariat and international partners. For each of those action items deliverable as indicators for successful implementation are defined. The plan defines its purpose on one hand as to “provide an overall direction” for all non-communicable diseases many of which are chronic and high burden diseases.

On the other hand, it lists four of them namely: cardiovascular disease, cancer, chronic respiratory disease, and diabetes making the largest contribution to mortality in the majority of low- and middle-income countries and it delineates the program

against conditions like blindness, deafness, oral diseases, certain genetic diseases, and other diseases of a chronic nature, including some communicable diseases. The relation of the action plan to other important chronic and non-communicable disease groups like muscular-skeletal diseases or mental diseases is not mentioned.

This may be just a matter of language and inclusion. This may be vague by purpose – not to exclude any options or for other reasons e.g. not to produce any conflict with other programs. However, clarity would help and that starts with the title: What does “control” of non-communicable diseases mean? Does it mean to “influence”, “restrain” or “manage” them, or does it only mean to “monitor” them? The ambiguity is resolved only to some extent by the objectives and measures described. This gives some indication of what can be meant by “control”. The document would win considerably if the ambiguous term would be replaced with a more clear and precise one, or at least it would have to be defined.

But scepticism may remain, because – and that is most worrying – none of the “performance indicators” measures the quality and accessibility of care for patients with non-communicable diseases. Instead, numbers of meeting, administrative units and budgets are measured. All very important, but what do they mean, if nothing changes in real health care? WHO may be reminded from

Objectives of the “WHO draft action plan for the prevention and control of non-communicable diseases”

- To raise awareness of non-communicable diseases and advocate for their prevention and control
- To establish or strengthen, as appropriate, national policies and plans for the prevention and control of non-communicable diseases
- To promote specific measures and interventions to reduce the main shared risk factors for non-communicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol
- To promote research for the prevention and control of non-communicable diseases
- To promote partnerships for the prevention and control of non-communicable diseases
- To establish systems for tracking global progress in the prevention and control of non-communicable diseases



time to time that it is the World's Health Organization and not only the World's Public Health Organization. This is more than just a play with words; people suffering from non-communicable diseases will be able to tell the difference.

The "Draft WHO action plan for the prevention and control of non-communicable diseases" is an important document for the further development of regional and

national health policies aimed to control and prevent non-communicable diseases as leading causes of deaths and burden of diseases. Just working on the reduction of the mentioned risk factors should lead to a measurable reduction of non-communicable diseases. And hopefully it will not only prevent a large number of cases but also enhance availability, quality and accessibility of care for patients with non-communicable diseases.

The "WHO draft action plan for the prevention and control of non-communicable diseases"

(WHO Document EB 122/9) can be downloaded from:  
[http://www.who.int/gb/ebwha/pdf\\_files/EB122/B122\\_9-en.pdf](http://www.who.int/gb/ebwha/pdf_files/EB122/B122_9-en.pdf)

## WMA Statement on Noise Pollution

*Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and amended by the WMA General Assembly in Copenhagen, Denmark, October 2007*  
 Preamble

Given growing environmental awareness and knowledge of the impact of noise on health, the psyche, performance and well-being, the fight against environmental noise is becoming increasingly important. The World Health Organization (WHO) describes noise as the principal environmental nuisance in industrial nations.

Noise affects people in various ways. Its effects relate to hearing, the vegetative nervous system, the psyche, spoken communication, sleep and performance. Since noise acts as a stressor, an increased burden on the body leads to higher energy consumption and greater wear. It is thus suspected that noise can primarily favour diseases in which stress plays a contributory role, such as cardiovascular diseases, which can then be manifested in the form of hypertension, myocardial infarction, angina pectoris, or even apoplexy.

The effects in the psychosocial field are likewise dramatic. The stress caused by environmental noise - particularly road traffic noise - is a central concern, not only in the industrial nations, but increasingly also in the developing countries.

Owing to the continuous and massive growth of traffic volumes, both on the roads

and in the air, the stress caused by environmental noise has increased steadily in terms of both its duration and the area affected.

Damage to hearing caused by leisure-time noise is also of growing concern. The most common source of noise in this context is music, to which the ear is exposed by different audio media at different places (portable music players, stereo systems, discotheques, concerts). The risk of suffering hearing damage is underestimated by most people, or even consciously denied. The greatest issue (or aspect) lies in creating awareness of

the problem in the high-risk group - which generally means young people. In this respect, the legislature is called upon to intervene and reduce the potential for damage by introducing sound level limiters in audio playback units and maximum permissible sound levels at music events, or by banning children's toys that are excessively loud or produce excessive noise levels.

In keeping with its socio-medical commitment, the World Medical Association is issuing a statement on the problem of noise pollution with the aim of making a contribution to the fight against environmental noise through more extensive information and more acute awareness.

### Recommendations

The World Medical Association calls upon the National Medical Associations to:

1. Inform the public, especially persons affected by environmental noise, as well as policy and decision makers, of the dangers of noise pollution.
2. Call upon ministers of transport and urban planners to develop alternative concepts that are capable of countering the growing level of environmental noise pollution.
3. Advocate appropriate statutory regulations for combating environmental noise pollution.
4. Support enforcement of noise pollution legislation and monitor the effectiveness of control measures.
5. Inform young people of the risks associated with listening to excessively loud music, such as that which emanates, for example, from portable music players, use of stereo systems with earphones, audio systems in cars, and attendance at rock concerts and discotheques.
6. Prompt the educational authorities to inform pupils at an early stage regarding the effects of noise on people, how stress due to environmental noise can be counteracted, the role of the individual in contributing to noise pollution, and the risks associated with listening to excessively loud music.
7. Provide information about risks of damage to hearing that arise in the private sector as a result of working with power tools or operating excessively loud motor vehicles.
8. Emphasize to those individuals who are exposed to excessive levels of noise in the workplace the importance of protecting themselves against irreducible noise.
9. Call upon the persons responsible for occupational safety and health in businesses to take further action to reduce noise emission, in order to ensure protection of the health of employees at the workplace.

# Physicians Call For Zero Tolerance to Female Genital Mutilation Across The World

Serious concern about the increasing tendency for female genital mutilation

(FGM) to be carried out by medical personnel has been expressed by the World Medical Association. In a statement to mark the international day of zero tolerance to FGM tomorrow (Feb 6), the WMA repeats its strong condemnation of this practice that it says constitutes a severe form of violence against women.

Dr. Jon Snaedal, President of the WMA, said a recent World Health Organisation report indicated that 'the rate of progress towards a significant decline in the practice is slow', although the practice was internationally recognised as a violation of human rights and many countries had put in place policies and legislations to ban it.

He added: 'Because of its serious detrimental impact on the physical and mental health of women and girls, female genital mutilation is a matter of deep concern to physicians. We are particularly worried to note the increasing practice of female genital mutilation by medical personnel. This is in contradiction with our code of ethics, as these practices violate the human rights of women and girls. The WMA is totally opposed to this "medicalization" of FGM'.

Dr. Snaedal called for all physicians and other health professionals to mobilise actively to stop these flagrant forms of violence against women.

In 1993, the WMA adopted a statement on female genital mutilation condemning such practices as a form of oppression of women.

In 2005 it strengthened its opposition, urging national medical association to develop educational programmes for physicians, which would:

- Include adequate information on the acute dangers of Female Genital Mutilations for women and girls;
- Raise awareness on such practices as a violation of women's human rights that physicians or other health professionals should never practice under any circumstances,
- Encourage physicians to inform women, men and children about FGM and discourage them from performing or promoting such practices.

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## The World Medical Association Statement on Female Genital Mutilation

Adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005

### Preamble

Female genital mutilation (FGM) is a common practice in over thirty countries. In many other countries the problem has arisen more recently due to the presence of ethnic groups from countries in which FGM is common practice, including immigrants and refugees who fled from hunger and war.

Because of its impact on the physical and mental health of women and children, FGM is a matter of concern to physicians. Physicians worldwide are confronted with the effects of this traditional practice. Sometimes they are asked to perform this mutilating procedure.

There are various forms of FGM. It can be a primary circumcision for young girls, usually between 5 and 12 years of age, or a secondary circumcision, e.g., after childbirth. The extent of a primary circumcision may vary: from an incision in the foreskin of the clitoris up to a phallic circumcision or infibulation removing the clitoris and labia minora and stitching up the labia majora so that only a minimal opening remains to allow for urine and menstrual blood.

Regardless of the extent of the circumcision, FGM affects the health of women and girls. Research evidence shows the grave permanent damage to health. Acute complications of FGM are: hemorrhage, infections, bleeding of adjacent organs, and excruciating pain. Long-term complications include severe scarring, chronic infections, urologic and obstetric complications, and psychological and social problems. FGM has serious consequences for sexuality and how it is experienced. There is a multiplicity of complications during childbirth including expulsion disturbances, formation of fistulae, ruptures and incontinence.

Even with the least drastic version of circumcision, complications and functional consequences can occur, including the loss of all capacity for orgasm.

There are various reasons to explain the existence and continuation of the practice of FGM: custom, tradition (preserving virginity of young girls and limiting the sexual expression of women) and social reasons. These reasons do not justify the considerable damages to health.

None of the major religions supports this practice. The current medical opinion is that FGM is detrimental to the physical and mental health of girls and women. FGM is seen by many as a form of oppression of women.

By and large there is a strong tendency to condemn FGM more overtly:

- There are active campaigns against the practice in Africa. Many African women leaders as well as African heads of state have issued strong statements against the practice.
- International agencies such as the World Health Organization, the United Nations Commission on Human Rights and UNICEF have recommended that specific measures be aimed at the eradication of FGM.
- Governments in several countries have developed legislation, such as prohibiting FGM in their criminal codes.

### Recommendations

1. Taking into account the psychological needs and 'cultural identity' of the people involved, physicians should inform women, men and children about FGM and discourage them from performing or promoting FGM. Physicians should integrate health promotion and counselling against FGM into their work.
2. As a consequence, physicians should have adequate information and support for doing so. Educational programmes concerning FGM should be expanded and/or developed.
3. National Medical Associations should stimulate public and professional awareness of the damaging effects of FGM.
4. National Medical Associations should stimulate governmental action in preventing the practice of FGM.
5. National Medical Associations should cooperate in organising an appropriate preventive and legal strategy when a child is at risk of undergoing FGM.

### Conclusion

The World Medical Association condemns the practice of genital mutilation including the circumcision of women and girls and condemns the participation of physicians in such practices.

## Informed Consent – Recent Developments



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### Introduction

The principle that any medical intervention, even if it serves the patient's health, needs his informed consent is in accordance with the international standard of medical ethics and medical jurisprudence: *salus et voluntas aegroti suprema lex*. Generally the therapeutic intervention is seen as a physical injury, justified only by the patient's consent which means with regard to the practitioner's liability that the physician in charge of the treatment has the burden of proof for the patient's informed consent.<sup>1</sup>

In the past decades this principle has been constantly put into practice by the jurisdiction. This has happened particularly with regard to the application of new and more unusual methods, above all in the domain of medical research. Seen thus, it is questionable whether minors, unconscious persons or such persons whose self-determination is restricted are capable of consent. Increasingly

it is considered doubtful if and to what extent an "open consent" is at all possible.

### New or unusual methods

In the more recent past the German Federal High Court of Justice (Bundesgerichtshof) has on several occasions given its opinion on the problem of employing new and unusual methods of medical treatment. It must, however, be emphasized that the particular decisions in question did in no case concern clinical tests. So the rules for clinical research were not to be applied unreservedly.

The first decision dealt with the insertion of a new hip-joint in a computer-aided operation (the so-called "Robodoc"). In the process of the operation certain nerves of the female patient were damaged which led to an impaired function of the legs and feet. The Federal High Court of Justice pointed out that the employment of a new method of treatment is only permitted if after careful consideration of the expected advantages of this method and its possible disadvantages compared with the standard treatment, the application of the new method is justified. Should that be the case, a mistake of treatment is excluded because the physician's freedom of choice as to the method of treatment has priority. But in respect of the patient's right of self-determination, the patient has to be informed of alternative methods of treatment if, with regard to a specific medical therapy several equally effective, and in a given case pertinent methods are available, though this might cause other physical strains or other risks, but also other chances of success to the patient. With respect to standard treatments, the patient need not be informed in general about the occurrence of unknown complications. They might in a particular case even worry him unnecessarily. This is different in the case of new methods of operations which (as for instance Robodocs) have been only clinically tested abroad for a few years

(in the USA). But in the above mentioned case the claim against the doctor was dismissed, as with the nerve damage a risk had materialised about which the plaintiff had been thoroughly instructed, even if only in connection with the established method of operation.<sup>2</sup>

A further decision of the Federal High Court of Justice dealt with an attempt at healing by a treatment with a drug developed in the USA and licensed only when the treatment had been already applied. The medicine was meant for the treatment of epilepsy and caused irreparable eye damage to the patient. At the time of the treatment it was licensed neither in the USA nor in Germany but in some European Countries. A clinical test in progress conducted by the defendant physicians, in which the plaintiff was not included, was undergoing phase III trials. The physicians knew that the medical product had not yet been examined for disturbances of eye functions in humans. Therefore periodic, say for instance monthly controls, of the strength of vision were indicated. The plaintiff did notice that his power of vision was impaired. But the medication was continued all the same and was stopped only several weeks later. In this case the Federal High Court recognised the liability of the physicians. It held that an individual attempt at healing with a medicine which had still to be licensed was not forbidden, but that the physicians were under the obligation to control the treatment continually, and particularly with regard to possible eye damages. Thus the omission of the necessary observation constituted a fault. The causation of the fault for the damages was even presumed since the Federal High Court assumed a serious fault in treatment, for in an attempt at healing a special standard of care has to be adopted, which reduces the requirements necessary for the affirmation of a serious fault of treatment. Furthermore, the Federal High Court assumed insuffi-

<sup>1</sup> *Gerfried Fischer; Hans Lilie, Ärztliche Verantwortung im europäischen Rechtsvergleich, 1999; Christian von Bar, Gemeineuropäisches Deliktsrecht, Bd. II, 1999, Rn. 299.*

<sup>2</sup> *Bundesgerichtshof, 13.6.2006, VI ZR 323/04, Sammlung des Bundesgerichtshofs in Zivilsachen Band 168, S. 103; aus der Literatur dazu Christian Katzenmeier, Neue Juristische Wochenschrift 2006 Seite 2738; Benedikt Buchner, Versicherungsrecht 2006, Seite 1460.*



cient information, because the patient had not been told that the medical product had not yet been licensed and that therefore unknown risks might arise. In such a case it could not possibly be presumed that the patient, when informed of the circumstances, would have given his consent to the treatment with a non-licensed medication.<sup>3</sup>

The third decision of the Federal High Court dealt likewise with a first time-administration of a medication with a view to testing its effects. The female patient was treated in a university hospital for arrhythmia with the medical drug Cordarex (Amiodaron). During the treatment her circulation ceased to function, which caused a permanent damage to the brain. The Federal High Court ruled that the information given to the patient had been insufficient. Though, in the opinion of the lower court the danger of a cardiac arrest was greater with the standard medication than with the new medication, the patient had to be informed that the new medication might likewise lead to a cardiac arrest. The Federal High Court has explicitly underlined that having regard to the right of self-determination, the patient has to be informed already before the first administration of a medication. Therefore, the Federal High Court rejected the opinion of the lower court which declared that the application of a new medication was temporarily admissible for an initial test in order to show if the medical drug is effective at all. The argument of the patient's hypothetical consent was also rejected by the Federal High Court of Justice since the new medication was not meant as a treatment with a view to prolongation of life, but only for reducing the pain of the patient. In such cases a hypothetical consent can only be presumed with great reserve.<sup>4</sup>

The subject of the most recent decision of the Federal High Court was again the ap-

plication of an outside method which was new at the time the treatment took place and which was scientifically disputed - scientific evaluations with statistical relevance as to the efficaciousness of the therapy were lacking. In the present case a slipped disc was treated with a so-called Racz-catheter. This method consists in injecting several medical drugs (a "cocktail") into the spinal channel with the aid of an epidural catheter. At the end of this procedure, the patient was in great pain. The physician prescribed by telephone an additional dose of pain-killers. When the pain still recurred he prescribed, again by telephone, a withdrawal of the catheter of one centimetre. This caused the pain to diminish, but with an aftermath of bladder and intestine trouble. Firstly, the Federal High Court underlined again the physician's freedom of treatment: The physician was not bound to apply in any case the surest therapeutic method. But a greater risk had to be justified objectively by a special situation in a concrete case, or else by a more favourable healing prognosis. Therefore the Federal High Court of Justice took the view that the present case constituted an error of treatment. At all events, as severe pain connected with the new method of treatment occurred, an augmented care and a detailed medical examination were indicated. Under the given circumstances, and even in taking also into consideration that the patient was medically treated in the hospital, the physician could by no means be allowed to give his instructions solely by telephone, but was bound to examine the patient personally. In addition, the physician was liable in the matter of insufficient consent, for the patient had not been informed that the projected intervention was not yet a standard medical procedure and that its effectiveness was not yet statistically confirmed. Again the Federal High Court of Justice rejected the appeal of the physician based on a hypothetical consent. It is enough if the patient affirms that he would not have consented to a new medical treatment outside the medical standards.<sup>5</sup>

## Informed Consent and Medical Research

Naturally, the above extends also to controlled clinical studies. The existing regulations at the level of international standard law (Declaration of Helsinki), at the level of the European Community Directives (Good Clinical Practice [GCP] Directive) and at the European level at large (the Biomedicine Convention together with the additional protocols) are in harmony with these principles, or at least do not contradict them.

It is important in this context to broach another subject which has likewise turned up in a more recent decision of the German Federal High Court. The Court looked into the matter of a unit of blood from a donor. In connection with this donation of blood of the patient, a policeman, the injection caused trauma to the nerve of the epidermis on his forearm. This brought on permanent pain. A complete recovery is more or less improbable. That the patient had been informed in writing of the slight possibility of a damage to the nerve was not enough. The Federal High Court of Justice did not go into the question of whether a mere information in writing in connection with a donation of blood was sufficient. The fact seems to be that the patient has also to be informed of the risks verbally. Considering the serious consequences, the information which the patient received was at all events not enough. Especially in a case where a patient consents to an intervention from altruistic motives, a particularly straightforward and clear information is distinctly indicated, because the patient does not profit personally from the intervention.<sup>6</sup> These principles are important in connection with medical research, for the decision of the Federal High Court makes it clear that the information given to patients in cases of experiments profiting others have to be more

3 Bundesgerichtshof, 27.3.2007, VI ZR 55/05, Sammlung des Bundesgerichtshofs in Zivilsachen, Band 172, Seite 1; dazu Dieter Hart, Medizinrecht 2007, Seite 631; Christian Katzenmeier, Juristenzeitung 2007, Seite 1108.

4 Bundesgerichtshof, 17.4.2007, VI ZR 108/06, Versicherungsrecht 2007, Seite 999.

5 Bundesgerichtshof, 22.5.2007, VI ZR 35/06, Neue Juristische Wochenschrift 2007, Seite 2774.

6 Bundesgerichtshof, 15.3.2006, VI ZR 279/04; Sammlung des Bundesgerichtshofs in Zivilsachen, Band 166, Seite 336; dazu Andreas Spickhoff, Neue Juristische Wochenschrift 2006, 2075; Horst Hasskarl, Pharma Recht 2006, Seite 311.

thorough than in cases of scientific experiments which are undertaken for the benefit of the patient himself.

## Open Consent

There is another question which presents itself in connection with medically controlled research namely, if a possibility exists for consent to be given in view of future scientific use of the relevant biological human material to establish a collection of cells, tissues etc. for future scientific use. This question is causing controversy in discussion. It should, however, with the agreement of the previous National Ethic Council in Germany (Nationaler Ethikrat) and a recommendation of the Council of Ministers of the European Council concerning the research with biological human material, be answered in the affirmative. Nevertheless, the special provisions as to data protection of a given country in which the research is carried out have to be respected. The next step is to inform the patient about the advantages and disadvantages of the "anonymising" or "pseudonymising" of the relevant tissue. Finally, examples of typical fields of application for a possible research in connection with a given material should be made plain to the patient. In addition to the appropriate printed form the information should be given verbally, since the printed forms of information are subject to the severe regulations controlling the general terms and conditions of trade. If all of these conditions are complied with, a general consent in the form of an "open consent" should be considered admissible. It has to be seen that it is even thought feasible for the patient to waive his right of information.<sup>7</sup> This follows from the patient's autonomy. Therefore, the opinion which states that an "open consent" was not effective cannot be agreed to.<sup>8</sup> The patient's health in particular is not endangered by such an open consent.

## Minors, Unconscious persons, persons incapable of consent

Research in connection with minors or adults incapable of consent presents a special problem. The GCP-Directive distinguishes in this instance between minors and adults. In an urgency it is permissible to attend to a patient by presuming his consent if, according to the state of investigation of the medical science or other methods of research, no sufficient results from the clinical examination of persons capable of consent are to be expected, and if, according to the knowledge of medical science, the application of the medical product still to be tested is indicated to save the life of the person in question, to restore his health or to alleviate his pains. Finally, such researches must be directly related to a life-endangering condition or a condition of extreme feebleness of the patient and the clinical examination must be as far as possible free from stress or other foreseeable risks. A group benefit alone - as in the case of minors - is not sufficient. In the case of minors, however, a group benefit is enough if the research includes only a minimal risk or a minimal stress for the minor. It is hardly understandable why under these additional requirements, a comparable research cannot be carried out where adults who are incapable of consent are concerned.

Another problem has to do with art. 5 of the GCP-Directive, (in the form of its incorporation into national law). According to the wording of the directive, a treatment which cannot be delayed in order to save a given person's life, to restore his health or to alleviate his pains is possible even within the bounds of the clinical research, when in an emergency a consent cannot be obtained. This, it is true, applies only to the treatment of adults capable of consent and not to minors or adults incapable of consent. The said principle should be nevertheless applied analogously to persons permanently incapable of consent or to minors, insofar as the patient's presumed opinion is in favour of his participation in the research project, and insofar as a legal representative can in

a matter of urgency not be reached, and insofar as the experiment can benefit the patient directly. Otherwise a whole group of patients might be excluded from possible therapeutic experiments in cases where the appointment of a legal representative before the beginning of the experiment is not possible.<sup>9</sup>

The already mentioned unequal treatment of minors and adults incapable of consent can be found also in the German jurisdiction. The Federal High Court of Justice is, at least where the medical practitioner's liability is concerned, of the opinion that even minors who have entered into their 16<sup>th</sup> year have only a right of veto against the consent of their legal representatives, their parents. The other way round, this means that minors cannot alone give an effective consent, even when they are quite capable of understanding. The Federal High Court decided in this sense in the case of a female (minor) patient who had undergone an operation on the spinal column that caused a paraplegia. Fortunately, she finally was awarded damages for having been insufficiently informed since she had neither given her consent, nor been informed at all.<sup>10</sup> It would be the right course of action, if the minor's decision alone would count. The jurisdiction does not rule otherwise in cases of adults incapable of consent. Even if an adult is incapable of consent his wishes with regard to the decision about the treatment are respected up to the limit of a serious risk to his health, and this applies equally to his refusal of consent and to his demand for treatment.<sup>11</sup>

7 Erwin Deutsch; Andreas Spickhoff, *Medizinrecht*, 8. Auflage 2008, Rn. 247; Andreas Spickhoff, in: Theodor Soergel, *Bürgerliches Gesetzbuch, Schuldrecht*, Band 10, 13. Auflage 2005, § 823, Anhang I: *Arzttaftungsrecht*, Rn. 184.

8 Anders aber Adolf Lauf, *Arztrecht*, 5. Auflage 1993, Rn. 207.

9 Erwin Deutsch, *Neue Juristische Wochenschrift* 2001, Seite 3361 (3363); Andreas Spickhoff, *Medizinrecht* 2006, Seite 707 (710).

10 Bundesgerichtshof, 10.10.2006, VI ZR 74/05, *Neue Juristische Wochenschrift* 2007, Seite 217.

11 Andreas Spickhoff, in: Theodor Soergel, *Bürgerliches Gesetzbuch, Schuldrecht* 10, 13. Auflage 2005, § 823 Anhang I: *Arzttaftungsrecht*, Rn. 108.

## Portrait of a key player

### The Danish Medical Association through 150 years



*Dr. Jens Winther Jensen, the President of Danish Medical Association, Dr. Otmar Kloiber and Dr. Nachiappan Arumugam*

The Danish Medical Association dates back a hundred and fifty years and celebrated its Birthday in 2007 amongst other initiatives by inviting the World Medical Association to Copenhagen to have its General Assembly in the autumn winds and sunshine of Copenhagen City Centre.

The following is a portrait of an association which has survived a 150 years of different regimes and of influence on health policy making in Denmark but without direct access to write the health laws that govern a public health care system.

The DMA is an umbrella organisation which seeks to influence the development of health and social policy and render visible the interest of the medical profession. Furthermore the DMA coordinates and unites the opinions of the four associations that constitute the Danish Medical Association. 95 % of all doctors working in Denmark are members of the organisation.

The Danish Medical Association  
(policy making body)

The Danish Association of Junior Doctors

The Danish Association of  
Medical Specialists



The Danish Organisation of Medical Practitioners

The highest authority of the DMA is the assembly of representatives which meets annually. The representatives are appointed by the above mentioned organisations according to the number of members. The Assembly of Representatives decides the general policy of the DMA, the budget, approve the accounts and elect the president and the council. The Assembly of representatives also elects the DMA arbitration committee, the medical ethics board and the Committee of Preventive Medicine.

The DMA council is responsible for the day to day leadership of the DMA. It consists of a chairman and six members, two each representing the three negotiating organisations. The Council points out a number of standing and temporary committees and working groups in order to attend to the various subjects that the organisation has to deal with.

#### Services

As most professional organisations the DMA provides services to its members. In the legal department, the lawyers give advice on patient complaints, the handling of criminal cases, duty on confidentiality, access to health information, medical ethics disputes and the overall regulation in the field of health care.

#### Training

The DMA offers a great variety of training. Mostly one day short courses in various fields and courses for trade union representatives. Through the DMA Committee on training and research the DMA influences the medical and specialist training.

#### Medical bulletin

The DMA arranges public meetings on various subjects and offers a medical bulletin with important news on research and debate on a weekly basis.

#### Working environment

The DMA seeks to improve the working conditions for Doctors and through influencing the legislation and cooperation with other health professionals. The DMA Committee for Doctor's Occupational environment especially focuses on inter-collegial relations and collegial spirit.

#### Cooperation with pharmaceutical companies

The DMA has established a cooperation with the umbrella body of the pharmaceutical companies and other stake holders in order to develop common independent information on pharmaceuticals. Furthermore the DMA has made an agreement with the pharmaceutical companies and the association of pharmacists in order to regulate the question of sponsorships from the industry towards doctors to ensure independence of all parties.

#### Ethics

The DMA has a strong engagement in ethical matters. The DMA Medical Ethics Committee has a consultation part and it is also independently creating policies on the contemporary ethical dilemmas, both with regard to the special problems relating to immigration and the use of new technology.



## The Norwegian Medical Association



*The president of The Norwegian Medical Association, dr.med., Torunn Janbu and secretary general Terje Vigen.*

### Organisation and membership

The Norwegian Medical Association (NMA), was founded in 1886 as the professional association and trade union for Norwegian physicians. Membership is voluntary, and approximately 96 % of Norwegian physicians are members. The main aims of the Association are to protect the professional, social and financial interests of its members, to promote their interests in matters concerning medical education, professional development and scientific activities, and to advance the quality of the Norwegian health care system.

### Some main bodies of the Norwegian Medical Association:

Annual Representative Meeting (ARM) is the chief decision-making body and elects the Central Board of 9 members, including the president and vice-president. The election period for the board is two years. ARM also elects the The Medical Ethics Committee (chairperson: Trond Markestad)

### The secretariat

The secretariat has five departments: Dep. of medical education, Dep. of information



and health policy, Dep. of finance and administration, Medical journal and Dep. of negotiation and legal section. The number of full-time staff members is 130.

### The role of The Norwegian Medical Association

The Norwegian Medical Association (NMA) is the only nationwide association for doctors in Norway. NMA has two main responsibilities:

- 1 Negotiating salaries and working conditions for the members
- 2 Taking care of the members professional and scientific interests

The medical association consists of 19 local branches, 7 occupational branches and 44 specialty branches.

The local branches represent the 19 counties.

The seven occupational branches organise members that share occupational interests: junior doctors, consultants, GPs, researchers, occupational health doctors, private practicing specialists and public health doctors. The occupational branches are negotiating salaries and working conditions, while the specialty branches take care of the

professional activities like education, quality improvement etc.

NMA has its own, independent research institute that among other things do research on doctors' health and well being.

### Some data about Norway

Norway has a population of 4 525 000 and is situated in the northern part of Europe and has borders to Sweden, Finland and Russia.

Public health services are financed by taxation and are designed to be equally accessible to all residents, independent of social status. With its 220 000 employees, the public health sector is one of the largest sectors in Norwegian society.

The public health system is under the jurisdiction of the Ministry of Health and Care services, which is responsible for devising and monitoring national health policy. Responsibility for provision of services is decentralized to the municipal and regional level. The municipalities are in charge of providing primary health services such as general practitioner, while the five Health regions provide the more specialized medical services, such as hospital care. Just a few number of authorized private hospitals and health services have been established in addition to the public facilities.

The numbers of doctors, inclusive students and retired doctors, are about 25 000. In relation to inhabitants we have among the highest number of doctors in Europe, in 2007 the ratio was one doctor per 244 inhabitants.

**The Committee on Human Rights;** since the early 1990s, the NMA has run human rights programmes in Turkey, the former Yugoslavia and now in China. These activities are funded mainly by The Norwegian Ministry of Foreign Affairs. In cooperation with WMA, The International Red Cross and Amnesty International the association has published, on the web, free of charge, a course for prison doctors.

**The Journal of The Norwegian Medical Association** is issued every second week and are in charge of the web-site [www.legeforeningen.no](http://www.legeforeningen.no).

### Post-graduate medical education

There are 44 recognised medical specialties in Norway of which eight are subspecialties under internal medicine and five are subspecialties under general surgery. The majority of the specialties relate to health services in institutions (hospitals). Specialties in primary health care are family medicine, community medicine, and occupational medicine.

### Health politics

The NMA is involved in many of the activities run by the health authorities through

appointing members to participate in different task groups, and also by meetings with the political parties in the Parliament.

**Officers** President Torunn Janbu, vice-president Bård Lilleeng, and secretary general Terje Vigen.

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## Joint Medical Ethics Reflections of the Nordic Countries



The ethics committees of the Nordic medical associations have a long tradition of meeting every two years to discuss current issues in medical ethics. The venue of these informal gatherings rotates between the five countries (Denmark, Finland, Iceland, Norway or Sweden).

In September 2007 the meeting was hosted by the Finnish Medical Association in Nauvo, a peaceful seaside resort in south-western Finland. There were altogether 37 participants, mostly practicing physicians



who are also members of the ethics committees.

Three themes of discussion at the meeting were chosen beforehand. They were

- Medical ethics of physicians working in leadership or administrative tasks
- Ethics of stem cell research
- Liability issues in telemedicine.

Each of the themes was first introduced in a plenary setting, then discussed in depth by a working group of about ten participants and finally reported back to the plenary. This method proved to be useful as everyone got a chance to concentrate on the issue closest to their heart and at the same time comment and reflect on the two other subjects.

### Medical ethics of physicians working in leadership or administrative tasks

This theme was introduced by Dr. Thomas Lindén from Sweden. Ethical rules as such are of course applicable to all doctors, but the question is whether they differ (and how) when a doctor is also working as a leader. Lindén presented the general ethical guidelines of the Swedish Medical Association and highlighted the points where problems might arise.

In the discussion that followed it was concluded that all the ethical rules also apply to doctors in leadership positions. Special challenges exist however. These include prioritisation when resources are limited, the benefits of one patient versus those of many

patients, loyalty conflicts and also potential conflicts related to economic profit.

Organisations should facilitate physicians in leadership or managerial positions to be able to follow high ethical standards. This could be done by facilitating the knowledge of ethics as well as ethical discussions and reflections at the workplaces. Also non-physician-leaders and managers should be included in these processes.

## Ethics of stem cell research

The meeting was honoured to have the current president of the WMA, Dr Jon Snaedal, as a member of the Icelandic delegation. He introduced the subject of stem cell research. The working group focused on the specific questions of using human embryonic stem cells. It presented three statements and argued for and against them.

The first statement was that production of embryonic stem cells solely for research purposes should be prohibited. Arguments speaking for this are the invasiveness of the procedure and potential harm caused by it as well as possible uncontrolled commercialisation. Using extra embryonic cells created in fertility treatments is therefore a less risky alternative. On the other hand reliance on these extra cells only may lead to double moral in their collection if and when research on embryonic stem cells is accepted.

The second statement argued that production and selection of embryos for therapeutic purposes is acceptable if it is performed under close supervision by an independent authority and based on individual risk-benefit estimation. This statement can be defended by the utility for the sick child, which may be major (while the harm to the selected sibling must be small). Helping one sibling does not prohibit the parents from loving the other also as an individual. Many western societies already have empirical evidence of tolerance from case examples. Points against this are the difficulty of preventing social strains on and between the children. The therapies using selected

siblings are still experimental and medical risks therefore unknown. It can also create as slippery slope towards mass production of embryos.



The third statement was that cloning of genes or genomes into stem cells for reproductive purposes is ethically unacceptable. Points for the statement are that the procedures are biologically uncertain and may have unforeseen consequences, they may create a "slippery slope" to genetic engineering for cosmetic or sport purposes and genetic copying of human beings involves unknown social and human risks. Arguments against the statement include the possibility of cloning to provide an alternative to using embryonic cells genetically identical cell lines without reproductive purposes. Cloning healthy somatic genes to reproductive cells also mirrors the selective abortion of severe disease genes (which is already performed today).

## Liability issues in telemedicine

The introduction to the theme on behalf of the Danish delegation was given by Dr Mogens Skadborg. He emphasized that as far as ethics is concerned, telemedicine does not differ from any other kind of medical practice. It is simply a new way of treating patients and requires technical expertise in fields other than medicine.

Their group discussion centred around three issues: who is responsible for the quality and results of the treatment, who has (or should get) access to patient records and why and what are the effects to the patient-doctor relationship.

The discussion produced some further conclusions. Ethics does not differ between different formats of consultation, but face-to-face contact is still the preferred way.



Accurate documentation of advice is important. Communication may be less effective and relevant information not received when there is no physical presence. Reliable identification may also cause problems. Therefore risks and benefits of using telemedicine must always be balanced.

The new tools offer new ways of informing patients of their health status and treatment. Patients however may have different capabilities of understanding that information. Misuse of information must be prevented and the trust of patients maintained.

In addition to the lively discussions on ethics the participants enjoyed each other's company on a cruise in the surrounding archipelago and a traditional Finnish smoke sauna. An excursion into the history of medical ethics was also made at the island of Seili, which was a hospital for lepers 1619-1785 and a then mental institution up to 1962.

The next meeting on medical ethics in the Nordic countries will be hosted by the Danish Medical Association in 2009.

*Jukka Siukosaari  
International Affairs Officer and secretary of  
the Medical Ethics Committee  
Finnish Medical Association*



## The Lithuanian Medical Association and its Priorities



*LMA vice president Loreta Leščinskienė, LMA president prof. Liutauras Labanauskas, LMA vicepresident Virginija Lukšienė, LMA Secretary General Asta Grigaliūnienė*

As far back as before the World War II, the medical men in Independent Lithuania had to solve the important health care problems. Even then, the society was formed which acted for the good of Lithuanian doctors. During the years of soviet occupation, the society was closed and only after more than 50 years its activities have been restored. The Lithuanian Medical Association (subsequently, the LMA) is an independently acting trade union, a volunteer organization bringing together 80% of Lithuanian medical doctors and defending their professional, labour, economic and social rights and interests. Founded in October 1924, the LMA operated until 1940. After regaining independence in 1989, the sixth congress re-established the LMA.

In 2004, the 12th congress of the LMA elected prof. Liutauras Labanauskas president of the association for a third term, Loreta Leščinskienė and Virginija Lukšienė as vice presidents, and Asta Grigaliūnienė as secretary. Standing commissions of the LMA are those of professional ethics, finance, law and the primary level of health care. Other commissions are non-standing and are normally established to solve some specific issues. The LMA represents the professional interests of its members in their relationship with employers and other legal and natural entities. It concludes collective

employment contracts and other agreements with employers and controls their implementation. The association also analyses salaries of medical doctors and submits remuneration proposals. The LMA strives to obtain higher salaries for medical doctors. As a result of implementation of this objective, on 3 May 2005 the LMA signed an agreement with the Government "On the increase of salaries for medical doctors".

In accordance with the 2001 agreement with the Ministry of Health and Vilnius and Kaunas Medical Universities, the LMA actively participates in the professional training of medical doctors. The training is financed by the Ministry of Health and performed by Vilnius and Kaunas Medical Universities with the LMA as a coordinator of the process.

In 2006-2007, the LMA successfully implemented a project to strengthen social partnership. For example, the project "The development of social partnership in the Lithuanian health care system". The key aim of the project is to develop social partnership among the equal partners of health care system. As a result of cooperation among the Ministry of Health, the Association of Representative Offices of Ethical Pharmaceutical Manufacturers, the Association of Pharmaceutical Manufacturers, and the LMA, the project "Fairer treatment with pharmaceuticals" has been implemented. Company Transparency International Lithuania is performing social research aiming at a more transparent relationship between the pharmaceutical industry and medical doctors. The LMA is a partner of the "Good mood programme" implemented by the private company AstraZeneca and aimed at reducing the stress experienced by both medical personnel and patients. Together with the TV program *Sveikatos ABC* (Health ABC) hosted by the TV channel LNK, the LMA has been implementing a social project called "Thank you, doctor".

The LMA actively cooperates with other professional unions and associations, international organizations of medical doctors abroad, as well as participates in the preparation and implementation of international programs. The LMA is a member of the WMA (the World Medical Association) and the CPME (the Standing Committee of European Doctors). In May 2006, a joint conference with other specialist societies discussed membership in the UEMS (European Union of Medical Specialists). This would allow the LMA together with other specialist unions to confer on professional problems of medical specialists on the highest level. The problems include internship, post-graduate studies, qualification training, and life-long learning.

Six years ago, based on the experience of foreign countries, the LMA initiated civil liability insurance for medical doctors (natural entities) that was successfully adopted in Lithuania. Currently, the LMA is initiating adoption of voluntary (additional) health insurance in Lithuania. Head of the LMA Secretariat Aistė Sivakovaitė is involved in analyzing information from state and local government bodies, coordinating the activity of the association on representation in labor groups, and preparation of the laws and legal acts. She also coordinates international cooperation and publishing activities of the LMA.

The LMA publishes the bi-weekly magazine *Gydytojų žinios* (Medical News) and, together with Vilnius and Kaunas Medical Universities, the magazine *Medicina* (Medicine). One-off publications such as *Lietuvos gydytojų sąjunga* (The Lithuanian Medical Association), *Lietuvos gydytojai* (Doctors of Lithuania), and a collection of laws for doctors and administrators. In 2007, the assessment of the situation in the world and Lithuania and the desire to help doctors who face challenges in their professional activities prompted publication of the book *Medical Ethics Manual* by the LMA in cooperation with the ethics committee of the World Medical Association (WMA) and the Lithuanian Bioethics Committee.

## The Republic of Belarus and its Health Care System in Brief

### General Information about the State

The Republic of Belarus is situated in the centre of Europe. The shortest transport communications connecting the CIS countries and Western Europe countries run through its territory. Belarus has common border lines with Poland, the Baltic states, Russia and the Ukraine.

The territory of the republic comprises 207 000 square kilometers, its population is about 10 million people, with 70% living in the cities. Nearly one-fifth of the population resides in Minsk, the capital of Belarus. According to its administrative division there are six regions in the republic. The official languages are Belarusian and Russian. The most common languages for business communication are Russian, English and German.

The Republic of Belarus is a unitary democratic social legal state and recognizes the priority of conventional principles of the international law.

The state power is conducted on the basis of its division into legislative, executive and legal. Belarus is a presidential republic. The President of the Republic of Belarus is the head of the state, the guarantor of the Constitution, the rights and liberties of an individual and a citizen. The legislative body of power is the Parliament consisting of two chambers. The executive power is run by the Government – the Soviet of Ministers, which is the central organ of power. Local power and self-government are carried out through local executive and administrative organs, self-government organs, referendums, etc.

Belarus is one of the economically developed CIS states. Industry comprises about one-third of the national output volume. The most developed branches of industry



*In the photo V.I. Zharko, Minister of Health, Republic of Belarus; V.N. Lektorov, Deputy Chairman of the Commission for Social Protection, Chamber of Representatives of the National Assembly, Republic of Belarus, Chairman of the Belarusian Association of Physicians.*

are motor-car industry, tractor construction and agricultural engineering, machine-tool and bearing construction, electrotechnical industry, oil extraction and processing, synthetic fibres production, mineral fertilizers production, pharmaceutical industry, production of building materials, light and food industry.

### Governmental Support of the Health Care

The state system makes the basis of the health care and is financed from state budget (4,5% of gross national output). The system of social standards has been developed for health care, which includes the norms for covering health care expenses from the budget for 1 citizen per year. This flattens the disproportion while distributing the resources over the regions of the republic.

The policy for developing paid medical services is aimed both at allocating additional means for health care development, and controlling the substitution of free medical services by paid ones, since the latter are not vitally important.

### Development of the Health Care System

The programme of social and economic development for 2006-2010 provides increased access and quality of health care for all population based on:

- introducing up-to-date medical technologies and creating scientific and practical centres;
- reconstructing the system for providing health care including the redistribution of the resources from in-patient to out-patient medical care, developing medical and social care and general medical practice;
- improving the system of social standards, as well as territorial programmes of guaranteed state health care;
- enlarging access to effective, safe and high quality medicines, creating the complex programme for providing some categories of citizens with medicines;
- improving the management and quality control, standardizing medical technologies, working out prevention and rehabilitation technologies.

The development and the implementation of standards for medical information systems, advanced medical technologies, telemedicine including, large computerization of medical institutions, creating local electronic computing systems, introducing electronic patients' medical charts are planned.

There are more than 40 000 doctors and about 109 000 nurses, more than 150 sanatorium and prophylactic establishments and 1700 treatment and prophylactic institutions. Medical staff is trained at 4 medical universities, 17 colleges, at the Belarusian Medical Academy of Post-Graduate Education and some centers for advanced training and improving the qualification of the nursing staff.

The reform of health care system is in progress, with the state budget financing being followed. The positive dynamics of the basic indices is seen. These are increase of birth rate, decrease of infant and mother mortality rate, postoperative lethality, morbidity

from common infectious diseases. Great attention is paid to the modernization and re-equipment of all treatment institutions. Medical modalities are planned to correspond to European standards by 2010.

### Public Organizations in the Health Care System

There are 32 medical public organizations including the multiprofile Belarusian Association of Physicians, founded in February 1992. During its history, it contributed

to developing the draft of new legislation for medicine, as well as concepts and plans for evolving medical system, working out Medical Ethics Code. In 2007, the new agreement on cooperation with the Ministry of Health was signed. Currently, the re-registration of fellows and structural units is under way, the plans for further evolution are being made.

### Some Basic Indices in 2007

Birth rate, mortality rate, infant mortality rate 10,7‰; 13,7‰; 5,2‰. Number

of medical visits per 1 inhabitant per year 12,7 (including 1,5 in dentistry). Number of hospital beds per 10 000 of the population 105,5. Number of admissions to the hospital per 1000 274 individuals. Average hospital stay 11,7 days per 1000 live births.

The following information sources have been used:

<http://www.president.gov.by/>  
<http://medicine.belmapo.by/>  
<http://minzdrav.by/>

## The Ukrainian Medical Association is going to Europe



*Part of the Board of UMA with our international partners.*

History of the Ukrainian Medical Association (UMA) – in Ukrainian language: Vse-Ukrainske Likarske Tovarystvo (VULT) was founded in 1910, but its activities were interrupted by the Soviet Communist regime.

In 1990 on June 30, in Kyiv the First Congress of Ukrainian Medical Association was held, which renewed the organization interrupted during the Soviet period. On August 17, 1990 in the 3-rd Congress of the WFUMA the UMA was accepted to the World Federation of Ukrainian's Medical Associations (WFUMA). Later on the UMA was involved in:

- In 1991, May 24-30, in Ivano-Frankivsk the 1-st Congress of Medical Association

for Ukrainians from Europe was held;

- In 1992, February 24, the UMA was registered by the Ministry of Justice of Ukraine (No.209).
- In 1992, November 7, in Uzhgorod the 2-nd Congress of UMA and scientific conference "Natural factors in sanatorium-resort treatment" took place;
- In 1995, April 28, in Kyiv the 3-rd Congress of UMA and scientific conference «History of Ukrainian medicine» were held;
- In 1997, May 17, in Kyiv the scientific conference on the problems of organization of public health and 4-th Congress of UMA were organized.
- In 1999, May 28-29, in Kyiv the 5-th Congress of the UMA and scientific conference "Primary medical healthcare and family medicine" were arranged.
- In 2001, May 18-19, in Chernivci in the Bukovina Medical Academy the 6-th Congress of the UMA was held;
- In 2002, January 25-26, in Kyiv the scientific conference of the UMA "The system of public health of Ukraine and the ways of reforms" took place;
- In 2003, May 16-17, in Ternopil the 7-th Congress of the UMA gathered.

- In 2005 on April 21-22, in Ivano-Frankivsk the 8-th Congress of the UMA dedicated to the 15th Anniversary of re-establishment of the UMA (1990-2005) in modern independent Ukraine was held;
- In 2008 on May 10-12, in Vinnytsja the 9-th Congress of the UMA took place. During the Congress the President of the UMA – Dr.Oleg Musii, the Honorary President (Previous President of the UMA) Dr.Ljubomyr Pyrih, the Chairman of Board of UMA Dr.Stanislaw Netchaiv and the Board of UMA (includes 33 people) were elected.

The total number of the members of the Ukrainian Medical Association – around to 20 000 physicians from 25 regions (oblast) of Ukraine. The number of physicians in Ukraine is about 200 000 persons. At this time the UMA is a non-governmental and non-profit public organization. There is individual and collective membership in the UMA. The individual members are physicians by education. The collective members are medical organizations of narrow specialists, scientists etc.

The UMA publishes a periodical of the UMA "The Ukrainian Medical News" journal. It was founded in 1918 and renewed again in 1997. Besides apart from this UMA publishes articles and interviews in different journals and newspapers in Ukraine and abroad.



Financing of the UMA consists of:

- membership dues 5%
- income from publications in the journal of the UMA - 20%
- income from participating in various grant projects - 10%
- income from the participants of congresses, conferences, seminars etc. - 10%
- income from firms-sponsors, exhibitors in the UMA congresses, conferences, seminars etc. - 45%

In Ukraine the UMA takes part in the activities of Public Council of the Ministry of Health of Ukraine and in Advisory Council of the Committee of Health of the Parliament of Ukraine. The UMA also cooperates with the Ukrainian Medical Law Association and the Ukrainian organization of protection of the patients rights «Health of People».

In Ukraine, the system of public health is under the control and regulation of the government. During the two last years the UMA has been writing and submitting to the Parliament of Ukraine the Draft Law «About medical self-government» (The European model of public health) for introduction in Ukraine. Today the promotion of this law is one of the basic activities of the UMA. In the international arena since 1990 the UMA is a member of the World Federation of Ukrainian's Medical Associations (WFUMA). The WFUMA includes the medical associations of Ukrainians from 14 countries around the world. In addition, the UMA has close contacts with many medical associations in other countries, first of all with the German Medical Association (*Bundesärztekammer*), the Finnish Medical Association (*Suomen Lääkäriliitto*), and the Polish Medical Association (*Naczelna Izba Lekarska*).

Among strategic objectives at an international level for the UMA is entering the leading international medical organizations like the World Medical Association (WMA), European Forum of Medical Associations (EFMA/WHO), the Standing Committee of European Doctors (SCED/

CPME), etc. It is decided that introduction of the World achievements of Medicare in Ukraine is utmost important to the citizens of our country. The importance of health management in Ukraine through introduction of medical self-government and medical ethics is also on UMA agenda for today. Entry into the WMA, SCED/CPME, EFMA/WHO will enable us to learn the principles represented in declarations and decisions accepted on the World Medical Assemblies and Forums of these organizations and introduction of these principles in Ukraine.

Mission of the UMA is:

- to promote the prestige of doctors in society through the observance by them the highest standards of professionalism, medical ethics and education in serving for health benefits to all Ukrainian people;
- to provide a high-quality medicare;
- to help medical doctors in their influence, participation and adaptation to changes in the system of public health;

Aims and objectives of the association:

- Assistance to protect and strengthen the health of people in Ukraine, development of national medical sciences, participation in discussing medical questions, assistance for professional growth of medical employees, their legal and social protection, satisfaction of legitimate social, economic, creative or other general interests.

The main tasks of UMA are:

- to assist in moral, cultural and national renaissance of Ukrainian physicians and all people of Ukraine;
- to increase the state and public significance of physician's profession; assistance with the renaissance of its authority and prestige; assistance in the improvement of level and qualities of medical service to all levels of population;
- to assist in growth of the professional level of Ukrainian physicians to international standards, by increase of qualification and practical skills; improvement of medical education; development of

creative potential and realization of the right of everyone for intellectual work and its results;

- to assist the formation of priority directions of a medical science; organize and participate in implementation of scientific researches of medicine and public health; introduction of such achievements in practice;
- to protect the interests of members of UMA in institutions of the government and state control, public organizations, court and office of the public prosecutor; assistance to ensure the legal protection of their civil rights, professional, social and economic interests.

Besides in the Ukrainian Medical Association (UMA) there are many societies of narrow specialties and subspecialties for example: cardiology, surgery, neurology, cardio surgery, plastically surgery, pediatric, ophthalmology, neurosurgery, pediatric ophthalmology, nephrology, sexology, internal medicine, radiology, gastroenterology, otolaryngology, hematology, dermatology, gerontology, urology, family medicine, oncology and etc. A physician at the same time can be a member of various such societies. Their basic activities are scientific researches, improvement of qualification and training medical doctors in their specialties. A part of such narrow professional societies are also collective members of our Ukrainian Medical Association. Besides in Odessa (the one of the 25 regions of Ukraine) the Society of Ukrainian Doctors was established with the aim to embrace the whole Ukraine. Unfortunately, it incorporated only the Odessa region. For all the time of its existence, not being able to expand, to our regret the Society practically has halted its activity. There is also a trade union of medical workers in Ukraine. It has remained since the times of Soviet Union. Its members are doctors, nurses, junior nurses; hospital attendants, paramedics and all other people who works in medical institutions. Competence of this trade union mainly is the treatment of social issues..

## The Bulgarian Medical Association



*Dr. Andrey Kehayov*  
President



*Dr. Plamen Demirov*  
Secretary General

The Bulgarian Medical Association (BuMA) was established one hundred and six years ago, and is therefore among the oldest professional organizations of physicians in Europe. During the period of socialist regime, however, it ceased to exist and was restored in 1991 by a group of enthusiasts. At that time membership was voluntary and the functions of the Association were rather limited. But the situation changed quickly and in 1998, thanks to a strong lobby, an act was adopted for the professional associations of medical doctors and dentists in Bulgaria, which regulated its functions and was practically a legal recognition of the existence of the BuMA. Membership became mandatory which enabled better control to be exercised on health service quality as well as the rights of the physicians to be defended.

As a lawful representative of the physicians, the BuMA won an important victory – the right to be a party to the negotiation process of determining the budget of the National Health Insurance Fund (NHIF) and fund allocation. From the very beginning the Association aimed at procuring the necessary resources for improvement of healthcare

quality. Regrettably recently the NHIF did not seem to be willing to cooperate in that respect as a consequence of which in 2006 and in 2007 no framework contracts were signed. This resulted in disregard of the rights of patients and physicians and deterioration of the healthcare system as a whole.

Despite the difficult situation in which it is functioning, the Bulgarian Medical Association makes efforts to ensure very good level of health services through providing incentives for the continuous medical education and professional development of physicians. It developed a credit system and undertook crediting of different forms of CME.

The BuMA pays much attention to the ethical issues of the profession. That is why, besides adopting its own Code of Medical Ethics, it acquaints the Bulgarian physicians with documents of international significance in this field, such as the Medical Ethics Manual of the WMA, which is not only a convenient tool for solving practical problems, but also brings about unification of standards and criteria in different countries. It was a privilege for the Bulgarian physicians to have this Manual presented

personally by its author, Prof. John Williams, at a meeting held in Bulgaria in September, 2006.

From its restoration the organization realized the significance of international relations and the need to share ideas. That is why two years after it resumed its activities the BuMA joined the big family of the WMA, and during the last few years became full member of a number of European organizations of physicians. This was done for the purpose of exchange of experience which enables finding better solutions to problems.

The BuMA has welcomed different initiatives of the WMA which we believe are important for preservation of the good traditions of the profession. Bulgarian physicians were nominated for the WMA publication *Caring Physicians of the World*. We all owe well deserved respect and recognition for physicians who are fully devoted to their mission and serve as an example of high ethical standards and humanity in practicing the profession.

Looking back to the years after the restoration of the BuMA – almost two decades now, and taking into account its achievements, one may say that the organization is going in the right direction, because the Association is heading to a future where no boundaries would exist both for the patients and for the physicians and everyone would have access to high quality healthcare, regardless of where they live. But this might only happen if the professionals could make the governments understand that healthcare is and should be regarded as a priority issue. Otherwise total collapse of the system might occur due to lack of medical personnel as we are living in a very dynamic and mobile world and this problem is already very familiar in some parts of the globe.

## The Czech Medical Association J. E. Purkyně (CzMA).

Our Association is a voluntary and independent organization of medical doctors, pharmacists and other workers in the healthcare service and related fields in the Czech Republic.

The number of our members has been gradually rising since 1989 when the CzMA became a democratic institution with democratically elected president and council. The members of the CzMA are affiliated on the basis of their specialities in individual scientific societies. In larger cities the doctors organize the local medical clubs. 104 scientific societies and 40 local medical organizations are currently working within CzMA. Both Czech citizens and foreigners may become members of the CzMA. Medical doctors

and associated health workers represent 90 p. cent of all health personnel in the republic.

The history of the CzMA dates from the middle of the 19th century and is closely linked with propagators of national Czech medical science. Their main representative was Jan Evangelista Purkyně (1787-1869), a world renowned scientist in physiology. His name thus gives prestige to the title of our Association. By associating ourselves with this great personality we wish to express that we are continuing the traditions of the humane and scientific legacy. The aim of J. E. Purkyně and his colleagues was, above all, the development and propagation of knowledge of medical sciences and relat-

ed fields and their application in healthcare for people. These fundamental aims remain unchanged to the present time.

The CZMA is involved in postgraduate and continuing medical education in almost all fields of medicine, in organizing national and international congresses, symposia, course etc.

The CzMA has also close relations with European and medical associations worldwide. Of these the most important is the World Medical Association (WMA), the Forum of European Medical Associations within WHO, the Council for the International Organization of Medical Sciences within WHO (CIOMS).

Thanks to the reputation of our Association, the CzMA also awards honours and prizes which are received with the respect they deserve.



### Dear Colleagues,

One of my proposals as president in 2000 of the WMA was to establish the regional offices of WMA in different parts of the world. The rationale of this proposal was to take into consideration differences which exist among regions of the world in health care, medical education, medical ethics, medical policy, management, human right issues etc. The WMA as a non-governmental body may directly contact individual NMAs and get valid information about their

health care systems in different regions. Another output of the activities of the regional offices is the increased visibility of the WMA in individual regions giving them an occasion to more detailed discussions on the WMA documents, which could be tailored to their specific conditions.

The role of the regional offices seems to me even more advantages at present when the World Health Professional Alliance unites the WMA, World Dental Federation (FDI), International Pharmaceutical Federation (FIP) and International Council of Nurses (ICN) bringing together more than 23 million health care professionals worldwide. (The WHPI should consider accepting also the World Federation of Medical Education) with the secretariat recently taken over by the secretariat of WMA.

The Regional office for Central and East European countries was founded in 2000 and hosted already 4 meetings. At the last one in Prague in December 2006 also other European NMAs were present including the general secretary and the president of the WMA. The program of the meeting included actual health care issues as avian influence, smoking and nutrition in respective regions.

The CzMA proposes to revitalize the activities of the regional offices and establish the regional offices of WHPA, perhaps in Prague.

With kind regards,  
Professor Jaroslav C MD., DSc.  
President, Czech Medical Association  
Former president, WMA



## The Austrian Medical Chamber



*Vice-President Harald Mayer, President Walter Dorner, Vice-President Artur Wechselberger, Vice-President Günther Wawrowsky. Photo: Alfred Habitzl.*

The Austrian Medical Chamber is the statutory professional organization of all doctors practising in Austria. We represent approximately 38 000 doctors - working either in a self-employed, or in an employed capacity. On the one hand, the Austrian Medical Chamber represents their professional, social and economic interests, on the other it constitutes the competent national authority for Austrian doctors. The responsibilities of the Chamber comprise, besides others, the following areas: involvement in medical training, continuing medical education and professional development, quality assurance in continuing medical education and medical practice, the conclusion of contracts with social insurance institutions and of collective agreements, admission to and administration of the medical register, recognition of foreign medical diplomas, execution of disciplinary legislation and arbitration.

The Austrian Medical Chamber deals with a variety of issues at national and international level. The reform of the medical training system and a recent governmental plan to restructure the Austrian health system are

some of the current issues at the national level. At the international level, the Medical Chamber is mainly concerned by European Union issues such as the migration of doctors, the Working Time Directive, the Health Services Directive, eHealth, etc.

In Austria, the medical training system is structured as follows: after having completed 6-year medical studies, doctors must engage in a 3-year medical training as a general practitioner or a 6-year medical training as a specialist in order to obtain their licence to practice. Due to a lack of training positions in Austria, many doctors migrate to other EU-countries for training purposes. At present, there are concrete plans for a reform of the training system and the introduction of a one year post-gradual training programme, after which doctors will be awarded their licence to practice. Besides, general practice will become a specialty with 5 years of practical training after the first, basic year. In 2007, Austria also underwent some changes in the training regulations introducing 3 new specialties: cardiac surgery, thoracic surgery and child and adolescent psychiatry.

The Austrian Medical Chamber is very concerned about the above-mentioned governmental plans to restructure the health system. Despite Austria was awarded the top position in the ranking of consumer-friendly health systems in Europe (European Health Consumer Index 2007), the Health Ministry tried to introduce what the Austrian Medical Chamber qualifies as a nationalisation and centralisation of healthcare, i.e. transfer of the Austrian Medical Chamber's competence of decision on the number of contracts with social security bodies to the ministry, introduction of guidelines on the treatment of patients by the ministry, control of the ministry over quality assurance, etc. For that reason the president of the Austrian Medical Chamber, Dr. Walter Dorner, met with the Health Minister, and a declaration of intention was signed, confirming that there will be no reform of the health system before a discussion with the Medical Chamber has taken place. In addition, the Austrian and the regional medical chambers called upon all Austrian doctors to inform their patients on the dangers of the initial plans of the government. For this purpose, a so-called information day was organised on November 8th, 2007 in medical practices all over Austria. Unfortunately, some of the concerns raised by the medical body proved later not to have been taken into account. Therefore, the Austrian Medical Chamber is still monitoring very carefully the next steps of the government.

From the international point of view, the Austrian Medical Chamber is very active and thus a member of different European and international organisations such as the WMA, CPME, EFMA/WHO, FEMS, UEMS, etc. Migration of doctors within the EU is also an important issue. As described earlier, Austria is soon to adapt its system so as to enable an even smoother migration of Austrian doctors. The Austrian Medical Chamber is also in close contact with Germany and has recently concluded a friendship treaty with the German federal state of Saxony aiming to promote bilateral mobility of doctors. Friendship treaties with other German states are to follow. This initiative is also supported by the European Union in the framework of the life long learning initiative.



## The German Medical Association

### Fighting fiercely for the freedom and independence of the medical profession

Liberal practice, which for physicians means clinical independence in selecting the best therapy for patients, seems to be a disruptive factor in a system of increasingly state-controlled health management in Germany. But physicians are demonstrating a new degree of solidarity, and the German Medical Association is fighting fiercely for the freedom and independence of the medical profession and the provision of the best medical services available for patients.



*Prof. Dr. Dr. h.c. Jörg-Dietrich Hoppe*

The Federation of the German Chambers of Physicians ("German Medical Association" - GMA) was founded in 1947 as the working group of the West German Chambers of Physicians. Today, all 17 State Chambers of Physicians are represented by the GMA. Membership in a Chamber of Physicians is obligatory; the GMA represents all 413,696 physicians, of whom 314,912 are practising (2007) - about 48% in the inpatient sector and 44% in the outpatient sector<sup>1</sup>. As part of the statutorily regulated system of self-government of the medical profession, the Chambers of Physicians are responsible for safeguarding the professional interests of

the physician community and exercise the sovereign task of registering and supervising physicians. They regulate and promote postgraduate medical education and continuing medical education and ensure the high ethical and scientific standards of doctors.

The elected presidents of all 17 State Chambers become members of the GMA Council, which convenes every month for an all-day meeting at the GMA's headquarters in Berlin. The GMA mediates the exchange of opinions and activities between the State Chambers, mutually coordinating their goals and working towards the most uniform possible regulation of all activities in the different regions. The 17 State Chambers send a total of 250 delegates to the annual Medical Assembly, which serves as the "parliament" of the physicians in Germany. The Assembly elaborates and adopts regulations regarding the professional code of conduct and postgraduate medical education curricula, passes changes in the statutes of the GMA and agrees on official positions on health policy issues. It establishes permanent or temporary committees to deal with individual subject areas and ongoing questions. The Assembly also elects the President and two Vice-Presidents of the German Medical Association. Prof. Jörg-Dietrich Hoppe was re-elected as President for another four-year term at last year's Medical Assembly. Dr. Cornelia Goesmann and Dr. Frank-Ulrich Montgomery are currently serving as Vice-Presidents.

With a population of 82.3 million, Germany has about 3.8 practicing physicians per 1,000 residents (2007)\*. Although the number of medical school graduates has remained relatively constant in recent years, it seems that a serious shortage of physicians will become a major issue in the near future. In 2006, more than 2,500 mostly young physicians left the country for better salary and improved working conditions abroad\*.

In addition, many medical school graduates chose to work in other, better-paid industries. Although Germany records a relatively high number of physicians immigrating from abroad, many more physicians will be



*Prof. Dr. Dr. h.c. Dr. Karsten Vilmar, Treasurer Emeritus of WMA*

retiring in the next few years. As a result, the provision of medical care may be jeopardised, especially in rural areas.

One of the tasks of the GMA is to respond to the needs of the high number of migrating physicians. Another task is maintaining contacts with other national medical associations and international healthcare organisations worldwide. On behalf of Germany's physicians, the GMA collaborates with the Standing Committee of European Doctors (CPME) and has been an active member of the World Medical Association (WMA) since 1951, where two GMA representatives are currently serving on the Council of the WMA. The GMA continuously supports the WMA's various activities, and GMA staff is actively involved in several WMA working groups, task forces and a number of projects, most recently the MDR-TB online course for physicians. The publishing house of the GMA's weekly "Deutsches Ärzteblatt" journal has been serving as the publisher of the World Medical Journal for many years.

*Dr. Ramin Parsa-Parsi, MD, MPH  
Head of the Department for  
International Affairs*

<sup>1</sup> National Association of Statutory Health Insurance Physicians, Department 4.1 (Need Related Planning, Federal Registry of Physicians and Data Exchange)

## The Georgian Medical Association



The Georgian Medical Association (GMA) is the doctors' independent, professional organization established to look after the professional needs of Georgian Physicians. GMA was established in 1989 and is considered as the first professional non-governmental organization in the country. The GMA represents doctors in all fields of medicine all over the country. The GMA is the voice for doctors, residents and medical students – in constant contact with relevant national authorities. The Georgian Medical Association plays an active role in the opinion-forming process in relation to health policy in society, and in legislative procedures.

The mission of Georgian Medical Association is to serve and unite the physicians in the country, for the highest achievable standards of health care; to promote the art and science of medicine and the improvement of the public health. GMA works for and by the medical doctors. In addition, the one of the important directions of activities are the patients' rights, quality of care and patients' safety.

GMA Membership is voluntary based. The types of membership include: individual,

collective, junior and honorary members. More than 50 professional field associations, working in different branches of medicine are the collective members of the GMA. Thus, the Georgian Medical Association represents the umbrella organization for the medical profession and organized medicine in the country.

The GMA is governed by the General Assembly (GA), which is the highest legislative and decision making representative body. General Assembly elects the GMA Board of Directors and giving the credential to this structure for governing the association between the periods of the GA. The Board of Directors includes the leaders of GMA: President, Vice-President, Secretary General and heads of committees. Georgian Medical Association represents the Georgian Medical Profession on European (European Forum of Medical Associations and the WHO) and International (World Medical Association) levels.

The relations with the Parliamentary Committee on Health care are developing rapidly and fruitfully. We are often invited by the parliamentary committee for Health

Care to participate in discussions on health care legislation and initiatives. During the years we have submitted several proposals to the Parliament to strengthen the protection of physicians' legal, social and professional in-



terests. Georgian Medical Association initiated the preparation of amendments and additions to the Georgian Law of Medical Activities. The GMA requested to add to the Law the additional chapter (94-1) on Legal Safeguards of Physicians. The GMA presidium discussed the amendments and submitted the document to the Health Care Committee of the Parliament. Another important direction of our activities is the relationship with the Office of Georgian Public Defender. We are participating in joint task force for elaboration of the amendments and changes in the Georgian Law of Patients' Rights.

The Georgian Medical Association is acquiring more and more important functions in health care sector of the country. The association closely cooperates with the Ministry of Health, Labor and Social Affairs and State Medical Regulation Agency. Based on this cooperation, GMA is carrying out the following activities:

**Medical Education:** The members of the GMA in association with the Tbilisi State Medical University elaborated the Postgraduate Curricula in several medical specialties.

**Professional Liability:** The physicians' rights were widely violated several months ago. The complaints of the patients (one year ago) in most of the cases were the background for professional or even criminal li-

ability of practitioners. The GMA expressed its concern and strong position against this trend. GMA raised this issue in Health Care Committee of the Parliament. The negotiations with the ministry of Health, Labor and Social affairs finished successfully. The GMA was delegated the privilege to appoint professional medical experts for investigation and review of medical records. Nowadays, any professional complaints against the physicians are forwarded to the GMA and the decision of the Licensing Board now is based on above conclusions. As a result, the physicians now are more protected and professional issues are solved only by professionals.

**Professional Standards:** The GMA started elaboration of the document about the Professional Framework of medical specialties. A part of the documents are already submitted to the Ministry of Health. As a result, the ministry reviewed existing standards and started amendments. The GMA is continuing the work on National Guidelines on Good Medical Practice. We strongly believe that mentioned document will improve the relations between the state and medical professionals. The members of the GMA, together with the different professional associations are very active in elaboration of the National Medical Guidelines and Protocols. Recently, The Georgian Medical Association, in association with the Georgian Association of Surgeons elaborated the guidelines for management of surgical emergencies in clinical practice for 4 diseases.

**Licensing and Certification of Physicians:** The Georgian Medical Association is actively involved in the process of the Licensing and Accreditation of the Physicians. Recent times, GMA was invited by the ministry of health to carry out the technical and organizational support of the exams. The persons recommended by the GMA are appointed as a Chairs and Members of the Examination Commissions. The GMA leaders are chairing the examination commission for the GP Licensing process, as well as the Appellation Commissions. The

examination tests are to be renewed before each examination session. The GMA in collaboration with the professional medical associations are making the mentioned updates and amendments.

**Medical-Social Expertise:** Georgian Medical Association and the experts from GMA, are providing the training cycles for the staff responsible for provision of Social-Medical Expertise to decide about the matter and degree of disability (mental and physical).

**Right of Physicians:** Georgian Medical Association is supporting its members, as well as non-member physicians in case of medical litigation. GMA representatives are attending the judiciary processes and submitting the professional conclusions in favor of medical doctors if the association believes that the doctor is deserving support. GMA tries to make the evident border between the medical error and medical crime. We strongly believe that the physicians should not be sentenced by the criminal courts for medical errors!

**Ethical Standards:** One of the most important directions of the GMA's activities is the development of Code of Medical Ethics. The Code is obligatory for the GMA members.

**Human Rights:** Georgian Medical Association, in close partnership with local organizations (RCT/EMPATHY and ARTICLE 42) developed and successfully completed the Istanbul Protocol Development Project (1 and 2 phase 2003-2007). The international partners of the project were: WMA, Physicians for the Human Rights – USA, Human Rights Foundation – Turkey, Redress and the International Rehabilitation Council of Torture Victims (Denmark). In the Frames of the Project, 15 medical professional was prepared and certified as an international expert in effective medical investigation and documentation of torture victims. The physicians prepared by the project now are used as trainers in other countries of the world.

**Undergraduate Medical Education Standards:** GMA is working now on the undergraduate medical education curricula. The standards should be based on recommendation of the World Federation of Medical Education / WHO. All the Quality Assurance tools are emphasized. In this respect, the GMA has the close partnership with Tbilisi State Medical University. Tbilisi State Medical University is kindly offering the office space for GMA during the past years up today.

**Foreign Medical Graduated:** According to the Georgian Law on Medical Activities, any foreign graduate, applying for the working License of the physician in Georgia should be recommended by the professional association. Recent years, more and more foreign graduates are applying us for recommendation. GMA is reviewing the applications and after the final interview is giving or declining the recommendations. Georgian Law on Medical Activities stipulates that any incoming foreign practitioner should have a temporary license for temporary work permit in the country. Georgian Medical Association is active also in this direction. In this respect our obligation is to find and collect the data about the clinical competence of the incoming physician and recommend them to the Licensing Board for granting the temporary working license.

**Regulatory Boards:** The leaders of the Georgian Medical Association, according to the local legislation are invited to work in different health care regulatory boards, such as: State Licensing Board of Medical Personnel; The Board of Postgraduate Medical Education and CPD; National Bioethical Council.

Abovementioned activities carried out by GMA is positively reflects on physicians professional environment and conditions.

*Dr. Levan Labauri M.D., Ph.D.  
Secretary General, Georgian  
Medical Association*



## The Israeli Medical Association



*Dr. Yoram Blachar,  
President-Elect of WMA*



*Adv. Leah Wapner*

The Israeli Medical Association (IMA) is an independent professional organization, advocating for the rights of physicians and patients throughout Israel. Established in 1912, 36 years before the founding of the State of Israel, the IMA has been confirmed by the courts as the representative body of physicians in Israel. Although membership is on a voluntary basis, 94% of physicians in Israel are members of the IMA. The IMA also includes within its ranks 155 scientific associations, societies and workgroups. The IMA is responsible for setting professional norms and ensuring high standards of medicine along with ethical behavior and professional integrity. It also strives to secure the physician's status, rights and autonomy. In recent years, the IMA has expanded its function to take a greater role in shaping national health policy, influencing the legislative process, and promoting public health and quality assurance.

The IMA has recently been involved in several key processes intended to improve the situation of both the individual physician as well as the state of health care in Israel.

In July 2000, the IMA agreed on behalf of all publicly employed physicians to give up the right to strike for ten years in exchange

for mandatory arbitration. The arbitration process only began in 2005 and continues today. The arbitrators are expected to arrive at a final decision within the coming months.

The IMA's list of demands include an additional salary of approximately 32% (for public doctors), accounting for a physician's overtime work when calculating his/her basic salary, a solution to the shortage of professionals in certain specialties, allocation of time and remuneration for those physicians who participate in CME/CPD and increasing pension pay from 70 to 85% of a physician's basic salary.

Another recent development which the IMA initiated was the establishment of the Public Forum to Update the Basket of Health Services. This public forum was formed when the Ministry of Health's advisory committee on the yearly basket of health services reduced the amount of physician and patient advocates allowed to serve on the committee. The Forum included experts in ethics and health economics, patient advocates, public representatives, and clergy members. As a result of the establishment of this alternative committee, the Israeli Medical Association was successful

at expanding the amount of resources committed to the basket of health services from 250 million New Israeli Shekels to 400 million New Israeli Shekels. Additionally, the alternative committee's establishment caused a ripple effect on the Ministry of Health's advisory committee, resulting in more transparent procedures, hearings that included patient testimony, the allowance of criticism from the media, and the opening of an advisory committee website.

On the international front, the IMA has been an active member of the World Medical Association for many years, drafting and contributing to statements and declarations and providing representation to several committees. Dr. Yoram Blachar, current WMA President-Elect, has served as chairman of the Socio-Medical Affairs Committee and the Finance and Planning Committee, in addition to two consecutive terms as Chairman of Council. Adv. Leah Wapner assists with legal counsel to the WMA and Adv. Malke Borow serves as an advisory member of the Medical Ethics Committee.

Currently, the IMA serves as a member of the workgroup on stem cells, and a member of the workgroup on clinical trials involving children, as well as leading the workgroup on task shifting, which will result in the drafting of a statement on the topic. Additionally, the IMA is at work on a number of other draft statements on different topics.

One of Dr. Yoram Blachar's goals for his upcoming presidency at the WMA is to increase the WMA's Arab member constituency. During his term as President-Elect, Dr. Blachar has already made contacts with various heads of NMAs of Arab countries currently not members of the WMA. Dr. Blachar will continue with these recruitment efforts during his upcoming presidency.



## The Estonian Medical Association and WMA



The Estonian Medical Association (EMA) is a voluntary nongovernmental organisation representing the interests of Estonian doctors. The EMA was founded on February 28 1921 as an Association of Estonian Medical Societies, dismissed in year 1940 by Soviet regime, and refounded on June 11, 1988 as a National Medical Association. EMA has the functions of trade union since 1992.

The main objectives of The Estonian Medical Association are to unite the physicians, develop and elaborate health policy, medical culture and ethics in Estonia as well as represent and protect the professional interests and rights of the members of the EMA. The EMA participates in the elaboration of the legislation concerning health and is represented in a number of organizations and commissions coordinating health care.

More than 70 % of Estonian doctors belong to Estonian Medical Association. Besides regional medical associations also the Estonian Junior Doctors' Association belongs to the EMA.

Dr. Andres Kork- a general surgeon at the West Tallinn Central Hospital has held the post of the president of association since 2002. The General Assembly is the highest decision-making body that is summoned once a year in November. The Council presides the EMA in the recesses. The Council is comprised of the president, Board members and the representatives of the regional associations. The Board is the organ of the executive-organizational administration of the EMA.

The EMA publishes its journal, the Estonian Medical Journal ([www.eestiartst.ee](http://www.eestiartst.ee)), which

also contains original research reports. Despite the fact that the number of people speaking Estonian is fairly low, EMA has made the best efforts to translate most of the medical terms into Estonian and keep the language medically useful.

### International relations

The Estonian Medical Association is a full member of the major medical organizations in Europe: the Standing Committee of European Doctors (CPME) and the European Union of Medical Specialists (UEMS). Estonian Junior Doctors' Association (EJDA) is a full member of the Permanent Working Group of European Doctors (PWG). EMA has joined World Medical Association in year 2004.

### EMA and WMA

There is no doubt that the World Medical Association is one of the most influential medical organizations worldwide. As Estonians have experienced the soviet political system which did not comply with the basic human rights and democracy we highly value the firm standpoint WMA has always had in these key questions.

Last year the EMA in conjunction with the Medical School of Tartu University published the Estonian version of the WMA Medical Ethics Manual. Now every medical student will receive his or her own copy of the WMA ethics manual when having ethics classes. Besides being a very clear and concise handbook of ethics, I believe that many students will realize with the help of that book, that the work and ethical standards of doctors is very similar in various countries.

*Vallo Volke MD, PhD  
Board member of Estonian Medical Association*

# The International Activities of the JMA and the WMA

## Outline of the JMA

The Japan Medical Association (JMA) was first established in 1916 and took on its present form following the Second World War in 1947. Membership comprises members of Japan's 47 local medical associations. As an academic organization, the JMA aims to promote policies that ensure the health of the general public and the autonomy of medical professionals through the formulation of national medical policies. Membership is voluntary, and currently numbers 165,000 (as of December 2007), which is 60% of the number of physicians in nationwide (approx. 270,000). Of these, approx. 85,000 are clinic physicians and 80,000 are hospital-based physicians.

Association affairs and important matters must be decided by the JMA Board; the highest decision-making organ is the General Assembly of House of Delegates. The Secretariat comprises 226 staff (as of December 2007) and the Secretary General must be a qualified physician (Tables 1 and 2).

## Two WMA Presidents

The JMA has provided by two WMA Presidents, Dr. Taro Takemi and Dr. Eitaka Tsuboi.

Dr. Taro Takemi served as President of the JMA for 25 consecutive years, from 1957 until 1982. In 1975, he was appointed as the 29th WMA President and the WMA General Assembly was held in Tokyo in the same year. Early in his research efforts on the theme of "the development and distribution of medical resources", Dr. Takemi foresaw that Japanese healthcare would in the future become intertwined with global health in the future. Dr. Takemi also took part in the establishment of the Confederation of Medical Associations in Asia and Oceania (CMAAO) in 1956, a major aim of which was to gather together of the voices of Asian physicians and to deliver them to the WMA for discussion. CMAAO membership now comprises the national medical associations of 17 countries, with the confederation carrying out various activities in order to raise health standards for the people of the region through the promotion of exchange between physicians and information exchange.

Dr. Takemi also founded the Takemi Program in International Health at the Harvard School of Public Health in Boston in 1983 with the aim of providing opportunities for health professionals, particularly those in developing countries, to further improve their skills. Even now, the program

**Table 1. Organization of the JMA**

1. Membership is voluntary.
2. There are 165,000 members (out of 270,000 physicians in Japan).
3. The highest organ is the General Assembly of House of Delegates.
4. The JMA Board serves as actual decision-maker.
5. Secretariat of 226 people works to implement the decision of the board.

**Table 2. Secretariat of the JMA**

1. Number of staff: 226; 185 are full-time.
2. Three departments and 20 divisions. The International Division has 5 staff.
2. JMA Research Institute: est. in 1997
3. Top is Secretary General (MD).
4. Office hours: 9:30 to 17:30; Monday to Friday.

recruits approximately 10 researchers from all around the world every year. Those who have completed the program are known as "Takemi Fellows" and they play central roles in healthcare all over the world.

Dr. Eitaka Tsuboi served as JMA President from 1996 to 2004; in 2000, he was appointed as the 52nd WMA President and the WMA General Assembly was held again in Tokyo in 2004 after a break of 25 years. Dr. Tsuboi was tireless in his international contributions, such as the implementation of health programs in developing countries.

In 1997, the Japan Medical Association Research Institute (JMARI) was established as a Think Tank for supporting the "Development of Health Care Policies for the Japanese People" promoted by the JMA through research activities, information gathering, and survey analysis. The JMA incorporates the results of JMARI research into its policy proposals and on occasion presents these directly to political party reviews as "Medical Workplace-led Policies",



*CMAAO Congress in Pattaya, 2007*

as opposed to bureaucracy-led or financially led policy proposals.

## Current and Future International Activities

The current executive of the JMA regards community healthcare in Japan as a part of global health and has carried out activities with an emphasis on international cooperation. The JMA Journal, official English journal of JMA, together with its English website, introduces major activities of the JMA including those of local medical associations, such as health policies, advocacy policies, analysis of health systems, reports of Takemi fellows and conferences and lectures. It also publishes international topics contributed by WMA and CMAAO related to physicians. This journal is a comprehensive one introducing JMA activities from the global perspective.

Three of the current WMA council members are from the JMA, and thus policy documents adopted by the WMA are always reported to the JMA Board. Important documents such as the Declaration of Geneva, Declaration of Helsinki, and Declaration of Lisbon are used as necessary as reference materials in JMA Ethics Committee and Patient Safety Committee discussions. In the spring of 2007, 220,000 copies of the Japanese version of the "WMA Medical Ethics Manual" were published and not only distributed to all JMA members, but also given to 45,000 medical students at 80 medical colleges nationwide as part of the JMA's support for medical education.

Information is also actively exchanged with individual national medical associations throughout the world. A broad range of information from both around Japan and from overseas is necessary for resolving

various health issues faced in Japan and international community as well, but overseas information obtained from the internet does not always meet our requirements. An international network centered on the WMA and CMAAO would be an extremely effective means for medical associations to efficiently acquire accurate and wide scope of information from overseas. In addition to expressing our heartfelt gratitude to the responsible officers in the NMAs that cooperate regularly with the JMA, we hope that this type of cooperation in exchanging information among NMAs will be maintained in the future.

*Masami Ishi, MD  
Executive Board Member, Japan  
Medical Association  
Council Member, World Medical Association*

## The Viet Nam Medical Association (VMA)

### Long tradition

The Viet Nam Medical Association (VMA) was established more than half a century ago, in 1955, and since then has brought medical doctors and pharmacists together under the mission of unification for the development of Viet Nam and to improve the quality of health care for all, with a focus on independence and medical ethics.

During the development of the VMA, some specialties, including pharmacists, traditional medical doctors and acupuncture doctors, lobbied to create independent associations for each of these professions. Based on the principles of voluntarism, the Exco of VMA agreed with this request to split these professional groups into specialty associations as well as incorporate a number of new associations under the VMA umbrella. Now the VMA has 43 national specialties and 63 provincial Medical Associations, as well as

the Viet Nam Nurses Association and the Viet Nam Midwives Association.

Since its establishment, the Presidents of the VMA have been symbols of Viet Nam intellectuals, both in general and especially

within the medical sector. Two of them have been chosen as the namesakes for two streets of the capital city HaNoi.

### Transparency

The VMA concentrates on publishing Medical Journals. Four of the journals were established fifty years ago, a further journal



*MASEAN 12th Midterm Meeting Council Hanoi Vietnam 10. November 2007. Delegates from: Indonesian Medical Association, Medical Association of Lao PDR, Malaysian Medical Association, Myanmar Medical Association, Philippines Medical Association, Singapore Medical Association, Medical Association of Thailand, Vietnam Medical Association, Ministry of Health, Brunei Bandar Seri Begawan*



began in 2007 and 30 journals belong to national specialties.

### International relations

The VMA was accepted fully as member of the South East Medical Association (Masean) and have hosted two Masean meetings in Ha Noi .

In addition, we have good relationships with the UK and USA Medical Associations as well as excellent linkages with the World Medical Association.

VMA will advocate a comprehensive policy approach against Hepatitis B, supported by *Bristol Squibb Meyer*. In addition, Pathfinder International will provide a project of

capacity building for VMA in three years, starting from 2008.

### Consultant for MOH

VMA has been actively involved as a consultant for MOH, especially on policy and health system structure and organization. The VMA now conducts monthly meetings with the Minister of Health to ensure a regular dialogue on key issues.

VMA will continue to promote a priority focus on improvements in the mental health of mothers and infants in collaboration with the Research and Training Centre for Community Development (RTCCD), a local NGO with remarkable skills and abilities in this area.

### Some ideas on further activities of WMA.

The 21 century is the Century of Knowledge and globalisation is on the way to being realized. The WMA must be the key association to provide continuing education as well as communication on the key health issues throughout the world. However the majority of medical associations are not in a position to make large payments, therefore free membership is necessary to ensure that the collaboration between organizations as well as knowledge dissemination by the WMA continues. The VMA hopes that the WMA will have the innovation to realize this noble task.

*Pham Song*  
President of VMA .

## The Ghana Medical Association

### 50 years of health advocacy, policy dialogue and welfare

By all the historical accounts, the 4<sup>th</sup> of January 1958 was a significant defining moment for the future of the medical profession in Ghana. In many ways, the significance of that achievement was not without drama of its own, deeply steeped in the rich colonial and political ethos of the time.

Mind you, 1958 was the year after Ghana, the first country south of the Sahara had achieved its independence. Kwame Nkrumah the Osagyefo was busily stamping the Ghanaian seal on all National emblems, monuments and organizations. Above all perhaps, he was also breaking off the shackles of colonialism from the minds of the recently colonized. The year was also interesting for keen observers of the medical scene not least because it witnessed the co-existence of two bodies which could neither be said to be serious rivals and yet not exactly complementary of each other's activities. Within this politically charged context, there had existed 25 years back in 1933, an organiza-

tion of mainly African medical practitioners whose main purpose according to celebrated medical historian, Prof Stephen Addae was to "act as a vehicle for redressing grievances of African medical officers in government employment." It had Dr. F. V. Nanka-Bruce as its first President and Spokesman and was officially known as the Gold Coast Medical Practitioners Union.

### But it was a beginning.

The second more powerful group of doctors was formed in January 1953 and was known as the Ghana Branch of the British Medical Association. Mind you, in the Gold Coast, the interests of medical practitioners were advanced by the parent British Medical Association whose branch it was. With an African government taking up the reigns of leadership in 1951, it must have felt increasingly anachronistic to look back to Great Britain for leadership. Being better connected and grouping a larger

body of doctors, this second group was more vibrant.

In fact in the words of Prof Addae, "the records indicate that the Branch Association was a very active body...It quickly established a good working relationship with the new African government and was soon recognized as the negotiating body for the medical profession in the country. It participated in the new Ministry of Health's plans for setting up a Medical and Dental Board and amending the existing Medical and Dental Practitioners Ordinance. Political goodwill prevailed." This Branch was led first by Dr. F. V. Nanka-Bruce of the initial Practitioners Union whose brief tenure was followed by the election of another African, Dr. C. E. Reindorf following the former's sudden death after only five months in office.

Theoretically therefore, by 1958 when the Ghana Medical Association was formed, we had these two bodies championing the cause of doctors in modern Ghana. Increasingly however, according to the late Dr. M. A. Barnor, third GMA President in his book *A Socio-Medical Adventure in Ghana*, debate had long been on-going as to how to transform the Branch organization as the Gold Coast itself



moved from a colonial status to an independent nation.

Now, this is where the plot thickens for within less than a year of his return to Ghana after his studies in America and Canada, one Dr. Schandorf in partnership with a few others achieved what others had only been debating for years. In Dr. Barnor's opinion, Dr. J. A. Schandorf whom he described as a "medical entrepreneur" and who was later elected the second president of the Ghana Medical Association was not controversial in what he set out to do.

"It was the way he went about doing it-which was the right way-but which people thought was controversial", observes Dr. Barnor.

And just what did our second president do? Once again, we defer to the first hand account of second general secretary and third president, Dr. Barnor.

"One day in 1958, there was a newsflash in the 'Daily Graphic' newspaper. The newspaper announcement indicated that a newly arrived doctor and a medical entrepreneur from the United States, Dr. J. A. Schandorf had announced he was going to launch a 'Ghana Medical Association' which would be recognized by government and would also be the mouthpiece of the profession in the country. The ceremony was to be performed by the Prime Minister, Dr. Kwame Nkrumah"

From all indications, Schandorf was strategic if not radical. As an American-trained doctor, he had been denied registration in England when he tried. He, therefore must have had his motivation for wanting a Ghana Medical Association that was not a branch of the British Medical Association. Secondly, he had a personal relationship with the Prime Minister with whom he had attended Lincoln University in the United States. Thirdly, he managed to rope in other heavy weights like Dr. C. E. Reindorf, Chairman of the Gold Coast Branch of the British Medical Association and Dr. W.A.C Nanka-Bruce, one time Secretary of the original Gold Coast Medical Practitioners Union.

And so it happened that on the 4th of January 1958 at 5 pm in the Arden Hall of the Ambassador Hotel, Prime Minister Kwame Nkrumah duly launched the GMA after stating "how pleased he was that the Ghana Medical Association was going to be formed, and that that would mean a strong body of doctors would from then on exist to help both the government and the medical profession itself. The Prime Minister also added that 'from now on, the Ghana Medical Association is the only organization of doctors my government is prepared to recognize'.

### Growing Pains

In the immediate aftermath of its formation, the GMA had to deal with issues of establishing the credibility of this first professional body including popularizing it among doctors and the general public, securing funding for its activities and contributing to the larger health agenda of the newly independent nation. And so it was that a new Executive was elected led by Prof Charles Odamtten Easmon as First President and Dr. F. T. Sai as his Secretary with the latter being later succeeded by Dr. M. A. Barnor on his departure to the United Kingdom for further studies in Internal Medicine.

As early as July 1959, Divisions of the GMA began to be set up in various parts of the country with Ashanti-Brong Ahafo being the first Division. This Division, an amalgamation of doctors from two Regions was led by Dr. Evans Ankomah who would later become the 5th GMA President. This was followed almost immediately the following month by the inauguration of the Western Division which incorporated the Western and Central Divisions. To quote Dr. M. A. Barnor, "this was a momentous occasion, exhibited by the rapidity with which almost all doctors in the region-private and government medical officers without exception – in no time became active, enthusiastic and pioneering members. It was a timely development and Dr. A. A. Akiwumi of Effia-Nkwanta Hospital was elected the first Chairman of the Western Division of the Ghana Medical Association."

The Eastern Division was to follow, curiously with its administrative base in the Greater

Accra Region with Dr. R.H.O Bannerman as Chairman. Then came the Northern Division comprising all three Northern Regions in 1973 and then finally Volta came. Today, of course, the Association consists of ten Divisions whose Chairmen together with representatives each of the Ghana Dental Association, Society of Private Medical and Dental Practitioners and Junior Doctors and the seven elected members of the National Executive Committee constitute the National Executive Council, the highest decision making body, second only to the authority of the Annual General Meeting.

Even at that early stage, the GMA quickly started organizing public lectures on health education, nutrition and hygiene in Accra, a tradition which it has maintained till date as its contribution to health education and policy dialogue. Today also, beyond the organization of Annual Public lectures, the GMA has sourced funding and is very advanced in its attempts to publish public lectures on Hypertension and Road Traffic Accidents etc as Supplementary Readers for Children in Ghana.

As part of its growing efforts, the Ghana Medical Association sought and gained international recognition when in 1959, it applied for and was granted membership of the World Medical Association followed in May 1960 by affiliation to the British Medical Association (BMA). Two years later, following a proposal from the BMA, the GMA would significantly co-sponsor the conversion of the 'British Commonwealth Medical Conference' into the Commonwealth Medical Association.

Today it is indeed a source of great pride to the Ghana Medical Association to have Prof Agyeman Badu Akosa, himself a Past President ascend to the high office of President of the Commonwealth Medical Association from 2005-2007. Having completed his tenure, he has been succeeded on the Executive by Past GMA General Secretary Dr. Oheneba Danso who is the current Secretary of the Commonwealth Medical Association.

*Sodji Sodji-Tettey*

## The Somali Medical Association



Dr. Abdirisak A Dalmar

Somalia Republic is situated in the horn of Africa. Its land is estimated to be 638,000 sq. km., and its coastline extends 3,330 km. Ethiopia borders it in the west, Kenya in the south, the Indian Ocean in the east, in addition to the Red Sea and the Republic of Djibouti in the north (Fig 3.1). The population of Somalia is estimated to be 10.8 million (2003); the capital city is Mogadishu with 2.5 million inhabitants. Somalia is divided into 18 regions. Major climatic factors are a year-round hot weather, seasonal monsoon winds, and irregular rainfall with recurring droughts.

Intermittent civil wars have been a fact of life in Somalia since 1977 with much casualties and famine. One of the world's least developed countries, Somalia has few resources with much of the economy being devastated by the civil war. Agriculture is the most important sector, with livestock accounting for about 40% of GDP and about 65% of export earnings.

### Somali Medical Association. Aims:

- To represent the Somali medical doctors and advocate for their rights.
- To provide continued medical education to its own members.
- To implement medical relief projects

### Establishment:

- Was founded in 1961, with the first 4 newly qualified medical doctors. Founded in 1961 with the first 4 Somali doctors.

- Grew in number and quality, and in 1990 the members were 1142.
- Ceased to work in 1991, due to civil war in the country.
- A lot of its members fled the country

### Current SMA:

- Re-established in 2000 by 143 doctors in Mogadishu.
- The current number is 481 working throughout the country.
- Member of the World Medical Association and Arab Medical Union
- Applied to become a FIMA member
- In late 2006 the Transitional federal government relocated to the capital city, Mogadishu with the support of Ethiopian troops.
- In early 2007 a local armed insurgency against the Ethiopian army presence started all over south-central Somalia.
- This caused a lot of internal and international displacement of the local population, including the medical doctors.
- There are only two major hospitals working at the moment, down from 15 hospitals in 2006.

### Structure of SMA

- **General assembly:** Held every two years, where all members are eligible to participate and elect the executive committee.
- **Executive committee:** Is elected for a period of two years, and it is composed of 10 members, including the Chairman, Deputy chairman, Treasurer and heads of different subcommittees
- **Subcommittees:** We have subcommittee on ethics, medical defense, international relations, training and research, social affairs, public health etc.

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Somali Medical Association

**Table 1:**  
Selected demographic and economic characteristics in Somalia

| Demographic Indicators                                    | Year | Value  |
|---|------|--|
| Population  | 2004 | 10.8 million*  |
| Population Growth Rate                                    | 2000 | 3.41%  |
| <b>Age Structure:</b>                                     | 2000 | 0-14 years: 44%<br>15-64 years: 53%<br>65 years and over: 3%           |
| Life Expectancy at Birth                                  | 2000 | Total population: 46.2 years<br>male: 44.7 years<br>female: 47.9 years |
| Total Fertility Rate                                      | 2000 | 7.18 children born/woman   |
| Birth Rate  | 2000 | 47.7 births/1,000 population   |
| Death Rate  | 2000 | 18.69 deaths/1,000 population  |
| Infant Mortality Rate                                     | 2000 | 125.77 deaths/1,000 live births  |
| Literacy (definition: age 15 and over can read and write) | 1990 | total population: 24%<br>male: 36%<br>female: 14%                      |
| Per Capita Income   |      | \$600  |

\* This estimate was derived from an official census taken in 1975 by the Somali Government; population counting in Somalia is complicated by the large number of nomads and by refugee movements in response to famine and clan warfare.

**Table 2:**  
Selected health indicators in Somalia

| Health Indicators                                     | Year | Value |
|---|------|-------|
| Physician Per 10,000 Population                       | 1997 | 0.4   |
| Dentists Per 10,000 Population                        | 1997 | 0.02  |
| Pharmacists Per 10,000 Population                     | 1997 | 0.01  |
| Nursing and Midwifery Personnel Per 10,000 Population | 1997 | 2     |
| Hospital Beds Per 10,000 Population                   | 1997 | 4.2   |
| Households with Access to Local Health Facilities (%) | 2003 | 72.2  |
| Population with Access to Safe Drinking Water (%)     | 1999 | 23.1  |
| Population with Adequate Excreta Disposal Facilities  | 1999 | 48.5  |

# The WMA Statement on Family Planning and the Right of a Woman to Contraception

*Adopted by the 48<sup>th</sup> General Assembly, Somerset West, Republic of South Africa, October 1996 and amended by the General Assembly, Copenhagen, Denmark, October 2007*

The WMA recognizes that unwanted pregnancies and pregnancies that are too closely spaced can have a serious adverse effect on the health of a woman and of her children. These adverse effects can include the premature deaths of women. Existing children in the family can also suffer starvation, neglect or abandonment resulting in their death or impaired health, when families are unable to provide for all their children. Social functioning and the ability to reach their full potential can also be impaired.

The WMA recognizes the benefits for women who are able to control their fertility. They should be helped to make such choices themselves, as well as in discussion with their partners. The ability to do so by choice and not chance is a principal component of women's physical and mental health and social well being.

Access to adequate fertility control methods is not universal; many of the poorest women in the world have the least access. Knowledge about how their bodies work, information on how to control their fertility and the materials necessary to make those choices are universal and basic human rights for all women.

The role of family planning and secure access to appropriate methods is recognized in the 5th Millennium Development goal as a major factor promoting maternal and child health.

The WMA recommends that National Medical Associations:

Promote family planning education by working with governments, NGOs and others to provide secure and high-quality services and assistance

Attempt to ensure that such information, materials, products and services are available without regard to nationality, creed, race, religion or socioeconomic status.

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