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Dear colleagues!

In keeping with our new tradition of featuring one of our member countries on each cover of the World Medical Journal, I am pleased to have Norway on our cover this month. Our cover shows a Norwegian doctor who has arrived by sled to care for a sick child. Norway can be proud of its exemplary medical care and its social conscience. Medicine in Norway today is characterized by impeccable ambulatory facilities and super-modern clinics. The Norwegian Medical Association was ahead of its time 25 years ago when it undertook the goal of eliminating smoking in Norway. Although this goal has only partially been reached, Norwegians can be proud of having the lowest rate of smoking and alcohol consumption not only in Europe but also in the world, as well as having among the greatest longevity and lowest morbidity rates in the world.

When we look at the World Medical Association today, we see an organization that has matured in 60 years to be a global force. Since its foundation, the main goal of the World Medical Association has been to establish and promote the highest possible standards of ethical behavior and care by physicians. The WMA has adopted policy statements on many ethical issues related to medical professionalism, patient care, research on human subjects and public policies, taken a leadership role against smoking, detecting cervical cancer early, increasing physical activity and exercise.

As doctors, we are aware of the deleterious effects of smoking and as a medical organization, the World Health Organization has taken a very strong stand against smoking. I would like to urge us to take an even stronger stand against exposure of children to secondary smoke (passive smoking), as well as children smoking. Smoking in an enclosed space fills the air with noxious substances such as ammonia, arsenic, benzene, benzoapyrene, butane, cadmium, formal-

dehyde, lead, nicotine, propylene glycol and turpentine. In addition to being carcinogenic, these harmful chemicals lead to vascular diseases and pulmonary disorders. Toxins from cigarettes are inhaled not only by the smoker, but also by non-smokers in the same room. If the non-smoker is a child, subjecting the child to such poison could be viewed as being as serious an offense as physical violence, paramount to sexual abuse, psychological trauma or other cruelty to children. Punishment for any abuse against children, including subjecting them to passive smoking, could be seen as a criminal offense.

The Latvian Medical Association has endorsed laws that would prohibit smoking in automobiles in which children are passengers. Such laws have been enacted in Australia, 21 states in the United States, parts of Canada, Cyprus and in other countries. We should encourage the health organizations in our countries to prohibit smoking in vehicles in which any passenger is younger than age 18, in all public buildings, in all educational institutions and facilities that deal with children, and in any building or room, including in private homes, in which children are present.

Smoking in the presence of children should be recognized as child abuse, since it is clear that passive smoking causes physical harm to the child. We cannot allow the excuse that a person, even in his own home, has the right to smoke if such smoking causes harm to a child.

Physicians should take a leadership role in the battle against cigarette smoking and set an example of a healthy lifestyle by not smoking. It goes without saying that a doctor who smokes is an anachronism. Let us lead by example and protect our next generation.

*Pēteris Apinis, M.D.
Editor-in-Chief of the World Medical Journal*

Editorial

In announcing the topic for World Health Day 2008, Dt. Margaret Chan, DG WHO, said *"Health professionals are in the front line in delaying the impacts of climate change. The most vulnerable are in countries where the health sector struggles to prevent, detect, control and treat diseases and health conditions, including malaria, malnutrition and diarrhoea..... we need to put public health at the heart of the climate change agenda"* and on World Health Day 7th April 2008 she said *"The warming of the planet will be gradual but the effects of extreme weather events – more storms, floods, droughts and heat waves– will be abrupt and acutely felt. Both trends can affect some of the most fundamental determinants of health; air, water, food, shelter and freedom from disease."*

The medical profession has increasingly over the past years faced major problems over and above those arising from its basic role in providing health care to individuals, to which we have referred in previous editorials – such as those associated with healthcare organisation, structure and function, changing roles, scientific advances and their application to medical practice – not to mention HIV/AIDs, the threat of pandemic spread of disease, (see editorial WMJ53(4)).

Now new problems also threaten to add to the burdens of providing health care to those in need.

Already there has been increasing international concern about the effects of **climate change**, which have become more apparent in the context of the "natural disasters" affecting many countries both in the east and the west. These have added to the calls for emergency medical care and other assistance, including food and water supplies. Now the problem of sustaining adequate food supplies is extending beyond those countries affected by natural disasters, not only increased by the effects of armed con-

licts but by the realities of a wider problem of producing enough food for an expanding global population.

While international aid has been directed to dealing with the consequences of natural disasters and the consequences of armed conflict, looking to the future the problem of coping with the diseases associated with malnutrition and starvation may well be enlarged beyond those countries affected by armed conflict and natural disasters in the past...

As if this were not enough, the current uncertain **financial** climate, with potential threats to global financial structures, also poses additional problems to those already facing existing healthcare systems. While the current trend to look towards preventive measures to reduce the incidence of some diseases and contain the financial burden of providing healthcare to treat them offers much for the future, the burden of such disease is likely to continue for some decades to come. To meet this need the concept of "task shifting" to offer some alleviation of the problems of scarcity of human healthcare resources needs careful consideration, not only to address the inequitable shortage of health professionals in some countries, but in all countries. This calls for realistic approaches by all the health professions. Likewise those responsible for health care policies have a difficult task in attempting to balance the financial burden needed to meet the immediate and mid-term needs of the present global population and the investment needed to extend disease preventive action required to contain the health care costs of future generations. For those suffering disease, whatever its cause, care and treatment are priorities, they do not have time to engage in mid- to long-term strategies to avoid disease. While lifestyle factors play an important role in the development of a number of diseases, it cannot be disregarded that in the working lifetime of many

practising physicians the burden of disease has been increased not only by the substantial increase in scientific knowledge and its application in diagnosing and treating diseases, but also by the substantial increase in life expectancy in much of the world. This is now reaching the stage in some countries where the size of the retired population is approaching if not exceeding that of those who actively engaged in gainful employment, resulting in increasing strains on the financial resources which can be applied to the provision of healthcare services to meet their needs.

While most of these considerations have been addressed by economists, healthcare providers and policy makers, they will now assume an even greater urgency than they have over the past few decades.

The combination of the possibility of impending widespread recession coupled with the growing inadequacy of basic food staples affecting even bigger populations than have previously been experienced, has the potential to not only increase the burden of disease but also to threaten the nature of medical care and treatment society will be able to sustain. It is therefore incumbent on NMAs to monitor and engage, where appropriate, in discussions on the effects of climate change and the maintenance of adequate resources for services to meet both short and long term needs.

While the monitoring of such activities fall naturally within the responsibilities of NMAs, at this time of increased threats to financial systems, those arising from climate change and to food supplies extending beyond national and regional limits, the need for a united voice from the leadership of the medical profession address these issues (where appropriate) is essential to inform and influence the political decisions which will be taken both nationally and globally.

Dr. Alan J. Rowe
Co-Editor of the World Medical Journal

Human Resources for Health



Jon Snaedal
President of the WMA

This is the name on a Forum organised by the Global Health Workforce Alliance (GHWA) in Kampala, Uganda 2-7 March 2008. The intention was to bring to light the problems of critical shortage of health workers in over 50 countries in the world and what forces dictate the migration from low income countries to high income countries. In the analysis of the problem during the meeting it became obvious that this problem is more complicated than it seems at first sight. Migration is also taking place inside countries, where health professionals leave the official health service and either move to the private health sector or leave the health service altogether. Migration is also taken place regionally from one low income country to another. The push and pull factors were discussed and to what extent these factors could or should be regulated. Furthermore, the role of the various stakeholders in this global problem was discussed.

The Forum was attended by several stakeholders. It was organised by the GHWA and as this is an agency established by the WHO, many officers of that organisation were involved. The major focus was on the

situation of the health workforce in Africa and therefore governmental officers; mostly from African health authorities were present but also some from the financial departments. There were also representatives of development agencies and from several NGO's, not least from associations of health professionals, both national and international. The aim of the Forum was to come to some mutual understanding of this enormous problem by issuing a declaration and in that regard, the meeting turned out to be successful.

Before we go any further into this issue it is important to look into the vocabulary used. The WHO and the GHWA use the term "health workers" which opens the possibility to include individuals with limited or nonprofessional education and training, but are nevertheless working in the health service. The WMA and other Associations of health professionals on the other hand stress the importance of looking specifically at the migration of health professionals and the reasons for their choices. It is of importance to realise that migration is an individual choice based on reasons which are very different from case to case and it is only when the total picture is analyzed that it is possible to see a pattern. It is very important that there will be no constraints by laws or regulations on individual choices and it was a relief to realise that no such ideas were put forward in the discussions.

Those who gathered in Kampala are not the only ones concerned were the problem. The Lancet has recently published a specific number on this issue (Vol. 371; 9613: February 23-29 2008). On the front page of this number there is one sentence which captures this huge problem very well: "Africa carries 25% of the world's disease burden yet has only 3% of the world's health workers and 1% of the world's economic resources to meet that challenge." This is the problem in a nutshell this continent is

dealing with in the first decade of the new millennium.

What are the driving forces behind migration of health professionals? They are of course many, but can be analysed separately by using the terms "push factors" meaning factors increasing the possibility to leave a country or a profession and by "pull factors" meaning those factors that are at play in the recipient countries or services. The aim of the meeting was not only to discuss problems but also to find solutions.

Amongst problems and solutions to pull factors discussed at the meeting were the following:

- Lack of health professionals in the *recipient* countries. Countries receiving health professionals from low income countries should increase the number of educated and trained health professionals in their own country and subsequently be self sufficient and not in need of recruitment from other regions.
- Ethical recruitment. There should be a generally accepted and respected ethical conduct for recruitment of health professionals in order not to "attack" vulnerable populations and strip them of well educated and trained people. However it is acknowledged that individual freedom of choice should not be constrained.

Amongst problems and solutions specific for the push factors were:

- Need for investment. The source countries should increase investment in health, both through their own means and by outside contribution.
- Investment in proper health education. This investment should be in education and training of health professionals, in increasing the offers of jobs after training and in making the work in the health service attractive.
- The role of International financial agencies. There is compelling evidence that the financial requirements of the International Monetary Fund for investment in the source countries makes investment in public health difficult and it will be very

hard to increase the GDP proportion to health without some deviation from these requirements.

- **Task shifting.** An increase in mid-level health workers and community health workers is needed in the short term in areas of most critical shortage, but task shifting should not be a long term solution. There is a difference in opinion on this part of the solution and it will be discussed separately.

In addition to these possible solutions to the problem there are other issues that “bridge” the push and pull factors or are part of both. One is to make contracts between agencies in both resource and recipient countries. These can be hospitals which agree to exchange health professionals for work and training, to provide technical material and training and other issues. These agencies can also be health regions or other specific health service agencies. Examples of this are to be seen in several arrangements between hospitals in the UK and in South Africa, leading to a substantial decrease in migration from South Africa to other countries in recent years.

Positive Practice Environment is a specific concept which includes various factors that make work places attractive to work in. In a pre-meeting organised by associations of health professionals this was specifically addressed. There are many factors or incentives that can be tailored for work places which increase the likelihood of retention of health professionals. These incentives can be categorised as financial or non-financial. Financial incentives are wages, bonuses, pensions,

insurance and other things, but there are also various non-financial incentives. Those might include safe and clear workplace, professional autonomy, sustainable employment, flexibility in work time, support and supervision, and occupational health and counselling services. One issue specifically mentioned was the fact that the prevalence of HIV and AIDS is higher amongst health professionals in many regions of Sub-Saharan Africa than in the communities they serve, but they do not receive the support and counselling they need.

Task shifting is an issue that the WHO has put on the agenda as a part of the solution and this was discussed separately at a previous meeting in Addis Ababa last January. Task shifting involves the transfer of tasks in the health service from individuals or professionals with high level of education and training to those with lower level of knowledge. That means, in practical terms, that tasks are shifted from doctors to others, but never the other way. This might be a solution to an urgent problem, but is problematic in the long run. One risk is that health authorities would see this as a means to decrease the cost of health services, but then without thinking of the quality of service provided. Another is that the shift of priorities from longer professional education and training to a shorter one will lead to diminishing number of properly educated and trained work force. In the long run this will lead to segregation of health service between countries with different level of service, based on different levels of knowledge. It was clear that the health ministers of Africa attending the Task shifting meet-

ing in Addis realised this and they stressed that it was very important to prioritise the traditional training and education.

A draft to the Declaration and an action plan was distributed on the first day of the Forum in Kampala and after adjusting the papers according to comments and critics; the Declaration was accepted by all. In a roundtable session of Health Ministers and high representatives of WHO, the WMA criticised however, the lack of transparency and consultation in the preparation of these documents as the drafts had been prepared without any consultation with the global associations of health professionals even though the problem was so closely associated with them. We, the representatives of the WMA, proposed several amendments most of which were principally accepted in the final version. The WMA could then accept the declaration in spite of lack of clarity on many points.

The Declaration and the Action plan are primarily aimed at governments and it was stated that due to the severity of this crisis, it should be a priority of the heads of governments, not only of health authorities.

It was finally decided that in two years time the situation should be evaluated in order to see the effect of the Declaration and the Action plan.

This article is based on a report made after the Kampala meeting and reflects the views of the author.

Positive Practice Environments (PPE) -

Quality Workplaces for Quality Care

In an unprecedented move, the global organizations of nurses, pharmacists, physiotherapists, dentists and physicians, and the International Hospital Federation, joined forces with the support of the Global Health

Workforce Alliance to tackle a root cause of the global shortage of health professionals. Poor working conditions rank second only to insufficient wages as the key reason health professionals are leaving their countries

in such large numbers, creating this global crisis. Even wealthy countries are witnessing emigration of health workers in search of better working environments. Through their campaign on Positive Practice Environments (PPE), these global partners are committed to promoting and facilitating safer, more secure and more attractive working environments and practice conditions for health care workers.

Today, many countries have desperate shortages of health care professionals, impacting negatively on patient care and health outcomes and creating sub-standard practice environments for those who provide care. Countries in sub-Saharan Africa and in parts of Southeast Asia have a particularly low health profession-to-population ratio. The reasons are complex: in most cases low wages and even concerns about whether there will be a paycheck each month are major factors driving out health professionals, especially physicians. Poor working conditions undermine professional performance, put both patients and health workers at risk and compel health professionals to search for better, safer working environments. For health professionals capable of speaking the language of one of the rich countries in the northern hemisphere, a ticket for a move is practically already printed.

The World Health Organization's (WHO's) core strategy to address the health workforce crisis depends on what it calls *Task Shifting*. Task Shifting is the substitution of health professionals by lay persons and ultimately assigns minimally trained community health workers with the tasks of physicians, nurses and midwives. With part of their jobs given away to lay persons, physicians may be forced out of the public sector into private practice, or out of the country. Even when they remain in-country, this effectively creates a two-tiered health system in which the wealthy have access to qualified physicians in the private sector while the health of majority of the population is left in the hands of a non-professional workforce. The preferred approach of PPE campaign members, who represent the various health professions, is to focus on stronger retention of health professionals through better working conditions.

Gathering the Professions

When the Global Health Work Force Alliance held its 1st Global Health Workforce Forum in Kampala in March 2008, the PPE campaigners took the opportunity to assemble for the first PPE workshop. Health professionals from all over Africa, Europe and

North America gathered to discuss and exchange views about how to strengthen health systems through better working conditions.

As keynote speaker of the meeting, WMA president, Dr Jon Snaedal, began by reminding the group of the alarming shortage of health professionals worldwide, but more critically in Sub-Saharan countries. He reviewed the three key actions currently identified and developed by decision-makers to address this workforce crisis: education, task shifting and retention. Unfortunately, of these three strategies, task-shifting has emerged as the prime focus of most efforts. Dr. Snaedal outlined the objections that many – including African health ministers – have against using task shifting as the primary solution to the health workforce shortage. He referred participants to a response developed by the World Health Professional Alliance and the global organizations of midwives and physiotherapists, to the WHO strategy on task shifting. Presented in Kampala, this resolution outlines twelve key principles necessary to avoid disastrous consequences from task shifting. (See Insert 2 for full text.) Dr. Snaedal emphasized that education and retention are equally, if not more important than task shifting, especially when the objective is to build comprehensive

and sustainable health care systems. Positive Practice Environments, he explained, is one of the retention strategies.

The African participants shared the very strong concerns on task shifting, yet recognized it as a possible complementary response to health workforce shortage, if pursued with the following approach:

Tasks must be shifted from one educated group to another educated group (e.g., physicians to nurses, nurses to assistant nurses, etc.). When tasks are shifted to unqualified personnel – referred to as “community health workers” – the creation of a second-class health care system is inevitable. Task shifting should not be used as a means to replace health professionals, but rather as a way to complement their work. Task shifting requires significant supervision of community health workers by health professionals and therefore does not lead to a decrease in the workload for already overworked health professionals. Even with task shifting, a strong increase in the number of health professionals is necessary.

It was clear that the current approach to task shifting, as driven by WHO and donor organizations, is far removed from these principles.

Quality Workplaces for Quality Care is the campaign title to promote Positive Practice Environments. The 5-year global campaign is spearheaded by key stakeholders – International Council of Nurses, International Hospital Federation, **International Pharmaceutical Federation**, **World Confederation for Physical Therapy**, World Dental Federation, World Medical Association and the Global Health Workforce Alliance. Its purpose is to ensure safe, cost-effective and healthy workplaces worldwide, thereby strengthening health systems and improving patient safety.

Positive practice environments (PPE) is a recognized strategy to address the global health workforce crisis. PPE are health care settings that support professional excellence by providing good working condition. They have the power not only to attract and retain staff, but also to improve patient satisfaction and outcomes, cost-effective services and most important health care safety.

The objectives of the PPE campaign are to:

- **Make the case** for healthy, supportive work environments, through evidence of their positive impact on staff recruitment and retention, patient outcomes and health sector performance.
- **Build a global platform** – share examples of good practices for healthy, supportive and efficient workplaces. For that the campaign will provide materials including an advocacy toolkit presenting evidence of the beneficial impact of PPE, a web based, user-friendly library of PPE reference materials or best practice guidelines for the health workplace.
- **Drive a sustained trend** in establishing and applying the principles of positive practice environments across the health sector.
- **Be open** to all countries, settings and health disciplines. The global campaign materials are open for adaptation to suit local preferences and to engage indigenous support and action.
- **Celebrate success** in support of effective strategies that promote sustainable health systems.

28 February 2008

Joint Health Professions Statement On Task Shifting

We, the representatives of more than 25 million health professionals, are committed to providing safe, accessible health care to the world's people. We understand all too well the impact of shortage of personnel, supplies and equipment on patients, families and providers. We witness the impact daily of not enough staff, not enough clean water, not enough drugs, not enough money to access services or to afford life's staples. We see health professionals mentally and physically exhausted daily. We struggle with the dilemma of resource restrictions and meeting the needs of everyone - and the evidence that shows that better health outcomes occur when higher numbers of professionals are engaged in direct care.

We understand the need to address today's human resource crisis. At the same time we are concerned that task shifting and adding new cadres of workers result in fragmented and inefficient service through reductionist and vertical approaches. We believe that for task shifting to be effective:

Skill mix decisions should be country-specific and take account of local service delivery needs, quality and effectiveness factors, efficiency, the current configuration of health services and available resources, as well as production and training capacity, and include the health professions in decision-making.

Roles and job descriptions should be described on the basis of the competencies required for service delivery and constitute part of a coherent, competency-based career framework that encourages progression through lifelong learning and recognition of existing and changing competence.

There needs to be sufficient health professionals to provide the required selection, training, direction, supervision, and continuing education of auxiliary workers.

Regulations for assistive personnel and task-shifting need to be set with the professions involved. It should be clearly stated who is responsible for supportive supervision to assistive personnel. In any case the curriculum development, the teaching, supervision and assessment should always involve the health professionals from whom the task is being shifted.

There must be adequate planning and monitoring to avoid the danger of generating a fragmented and disjointed system that fails to meet the total health needs of the patient, offers a series of disconnected and parallel services that are both inefficient and confusing, and may lead to de-motivation and high attrition rates.

Assistive personnel need compensation and benefits that equal a living wage, a safe workplace and adequate supplies to ensure their own safety and that of patients. At the same time they should be expected to work within the code of conduct of their employer.

Deploying assistive personnel will increase demand on health professionals in at least three ways: (1) increased responsibilities as trainers and supervisors, taking scarce time away from other tasks; (2) higher numbers will be needed to take care of the new patients generated by successful task-shifting; and (3) health professionals will be faced with patients who have more complex health needs (the simpler cases will be covered by task-shifting) and thus require more sophisticated analytical, diagnostic, and treatment skills.

There needs to be credible analysis of the economic benefit of task shifting to ensure equal or better benefit, i.e. health outcomes, cost effectiveness, productivity, etc. Ongoing evaluation, particularly in skill-mix changes and the introduction of new cadres and or new models of care, should systematically consider the impact on patient and health outcomes as well as on efficiency and effectiveness.

When task shifting occurs in response to specific health issues such as HIV, regular assessment and monitoring should be conducted on the entire health system of the country concerned. In particular, quality assessment linked to overall health outcomes of the population is essential to ensure that programs are improving the health of patients across the health care system.

Assistive workers should not be employed at the expense of unemployed and underemployed health professionals. Task-shifting should be complemented by fair and appropriate remuneration of health professionals and improvement of their working conditions.

Where task shifting is meant as a long-term strategy it needs to be sustainable. If meant as short term, there needs to be a clear exit strategy.

Assistive workers need to be integrated into health care delivery systems and treated as part of the team.

Conclusion

In geographical areas facing a critical shortage of health professionals, efforts should be made and supported to increase professional training opportunities (undergraduate and graduate), and to provide incentives for the retention of health professionals.

Whatever the strategy selected, task-shifting should not replace the development of sustainable, fully functioning health care systems. It is not the answer to ensuring comprehensive care, including secondary care, is accessible to all.

International Confederation of Midwives
International Council of Nurses
International Pharmaceutical Federation
World Confederation of Physical Therapists
World Dental Federation
World Medical Association

Participants then turned their attention to the PPE campaign and identified some aspects that must be addressed:

While health professionals work under very difficult circumstances to serve their patients, their own health is often neglected. PPE should include proper access to good quality health care for health professionals.

Instead of tolerating or even accepting bad working conditions, health professionals must advocate for, and actively drive, change.

In all countries, working conditions for health professionals could be significantly improved. As conditions and priorities in each country differ, planning and implementation for PPE must be undertaken at the national level.

After careful analysis, with particular attention to the situation in Africa, participants identified **two complementary strategies** to respond to the health workforce shortage and to promote PPE:

Capacity building: Currently, national organizations of the various health professional groups are not equipped to create the strong advocacy force required to impact decision-making at the national level. Strong health professional organizations could help to propose, promote and implement efficient health policy. Capacity building for national health professional organisations is therefore a critical priority.

National coalitions: Even where professional organizations are effectively working, their impact could be improved by better

collaboration at the national level. Many participants recognized the value of meeting as a global coalition in Kampala. Creating similar national forums where health professionals' organisations can meet and exchange good practices, combine resources and pursue common strategies, would be extremely useful. Some suggested establishing formally a national body composed of representatives of health professions organisations to pursue joint actions, develop campaigns and exert political leverage. In addition, the need to promote a change of mindset toward more solidarity and joint mobilisation among nurses, physicians and other health professionals was clearly evident and strongly supported.

Clarisse Delorme
Advocacy advisor, World Medical Association

Call for Equal Access to Cervical Cancer Treatment for All Women and Girls

A comprehensive prevention strategy for reducing the threat of cervical cancer has been called for by the World Medical Association and the Medical Women's International Association.

In a joint statement to mark international women's day (March 8), the two organisations demand action for women and girls around the world to have equal access to the highest quality prevention and treatment options for cervical cancer and say that such a strategy should include screening and vaccination.

Dr. Shelley Ross, Secretary-General of the Medical Women's International Association, said: 'Cervical cancer is the second most common cancer among women. But it is now preventable due to the availability

of a vaccine against human papillomavirus (HPV)'.

She said that every year cervical cancer affected 500,000 women and took the lives of a quarter of a million women worldwide. Women in poor countries were the most affected, with 80 per cent of the deaths from cervical cancer due to extremely limited screening and treatment availability.

Dr. Ross added: 'When reflecting back on major advances in women's health in years to come, HPV vaccine will be listed as one of the major breakthroughs. It is urgent that governments across the world start prioritizing cervical cancer with sustainable political and financial commitments. Not doing so means losing lives. It means also not granting to women and girls in poor countries the right

to equal access to life-saving technologies'. Four of the common types of HPV could be prevented through vaccination although there was currently no treatment available which could cure an HPV infection. HPV vaccine therefore had the potential to substantially reduce the prevalence of cervical cancer, although not to eradicate it.

Dr. Jon Snaedal, President of the WMA, said 'Medical associations have a key role to play in this strategy in making information on HPV vaccine available to physicians and to encourage physicians to alert their patients on this innovation'.

'Cost must not be a barrier to making the vaccine available to women and girls worldwide. We are calling for a strong mobilisation of decision-makers, international organisations, international donor community and development partners, as well as medical associations, civil society and industry to act now for a change, to stop cervical cancer'.

Health Professionals Taking Action on Climate Change

A web report from the British Medical Association's Board of Science

In April 2008 the British Medical Association (BMA) published "Health professionals taking action on climate change", a web based resource which calls on health professionals to take a lead in tackling climate change. As ambassadors of health, doctors have both the opportunity and a responsibility to highlight the public health risks of climate change. The resource aims to provide an overview of the science of climate change and the resulting implications, particularly for health in the UK. The key purpose is to highlight what practical actions health professionals and healthcare organisations can take in order to reduce their carbon footprint. Some of the simplest measures include turning appliances off stand-by, reducing unnecessary heating,

repairing leaking taps, minimising waste, and reusing items and recycling where possible. The resource also includes examples of good practice and links to sources of further information.

As well as reducing their own carbon footprint, health professionals are well placed to influence and promote social change. With a history of combating major public health concerns, health professionals can play a vital role in tackling climate change and the related adverse effects on health. By highlighting the numerous health benefits associated with more environmentally friendly activities and lifestyles, they can empower individuals to become greener and encourage public debate.

Healthcare organisations are significant contributors to carbon emissions. In the UK for example, the NHS is the largest single organisation, with an annual purchasing budget of around £17 billion. It employs over one million people and emits around one million tonnes of carbon every year. There is huge potential for NHS to promote combating climate change, through taking practical steps to reduce carbon emissions and by raising staff and public awareness to these initiatives.

The BMA believes it is essential that all doctors and healthcare organisations lead by example in reducing their negative impact on the environment; work together to reduce the carbon emissions of healthcare organisations; and promote greener lifestyles to ensure a healthy, sustainable future.

The web resource can be accessed by visiting the BMA website at <http://www.bma.org.uk/ap.nsf/Content/climatechange>

Mercury-free Health Care



Introduction

Mercury, one of the world's most ubiquitous heavy metal neurotoxins, has been extensively used in health care since antiquity. It has been an integral part of many medical devices, most prominently thermometers and sphygmomanometers. These both add to the global burden of mercury removed from its below ground repository and spread about on the surface to form highly neurotoxic organomercury compounds. Further, these devices break or leak with regularity, exposing health care workers to the acute effects of the inhalation of the metal itself. In view of this, as part of a global initiative to reduce the use and spread of mercury in all aspects of society, health care providers and institutions have begun to replace mercury-based medical devices with affordable, accurate and safer alternatives.

In 2005 the World Health Organization advised, in its eloquently crafted policy paper on the topic, a global transition of the health care sector toward the use of mercury free care alternatives. Specifically, the paper projected a 3 step approach:

"Short Term: Develop and implement plans to reduce the use of mercury equipment and replace it with mercury-free alternatives. Address clean-up, storage and disposal."

Medium Term: Increase efforts to reduce the use of unnecessary mercury equipment in hospitals."

Long Term: Support a ban of mercury-containing devices and promote alternatives."

In Europe, reflecting the elimination of the use of mercury devices by all major providers, several countries, including Sweden, the Netherlands, and Denmark have banned the use of mercury thermometers, blood pressure devices and a variety of other mercury containing equipment. In 2007, the European Parliament extended the ban on mercury thermometers to the entire Union.

In the United States, Canada, Mexico, Argentina and countries in between, thousands of hospitals, pharmacies and medical device purchasers have switched to digital thermometers along with mercury free aneroid and digital sphygmomanometers. These initiatives have become so widespread in the U.S. that the health care market has been fundamentally restructured toward mercury free devices for all applications.

In Sao Paulo, Brazil, more than 92 hospitals have signed agreements committing to eliminate mercury-based thermometers and sphygmomanometers – more than 42 have already done so. The Buenos Aires city government, which runs the largest health care system in Argentina, is implementing a policy to phase out mercury-based medical devices in 33 major hospitals and 38 smaller health care centres and three Provinces have issued letters of intent to phase-out mercury-based medical devices. Cuba has replaced nearly all of its mercury sphygmomanometers with aneroid devices.

In Asia and Africa as well, despite economic constraints, a growing number of hospitals have committed to going mercury-free, and a number of large cities, states, and national governments are developing model policies for mercury-free health care. In India, the Delhi city government is pursuing a mercury free policy for its health facilities. The Province of Kwa Zulu Natal in South Africa has

issued directives banning the purchase of mercury thermometers and sphygmomanometers. On a national level, the Philippines are developing an Administrative Order to phase-out mercury in health care and Taiwan has banned mercury fever thermometers.

The transition to mercury free health care today is neither smooth nor universal. It presents a series of challenges to the health care sector that must be practically confronted with evidence based solutions that neither increase patient risks nor contribute to the increasing costs of health care. Yet solutions are available that permit health care institutions to reduce their contribution to this toxic environmental exposure that risks patients' health and well being. Health Care Without Harm, an international coalition of medical providers, nurses, health care institutions, professional organizations, and environmentalists seeking to reduce the environmental impact of health care, has taken on the challenge presented by these issues.

Physicians have a special role to play in this effort to improve the public's health through primary prevention. They are uniquely able to translate the toxicologic and epidemiologic information in the medical literature for the public and policy makers. They are often the leaders of health care institutions, always are the key and deciding element in the provision of patient care, and they hold influential positions in most countries as community leaders. National and international medical societies are playing and will continue to play an important role in this global process.

The Problem

Mercury in the Environment

Mercury is a naturally occurring heavy metal. At ambient temperature and pressure, mercury is a silvery-white liquid that readily vaporizes. When released into the air, mercury may stay in the atmosphere for up to a year, and is transported and deposited globally. It is within this environment that inorganic and organic compounds of mercury are formed.



Since the start of the industrial era, the total amount of mercury circulating in the world's atmosphere, soils, lakes, streams and oceans has increased by a factor of between two and four. This increase has been affected by human endeavours, which include the removal of mercury from its subterranean home through mining and the extraction of fossil fuels. Human exposure to mercury can result from a variety of sources, including, but not limited to, consumption of fish rich in methyl mercury, and due to spills or leaks of the metallic element itself.

Mercury causes a variety of significant adverse impacts on human health and the global environment. Mercury vapour may produce pneumonitis and pulmonary edema if inhaled and toxic levels can be absorbed through the skin due to handling of the liquid metal especially if the epithelial barrier has been broken due to cuts or abrasions. Target organs other than the lungs include kidneys, nervous system and GI tract. Anecdotal reports from hospitals utilizing mercury thermometers report breakage ranging from several to several hundred a month. These reports are paralleled by those noting leakages of mercury containing sphygmomanometers as well with the potential for significantly larger amounts released.

Yet, of even more concern is potential for developmental neurotoxicity produced by low dose methyl mercury exposure through food. Elemental mercury accumulates in lake, river, stream, and ocean sediments, where it is transformed into methyl mercury, which then accumulates in fish tissue. This contamination of fish stock is ubiquitously present in oceans and lakes throughout the world, concentrating sev-

eral hundred thousand times as it moves up the aquatic food chain.

Methyl mercury is of special concern for fetuses, infants, and children because it impairs neurological development. When a woman eats seafood that contains mercury, it accumulates in her body, requiring months to years to excrete. If she becomes pregnant within this time, her foetus is exposed to methyl mercury in the womb, which can adversely affect the foetus' central nervous system. Impacts on cognitive thinking, memory, attention, language, and fine motor and visual spatial skills have been documented in children with exposure in utero to levels of methyl mercury commonly found in women of child bearing age.

Along with WHO, the United Nations Environment Programme (UNEP) has identified the adverse effects of mercury pollution as a serious global environmental and human health problem. The UNEP Governing Council, representing all UN represented countries, has targeted reducing methyl mercury accumulation in the global environment as a major global priority.

Sources of Mercury Pollution:

The health care sector is far from the greatest source of organic mercury compounds in the environment. Rather, coal-fired power plant emissions and mercury cell chlor-alkali plants, along with artisanal gold mining and battery disposal are all far more significant polluters. However, the health care sector does play an important role as a source of global emissions, as well as a source of low-level, chronic and acute elemental mercury poisoning.

Mercury can be found in many health care devices and present in fluorescent lamps as well as dental amalgams. Mercury is also found in many chemicals and measurement devices used in health care laboratories. Medical waste incinerators, as well as municipal waste incinerators, emit mercury into the atmosphere when they burn wastes that contain mercury. According to the U.S.



Environmental Protection Agency (EPA), in 1996, prior to the mercury phase-out in U.S. health care, medical waste incinerators were the fourth largest source of mercury emissions to the environment. Hospitals were also known to contribute 4-5% of the total wastewater mercury load. And mercury fever thermometers alone contributed about 15 metric tons of mercury to solid waste landfills annually.

In 2005, Transande et al. using national blood mercury prevalence data from the US Centers for Disease Control estimated that between in this century 316,588 and 637,233 US children each year have cord blood mercury levels $> 5.8 \mu\text{g/L}$, a level associated with loss of IQ. They estimated that lost productivity due to this amounts to \$8.7 billion annually (range, \$2.2-43.8 billion).

While no comprehensive figures are available, anecdotal evidence suggests that in most of Asia, Africa and Latin America, mercury spills are not properly cleaned, nor is the waste segregated and managed properly. Rather, it is either incinerated, flushed down the drain, or sent, via solid waste, to a landfill.

Thermometer breakages on a case-by-case basis pose some harm to patients, nurses and other health care providers when mercury is absorbed through the skin or mercury vapour is inhaled. Only a relatively small amount of mercury – roughly one



gram – is released when each thermometer breaks. However, when taken cumulatively on a hospital ward, in an entire hospital, nationally and globally, the situation takes on more serious dimensions.

In Buenos Aires, for instance, the city government, which runs 33 hospitals and more than 38 clinics, was purchasing nearly 40,000 new thermometers a year, until it began to switch over to alternatives in 2006. Given that nurses and other health care professionals often buy their own thermometers to supplement the city's procurement,

Table 1
Monthly Mercury Thermometer Breakage at Federico Gomez Children's Hospital Mexico City

Sevices	Broken per month
Intensive care unit	20
Postoperative recovery	20
Emergency Room	30
Out-patient studies recovery	6
Surgery	15
Pediatric ICU	15
Surgery ICU	15
Nephrology	30
External consultation	20
General consultation	30
Out-patient surgery	2
Pediatrics I	15
Pediatrics II	30
Immunosuppressive illness	30
Chemotherapy	2
Urological surgery	45
Special care	30
Orthopedics	30
Total:	385
Approximate yearly total:	4.620

Source; HCWH/CAATA, 2007

the city's health system was using well over 40,000 thermometers a year, most of which would break, and some of which would be taken home (where most would ultimately break as well). The system was ultimately emitting in excess of 40 kilograms of mercury into the local hospital environment and into the global ecosystem every year.

If one were to use this figure and extrapolate for the entire country, one can estimate that until recently thermometers broken in Argentina's health care system were spilling 826 kilos, or nearly 1 metric ton of mercury, into the global environment every year.

In Mexico City, the 250-bed "Federico Gomez" Children's Hospital is a medical service, teaching, and research hospital affiliated with the National Autonomous University of Mexico. This prestigious children's hospital documented a thermometer breakage rate of 385 per month, or well over 4,000 per year (see Table 1). The total number of estimated broken thermometers in this one hospital between 2002 and early 2007 is nearly 22,000 – the equivalent of 22 kilograms of mercury.

While the Federico Gomez hospital has now committed to substitute its mercury devices with alternatives, when it undertook its initial assessment there was no clean-up protocol for mercury spills. Rather, mercury waste was deposited with both infectious and biological hazardous wastes, or with municipal wastes. Broken fluorescent lamps were also treated as municipal waste. Mercury containing equipment was not repaired if broken, and the procedure followed was to merely register the loss and replace it with new equipment.

The regular and ongoing breakage of thermometers and the lack of mercury waste management protocols and practices found at the Federico Gomez hospital is not an exception, but more generally the rule in hospitals throughout much of the Global South, where patients and health care workers are regularly and unknowingly exposed to this toxin.

This is the case, for instance, in India, where far fewer thermometers are employed in many hospitals). In a study of New Delhi hospitals, the NGO Toxics Link found dangerously high levels of mercury in a series of indoor air samples. They found the "substantial presence of mercury in ambient air of both the hospitals" studied. These levels, which ranged from 1.12 microgram per cubic meter to 3.78 microgram/m³, were all higher than numerous international standards.

One of the biggest mercury hot spots that Toxics Link found in its study was the room used to calibrate blood pressure devices (sphygmomanometers), which contain 80-100 grams of mercury or 80-100 times the amount found in a single fever thermometer.

Mercury release and contamination from sphygmomanometer calibration is a common problem throughout the world. Louis Havinga, Manager of Health Technology Services for the KwaZulu Natal Province Department of Health in South Africa explained:

This is the most important point why the Health Technology Services has moved away from the use of mercury products. The technicians were exposed to mercury when they repaired mercury column sphygmomanometers. Special precautions and equipment is needed if working with mercury products like a dedicated fume/vapour extraction unit within the maintenance department. The mercury is extracted from the device and placed in a special marked container. The container must be able to seal and should remain inside the fume/vapour extraction unit. Once the container is full, the container must be disposed of in a well documented and controlled manner by making use of a recognized hazardous waste disposal company which is very costly.

And while sphygmomanometers break less frequently than thermometers, the spillage is significant and therefore problematic from an environmental health perspective. At the Mayo Clinic in the U.S., between 1993 and 1995, 50 spills were documented

relating to leakage and spills from sphygmomanometers.

Overcoming the Obstacles: *Accuracy, Affordability, Disposal*

It is clearly in the interest of public health and the environment to replace mercury-containing measuring devices in the health care sector. However, actually implementing such a transition runs into three fundamental challenges.

First, is that the long term use of healthcare mercury devices has helped to support a belief that mercury products are accurate and do not need calibration. Together with this belief, there is a deep scepticism in much of the medical community regarding the accuracy of alternatives. Second, replacing mercury-based medical devices is often seen as an expensive proposition that is unobtainable for cash-strapped health care sectors in the developing world. Third, is the thorny question of what to do with mercury that is taken out of circulation in the health care setting. Many governments lack the infrastructure to manage mercury waste, so it is often not clear what to do with this toxic element once a hospital takes it out of circulation.

These are relevant concerns and good questions, yet there are answers and proven approaches to replacing these devices.

Accuracy

Some medical professionals still consider mercury to be the only accurate and consistent method of measuring temperature and blood pressure. Yet, as peer reviewed studies from the last decade demonstrate, this is not currently the case, and in fact our attitude toward the accuracy of mercury thermometers and sphygmomanometers was probably overly positive in years past as well.

The mercury filled glass thermometer, though easily and frequently broken, is one of the simplest and most widely used diagnostic tools. It was therefore the first clinical

mercury device to be evaluated for accuracy in comparison with a growing number of available alternatives.

After considerable debate in the 1990s, Leick-Rude and Bloom, during routine accuracy testing in a study, reported that 25% of the glass/mercury thermometers tested differed from the reference thermometer by >0.2 degrees Centigrade. This finding was consistent with the authors' review of prior work. Indeed, another recent study had rejected 28% of glass/mercury thermometers due to inaccuracy.

Digital thermometers, the most commonly used mercury-free temperature device, use a thermistor to convert temperature into a known electrical resistance, and are highly sensitive. As with most products (mercury or mercury free) their accuracy is dependent on manufacturing quality and techniques. Standards organizations such as the ASTM International have developed protocols that will help the healthcare community identify accurate alternatives. It is imperative that the healthcare community and governments ensure that thermometers are purchased from manufacturers that follow techniques and testing protocols that are independently certified by ASTM or other internationally established regimes, so as to provide a product that provides the accuracy required.

Sphygmomanometers represent the largest reservoir of mercury in current medical use. As with thermometers, mercury and non-mercury blood pressure devices provide accurate measurement so long as both instruments are calibrated. Examples of both inaccurate mercury and mercury-free sphygmomanometers can be found in the medical literature, though this inaccuracy is typically related to poor maintenance and calibration. A large number of scientific studies have concluded that mercury-free measuring devices produce the same degree of accuracy as mercury devices, provided they are properly maintained and calibrated. For instance, a study at the Mayo Clinic in the US concluded that aneroid sphygmomanometers provide

accurate pressure measurements when a proper maintenance protocol is followed.

Some have argued that for accurate blood pressure measurement the reference device used for calibration must be a mercury blood pressure device (with a typical error of ± 3 mm of mercury). Yet, when calibrating a device the error of the reference pressure should be added to the specified accuracy of the instrument under test (± 3 mm Hg) to determine the working accuracy of a calibration set-up. As a result, if using a manometer (mercury column or aneroid gauge) rated at ± 3.0 mm Hg as a reference, one will be able to determine the accuracy of the gauge being tested to only ± 6.0 mm Hg. This is outside the range of ± 5 mm of mercury typically desired by medical professionals. Many facilities and device manufacturers are using a device (e.g., digital pressure standard) rated at ± 0.1 mm Hg, one will be able to determine the accuracy of the gauge being tested to within ± 3.1 mm Hg. This has been well documented to be far less than the inter or intra provider differences on multiple readings.

A U.S. study from 2003 concluded in summary that "research on sphygmomanometers suggests that there are numerous good alternatives to mercury sphygmomanometers. Aneroid sphygmomanometers are cost competitive, have a long history in the field, and have been found acceptable by many hospitals."

In a UK study, an aneroid device achieved an A grade for both systolic and diastolic pressures and fulfilled the requirements of the Association for the Advancement of Medical Instrumentation. The conclusion was that the aneroid device could be recommended for use in an adult population.

The UK Medicines and Healthcare Products Regulatory Agency (MHRA) states that aneroid and mercury sphygmomanometers both need to be checked regularly in order to avoid errors in blood pressure measurement; the British Hypertension Society recommends testing every 6 to 12 months.

Frequently lost in the discussion over device accuracy, and equally important is the issue of measurement technique. A 2002 Working Meeting on blood pressure measurement in the United States highlighted numerous studies which found that basic measurement technique, inappropriate cuff size and poor cuff size were providing significant errors in measurement.

Switching to mercury free sphygmomanometers in clinical settings has not caused problems in clinical diagnosis and monitoring in Sweden or Brazil. The Swedish government, in fact, has completely eliminated mercury column sphygmomanometers.

One problem that several hospitals in developing countries have encountered as they substitute mercury-containing sphygmomanometers is that many aneroid and digital devices are of poor quality yet many devices currently produced satisfy the criteria of professional organizations such as the British Hypertension Society, the European Hypertension Society and the Association for the Advancement of Medical Instrumentation. The British Hypertension Society (BHS) has created a list of vendors of sphygmomanometers that have met the BHS criteria and are suitable for clinical practice and posted it on their web site.

As health care sectors in developing countries begin their substitutions, many are finding the non-mercury alternatives to be viable. As Louis Havinga, Manager of Health Technology Services for the Kwa-Zulu Natal Province Department of Health in South Africa observes, before they decided to phase out mercury-based medical devices in the province, "clinical trials and technical trials were conducted and various electronic sphygmomanometers were found to be consistent and within acceptable accuracy range for clinical use."

Affordability

Many healthcare practitioners are concerned about the availability of alternatives. In fact, there are many mercury-free thermometers

and sphygmomanometers available from major medical equipment suppliers who service the global market.

Yet the issue of affordability is still a challenging one, especially where the costs of human and environmental impacts of mercury releases are not included in the health institution's accounts or budgets. From a

developing economy's perspective, these costs must be taken into account in national strategic planning.

In countries such as the United States, where market demand for mercury alternatives has begun to be felt and clean up costs quantitated a mercury free purchasing policy has become the most economic.

Table 3

Costs of Mercury vs Digital Thermometers. the experience of Posadas Hospital, Buenos Aires Argentina: April-June 2006/ Before Mercury Replacement

	Total thermometers	Cost per Unit in \$ US equipment	Total cost
Mercury Thermometers	3152	1,33	4.192
Digital Thermometers	0	4,00	0
Total	3152		4.192

April-June 2007/ as Digital Thermometers are Introduced

	Total thermometers	Cost per Unit in \$ US equipment	Total cost
Mercury Thermometers	335	1,33	445
Digital Thermometers	188	4,00	752
Total	523		1.197

Total savings for 3 months u.S.\$ 2.995

Table 4

Estimated Costs of Replacing Mercury Equipment in Hospital Sao Luiz, Sao Paulo Brazil

	Year 1	Year 2	Year 3	Year 4	Year 5
Digital Devices					
Initial investment	9.412				
Annual Maintnace	2.630	3.892	3.892	3.892	3.892
Total costs adjusted by 12% annually for inflation	12.040	17.381	23.360	30.054	37.560
Mercury Devices					
Annual Maintnace	5.923	5.923	5.923	5.923	5.923
Total costs adjusted by 12% annually for inflation	5.923	12.559	19.991	28.314	37.37
difference	6.125	4.829	3.377	1.751	69
Annual savings after Year					\$2,031

Figures in US \$ converted from Brazilian reals

Table 5

A Comparison of prices of Mercury and Digital Clinical fever Thermometers in Selected Countries 52

	Argentina	Brazil	Mexico	India	China	Philippines	South Africa	USA	England	Czech. Rep
Mercury Thermometers	\$1.33	1.52	1.24	0.62	0.41	0.55	0.80		1,50	1.00
Digital Thermometers	4.00	10.52	3.77	5.35	4.65	4.67	4.37	2.09	7.00	5.00
Price ratio	3:1	6.9:1	3:1	8.6:1	11.3:1	8.5:1	5.5:1	0:1	4.6:1	5:1

In a study done by Kaiser Permanente, the largest not-for-profit Health Maintenance Organization (HMO) in the United States, it was determined that when associated life-cycle costs are included (compliance, liability, training, etc.) the total cost per unit of an aneroid sphygmomanometer is about 1/3 that of a mercury-containing device. Mercury-containing devices are no longer being purchased by Kaiser Permanente.

Yet in the global market, mercury-based medical devices are still significantly less expensive than their digital or aneroid counterparts. In the absence of strict environmental health regulations, and with limited healthcare budgets, many health care systems and hospitals today still face the challenge of deciding between a mercury device and its alternative. Those facilities with limited budgets have been able to successfully avoid this road block through operational strategies.

For example, when planning future budgets hospitals are counting the frequent mercury thermometer breakages for inclusion in the cost of current practices for comparison with the cost of a digital or mercury-free alternative. Frequently, the additive cost is comparable to the replacement cost of the mercury thermometers, as the alternatives are typically more durable.

The Hospital Posadas in Buenos Aires, Argentina pursued just such a strategy and reported significant savings when it replaced all of its thermometers. Table 3 shows that between April and June 2006, this 450 bed hospital purchased 3,152 mercury thermometers. A year later, during the same period in 2007, it purchased 355 mercury thermometers and 188 digital devices. The cost savings totalled nearly U.S. \$3,000.

At the Federico Gomez Children's Hospital in Mexico, it is estimated that this 250 bed institution will save a minimum of U.S. \$10,000 over six years when replacing mercury thermometers. This estimate includes the costs of digital device and battery re-

placement, as well as mercury and battery disposal.

In the Hospital Sao Luiz in Sao Paulo, Brazil, a 116 bed hospital, health care officials found that the costs of maintenance and calibration of digital and aneroid thermometers and sphygmomanometers were significantly lower than the costs of maintaining existing mercury devices. In fact, they determined if they were to replace all sphygmomanometers, wall thermometers and clinical thermometers in the hospital with alternative devices, that the savings on maintenance and calibration would pay back the initial capital investment of more than U.S. \$9,000 in five years, while saving another U.S. \$2,000 a year thereafter (see Table 4).

However, in some parts of the world, the economic calculus is not yet as positive.

Mercury thermometers, most of which are produced domestically, cost around U.S. \$ 0.62 in India – or half of what they cost in many other places in the world. Meanwhile a decent quality digital thermometer, most of which are imported, costs USD \$5.35, or 33 percent more than in much of the rest of the world. The situation in China is similar (see Table 5).

Disposal

The problem of what to do with other mercury waste remains a vexing one. This includes waste from spills that occur until replacements are made, waste from mercury devices that are taken out of use, the ongoing collection of dental amalgam waste, and waste from used digital thermometer batteries that contain trace amounts of mercury and fluorescent bulbs.

One option for disposal, though not ideal, occurs in North America and many European countries, where governments have developed infrastructure for the collection of mercury waste products. These wastes are "recycled" into new mercury-containing products. Ideally, these products involve

essential uses of mercury for which alternatives do not currently exist. While this scenario provides healthcare facilities and others with a means of removing mercury waste from their facility's waste stream, the continued sale and use of mercury-containing products will invariably result in breakage and escape to the environment during product life or end of life.

The preferred scenario is one in which mercury and mercury-containing products are no longer used, and the mercury in use is collected and no longer returned to the marketplace in products. There is no one simple solution to the mercury problem, and until the goal of mercury elimination is realized, a variety of strategies must be implemented that move toward this solution.

Conclusion

With Europe, North America, and individual countries, provinces, and cities throughout the world well on the road to mercury-free health care, shifting the production and consumption patterns in developing countries as a whole is the largest remaining challenge to this transition.

Mercury free health care is not only possible, but if the right forces converge, the day is not far off when most health care institutions will be virtually mercury free. Individual physicians, their specialty societies, and national medical associations are and will continue to play a leading role in this transition.

In October 2007 a resolution on control of mercury pollution was passed from committee to the World Medical Association's Council at a meeting in Copenhagen, which says in part:

"Major institutions around the world have demonstrated that safe, effective alternatives exist for nearly all traditional health care uses of mercury. Historical concerns about the inaccuracy of mercury-free alternatives, and the belief that the mercury sphygmomanometer is the gold standard,

are not borne out by the experiences of the multitude of institutions that have eliminated their mercury sphygmomanometer units."

The resolution was approved for distribution and discussion amongst the WMA's national medical associations. It will be acted upon with final action at the 2008 Assembly meeting in Seoul Korea.

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Normal Physiologic Changes with Aging: Influence on Falls in the Elderly



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Introduction

In recent years, much attention has been paid to issues of healthcare in essentially every nation in the world. The tasks of controlling known chronic diseases, caring for those afflicted with infectious diseases, and in general, delivering healthcare to the masses, continue to be a major financial and social problems for us all. A portion of the world's population that needs immediate attention is the elderly (over the age of 65). They represent one of the fastest growing proportions of world population. The reasons for this growth in population are multi-factorial including better healthcare in some areas of the world, more effective treatments and prevention of chronic disease, and in many cases, improvement of social economic status which has allowed individuals of age to thrive. With the increase in numbers of the elderly, the normal physiologic changes that occur with

aging need to be recognised by the medical community along with how these changes influence specific disease processes and injuries. Many countries in the world have fully developed specialties and subspecialties in Geriatrics and Gerontology. As this portion of the population in these countries increase, one of the many issues in providing healthcare to the aged is the supply of healthcare providers available. In emerging countries, the issue is a need for recognition of the elderly as a separate population; having different physiological responses and requiring specialised care. To effectively care for the elderly population, it is important that we recognise the normal changes that occur in the human body over time. It is important to remember that these changes are outside the definition of acute and chronic disease, and for the purposes of this discussion, also outside the effects of any medications that may be administered to the elderly.

In this discussion, we will focus specifically on the physiologic changes that occur in the human body that increased an elderly patients' tendency to fall. In the literature, a fall is defined as "a situation where a person comes to rest inadvertently on the ground or a lower level".¹ Falls are one of the most common threats to the health and longevity of the aged. It is also a significant cause of death in this population. Most of the discussions on falls do not include those caused by a loss of consciousness (i.e. syncope or seizures). Approximately 40 per cent of the elderly population in the community over 65 experience one fall. That percentage increases to 60 per cent if there is a prior history of a fall. Fif-

teen per cent of falls result in serious injury. The overall ideology of falls is often multi-factorial. This complex interaction of many factors intrinsic to the individual including age related changes; chronic disease; illness; medication; changes of postural control; increased risk-taking behaviour; underlying mental status; and other mediating factors. The purposes of this discussion will be to focus on multi-physiologic changes intrinsic to the individual.

Aging and Physiology

The normal physiologic changes in the elderly relevant to our discussion here include changes in the muscular/skeletal system, the neurological system, cardiovascular as well as other constitutional environmental changes that occur to the human body during the normal aging process.

The Musculoskeletal System and its physiological changes with aging comprise one of the most important systems to consider. The changes in skeletal muscle itself include a decrease in muscular strength, endurance and bulk involving essentially all of the muscles of the body except, interestingly, the diaphragm and cardiac muscles. These changes obviously decrease an elderly person's ability to react swiftly and with the amount of physical strength needed to avoid certain situations. The connective tissues in the body, particularly those lining the joints and supporting the joint spaces containing collagen over time become more dry and brittle. This change leads to stiffening and produces a significant change in the mechanical function of joints and their articular surfaces. When one considers these changes and their effect on something as simple as the posture, the following effects are observed. Elderly individuals are found to have flexion at the hip and knee joints which gives rise to the typical

posture seen in an elderly person; one needs to simply watch an elderly individual walk across a room. While their joints retain normal range of motion, they are stiff and therefore, flexion of the major joints in the hips and legs persists with ambulation. A simple solution is to prescribe a range of motion and stretching exercises before even the most common and rudimentary activities. In the elderly female, it is common to see a kyphosis of the upper thoracic spine which further flexes her frame forward and forces her into the commonly observed "forward slumped posture" as she walks across the room. Given this change and the postural change they produce, along with the hip and legs joint changes named above, it is easy to see how there is an increased tendency toward falls in the elderly female. In fact, it has been documented that wrist and hip injuries are more severe in the elderly female population.

The second category of significant change with time is in the Neurological System. There is a documented decrease in proprioception in the extremities of elderly patients. The vestibular system undergoes changes that lend a tendency to an increase in sway during ambulation. Additionally there is a decrease in muscle activation and co-ordination in this population as well. These changes as a group place elderly individuals in a situation where they become more dependent on visual cues for placing their extremities while ambulating. Older persons also become more dependent on visual reference points and on the use of their hands and arms for stabilisation when walking than their younger counterparts because of the issue of increased sway in their gait.

Significant neurological change occurs in the eyes. There is a gradual decrease in visual acuity with age such that subtle changes in the visual field may go unnoticed. The best example of how this change may manifest is when one considers a long hallway that ends in a set of stairs. Often, the floors of the hallway and the stairs have the same material covering them, if the pattern is subtle and without contrast, an elderly person may misjudge the distance to those stairs because they are unable to see

them or distinguish them for the rest of the hallway. This simple subtle fact may dramatically increase their risk of falling, as again their dependence on visual acuity is high. Another vision change is Presbyopia, which is the inability to see near objects because of stiffness in the lens of the eye of the elderly. It is easy to see how this can further create problems for the older person. The most significant and common visual change with age is in light/dark adaptation. An elderly person's ability to visually adapt from a dark room to bright sunshine, or its reverse, is dramatically slowed when compared to a younger person. It is easy to imagine how this increases fall risk during common daily activities. Imagine an elderly person emerging out into bright sunshine from inside a structure, particularly in unfamiliar settings. The bright light immediately removes the visual cues for that elderly individual. If they proceed without allowing for adaptation to that new level of light, a fall or injury usually ensues.

Changes in hearing are well documented. In the elderly there is a decrease in pitch discrimination on the high and low ends of the scale, as well as a dramatic increase in the hearing threshold. Particularly in public settings, this leads to issues of being unable to hear when there is a loud level of ambient noise. This hearing loss can lead to directional confusion and an inability to avoid falls when auditory cues that potentially warn cannot be heard.

The Cardiovascular System undergoes dramatic change in the elderly. While there are many issues that one could discuss in the cardiovascular system, the major focus needs to be on the regulation of systolic blood pressure and the maintenance of blood pressure during activity and postural change. Regulation of systolic blood pressure becomes more difficult in the elderly patient for several reasons. There is a decrease in total body water as the elderly person's physiologic make-up shifts more toward increased adipose tissue as opposed to water soluble tissue; decreasing the amount of total body water. This is further affected by a slowing in the response of the renin-angiotensin axis and a decrease in the

aldosterone responsiveness. These changes make the elderly patient less tolerant to hot environments, allow them to become more easily weakened and fatigued during times of high musculoskeletal activity, and therefore make them more prone to falls and injuries at those times.

Postural changes in blood pressure response also vary quite significantly in the elderly. One good example is post-prandial blood pressure drop. This is a blood pressure drop that naturally occurs in virtually all elderly patients in mid-afternoon. It appears to be associated with several normal physiologic occurrences such as the swings in the renin-angiotensin, aldosterone system as it varies throughout the day, as well as the increased activity of the digestive system after the noon meal. This is thought to lead to a period of time in the mid-afternoon when the elderly may be more vulnerable to decreases in blood pressure with postural change. Of note, this time of the day also tends to be a period of time when morning medications given for blood pressure, diuresis or other cardiovascularly active drugs reach their peak activity. As one might expect, this is a common time, particularly in nursing facilities, when there are more reports of falls.

While there are many other physiologic changes that occur with aging that may, in a minor way, contribute to falls we have focused above on the major ones. It should be noted that the elderly population does not have a natural understanding of these changes, and because these changes occur to an individual over time, they often go unnoticed. It is this lack of education, lack of modification of environmental factors, and recognition of home safety hazards that further contribute to the multi-factorial nature of falls in this population.

We wish to stress again, that we did not detail here the age-related associated diseases that are very common in the elderly such as Parkinson's disease, osteoarthritis, and cataracts, which affects the major systems we have outlined above and further place an individual at risk of a fall. Lastly, medications

including prescribed, over the counter, and home remedies, are also major contributors to falls. The good news here is that they are the most easily modified group of risk factors in this population.

Evaluation

It is in the area of patient evaluation that knowledge of the changes in aging by a healthcare provider trained in the area of Geriatrics is most important. Elderly individuals must be evaluated for their fall risk. This evaluation involves assessments of many of the issues outlined above and then the development of a multi-factorial intervention process to help prevent or decrease the risk.

Unfortunately, most elderly individuals usually present for medical care after the initial fall. Ideally, however, as we develop awareness for the specific and unique issues with aging, this assessment needs to occur as a part of the wellness evaluation of an elderly person. The evaluation should include a thorough history: gathering information, not only about medical issues, but support, social and economic issues that may be obstacles in the care of the elderly patient. Finding out about the person's medications are also a part of this history as is the recording of any risky behaviours or substance abuse habits that may exist. A thorough assessment of their vision with emphasis placed on their visual acuity, light/dark adaptation, and the influence of presbyopia in their vision is important. One should also get a sense of how dependent the individual is on their vision by assessing some of the other systems outlined above. It may be necessary to test a patient to assess how dependent they may be on visual inputs for activity and locomotion. A gait and balance assessment is important, keeping in mind the physiologic changes noted above. Simple observation of the gait is important, as well as paying close attention to the use of visual cues, arms and hands during ambulation. A decrease in a person's ability to reach out may also place them at higher fall risk if they are quite dependent on arms and hands as they walk. Evaluation of lower limb joints, range of motion, and particularly stiffness of

those joints must be documented. A screening neurological evaluation is needed including an assessment of the ability of the patient to transfer out of a chair.

Cardiovascular evaluations involve the assessments of the included organ systems, but in addition need to include an assessment of blood pressure, as well as the measurement for the presence of orthostatic blood pressure changes. There are no standard laboratory diagnostic tests and evaluations of an elderly person with a history of falls or a high risk of falls. Obviously any areas of concern that come to light during the history and physical examinations should guide the physician towards any relevant laboratory studies that may be required for an individual elderly patient.

Treatment and Prevention

Treatment and prevention usually involves multi-factorial interventions. An individual provider using the information collected, can often times set the interventions in motion to address many of the risk factors and natural deficits that occur in this population. Interventions including exercise and physical therapy particularly focused towards strengthening of the leg and torso musculature, as well as range of motion exercises and stretching activity is important. Modifications of home hazards in consideration of gait and visual difficulties; instructions about patterns on carpeting, loose electrical cords, and other pieces of furniture which may present problems or obstructions in the path of an elderly patient should be assessed and ways to avoid these hazardous situations can be taught. On occasion, cognitive behavioural intervention is effective, particularly in individuals who may have particular habits or activities that place them at higher risk of falls. Frank conversations and education of the individual about these activities can lead to dramatic changes and habits. Adjustment of medications, withdrawal of many medications in the elderly, particularly of those with chronic disease is another important and as mentioned before easily modifiable risk factor. Nutritional support is important

particularly, as relates to an individual's ability to maintain their blood pressure. One must assure that they hydrate and consume the proper numbers of calories and protein as physiologically required. We have stressed the importance of visual acuity in an elderly patient and certainly any elderly patient who is ambulatory should have a referral for correction of any visual deficiencies that they have. Referral is also important in individuals who may be significantly hearing impaired. Multi-disciplinary teaching, multi-factorial health and environmental risk factor screening in intervention is always important, particularly in this population of individuals. Instruction regarding support at home, investigations into the type of care givers and support an elderly individual has around them at any given time is important to decrease their potential of getting into high risk activity or situations where they are in danger of falling and causing serious injury. Recently, there have been many studies showing the benefit to the prescription of hip protectors in elderly individuals who are high-fall risks or compliance with these garments. While putting them on is at times difficult and while adherence to the use of the device is low, some studies have shown benefits in decreasing hip fractures during falls in very high risk ambulatory individuals.

Summary

In summary, while we have not intended this article to be an outline all of the normal physiologic changes that occur in the elderly and certainly have not undertaken an exhaustive discussion of falls in the elderly, it is important that these types of discussions begin on the world stage to help us recognise the unique issues and problems that develop with aging of our populations, and how the medical community needs to and responds to these new challenges.

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The Migration of Health Professionals and its Impact on Patient Safety



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The speech on the UEMS (The Union of European Medical Specialists) 50th
Anniversary Conference. Brussels,
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Both European institutions – UEMS and the European Parliament are at the same age, both are well known in Europe and beyond. At the same time, being a representative from one of the so-called new EU Member States – Latvia – a professor who has spent 30 years in post-graduate medical training, I have to admit that those states, which were for 50 years behind the Iron Curtain, could fully recognize the value and significance of the work of both institutions only during the last decades.

My beloved speciality was anaesthesiology and intensive care. Today it may sound anecdotic, but, under Soviet rule, we had to provide so called primary specialization in 6 months time! For the next step in post-graduate medical training – so called improved qualification – some more months were added.

Slowly, step by step and with the help of the European Academy of Anaesthesiology, we tried to change the situation even before the Soviet system collapsed. Today the pe-

riod of training in my speciality in Latvia exceeds by two years the minimum, required in the Directive 2005/36/EC of the European Parliament and the Council of 7 September 2005.

That gives our Ministry of Health the chance to plan a shortening of the period of training in accordance with the proposed minimum of three years. The Latvian Association of Anaesthesiologists is convinced that, taking into account the dramatic changes – not only the new technologies, that it is time to review and update the length of training. But, it is of course up to you to decide and to advise the European Commission on this matter.

As many of you already know, the European Parliament as a whole is quite often involved in solving different medical and health care problems. In spite of the fact that the delivery of health services lies primarily within the competence of the Member States, the EU, adhering to the principles of subsidiarity and proportionality, in accordance with Article 152 of the EU Treaty, has a responsibility where necessary to act so as to support Member States to co-operate and to co-ordinate their activities.

Even more so, in the light of a January 2008 survey conducted by Eurostat in all 27 Member States, entitled "Citizens views of the European Parliament: perceptions, knowledge and expectations" where 39% of all respondents answered that they would like to see improvement of consumer and public health protection given a priority status.

The reflections on the Communications put forward by the European Commission to the European Parliament and the Council which address health issues, falls within the duty of the Rapporteur from the Committee on the Environment, Public Health

and Food Safety (ENVI). Different health topics are systematically discussed within the framework of the Working Group on Health which is a specialized Group set up within the ENVI Committee. Apart from that there are several different interest groups, meeting regularly under the patronage of MEPs (for example MAC – or Members Against Cancer, the MEP Heart Group or the Working Group on Diabetes). I mentioned only those Groups in which I myself am very active as is the case with MAC or the other two which I have the honour of being the co-chairman.

Working in close contact with corresponding patient groups, medical and other experts as well as with representatives from the Commission, it is possible to initiate questions to the Commission, and to table different Motions for Resolutions or Declarations.

As an example of such a Motion for a resolution, which by the way deals also with your competence, is the European Parliament Resolution of 10 April 2008 on combating cancer in the enlarged European Union which was adopted at the plenary meeting with 621 votes in favour, 10 votes against and 6 abstentions.

I want to quote just Recital S and Article 22 of this Resolution:

Recital S: "whereas oncology is recognised as a medical speciality not in all Member States, and whereas continuing medical education needs to be provided",

Article 22: "Urges the Commission and the Member States to recognise oncology as a medical speciality and to make provision for lifelong learning for medical oncologists in accordance with agreed guidelines."

And now, some thoughts about the migration of health professionals and its impact on patient safety: The European Commission launched on 25 March of this year an eight week public consultation on patient safety in order to help in the development

of the Commission's proposal for general patient safety issues planned for the end of 2008. Patient safety is defined as freedom for a patient from unnecessary harm or potential harm associated with health-care. Although patient safety is narrower in its definition than healthcare quality more generally, it is the foundation of any high quality health system.

As such it is recognised as a major concern for governments and competent authorities, as well as health professionals and civil society across Europe. The type of health-care setting itself will also be an influencing factor on safety levels. Therefore, the focus should be a broad one. As it is well known human resources are an essential factor in the provision of health care, directly influencing the performance of health care systems. Accessible health care requires a well-trained and well-motivated workforce of physicians and nurses – of an adequate size – that are able to deliver safe, high-quality medical services. However, concerns have been voiced in many EU countries, especially in the new Member States, that a gap is increasing between demands for and supply.

Due to an aging population, technological advances and higher expectations from patients, demand is likely to increase. On the other hand, supply is expected to fall as a result of physician and nurse workforce aging, trends towards early and partial retirement and the mobility of the highly skilled – even Brain Drain of medical specialists and nurses.

Migration of Health Professionals was the main topic at the ENVI Working Group on Health meeting in October last year. Our guest speaker, Jean-Christophe Dumont (representing the International Migration Division at the OECD, Paris) gave us an overview on recent migration flows and migration policies for health workers in the OECD countries where a potential competition to attract and retain health professionals exist. The question of "Brain drain" from Central and Eastern Europe to the

Northern and Western Europe was also debated. Although no precise data is available, it is known that tens of thousands of doctors and nurses have left their home countries because their national health systems cannot compete with the salaries offered by other EU Member States and other countries, like the USA.

Having said this, I would like to mention some of the available data to give you a clearer idea about the scope and significance of this problem, especially in regards to the situation within the new Member States.

In Ireland, the employment of nationals from the new Member States (excluding Malta and Cyprus, also called the EU8) in the health sector doubled between September 2004 and 2005, from 700 to approximately 1300 persons; in Finland, 432 authorisations were issued to physicians and dentists from the EU8 countries until December 2005, and in Sweden the number of authorisations granted to EU doctors jumped from 230 in 2003 to 740 in 2004.

Available data from countries of origin confirm these trends: In Estonia, by April 2006, 4.4% of all health care professionals had applied for a certificate to leave (61% of them were physicians); in my home country, Latvia, in 2005 more than 200 doctors expressed their intention to leave; in Poland, between May 2004 and June 2006 more than 5000 certificates were issued to doctors (which is 4.3 % of the active workforce) and 2800 to nurses (this equals 1.2 % of the active workforce). Furthermore, some specialities seem to be more directly affected such as anaesthesiologists in Poland (16 % were issued a certificate) or for instance plastic and reconstructive surgeons in Estonia where 30 % were issued a certificate.

Unfortunately, this study, although being supported by a grant provided by the European Commission, reflects the situation only in 18 EU countries – which are member States of the OECD. At this time, no survey is available on this issue that would reflect the situation in all EU member

States. A representative from DG SANCO informed the participants, however, that the mobility of health professionals would be a priority issue in the Commission Annual Policy Strategy for 2008. It was assured that the Commission needs to look into this matter – even if it is in principle a responsibility of the Member States.

Within the EU, the last enlargement has had a considerable impact on the migration of health professionals. There is, however, little data on the actual migration flows and the OECD study is the first one on this subject. The collection of data is due to improve, since the 7th Research Framework Programme will fund studies relating to this issue. DG SANCO will also adopt a non-legislative document on the mobility of health professionals in the EU in 2008.

We have to deal with two sides of the same coin called effective health care and patient's safety.

On one side is written that "there are immense benefits to health systems in Europe and the health of European citizens from the free movement of health professionals, most of whom make a strong contribution to delivering high quality healthcare".

On the other side one must see the problem and the consequences of the Brain drain. According to the Terminology on International Mobility of Skilled Workers, Brain Drain may occur if emigration of tertiary educated persons for permanent or long-stays abroad reaches significant levels and is not offset by remittances, technology transfer, and investments trade. A Brain Drain reduces economic growth through uncompensated investments in education and depletion of a source country's human capital assets.

The Union of European Medical Specialists

History of UEMS

The Union of European Medical Specialists (UEMS) was established in 1958, following the signing of the Treaty of Rome in 1957. In the Treaty of Rome harmonisation and mutual recognition of diplomas is foreseen. The objective of the UEMS has always been bringing together the medical specialists of the member states and reaching consensus on content and quality of medical specialist training and practice. The outcome of this process was meant to serve as foundation for EU legislation.

The start was slow, but in the seventies the EU moved towards legal provisions in this matter. The Specialist Sections were established from 1962 onwards and the UEMS with its Sections was instrumental in the shaping of the "Doctors Directive" in 1975, which established the mutual recognition of medical diplomas between the member states of the EU.

However, in the follow-up little attention was paid to the contributions of the UEMS, and quality requirements in the Directive

basically remained limited – also in Directive 93/16/EEC, the consolidation of later updates – to the minimum duration of training (art. 26-27) and the requirement of recognized training institutions (art. 24).

The EU blocked progress of implementation of quality requirements in the Directive during the eighties and a new approach was required.

Nineties

The UEMS emphasis moved away from providing the EU with recommendations towards broadening the work on harmonisation and improvement of content of quality of training and practice on the shop floor of medical specialists.

For this purpose European consensus documents were developed during the nineties concerning key-issues as professional training, continuing education, quality assessment and tools like logbooks and visitation of training centres. The outcome of this process was embodied in the UEMS Charters. These Charters were presented to the profes-

sional authorities in the European countries as models and recommendations for national policy. Although the Charters do not have legal value, their influence upon national regulations has been considerable.

Following charters were proposed by the UEMS: a Charter on Continuous Medical Education, a Charter on Quality Assurance in Specialist Practice in the European Union, a Charter on Visitation of Training Centers, a Charter on Continuous Professional Development (also called the Basel Declaration), the Declaration on Promoting Good medical Care, Ensuring the Quality of Medical Care (also called the Budapest Declaration) and the Policy Statement on Assessments during Postgraduate Medical Training.

Actual situation

The philosophy of all national professional medical organisations is that patient care is best served when quality and content of medical training and practice are the domain of the medical profession. In each country the profession is defending this position. Unfortunately we are experiencing that this defence is becoming more and more difficult. Governments, insurances, commercial interests are eager to take over the quality agenda.

A strong continuing effort of the profession is needed if the profession wants to maintain and improve quality in the proper way. In order to do this unity of purpose and action is necessary. This requires balancing of professional and political views and interests.

National level

Unification of policy has to start at national level. The professional societies in the specialties at national level are doing a great job in quality improvement. But this has to be implemented at each level of medical practice, all the way from individual private practise to hospital management, training requirements, certification, validation, professional regulations, national legislation.



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Close cooperation of the professional societies with the political national medical associations and societies is necessary to achieve implementation of quality policy in a proper way. Only with unity of purpose and policy results can be achieved.

Unfortunately in many European countries this unity of purpose and policy is not that what it should be, and a greater effort on this issue is necessary. National professional organisations should be more aware of the significance of a strong European representation.

European level

The lack of national unity of policy reflects itself immediately in the representation of the medical profession on European level. Too often delegates of organisations of the same country are bringing opposing views in different European medical organisations.

European medical organisations

On the European scene there is the UEMS with its UEMS Sections and European Boards, the European professional Societies in each specialty, but there are also the umbrella organisations of the national medical associations (Comité Permanent of European doctors CPME), and other independent medical organisations such as the European associations of junior doctors (PWG), hospital doctors (AEMH), salaried doctors (FEMS). Basically each group started out as a lobbying group for its own interests, but progress in the unity of purpose and policy has been made. This process of confederation has to be pursued.

Future

The UEMS with its Sections and Boards is by far the largest of all political European Medical Associations, and it has an extensive grass-root support. It has done a lot, but more is needed. So far each country is autonomous in health care matters, but European integration is gaining momentum. The profession must be ready to play its role in a future integrated European health care policy.

In order to meet the challenge of increasing involvement of the European Union in health care matters in an enlarging Europe, a stronger position of the profession is needed. It has to start at national level:

- Unity of purpose and policy of national organisations,
- Coordination of separate national organisations,
- Enlargement of investment by national medical organisations in European medical matters, in imagination, in people, expertise and financial means.

At European level a more unified voice of the medical profession is needed, leaving intact the professional independence of sectoral groups like medical specialists, general practitioners, etc. Here the same unity as at national level should be achieved.

Presently the Directorate Health and Consumer Protection (SanCo) has only authority in the field of Public Health. Its main issues currently are health surveillance, health threats and health determinants.

Very likely EU authority will expand in the future. The medical profession should bring forward its views on the quality issue in one voice. It should prepare itself to be ready to provide the EU in the future with constructive and well founded recommendations on key issues.

Structure of the UEMS

To simplify UEMS can be seen as three different structures. First, the Council where the National Medical Associations are meeting, secondly, the Sections and Boards based on the Specialties and thirdly, the youngest "child" of the UEMS, the EACCME, European Accreditation Council for Continuous Medical Education.

The Council is the oldest structure of the UEMS and was called in the past Management Council. It is the political body where the decisions are made and statements are taken on issues in the field of Specialist Medicine. The National Medical Associations are



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mainly organizations that represent Medical Specialists in the different European Union Member States and the European Economic Area and Switzerland. We have also representatives of countries of Europe that are not Member of the European Union.

The Sections and Boards were created more recently but some of them have also a long history. They are based on the different Specialties that are present in Europe and are made up of two delegates of the countries where their specialty exists. It represents so quite well the field of each Specialty in Europe and is responsible for the harmonisation of training throughout Europe, and the defence of their specialty. This of course is also important for the patient because quality of health care is also in the benefit of the patient.

In 1999 the UEMS created the EACCME that started its operations in 2000. This structure of the UEMS tries to harmonize the CME-CPD in Europe by helping the doctor to have his credits earned at international events approved by UEMS-EACCME accepted in all UEMS Member States.

Accreditation

CME/CPD is an important part of the medical practice today. When we look at the training to become a (specialist) doctor, it starts with undergraduate and graduate training at the University followed by the Postgraduate Training that is done in cooperation between the Profession and the University ideally.

In the past this was the end of the process but it is more than obvious that a long life

learning has to be done in order to maintain knowledge and skills for the practitioner.

Here CME / CPD is an important factor.

It started with Continuous Medical Education where mainly theoretical courses and congresses were organized.

Nowadays this is completed by the improvement of communication, IT, managerial and social skills and is more concentrated on the practice of each individual practitioner and his or her needs.

The CME / CPD needs and the way it has to be organized is a duty of the National Accreditation Authority in each European Union Member State and can be National or Regional (or a combination of both).

The NAA has to define how many "credits" and which kind of credits are needed each year or each period of time.

It is more than obvious that one can not gain all his or her credits by following only one means of CME / CPD, meaning that for instance not all credits may be earned by following Long Distance Learning Programs only.

Other means such as Live Events, Enduring Material, like CD-ROM's, or articles have also a certain role to play in the whole picture of the CME / CPD of a (specialist) doctor.

It is clear that this remains a responsibility of each NAA.

UEMS has started the EACCME® in order to help the European Medical Specialist to have the credits he or she has earned by going to International Meetings approved by his or her NAA in order to avoid a duplication of the process.

For instance when I as a Pathologist go to a meeting organized by the British Division of the International Academy of Pathology and that has been approved for CME by the Royal College of Pathologists of the UK,

why should the Belgian Accreditation Authority starts the process of approval again.

This was the start of the EACCME® where we proposed to have a clearing house where requests for European Accreditation could be sent to.

The aim was to have an approval of both the responsible NAA and the involved UEMS Specialist Section.

The responsible NAA is the NAA of the country (or of the region) where the event takes place.

The involved Section is the Section of the Specialty that is most involved with the meeting for instance as a target audience.

As the Sections are constituted by two delegates representing the Specialty in each EU Member State, they can be considered as giving a quite representative opinion of the field on each evaluation.

History and political background of European Accreditation Council for Continuous Medical Education (EACCME®)

Continuing Medical Education ("CME") and Continuing Professional Development ("CPD") have always been one of the major key elements of UEMS as it notably promotes the quality of care and the best level of training for medical specialists. This became concrete in 1993 when "UEMS Charter on CME" was adopted. Since then, further work has been laid down in the field of CME and CPD and other declarations and position papers were adopted such as the "Basel Declaration on CME" (2001) or "UEMS Declaration on the promotion of good medical care" (2004).

At the same time, many European countries have been taking steps towards mandatory CME together with legal or professional re-certification or re-licensing, financial incentives or contracts with insurances and hospitals. Even though UEMS defends vol-

untary CME, it was felt appropriate to help European medical specialists in this respect. Therefore, in October 1999, UEMS Council set up the European Accreditation Council for CME (EACCME®), with a view to:

- Facilitating access to quality CME for European doctors;
- Contributing to the quality of CME in Europe; and
- Exchanging CME credits in Europe easily.

The quality control of CME activities is a key element in this process. It was thus decided to operate in a decentralised way by using the expertise of existing European and national professional bodies involved in accreditation.

The everyday management of European accreditation by EACCME® provides this link between European and national levels. One has to remind the political necessity to comply with the political authority of national professional regulatory bodies, as these bodies are responsible for registering doctors' CME-CPD and awarding licences to practice.

EACCME® Structure

EACCME® was founded in 1999 as a separate entity from UEMS even if it was ruled by its Management Council. In the revised Statutes, it was proposed by the Executive upgrading EACCME® as one of the five genuine bodies of UEMS in order to stress the importance of this body.

EACCME® management would though remain as it is:

- The governing body is UEMS Council, which is made up of representatives from national associations of each UEMS member country.
- An Advisory Council provides recommendations with regard to the management of European accreditation. This body is made up of representatives from:
 - National professional CME authorities, including national CME accrediting bodies;
 - UEMS, including its Sections and Boards;

- Professional specialist organisations and societies.

This Advisory Council provides full exchange of expert-knowledge and collaboration between the various partners involved in accreditation at European level. UEMS convenes a meeting of this committee each year as it is committed to the further evolution of EACCME® procedures in cooperation with the members of this advisory committee.

The daily proceedings of the EACCME® are managed by UEMS Executive in its Brussels Secretariat.

Right from the start, it was clear that national professional regulatory bodies would approve a structure, such as EACCME®, which would make CME credits in Europe exchangeable. The only condition was that these bodies would remain in charge of events in their own country and would have a major input in the process of EACCME®. This is a political reality. Moreover, it is expected that within a few years mandatory recertification would apply in several countries. CME credits would then be the instrument used in this respect.

Practical operation

EACCME® received its mandate from national regulatory bodies together with several distinct conditions.

- National authorities are maintained. EACCME® does not become a supranational body, but a link and clearing-house between national regulatory bodies.
- The final word concerning accreditation of each activity remains the decision of the national regulatory body in the country where the activity takes place.
- The Brussels administration should be as lean as possible.
- Quality assurance and determination of number of credits of separate CME activities would be decentralised, EACCME® relying upon the expertise of professional bodies in each specialty (such as the UEMS Sections and/or Boards and Eu-

ropean Speciality Accreditation Boards). This aims to avoid duplication of quality assurance proceedings.

- There would be no accreditation of commercially biased activities, internet activities and for the time being each activity should be judged separately. So providers are not accredited for series of activities stretching over years.
- Administrative expenses of EACCME® are borne by the providers of activities applying for European accreditation. Expenses would be limited, avoiding duplication in Brussels of work already done by other accreditation bodies.

The recognition of EACCME® credits (ECMEC's) is only guaranteed by national authorities within the framework of these conditions. EACCME® strictly complies with this set and operates according to the procedure:

The accreditation process in Europe involves two partners, on the one hand the National Accreditation Authorities and on the other hand the UEMS Specialist Sections and/or Boards. The responsible National Authorities are determined according to the place where the meeting is organized and the involved Specialist Sections are determined based on the specialty that is most involved or to the target audience of the event.

Let us now look how the process works in practice.

The organizer of an event send the request form with all the relevant and needed documents to the UEMS – EACCME® Office in Brussels or fills in the webbased request form.

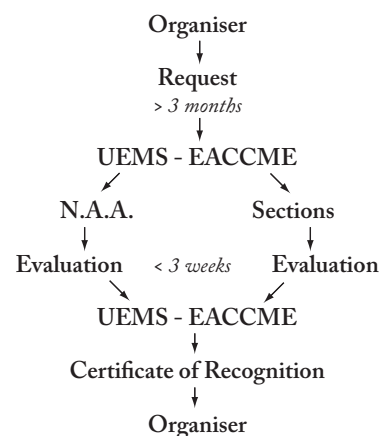
Here the request form will be distributed to the two partners.

The relevant UEMS Section and/or Board assess the scientific value of the CME activity. This evaluation strictly follows UEMS Quality criteria defined in D-9908.

Both partners are requested to give in a well determined time scale an approval or a re-

fusal for accreditation, the number of credits being determined by UEMS – EACCME®.

Flowchart of the process



Credit system

As the different National Accreditation Authorities apply different credit systems, the European CME Credits (ECMEC) were introduced in order to harmonise the number of credits on the following basis :

- 1 ECMEC per hour;
- 3 ECMEC for half a day; and
- 6 ECMEC for a full-day event.

National authorities can then convert these credits into national units, following the National rules.

When both partners agree on the approval, the organiser will receive a letter confirming the approval of the European Accreditation.

This letter contains three sentences : the first stating the approval and precises which partners have been involved.

The second sentence gives the number of ECMEC's granted to the event (and eventually the number of National Credits granted following the rules of the National Accreditation Authority of the country where the event takes place).

The third sentence informs about the mutual recognition of credits between UEMS – EACCME® and AMA PRA Class 1 credits.

Evaluation of events

It is very difficult (if not impossible) to fully evaluate an event before it is held based on documents that are provided by the organizer. Therefore in the future efforts will be concentrated to ask the organizers to have an evaluation of the event by the participants. This evaluation can be quite simple because at the end a too much detailed evaluation will be problematic to analyze. The main questions could be:

- was the event well organized.
- did I learned something from the event.
- will what I learned from the event change my practice.
- did I felt any bias.

The evaluation can be graded from "fully agree" to "fully disagree" by five steps for instance.

The principal aim of this evaluation is not to retrospectively throw away the allocated credits but rather help in the evaluation of the next meeting of the same kind organized by the same people.

EACCME is mostly involved in the evaluation of big international events that are recurring events so this will help in the process.

Which added value?

As shown, the added value of EACCME® lies in the link set up between the professional societies, the CME providers and the national regulatory bodies. Any change to this procedure would need the consensus of national regulatory bodies. Any deviation from this consensus would defeat the purpose of the EACCME® and it would also mean loss of the agreement with the American Medical Association concerning mutual recognition of EACCME and AMA credits.

From the point of view of the organizers of events, the added value sits in the international dimension that would be given to an event. More participants from abroad and also from the USA would be interested in joining their meetings.

The agreement with the American Medical Association has been renewed and is now valid from July 1st 2006 for a period of four years.

The long term benefit is the link with the national regulatory bodies. These bodies are very keen to preserve their national authority in the awarding of credits to the doctors in their own countries. The EACCME® of-

fers an institution in which they participate and have authority. In this way the profession facilitates exchange of CME credits in Europe in a similar way as postgraduate diplomas are mutually recognised according to European law.

At the end it are the National Accreditation Authorities together with the National Licensing Authorities that gives to license to practise.

The ultimate goal is to develop a system that makes life easier for our colleagues and to provide them with recognised quality CME with the guarantee that they can use their CME credits to meet national requirements.

Fee

The UEMS – EACCME asks a fee for the processing of the applications. This fee is based only on the number of participants and is a sliding scale. As we have two equal major partners in the European Accreditation, they also share their part of the fee.

Dr. Bernard Maillet
Secretary General

History and Recent Activities of the CMAAO

(Confederation of Medical Associations in Asia and Oceania)

I. Establishment of CMAAO

CMAAO (Confederation of Medical Associations in Asia and Oceania) is a confederation currently comprising 17 medical associations. Established around 1958, CMAAO initially held Congresses once every two years, but now meets every year, with Congresses and Midterm Council Meetings held in alternate years.

The objectives of CMAAO, as stated in its constitution, are to raise the health standards of people living in the Asia-Pacific region by promoting exchange between physicians in the region and establishing relationships and exchanging information with other world organizations, and to promote friendship between member medical associations mainly through information

exchange and discussion regarding shared medical issues.

CMAAO began as the Southeast Asian Medical Confederation (SAMC) advocated by Dr. Rodolfo P. Gonzalez of the Philippine Medical Association (PMA), which played a central role in creating the organization together with Dr. Taro Takemi mentioned below. With the Australian Medical Association joining the SAMC, the organization's name was changed to the Confederation of Medical Associations in Asia & Oceania (CMAAO), and the 1st CMAAO Congress was hosted in Tokyo in 1959 by the Japan Medical Association (JMA) under the presidency of Dr. Gonzalez.

At this Congress, it was decided that the confederation would initially operate on voluntary donations as the budget was as yet undecided, with the JMA donating \$1,000 and the PMA donating \$500. Furthermore, it was decided to base the CMAAO Secretariat permanently in Manila in the Philippines and Dr. Victorino de Dios of the PMA was appointed as the inaugural Secretary/Treasurer who serves as both secretary and financial officer.

The JMA President at that time was Dr. Taro Takemi, a leader who served as JMA President for 25 years (1957-1982). Dr. Takemi said that one of the major objectives for establishing CMAAO was to create an organization in Asia to ensure the opinions and ideas of the medical profession in these areas to be reflected in the activities of the World Medical Association (WMA).

CMAAO membership as recorded at the time of the 1st Congress comprised 11 national medical associations: Australia, Burma, Taiwan, Indonesia, the Philippines, Japan, the Republic of Korea, Iran, Pakistan, Thailand, and India. In discussions, the issue of international medical licensing was raised. At the 2nd Congress, held in Manila in 1961, Dr. Takemi was appointed as CMAAO President. At this meeting, discussion themes included prevention and eradication of malaria in the Philippines, research on Japanese encephalitis, Tsutsugamushi disease (trombidiasis), and independent physicians and military medicine in the Philippines.

This is how CMAAO operated in its early days.

II Consolidation of the basis of the activities of CMAAO

For the theme of the 10th CMAAO Congress, held in Tokyo in 1977, Dr. Takemi chose the issue of population aging, with particular emphasis on the need for health education in aging societies. He also pointed out the seriousness of the effect of pollution and waste as well as the huge impact

of changes in the global environment, as well as the unavoidable problem of global healthcare economics as the burden of healthcare on government finances grew as health costs escalated with technological advances in medicine and the aging of society. He also mentioned the necessity of examining the issue of development and allocation of medical resources in relation to escalating costs and of providing welfare that enables better living conditions. These concerns clearly show Dr. Takemi's farsightedness, and it was under this visionary leader that CMAAO continued its activities. In commemoration of Dr. Takemi's tremendous contribution since the inception of CMAAO, a special lecture entitled the "Taro Takemi Memorial Oration" was established and is presented at each Congress by a distinguished expert in the medical field from the host country. At the 17th CMAAO Congress held in Hong Kong in 1991, the Takemi family and the JMA presented CMAAO with a fund named "Takemi Memorial Fund" to support the Oration. At the 2007 Congress held in Thailand, this Oration was presented for the 8th time.

III. Recent CMAAO Activities and Future Perspectives

At the 18th Congress, held in Malacca in Malaysia in 1993, the CMAAO Secretariat was moved from the Manila to Malaysia. The role of Secretary/Treasurer was also passing from the Philippines to Malaysia. Following some subsequent reorganization, the Secretariat was relocated to Tokyo where Executive Board member of the JMA in charge of international affairs took office of Secretary General supported by International Manager.

CMAAO is now reaching its 50th anniversary, and the time has come to reconsider the organization's role and activities. Initially, CMAAO was established with the clear purpose of creating an organization that would represent the voices of Asian within the WMA. Since then, CMAAO operations have expanded based on this objective, and within this framework, the JMA had striven

to further invigorate CMAAO activities. As part of these efforts, the CMAAO SARS Network Office was set up within the JMA Secretariat to work to gather information about SARS and avian influenza in Asian countries. There are still many common issues for CMAAO to consider in the future, including issues unique to the Asia region. Some of the common problems are movement of physicians across borders, standardization of medical education in relation to medical licenses, continuing professional development, provision of healthcare services to foreign-national residents, and medical accidents or patient safety and those unique to these regions include various issues related to newly-emerging infectious diseases and the problems of medical assistance in the event of natural disasters such as tsunamis or earthquakes.

Recently, together with proactive efforts to resolve issues such as these, there have also been moves to revise the CMAAO Constitution and By-laws to be used for the next 50 years. As the CMAAO Secretariat, the JMA is working to devise the most appropriate way to manage the activities of CMAAO to improve healthcare in the Asia-Pacific region based on our long experience as a WMA member as well.

Masami Ishii, MD
Secretary General of CMAAO,
Executive Board Member of the JMA
and
Hisashi Tsuruoka,
Manager,
International Affairs Division, JMA

The Permanent Working Group of European Junior Doctors

The Permanent Working Group of European Junior Doctors (PWG) was formally created in Bad-Nauheim, Germany, in May 1976. Since then, the PWG has become the European medical organisation with the most comprehensive national membership, representing the junior doctors of 26 European countries.

The PWG's initial objectives include safeguarding the interests of the junior doctors in Europe, improving relations between its member organisations and narrowing the gap between the junior doctors of the European Union and those of other European countries. Over the last three decades, the PWG has actively intervened in defence of the medical profession in Europe with the purpose of contributing to the development of junior doctors' work and education and has had an important role as a background group for the organisations of junior doctors in countries preparing to join the European Union. From the beginning of the PWG's existence, it became evident that the junior doctors of the various countries have many similar experiences and difficulties. Therefore, after pooling the information and exchanging ideas, the PWG was able to identify the main areas of interest to junior doctors in Europe.

The status of the medical workforce was one of the most important issues in the PWG's early years. The PWG conducted several studies that drew the medical profession's attention to the fact that this issue is not static and that long-term planning, though difficult, is essential. The different perspectives within the European Union influence the migration of doctors, as well as the working conditions, quality of training and quality of patient care. Therefore, the PWG has endeavoured to gain a better insight of the workforce policy of its member countries in order to, where necessary, influence policy makers by providing examples of more successful planning. Other major areas of interest to junior doctors, and to the PWG, have been temporary migration for educational purposes, postgraduate training, continuing medical education, future medical work and working conditions.

In its first years, the PWG embarked on the important task of compiling information to facilitate the migration of doctors in training in Europe. The objective of this work was to provide true freedom of movement, in accordance with the principles established by the Medical Directives in 1976. The PWG's greatest contribution was the publication of

a series of booklets containing relevant information for doctors wishing to seek employment or complement their training in a foreign country.

In 1995, at its conference on "Postgraduate Training: a European Future", the PWG publicly presented its most recent policy on this issue, which is still a reference for European doctors. This policy statement brings to light a significant number of principles concerning the structure and quality of this phase of medical education, which coincide with several points in one of the most important official documents on this issue, the 4th report of the Advisory Committee on Medical Training (ACMT), published in 1997. In the same year we had the opportunity of disseminating an important new paper on "Future Medical Work", which has proven fully up-to-date. This paper concerns the organisation of work in health services and its influence on the working conditions of junior doctors. The greater expectations of patients, allied with factors such as ageing, migration and mobility, have led to a progressive increase in healthcare costs. As a result, most European countries have undermined doctors' working conditions with policies of economic management and redistribution of resources. Our recommendations include concepts such as the creation of a positive workplace, organisational development, project management and other strategies that enhance the structure, process and outcomes of health promotion for patients as well as doctors.

In May 2000, the PWG published a policy statement on Continuing Medical Education/Continuous Professional Development (CME/CPD) and organised a conference in which it was possible for experts from various European medical organisations to exchange their views on CME/CPD before an expert audience. We have recently witnessed the publication of several different documents on CME/CPD that generally defend the principles that became evident during the Conference. Fundamentally, the medical profession believes that CME/





CPD is both a moral obligation and a right, and that access to appropriate CME/CPD must be ensured for all doctors, including those in training. The PWG's Policy Statement opposes a system of recertification and states that it is a misconception that such a system would contribute to the identification of unsuitable doctors, hence defending the concept of quality improvement, as opposed to quality control.

The PWG was actively involved in finding a solution to the problem that was created when the European Working Time Directive (Directive 93/104/EEC) excluded doctors in training from certain aspects of the organisation of working time. In December 1995, the PWG, in collaboration with the European Commission, organised a major conference in Brussels to address the issue of junior doctors' working conditions. In the year 2000, after many years of intense negotiations with the European authorities, the European Parliament and the European Council finally agreed to include doctors in training within the scope of the European Working Time Directive (Directive 2000/034/EC). Although the PWG considers this agreement a positive step forward in protecting the health and safety of doctors and their patients, it deplores the unnecessary delays to the full implementation of the Directive. The European Parliament and the European Council established a total transition period of nine years to reach the 48-hour week, which the PWG regards as unnecessarily long because junior doctors often work until exhaustion in several European countries, jeopardising their health and safety, as well as that of their patients. The

PWG continues to draw the attention of EU Member States to the need for real reductions in junior doctor's working hours and the full implementation of this Directive within the shortest possible time.

Curiously, our organisation was founded as the "Permanent Working Group of European Junior Hospital Doctors", which later proved inappropriate because the PWG includes doctors in training in non-hospital fields and there was no organised body of junior doctors in the field of primary care. Therefore, in 1996, during an important revision of our statutes, by a working group coordinated by Dr. Kirsi Ailus (SF), we dropped the word "hospital" and became the Permanent Working Group of European Junior Doctors.

From the beginning, the PWG has sought to develop productive relations with various European medical organisations and authorities. We have had formal relations with the Standing Committee of European Doctors (CPME) since 1983 and we were granted consultative status in the Council of Europe in 1986. We also have good relations with the Regional Office of the World Health Organisation, the European Parliament and the European Commission. Since 1991 each UEMS Specialist Section and European Board has welcomed a representative from PWG to represent European doctors in training. At the Executive meeting of UEMS in May 2007 it was agreed that PWG delegates also are invited to represent doctors in training in UEMS Multidisciplinary Joint Committees. The PWG has regular meetings with the most important European medical and medical students' organisations to coordinate activities and increase efficacy. In November 2000, these organisations approved a protocol governing the relations between them and the CPME. The PWG is now a member of a group of institutions that speak with one voice and represent the medical profession in Europe, although it is aware of the fact that it must maintain its independence and capacity of negotiation with the European authorities.

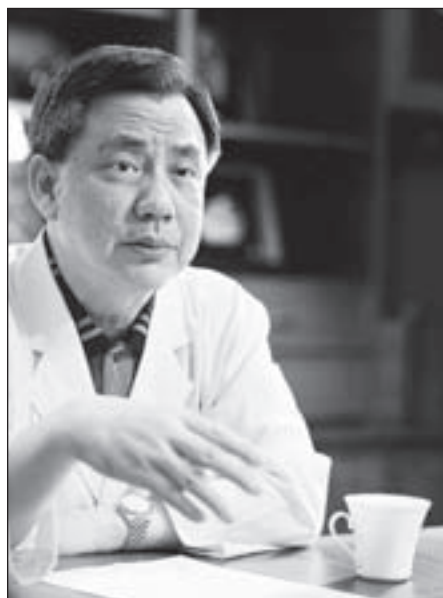
Our top project at the moment is the EuroMedMobility; this a joint PWG/EMSA project that, among other objectives, aims to improve the mobility of doctors in training within European countries, increasing the diversity in training opportunities for all European medical professionals.

During the first 31 years of the PWG's existence, it has organised numerous plenary Assemblies all over Europe and the rotation of meetings has ensured mutual understanding and the exchange of information.

Since its beginning, in Bad-Nauheim in 1976, the PWG has been presided over by Dr. Per Vagn-Hansen (DK), the first Coordinating Secretary of the PWG for the 1976-1979 triennium, followed by Dr. Anton Seiler (CH), Mr. Douglas Gentleman (UK) and Dr. Hans-Ueli Würsten (CH). Dr. Jesper Poulsen (DK) was the first person to be elected President of the PWG (1994-1997), an indication of the positive development of this organisation. Eduardo Marques (P) was the second President of the PWG (until 2001) and the Dr. Nina Tiainen (SF) as the third (2001-2005). At the moment the president is under Portuguese Presidency, Rui Guimarães (P). Many junior doctors from all over Europe have had greater or smaller roles in the PWG's work and some are now accredited leaders in national or European medical organisations. Some non-medical participants, who have witnessed the life of this organisation from the beginning, have generously placed their knowledge on issues of medical policy at our disposal. The junior doctors of 26 European countries now have an influential organisation that defends their interests effectively and, due to the hard and dedicated work of many individuals, we are all proud of its achievements. However, there is always much to be done and we are aware that the structure of our organisation must evolve if we wish to maintain our recognised role and capacity of intervention.

Rui Guimaraes
www.juniordocctors.eu

The Taiwan Medical Association



Dr. Ming-Been Lee, the President of TMA

The Taiwan Medical Association (TMA) was established in 1930 to advance medical knowledge, to uphold members' rights, to strengthen physician-patient relations, as well as to advocate social services. The TMA is composed of regional medical associations from 23 counties around Taiwan.

Its membership is compulsory for every practicing physician. Among the total 36 991 TMA members (figure for the end of 2007), 30% practice in medical centres, 13% in regional hospitals, 18% in local hospitals, and 39% in private clinics. The physician-patient ratio is 1:653.

The TMA has formed ten committees to carry out its various missions and duties. These include Health Care Policy Committee, National Health Insurance Committee, Health Industry Advisory Committee, Medical Laws and Regulations Committee, Academic Committee, Member Welfare Committee, Medical Ethics and Discipline Committee, International Affairs Committee, Public Relations Committee, and Publications Committee. In many areas, ad hoc task forces are set up to study relevant issues and to provide policy suggestions for the Executive Board.

For more than a decade, the TMA has actively participated in several key areas to promote the health of all Taiwanese, including the formulation and revision of a patient-centred National Health Insurance Policy in Taiwan, the advocacy of quality

of care and patient safety, the implementation of continuing medical education, and the uplift of moral standards of health care professionals. In the international forum, the TMA joins forces with the rest of the world through the World Medical Association and CMAAO to increase its visibility, and to express Taiwan's good will to serve the international community. In time of disasters and emergency around the globe, the TMA has taken little time in mobilising its members to provide emergency relief and medical aid to people in need.

The TMA has established close interaction with the WMA in recent years by participating in various programs and activities. The translation and publication of "Manual of Medical Ethics" of WMA enables TMA members to share WMA's policy changes, its functions and the contribution to all physicians around the world. By working with the WMA in devising declarations and policies, the TMA acquires updated information on medicine, ethics, and medical education.

The TMA strongly believes in the collaboration among all national medical associations under the auspice of the WMA. The sharing of information and resources, and the joint effort in international medical assistance will enable us to create a truly global village.



Taiwan Medical Assembly in 2007

Medical Association of Uzbekistan – Experience and Perspectives



*President of Medical Association of Uzbekistan,
Professor Abdulla Khudaybergenov*

Medical Association of Uzbekistan was the first a non-state non-commercial medical organisation (NGO) created in the Republic of Uzbekistan in 1992. The initiators of the Association were: Khudaybergenov A.M., Kosimov E.J., Asadov D.A., Rizaev M.N., Ir-gashev S.B., Mustafaev H.M., Sidikov Z.U., Junusov M.M., Akbarov A.A., Vajnshtejn V.S., Nurullaev L.D., Usmonhuzhaev A.H..

The Association was registered by the Ministry of Justice of the Republic of Uzbekistan on 11th November 1999. The mission of the Association is - assistance to the development of medical practice and science for the preservation and strengthening of the health of citizens of the Republic of Uzbekistan.

According to the Charter of Association its primary goals are:

- Participation in reforming the system of public health services of the Republic of Uzbekistan;
- Medical, economic and legal aid to members of Association;
- Support for private practice and private medical institutions in medicine;
- Participation in the development of uniform standards for control and quality in public health services;
- Support of doctors of veterans and use of their experience;

- Improvement of international co-operation, holding of conferences, seminars and symposiums.

The Association has 14 regional branches in which have been registered as members 20 thousand doctors, and also a publication – “The Bulletin of the Medical Association of Uzbekistan”, which 4 times a year which has been regularly printed already for more than 10 years. In the publication are printed articles devoted to management, economy, law, marketing, new methods of diagnostics and treatment, information on seminars, conferences and to the private sector in public health services. The general circulation of the publication is more than 5 thousand, which extends to all medical institutions in the Republic of Uzbekistan. The president of the Medical Association of Uzbekistan is Doctor of medical sciences, Professor Abdulla Khudaybergenov, and his assistants are Academician Tulkin Iskandarov and Candidate of Medical Sciences Zafar Sidikov. The executive director of the Association is Zakhid Abdurakhimov. The Medical Association of Uzbekistan since 1997 is a member of the European Forum Medical Association and takes part in them (Copenhagen, the Vienna, Berlin, Warsaw, Oslo, Lisbon and Israel).

For the last the Medical Association of Uzbekistan took part in several grant aided projects and in 2008 has finished the grant of the World Bank on “Monitoring of rendering of medical aid in jails”. The basic purpose was the monitoring of jails regarding protection and maintenance of the rights of prisoners to medical aid. Informing the public on the condition and problems of public health services in jails will allow the taking active actions by various NGOs, initiative groups and funds on improvement of the health of prisoners. In turn improvement of preventive and medical work in prisons will allow the reduction of disease, physical inability, and also the death rate



among prisoners, which will allow them to join more quickly civilian life after being released from jail. As a result, we would like to emphasise, that reform in the sphere of public health services spent by Uzbekistan, is carried out everywhere, including in the corresponding services of prisons.



The measures directed to strengthening of health of citizens being held in prisons, carrying out preventive and explanatory work among prisoners concerning a healthy way of life, developing of the activity of the medical personnel, and increasing their knowledge in the sphere of maintenance and protection of the rights of prisoners, will allow the reduction of the burden on the system of public health services of the country as a whole and keep what is most valuable the health of a person.

The Medical Association of Uzbekistan being the representative of a civil society is not indifferent to problems of the health of the nation, and so systematically and consistently carries out activities on improving of the public health of society and citizens of the Republic of Uzbekistan and also protects the interests of medical workers and their associations.

Professor Abdulla Khudaybergenov

The Canadian Medical Association

140 Years and Counting



The Canadian Medical Association (CMA) was born in October 1867, barely three months after the birth of Canada, and it has been the main national body representing Canada's physicians since then.

Following that first meeting, the CMA had 167 members. Today, it has more than 67,000 members living in Canada's 10 provinces and three territories, and approximately 50 other countries. Membership is voluntary, and approximately 70% of eligible physicians choose to join.

The online archive of the *Canadian Medical Association Journal* (www.cmaj.ca), which contains all articles published since the journal's launch in 1911, provides a fascinating look at how far Canada, its physicians and the CMA have come since then.

It also provides a suitable backdrop for the CMA's two-part Vision Statement, "A healthy population and a vibrant medical profession." One of *CMAJ*'s first reports indicated that the infant mortality rate in the city of Ottawa – the nation's capital – stood at 224 deaths per 1,000 live births in 1908. One hundred years later, Canada's nationwide infant mortality rate is 4.63/1,000.

The CMA was the national medical voice that helped make many such improved health outcomes possible. It was the driving force behind the creation of national bodies to regulate medical education and certify

new doctors, which in turn set the stage for the development of a science-driven, rigorously regulated medical profession that quickly earned the public's confidence.

Once that confidence was earned, the public listened when the CMA supported public health initiatives such as the pasteurization of milk and the need for safe, reliable drinking water. In 1961, the CMA told members they had a duty to warn patients about the link between smoking and cancer, and the proportion of smokers has fallen to less than 20% of adults. Today, Canadians' average life expectancy of 80.34 years is among the highest in the world.

The second part of the Vision Statement, "a vibrant medical profession," also occupies a large share of CMA efforts because the country's health care system is under considerable stress due to funding issues, human resource shortages and an aging population.

One sign of this stress became clear when the CMA conducted a survey in 2003 and found that 46% of physicians considered themselves "burned out" by their work. The CMA responded by creating the world's first Centre for Physician Health and Well-Being, which also links physician health programs across the country.

On the human resource front, Canada is still paying for a 1992 decision to cut medical school enrolment in the face of rising government deficits and a perceived "surplus" of physicians. Today that surplus has turned in to a serious shortage, with an estimated five million Canadians having no regular access to a family physician. The CMA recently launched a national public relations campaign to draw attention to the issue.

The CMA has also enjoyed unique success among medical organizations because of its early and successful efforts to help members in areas such as retirement and financial

planning. The CMA entered the field in 1957 after its extensive lobbying of the federal government meant Canadians could set aside tax-free retirement savings for the first time. The CMA launched its financial subsidiary that same year with an investment of \$50,000. Today that company – MD Management – manages more than \$25 billion in investments for CMA members and their families.

In 2008, with Canada's population having passed 33 million, the CMA remains the national voice for the country's physicians, and it works closely with its divisions in the provinces and territories to respond to and deal with members' priorities.

Its message does appear to be getting through. A recent survey of Canadian politicians and senior public servants found that, among a dozen major national organizations in fields ranging from health care to brewing and broadcasting, the CMA ranked first in all categories, and that 79% of respondents considered it "very" or "somewhat" influential in setting the country's national priorities.

The CMA has also been an active participant in the World Medical Association since its inception. Recent contributions include revision of several key WMA policy documents, individually or as part of working groups, and the chairmanship of the WMA's Ad Hoc Committee on Advocacy by Dr. Dana Hanson, a CMA past president.

Dr. Henry Haddad, another CMA past president, also chaired the Sociomedical Committee for several years, and in this role was instrumental in introducing the consent agenda to the WMA.

The CMA looks forward to hosting the WMA General Assembly in Vancouver in October 2010. This will mark the third time the meeting has been held in Canada, and the first time since it was held in Ottawa in 1998.

Barbara Drew, Associate Secretary General and Chief Operating Officer

Medical Union of Uruguay



*Dr. Alfredo Toledo Ivaldo,
President of the Medical Union of Uruguay*

First, we would like to thank the people in charge of the World Medical Journal for the space offered to the Medical Union of Uruguay in order to be able to briefly update on the general situation of health in our country and of the doctors in particular. 2008 has begun and the sector of health has been immersed in a process of change, of transformation. The Medical Union of Uruguay on many occasions has specified its opinion in relation to this issue and has participated in all the events to which it was invited by the sanitary authorities. For the Union it is of historical importance and related to the commitment to healthcare of the Uruguayans, so non-participation was out of the question. We have applauded the firm stand of the government on healthcare reforms and the creation of a coordinated and efficient National Healthcare System, which would provide a rational use of resources, focusing on the most vulnerable groups of population.

The position that the national medical body has expressed through the Medical Union of Uruguay has not always been well understood. We recognise the necessity for change and this is so because the general and basic principles of transformation of the health system have been originated by this very Union. These principles were not only generated but also defended, considering that they form the solid base of the Healthcare System.

The complementary and different vision of the proposed reform as offered by the Medical Union of Uruguay does not constitute an obstacle but a contribution which we considered essential to reach the goals in the shortest time possible, to meet the expectations of the Uruguayan society to enjoy better care constructed on firm basis.

Doctors constitute the foundation on which a health system would be built; they are the central axis of the structure and a very complex organisation united by a common and principal mission to maintain health and to fight diseases. The doctor is the professional who is suitable, trained and qualified to fulfil this task. Therefore the Medical Union of Uruguay maintains that all reforms, all changes in the healthcare system must take into consideration the medical professionals, from the pre-degree to the retirement group. This practice cannot be optional; it must be the rule if we really wish to affect the health-disease process. The conditions and form of work of the doctors must change; it is essential to improve labour concentration, also educational and investigation activities, establishment of a principal national award, the search of real alternatives for the introducing of the young doctor into the labour market, solutions that give opportunity for a worthy retirement from the medical profession, the relation between the professionals and the administration of institutions, considering the essential necessity that nowadays for

doctors to stay qualified, they have to be engaged in lifelong education.

The implementation of these changes will ensure a new form of work for the doctor but, more importantly, it will give an answer to many of the complaints raised by the patients and their relatives in relation to medical care. There are many and varied instances on which, throughout its history, the Medical Union of Uruguay has indicated the necessity that the healthcare system should be considered an object for urgent transformation because it has been delayed. It is obvious for the patients and doctors alike, that the present system has deficiencies which make a change essential.

Fragmented, unavailing and with superstructures that make it inefficient, this system (asistema or "non-system" as some prefer to call it to demonstrate how little system that it has), implies for a good part of Uruguayans the serious problems of fair treatment and access, whereas for the doctor it is strongly indicative of wide conspiracy against the quality of life of the professionals, the capacity of their performance, suitable attention and institutional attachment. In view of the accomplishment of the last Consultative Council (the nucleus of all the actors involved in the health-disease process) in the past year we left the position of the medical union in the sense that obviously the year of 2008 had to be the year of the change in the conditions and the form of work of the doctors and that this had to be considered by all healthcare actors as a basic and fundamental element to really obtain consolidation of the reform process.

The MUU (SMU) is going to put in maximum effort and will dedicate all the resources that are at their disposal so that the change in the conditions of work of the doctors is a reality in the short term, thus contributing to the overall consolidation of the healthcare system as a whole and in particular, offering the best-quality care to the patients.

Dr. Alfredo Toledo Ivaldo

The Malaysian Medical Association



*Dr. Nachiappan Arumugam
WMA Immediate Past President*

The Malaysian Medical Association (MMA) is the first and currently the largest professional medical association in Malaysia. Though many medical associations have sprung up after that, representing various interest and speciality groups, the Malaysian Medical Association still remains the largest and one of the more active associations in the country. It was formed with a commitment to promote the highest possible professional and ethical standards of health care. The MMA has ever since played a prominent role in promoting quality and equitable health care, while preserving the autonomy and professional integrity of the physician. The forerunner to the MMA was the Straits Medical Association (SMA) which was the official association of the then Malaya and the Straits Settlements. The SMA was started and operated by expatriates working here and this was later replaced by the Malaya Branch of the British Medical Association (BMA). When Malaya became independent in August 1957, Singapore chose to remain a British Colony, but the BMA Malaya Branch still remained the only professional medical association for both these countries. In 1958 two separate associations representing the two countries were formed namely the – The Malayan Medical Association and The Singapore Medical Association. The Malayan Medical Association in 1971 grew to become the Malaysian Medi-

cal Association with the inclusion of the states of East Malaysia.

Currently there are many sections and societies under the MMA representing the various activities of the association. There are two main sections of the MMA namely the SCHOMOS and PPS. The SCHOMOS or Section Concerning House Officers and Specialists was formed in 1981, creating an official channel of communication between government and doctors in the public sector. Since its formation SCHOMOS has had protracted and difficult negotiations on behalf of the government doctors with different authorities championing their cause. The results reached through these negotiations have made many positive changes to the working conditions, allowances, promotions and other issues benefiting all government doctors.

The Private Practitioners Section (PPS) was officially registered in 1991 to address the various issues faced by the private practitioners. The terms of reference for this section was – “To represent views, interests and aspirations of members of the MMA in private practice. – To study problems faced by private practitioners and commend solutions to the MMA Council. – To encourage the active participation of private practitioners in activities related to healthcare and to assist them to adequately respond to changes.”

Ethics Committee

This was one of the first committees to be formed after the registration of the MMA. The initial task of this committee was to draw up the ethical code of ethics, in the context of the local medical situation and culture. The ethical code has been extensively revised twice, once in the year 1998 and again in 2001, to incorporate emerging ethical issues. The Association has encouraged the correct behaviour of the members of the profession, by guiding and giving advice on good medical practice while

reprimanding unethical conduct. An essay competition on different aspects of medical ethics is organised annually in conjunction with the world ethics day of the World Medical Association to create an interest in ethics among medical students. The ethics committee is active in organising seminars and updates on ethics of medical practice on a regular basis to update the members.

Medical Education

The training of sufficient and appropriate number of doctors has been a challenging task for many countries including Malaysia. The first medical college was established in the University of Malaya in 1964 and was the only college for many years. Over the last few years there has been a flurry to open new medical colleges both public and private. The rapid expansion of medical colleges in the last few years is a cause for concern as it has stretched the available resources of both manpower and facilities. The Malaysian Medical Association has on a few occasions brought together all interested parties, universities, Ministry of Health, Ministry of Education and held Medical Education Conferences to chart the future of Medical education in the country.

Estate Medicine Committee

Healthcare provision in the rubber and palm oil estates has generally lagged behind national healthcare provision in the country and has been semi-independent. Though some larger estates had reasonable healthcare facilities and personnel most estates only had a rudimentary service. The distance of estates from hospitals and government health facilities made it difficult for estate workers to obtain proper medical care. The MMA commissioned study, on the availability of health facilities for the estate workers, painted a bleak situation and the study was presented to government and concerned authorities. Though there were some remedial measures taken as a result, health care provision in the estates remains inferior to that of the country. The MMA continues to champion the right of health for the estate workers and for



estate health system to be incorporated into the mainstream healthcare delivery system of the country.

Physicians for the Prevention of Nuclear War committee

The Physicians for the Prevention of Nuclear War committee has highlighted the dangers of nuclear warfare and its disastrous effects on health. It has persistently lobbied against the production and stockpiling of nuclear arms. The committee and its long standing chairman Datuk Dr Ronald McCoy, also a past president of the MMA, received international recognition by being appointed to the Canberra Commission on the Elimination of Nuclear Weapons in 1996. The Canberra Commission on the Elimination of Nuclear Weapons was established as an independent commission by the then Australian Government in November 1995 to propose practical steps towards a nuclear weapon free world including the related problem of maintaining stability and security during the transitional period and after this goal is achieved.

Continuing Professional Development Committee (CPD)

The MMA has in collaboration with Universities, hospitals and pharmaceutical companies been organising medical meetings for many years to update the members on the developing trends in medicine. Initially the Continuing Medical Education (CME) committee was formed to co-ordinate the activities and latter the name was changed to Continuing Professional Development Committee (CPD) committee to be more reflective of the work it was doing. In 1995,

the CPD was formalised with the Malaysian Medical Council and the MMC-CPD Grading system was introduced and the MMA was made the secretariat for running the system. This voluntary system enabled all doctors to register all their continuing medical education and professional development activities with the MMA and the MMC issued certificates of attendance annually.

International Medical Associations

The Malaysian Medical Association is a member of important regional and international organisations namely, Medical Associations of South East Asian Nations (MASEAN), Commonwealth Medical Association (CMA), Confederation of Medical Associations in Asia and Oceania (CMAAO) and World Medical Association (WMA). The MMA has taken an active part in the activities of these associations and some of the leaders of the MMA have held various posts in these organisations. It was indeed a historic occasion for MMA when Datuk Dr Arumugam was elected and installed president of the WMA in 2007. It was also an honour when Datuk Dr T.P. Devaraj was chosen as one of the Caring Physicians of the World by the WMA.

Public Health and Community Service

The Malaysian Medical Association has been in the forefront of public education. It has initiated and carried out many public health campaigns to raise awareness of the public to various diseases and healthy living.

Action on Smoking and Health (ASH) Committee

One of its earliest public health activities was to discourage students from picking up the smoking habit and to encourage smokers to quit smoking. MMA was one of the pioneer organisations in this country to have started the anti-smoking campaigns through the MMA-ASH committee and has continued to be committed to this activity till today. The MMA has over the years promoted the Annual No-Smoking Day and incessantly high-

lighted the dangers of smoking to the citizens of the country. The association has also organised scientific meetings and workshops to stimulate interest in anti smoking activities among the doctors and allied health staff. The MMA-ASH committee has over the years helped to draft and successfully lobbied for the implementation of various rules and laws to discourage and curb smoking in flights, restaurants and public places.

Adolescent Health Committee

Adolescent Health has now become an important sub-specialty with its unique set of problems and needs. The MMA adolescent Health sub committee organised courses to upgrade the understanding of the health needs of this group in different states for health personnel. The committee also had awareness programmes and hepatitis B immunisation for some school children.

Health of the Older Person Committee

In view of the increasing number of older persons in the country, a Committee was formed to create an interest in the health of the aged among the profession and awareness in the society of the problems and challenges faced by this population. In 2005 a 'Senior Citizen's Charter' was launched by the MMA. As this older population face special medical problems the committee has ventured in educating doctors on these common conditions affecting this group of patients. The association also has activities to mark Senior Citizens Day on 1st October 2006. The association, as the largest professional medical organisation in the country, through representation in many government and non-government organisation and many of its committees like the Traditional and Complimentary medicine committee (TCM), Society of occupational and Environmental Health (SOEM), Ophthalmological society, Public health society, Sports Medicine society, Accident prevention committee has not only advanced the interests of its members and profession, but also the health and welfare of the citizens of the country.

Dr. Nachiappan Arumugam

The Finnish Medical Association

Approaching One Hundred Years of Promoting good Quality Healthcare and Physicians' Interests

The Finnish Medical Association (FMA) was founded in 1910 and is already preparing for its centennial celebration that takes place in just under two years. Since its establishment the association has defended the professional, social and economic interests of its members and strived to develop health care and advance medical expertise, safeguarding thereby the interests of both doctors and their patients.

The Finnish health care system

In Finland the organization health care is a public responsibility. The system is financed both by taxes and through a statutory health insurance scheme. User charges exist also, and



Dr. Olli Meretoja

they are relatively high in a European comparison. The organizational model is decentralized; the local government (municipality) level is responsible for arranging health and medical care for the citizens. There are about 400 municipalities and they are relatively free to choose how they organize primary health care. In addition to the public service that is available to everyone, employers are obliged to provide occupational health services to all their employees. Primary care is mainly arranged in health centres that the municipalities operate either individually or together. Physicians working in health centres are therefore municipal employees, even those who work under the system of "personal doctors", a Finnish variant of the family doctor. For specialized medical care the

country is divided into 20 hospital districts. All municipalities are obliged to belong to one of these through federations formed by them. Each of the districts is responsible for providing and coordinating the specialized services within its area. The quality of services and health care facilities are of a high standard. The population of 5.3 million inhabitants is also in general satisfied with the services, although regional variations exist. Finland was the first country in Europe to introduce a law on patients' rights in 1993. The main challenges facing the system are related to manpower planning and the coordination of operational costs and capital investments.



Dr. Heikki Pälve

Role and Structure of the FMA

The FMA acts both as a professional organisation and a trade union. It is a proactive and well respected consultation partner for the government and parliament in all aspects of health policy. Developing education of physicians together with the medical faculties forms an important part of the association's activity. It also has a major role in organising and overseeing continuous professional development of its members. As a trade union the FMA negotiates the salaries and working conditions of the physicians working in the public sector. The FMA membership is voluntary and individual. Some 94 % or 21.400 of all physicians

licensed to practice in Finland are members. The association forms an umbrella structure both for the specialists', GP's and junior doctors' national associations, as well as for organisations based on geographical location or specialty. The FMA therefore truly unites the opinions of doctors in Finland and enables the profession to speak with one voice. The decision-making is based on elections held every three years, where all members choose their representatives to the 60-member FMA "parliament", called Delegate Committee. That then elects the board and its members, including the president who has a one-year renewable term.

The FMA office has some 70 members of staff, who serve the members in various ways, prepares the policies for the board to adapt and implements them. The FMA publishes a weekly journal that reaches the whole membership free of charge. The FMJ is a scientific journal as well as a major forum of health policy discussion in Finland.

Ethics and the professional oath

A core activity of the FMA throughout its existence has been to promote and develop medical ethics. In 1910, the first President of the association expressed the hope that the FMA would become the heart and conscience of the medical profession. That wish has since become a reality. The FMA publishes a regularly updated book on medical ethics. This compilation of ethical thinking and approved guidelines offers the members a toolkit that helps them to make difficult decisions in their everyday work. The book is published in both the official languages (Finnish and Swedish) and it is distributed to all the members of the FMA, as well as to medical students. An ancient tradition of the honorary position of the Archiater, the eldest of the medical profession still exists in Finland. This title, which can only be held by one person at a time and is awarded by the President of Finland, has existed since the days Finland was part of the kingdom of Sweden, over 200 years ago. Today the Archiater is the moral leader of the profession and actively participates in the public

discussion on medical ethics in the country. The association has also reintroduced the professional oath, which was earlier a part of the medical degree in the faculties. The swearing of the oath is now voluntary, but practically all the graduates choose to swear it at their graduation ceremony, where the Archiater and the president of the FMA are present.

International activities

The values and tasks of the FMA are not bound by the borders of Finland. The association is an active member of several international medical organisations, most importantly the World Medical Association (WMA), Standing Committee of European

Doctors (CPME), European Union of Medical Specialists (UEMS), European Union of General Practitioners (UEMO) Permanent Working Group of Junior Doctors (PWG) and the Nordic Medical Council (NLR).

*Dr. Olli Meretoja,
Dr. Heikki Pälve, Dr. Jukka Siukosaari*

The FMH: the Professional Association for Physicians in Switzerland

The *Foederatio Medicorum Helveticorum* (FMH) or Swiss Medical Association is the umbrella organisation for the medical profession in Switzerland. Just over 90% of the approx. 30,000 physicians in the country are signed-up members. As a professional organisation, the FMH aims to:

- ensure a high standard of medical care in Switzerland;
- promote the professional development of physicians;
- foster relations between its members; and
- act at the political level to create a framework in which physicians can work effectively.

Structure and bodies at the FMH activities

Legally speaking, the FMH is an association. Its two main bodies are the Medical Council which has 200 delegates and acts as the 'parliament', and the 11-member Central Committee which serves as the 'government'. A 33-member Delegates General Meeting (DGM) advises and supports the Central Committee in all important subject areas. The DGM is also authorised to make decisions itself, especially in the field of health policy. To become an ordinary member of the FMH, the applicant must be able to show that he or she has a Swiss medical degree or its equivalent, works in the healthcare sector in Switzerland, and is of reputable character. Ordinary members automatically become members of one of the local organisations.

The FMH's General Secretariat in Bern has a dual role of a service centre and the head office. About 75 people work there in the various departments which include:

- Members Services
- Undergraduate, Postgraduate & Continuing Medical Education
- Fees Guidance
- Legal Service
- Data, Demographic Information & Quality Management
- Prevention
- Communications & PR

One of the main tasks at the FMH is to monitor the specialist training of physicians after their state examinations. In most cases, this training leads to the title of 'specialist'. The FMH is also active in the fields of quality management, working closely with the specialist medical associations and the parties involved in negotiating doctors' fees.

The *Schweizerische Ärztezeitung* ('Swiss Medical Journal') is a major platform and source of information for the medical profession in Switzerland. Published by *Editiones Medicorum Helveticorum* in Basel, the FMH's official journal comes out on a weekly basis (www.saez.ch). On behalf of its members, the FMH campaigns extensively and maintains close networks with politicians and the media. Its motto – "No healthcare policy without the FMH!" – comes over loud and clear.

The President's Office

As President and Chairman of the Central Committee, Jacques de Haller has been in charge at the FMH since 2004. Under his management over the last four years, the FMH has succeeded in shaping a coherent policy for



Dr. Jacques de Haller, President FMH

the medical profession in Switzerland and in creating a distinct and credible profile, both in the eyes of the public and of other major players in the Swiss healthcare sector.

One great challenge facing the FMH is safeguarding the 'freedom of occupational practice', a right which is increasingly coming under attack from many a side — the insurance companies and the state in its role as regulator, for example. The task of the FMH here is and will be to organise political campaigns and lobby on a broad basis to ensure that traditional values are maintained and that relevant threats are averted.

Only with a united association, speaking with one voice and represented by a strong and professional leadership, can these aims be achieved.



*Dr. Herzog, General Secretary of the FMH
Swiss Medical Association*

Organisation of Professional Self-government of Physicians and Dentists in Poland

The Polish Chamber of Physicians and Dentists (*Naczelna Izba Lekarska*) and the regional chambers of physicians and dentists (*okręgowe izby lekarskie*) are the organisational bodies of the professional self-government of physicians and dental practitioners who are associated in the chambers with equal status.

The professional self-government of physicians and dental practitioners in Poland was founded in 1922, dissolved in 1952 and re-established in 1989.

There are currently 23 regional chambers and a separate chamber of military physicians and dentists that has legal status of the regional chamber although it is active in the entire country. Chambers of physicians and dentists deal with all kinds of matters concerning the exercise of medicine and dentistry in Poland.

The highest authority of the Polish Chamber of Physicians and Dentists is the General Medical Assembly whereas the regional medical assemblies are the highest authorities of the regional chambers. In the period between assemblies – the Supreme Medical Council and regional medical councils respectively.

The Supreme Medical Council represents the medical professions at the state level, and regional councils at regional levels.

Membership in the chambers is mandatory. Every physician and every dental practitioner who holds the right to practice the profession in Poland is a member of the chamber by virtue of the law.

Number of members of the chambers in 2007:

- Physicians – appr. 128 000
- Dental practitioners – appr. 34 500
- Persons with both professional titles – appr. 550

The tasks of the self-government of physicians and dentists include:

- supervising the proper and conscientious exercise of the medical professions;
- determining the principles of professional ethics and deontology binding all physicians and dentists and looking after their compliance;
- representing and protecting the medical professions;
- integrating the medical circles;
- delivering opinion on matters concerning public health, state health policy and organization of healthcare;
- co-operating with scientific associations, universities and research institutions in Poland and abroad;
- offering mutual aid and other forms of financial assistance to physicians and dentists and their families;
- administering the estate and managing the business activities of the chambers of physicians and dentists.

The Chambers:

- award the right to practice the profession of a physician or dentist and keep the register of physicians and dentists;
- negotiate conditions of work and remuneration;
- make decisions on matters relating to fitness to practice as a physician or dentist;
- co-operate in the field of continuous medical education;
- deliver opinion on draft legislation concerning health protection and exercise of the medical professions;
- delivering opinions and making motions regarding under- and postgraduate training of physicians and dentists;
- act as medical courts in matters involving professional liability of physicians and dentists;
- defend individual and collective interests of members of the self-government of physicians and dentists;
- co-operate with public administration agencies, political organisations, trade



Office of the Polish Chamber of Physicians and Dentists in Warsaw



Meeting of the Supreme Medical Council

unions as well as other social organisations in matters concerning protection of human health and conditions of exercising the medical professions.

International Policy of the Polish Chamber of Physicians and Dentists

One of the main priorities of the Polish Chamber of Physicians and Dentists is to take active part in international organisations of physicians and dentists and to actively co-operate with the medical and dental organisations and chambers abroad. The Chamber is active in the works of the following international organisations of doctors and dental practitioners:

- Standing Committee of European Doctors (CPME);
- European Union of Medical Specialists (UEMS);
- European Forum of Medical Associations and the World Health Organization (EFMA/WHO);
- Symposium of Medical Chambers of Central and Eastern Europe;
- Council of European Dentists (CED);
- World Dental Federation (FDI);
- European Regional Organization of the World Dental Federation (ERO/FDI).

Medical Confederation of the Argentine Republic



*Dr. Jorge Carlos Jañez,
President of the Medical Confederation
of the Argentine Republic*

As a consequence of the implemented neo-liberal policies, the repetitive budget cuts have damaged the social, political and institutional situation not only in our country, but in the entire Region.

Health services have been deteriorating gradually, public healthcare spending is decreasing in terms of the income per capita ratio, and the scarce resources had to be adapted by giving importance to treatment over prevention.

At the same time, new changes have been introduced in the financial aspect, and there is a rising tendency to privatization and the operating expenditure belongs to the user now.

Within the framework of these neoliberal policies, several reasons were stated which privilege the following: expenditure is now afforded by the users of the system, private resources are excessively used and the public services administration is decentralized.

In addition to the aforementioned, the sector shows extreme sanitary anarchy, and a lack of co-ordination between the public and the private sector, which results in the doubling and superposition of services and the low use of resources.

Social Security defnancing is a consequence of the unreleased unemployment rate. The unemployed population lost their health insurance coverage, which led to an overload of Public Hospitals, as well as a fall in the private sector provision of services. As a result, doctors who perform in this subsector have been directly affected.

Given that the infrastructure and the public sector supplies are in a bad condition, doctors lack all kinds of support before patients. The latter not only demand a medical assistance that doctors cannot provide on their own, but also take legal action against them more frequently. Thus, a patient's right before an undesired treatment result was turned into the so-called "medical malpractice insurance industry".

It is even worse when faced by the lack of strain of relatives or the same patient, since they are becoming more and more aggressive, and may end up assaulting physically. Apart from these unfortunate situations, it must also be mentioned the doctor's proletarianization, caused by several factors:

Professional plethora which shows a doctor to patient ratio of approximately 360. In some large places, big urban centres, the ratio is 120 inhabitants per doctor.

Increase of professional medical licenses up to 5 times faster than the population.

No planning of geographical distribution.

High percentage of specialists (80%, 70% out of this 80% are in the big urban centres)

After the proposal of the National Integrated Health System in 1973, which was injected, and laws 23660/61 of the National Health Insurance (last essays on national policies), there was a crisis in the service provider which still continues, and signs indicate it will get worse.

This deep crisis demands a health system reform in accordance with a State Policy under consensus of all participants, basing the system program on the following proposals:

Give priority to Primary Attention (Mother & Child Programs, Special Plans for the needed, etc) as a response to the emergency.

Complement all subsectors in order to shift the fragmenting system by using the idle installed capacity.

Coverage based on an Obligatory Medical Insurance.

State administration and regulation which comprises:

- High Complexity
- High Medical Technology.
- Medicine.

Regulation of professional practice which comprises:

- Adaptation of programs of study in the Medical Schools.
- Planning the number of students who enter Schools according to the needs of the system.
- Planning access to the work source.
- Programming geographical distribution.
- Professional certification and recertification.
- Professional Career.
- Regulation of specializations.

Dr. Jorge Carlos Jañez

Association of Hungarian Medical Societies

MOTESZ – the Association of Hungarian Medical Societies – the largest organisation based on voluntary membership – was founded in 1966 with the participation of 36 associations. During the almost forty years of existence, the objectives in the By-laws have only been changed by completing them with new ones meeting the requirements of changing needs. The activity of MOTESZ can be seen at several levels manifested in co-operation with numerous organisations (governmental and public organisations, universities).



At the moment MOTESZ has 125 member-societies facilitating the connection of some 30 000 Hungarian medical doctors to the Association, and the most important aims of MOTESZ are to co-ordinate activities, collaboration of member-societies at the Association's level, and to help with solving mutual problems.

Levels of the activity

Federal Council (consists of Presidents of member-societies, having meetings quarterly);

Presidium (consists of 9 members, having meetings monthly);

The operative work is executed by Working Committees leading by vice presidents and members of the Presidium of MOTESZ and ad hoc committees.

National activities

The MOTESZ makes efforts to represent the interests of the member-societies in the National Health care legislation and implementation, and as a standing invited delegate follows the legislation process of the Health Care Committee of the Hungarian Parliament expressing its own standpoints in issues influencing the Medical Society in a direct and significant way.

On request the MOTESZ has regularly been taking part in giving opinions to draft regulations affecting Health Care forwarded by the Ministry of Health, and working out, forming and discussing those topics which affect all the stakeholders of the Hungarian Health Care.

It is provided by law that the MOTESZ organises and implements the election of the National Advisory Boards, which are advisory bodies of the Minister of Health. This task was accomplished for the first time in 2004 and for the next time it will be managed in the first half of this year.

In 2006 MOTESZ had a major role in inserting one of the most important programmes, the Heart and Cardiovascular Pro-

gram into the row of National Health Programmes. MOTESZ also gained the task of co-ordination of all the four National Health Programs from the minister of that time. The remaining three are: Child Health, National Programme against Cancer, National Programme of Emergency care.

In 2006-2007 the Association was participating actively in the preparation and implementation process of Health Reforms. Upon invitation of the Ministry of Health and Health Care Committee of the Hungarian Parliament the MOTESZ established ad hoc committees for development, reporting particular topics and drew representatives of member-societies and co-partners into the Committees' work. In the framework of legislator's support, the Association took part in seven working groups, which groups reviewed some areas of Health Care, outlined the most important tasks, and determined the action program.

Some of the proposals drafted with the help of MOTESZ co-ordination were put into practice during the Reform process. The working groups established for assessment in primary care, out-patient care, in-patient care, human resources, public health and reform acts prepared working documents and informed the members of the Federal Council continuously about the work completed. The MOTESZ also organised a National Forum in relation to issues of in-



MOTESZ delegation in Beijing

patient care structure and prepared comprehensive summary about it.

On 1st March 2007, the Association was asked by the State Secretary of the Prime Minister's Office to help in the activity of the Monitoring Working Group established within the Prime Minister's Office, in order to follow the implementation of ongoing Health Care Reform. The Association invited its co-partners to share their thoughts, proposals about current issues, difficulties, impact of modifications in legislation – that concern and affect all of us – concerning health care. Every week the MOTESZ received reports, completed by the comments of experts and forwarded them to the Prime Minister's Office. The Association then regularly was informed about the implementation of the proposals.

It is important to mention that MOTESZ has Agreements of Co-operation with four Medical Faculties.

Besides the Association's basic tasks, the MOTESZ Congress and Travel Agency play an important role in its activity. The MOTESZ not only facilitates participation of Hungarian doctors in events with international participation, as well as in international conferences, in international recognition of their knowledge, achievements, but these events are very important pillars for the domestic continues medical education. Another pledge of the successful and continuous running of the programmes is the organisation of travelling, hotel accommodation of doctors, researchers and professionals, as well as other programmes.

The Association is proud of the MOTESZ Magazine, the informative professional journal which includes scientific, health policy issues and is published in 25 000 copies. In 2007 the International Editorial Advisory Board was established and prominent foreign experts were invited to participate in its work in order to accomplish in the best possible way the tasks ahead of the MOTESZ. For those who follow modern sources of information, they could visit the

MOTESZ website where besides others the latest issue of the Journal can be found. The topical issues are linked to the forums, so the visitor could participate in its formation in a direct way. Both the Magazine and the website give the opportunity for partners to communicate issues of health care policies to the public.

The Association continuously makes efforts to facilitate that its proposals, opinion and lobbying activity be included with due emphasis in all processes that could modify e.g. the provision of health care or the health care structure itself etc, however the main goal remains unchanged: representation of professional interests of its member-societies, putting forward the professional work in any activity that could effect Medical Policy and Health Care.

International activities

The Association attaches great importance that its activities be integrated into national and international professional organisations. The most essential international relations at multilateral level are the following:

Standing Committee of European Doctors (CPME); European Working Group of Practitioners and Specialists in Private Practice (EANA); European Forum of Medical Associations and WHO (EFMA/WHO); European Union of General Practitioners (UEMO); European Union of Medical Specialists (UEMS); World Medical Association (WMA).

Since 1988 the MOTESZ has been taking part in the WMA as a full member and is proud that it hosted and organized the WMA General Assembly in 1993. It is a great pleasure that the MOTESZ representatives were elected Vice Presidents in two Organizations – UEMS and UEMO. Due to the broad international activity and WMA membership, the Association plays a major role in health care related legislation in Hungary.

MOTESZ has bilateral agreements with the German Medical Chamber, the Royal Soci-



Prof. Kálmán Magyar

ety of Medicine, Chinese Medical Association (CMA) and the Heilongjiang University of Chinese Medicine (HLJUCM). The Association has very good relations besides others with the American Medical Association, Conseil National de L'Ordre des Médecins. On the basis of the outstanding international relations, MOTESZ is able to follow in an up-to-date manner and influence to a certain extent the evolution of European guidelines that determine Hungarian professional policy.

In 2007 due to financial difficulties the Association was not able to participate at some meetings of International Organisations; however it sincerely believes that this year it will continue this activity under more favourable conditions.

Some suggestions relating future activities of the WMA

The MOTESZ would appreciate receiving adequate information from the WMA relating to care of the elderly, genetics, and ethics of molecular bio-research.

It would be also useful if the WMA could monitor the situation of health care workers in member countries, and could give guidelines regarding competence levels, and minimum terms/conditions for their members.

*Prof. Péter Sótönyi, Past President
Prof. Kálmán Magyar, Vice President,
President of International Committee
Prof. Tibor Ertl, Vice President
Dr. Ferenc Oberfrank,
Vice President of International Committee*

Turkish Medical Association

Turkey is located between Europe and Asia with its geopolitical significance. According to official statistics the population is 70,586,000. According to recent statistics given by the Ministry of Health and Higher Education Council there are 103 000 active practicing physicians (1). With these figures we can estimate that there is 147 physician per 100 000 population, but there are significant variances between the regions and between the urban and rural areas. About 45 000 of these physicians are specialists. Turkish Medical Association is organized voice of doctors in Turkey, under the constitutional guarantee as a non-profit, non-governmental, public association, founded by law in 1953 in Istanbul. Then the association was moved to Ankara in 1983. Membership to the Turkish Medical Association is through the Medical Chambers located in provinces with more than 100 physicians. Currently there are 64 medical chambers. 80% of physicians are members of the Turkish Medical Association.

Aim

Turkish Medical Association was established with the aim to maintain and protect deontology and solidarity between physicians, to promote medical practice for the benefit of the public and the individual and to protect the rights of the physicians as a public professional association. The Turkish Medical Association besides these primary aims has the duty to promote health for the benefit of citizens in Turkey and work for a high quality health care which is achievable for everybody with suitable cost, promote professionalism, work on improving medical education at all levels and establish guidelines for ethical conduct among the members.

Structure

The Turkish Medical Association is an umbrella organization of 64 Chambers of Medicine. These chambers are founded in

provinces with more than 100 physicians. Each chamber will have executive, auditing and discipline committees. Chambers with less than 500 members will have 5 members and those with more than 500 members will have 7 members in the executive committee. Each chamber will elect its delegates for the formation of the main congress. The President of each chamber is a member of the main congress. The main congress is the main decisional organ guiding the council for political decisions. The other important duty of the main congress is election of the Council of Turkish Medical Association with the central auditing and high discipline committee. The number of delegates are determined by the number of members of that chamber. The Council of Turkish Medical Association is composed of 11 members who are elected by the delegates. The elected members both for the chambers and the council serve for two years and can be elected for only two terms. All these positions are on voluntary basis without any payment.

What does Turkish Medical Association do for the profession?

One of the most important task and responsibilities of Turkish Medical Association is collaborate with the national authorities and give feed-back about issues and/or politics which may effect the public health and the rights of the physicians. It has been the primary force as the voice of the profession and the public against the significant changes in the health system and politics that have been proposed and tried to be implemented in coordination with other associations, syndicates or unions. Various reports have been published on different relevant issues, such as consequences of changes in health system, vital statistics, directives and laws in medicine, professional ethics etc.

Turkish Medical Association has an important mission on improving medical educa-

tion at all levels. It is putting a report on undergraduate medical education every other year based on a questionnaire filed by the medical schools. These reports are detailed on the current state of medical education regarding the infrastructure, manpower, curriculum and developments in a qualitative manner. This year a qualitative evaluation on medical education was conducted based on Global Standards of WFME European Specifications.

Together with the specialty societies Turkish Medical Association has been involved in forming specialty boards to improve the quality of postgraduate training in Turkey. To date, 28 member specialty societies have founded boards and commissions in their sections, 21 have prepared curriculums, 23 have prepared log-books, 17 have organized board examinations, and 2 have begun a visitation program in its own section's teaching hospitals. These numbers are increasing every year and we aim to have active working boards on education in every specialist section in our country. Currently re-licensing does not occur. However, re-licensing is being discussed now in various boards and we believe it will start to be used within the next 7-10 years.

Turkish Medical Association was the driving force for implementation of CME/CPD in Turkey. After organizing a workshop on CME it created awareness in the field in 1991. A CME/CPD Accreditation Council of the Turkish Medical Association was founded in 1994 for accreditation of CME/CPD activities, provided the organizer applies for accreditation. The council has reviewed the by-laws and changed various aspects parallel to the EACCME principles. The Turkish Medical Association has signed an agreement with the UEMS (February 2006) for mutual recognition of CME credits and CME accreditation. Annually, 1,000-1,200 CME/CPD activities are reviewed for accreditation and 800-1,000 of these activities are accredited by the council. A total of 7,560 activities have been accredited and the Council has awarded 81,088 CME/CPD credits since 1994.

Annually, on average 8-9,000 CME/CPD credits are being awarded when the last 6 years are evaluated. The activities accredited between the years of 2002-2006 were provided by the professional societies in 38 % of the cases, and respectively, medical faculties in 32 %, chambers of medicine/medical association in 19 %, teaching hospitals in 6 % and others in 5 % of the cases. 27 activities in 2007 have been accredited jointly with EACCME: A recent workshop was organized to create awareness and promote CPD activities for life-long learning.

Turkish Medical Society organizes conferences, workshops, symposia, working group meetings and publishes various publications both for informing the members and contributing to their education.

Politics

Turkish Medical Association contributes to the health politics by representation in various commissions and committees. The association gives their opinion regarding various

professional issues and health politics. The public is informed as well. It is involved in the preparation of various laws in the parliament and other related institutions.

International Relations

At the international level, the Turkish Medical Association is a member of the World Medical Association, associate member of the UEMS.

Ethics

Ethics is one of the major areas in the Turkish Medical Association. The association has prepared a code of professional ethics to guide the members. The ethics committee prepares statements regarding various issues for medical practice, medical research and promotional activities (physician-pharmaceutical industry relations).

Turkish Medical Association informs the public about on various medical issues through its publications both as hard copy

and on the web site. It releases files to the press both for information and creation of awareness. Prepares reports regarding public health issues to inform the public. Radiation, clean water supply, environmental medicine, infectious diseases, smoking are some of the fields of information delivered. It prepares and shares reports on criticism of health reforms which are related to the public.

Human Rights

Human rights have been another major area of interest for the Turkish Medical Association. The major areas are the right of living, patients rights, torture and hunger strikes and activities against war. In 1997 because of the activities related to human right the Turkish Medical Association was awarded Human Rights Award by the Physicians for Human Rights. National awards have also been given regarding the activities on human rights.

Iskender Sayek M.D., FACS. Council Member, Turkish Medical Association

The Haitian Medical Association

The Haitian Medical Association is an Institution created on 8th April 1948, which gathers the whole of the Haitian doctors militant on the territory in the various branches of medicine. It was recognised as public utility by presidential decree on 5th August 1974.

The goals of the Haitian Medical Association are:

- To reinforce the links which exist between the Haitian doctors
- To defend the medical interests of the Haitian community
- To work with the advance of medicine in Haiti and the establishment, on the scientific and medical level, of relations with foreign companies;
- To co-operate with national and international institutions concerned with the wellbeing of the Haitian population

The Statutes and Rules of procedure of Association envisage the existence of the following Committees which are elected for a two (2) years mandate:

- The Board of Management of seven (7) members;
- The General Council;
- The Council of Mediation;
- The Scientific Council.

The Haitian Medical Association includes different members: active, adherent and honorary and these statutes are acquired following the handing-over of the form of adhesion and the payment of the annual contribution. However, only the active members and adherents are compelled with the payment of the annual contribution that gives them the right to become candidates at the elective stations within the Association and to also vote at the time of the elections which are

held every two (2) years. In the rules of procedure, in order to be an active or adherent member, the medical licensed doctor of Haitian nationality must submit to the Board of Management a completely filled form which is regarded as a request written for inscription.

In its article III, the association is defined as "a Company grouping a professional sector with an economic and social life and whose purpose is to defend the common interests of the doctors from the point of view of their profession". There also local Committees which function like peripheral antennas placed in the various geographical departments of the country. They gather the doctors practicing in these areas who are informed of the scientific activities programmed and/or carried out by Association. Since its creation to date, the Association opened doors to the outside while being registered as a member of: The Association of the Doctors of the

Latin America (CONFEMEL) and the World Medical Association (AMM).

The Association almost never misses the occasions to take part in work of these various entities and regularly pays the annual contribution. It maintains with them a relationship marked under the seal of the dynamic and effective partnership. It establishes and maintains relations with the Haitian doctors practitioner living overseas who are gathered under the term of Association of the Haitian Doctors living Abroad (AMHE). The projects and activities carried out by the members of the AMHE on the Haitian territory, particularly those addressed to the young Haitian doctors who specialise at the Hospital of the Haitian State University, are done in co-ordination with the AMH and the agreement of the Ministry of Public health and Population and the Vice-chancellorship of the UEH.

The Association exists only by and for its members and for this reason its interventions are always addressed to them. In a specific way, it always gives itself the means to ensure the continuing formation of its members at the time of the various congresses, seminars and workshops organised on the actual health problems which strike the population. The colleagues practicing in province are not always forsaken. Besides the local antennas in which they belong, they are also invited to share their fellow-member's experiences working in a more favorable professional environment. The regular publication of the bulletin of the association constitutes an open window on the doctors practicing here and elsewhere since through this channel of communication, the members are aware of the activities planned and organised by the association. In this same order of ideas, the relationship with the population is established directly with the doctors in their consulting-rooms. However, each time the need is felt, particularly at the time of natural disasters or others, the Association answers always favorably the call of the authorities to place at their disposal the competences of its members and in these particular cases, gifts in

cash and in kind are sometimes collected to be distributed through the qualified structures existing in the country.

The relationships with the Ministry of Public Health and Population are always marked under the seal of the mutual respect for the benefit of the Haitian population. The Association is an active member of the various commissions and committees created by the Ministry to reflect on the great medical challenges confronted in Haiti and its voice is very listened. A partnership is also established not only with other socio-professional organizations of health (ASPHA and ANILH) which militate in the country in the defense of the interests of health of the community, but also with the agencies of technical and financial co-operation like the OPS/OMS, the UNICEF, the ACDI, USAID etc. Always in the same tread, an agreement of partnership was signed with the Association of the Dominican Doctors (AMD) and this results in technical and scientific exchanges between the two associations on the basis of their own availability and expertise.

However, the Association knew dark moments and one of them was the suspension of its activities for approximately ten years. At the time of the great sociopolitical events which shook the Haitian nation during these two last decades, the Association has to take serene positions recalling to the respect of fundamental freedoms and human life. The wind even badly turned during this same time for certain fellow-members who were embanked by political violence which continues to mark the Haitian landscape. The association still remembers some of its members who were assassinated within their private clinics or sometimes even inside their residences. However, the wisdom and the solidarity of our members made it possible to overcome these inherent difficulties.

Thus, this spirit of mutual aid allowed the Association, sixty years after its creation, to concretize a dream cherished a long time and so expensive with several of our predecessors; it acts in the acquisition of our

own registered office which now became a reality. This new building is a legitimate reason for pride for all the members since it was bought thanks to their contributions whereas work of refitting was financed with a support of the USAID through Project MSH. This building is located in a very strategic zone with: a room of conference which can contain a hundred participants, two other small rooms for approximately 25 people for companies and the subsidiary companies to hold their meetings, the president's office and his secretariat.

One of the major challenges which crossed all the existence of the Association consists in its possibilities of gathering the whole of the medical brotherhood since until date it never could cross the threshold of the five hundred (500) active members whereas there are more than one thousand medical doctors practicing in the country. In addition, the renovation of the executives also represents another shelf to be crossed because the young doctors graduated from the various Faculties of Medicine are rare to register like members and that in spite of the efforts of bringing together authorised by the leaders and of the goodwill expressed by the chairmen of these schools of basic training to open to us the doors of these centers of knowledge and academic excellence.

Today, the AMH can be proud to have crossed the years and turpitudes of an existence full of enriched experiments for the medical world. It became now a space of reflexion and together with the official sectors and other organizations it can continue to carry out this permanent combat against the war of diseases and suffering. It has still many ways to traverse and it must continue to actively play its role of leader in the field of health. May it obtain the instruments necessary to better serve its members and the Haitian Population. It is only thus and only as it will be able to continue to live again for another sixty (60) years.

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