

WORLD

MEDICAL JOURNAL

54

Vol.

No. 3, September 2008

OFFICIAL JOURNAL OF THE
WORLD MEDICAL ASSOCIATION, INC.



World Medical Association Officers, Chairpersons and Officials

Dr. Jón SNÆDAL
WMA President
Icelandic Medical Assn
Hlidasmari 8
200 Kopavogur
Iceland

Dr. Yoram BLACHAR
WMA President-Elect
Israel Medical Assn
2 Twin Towers
35 Jabotinsky Street
P.O. Box 3566
Ramat-Gan 52136
Israel

Dr. Nachiappan ARUMUGAM
WMA Immediate Past President
Malaysian Medical Assn.
4th Floor, MMA House
53000 Kuala Lumpur
Malaysia

Dr. Edward HILL
WMA Chairperson of Council
American Medical Assn
515 North State Street
Chicago, ILL 60610
USA

Dr. Kazuo IWASA
WMA Vice-Chairman of Council
Japan Medical Assn
2-28-16 Honkomagome
Bunkyo-ku
Tokyo 113-8621
Japan

Dr. Eva NILSSON-BÅGENHOLM
WMA Chairperson of the Medical
Ethics Committee
Swedish Medical Assn.
P.O. Box 5610
11486 Stockholm
Sweden

Dr. Jörg-Dietrich HOPPE
WMA Treasurer
Bundesärztekammer
Herbert-Lewin-Platz 1
10623 Berlin
Germany

Dr. José Luiz GOMES DO AMARAL
WMA Chairperson of the Socio-
Medical-Affairs Committee
Associação Médica Brasileira
Rua Sao Carlos do Pinhal 324
Bela Vista, CEP 01333-903
Sao Paulo, SP
Brazil

Dr. Otmar KLOIBER
WMA Secretary General
13 chemin du Levant
France 01212 Ferney-Voltaire
France

Dr. Guy DUMONT
WMA Chairperson of the Associate
Members
14 rue des Tiennes
1380 Lasne
Belgium

Dr. Mukesh HAIKERWAL
WMA Chairperson of the Finance
and Planning Committee
58 Victoria Street
Williamstown, VIC 3016
Australia

Dr. Karsten VILMAR
WMA Treasurer Emeritus
Schubertstr. 58
28209 Bremen
Germany

www.wma.net

Official Journal Of The World Medical Association

Editor in Chief

Dr. Pēteris Apinis
Latvian Medical Association
Skolas iela 3, Riga, Latvia
Phone +371 67 220 661
peteris@nma.lv
editorin-chief@wma.net

Co-Editor

Dr. Alan J. Rowe
Haughley Grange, Stowmarket
Suffolk IP143QT, UK

Co-Editor

Prof. Dr. med. Elmar Doppelfeld
Deutscher Ärzte-Verlag
Dieselstr. 2, D-50859 Köln, Germany

Assistant Editor Velta Pozņaka
wmj-editor@wma.net

**Journal design and
cover design** by Jānis Pavlovskis

**Cover painting : impressions on a wall
in northern Somalia, dated back to over
3000 years. A cover picture is selected as a
moral support of WMA for Somalian people
and physicians**

Layout and Artwork

The Latvian Medical Publisher "Medicīnas
apgāds", President Dr. Maija Šetlere,
Hospitāļu iela 55, Riga, Latvia

Publisher

The World Medical Association, Inc. BP 63
01212 Ferney-Voltaire Cedex, France

Publishing House

Deutscher-Ärzte Verlag GmbH,
Dieselstr. 2, P.O.Box 40 02 65
50832 Köln/Germany
Phone (0 22 34) 70 11-0
Fax (0 22 34) 70 11-2 55

Business Managers

J. Führer, D. Weber
50859 Köln, Dieselstr. 2, Germany
IBAN: DE83370100500019250506
BIC: PBNKDEFF
Bank: Deutsche Apotheker - und Ärztebank,
IBAN: DE28300606010101107410
BIC: DAAEDED3
50670 Köln, No. 01 011 07410
At present rate-card No. 3 a is valid

The magazine is published quarterly.
Subscriptions will be accepted by

Deutscher Ärzte-Verlag or
the World Medical Association

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

Printed by
Deutscher Ärzte-Verlag
Köln, Germany
ISSN: 0049-8122



Opinions expressed in this journal – especially those in authored contributions – do not necessarily reflect WMA policy or positions

Editorial

We are occasionally faced with the question: What is the role of the physician? Is it to care for the individual patient, or does the physician's responsibility extend to include the health of the whole nation or even the entire planet?

Some of my colleagues have expressed the view that a national medical association's task does not extend to the medical care for the whole nation. In their opinion, that responsibility belongs to the government or an agency of the government, or to society as a whole; the doctor's job is to care for his or her patients. Although this latter statement is true, our professional medical education puts us in the position to be the best guarantors of public health. I hold physicians in very high regard as specialists who invest and synthesize their energy, knowledge and experience in the total care of their patient.

However, each physician's mission is broader than the care of individual patients, just as the mission of every national professional society extends beyond the inhabitants of the country. The mission of the physician, the national medical organization, and the World Medical Association should also be the health of society as a whole. Because no one else has a grasp of the issues, only the doctors and their professional associations can effectively deal with the health of the general population.

The health of the population worldwide could be dramatically improved by paying attention to a few basic concepts: adequate nutrition, sufficient exercise, clean water and air, primary and secondary prophylaxis against disease, access to medication, access to qualified medical personnel, improvement in physical and mental well-being and eradication of harmful behaviors such as smoking, alcoholism and the use of drugs.

Today, inspired by the Olympic Games in Beijing and the Declaration of Helsinki Conference in São Paulo, I would like to discuss the importance of exercise in the improvement and maintenance of good health.

We were enthralled by the incredible new Olympic stadiums in China, the spectacular opening and closing ceremonies and the world-class competition of athletes in Beijing. While winning a gold medal is a significant achievement, participation in the competition is even more important. We should encourage all to participate in physical activity even if they have no chance of winning a medal. China provides a good example by the large number of people of all ages who practice Tai Chi every day as a means to physical and

spiritual well-being. Athletics can inspire as a spectator sport, but it should be a reality in the everyday life of all people.

The Declaration of Helsinki Conference took place in São Paulo, Brazil in August 2008. Each conference participant took something away from this meeting. For me, the most striking insight was the one I gained during several very early mornings in a park. I was not the only person running. Many thousand people, primarily 40- to 60-year-olds, were also running, alone or in lively groups. I now understand why Brazilian athletes are the trend-setters in soccer, volleyball and athletics worldwide: they simply love to exercise, and they continue to exercise all their lives.

My proposal is simple. The World Medical Association and each national medical association should undertake to promote at least some daily exercise and physical training in every individual, young and old.

Senior sports should also be included in a nation's public health program. In the world literature there are reports of research studies showing that regular, daily exercise at a sufficiently high level of intensity (including activity in an anaerobic regimen) can bring about a noticeable improvement in health status, increase in muscle mass, amelioration of coordination disturbances, and stabilization of the heart and circulatory system. Exercise programs in 80 to 90 year old patients can save on resources that would otherwise be spent in the health or social services. Furthermore, exercise is the best way to combat the worldwide epidemic of obesity and the sharply increased incidence of type 2 diabetes.

At the moment there is no clear strategy internationally to promote exercise in older people. Senior sports enjoy prestige in only a few countries. In Scandinavian countries, for example, the sport of orientation attracts many people at retirement age, who then start training in earnest, attend training camps in mountainous regions, and go to training camps in the winters in southern Europe. It is time for us to find recognition for senior sports championships equal to those enjoyed by youths and 20- to 30-year-olds. Most resources are invested in youth sports, on the assumption that these young people will then mature into adults who love to exercise. However, elderly people should also be encouraged to participate in sporting activities, consistent with their abilities.

Our goal in promoting good health is sufficient exercise and optimal nutrition for every person, regardless of age.

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

179th WMA Council Meets

The 179th Council met in Divonne-les-Bains, France 15-17th May 2008 under the chairmanship of Dr. Edward Hill.

Opening the meeting the Chair called on Dr. Ishii, member of Council and Secretary General of the Confederation of Medical Associations in Asia and Oceania, who spoke of the mortality, injury and devastation caused by the earthquake in China and the cyclone in Myanmar. This raised huge challenges in the Region. The Chair, echoing these remarks, also referred to the effects of armed conflict and violence on human health. In particular he referred to the tragedy affecting the family of Prof Bartov, member of council. He then read a letter written on behalf of Council to Professor Bartov and Council stood in silent tribute to those who had lost their lives in the earthquakes and the victims of natural disasters, war and violence.

The President, Dr. Snædal reported that he had visited a number of NMAs, referring in particular to a successful meeting on Communicable diseases in Taiwan and to the enormous problems facing NMAs in Sub-Saharan Africa. He continued by speaking of meetings which he, with others, had attended in Ethiopia and Uganda on Human Health Resources and the concept of Task Shifting (also being considered by the WMA working group). Task shifting was very important as it removes tasks from medicine to others. The other health professions had also recognised that this had implications for them. Other important issues would be referred to in the Report of the Secretary General.

Dr. Otmar Kloiber, Secretary General, reported that the staff increases would facilitate increased WMA representation and advocacy at political level. He was grateful

to the AMA for facilitating the appointment of Clarisse Delorme, a Human Rights lawyer, as the Advocacy Adviser. There had been a lot of activity on Task Shifting (TS).

Task Shifting While this seemed shocking at first, it was nevertheless necessary to address the problem of areas where the Physician/Population ratio was down to 1 : 50000 - meaning that the sick had no chance of seeing a physician. In these extraordinary circumstances there was a compelling need



Presidium of 179th WMA Council

to act. On the other hand WHO and donor organisations gave the impression of considering Task Shifting as a general concept widely applicable to dealing with all



Delegates of the Council by the Divonne-les-Bains Palace

healthcare human resource problems. They don't view this concept as only applicable to poor countries with human health resource deprived areas, but rather it could be used as a tool to solve the problems of Health care systems in developed and rich countries. They are looking at countries, notably in the west such as the USA and UK, who have already started Task Shifting, etc. These countries don't have to face the sort of shortages experienced by African countries. Last year and this we have had a chance to influence a Task Shifting policy document, and point out that this is primarily for addressing the problems of shortages of human resources. In Addis Ababa we learnt that the African Ministers of Health were not aware of the western proposal of Task Shifting. Dr. Kloiber referring to the Kampala meeting said that the Health Professions requested but, were given no opportunity for, direct influence on policy as there was no open discussion of the prepared document, but simply information on what was planned. The Declaration of Kampala* outlined the importance of Task Shifting, but pressure by the WHPA resulted in the inclusion of the President of WMA in a closed ministerial round and some modification of the final document to recognise the needs for health professionals.

Tuberculosis Staff member Dr. Julia Seyer in charge of MDR-TB project, reported to council that for some years WMA had been working with the Stop TB Alliance and commented that the provision of theoretical knowledge as to how to teach about Tuberculosis on-line should help this campaign. Together with the ICN, WMA was engaged in workshops on the training and on healthcare workers' safety guidelines in managing tuberculosis. She referred on agreement signed on the previous day and the plan for the second phase of the project and its enlargement (including China, Russia and India). She would like to extend the on-line course to a CD-ROM and a Handbook. Concerning the training of trainers' courses on education in learning styles,

there was cooperation with the World Economic Forum who had a toolkit for working in countries such as China (where Tuberculosis is stigmatised), addressing the problems of how to diagnose, treat and manage tuberculosis. Referring to ethics in relation to tuberculosis, she highlighted the right of society to enforce Tuberculosis control.

Tobacco /Alcohol Dr. Kloiber then referred to the new approach to Tobacco developed in Copenhagen where WMA were invited to work on Legal controls. NMAs had selected the issues of education and communication in Tobacco Control and also on limiting exposure to tobacco smoke. The WMA had co-sponsored a seminar on Tobacco control at the EFMA/WHO annual meeting in Tel Aviv and WMA would host a side event at the World Health Assembly on "Focussing Opportunities for Tobacco Cessation". Responding to a question from India on collaboration he stressed that there would be more opportunities for NMA involvement in the projects new phase. Turning to Alcohol which was now before the World Health Assembly, the recommendation before the Assembly included a direction that the Secretary General should cooperate with the Alcohol industry. In view of the

lobbying by the industry this was a matter of concern.

Leadership The WMA course Leadership was held in the autumn together with INSEAD, with 32 participants from all over



Meeting „Focussing Oportunities for Tobacco Cessation” in Geneva

the world. Dr. Kloiber thanked Pfizer for making this course possible. The course was such a success that it would be repeated.

*WHPA*** The WMA had taken over the secretariat of the World Health Professions Alliance (WHPA) from the International Council of Nurses (ICN) for the next period after which it would rotate though the other professions. WHPA is a very strong



From the left: Burton Conrod, President FDI; Hiroko Minami, ICN President; John Snaedal, President WMA; Marilyn Moffat, President WCPT; Kamal Midha, President FIP

* see page 82

** see more page 95

alliance of the health professions who found, to their surprise, that they had a common experience in their difficulties in getting their views to be taken seriously by WHO, who considered that their views would be sectional and partial in the global health field. The professions who joined together in this alliance found that this changed the situation and the WHPA had been successful in presenting a broader collective voice from the health professions. The need for this alliance had been enhanced by the professions recognising the threats implicit in Task Shifting.

Dr. Kloiber then introduced Ms Clarisse Delonne, a French Human Rights lawyer advising on Advocacy for and by the profession. She reminded council that an approach had been made to Paul Hunt the previous UN Special Rapporteur on Health in Human Rights. She set out the role of the Rapporteur on the Right to Health and the need to influence the Commission to extend the mandate of the Commissioner to include integrity of health professionals in the mandate. WMA has worked extensively with the ICN lobbying on extending this role. A joint statement was being prepared which would be sent to the Human Rights Commission requesting that Independence and Integrity of health professionals be included in the Special Rapporteur's mandate.

In discussion Dr. Nathanson (BMA) pointed out that the Special Rapporteur on Torture had an interest in the problems of physicians in reporting torture and this aspect should also be addressed to Mr Nowak with whom we could also work.

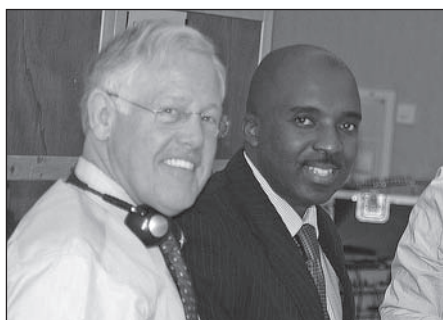
Dr. Wilks (President of the CPME) said that the BMA had worked with Paul Hunt and discussed with him the NMAs' role in increasing indices of health. With reference to Alcohol, Europe had experience to offer. In the European Union they had been able to harness industry in actions on Alcohol control. The Chair, Dr. Hill, commented that in the USA where the industry decided to advise the young on the hazards of drinking, however, drinking in the young

had increased in those areas where the industry was involved.

Dr. Letlape considered that WMA needed a position on this topic. Dr. Nathanson agreeing added that alcohol was not as socially acceptable for control action as was Tobacco.

Dr. Haikerwall returning to Task Shifting said the trend was towards removing medical care from Health care.

Human Rights in Zimbabwe. The Chair of Council introduced Dr. Paul Chimedza, President of the Zimbabwe Medical Association (ZiMA) who had been invited to speak about the report of health related human rights and violence in Zimbabwe.



*From the left Dr. J. E. Hill,
Dr. Paul Chimedza*

Thanking council for the opportunity, Dr. Chimedza said that political tensions and violence began to rise after the recent elections in Zimbabwe and that this was being perpetrated by both political parties. He denied that any patients had been refused medical care on the basis of political affiliation and stated that ZiMA had stressed to its members that they should report any instances in which they were prevented from treating patients. The ZiMA had received no such reports from its members.

Referring to Harare he said there was no problem with the elections but that these arose after the election, when the political temperature rose. There had been a lot of allegations about the profession. He had received e-mails alleging that the Minister

of Health and Dr. Chimedza himself had been involved in political violence and that the ZiMA as an organisation was supporting violence. The allegations came from the Zimbabwe Doctors for Human Rights (ZIDHR). He had met with the Chairman of ZiDHR before travelling to the WMA council meeting in Divonne. During this meeting the Chairman of ZiDHR said that they had no evidence to support the allegation but had heard rumours. Dr. Chimedza commented that it was sad "that a professional organisation could make such serious allegations without evidence to support them." He accepted that there was a strained relationship between ZADHR and ZiMA from the time that ZADHR had been denied associate membership of the ZiMA. This was however because the ZiMA constitution required affiliates to be specific medical professional groupings, such as paediatricians etc. ZADHR as a human rights association was therefore not eligible for affiliation. In fact there had been efforts at three successive ZiMA Congresses to amend the constitution to admit ZADHR and they had all failed. Despite this ZiMA had been accommodating to ZADHR whose Chairman was a member of the Executive of ZiMA's Mashonaland branch. Dr. Chimedza stated that ZiMA was against violence of any kind, perpetrated by anyone. ZiMA had resisted being pressurised. In an overview of ZiMA's action he referred to its Social Responsibility Programme in which there were many actions such as outreach to rural health centres, including equipment provision also funding for furniture in HIV clinics, provision of drugs and assistance in refurbishing hospitals, such as operating theatres, as well as engaging in many other actions to assist the Zimbabwean people.

Dr. Nathanson commented that ZiMA was vulnerable to the sort of allegation referred to and this was because people were not aware of its work. It was a good example of how the WMJ could be used to publicise these activities. Dr. Chimedza felt this would be helpful and stated that he would request ZiMA Ex-

ecutive to allow a WMA delegation to conduct a fact finding mission to investigate the allegations which had been made. This would also allow WMA to see the work that ZiMA is doing, the challenges it faces, and identify ways in which WMA could assist them. Dr. Plested asked whether in an environment so politically violent physicians were at personal risk. Dr. Chimedza said this was a major worry. There was no violence before but after the election. "None of our member physicians had been targeted". Problems were related to the economy.

The immediate Past President proposed a motion to support such a delegation, to which the Secretary General observed that this was unnecessary as it was covered by the Resolutions adopted by Council and the General Assembly in 2007.

Dr. Nielson asked whether it would be appropriate for the WMA to call on all physicians throughout the world to behave according to the highest standards of the medical profession, a suggestion subsequently **adopted by the Council**. While indicating that the AMA would support sending a delegation to Zimbabwe AMA felt that it would not be appropriate to describe such a delegation as "a fact finding mission".

The Dr. Nakia informed Council that a Canadian University had for many years an infectious diseases health group going to Zimbabwe, but had difficulty recently in getting supplies into the country, as well as concerns about the safety of physicians and she enquired whether ZiMA would be able to look into the question of safety for these physicians. Dr. Chimedza responded that ZiMA did not have the capacity to guarantee the safety of anyone who was not directly involved in ZiMA programmes and that ZiMA had temporarily suspended its own programmes until violence subsided.

The Chair of Council reiterated WMA's wish to assist ZiMA on issues affecting physicians and patients and Council **adopted a resolution** calling on all physicians to observe the highest standards of medical ethics.

Medical Ethics Committee

The Chair, Dr. Bagenholm welcomed new members of the committee and the minutes of the last meeting in Copenhagen were approved.

Helsinki Declaration

Moving to the Declaration of Helsinki revision, Dr. Bagenholm said that the working group had corresponded, producing a number of drafts and had had a productive meeting. She asked Dr. Williams, who had done most of the writing, to set out the situation and outline the most controversial issues.

Dr. Williams said that the group were conscious of their mandate which was to identify gaps and to promote the Declaration of Helsinki (DoH). The group meeting in Helsinki looked at the most controversial sections, considered suggestions for additions, but had sought not to expand but try to capitalise the ideas into one or two sentences and this constituted the agenda. In the report before the committee most of the changes were editorial. In considering the vocabulary it was decided that the best term to be used for those submitting to research was "research subject". He then referred to specific items setting out the reasons for the group's decisions, mentioning the need to avoid long sentences and points which needed clarification. The Chair, Dr. Bagenholm speaking of the process, said that there would be a further revision after the Ethics committee and a workshop in Brazil in September, with a view to getting a final document to Council and submission to the General Assembly this year. She reported that an invitation had been received to a WHO meeting in Cairo of the Eastern and North African Mediterranean countries to be coordinated by the WHO Cairo Office and UNESCO to discuss "Challenges to Ethics and Medical Research" It was hoped that there could be a parallel meeting on DoH for WMA members and stakeholders.

Opening the discussion Dr. Nathanson (UK) referred to the use of the word "hu-



Dr. John R. Williams, Ph.D.

Dr. Eva Nilsson Bågenholm

man". This was a key issue. It should not be interpreted in DoH as including "embryos". In DoH we are talking about humans from birth to death. President Snædal thanking Dr. Williams for his work commented that the paragraphs appeared to be lengthened, they need dividing. Turning to "Research in Children" he commented that this subject had not been worked on. The alternatives were to include it in DoH, or in the Declarations of Lisbon or Ottawa. Dr. Lemye requested that Belgium be included in the working group. An amendment which Belgium had submitted appeared not to have been considered. Dr. Bagenholm responded saying that all representation were considered in Helsinki and were incorporated as far as possible, if appropriate. Dr. Havaux (Switzerland) considered the document generally to be very satisfactory except the problems arising from the DoH in many languages. He expressed great concerns about the French translation. It was not only a problem of translation but also of guidance for the French speaking countries. He proposed that the documents should be circulated in French. Dr. Kloiber agreed that we need to change the translations and asked if some of the four language groups could join the editorial group to agree final versions. Dr. Mot added that France had also some similar concerns and had added the African French speaking group to their editorial group. Dr. Collins-Nakai (Canada) thought there were three areas of concern:

- access of post trial patients,
- use of placebos,

- the current language was too restrictive. Informed consent there had been remarkable developments in the CMA.

Dr. Bagenholm, reverting to the topic of Research on Children, reported that there were comments on this from many NMAs.

Dr. Bagenholm opened a discussion on the proposal on Research in Children reported that there had been many comments from NMAs. When the committee had discussed DoH it could then decide on how to deal with children. It could either be dealt with in the context of this revision or dealt with separately. After recalling that the revision of DoH was not to include new material, she called for expressions of interest in including it in DoH. The CMA wanted it included in DoH, using the inclusive term “vulnerable populations”. Dr. Palve (Finland) felt that the DoH should have a broad approach “If we take up any one group why should other groups not be taken up? It would be better if these were dealt with in separate statements”. Dr. Nathanson UK said a lot depended on the timescale. She recognised that children were particularly vulnerable. “We could use a small addition to DoH. It was possibly quicker to deal with it in DoH”. Dr. Nakai (Canada) felt that research on children was very important- we could use minor amendments to DoH. But perhaps the WMA should consider amendment of the Declaration of Ottawa or include this topic in a Charter on Children’s Health, which could include the proposed statement as well as assessment and promotion of children’s health.

Dr. Plested (USA) favoured inclusion in the DoH. The Declaration would be weakened if we did not include the issue in this seminal document. Prof Spumont (Switzerland) said it was a question of principle. This was the sixth revision of Helsinki. It dealt with the constitution of research ethics. The world and science were changing. If we wish to preserve the value of the DoH it should be limited to principles. It would be better to link specific declarations/statements to the DoH. Having analysed the different

ways in which the DoH has been incorporated in legislation, this would be a way to proceed. Dr. Ishi (Japan) thought it had been agreed that the statement proposed on Research in Children should be dealt with as a separate document and Dr. Letlape (South Africa)) considered that while there might be some amendment, we still needed a specific document. Avv. Wapner (Israel) favoured one document – that of the DoH. The proposed statement would dilute the DoH. The problem was with “vulnerable populations” – children, the elderly, prisoners etc. President Snædal felt that the issue of research in children must be addressed. We have a proposal, also one on “Making medicines child size” by WHO. WMA had approved this initiative on research in children it would be very expensive to extend the DoH. Dr. Letlape felt the DoH should be generic; we can’t stop initiatives from outside. The Paediatric Society would produce a child friendly version of the DoH. Dr. Parsa Parsi (Germany) supported inserting small changes into DoH. Dr. Kumar (India) called for the inclusion of embryos in the DoH.

Dr. Williams indicated that Dr. Appleyard had not proposed alterations in DoH. He wanted a separate document. This document applied the principles of DoH to children. He also reminded the committee that the word “assent” not “consent” was in the DoH.

In Council later, Dr. Bagenholm reported that comments on this from NMAs had been received, but the working group had not produced any new draft proposals for action or wording. The options were that this should be included in DoH, or that the DoH be considered to be adequate in this matter, that there should be a new statement, or that the proposal be combined with the Ottawa Declaration.

Dr. Plested agreed that the proposal should go back to NMAs for their comments on the options. Dr. Nathanson said there were many good reasons to do this. Do NMAs want a holistic document or a series of statements? We needed to ask the opinion of NMAs.

The Chair of Council asked what do we do if we go through a new statement and lose ownership of the document? Dr. Kloiber responded that we must try to ensure that we justify our position. We could ask NMAs if there was anything in the proposed statement which should go in DoH. Dr. Williams was worried that this would hold up the revision. He wondered whether the working group could review the proposed statement and put it in the next version of DoH i.e. he suggested that the work group look at this before the next revision of DoH.

The Council finally **adopted the following decision,**

- **that the proposed statement on Ethical Principles for Medical Research on children be not accepted as a WMA document but that the subject of research on children be addressed by WMA in the context of the DoH.**
- **that the DoH workgroup take into consideration appropriate issues from the proposed statement in finalising the next revision of DoH for broad consultation.**

Ethics committee further discussion on Helsinki

The Chair of Ethics committee then commented that the paragraph on disease was very long, and needed some attention and also asked Dr. Williams what was included in the use of the word “humans”. Dr. Williams replied that some thought there were important differences. As long as the word was used as an adjective it meant “being” or “tissue”. When using it as a noun it meant “born subjects”. He noted that some had called for a glossary of DoH terms but the project had been abandoned. Dr. Andrade (Brazil) considered the DoH to be a core document. It should therefore remain a basic document of principles. It deals with the vulnerable. The question was who were the most vulnerable – for him these were children. He thought DoH should set standards – a document which cannot be ignored. It should be readable and consist of primordial principles. The definition of “humans” is biological and that of “being”, philosophical.

The committee then considered the suggested revision document paragraph by paragraph. In the course of the debate there was considerable discussion of the issue of dealing with principles and the danger of making exceptions was pointed out. When dealing with the issue of consent and the emphasis placed on the individual in the DoH, it was pointed out that this raised more than matters of consent. It also raised the issue of the balance between issues of individual concern and issues which were the concern of population groups - the speaker as a further example posed the question as to whether individuals have the right in exceptional circumstances to object to the use of blood taken for one purpose being used for another. This question and a number of others were referred to the working group.

After detailed and lengthy discussion of the proposed amendments and other issues the committee agreed to recommend that the new draft amended by the working group would be presented to council before it concluded its meeting and that this be sent to NMAs and circulated widely for public comment. Following the conference in Brazil, which would include other stakeholders, a new draft would be prepared for council and if approved, sent to the General Assembly in Seoul. These recommendations were **adopted by Council**.

Stem Cell Research

The committee engaged in further consideration of this draft proposal. There was some discussion concerning conflict with national law in some countries. It was agreed that the document, as amended, would be sent out to NMAs for their views. **Council adopted this recommendation.**

Professionally led Regulation

The committee considered a paper on this topic which, it was pointed out, arose out of the consideration of the Madrid Statement and new thinking. Dr. Blackmer pointed out that the paper had been circulated and the comments had mostly been editorial. In the

effort to support professionally led regulation there was, however, a need to recognise that there must be some public involvement. Dr. Haikerwall (Australia) stressed that this was an important issue. The question was how to translate the importance of professionally led regulation to the public. The Past President Dr. Letlape, (South Africa) said that the concern for his country, which might not apply elsewhere, was that advocacy by physicians for the patient is falling off. There was a need to be honest that professionalism and advocacy for the patient is diminishing. We haven't kept our duty to society. The profession needed to be seen to be the body appropriate to regulate itself and take this responsibility. The Swedish Medical Association opposed the statement. Self regulation was important for some NMAs. For the SMA this is too much. However, involvement of outside bodies may be good or not so good, and in this connection reference was made to the varying functioning of patient associations. The Danish Medical Association agreed with SAMA. It observed that Dr. Blackmer had had a difficult task in Denmark and Sweden "we don't place much emphasis on self regulation" and the DMA was happy with the authority in Denmark. We should try to get a common position. Sir Charles George (BMA) supported self-regulation, a concept which is being challenged in the UK.

After further discussion it was agreed to recommend to Council that a work group be established. This recommendation was **approved by Council**.

Professional Autonomy

During discussion of a Declaration on Professional Autonomy and Clinical Independence, a number of speakers pointed out related issues which need addressing and agreed that these would not be appropriate for this document. Dr. Blackmer observed that the discussion paper would inevitably lead to a series of papers. It was agreed that "conflict of interest" was not appropriate for this document but needed addressing and the committee recommended that the pro-

posed statement should go to the General Assembly in 2008, a recommendation later **agreed by Council**, together with a request that Dr. Blackmer develop a statement on "conflict of interest".

Common guidelines for physicians and the pharmaceutical industry

Following further discussion in committee, the Council **adopted a recommendation** that this issue **be not pursued** but determined that the working group should develop a proposal indicating how the WMA and the Pharmaceutical Industry should interact.

1998 policy reviews

Continuing its review of 1998 policies Council accepted that **Resolutions on SIrUS and on Health related Violations of Human Rights in Kosovo**, should be **rescinded and archived**.

It was recommended and agreed by Council that the **Ottawa Declaration** should undergo a **major revision**.

Concerning further revision of the *statement on Capital punishment*, it was reported that **further work** would be done by the French and American Medical associations to deal with the need for legal wording to satisfy translation and other problems.

Denunciation of Acts of Torture and Cruel and Degrading Treatment

The committee considered suggested editorial changes to the statement on Denunciation of Acts of Torture and Cruel or Degrading Treatment, following the request of the Copenhagen General Assembly that duplication be removed. After more examination and an assurance that the suggested changes reflected the request of the Assembly, Council **approved the changes**.

Dr. Alan J. Rowe

Human Resources for Health, Kampala

Declaration and Agenda for Global Action

- We, the participants at the first Global Forum on Human Resources for Health in Kampala, 2-7 March 2008, and representing a diverse group of governments, multilateral, bilateral and academic institutions, civil society, the private sector, and health workers' professional associations and unions;
- Recognizing the devastating impact that HIV/AIDS has on health systems and the health workforce, which has compounded the effects of the already heavy global burden of communicable and non-communicable diseases, accidents and injuries and other health problems, and delayed progress in achieving the health-related Millennium Development Goals;
- Recognizing that in addition to the effective health system, there are other determinants to health;
- Acknowledging that the enjoyment of the highest attainable standard of health is one of the fundamental human rights;
- Further recognizing the need for immediate action to resolve the accelerating crisis in the global health workforce, including the global shortage of over 4 million health workers needed to deliver essential health care;
- Aware that we are building on existing commitments made by global and national leaders to address this crisis, and desirous and committed to see immediate and urgent actions taken;

Now call upon:

1. Government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing political momentum to the process.
2. Leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans.
3. Governments to determine the appropriate health workforce skill mix and to institute coordinated policies, including through public private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialized staff.
4. Governments to devise rigorous accreditation systems for health worker education and training, complemented by stringent regulatory frameworks developed in close cooperation with health workers and their professional organizations.
5. Governments, civil society, private sector, and professional organizations to strengthen leadership and management capacity at all levels.
6. Governments to assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workforce.

7. While acknowledging that migration of health workers is a reality and has both positive and negative impact, countries to put appropriate mechanisms in place to shape the health workforce market in favour of retention. The World Health Organization will accelerate negotiations for a code of practice on the international recruitment of health personnel.
8. All countries will work collectively to address current and anticipated global health workforce shortages. Richer countries will give high priority and adequate funding to train and recruit sufficient health personnel from within their own country.
9. Governments to increase their own financing of the health workforce, with international institutions relaxing the macro-economic constraints on their doing so.
10. Multilateral and bilateral development partners to provide dependable, sustained and adequate financial support and immediately to fulfill existing pledges concerning health and development.
11. Countries to create health workforce information systems, to improve research and to develop capacity for data management in order to institutionalize evidence-based decision-making and enhance shared learning.
12. The Global Health Workforce Alliance to monitor the implementation of this Kampala Declaration and Agenda for Global Action and to re-convene this Forum in two years' time to report-and evaluate progress.

Health – a global overview

WHO Director General addresses the 61st World Health Assembly

Dr. Margaret Chan opening her address said "We are meeting at a time of tragedy", expressing her condolences to the millions who had lost loved ones, homes and livelihoods in the cyclone in Myanmar and the earthquake in China. Commenting on the great generosity shown by the international community in

responding to crises of this nature, she stressed the importance of early warning systems and preparations to reduce risks in advance.

Dr. Chan referred to three global crises looming on the horizon, all of which have health effects. The first was Food Security, in which WHO is part of the "high level" task force. In order to guide priority actions, WHO identified 21 "hot spots" around the

world where there are high levels of acute and chronic under-nourishment? The second was Climate Change, on which she elaborated and indicated the draft resolution before the Assembly which defined clear WHO responsibilities. The third global crisis looming is that of Pandemic Influenza, where the threat had by no means receded. "As with climate change all countries will be affected, though in a far more rapid and sweeping way". While these events "could set back progress in reducing poverty and hunger", the Millennium Health related Goals



*From the left WHO Director General
Dr. Margaret Chan*

reaching the world would vastly increase the world's capacity to cope with these international threats.

With better data and statistical methods WHO and UNAIDS had been able to chart the evolution of HIV/AIDS with greater precision. Prevalence had been level since 2001 and deaths from AIDS have significantly declined in the past two years.

Referring to Tuberculosis, Dr. Chan said that poor medical practice, which contributes to the development of drug resistance, has continued to be and is a major concern.

MDRTB has now reached the highest level ever recorded. "To allow this form of TB to become widespread would be a set back, a set-back of epic proportions." There had continued to be solid progress in Malaria control.

Turning to immunisation she referred to the successful Global Immunisation Strategy and also spoke of the broad based impact of Integrated Management of Childhood Illness which was now adopted as the principal child survival strategy in 100 countries. Research coordinated by WHO had also demonstrated that home based treatment of pneumonia in children was as effective as hospital care.

Improving women's health had proved disappointingly slow, notably in reducing maternal mortality.

In her comments on non-communicable diseases Dr. Chan referred to the first ever Global Tobacco Epidemic report launched with the Bloomberg Foundation in February and she emphasized that tobacco taxes were the most powerful tobacco control measures.

It was the aim to control Neglected Tropical Diseases by 2015, and she noted that we were on the brink of eradicating guinea-worm disease. While efforts to control polio in the four remaining countries continue, she was concerned about a new strain emerging in Africa.

Dr. Chan stressed the need to return to Primary Health Care in strengthening health care systems. Primary Health Care would be the subject of the World Health Report and would be published on the 30th anniversary of Alma Ata in mid-October.

Finally, speaking about the 60th year of the foundation of WHO, whose task then was to restore Health Services in a world devastated by war, she said that the landscape of Public Health was now very different. It is now a time of unprecedented global interest and investment in health, as well as an unprecedented challenge. WHO had a clear role in which, amongst the reforms being introduced, the Global Management System would contribute to improving WHO efficiency and transparency in carrying out its role.

An alternative to better global health

Focusing on local communities and players seem to be the better alternative

Vital Report of Global Health Group

For more than a decade, the concept of "global health" has been widely promoted around the world. Generally speaking, the term refers to health problems that transcend national borders and that are best addressed by cooperative and collective actions.

The recent pandemics of HIV/AIDS, SARS, and avian flu, as well as the growing health inequities within and between nations, have increased the visibility and popularity of global health. Further, globalization has accelerated and deepened health interdependence among societies. In 2000, world leaders committed to the Millennium Development Goals, (MDGs) – ambitious development

goals to be achieved by 2015 – which specifically focused on health and seemed to promote global health even further.

However, many argue that global health action is still confined inside the ivory tower of high-ranking health administrators, or within the major international organizations. In other words, many recent global health initiatives have actually followed a top-down process. Increasing numbers of health actors, while trying to prove their effectiveness in the local context, have asked the following questions concerning global health: How do citizens around the world perceive the value of global health? Can global health be integrated into public lives and values, like the stock markets or

oil prices? How can global health be recognized as essential for local health needs?

Local efforts must be taken into consideration in the overall broader scope of global health. Donors have been advised to consider how local communities benefit from global health activities and how local communities can possibly recognize the contributions of these efforts. It seems urgent to re-design the approach to address existing global health challenges. Focusing on local communities and players seem to be the better alternative.

These considerations lead to the rationale of the Initiative for a Vital Report on Global Health (VRGH 2008) launched on April 8th, 2008, in the European Parliament in Brussels. The VRGH is unique in the sense that its goal is to provide an analysis on how people around the world and notably those living in the developing countries perceive

global health. The initiative in collecting and reflecting these perceptions represents a pertinent aim to bring the value of global health to and from the public, and to advise the world health decision-makers in forthcoming actions.

The VRGH has been operated by an interactive process, and an online survey has been launched to lead the opinions of global con-

cerns. This multilingual questionnaire has been offered through the internet (<http://vrgh2008.blogspot.com>).

VRGH has been supported by dozens of global health advisers and actors throughout the world, and a report is expected to be available in December, 2008, to commemorate the 60th anniversary of the Universal Declaration of Human Rights.

The VRGH represents an essential and an important first advanced and more sophisticated step toward harmonizing and strengthening the global health practices that will ultimately benefit the health of all people globally.

Coordinator:

Pr. Peter Chang, MD, MPH, ScD

Co-coordinator:

Vincent Rollet, MIR

The new revision process of the International Classification of Diseases

The international Classification of Diseases (ICD) provides a global standard to organize and classify information about diseases and related health problems. It was developed by the WHO, based on the International List of Causes of Death from 1893 and was printed and published for the first time in 1948.

The actual ICD system provides information for the morbidity and mortality statistics worldwide and is the database for reimbursement systems, hospital records, the general health situation of population groups and shows incidences and prevalence of diseases. The classification is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics.

The 10th edition of the ICD has been in use since 1994 and will now be updated and adapted to additional necessities and an increased IT usage.

WHO reported that the revision process for ICD 10 is not only an update but will also include new information, combines different national and international classifications, offers different formats for users and is will be globally accessible for comments through the internet. The following summarizes the WHO planning for ICD 11.

The structure of ICD 11

ICD 11 will have a three level approach to offer the right information for various users. The first level is for the primary care setting, where the focus is on most frequent conditions in primary care with broader categories. The second level is for clinical care, which includes more details. The last level is for research with standardized detailed criteria and tentative disease labels that are not yet in official classifications.

The information on disease in ICD 11 will be extended and in comparison to the ICD 10 version where only the disease, the epidemiology, physiology and pathology is included, now interventions and treatment guidelines will be incorporated as well.

The new ICD 11 version will contain all different international and national classifications (for example WONCA, ICD, ICFD, ICHI) and therefore be the mainly used classification.

To capture all this information and make the use easier, the ICD 11 version will be placed in a Health Information System and benefit from new IT technology. Through the online storage of the data, linkages to health information bases such as population registry, insurance systems, and health services, can be developed and the direct use of information for i.e. clinicians, administration and health reporting departments

including the electronic health record will be possible.

The process of the revision

The tentative timeline is that in 2010 an Alpha version of ICD 11 will be prepared. That means a draft version will be written. By 2011 the Beta version including field trials will be ready and in 2013 the final version for public viewing will be available. At the WHA in 2014 the ICD 11 will get approval and will be implemented by 2015.

For the previous revision process for ICD 10 comments could be handed in only in the annual meetings, which gave an advantage to the richer countries. In order to have an equal balance in receiving comments an ICD revision platform (Hi-Ki) via the Internet is implemented to collect comments. Now everyone is allowed to send comments and the more comments someone hands in the more relevance their comments will get in future. However the governing body consisting of the Top Advisory Group, the Revision Steering Group and the WHO-FIC committee will finally revise all comments.

The governing body at WHO

A Revision Steering Group will serve as the planning and steering authority in the update and revision process and focus on reviewing the scope of health care diseases and ensuring that they are consistent with the overall structure. They identify users of the classification and address their needs and define basic taxonomic and ontological principals.

The Topic Advisory Groups (TAG) will serve as the planning and coordinating advisory body for specific issues, which are key topics in the update and revision process, namely Oncology, Mental Health, External Causes of Injury, Communicable Diseases, Non-communicable Diseases, Rare Diseases

and others to be established. Each TAG will determine the number and content areas of the workgroups, identify the members and chairs of the workgroups, present an initial mandate to each workgroup and establish procedures for the activities of the workgroups. They will also give advice in

developing protocols for and in implementing field trials.

Further information can be found on the internet page: <http://www.who.int/classifications/icd/en>

Dr. Julia Seyer

DoH Revision meeting in São Paulo

The Brazilian Medical Association (AMB) was honored to host the Work Group from World Medical Association (WMA), which discussed the Review of Declaration of Helsinki, on August 20th and 21st. The meeting was held in São Paulo, one of the largest cities of Brazil.

On August 19th and on the morning of 20th, before the WMA's Work Group meeting, AMB organized a debating forum and invited renowned Brazilian researchers to debate the placebo and post-trial access to treatment. The event raised different points of view.

Comments given on the first day of the event served the basis for suggestions made to Eva Bagenholm, President of WMA's Ethics Committee, and Otmar Kloiber, General Secretary, who kindly accepted AMB's invitation to discuss with the forum participants. It was a very productive moment, because Brazilian participants could express their thoughts about the Declaration.

On 20th during the afternoon, the Work Group, composed of Brazilian, South African, German, Japanese and Swedish representants, got together to debate changes that eventually will be presented in Seoul. There were also representants of Medical Associations from Uruguay, Canada and Portugal, as well a member of International Federation of Pharmaceutical Manufacturers & Associations.

John Williams, Ethics director explained to participants when previous Declaration reviews, occurred each review's purpose and the need of adding notes of clarification.

Next, he described how the process of review would be conducted: there will be no changes in the structure, just on the scope and terminology; review of controversial issues of paragraphs 29 and 30, besides enclosing notes of clarification. At that point came, up a question whether the document should be only destined to physicians or to all people that do research. After justified arguments, it was decided that the Declaration should be destined initially to physicians, but other participants in medical research involving human beings should be encouraged to follow the same principles.

Another aspect discussed was the use of "should" or "must". It was explained that translations are complicated because not all languages have this differentiation. To some people, must has a legal value and the Declaration of Helsinki is just a guide and not a document with legal validity.

The discussion gained more rhythm and participation when was announced that changes would be discussed in the previous paragraph 29 (version of 2004 of Declaration) and current paragraph 32 (last version of draft), which embodied one note of clarification. On that moment, all participants gave their opinion and the placebo issue took all afternoon.

Some people defended that the, use of placebo should not happen when there is effective treatment, because in face of an innocuous substance, any new medicine would be valid. All participants agreed that the use of placebo must be extremely controlled and

limited to circumstances in which there are no other effective method.

The importance of placebo in certain kinds of therapeutics and this decision must be solely based on ethical principles was also pointed out.

The first part of the morning of 21st was opened with discussions about paragraph 30, which in the latest review will be the 14th and will include the second note of clarification. Among the arguments brought up about the writing of this paragraph are: until when should treatment be guaranteed? Is the right endless? How to deal if the drug is not approved in the country? The remaining question was how to include the guarantee of post-trial access to treatment in the current version of the Declaration of Helsinki. In this case, they all agreed that arrangements must be detailed in the protocol.

After a small break, discussion was resumed with announcement of other proposal changes. One of them was the possibility of including in the Declaration a note of clarification about children research. Changes done on the paragraph 5 met part of this need. Besides that, information might be included in the Declaration of Ottawa, which regulates rights of children to health care, that refers to ethical principles of Declaration of Helsinki.

After conclusion, representatives of the Work Group, Eva Bagenholm, John Williams and Otmar Kloiber came together during a private lunch to consolidate the last issues about the Declaration of Helsinki.

*Paula Mobaid,
AMB, International Relations*

Co-operation of WMA and the Stop TB partnership – Private-Public-Mix in the fight against TB



Dr. Julia Seyer

To achieve the Millennium Development Goals and established targets for 2015, the Stop TB Strategy was expanded in 2006 to address the pressing challenges posed by HIV/AIDS co-infection, TB drug resistance and limited access to adequate care. One of the strategy's chief components is to engage health care providers from all public and private sectors, as well as to strengthen health systems, recognizing that in many high-burdened countries, ill patients often seek care outside the National TB Programs (NTP). The DOTS Expansion Working Group (DEWG), established under the STOP TB Partnership, has moved to promote the expansion of quality DOTS among all relevant public and private health care providers in TB control through the Public-Private Mix (PPM) initiative.

The PPM approach starts with a National Situation Assessment where all relevant public and private health care providers are identified and their roles analyzed in order to define where PPM should be implemented and what the requirements are for this. The National TB programs will have the responsibility of funding, regulation and monitoring TB care and control. The actual

TB care and treatment is provided by local NTP facilities or private and public hospitals, clinics, specialists, GPs. They are called non-NTP providers.

The 5th Private-Public-Mix (PPM) subgroup meeting in Cairo

The fifth meeting was hosted by the WHO regional office of the Eastern Mediterranean (EMRO) and concentrated on mechanisms and tools to build capacities of institutions supporting and/or undertaking TB care provision such as national professional organizations, large hospitals, and corporate sector health establishments.

The conference started with an overview of the global and regional progress on PPM from the implementation in 2002 until now. To date, over 40 PPM projects have been implemented in 14 countries, of which 25 have been evaluated with regards to progress and outcomes. The detection rate of TB under PPM increased from 10 % to 60 % and the treatment success rate is between 75 % and 90 %. However these figures are misleading in this context. Much data is still missing and only a small proportion of all TB patients are receiving the PPM DOTS services.

Project managers from NTP national level reported that they are overwhelmed with their workload. They have too many different kinds of responsibilities and need a stricter role definition. They should focus mainly on organisation and less on technical assistance. Other stakeholders like professional associations or care providers should be included and could offer the latter as well.

The PPM subgroup meeting identified mechanisms and tools to engage institutions, especially national professional orga-

nizations, large hospitals and the corporate sector, and patients and communities in TB care and control.

The group "Mobilizing professional associations and promoting ISTC (International Standard of TB Care)" developed key recommendations for PPM subgroup and NTPs on how to engage professional associations on a global and national level. Professional associations are seen as a very important partner in developing and implementing the PPM strategy and communication and cooperation needs to be increased. They should take part in the national situation assessment, development of regular outcome reports, delivery of TB treatment and their facilities should be certified by the government. Ways to foster the communication with professional associations are through TB training, CME, articles in medical journals, TB campaigns and more. The main focus is at the moment on the medical professional associations because physicians are the main persons offering TB treatment. It is the expectation that PPM through professional associations can reach out to public and private working physicians. However in future other professionals like nurses or hospital managers will be included as well.

During the UNION conference from 15-18th October the next PPM subgroup meeting will take place and the PPM strategy will be announced to the DOTS expansion working group. All participants and especially the WHO welcomed the WMA attending the meeting in Cairo. Without the participation of the physicians the PPM strategy won't be possible.

Information material available:

- Guidance on implementing PPM- engaging all health care providers in TB control
- Toolkit for National situation assessment
- General guidelines and practical tools for implementing hospital DOTS linkage
- Handbook for using the ISTC
- Report from the inter-regional planning workshop on PPM

Lilly Commits \$1MM to World Medical Association to support Innovative Tuberculosis training course

Geneva, 14 May 2008 – Eli Lilly and Company announced the scaling-up of an existing partnership with the World Medical Association (WMA) by providing a grant of \$998,773 to expand training courses for physicians on multi-drug resistant tuberculosis (MDR-TB). Tuberculosis (TB) is a preventable disease that kills close to two million people every year and infects an estimated nine million more. Of these, nearly 500,000 have multidrug-resistant TB.

The purpose of this online training is to help physicians, both in the public and private sector, to use the latest international guidelines and treatment protocols for MDR-TB care in their daily work. This will allow more physicians around the world to acquire the basic knowledge on standard TB management at a time when there is a resurgence of the epidemic. A new toolkit will also be developed for physicians on how to manage TB in the workplace. This will be produced with the World Economic Forum for use in China and South Africa.

The announcement of the new four-year joint partnership agreement was marked in Geneva today by a signing ceremony between Jacques Tapiero, president of Lilly's intercontinental operations and WMA president Dr. Jon Snaedal. Lilly's key partners including the World Health Organization (WHO), the Stop TB Partnership, the International Council of Nurses, the World Economic Forum and alongside Geneva-based diplomats and foreign dignitaries, were invited to the ceremony.

Dr. Snaedal said: "We shall now be making the course more interactive with more case studies and a progressive learning pattern. A TB refresher course was important to get physicians back on track regarding the basic knowledge of standard TB."

Jacques Tapiero added: "We applaud WMA's commitment to developing innovative approaches to stemming the MDR-TB global burden. Given adequate health-care infrastructure and adherence to proper medication regimens, MDR-TB is not only treatable, but indeed curable. This online training course was an important addition to the already existing tools and activities of a larger partnership of 16 public and private organizations worldwide dedicated to fighting MDR-TB."

With underwriting from Lilly, the WMA over the past year has already developed an online training course for physicians to more effectively diagnose, prevent and treat multi-drug resistant tuberculosis. Clinical guidelines were developed and harmonized with evidence-based material sourced from the WHO, the International Council of Nurses and the International Hospital Federation. The course was tested among physicians in South Africa. The Norwegian Medical Association has adapted the material to a web-based format and will be providing CME credits to those following the course. The German Medical Association assisted in providing managerial support in the conception of the project.

The online course will be expanded to develop a TB refresher course and a training course on MDR-TB training. Training champions in MDR-TB treatment will be created in South Africa, India and China.

The course, already available in English, is being translated into Spanish, French, Chinese and Russian and will be published in handbook and CD form in addition to the online format. MDR-TB is a serious public health threat in many parts of the world, notably in Sub-Saharan Africa, Central and

Eastern Europe, mainland China, Southeast Asia and in Central and South America.

The recent identification of extremely virulent TB and the increasing number of MDR-TB cases show that the knowledge and handling of TB treatment is still insufficient. With concrete evidence that incomplete TB treatment is responsible for the occurrence of extremely drug resistant TB, an ethics policy is being planned to look at whether and how patients can be encouraged to complete their treatment regimen and where the autonomy of a patient ends in order to safeguard public health.

The World Medical Association is the independent confederation of national medical associations from more than 80 countries and represents more than eight million physicians. Acting on behalf of patients and physicians, the WMA endeavours to achieve the highest possible standards of medical care, ethics, education and health-related human rights for all people. www.wma.net

The Lilly MDR-TB Partnership was created to confront multidrug-resistant tuberculosis, a disease so daunting that no single organization can fight it alone. Since 2003, the public-private initiative, mobilizing 16 partners on five continents, has worked together to share expertise in the quest to contain and conquer one of the world's oldest diseases. The Partnership's multi-pronged approach includes: community support and patient advocacy; treatment, training and surveillance; transferring technology; research; and awareness and prevention. Additional information about The Lilly MDR-TB Partnership is available at www.lillymdr-tb.com

Contact:

*Nigel Duncan. WMA Public Relations Consultant. nduncan@ndcommunications.co.uk
JJ Divino. Communications Manager, International Aid Unit, Eli Lilly and Company. divinojj@lilly.com*

What Physicians are *REALLY* Thinking



Bob Miglani
Senior Director, External Medical Affairs International, Department of the Chief Medical Officer, Pfizer Inc.

It doesn't take a doctor to diagnose that the healthcare systems of the world are in very bad shape. Factors such as the ageing population and increasing prevalence of lifestyle-related conditions like obesity are placing untenable pressure on traditional models of healthcare provision. But while many healthcare "experts" seek solutions and propose reforms, those at the delivery end of healthcare, namely physicians, are often overlooked and excluded from health policy decision-making.

The result is that physicians around the world are working within health systems imposed upon them, usually without any consultation let alone involvement. Designed with time and money rather than patient care in mind, these systems restrict and confine doctors making it increasingly difficult for them to practice medicine as they wish. Growing frustration is leading many healthcare professionals to take direct action as they seek to influence healthcare reform and policy direction for the future.

Throughout 2006 and 2007 German physicians from across the country held various protests to demonstrate against new restrictive contracts being imposed on them by the government and which they felt would greatly reduce their effectiveness. In March last year UK junior doctors marched in protest against a new training system which made it impossible for them to apply for the posts they wanted. In September of 2007 Spanish doctors undertook strikes to ask for more time with each patient (to a total of just 10 minutes) and this summer, in the US physicians and nurses have also made their voices heard in major cities to advocate for universal healthcare.

While the exact catalyst for these protests may vary, they all share a common theme: a desire to be allowed to exercise their vocation as they wish. To be allowed to do what they do best: be doctors.

Whether they practice in Barcelona or Beijing, Montreal or Munich, physicians want to spend their time treating patients to the best of their ability, not filling out forms, wrestling with financial targets or poring over guidelines to determine which treatment approaches they are permitted to take for their patient.

As part of its Medical Partnerships Initiative, Pfizer has been tracking the attitudes and opinions of health professionals over the past few years. A series of surveys investigating how physicians feel about their role in healthcare, developments in the quality of care and the future of their profession, has been conducted in Asia, Europe and the Americas. The findings making salutary reading not only for physicians but for all those involved in healthcare delivery, and highlight just how widely shared the concerns and issues discussed above, are across the globe.

The most recent of these surveys was carried out earlier this year among primary care physicians and specialists in 13 countries around the world. Research company APCO Insight interviewed 1,741 doctors in Asia, Europe and North America and found some interesting trends and variations from region-to-region.

Medicine Moving in a Negative Direction

While across most of the globe, doctors remain moderately satisfied with their own personal experience of practicing medicine (out of 10 Asia 7.25, Europe 6.32 and North America 6.94), when it comes to the bigger picture and the practice of medicine overall, European and North American doctors are generally negative. Over half of European doctors (51 percent) consider that the practice of medicine is going in a negative direction and in North America this figure was 39 percent.

The data from Asia was less homogenous with a clear split between Chinese and Indian doctors and those from Japan and Korea, with Australian physicians somewhat in the middle. Japanese and Korean doctors (79 percent and 87 percent respectively) agreed with European and North American physicians that medicine is going in a negative direction. However, Chinese and Indian doctors (78 percent and 77 percent respectively) felt medicine was going in a positive direction. Australian physicians were less definitive with 50 percent positive and 30 percent negative.

The most frequently cited reasons for the belief that the practice of medicine is going in a negative direction were "government mismanagement of healthcare systems" in Asia (32 percent), "non-medical entities interfering in medical decisions" in Europe (36 percent) and "business aspects of medicine" in North America (42 percent).

Top 5 Unprompted Reasons Practice of Medicine Going a Negative Direction							
Reason	Global Total	Asia Total	Asia High	Europe Total	Europe High	N America Total	NA High
Doctor patient relationship deteriorating	28%	31%	50% <i>China</i>	25%	36% <i>France</i>	26%	27% <i>Canada</i>
General aspects of profession	25%	28%	55% <i>China</i>	24%	27% <i>Germany</i>	20%	26% <i>Canada</i>
Business aspects of medicine	25%	19%	69% <i>Korea</i>	28%	40% <i>Germany</i>	42%	45% <i>US</i>
Government mismanagement of healthcare systems	22%	32%	70% <i>Korea</i>	8%	16% <i>Belgium</i>	13%	15% <i>US</i>
Non-medical entities interfering in medical decisions	21%	8%	23% <i>Australia</i>	36%	46% <i>Germany</i>	39%	44% <i>US</i>

Is the Doctor-Patient Relationship on the Critical List?

As can be seen above, at the top of the list was the deterioration of the relationship between doctor and patient. When asked about the factors which have changed the doctor-patient relationship, the majority of doctors believe this has been affected by patients:

- expecting to spend more time with their doctors (Asia 96 percent, Europe 72 percent and North America 64 percent)
- being increasingly concerned about being able to pay for their care (Asia 93 percent, Europe 62 percent and North America 81 percent) and,
- specific treatment expectations (Asia 84 percent, Europe 85 percent and North America 92 percent), presumably which the physician cannot always meet.

Other factors which physicians believe adversely impact their relationships with their patients include patients being concerned that they are not offered the best choices for quality care and increasing skepticism around physicians' authority. In fact, the survey found that between 47 percent (Asia and North America) and 63 percent of physicians said that government-led clinical assessments had limited the treatment they could choose on behalf of patients.

From this analysis of the doctor-patient relationship, it is clear that patients are suffering from the adverse effects of many of the unwelcome changes in healthcare that have negatively affected physicians. Primarily, this might best be summarized as a loss of autonomy or outside interference in medical practice. As highlighted above, this is borne out by the fact that "government

mismanagement of healthcare systems" and "non-medical entities interfering in medical decisions" were among the most frequently cited reasons for the perception that medicine is moving in a negative direction. This is further reinforced by other results of the survey below.

Time is of the Essence

So reducing the amount of interference in clinical practice might be one way of improving the ailing doctor-patient relationship. The survey results also highlighted possible prescription for success: doctors spending more time with their patients. In Europe and North America, half of the doctors surveyed (53 percent and 51 percent, respectively) say the average time spent with patients has decreased since they began practicing medicine. While in Asia the majority (41 percent) believe time spent with patients has remained the same.

This finding was reinforced by another question posed in the survey: "what would you change to improve the quality of patient visits". The most frequently quoted response was "increase time with patients" with 51 percent of North American and 49 percent of European respondents giving this answer. In Asia, 30 percent suggested this, second only to increased medical facilities.

Time also came to the fore when European physicians were asked to rank the significance of various factors in relation to their job satisfaction. "Having enough time with each patient to provide care in the way I would choose" was the most significant issue in Europe with the top score of 8.05 out of ten.

But when it comes to spending time with patients, it is not just doctors' desires that are an issue here: the vast majority of doctors worldwide (93 percent) agree that spending more time with each patient would contribute to better health outcomes for those patients, a view shared equally among Generalists and Specialists.

Percentage who "strongly agree" or "somewhat agree" with statement							
Statement	Global Total	Asia Total	Asia High	Europe Total	Europe High	N America Total	NA High
Physicians have lost control of medical care decisions to other people	46%	38%	81% <i>Korea</i>	67%	87% <i>Portugal</i>	82%	85% <i>US</i>
Reducing government involvement in healthcare would be better for everyone	68%	66%	89% <i>Korea</i>	72%	85% <i>Germany</i>	70%	73% <i>US</i>

For each of the following problems please tell me how significant the problem is to your job satisfaction. Please use a 10 point scale, where a 1 means completely insignificant and a 10 means extremely significant problem affecting job satisfaction

Statement	Global Total	Asia Total	Asia High	Europe Total	Europe High	N America Total	NA High
Protecting my medical practice from threat of lawsuits or civil actions	8.3	8.58	8.93 China	7.27	7.84 Portugal	7.78	7.89 US

While it could be argued that there is little that can be done about the increasing number of patients who seek their doctors' time, there is surely a better way to allocate doctors existing and increasingly precious time. The survey found that 51 percent of European doctors who said that they were spending less time with patients said that this was because of "administrative bureaucratic requirements".

There is perhaps a correlation here with another question, when European physicians were asked "which experience in the practice of medicine today is the most unsatisfying to you?", the most frequently cited response by some margin was "administrative tasks" (30 percent). Perhaps European doctors would be happier if they could switch their focus back to treating their patients rather than filling in forms. It is therefore not surprising that, another business-related aspect of medicine was a cause of dissatisfaction:

Few physicians take up the profession to become more familiar with accounting procedures and indeed, money matters leave most physicians distinctly deflated. When asked to state the most unsatisfying experiences in their practice, globally, 17 percent cited "rationing care/cost containment", 14 percent "compensation" and 13 percent "payer issues".

Seeking Solutions and Support

Over the past five years as our research has tracked the belief among physicians around the world that they are no longer masters of their own destiny, we have seen a cor-

responding rise in what is termed, physician-activism. A variety of movements and organizations have emerged in countries around the world, created by and for physicians as they aim to take their place at the health policy table. This wave of activism is reflected in the survey, with 90 percent of physicians worldwide agreeing that improving healthcare will require public leadership from physicians. This view was shared across all three regions: strongest in North America (96 percent), then Europe (90 percent) and Asia (89 percent).

Physicians in all regions, generalists and specialists, strongly agree that they should speak out about the problems facing the practice of medicine. Again, agreement was strongest in North America at a staggering

98 percent, but Europe at 90 percent and Asia with 86 percent were not far behind.

An obvious place for physicians to turn when seeking to have their voices heard would seem to be the professional organizations and medical societies which exist to support the profession. Yet membership and enthusiasm levels in our survey appeared low when questions were asked about these groups. Globally only 43 percent said they were members of any professional organization or advocacy group that advances the interests of physicians. When questioned about how effective such bodies are, 82 percent responded either "somewhat effective" or "somewhat ineffective".

When asked about a group which would specifically advocate on behalf of physicians, enthusiasm was more evident. Three quarters of physicians around the world professed that they would join an advocacy organization which aimed to educate the public about the importance of the role of physicians to public health and to also influence government policies affecting the practice of medicine. This hunger for support continued when given some suggested ways in which they might advance their case:

Percentage who "strongly support" and "somewhat support" the following ideas that have been suggested to support physicians							
Statement	Global Total	Asia Total	Asia High	Europe Total	Europe High	N America Total	NA High
Participate in training programs to help physicians become better advocates for reform of healthcare policies	89%	92%	98% India	79%	99% UK	93%	94% US
Cooperate with third-parties to publicize the important role of physicians in society	84%	84%	86% China, India and Australia	83%	87% Belgium	90%	91% US
Form a coalition between healthcare professionals and private companies to defend physicians' right to make independent medical decisions	79%	81%	94% India	71%	73% France and Germany	86%	90% US

A Glimmer of Hope

In summary, then, this latest round in Pfizer's continuing investigations into the issues affecting the medical profession, has painted a gloomy picture for some countries. On a macro level, physicians in Europe and North America are generally negative about the direction of medicine, as are those in Japan and Korea. This negativity is largely attributed to interference in medical practice by non-medical entities such as governments and insurance companies. Physicians in China and India are very satisfied with the direction of medicine and believe their respective medical societies are serving their needs effectively and that they are still in control of medical care.

Taking a closer look at Asia, Indian doctors tend to be more positive about the practice of medicine, perhaps partly because they report little interference in their medical decisions from third-parties. At the other extreme, Korean doctors are negative about the direction of medicine generally: third-party payer issues dominate their dissatisfaction and prevent them from providing care according to their medical judgment. Japanese doctors express similarly high levels of dissatisfaction with the practice of medicine; however attribute less blame to third-party payers than the Koreans. Australian and Chinese doctors are more moderate, even variable in their attitudes.

Across the EU, doctors suffer from similar challenges regarding too little time with patients (which leads to negative health outcomes) and too much time with administrative burdens (which also leads to negative health outcomes), causing a decline in the quality of the doctor-patient relationship. Consensus also emerges in Europe that healthcare system changes will require the public leadership of physicians and they are supportive of various potential programs to help them advocate.

US doctors are subject to high levels of third-party interference, suffer burdens of managing private practice and, therefore,

spend more time than they want with administrative burdens. Canadian doctors suffer less from these particular ills though both countries suffer from similar challenges regarding time management. They are similarly experiencing changes to the doctor-patient relationships and agree that healthcare system changes will require their public leadership.

Taking a worldwide view, perhaps one of the most disturbing findings for the profession is that the long-cherished doctor-patient relationship is under severe threat as patients become frustrated by the time they get to spend with their physician and failure to meet their expectations around treatment.

Another point of agreement and indeed, hope among doctors across the globe is that in order to change today's healthcare systems and move them away from their focus on cost rather than patient care, they are going to have to take a lead themselves. Physicians need to speak up and make the broader public aware of the threat facing medicine. Only by taking a strong leadership position does the profession see any hope of change.

So, though it may not take a doctor to diagnose the problem with healthcare today, it is certainly going to need doctors to develop, administer and manage the necessary treatment. Today the profession is faced not so much with a case of "physician heal thyself" as "physician, heal healthcare".

About the Survey Methodology

Pfizer Inc. External Medical Affairs, International, commissioned APCO Insight, a global opinion research firm, to conduct a scientific probability survey with physicians in North America, Europe and Asia concerning their attitudes toward the practice of medicine. Interviews were conducted among 1,741 general practice and specialist physicians in the United States (n=248), Canada (n=95), Germany (n=138), France (n=127), the UK (n=125), Belgium (n=126), Portugal

(n=127), the Netherlands (n=125), China (n=125), India (n=130), Korea (n=125) Japan (n=125) and Australia (n=125). Interviews were conducted between December 15, 2007 and March 1, 2008 utilizing a variety of data collection methodologies tailored for each country, including mail (US and Canada), telephone (Germany, France, UK, Belgium, Portugal, Netherlands, Japan and Australia) and in-person (China, India and Korea). Sample frames were selected in each country to provide maximum coverage of practicing physicians and included professional association member and non-member lists, licensing registries, public directories and health organization databases. The margin of sampling error for the global sample is $\pm 2.3\%$; sampling margin of error at regional and country levels are higher depending on sample size. The sample was stratified among the 13 countries, and within each country, stratified by medical specialty (general practice and specialists). The final dataset was post-weighted to be representative of the actual distribution of practicing physicians across the countries and specialties.

*Bob Miglani,
Senior Director, External Medical Affairs
International, Department of the Chief
Medical Officer, Pfizer Inc.*

Smoking: A disease that starts in the brain and goes to the whole body



*Dr. Analice Gigliotti
President of Brazilian Association on Studies
of Alcohol and Drugs (ABEAD)*

Smoking is currently the leading preventable cause of death in the world. If nothing is done, by the end of the century this addiction will have killed one billion people, anticipating the death of half the smokers, who lose from 8 to 22 years of life. According to the World Health Organization, four million people die every year due to diseases caused directly by tobacco derivatives. It is estimated that 100 million individuals died in the 20th century due to nicotine dependence and, if the present trend prevails, this number will be 10 times higher, reaching one billion deaths in the 21st century. Many of these deaths are potentially preventable if tobacco users quit smoking.

Despite all the mortality and morbidity caused by tobacco, its global consumption keeps growing. The propagated decrease of consumption of this product takes place only in some industrialized countries. Among the less favoured ethnic minorities, tobacco consumption continues to be an extremely common problem. China, for instance, is responsible for great part of the

increase of *per capita* cigarette consumption in the world. Following the decrease of tobacco consumption in developed countries, the tobacco industry increased their sales in developing countries. In the next decades, 70% of the deaths caused by tobacco will occur in the Third World, where the problems associated to tobacco consumption will share the scenario with basic health problems such as malnutrition and lack of sanitation.

Most people are unaware of the damage caused by smoking. About 30% of all cancer cases and at least 85% of lung cancers are caused by tobacco. Oral cavity, faring, larynx, stomach and esophagus cancers are also closely associated to tobacco consumption. Even the organs not directed associated to the habit of cigarette smoking – such as bladder, kidney and pancreas – are more affected by cancer among smokers than in non-smokers.

Other fatal diseases such as Chronic Obstructive Pulmonary Disease (COPD), peripheral arteriopathies, aortal aneurism and myocardial infarct are also associated to smoking. Even less lethal diseases such as respiratory infections, stomach and duodenal ulcers, osteoporosis and dental problems are associated to tobacco. Smoking is the leading cause of coronary disease among women.

Tobacco also affects the development of pregnancy in smoking pregnant women. Consequently, the loss of the fetus is more frequent in all phases of pregnancy, with a probability 70% higher of miscarriage. The risk of prematurity increases 40% and the children of smoking mothers are born with approximately 200 grams less than children of non-smokers. They are also particularly more likely to present sudden infant death and other peri and neonatal diseases. Even more alarming data shows that non-smok-

ing pregnant women, exposed to environmental tobacco pollution can also give birth to babies with low weight. The concentration of seric cotinine (a metabolite of nicotine) is higher in non-smoking pregnant women who live with smokers.

Environmental exposition to the smoke of cigarettes is also harmful, being the third leading cause of preventable death in the world, second to active tobaccoism and excessive alcohol intake. The main symptoms non-smokers exposed to environmental tobacco pollution (EPS) complain are cough, headaches and sore eyes. They also have an exacerbation of rhinitis, sinusitis and asthmatic bronchitis, besides showing a higher probability of developing lung cancer. The U.S Environmental Protection Agency designated classified EPS as carcinogen Class A, that is, showing enough evidence of cause between exposition and cancer in human beings. The risk of lung cancer in non-smokers exposed to cigarette smoke is 30% higher than in non-smokers who are not exposed to ETS. Cardiovascular diseases are also higher in passive smokers. The risk of coronary disease in non-smokers exposed to ETS is 24% higher than in non-smokers who are not exposed to it.

Children of smokers are more easily subject to develop respiratory infections and present worse allergic features than children who live with non-smokers.

In the last decades, due to the development of public awareness of the damages of tobacco and to anti-smoking governmental campaigns, a progressive decreasing prevalence of smokers can be noticed, especially in some developed countries, such as the United States, where the number of smokers stabilized in 25% of the population in 1993, decreasing to only 20.5% in 2007, due to public health policies in the country.

However, further reducing these rates is becoming a hard task. Although in the last years a decrease in the number of adult smoking women in the United States can be noticed, more young girls are starting to

smoke, a phenomenon that is also happening in a great number of countries around the world, as in Brazil, for instance. Nicotine dependence prevalence in the United States fell from 42% in 1965 to 25% in 1982, nevertheless since then these numbers change with great difficulty. This occurs because of the addictive properties of nicotine that result in only 2.5% of smokers abstaining from the drug each year.

The scientific community made widely known the addictive characteristics of nicotine publishing, in 1988, an important report with the following conclusions:

- Cigarette and other tobacco forms cause dependence.
- The cause of dependence in tobacco is nicotine.
- The pharmacological and behavioural processes that determine the tobacco addiction are similar to those which determine the addiction to other drugs such as heroin and cocaine.

Each cigarette contains approximately 8 mg of nicotine, from which 1 mg is rapidly absorbed by the lungs. In 10 seconds the smoker feels the “good” effects of the drug, such as better attention and concentration, the diminishing of appetite, the increase of the alert state, the reduction of anxiety and depressive mood improvement.

With the suspension of smoking, the symptoms of the abstention syndrome reach their peak in two or three days. At the end of the first week they decrease, normally disappearing in 2 to 4 weeks. Residual symptoms can persist for even 6 months in some cases, mainly the symptom of augmented appetite.

The proof that nicotine is a drug that can lead to addiction is the fact that cigarettes from which nicotine is taken artificially is often abandoned by smokers, who change to the normal ones. In fact, smokers are used to regulate the concentration of nicotine in their body, with the objective of keeping it in the limits that satisfy their needs. Even when they change their habitual brand to

another one with lower nicotine content, tobacco users usually try to compensate it - increasing the number, depth and length of drags, for instance - trying to compensate the changes made and keep the concentration of nicotine constant.

The direct action of nicotine on nicotinic-cholinergic receptors is distributed all over the brain. Although its direct action is exclusively in these receptors, the final result is frequently a complex pattern of the indirect effects in other transmission systems, such as dopaminergic, adrenergic, serotonergic and glutamatergic.

The neurons of the ventral tegmental area, where the nicotine bonds, are projected to the nucleus *acumbens*, where they release dopamine in large amounts, substance that is associated to the gratifying sensation addicts feel. The bigger and faster the liberation of dopamine in this nucleus, the higher the pleasure users get.

Nicotine has a double effect in the central nervous system: initially it stimulates the nicotinic receptor - agonist effect - and then it blocks it - antagonist effect. To adapt to the disorganisational effects of the drug, the brain tries to surmount the blocking effects of nicotine, through an increase in the number of nicotinic receptors. On the other hand, part of the abstinence symptoms is mediated by desensitization in the noradrenergic neurons of the *coeruleus locus*.

Many smokers use tobacco according to a classic cyclic model of drug addiction, in which they search for the beneficial effects of nicotine, but what keeps the individual smoking is the relief of the abstinence symptoms. However, it is not only the nicotine which determines the persistence in its use. As with any other drug, the desire of consumption can be triggered by environmental stimuli independent from organic need. That is the reason why the individual can have a “craving” for smoking, even years after the abstinence syndrome is over, when they have any contact with “triggering situ-

ations”, such as drinking and seeing someone smoking, for example.

There is a projection for the first half of the XXI century of 500 million premature deaths, 1/3 being preventable should the adult individuals stop smoking. This means that a public health approach aiming to stop the use of cigarettes is a fundamental element in governmental policies in the control of smoking. Other actions recommended by the World Health Organization include preventing children from becoming tobacco addicts, protecting non-smokers from the involuntary exposition to cigarette smoke; eliminating all publicity, direct or indirect, of tobacco products, and controlling tobacco products, including warnings in tobacco products and in any publicity eventually residual, among others.

Although the measures of primary prevention are fundamental, it is a mistake to think that the treatment of addicts is a minor issue. On the contrary, approaching smokers is among the best cost/benefit relations in medical interventions.

Thus, to deal with such lethal pandemic, one must use a combination of preventive measures to prevent children from smoking and treatment measures in order to motivate and support smokers to quit. Cessation support has also an effect on prevention, since it turns smoking a less frequent and less socially accepted behaviour.

Nicotine dependence is a chronically relapsing disorder of the brain. In fact, although smokers know smoking is harmful for their health and most of them would like to quit, only a few really try, and even fewer succeed. Without treatment, only 3 % of the smokers are able to achieve six months of abstinence. With pharmacological and psychotherapeutic treatment, abstinence rates raise up to 25-30% up to 6 months of abstinence. To stop smoking is much more complicated than deciding to stop eating avocado. Smokers need to be motivated to quit, and treatment should be widely provided.

In order to increase the availability of cessation support, educational measures must be taken, such as:

- the elaboration of guidelines,
- inclusion of diagnosis and treatment of tobacco dependence in health professionals curricula,
- provision of counselling services on cessation of tobacco use in national programmes,
- offering training programs to all kinds of health professionals.

Evidence based treatments should be offered and tailored to individual preferences and needs. They can be divided in wide reaching treatments (with low efficacy and low cost) and face to face treatments (high efficacy and high cost).

1) Wide reaching treatments:

- Telephone help-lines (the proactive ones and a bigger probability of efficacy),
- SMS messages,
- Web based treatments.

2) Face to face treatments:

- Brief advice (up to 3 min),
- Basic advice (up to 10 min),
- Intensive support (once a week or more).

In general, there is a dose-response rate, in which the higher the dose (the frequency and time during consultations) the higher the abstinence rates reached.

In conclusion, those evidence based treatment and preventive measures must be used to decrease the prevalence of smoking. If

this alert is not heard and the policies here suggested are not implemented around the world, we will face the unnecessary death of hundreds of million people in the near future.

References

1. American Thoracic Society. Cigarette smoking and health. *Am J Respir Crit Care Med* 1996;153:861-5.
2. Jha P, Chaloupka FJ. Tobacco control in developing countries. Oxford University Press on Behalf of World Bank and World Health Organization; 2000.
3. Mackay J, Eriksen M. Tobacco Atlas. WHO; 2002.
4. Peto R, Lopez AD, Boreham J, Thun M, Heath C. Mortality from smoking in developed countries (1950-2000). Indirect estimates from national vital statistics. New York: Oxford University Press; 1994.
5. Proctor N. Tobacco and the global lung cancer epidemic. *Nat Rev Cancer* 2001;1(1):82-6.
6. Raw M, Anderson P, Dubois G, Hasler J, et al. WHO evidence based recommendations on the treatment of tobacco dependence. *Tobacco Control* 2002; 11: 44-46.
7. WHO Report on the Global Tobacco Epidemic, 2008 The MPOWER package. Geneva, World Health Organization, 2008.
8. United States. Morbidity and Mortality Weekly Report (MMWR). Cigarette smoking-attributable mortality and years of potential life lost. Centers for Disease Control and Prevention. *MMWR Morb Mortal Wkly Rep* 1990;42:645-9.
9. United States. Morbidity And Mortality Weekly Report (MMWR). Trends in Cigarette Smoking Among High School Students. United States, 1991-2001. Centers For Disease Control And Prevention. *MMWR Morb Mortal Wkly Rep* 2002;51(19).
10. United States. Morbidity and Mortality Weekly Report (MMWR). Cigarette smoking

among adults. *MMWR Morb Mortal Wkly Rep* 2002;51(29):642-5.

11. United States Department of Health and Human Services (USDHHS). The health consequences of involuntary smoking. A report of the Surgeon General. Washington DC: US Government Printing Office; 1986.

12. United States Department of Health and Human Services (USDHHS). The health consequences of smoking: nicotine addiction. A report of the Surgeon General. Rockville: Public Health Service, Office on Smoking and Health; 1988.

13. United States Department of Health and Human Services (USDHHS). The health benefits of Smoking Cessation. A report of the Surgeon General. Atlanta (GA): Centers for Disease Control and Prevention; 1990; DHHS Publication No: (CDC)90-8416L.

14. United States Department of Health and Human Services (USDHHS). Best practices for comprehensive tobacco control programs. Centers for Disease Control and Prevention, National Center for Disease Prevention and Health Promotion, Office on Smoking and Health; 1999.

15. United States Department of Health and Human Services (USDHHS). Clinical practice guideline: treating tobacco use and dependence. Public Health Service; 2000.

16. United States Department of Health and Human Services (USDHHS). Reducing tobacco use: a report of the Surgeon General. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000.

17. United States Department of Health and Human Services (USDHHS). PHS Clinical Practice Guideline, Treating Tobacco Use and Dependence; 2007.

Dr. Analice Gigliotti
President of Brazilian Association on Studies of Alcohol and Drugs (ABEAD)

Working together for safe health care, the World Health Professions Alliance (WHPA)

About WHPA

The global organisations representing the world's nurses, pharmacists and physicians joined forces in 1999, creating a unique alliance to address global health issues - the World Health Professions Alliance. In 2005, they were joined by the global representative organisation of the dental profession. Dentists, nurses, pharmacists and physicians deliver health care to individuals, families and communities regardless of their colour, creed, gender, religion or political affiliation. The World Health Professions Alliance, speaking for more than 23 million health care professionals worldwide, assembles essential knowledge and experience from the key health care professions. The WHPA aims to facilitate collaboration between key health professionals and major international stakeholders such as governments, policy makers and the World Health Organization. By working in collaboration, instead of along parallel tracks, the patient and health care system benefit.

Member Organisations

The International Council of Nurses (ICN)

is a federation of national nurses' associations in 129 countries, representing the 13 million nurses working worldwide. Founded in 1899, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce. www.icn.ch

The International Pharmaceutical Federation (FIP)

is the global federation of 114 national organisations of pharmacists and pharmaceutical scientists. Pharmacists are health professionals dedicated to improving the access to and value of appropriate medicine use. www.fip.org

The FDI World Dental Federation (FDI)

is the authoritative, worldwide voice of

dentistry with more than 130 member associations in more than 125 countries around the world, representing almost one million dentists internationally. Its main roles are to bring together the world of dentistry; to represent the dental profession of the world and to stimulate and facilitate the exchange of information across all borders with the aim of optimal oral health for all people. www.fdiworldental.org

The World Medical Association (WMA)

is the global federation of national medical associations, representing millions of physicians worldwide. Its membership is made up of national medical associations from around the world, directly and indirectly representing the views of more than seven million physicians. The WMA was founded in 1946 and endeavours to achieve the highest possible standards of medical science, education, ethics and health care for all people. In order to achieve this ideal, the WMA is active in the fields of policy development and the setting of professional standards. www.wma.net

Priorities and Actions

WHPA is focused on the following key priorities for improved global health care.

Health as a human right

As health professionals, all WHPA members support and promote the principle of health as a basic human right. This includes the right to access safe and appropriate health care for all people of the world.

Patient safety

Health care interventions are intended to benefit the public, but due to the complex combination of processes, technologies and human interactions there is an inevitable risk that adverse events will happen. The WHPA is working actively to improve systems and therefore reduce such incidents.

Alliance partners are also acting together on other issues of patient safety, including the presence of counterfeit medicines, antimicrobial resistance and the fight against HIV/AIDS.

Global tobacco control

The WHPA encourages governments to ratify and implement the WHO Framework Convention on Tobacco Control. This includes the developing of policies that ban tobacco advertising and promotion; require prominent and significant tobacco warnings on all tobacco products; ban smoking in public places and commercial airline flights; provide public education campaigns against tobacco use; and encourage tobacco farmers to shift to crop substitution. WHPA also promotes an active role for health professionals in tobacco control, both on the clinical care level and on the association level where advocacy is key.

The WHPA Leaders' Forum

Better health worldwide can only be achieved through collaboration, communication and dialogue to explore and exchange new approaches and methodologies. One of WHPA's important contributions to this is to bring together leaders representing the member organisations and other stakeholders in international health in a biennial WHPA Leaders' Forum, strengthening the bond and encouraging collaboration between the four health professions in all countries and settings.

The Future

WHPA is dedicated to continuing its role in addressing global health issues. The Alliance's strategic orientation for the future will involve both proactive work on specific initiatives and responsive action to issues as they unfold. These issues include: ethics, equity and access to health care, patient safety, tobacco control, strengthening health professionals' involvement on policy and health human resources planning. With a forward looking vision and collaborative spirit, the Alliance partners have committed to taking an unprecedented proactive role to deliver improved health care to populations worldwide.

IFPMA Appoints Alicia Greenidge as New Director General

(IFPMA) The International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) has appointed Alicia Greenidge as its new Director General. She took office on 2 June 2008 and succeeds Dr. Harvey Bale, who retired after almost eleven years in the position.

Mr. Fred Hassan, President of the IFPMA and Chairman and CEO of Schering-Plough, said: "Ms. Greenidge has extensive experience working with the Geneva-based intergovernmental organizations, as well as substantive knowledge of many issues of concern to the IFPMA. This experience, combined with a practical approach and keen mind, will equip her well for this challenging role. I am very pleased with her appointment to lead IFPMA."

Ms. Greenidge comes to the IFPMA with more than fifteen years experience in bilateral and multilateral negotiations with governments in the Americas, Africa, Asia, Pacific, Middle East, and Europe, working largely for the Office of the United States Trade Representative (USTR), both in Washington and in Geneva. In Geneva for nearly ten years, Ms. Greenidge served for a period as Acting Deputy Chief of Mission and, for the last eight years, as Assistant Deputy Chief of Mission and Senior Counsel.

Ms. Greenidge has gained a reputation as a strong and effective negotiator, but also as a bridge and coalition builder. She has kept channels of communication open and contributed to many settlements and decisions before the World Trade Organization, notably the Public Health Declaration leading up to and at Doha, Qatar in 2001 and subsequent agreements with regard to local pharmaceutical manufacturing capacity in developing countries, especially Africa. She has participated in deliberations concerning questions on the relationship of the

Trade Related Intellectual Property Rights agreement (TRIPS), traditional knowledge and the Convention on Biodiversity and led in negotiated agreements on Least Developed Country matters under TRIPS.

Since 1998, she also has interacted with, and advised on issues before other inter-governmental organizations, such as WHO (including IGWG issues and the IGM on virus sharing and access to vaccines), UN-AIDS, WIPO, UNCTAD and others. In addition, she has engaged constructively with several non-governmental organizations in Geneva.

During her government service, she has interacted with industries and associations representing various sectors, including Pharmaceuticals and her activities spanned across other subjects as well, such as trade remedies, dispute settlement, textiles, electronic commerce, investment measures, development assistance, aspects of the cotton issue, bananas and services trade.

Ms. Greenidge has a *Juris Doctorate* from Boston College, a Master's degree in Public International Law & International Development Economics from the American University, and a Bachelor's degree in International Relations and Sociology from C.W. Post College/LIU in the United States.

About the IFPMA

The International Federation of Pharmaceutical Manufacturers & Associations is the global non-profit NGO representing the research-based pharmaceutical, bio-

tech and vaccine sectors. Its members comprise 25 leading international companies and 43 national and regional industry associations covering developed and developing countries. The industry's R&D pipeline contains hundreds of new medicines and vaccines being developed to address global disease threats, including cancer, heart disease, HIV/AIDS and malaria. The IFPMA Clinical Trials Portal (www.ifpma.org/clinicaltrials), the IFPMA's Ethical Promotion online resource. (www.ifpma.org/EthicalPromotion) and its Health Partnerships information www.ifpma.org/HealthPartnerships - Developing World) help make the industry's activities more transparent. The IFPMA strengthens patient safety by improving risk assessment of medicines and combating their counterfeiting. It also provides the secretariat for the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH).



Alicia Greenidge, new Director General of IFPMA and Otmar Klobner, WMA Secretary General at the WMA office in Ferney-Voltaire

Representing pharmacists and pharmaceutical scientists – your partners in healthcare

The International Pharmaceutical Federation



*Myriah Lesko, BSc. Pharm., BSc.
Projects Coordinator FIP*

Founded in 1912, the International Pharmaceutical Federation (FIP) is the global federation of national associations of pharmacists and pharmaceutical scientists. FIP has been in official relations with the World Health Organization (WHO) since the WHO conception in 1949 and through its 120 Member Organisations in 90 countries represents and serves almost two million practitioners and scientists around the world.

Throughout its almost 100 year history, FIP has expanded both literally and figuratively. The emergence of pharmaceutical care as a cornerstone of the profession and the growing recognition of the pharmacist as an invaluable contributor to health outcomes have lead FIP to become a visible advocate of the role of the pharmacist in the provision of healthcare, while still maintaining its grounding in pharmaceutical sciences.

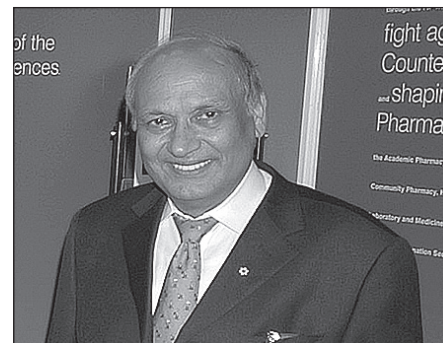
Over the past several years, FIP has worked towards advancing pharmaceutical sciences, pharmacy practice and more recently pharmacy education to the ultimate benefit of the patient. This has resulted from the work FIP has done internally and through mutually beneficial partnerships with key global players, such as WHO. This collaboration has served to promote the role of pharmacists in the WHO healthcare agenda and has further led to some of the most signifi-

cant partnerships between the key players on the global healthcare stage.

FIP is focused on improving the health and well being of communities through specific and targeted projects. FIP works within the WHO International Medical Products Anti Counterfeiting Taskforce (IMPACT) to advocate for the input of health professionals in assuring the integrity of the supply chain of medicines, inherently including the identification and reporting of counterfeit medicines. The implementation of the WHO-FIP Good Pharmacy Practice Guidelines through the Good Pharmacy Practice Pilot Projects is a prime example of enabling pharmacists with the opportunity to use their specialised knowledge and skills, to interact with their patients and communities in order to positively influence health outcomes.

The past several years have seen FIP bring on an additional focus: pharmacy education. Firmly believing that influential scientists and practitioners are the result of comprehensive and quality education, FIP has created the Pharmacy Education Taskforce. The Taskforce is dedicated to coordinating and catalyzing action to develop pharmacy education, to be accomplished through the Pharmacy Education Action Plan. In March of 2008 FIP, WHO and UNESCO officially launched the first phase of the Action Plan, which will be implemented between 2008-2010.

Never forgetting its roots, FIP continues to be fully engaged in the Pharmaceutical Sciences and has successfully implemented a series of Pharmaceutical Sciences World Congresses, which serve as global platforms for the exchange of information related to the pharmaceutical sciences. The parallel development of numerous FIP initiatives within pharmacy practice, education and the pharmaceutical sciences has demonstrated that the Federation is able to grow with concurrent streams of interest without losing ground.



Kamal Midha, President FIP

In 1999, FIP, the World Medical Association (WMA) and the International Council of Nurses (ICN) founded the World Health Professions Alliance (WHPA) (the World Dental Federation (FDI) came on board in 2005). This unique and first-of-its-kind alliance brings together pharmacists, physicians, nurses, and dentists in initiatives that focus on effective interaction between health professionals, while recognizing the unique values and distinctive contributions that each brings to patient care.

The potential of what may come of the communication and interaction brought about by the partnerships built within the WHPA is of pinnacle value to all professions and the communities we serve. FIP is very pleased to have clear and open opportunities for collaboration with our dedicated partners in health. The Federation believes - and advocates to our Members - that comprehensive patient care can best be achieved through partnership, team work and mutual respect and understanding of what each profession can contribute.

It is with this philosophy of growth that FIP is headed into the future: the changing tides of healthcare, its delivery and the role of pharmacists and pharmaceutical scientists demand that the Federation not only keep pace but also provide solid leadership to its Members and quality information and solid input to its peers in healthcare, thereby empowering all to positively influence global health.

The South African Medical Association (SAMA)

Uniting doctors for the health of the nation



Aquina Thulare, Secretary-General of the South African Medical Association

The South African Medical Association (SAMA) is an independent professional association for medical doctors without any statutory or disciplinary powers. SAMA is a member of the World Medical Association (WMA), a global federation of national medical associations representing doctors worldwide.

The South African Medical Association was established on 20 September 1997, following the unification of the Medical Association of South Africa (MASA), founded in 1927, and the Progressive Doctors Group (formerly NAMDA). The name change was effected on the 21 May 1998.

On 30 April 1999 total unification of the major groupings for medical practitioners was achieved when the National Medical Alliance, representing the SA Medical and Dental Practitioners, Society of Dispensing Family Practitioners, Family Practitioners Association, Dispensing Family Practitioners Association and the Eastern Cape Medical Guild, affiliated to SAMA.

Membership to the Association is voluntary. It is also a registered trade union for



Prof. Ralph Kirsch, President of the South African Medical Association

its members employed in the public sector. At present some 70% of doctors in both the public and private sectors are members of the association, which is registered as an independent, non-profit section 21 company.

The Association's activities focus on both the professional and business aspects of medical practice.

Our Mission

- To represent doctors with authority and credibility in all matters concerning their interests in the health care environment.
- To promote the integrity and image of the medical profession.
- To develop medical leadership and skills.
- To provide doctors with knowledge relevant to the demands of medical practice.
- To promote medical education, research and academic excellence.
- To encourage involvement in health promotion and education.
- To influence the health care environment to meet the needs and expectations of the community by promoting improvements to health reform, policy and legislation.

Objectives

SAMA represents doctors in all matters concerning their interests with authority and credibility in the healthcare environment.

These objectives include:

- promoting the integrity and image of the medical profession,
- providing doctors with knowledge relevant to the demands of medical practice,
- promoting medical education, research and academic excellence,
- influencing the health care environment to meet the needs and expectations of the community by promoting improvements to health reform, policy and legislation,
- encouraging involvement in healthcare promotion and education,
- promoting trust, integrity, professional conduct, efficiency and goodwill within the profession,
- to support, improve and protect the status, rights, privileges and interests of all members,
- to lobby Government and any relevant body on behalf of the profession,
- to facilitate in the maintenance of standards of practice by members to the public via continuing medical education,
- to judiciously use all subscriptions, entrance fees, levies and donations for the pursuance of the aims and objectives of the Association, while also using funds entrusted for the furtherance of medicine by way of bursaries, research grants and subsidies,
- to be the guardian of the codes structure for members; setting out the practice guidelines in all fields of practice,
- to disseminate information to members in order to keep them up to date with the latest developments in our industry by means of relevant publications; and
- to act in an advisory capacity regarding member concerns and enquiries where possible.

SAMA has 20 branches countrywide that serve members on a more personal level, and represent their interests and needs in that particular geographical area. Branch council

members are elected through a democratic process every three years to represent members at the annual National Council meeting of SAMA. Branch offices arrange their own activities such as Continuing Professional Development (CPD) events and regular branch meetings, and offers a branch peer review function when needed. Branch support staff also deals with day-to-day queries from members, with the assistance from head office. New members are encouraged to contact their local SAMA branch and become involved in SAMA activities.

Affiliated groups

Members also enjoy representation through the various affiliated groups. SAMA has more than 56 affiliated specialist and special interest groups with proportional representation on National Council.

Decision making at SAMA National Council

As a representative body for doctors, SAMA encourages and facilitates member participation in decision-making through a democratic and transparent governance process. Ordinary members can participate at local level in the activities of the 20 branches and the 56 specialists and specialist interest groups. Branches and groups have proportionate representation on the SAMA

National Council, which meets once a year when all elected representatives meet to discuss and debate issues affecting doctors on a national basis.

Board of Directors

National Council appoints a Board of Directors, which meet quarterly to discuss matters regarding the business affairs of the Association including policy, budget, financial, economic and management issues.

Standing Committees

National Council also appoints the members of ten standing committees, which each have a specific mandate. These include human rights, law and ethics, private practice matters, public sector doctor issues, health policy, and education, science and technology. These committees meet regularly and report back at the quarterly meetings of the SAMA Board of Directors, and to their peers at the annual National Council meeting.

Secretariat

A secretariat is situated in Pretoria, Gauteng with a full-time support staff of 55. The Secretary-General is the head of the Secretariat from where she directs and administers the affairs of the Association within the framework of operating policies established by National Council and the Board of Directors. She also exercises control over all



*Dr. Kgosi (TKS) Letlape,
Chairperson SAMA, former President WMA*

matters concerning the administration and management of the head office and staff.

In an environment that is constantly changing, membership of The South African Medical Association (SAMA) provides doctors with the kind of support that they need in order to be able to practise medicine successfully. On behalf of its members, the Association strives for a healthcare dispensation that addresses the challenges of healthcare delivery in South Africa.

The Association provides doctors with individual and collective representation aimed at influencing medical and health legislation, regulation and policies.

Overview of the Nigerian Medical Association (NMA)

The Nigerian Medical Association founded in 1960, began as a branch of the British Medical Association in 1951. It is the largest medical association in the West African sub-region with over 35 000 members from 36 state branches and a branch from the Federal Capital Territory. 70% of doctors practice in urban areas where only 30% of the population resides. The population of Nigeria is about 130 million. Policy decisions are made by the Association's National Executive Council (NEC), which is the

governing body. The constitution of NMA is supreme and its provisions have binding force on all authorities, organs, branches and members of the Association and, where applicable, on any other persons.

While our Vision is to build a formidable professional body committed to fostering effective and efficient health care delivery, high ethical standards and the interest of its members, our mission is to build a sustainable professional association of medical and

dental practitioners that will advance the delivery of qualitative health care services through continuing professional development, advocacy, and policy development, knowledge management, public education



Dr. Ishaq Abdul (R) handing over to the Current Secretary General, Dr. Kenneth Okoro (L)



Group picture of both the Immediate Past and Current Executives after the Handing Over Ceremony

in collaboration with other collaborating partners in health.

Any medical or dental practitioner registered under the Medical and Dental Practitioners' Act CAP 221 Laws of the Federation of Nigeria (1990) and as subsequently amended shall have a right of membership of the Association on payment of the annual practicing fee in the said Act as may be reviewed from time to time, unless otherwise prescribed in the constitution. The Association has both governance and management structures with the Annual Delegates' Meeting (ADM) as the highest decision making body. The management is by the National Officers' Committee (NOC) led by the President and this occupies the third level. The NOC has seven elected members who are democratically elected every two years and has responsibilities for managing the affairs of the Association. The current National Officers' (2008/2010) are: Dr. Prosper Ikechukwu Igboeli, President; Dr. Bala Mohammed Audu, 1st Vice President; Dr. O.O. Alan Taiwo, 2nd Vice President; Dr. Kenneth Johnson Okoro, Secretary-General; Dr. Chris Enoch, Deputy Secretary-General; Dr. Ibrahim Abubakar Kana, Treasurer; Dr. S.N.C. Anyanwu, Editor, Nigerian Medical Journal

The administrative head of the secretariat is the Secretary-General and is assisted by a core of support staff for the smooth running of the secretariat.

The Association's Journal, **Nigerian Medical Journal (NMJ)** was founded in 1964 with the following aims:

- to provide a medium for the dissemination and permanent record of the result of clinical experience and scientific medical research, particularly in Nigeria.

- to serve as a forum for the dissemination of general information and report on conference of the Nigerian Medical Association among members.

Although the Association is involved in many of the government's activities, it is consulted formally by the government only on an 'ad-hoc' basis. It is not consulted as 'of right' on health issues and has to press for its participation. The Association nominates eleven members of the Medical and Dental Council of Nigeria (MDCN), which regulates the practice of medicine & dentistry in Nigeria and the curricula of its medical schools.

The NMA is at present involved in influencing health policy formulation in an ad hoc manner. This is done by making unsolicited recommendations to government on various health issues and also by making inputs, whenever invited, to some of the national committee meetings on policy formulations.

The Association holds training courses for doctors, and participates in radio programmes and TV talk shows. It has several on-going projects including those on AIDS, on family planning and on Primary Health Care (PHC). Project development is dependent upon outside funding. Funding agencies supporting the Association's activities include UNFPA, UNICEF, WHO, USAID, the Ford Foundation, and the John D and Catherine T MacArthur Foundation.

The Association collaborates in specific projects on health issues with individual NGOs and with the National Association of Non-governmental Organizations on Health (NANGO). The NMA plans to make more in-roads into the Federal Min-

istry of Health to ensure that it is involved in all aspects of policy formulation, especially in the planning stages.

It is also planned that the NMA continues to cooperate with government in project development so that the association may be represented on the delegations to regional and international health conferences.

The Nigerian Medical Association (NMA) is the host of the permanent secretariat of the Confederation of African Medical Association and Societies (CAMAS). The Association is developing a proposal to involve all African Medical Associations and Societies in efforts to improve reproductive health and safe motherhood in Africa.

The Nigerian Health System performance has been poor, having been ranked 187th amongst 191 member states in 2000. Infant Mortality rate was 97 per 1000 live births and has worsened to 110 per 1000 live births in 2005. This is against the MDG - 4 targeted improvement to 30 per 1000 live births by 2015. Maternal Mortality rate was 704/100,000 births and has also worsened to 800/100,000 births in 2004 as against the MDG - 5 targeted improvement to 75/100,000 births by 2015. Life expectancy at birth is 45 years for males and 46 years for females.

While budgetary provisions for health remain grossly inadequate, other major factors contributing to the above poor health indices include unfavourable working environment, inadequate lack of essential medical equipment, poor health seeking behaviour of many Nigerians, lopsided distribution of health facilities and very poor remuneration of Medical Personnel. Lack of desired motivation has led to the massive brain drain of Medical Professionals whose exodus from Nigeria became very noticeable in 1985. In deed, over 10,000 Nigerian Doctors are practising outside the country.

It is hoped that the above scenario will change for the better in the coming years.

*Dr. Kenneth Johnson Okoro,
Secretary-General*

The National Order of Physicians of Côte d'Ivoire: presentation and perspectives



*Dr. Florent Aka Kroo,
President of the NOPCI*

Located in the Guinea Gulf, the Republic of Côte d'Ivoire is a West African country, independent since August 1960 and with currently about 18 million inhabitants. The National Order of Physicians of Côte d'Ivoire (NOPCI) was established in September 1960, one month after the birth of the Ivorian State by Parliament # 60-284 law of 10 September 1960.

The NOPCI has two major missions, which are as follows:

- to empower all physicians who are willing to practice Medicine in the Country; they must go through a yearly registration with the National Board of Physicians;
- to see that all physicians are respectful of the principles of morality, probity, and devotion which are indispensable for the practice of Medicine; the NOPCI ensures as well the respect by all its members of the professional duties and the rules of the code of ethics; it defends the honour and independence of the medical profession; it can also provide support and assistance to its members.

The NOPCI went through a long 40-year period of lethargy. However, since 30 Oc-

tober 2004, it is becoming more dynamic thanks to a new management team.

Therefore the participation index which was 15% (about 350 registered physicians in good standing), is currently up to 85% (about 3800 physicians out of 4500). The national ratio is 1 physician for 5000 inhabitants.

The new team's effort is also extended outside the national area, to:

- the sub-regional area in relation to the Orders Conference of the West African Economic and Monetary Union States (WAEMUS),
- the French speaking area with the recently established French-speaking Orders Conference (over 30 countries with French as a full or partial language),
- the international and global arena with the NOPCI membership application to the World Medical Association (WMA). This application shall go through a vote at the General Assembly of the WMA to be held in Seoul (Korea) on 15-18 October 2008 and we hope it will succeed.

The NOPCI is aware of its position of "Guardian of the Temple" in Ivorian Medi-

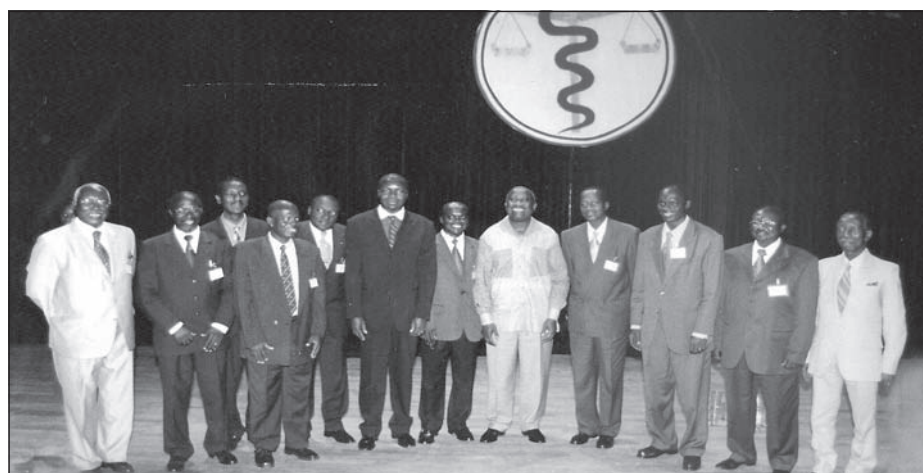
cal practice. However it considers it important to be informed of its members' acts and thoughts should they be willing to do so. Therefore it is planning to establish the Ivorian Medical Association prior to the WMA General Assembly of October 2008. Such an initiative will bring Ivorian physicians to more representation at a global level.

The Côte d'Ivoire went through an ecological disaster in September 2006 as toxic waste was poured out in Abidjan, the economic capital and its suburbs.

Over 100 000 inhabitants of the City were considered victims of gas emissions, 12 of them died, 79 were admitted to care settings, and more than 100 000 consultations were recorded.

In January 2007, the NOPCI organised a scientific workshop in order to check the medical aspects of this disaster, and its mean and long term effects, as well in exposed subjects. It is now planning to establish a non-governmental Observatory, and needs technical and financial support.

The NOPCI along with the upcoming Ivorian Medical Association is willing to be on the same wavelength as the WMA, regarding its objectives: improvement of patients' care, respect of medical ethics, patients' rights, and sustained effort to ensure a post-academic training of quality.



National Order of Physicians of CI with CI President Gbagbo

The Medical Association of Thailand under the Royal Patronage of his Majesty the King



Dr. Aurchart Kanjanapitak, President of The Medical Association of Thailand

Background

The Medical Association of Thailand is a non-governmental non-profit making social promotion organisation of the Medical Professions in Thailand. It was founded in 1921 in Bangkok. It is, at present, located at the Royal Golden Jubilee Building # 2 Soi Soonvijai, New Petchburi Road, Huaykwang district, Bangkok 10310, Thailand. CABLE Address "MEDITHAI" Tel. (66) 2 3144344, (66) 2 3188170 Fax. (66) 2 3146305 Email address: math@lox-info.co.th and <http://www.mat.or.th>.

The present governing body of the Association is composed of a President (Dr. Aurchart Kanjanapitak), President Elect (Pol. Major General Dr. Jongjate Aojanepong), Vice President (Dr. Chatri Banchuin), Secretary General (Associated Professor Dr. Prasert Sarnvivad) with other 16 council members and also Presidents of all specialty colleges and faculties and invited past presidents and recognised members. The term of the committee will be 2 years from general election amongst members. The membership of the Association at present is 23,000 out of a total 33,000 graduates or about 70 %



Prof. Dr. Somsri Pausawasdi, President of CMAAO

Functions:

- The Medical Association of Thailand works towards;
- Promoting and coordinating Medical Professions under ethical integrity;
- Promoting relationship amongst members;
- Promoting education, research and medical services;
- Providing welfare to members;
- Coordinating and collaborating with other medical organisations both in governmental and in private sectors to improve better standard of medical provision and public health to meet international standard;
- Advocating health promotion (exercise and antismoking campaigns), prevention, and medical services to public;
- Collaborating with international health and medical organizations to keep the global standard.

The Medical Association of Thailand has a role in bringing all health and medical providers from both governmental and private sectors to work together through the elective executive committee which is composed of members from various sectors. The Medical Association of Thailand is also one of the three components forming a collaborative body from the Ministry of Public Health, the

Medical Council and the Medical Association as a platform to oversee and overcome the arising problems in the Medical profession and allied professions at monthly meetings.

The Medical Association is also taking a role in providing compromises in the conflicts amongst medical providers and consumers.

Journal of the Medical Association of Thailand is an accepted world class medical publication for medical education, research and medical know-how. It is published bi-monthly and distributed amongst members and medical institutes including medical faculties and medical libraries in the whole country.

The Medical Association of Thailand is also currently providing not only mobile teaching teams to the remote areas, but also supports them with the professional insurance.

International Relationship

At present the Medical Association of Thailand is taking more part in the international affairs. One of its past Presidents (Prof. Dr. Somsri Pausawasdi) has currently been elected to the President of CMAAO (Confederation of the Medical Association in Asia and Oceania with 17 member countries). Also its international relations chief officer (Dr. Wonchat Subhachaturas) is the elected Chairman of the Council in CMAAO, as well the President of the Association is automatically a councillor in the CMAAO and the MASEAN (The Medical Associations in South East Asian Nations).

The Medical Association of Thailand provides full support to the WMA (World Medical Association) as an active member and send its representatives to participate in every General Assembly Meeting and always works closely with member countries through e-mails and the website (<http://mat.or.th>). Exchange visiting programmes are also well ongoing within the region and outside upon the invitations.

*Wonchat Subhachaturas M.D., FRTCS
International Relations for the MAT*

The Hong Kong Medical Association (HKMA)

The Hong Kong Medical Association (HKMA) was established in 1920. It is the professional body representing doctors in Hong Kong, and is an independent non-government organization. It has a membership of 7,943, out of the 10,979 doctors within a population of 7 million in the Special Administrative Region of China. Hong Kong enjoys freedom due to the "One Country Two System" policy and practice of the People's Republic of China.

The motto of HKMA is "Safe-guarding the Health of People".

We have roughly half of our members working in the public sector, and another half in the private. The issues that HKMA is concerned with are usually important to both the private and public doctors.

The professional autonomy of the medical profession is manifest by the peer-groups-review practice and self-regulatory power of the Medical Council of Hong Kong which is the quasi-statutory body responsible for the setting of standards, implementation of regulation and disciplining doctors.



We are aiming at a better democratic representation on the Medical Council as our medical regulatory body and independence from the government.

The Food and Health Bureau has been considering health reform with Healthcare Financing Consultation. The HKMA has conducted survey within the profession to collect the opinions of physicians towards the proposed health reform and healthcare financing, especially the pros and cons of mandatory medical insurance and medical saving. HKMA also met regularly with medical insurers to work on core elements of good medical insurance scheme.

In Hong Kong, we are concerned that the family doctor concept should be better implemented and more training opportunities for family physicians. There is a specialist register here but not a primary care register. We also strive to improve public-private collaboration. The HKMA proposed a primary care register but the medical council is apparently not yet ready.

The HKMA has been fighting for maintaining the right of dispensing by physicians. Public opinion poll was done in 2007, conducted by the public opinion program of the University of Hong Kong. The results showed that 3/4 respondents objected to the separation of dispensing and consultation. However, the pharmacists are still campaigning to change the practice in Hong Kong to strip doctors of the rights to dispense and to deprive patients of the choice of getting medicine from the doctors they consult.

We had published the Good Dispensing Manual, encouraging members and their staff to continually update themselves with good dispensing methods and risk management. Dispensing errors occurred not only in the private sector, but also in the public,

i.e. the Hospital Authority; not only by doctors but also by dispensers or pharmacists.

The HKMA cooperates with the Medical Protection Society (MPS) to assist doctors in medico-legal litigation. These disputes often cause immense stress and serious consequences to doctors. The secretariat of HKMA will help members to contact the MPS. The soaring annual premiums for doctors become unbearable. HKMA is negotiating with MPS and the government to think of ways to limit these burdens of doctors. We have established a mediation committee to promote this "win-win" mediation approach to solve patient-physician conflicts.

In the private sector, doctors suffer from unscrupulous rental increase in public housing estates which cause tremendous difficulties in running clinics. HKMA led our members to protest against Link Real Estate Investment Trust (Link REIT) and organized rally and march by our members together with workers of other trades. Private Doctors are also troubled by medical groups and HMOs which have too much emphasis on customers' service, marketing and commercial elements of medical practice, but might erode professional autonomy. HKMA strived to persuade the government and the legislature to regulate HMO, group practices as well as insurance-run clinics to ensure level playing field for solo practitioners.

In the public sector doctors suffer from long inhuman working hours, poor working environment, inadequate training and low respect for professionalism from the government and the public. The morale has been worsening and there has been staff exodus from Hospital Authority, resulting in deterioration in quality service. This problem will eventually jeopardize the whole medical work force in the territory. The HKMA is fighting the battle together with our public colleagues especially our junior members who were so demoralized. We had sent a letter to WMA to see the working conditions of junior colleagues in other NMAs. Our members demonstrated together and



marched to the government house to fight, hoping to bring a brighter future for our profession and our next generation. Now, there has been some improvement in working hours and training prospects after lengthy battles, but more need to be done.

The government (the Education Bureau, Food and Health Bureau and University

Medical School) proposed to increase the intake of medical students, aiming to double the number of graduates. HKMA opposed and the Secretary for Education promised to look into the matter from the perspective of overall supply and demand of physicians and also the training prospect of the medical graduates.

We have regular exchange programmes and cooperation with the Chinese Medical Association, while we are totally independent of each other. The HKMA has 12 monthly HKMA newsletters, 12 monthly CME Bulletins, and bi-monthly Hong Kong Medical Journals. We are providers, organizing CME activities, as well as accreditor of CME activities. We have an on-line CME website as well as lots of cultural and sports activities organized for our members. There are HKMA orchestra, HKMA choir

and singing group, HKMA no. one band, and a HKMA charitable foundation. We have a theme song of the HKMA: "We are concerned". This year, the HKMA has organized several concerts in theatres, as well as mini-concerts in malls and streets to raise donations for needy people, patient groups and the earthquake victims in Sichuan.

*Dr. Alvin Yee Shing CHAN,
Vice President of the Hong Kong Medical Association, Chairman of International Affairs Committee, Chairman of Rehabilitation Committee, Central Coordinator of the HKMA Community Network, Chairman of HKMA Orchestra Committee and Choir Committee, Elected members of the Medical Council of Hong Kong*

The Azerbaijan Medical Association (AzMA)



Dr. Safarli Nariman, AzMA president

The Azerbaijan Medical Association (AzMA) is the country's leading voluntary, independent, non-governmental, professional, membership medical organization for physicians, residents and medical students who represent all medical specialties in Azerbaijan.

In 1999, Dr. Nariman Safarli and his colleagues founded the Azerbaijan Medical Association (AzMA) and association was officially registered by Ministry of Justice of Azerbaijan Republic in December 22, 1999.

Since its inception, the AzMA continues serving for a singular purpose: to advance healthcare in Azerbaijan.

The mission of the AzMA - is to unite all members of the medical profession, to serve as the premier advocate for its members and their patients, to promote the science of medicine and to advance healthcare in Azerbaijan.

The main aims of AzMA are:

- to protect the integrity, independence, professional interests and rights of the members,
- to promote high standards in medical education and ethics,

- to promote laws and regulation that protect and enhance the physician-patient relationship,
- to improve access and delivery of quality medical care,
- to promote and advance ethical behavior by the medical profession,
- to support members in their scientific and public activities,
- to promote and coordinate the activity of member- specialty societies and sections,
- to represent members' professional interests at national and international level,
- to create relationship with other international Medical Associations.

The AzMA's vision for the future, and all its goals and objectives are intended to support the principles and ideals of the AzMA's mission.

In 2000, the AzMA established its Permanent Committees and the mission of the association is accomplished through its committees as it realizes the decisions of the AzMA General Assembly, studies health care delivery in Azerbaijan, and works out and performs health policy and activities through the Executive Board. The AzMA

Permanent Committees are: Science and Education Committee, International Relations Committee, Ethics Committee, Administration & Finance Committee, Membership & Bylaws Committee, Public Health Committee, Information & Publications Committee, Private Medical Practice Committee, Legislative Services Committee, Public Relations Committee, Physicians Health Committee. Member physicians volunteer countless hours to participate in one or more of the 11 Permanent Committees which meet on a regular basis throughout the year.

In 2000, the AzMA has developed special membership sections to address the unique interests and concerns of association members. These sections are following- Medical Student Section, Organized Medical Staff Section, Resident Physician Section, Young Physician Section, International Medical Graduate Section. Now AzMA is in the process of establishing its local AzMA branches in 13 regions and also assists in creation of member-scientific societies on specialty level.

International Relationship

Today AzMA continue to work closely with other medical organizations both within the country and at an international level. The following are the AzMA's national and international affiliations.

National affiliations: In 2000, AzMA became a full member of the National NGO Forum of Azerbaijan Republic.

International affiliations: The year 2002 yielded memorable and historical events for Azerbaijan Medical Association such as membership to the World Medical Association (WMA). AzMA became a part of the WMA family. AzMA president participated in several General Assemblies of WMA, and these were unique chance for our association to develop its relations with other member National Medical Associations and also gain new experience in different fields of partnership within the WMA family. In 2002,

AzMA became an associate member of the European Union of Medical Specialists (UEMS). In 2000, AzMA was admitted as member in the European Forum of Medical Associations (EFMA) with the right for consultation. In 2000 Azerbaijan Medical Association became a full member in the Forum for Ethics Committees in the Confederation of Independent States (FECCIS).

AzMA Membership Services

As a professional organization the AzMA provides services to its members. In the Legislative Services Committee, lawyers provide effective advocacy and legislative representation for member physicians. They give consultation on related legislative matters. The committee regularly organize legislative seminars for physicians, students, hospital and private medical centers staff members.

Also since 2000, the "AZMED" Resource & Training Center - organize for its members regular courses on following issue: Basic Principles of Bioethics, Medical Law and Health Legislation, English for Doctors, Basic and Advanced Computer and Internet courses, Project proposals writing and fundraising courses for Doctors, Leadership and Management for Doctors.

The total number of members of the Azerbaijan Medical Association is 1250 (including student membership). The administrative bodies of the Association are the General Assembly, the Councils, and the Executive board. AzMA staff consists of 8 persons, who are working on voluntary basis. Also working group which consists of 30 doctors and students actively involved to organize the AzMA regular seminars, trainings, conferences and work on edition and publication of AzMA quarterly bulletin for members- "AzMA VISION".

Relationship with Government

Since its establishment the AzMA work closely with MOH, especially on policy and health system structure and organization.



Meeting "Role of Health Organizations in National Health System" with the representatives of Ministry of Health, UN agencies and other International organizations functioning in Public Health field in Baku 2003

In 2001-2003 years, AzMA has been actively involved as Health NGO joining Public Health Workgroup of the cooperative program of World Bank and Azerbaijan Republic about "Eradication of Poverty in Azerbaijan". In 2008, AzMA also actively cooperate with MOH in National Health Reforms program, which financially support by World Bank. During this year AzMA conduct meetings several times with Health Reforms Center of MOH which have authority to make decisions in the field of Health Care Policy.

Future plans

Currently AzMA is preparing to realize in near future its next project in Public health field named as "Be Healthy" online health education for population of Azerbaijan. Project goals: to make available online health information and consultation to Azerbaijan citizens who use internet. In 2009, AzMA planning to publish a scientific journal "Azerbaijan Medical Association Journal" for Azeri physicians. On 17-18 June 2009, AzMA will organize the International conference "Cross-Cultural Aspects in Bioethics".

Today, AzMA members work hard to promote the science of medicine and to protect the health of Azerbaijan citizens.

*Contact information:
E-mail: info@azmed.az
azerma@hotmail.com
Website: www.azmed.az*

The Australian Medical Association – a voice for patients and doctors



Dr. Rosanna Capolingua, AMA President

About the AuMA

The Australian Medical Association serves to represent and protect the needs of patients in Australia. In doing so, it represents the goals of the Medical Profession. The Australian Medical Association (AMA), the country's peak health advocacy organisation, was incorporated in 1961. Prior to this, it operated as a branch of the BMA.

We currently represent more than 27,000 doctors from each Australian state and territory and across every specialty craft group. These include salaried doctors in the public sector and doctors in private practice, doctors-in-training and medical students.

The President, Vice President, Chair of Council and Treasurer are elected annually at the National Conference. The Executive committee is made up of these office bearers and two Federal councillors elected by the Federal Council. The policy setting for the organisation is performed the Federal Council. This comprises 34 elected representatives from the Australian States and

Territories and each craft group (including the Australian Medical Students' Association President and the Committee of Doctors-in-Training) together with the four Office-bearers.

AMA membership is discretionary. AMA branches are set up in each state and territory. These run independently and focus primarily on State issues, industrial representation and services for members. They enjoy a close, collaborative relationship with the federal Association - with all State and territory members being members of the Federal AMA. The federal AMA drives the national agenda - primarily in lobbying Federal Government, policy development and dissemination, and maintains a national media profile of the Federal President.

The AMA is a strong voice in the medico-political arena. Australians deserve a health system that continues to improve and go forwards. Government decisions on health care based on a political foundation and not quality of care are not acceptable. The AMA is loud and clear that it will not accept compromise to patient care. Our Association believes the solution is to build on the strengths of our current system, using clinically-driven reform to improve access to services.

Current Challenges in Healthcare for the Australian Medical Association

The Australian health system ranks well in the world on many of the measures used by the WHO and amongst OECD countries. We acknowledge that there are some problems within the system but, overall, it provides well for the vast majority of Australians. There are many reasons for this consistently good performance but central is the system of universal access to medical services, pharmaceuticals, free public hospital care and a subsidised private health insurance scheme, which equalises premiums

across the community with a 'community rating'. This is underpinned by good access to highly-trained medical practitioners providing excellent patient-centred care to individuals whilst participating in continuous improvement cycles that enhance that quality of medical care.



Dr. Mukesh Haikerwal, Immediate Past President AMA, Representative on WMA Council

However, key challenges for health care delivery within Australia mirror the rest of the world - primarily due to increasing costs of innovation and technology, an ageing population, increased needs for patients with chronic and complex conditions and a workforce struggling to meet demand as the average working age increases, participation time at work reduces and morale and retention rates of health care professionals fall.

One of the strengths of our health system is that it is predominantly a primary health care delivered system with the general medical practitioner role being central as the physician, philosopher and friend or guide of the patient through what is the health care maze. GPs perform roles in acute care, initiating investigations and diagnosing as well as making referrals to the other specialist medical and allied health providers in the system. This is an effective and efficient system but the current reform environment

sees proposals to shift some of the medical practitioner's responsibilities and roles to other health providers including allied health, paramedics, physicians' assistants, pharmacists and nurses.

Achieving a balance within a multi-disciplinary team is challenging. The medical practitioners should provide the medical care coordination. They do work collaboratively with the various providers of health care, in a cooperative, holistic and continuous way avoiding duplication or, worse still, fragmentation and neglect. Responsibility and oversight as well as support for health providers by medical practitioners are currently markers of quality and the safety of the patient, which is paramount.

There are notable exceptions to the overall good health outcomes in Australia, these being Aboriginal and Torres Strait Islander Australians and people in regional, rural and remote areas that are currently disadvantaged in terms of care provision and outcomes. Aboriginal and Torres Strait Islanders have a 17-year less life expectancy compared to non-Indigenous Australians.

The AMA has entered a coalition of health and welfare groups to 'Close the Gap'. There is a concerted and detailed plan of action setting out an agenda to improve health outcomes for Indigenous people and increase the number of people in the Indigenous health workforce. A series of indicators and benchmarks for success have been detailed and agreed by the coalition. AMA members are also concerned about the proposed National Registration and Accreditation scheme. At the moment, each state and territory has its own medical registration body. The Australian Medical Council provides national consistency for new entrants from medical schools and overseas. Professional accreditation has always been a professional responsibility exercised by the learned Colleges. The AMA supports a system of National Registration of doctors to enhance workforce mobility. The new scheme for Australia will however, be centralised, bureaucratised and removed from where

medicine is practised. At the same time the new scheme holds greater dangers with the proficiencies and standards for clinical credentialing and accreditation wrestled from the profession and placed into the political control of government.

The loss of the independence of standard setting and accreditation of medical training will serve to undermine standards and compromise quality of patient care.

Access to free service in the nation's public hospitals is a core component of our system. Unfortunately, these have suffered from funding shortages and administrative and bureaucratic failures. Many doctors stop working in these hospitals, as they feel under-valued, unable to teach or to participate in research. Further, they feel they are compromised in their ability to deliver care to patients.

Public hospitals run close to or above 100 per cent occupancy throughout the year and this often results in no availability for care in the hospital. Cancellation of elective waiting lists, long delays in elective and sometimes more urgent surgery, overcrowding in emergency departments, ambulance bypass and ambulance ramping are all symptoms of bed shortages and excessive occupancy.

The AMA wants two immediate measures undertaken: establishing 85 per cent occupancy as a national safety benchmark; and the provision of 3,750 additional acute beds.

Australia is lucky to be looking forward to significantly more medical graduates. The challenge is to provide adequate high-quality clinical training for these students and then specialist training places to allow them to practice independently as GPs or other specialists. General practice and the private sector and other settings will be needed to contribute to providing this training environment.

Around 36 per cent of doctors practicing in Australia at the moment have graduated from an overseas medical school. International medical graduates are an essential part of looking after patients in Australia. Recently, there has been a focus on their role and the need for nationally-consistent assessment processes. There is an identified need to support new entrants from overseas as they enter the Australian workforce.

The Australian Medical Association has been going strong and celebrates its 50th anniversary in 2011. We will continue to fight for the best outcome for doctors, but our fundamental concern will always be the health and welfare that benefit patients.



AMA Federal Council in Canberra in 2007. Front row, from the left, AMA Vice President Dr. Gary Speck, AMA Chairman of Council Dr. Dana Wainwright, Dr. Capolingua, and AMA Treasurer Dr. Samuel Lees

The New Zealand Medical Association

The New Zealand Medical Association (NZMA) is the largest pan-professional medical representative group in New Zealand. The NZMA aims to provide leadership of the medical profession; and promote professional unity and values, and the health of New Zealanders. The key roles of the NZMA are to provide advocacy on behalf of doctors and their patients, to provide support and services to members and their practices, to publish and maintain the Code of Ethics for the profession, and to publish the New Zealand Medical Journal.

Completely independent, the NZMA is a strong advocate on medico-political issues, with a strategic programme of advocacy with politicians and officials at the highest levels, aimed at influencing the direction of government policy. NZMA representatives are in regular contact with the Minister of Health, Director General of Health, Opposition party health spokespeople, and officials from the Ministry of Health, and many other agencies.

The NZMA's main focus in recent years has been the ongoing workforce issue, which is the greatest risk to New Zealand's ability to provide ongoing quality health care. It is not just a crisis of the number of doctors or sub-specialities, but a shortage of all health workers. The average age of doctors is increasing. While we acknowledge the global marketplace for health professionals – doctors, nurses, and others – in New Zealand we have become aware that we need to be smarter in creating an environment that keeps those professionals in our country, rather than has them leaving to work in countries which pay higher salaries.

New Zealand is extremely reliant on overseas trained doctors. More than 42 percent of doctors registered in New Zealand trained elsewhere in the world. For every 315-320 new doctors registered here each

year (the medical schools' output of graduates), between 1200-1600 doctors who trained overseas are also being registered (although around half of them do not stay more than a year). It is imprudent for a first world country to not strive for self sustainability in medical practitioners.

New Zealand is not training enough medical graduates. Compare us with Australia which has doubled its medical student intake. The NZMA has called on the Government to double the number of medical graduates trained here.

Another aspect of New Zealand's health system which continues to be of great interest to the international medical community is our no-fault accident compensation legislation.

This dates back to 1966 when the Royal Commission on Worker's Compensation (known as the Woodhouse Commission) proposed sweeping reforms. The Accident Compensation Act was passed in 1972 and came into force in 1974, and remains to this day, with some changes.

The Woodhouse Commission proposed five general principles:

- community responsibility,
- comprehensive entitlement,
- complete rehabilitation,
- real compensation,
- administrative efficiency.

The ACC system replaced a system of compensation which, similarly to many other countries, was expensive in legal costs, slow in operation, and capricious in that similar injuries suffered under similar circumstances might produce vastly different financial outcomes. The outcome was a scheme that was considered radical. The right to sue for damages for the tort of negligence causing injury was removed, and in return injury

would be compensated regardless of fault, including fault of the injured.

Four main factors have contributed to the system's affordability. First, New Zealanders benefit from a strong social security system. Injured patients, like everyone else, receive free hospital care and subsidized pharmaceuticals. (Yet per capita health spending was only US\$ 2448 in 2006, compared with US\$ 6714 in the United States.) Thus, New Zealand's public health and welfare systems cover many of the damages that would be at issue in a U.S. medical malpractice claim, leaving the ACC with a much smaller compensation burden. Second, compensation awards are generally lower and more consistent than under a malpractice equivalent. Third, the New Zealand experience suggests that even under such a system (which includes a legal duty of open disclosure), most entitled patients never seek compensation, and many may be unaware that they have even suffered an adverse event. And finally, the New Zealand system does not incur large legal and administrative costs. The system has been very cost-effective, with administrative costs absorbing only 10 percent of the ACC's expenditures compared with 50-60 percent among malpractice systems in other countries.

Separate and independent processes are available for responding to patients' non-monetary interests (such as the desire for an apology, an explanation, or corrective action to prevent harm to future patients). In particular, the Health and Disability Commissioner resolves complaints by advocacy, investigation, or mediation.

One of the anomalies in the first 30 years of the scheme was its handling of complications and undesirable outcomes of medical treatment. If the provider of care was at fault, then this was an injury and was compensated. If it was a rare occurrence, for which the provider was not at fault (expected in fewer than 1% of cases) then it was a medical mishap, and compensated. If it did not meet either of these criteria, then it was not compensated. This always seemed

anomalous in a no-fault scheme. A review carried out in 2003 found that the requirement to establish fault impacted on health professionals by creating an overly blaming culture (rather than a culture of learning from mistakes) – by focusing too much on the actions of individual health professionals, and by making health professionals uneasy about participating in the medical misadventure claims process for fear of the repercussions, particularly from inter-agency reporting. The consequences of this included less focus on the patient's injury, less focus on the prevention of similar injuries, confusion over the ACC's role, and opportunities to learn (and therefore improve) safety being limited.

The NZMA had advocated for, and strongly supported, the amendment that came into force in April 2005 redefining all such occurrences as "treatment injury", and compensating regardless of perceived fault. That provides a much more equitable outcome for patients, and helps to avoid the adversarial situation that could previously arise where a patient was required to assert negligence on the part of the doctor in order to receive compensation.

In a population of four million people, in 2005/2006 more than 1.2 million people had injuries treated by their local GP and paid for by ACC, with ACC paying for over 2.3 million visits. ACC funded 2.6 million physiotherapist visits, 2.4 million visits to other treatment providers and 250,000 rehabilitation services. Rehabilitation rates are high: 66 % of people return to work after three months, 84 % after six months and 93 % after a year. Injury prevention is a primary focus of ACC's work, with campaigns focused on safety at work, at home, on the road and playing sports.

Another issue which has been high on the NZMA's priorities is the membership of the statutory registration body, the Medical Council of New Zealand (MCNZ). The general public needs to have confidence that the regulation of doctors is fair and open and transparent. In essence the public needs to

be able to trust the medical profession, and the NZMA strongly supports this need.

The Health Practitioners Competence Assurance Act 2003 (which regulates all health practitioners) took away the right of the medical profession to have directly elected members on the MCNZ. This can be viewed as part of a global trend to move away from pure self-regulation to regulation in partnership between the profession and the public.

Self regulation is a cornerstone of professionalism, and the NZMA has called for at least 50% of members to be elected from the profession.

New Zealand has had a Primary Health Care Strategy since 2001, and the NZMA is fully supportive of many of its aims, such as improving access to primary health care.

The Government has substantially increased funding to primary care, particularly by increasing the level of patient subsidies with consequent improved access to general practice services. However, with this has come attempts by the Government to impose controls on the setting of general practice fees. The NZMA has since 1938 supported the right of private sector medical practitioners, including GPs, to set and charge fees commensurate with the services they provide. This right has come under increasing

and unprecedented pressure in recent years. General practices are, in the main, private businesses whose continued existence is dependent on them remaining viable.

The NZMA is working with other general practice organisations to assist the Government in achieving its health goals in primary care.

Towards the end of this year New Zealand will have a General Election. A Labour-led Government, headed by Helen Clark, has been in place for nine years, but political polls are consistently putting the Opposition National Party substantially ahead. This means there may be a new government in place by the end of the year. But whoever is in power, the NZMA is willing to work closely with them to ensure that the health system and the health of New Zealanders remains a top priority.

References

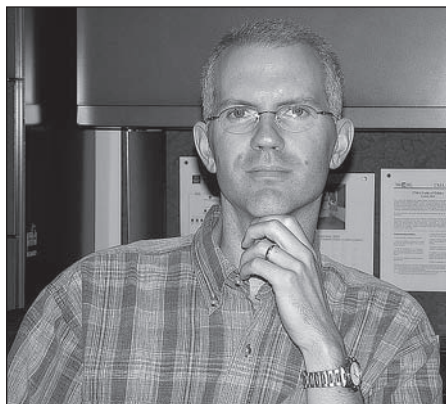
1. Bismark M and Paterson R. No-Fault Compensation In New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety. Health Affairs. 2006. 278-283.
2. Bismark M. Compensation and Complaints in New Zealand. BMJ. 2006 332:1095.
3. Accident Compensation Corporation. Review of ACC Medical Misadventure: Consultation Document. Wellington: ACC; 2003 (quoted in: Coates J and Smith K. Reform of ACC Medical Misadventure. NZ Med J. 2004. Vol 117 No 1201)

Dr. Peter Foley, Chairman



From the left Dr. Peter Foley, Chairman, Steve Chadwick, Associate Minister of Health, Dr. Mark Peterson, GP Council Chair

Ethics and professionalism at the Canadian Medical Association



Jeff Blackmer, MD MHSc FRCPC

Ethics and professionalism have long been priority issues at the Canadian Medical Association. The Association was established in 1867 and produced its first Code of Ethics in 1868, making it one of the oldest such documents in existence.

The CMA Code of Ethics is arguably the most important policy produced by the organization. Since its original inception, it has undergone several modifications. The last revision, considered to be "minor" in nature, was completed in 2004. In general, major revisions of the document occur every 15-20 years, with 1-2 minor revisions in between. The Code is considered to be "hybrid" in nature as it is somewhere in length and content between setting out basic principles at the one end, and trying to cover all ethical topics and eventualities at the other. It is intended to be of sufficient detail so as to provide clinicians with practical guidance in dealing with complex ethical issues, but not so detailed as to be behaviour-determining.

The CMA Code of Ethics has been adopted by all major medical bodies in Canada (with the exception of the province of Quebec, which generally produces its own Codes and regulations separate from the rest of the country). For example, the provincial medical regu-

latory bodies, the national educational colleges and the provincial medical associations have all adopted the CMA Code. It is to the benefit of physicians to have only one Code of Ethics, and not competing codes which would serve as a point of confusion and potentially conflict. This harmonization has occurred through extensive and open dialogue and negotiations over the years to try and ensure that the Code meets, to the extent possible, the needs of all the stakeholders involved.

The Canadian Medical Association Office of Ethics, Professionalism and International Affairs is responsible for working on policies, providing support and education to the Association and its member divisions and affiliate specialty societies, and providing support to the CMA Committee on Ethics. The Office has existed in one form or another at the CMA for many years.

In 1989, the CMA increased its commitment to ethics with the establishment of the Division (later Department) of Ethics and Legal Affairs. Work began on abortion, status of the foetus, transplantation of organs, reproductive technologies, and physicians and the pharmaceutical industry. In 1991 the CMA rejoined the World Medical Association and CMA ethics staff began to play a major role in the ethics activities of the WMA. In 1996 the CMA staff structure was reorganized and Ethics and Legal Affairs were separated. The Director of Ethics became a member of the Professional Affairs Directorate. In 2001, the staff structure was reorganized again and the Director of Ethics became a member of the Research, Policy and Planning Directorate (now titled the Research, Policy and Ethics Directorate).

The Office is currently staffed by a full time Ethicist (with a background in basic philosophy and ethical theory, as well as formal training in clinical bioethics), an Executive Director (who has an advanced degree in bioethics

and also continues to work part time as a physician) and administrative support. At any point in time it is common to have students or interns rotating through the Office, as well as temporary staff who are employed to work on specific projects or policies for a finite period of time. The Office has provided training and experience for several students over the past few years in research, policy development and the practical application of ethical concepts and principles.

The CMA Committee on Ethics meets in Ottawa twice a year for two-day sessions. During this time, Committee members debate ethical issues and help direct policy development in this area. With the support of Office staff, they assist in identifying current ethical and professional issues that are of importance to Association members, and decide how best to address these issues.

The Committee on Ethics is the longest standing Committee at the CMA and is considered unique in many respects. It is the only Committee that is elected by, and reports to, the General Council of the CMA, which is considered to be the "Parliament" of Canadian organized medicine. Committee members are selected on a regional rather than provincial basis, and the smaller size of the Committee allows it to respond more quickly to issues as they arise. In addition, Committee members are expected to have some background or expertise in the area of ethics as part of their membership on the Committee. Between General Council sessions, which happen only once a year, the Committee reports through its Chair to the CMA Board of Directors, and most policies are discussed and approved at this level.

Until the 1970s the Committee on Ethics concerned itself mainly with professional issues. During the 1970s it began addressing bioethical issues. During the 1980s the Committee presented reports to General Council on issues such as AIDS, as well as some amendments to the CMA Code of Ethics. Between 1991 and 1996 the Committee completed policies on advance directives, confidentiality, and physician-assisted dying; revised the

Code of Ethics and the policy statement on physicians and the pharmaceutical industry; and advised on CMA's brief on the revision of the Criminal Code and the "Joint Statement on resuscitative interventions."

Between 1996 and 2001 the Committee revised policies on organ and tissue donation and transplantation, physicians and the pharmaceutical industry, and, together with the Council on Health Care and Promotion, viral serological status testing; and guided CMA participation in the development of a "Joint Statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care." It contributed to CMA policy development on assisted reproduction, health information privacy, direct-to-consumer advertising, the Charter for Physicians, the future of medicine and scopes of practice.

Recent work by the Committee has included an extensive revision of the policy on physician-industry interactions, the development of a new policy on ethical obligations of physicians during a pandemic and a new policy on blood borne pathogens in the health care setting. Current work is

underway on a major revision to the CMA Health Information Privacy Code, the issue of conscientious objection by health care providers, a research ethics template for practicing physicians and a project, together with the national organization of medical regulators, to produce a series of clinical vignettes based on the CMA Code of Ethics.

The issue of medical professionalism is extremely topical in organized medicine. To reflect the importance of professionalism, the Canadian Medical Association has added the term to the title of the Office (a recent development) and has also included work in medical professionalism (and ethics) in one of the Key Result Areas in its current strategic plan. This has helped to demonstrate in a tangible way the importance of these issues within the overall structure and strategy of the organization.

The CMA is the founder and Chair of the Canadian Stakeholders Coalition on Medical Professionalism, a collection of several medical organizations from around the country with an interest in medical professionalism, including educators, regulators, professional liability insurers and others. The Coalition has been active in trying to

ensure a consistent nation-wide approach to defining, teaching, measuring, assessing, promoting and role modelling the key aspects of medical professionalism to physicians and physicians-in-training throughout the continuum of the medical life cycle. Current efforts are aimed at ensuring consistency in how professional behaviours and traits are evaluated.

Staff at the CMA Office of Ethics, Professionalism and International Affairs works closely with the World Medical Association both during and between WMA meetings. Currently, CMA staff is assisting the WMA with the drafting of new policies in medical professionalism (including professionally-led regulation, professional autonomy and conflict of interest) and revision of current WMA policies (including telemedicine and health human resources). The relationship between the CMA and WMA has always been a close one, as evidenced by the fact that John Williams has served as the director of ethics for both organizations, and the author of this paper recently completed a secondment at the WMA office where he assisted with policy development and coordination in ethics and professionalism.

The "Consejo General de Colegios Oficiales de Médicos"



Dr. Isacio SIGUERO, President

The "Consejo General de Colegios Oficiales de Médicos" (general medical council) is the body that brings together, co-ordinates and represents the 52 local medical associations (colegios oficiales de médicos) at national and international level, and for all purposes it has the status of Public Law Corporation, with own legal personality and full capacity to comply with its objectives.

Since 1898 it has been compulsory for doctors to register as members in Spain and there is a local medical association for each of the 52 Spanish provinces. The overall representation of this "Consejo General" dates back to the year 1930. The Spanish Constitution recognises the existence and

representation of professional associations, with the requisite of having a democratic functioning, like the undertaking of the "Consejo General", the final purpose of these institutions being to oversee a good professional practice, namely the defence of the professional and patient.

The "Consejo General" is made up of a Board and a General Assembly. The Board is formed by the president, vice president, general secretary, vice secretary and treasurer, all these being positions democratically elected every four years. The rights and interests of the corporation and profession are defended through this Board *vis à vis* all classes of jurisdictional, administrative and institutional bodies.

The General Assembly is integrated by the Board, by the Presidents of the 52 local medical associations, and by the national

representatives from the different professional sections through which doctors are represented according to the modality and form of professional practice they undertake: hospitals, urban and rural primary care, pensioners, in training, public administrations, with unstable employment, and own private medical practice or as employee. The task of these sections is to provide guidance in matters of their speciality and to undertake studies and proposals. Together, the Board, local Presidents and sections' representatives form the General Assembly, which is the top governing authority of the "Consejo General".

The "Consejo General" and the 52 local medical associations form what is known as "Organización Médica Colegial (OMC)". This body represents all registered doctors in Spain, acting as safeguard for the core values of the medical profession: deontology and code of ethics.

The "Consejo General" is officially responsible for representing the OMC before the General Administration of State and the public agencies related with or dependent on it, as well as for coordinating the profession at the different organisational levels.

To quote a few examples, the work of the "Consejo General" is today centred on various questions of professional and social interest that include the study of medical demography to try and correct the deficit in doctors and carry out a suitable planning of human resources, even controlling the official recognition of foreign medical qualifications, fostering training and accreditation, using its own Council officially recognised by the Government.

Other facets of its work include professional and social promotion of doctors and their adaptation to scientific and professional changes, as well as permanent and accredited professional development. It also has a

social Foundation to assist the needs of doctors and their families, this being one of the most important works of the health sector.

Through its "Consejo General", the OMC is present at almost all international medical organisations, at which it provides its experience. These actions imply benefits for the professional practice, for the patient – end receiver of such actions and true central hub of the National Health System – and finally for society as a whole.

Defending the values of the medical profession and rights of doctors and the patients, the "Consejo General" is now undertaking actions in favour of prescriptions being an act that is the exclusive competence of the doctor being the only professional who, considering his training and qualifications, can assure a safe and efficient quality treatment for the patient; without waiving collaboration with other health professionals, to assure the quality of the health care process.

The Slovak Medical Association



Prof. MUDr. Peter Kríšťufek, CSc. President



MUDr. Irina Šebová, CSc. MPH, Scientific Secretary

The Slovak Medical Association (SkMA) is an affiliation of professional medical and pharmaceutical societies and also regional societies of physicians, nurses and pharmacists. SkMA is a non-profit, non-governmental association representing more than 22 000

members. The tradition of SkMA goes back to the 19th century. On 3 January 1833 a group of young medical students established the Slavonic Medical Association as a self-learning medical society. Following the founding of Czechoslovak republic there was in place local medical societies in Košice and Bratislava (1919-1920) and various professional associations, which from 1949 comprised the organisational units of the Czechoslovak Medical Association, and from 1969 separate Czech and Slovak Medical Association. After the establishment of independent Czech and Slovak republics in 1993, the Slovak Medical Association continued to work on an autonomous basis.

Main activities:

- Education (Continuing Medical Education, Non-institutional life-long Education)
- Publications of Medical Journals (co-operation with professional medical societies, editors and publishers)
- International Activities and Contacts, Medical ethics
- Health care legislation, Quality of health-care development
- Membership service, awards approval, public relations

1. Education

One of the main missions of the Slovak Medical Association is the organisation of scientific events and scientific congresses, conferences, symposiums and other professional meetings with domestic and foreign participation, to support the involvement of own experts in similar events abroad and to publish and support the issue of professional magazines and publications. On basis of a mutual agreement among the statutory representatives of the Slovak Chamber of Physicians, the Slo-

vak Medical Association, the Slovak Medical University, the Association of Private Physicians and the Association of Medical Faculties in Slovakia, the Slovak Accreditation Council for Continual Medical Education (SACCME) was established in May 2004. The SACCME provides credits for CME activities, as well as with the implementation of a quality control mechanism (standard participants satisfaction questionnaire). 250 credits over a 5-year period were proposed, 150 from them are obtained from external educational activities (passive or active participation, auto-didactic tests in medical journals, publications, presentations, teaching) and 100 credits are received for professional performance and for self-teaching.

2. Publications

17 medical journals (mainly in the Slovak language with English summaries):

- Medical Monitor (6/year),
- Revue of Nursing and Laboratory Methods (4/year)
- Acta Chemotherapeutica (6/year)
- Head and Neck Diseases (4/year)
- Clinical Immunology and Allergology (4/year)
- Slovak Physician (12/yars)
- Urology (2/year)
- Practical Gynaecology (4/year)
- Haematology and Transfuziology (4/year)
- Atherosclerosis, Clinic, Treatment (3/year)
- Laboratory Diagnosis (4/year),
- Surgical News (4/year)
- Slovak Radiology (4/year)
- Cardiology (4/year)
- Pediatricon (4/year)
- Respiro (4/year)
- Geriatria (4/year)
- Accupunctura Bohemo-Slovaca (2/year)
- Slovak Sexology (2/year)
- Microbiology and Epidemiology News (4/year)
- Farmacoeconomics and Drug's Policy (4/year).

3. International activities and contacts

The Slovak Medical Association is a member of World Medical Association (WMA),

European Forum of Medical Associations and WHO (EFMA/WHO), Union of European Medical Specialists (UEMS), Council for International Organizations of Medical Sciences (CIOMS). International cooperation is supplied also directly by means of various SkMA professional societies and their colleagues in European Union or abroad.

In co-operation with **WMA** representatives the Slovak version of the Medical Ethics Manual was finalised and will be distributed among our members. The SkMA support all ethical, social and environmental activities of the WMA. On 19 September 2006, the SkMA and Slovak Association of Pharmaceutical Companies (SAFS) signed an agreement concerning ethical principles co-operation between the medical profession and the pharmaceutical industry.

From 2007, the SkMA has representation on the **EFMA/WHO** committee (Irina Sebova-liaison officer). On 1-3 April 2009, we will be organising the Annual Conference of EFMA/WHO in Bratislava. Proposed topics: CME/CPD, Palliative Care, Creation of quality standards, Seniors Care.

The good co-operation between the SkMa and the **UEMS** was confirmed on 19 March 2006 in Brussels by the signing of an agreement between the European and Slovak accreditation councils for CME (EACCME and SACCME). The institutions declared that they are interested in co-operation in field of CME accreditation through a formal agreement aimed to foster the interchanging of experiences and the implementation of a formal system mutual recognition of CME credits. The SkMA was the organiser of UEMS Meeting (Board and Council) on 11-13 October 2007 in Bratislava. One of the most important documents adopted at this Meeting was the Bratislava Declaration on E-Medicine.

Of growing importance are activities with regard to international contacts with **CIOMS**, as well as membership of professional SkMA societies in partnership with

European or non-European organisations. The SkMA co-operates very closely and intensively with the Czech Medical Association.

4. Health Care Legislation, Quality of Healthcare Development

The public Health System in Slovak republic is under the jurisdiction of the Ministry of Health, which is responsible for managing national health policy. The SkMA acts as an opponent in discussions on health care legislation proposals from Ministry of Health, proposes the nomination of the Main Experts, the Consultants for the Drug Categorization Commissions and the Members of the Medical Performance Catalogue Committees.

In co-operation with other medical institutions and professional associations submits SkMA suggestions or projects for improvement of healthcare quality.

5. Membership service, awards approval, public relations

The SkMA has 87 professional societies according to specialization or field of particular interests and a total of 48 regional societies or alliances according to geographic location independent from profession. Membership in the SkMA is voluntary. Main executive bodies of the SkMa in place of the Representative Plenary Meetings are the Presidium, Supervisory Board and Executive Secretariat. The Presidium of SkMA, elected for 4 years period, encompasses 13 members including the President, Scientific Secretary and two Vice-Presidents. The Supervisory Board has 3 members including the chief of Administration and is staffed with 19 full time employed persons headed by the Director of Secretariat.

The official residence of SkMA is the House of Medical Officers (Domus Medica, Dom zdravotnikov) with a Congress office, Department of membership service, Economic department and Auditorium.

Korean Medical Association The WMA General Assembly Seoul 2008



32nd KMA Scientific Congress

The year of 2008 is very significant in the history of Korean Medical Association (KMA), as it celebrates its 100-year anniversary. Modern medicine was introduced in Korea in the year of 1884 by an American missionary physician. During a relatively short period, Korea has made rapid progress in medical science and the practice.

In 1908, KMA was established in Seoul and soon became the national organization representing all medical doctors in Korea. In spite of many difficult situations occurred in the Korean peninsula, KMA has made unified efforts to promote health of the people. Through the period of Japanese occupation, Korean War, rapid economic development, and advance to the democratic society, KMA has always been for the people to secure health and happiness, enhancing the standard of medical science and education, and participating actively to the decision-making process. With the devotion and support of physicians in care for people, the government could achieve the universal health insurance policy in 1989 only 12 years after the launch of the national health insurance program.

KMA's efforts to enhance international cooperation contributed to the drastic improvement of the standard of health care

and now it reached the highest standard akin to the advanced countries in OECD. The number of members has increased into 90,000 physicians today and the roles and responsibilities of KMA become more and more important in observance of medical ethics and provision of continuous medical education: training and certification of specialists, introduction of malpractice insurance program.

In this October, KMA is privileged to host the WMA General Assembly Seoul 2008. The Organizing Committee was launched in September 2006 as the official decision-making body for KMA and is spearheaded by Dr. Tai Joon MOON, the President Emeritus and Dr. Soo Ho CHOO, the President of KMA. Dr. Dong Chun SHIN serves as secretary general of the committee. To make the Assembly successful and meaningful, KMA has been working very hard. We have organized the scientific session under the theme of "Health and Human Rights" to cover health equity, health for under-privileged people, health problems from environmental perspectives and medical ethics and human rights, and so on. As keynote speeches, UN's activities and strategies for protecting human rights and an overview on WMA's policies and history

of health and human rights will be presented and discussed.

To commemorate the meaningful centennial anniversary, KMA is planning a photo exhibition on the sidelines of the Assembly showing historic highlights of development of medical sciences from the late 19th till



Korea launch of universal health care insurance



The hosting of the 12nd CMAAO Meeting

present days in front of the main meeting hall of Shilla hotel during the Assembly.

Tour programs will include beautiful sites of Seoul city. We expect excellent weather in October and you will enjoy the unique attractiveness of Seoul where tradition meets modern vitality.

KMA would like to welcome you all to Seoul and we are honored to share important discussions with you and exchange friendship among leaders of organized medicine of the world during the Assembly.

Bo-kyung Kang,
International Relations

Cross-border healthcare:

Debate between the EU institutions, health professionals and patients on the draft directive launched

The roundtable "High Quality Healthcare in Europe," organized jointly by the Council of European Dentists (CED) and the Standing Committee of European Doctors (CPME) on the 11th of September, in Brussels, provided one of the first opportunities for stakeholders to discuss the Commission's recent proposal for a Directive on Patients' Rights in Cross-Border Healthcare. The event under the patronage of Othmar Karas, MEP, brought together Commission officials and MEPs to exchange views with the main organisations of European health professionals and patients on the proposed Directive, as well as on the wider institutional and political framework for cross-border healthcare in Europe.

EU Commissioner for Health and Consumers, Androulla Vassiliou, opened the debate with a keynote presentation. She confirmed the continued commitment of the Commission to dialogue and cooperation

in the process leading to the adoption of the proposed Directive on Patients' Rights in Cross-Border Healthcare with those most directly affected by it: the health professionals and the patients.

During the debate, all representatives, those of the health professionals as well as the patients, welcomed the directive and reiterated the need to enshrine patients' rights of access to safe and high quality healthcare throughout the EU in a legal document.

CPME President Dr. Michael Wilks pointed out, among other issues, the necessity of good information systems for both patients and physicians that support cross-border care.

CED President Dr. Orlando Monteiro da Silva noted that quality is definable but very difficult to measure. "We must focus on the three main principles of strategy, high

quality and efficiency, doing the right thing right."

The moderator, Dr. Matthias Wismar of the European Observatory on Health Systems and Policies, concluded that there is a consensus among the panellists on the need for this directive.

Othmar Karas, MEP (EPP), played a lead role in negotiating an agreement between the European Parliament and the Council under the Austrian EU Presidency in 2005, leading to the exclusion of health services from the Services Directive. Other speakers included DG SANCO Head of Unit Bernard Merkel, MEPs Bernadette Vergnaud (PES) and Holger Krahmer (ALDE), and Dr. Anders Olauson, President of the European Patients' Forum.

Claudia Ritter, Director / Brussels Office, CED, Council of European Dentists.
www.eudental.eu

Lisette Tiddens-Engwirda, Secretary General, CPME, Standing Committee of European Doctors. www.cpme.eu

Contents

Editorial	75
179 th WMA Council Meets	76
Human Resources for Health, Kampala	82
Health – a global overview	82
An alternative to better global health	83
The new revision process of the International Classification of Diseases	84
DoH Revision meeting in São Paulo	85
Co-operation of WMA and the Stop TB partnership – Private-Public-Mix in the fight against TB	86
Lilly Commits \$1MM to World Medical Association to support Innovative Tuberculosis training course	87
What Physicians are <i>REALLY</i> Thinking	88
Smoking: A disease that starts in the brain and goes to the whole body	92
Working together for safe health care, the World Health Professions Alliance (WHPA)	95
IFPMA Appoints Alicia Greenidge as New Director General	96
Representing pharmacists and pharmaceutical scientists — your partners in healthcare	97
The South African Medical Association (SAMA)	98
Overview of the Nigerian Medical Association (NMA)	99
The National Order of Physicians of Côte d'Ivoire: presentation and perspectives	101
The Medical Association of Thailand under the Royal Patronage of his Majesty the King	102
The Hong Kong Medical Association (HKMA)	103
The Azerbaijan Medical Association (AzMA)	104
The Australian Medical Association – a voice for patients and doctors	106
The New Zealand Medical Association	108
Ethics and professionalism at the Canadian Medical Association	110
The "Consejo General de Colegios Oficiales de Médicos"	111
The Slovak Medical Association	112
Korean Medical Association. The WMA General Assembly Seoul 2008	114

