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## Back to the 50s?

*A draft Regulation of the European Union on Clinical Trials falls back in the time before the Declaration of Helsinki*

All new medical drugs need testing in humans. Experimentation with human beings has become a matter of international attention after World War II, when in the Nuremberg Doctors' Trial an American Military Tribunal set up ten rules for such experiments. Interestingly enough the so-called Nuremberg Code did not find wide reception until nearly half a century later, when historians rediscovered it. However, in the late 50s and early 60s the World Medical Association began working on rules for experimentation on humans resulting in the Declaration of Helsinki in 1964.

The Declaration of Helsinki since then is being regarded as the gold standard for experiments on humans and it has directly or indirectly made its way into many national and international regulations and laws. In 1964 the mayor step forward was the requirement of informed consent. Not only should nobody be subjected to an experiment, but he or she should know what it is means for them personally to be subjected to an experimental situation. This concept was not new – at least in a few countries – but for the first time it was demanded by an international policy. In 1975 the World Medical Association went a step forward to include the concept of ethics reviews by independent ethics committees.

To bring new medicines to the market is a highly expensive process. Extreme scrutiny is being applied not only to make the drugs safe (and hopefully effective) but also to make the process of testing safe and ethically acceptable. The protection of the subjects in a clinical trial preceding the marketing authorization as well as the patients receiving the medicines later should be paramount. On the other hand there are at least three reasons to make this process as fast as possible: First, if new medicines are better than old ones, patients everywhere should benefit from them as soon as possible. Let's not forget, until today many, if not most diseases wait for a final cure. Second, the high development cost and a limited patent lifetime favour an early market access to produce a return on investment. Third, having innovations first secures an economic advantage over your international competitors.

Competition in this global market requires clear structures in the process of bringing new drugs to the market. In the late 90s the European Union (EU) started to develop a common set of rules for the testing of new drugs now including 27 European States resulting in the Clinical trials Directive (CTD) from 2001.

However, the legislative approach fell short of the expectations. The process of getting a new drug to the market appears being still too long. The European Commission has now presented a draft regulation that is meant to replace the 2001 CTD.

This draft however has (or reveals) three major problems:

- Ethics reviews by independent ethics committees are no longer expressively mentioned as an obligatory requirement,
- the timelines to authorize a clinical trial by the ethics committees are very short and appear non-workable in practice, and
- one member state will be in charge taking the final decision on the acceptability of a trial, which may happen even, if other member states find them scientifically or ethically unacceptable. Although, member states can opt out from a specific trial under certain circumstances, they have to accept a marketing authorization finally resulting from this process.

In a common effort with the Standing Committee of European Doctors (CPME) the President of the World Medical Association, Dr. Cecil Wilson and the Chairperson of the WMA Council, Dr. Mukesh Haikerwal, raised their concerns to the Members of the European Parliament currently dealing with the draft regulation. The WMA leadership also stressed the potential effect of the EU Regulation for non-EU countries. It would be a fatal signal, if the European authorities no longer require an ethics review in all countries where trials are being performed.

Mrs. Glenis Willmott MEP, lead rapporteur on the draft regulation for the European Parliament proposed to reintroduce the mandatory ethics review by ethics committees and referred to the WMA Declaration of Helsinki. Many of the national governments have raised their concerns against the short timelines dictated by the draft regulation. There is hope that the draft regulation as incomplete as it is will not pass the Parliament and Council (the representation of the national governments) without major changes.

However the third problem of forcing member states to accept what they believe are marketing authorizations based on insufficient scientific or ethical standards remains. It may lead to an "ethics shopping", which means that producers of new drugs could try to find the "least critical" country for their trial. Fixing those problems may require additional amendments in the laws on marketing authorization, but starting now to deal with that problem would be a good sign. Not only for Europe.

Otmar Kloiber



## Declaration of Helsinki. Expert Conference

Distinguished ethicists, educators and government officials from around the world met in Cape Town, South Africa, December 5, 2012 for a three-day conference to evaluate potential revisions of the Declaration of Helsinki (DOH).

The DOH was first adopted by the World Medical Association (WMA) in 1964 and is a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. It is widely recognized as a core standard for ethical research.

The DOH is the loadstone; the North Star if you will that guides physicians, governments and industry in the area of advice on doing medical research on human subjects. The DOH has undergone multiple revisions over the years, not to change core principles but to determine whether more guidance in the importance area of medical research in this area is needed to deal with the complexities of today's world.

The process by which the WMA is conducting work on potential changes in the DOH is to draw on the expert opinion of a wide spectrum of leaders in ethics around the world and to work in a public, transparent way to reach agreement.

What gives added significance to this work is that 2014 will mark the fifty-year anniversary of this important document.

87 delegates from 26 countries were in attendance at the conference and provided rich discussions that were for me reassuring confirmation that physicians as a profession care deeply about ethics. The diversity of attendees and the quality of presentations validated the worldwide importance of the DOH to those in the field.

The South African Medical Association under the leadership of Dr. Zephne M. van der Spuy, president who along with Precious Matasoso, Director General, South African Ministry of Health, provided welcoming remarks, ably hosted the conference.

Those participating in the conference included among others representatives from the World Health Organization, US Department of Health and Human Services (HHS), European Medicines Agency (EMA), The Society of Swiss Physicians (FMH), Medicines Control Council South America, International Federation of Pharmaceutical Manufacturers and Associations, (IFPMA), the European Clinical Research Infrastructures Network (ECRIN), academic medical centres from around the world and representatives from member associations of the WMA.

Topics discussed related to the DOH included vulnerable groups, bio banks, post-study arrangements, and ethics committees. There was also consideration about whether the DOH should provide additional guidance in insurance/compensation/protection, use of proven interventions, placebos, broad consent and medical research involving children. Urban Wiesing, Director Institute for Ethics and History of Medicine University of Tübingen described the process for revising the DOH and the history of previous similar efforts. The questions, debate and engagement of attendees responding to the speakers were probing, passionate and persuasive.

As part of this process I think it is important to remember some of the core principles specified in the introduction to the Declaration of Helsinki as follows:

- Although the declaration is addressed primarily to physicians, the WMA encourages other participants in medical research involving human subjects to adopt these principles.
- It is the duty of the physician to promote and safeguard the health of patients, including those who are involved in medical research.
- The Declaration of Geneva binds the physician with the words. "The health of my patient will be my first consideration".
- The International Code of medical Ethics declares, "A physician shall act in the

patient's best interest when providing medical care."

- In medical research involving human subjects, the well being of the individual research subject must take precedence over all other interests.
- Medical research is subject to ethical standards that promote respect for all human subjects and protect their health and rights.
- Physicians should consider the ethical, legal and regulatory norms and standards for research, involving human subjects in their own countries as well as applicable international norms and standards.

In remarks at the opening session I shared with the participants my enthusiasm about the process being undertaken with the following remarks:

- On behalf of the member associations of the World Medical Association and the patients and physicians we represent let me express my appreciation for your willingness to take time out of very busy lives to be a part of this effort.
- I am awed by the experience, expertise and the international reputations you bring to this conference.
- I thank you for your interest in this important subject and for your participation in this endeavour. I look forward over the next three days to being educated and impressed.

The WMA Council last year established a Working Group to lead the effort of evaluating the DOH for possible changes. The Working Group has scheduled an additional expert conference to be held in Tokyo in February (2013) to receive input and perspectives from experts in the Far East geographic region. It is anticipated that draft document will be submitted to the WMA Council in the spring, followed by solicitation of public comment. Plans are for presentation of a revised DOH in conjunction with celebration of its fiftieth anniversary in 2014.

Thanks again to the South African Medical Association for hosting the DOH Expert Conference. I was educated and impressed.

*Cecil Wilson, MD, MACP, President, WMA*

## A Guideline for Treatment Decisions on CAM in Oncology: Prerequisites for Evidence Based Integration



*Karsten Münstedt*



*Jutta Hübner*

Cancer patients often turn to complementary (CAM) therapies because they believe these will improve their body's ability to fight cancer and therefore their chances of survival or at least will ameliorate quality of life. This article suggests recommendations which represent a framework for advice on and safe application of CAM methods in oncology.

In oncology safety with regard to CAM is even more important than in other areas of medicine because data on effectiveness are mostly missing and any intervention that is able to enhance cancer cell survival either directly or indirectly by interactions could also reduce patient's chance of cure or longer survival. In contrast to other disciplines in oncology any delay in effective therapy may enhance the possibility of resistance of the disease, incurability and progress. Wrong decisions taken during primary (or later) treatment of most types of cancer can not be compensated for later on. This very reason makes it important to monitor cancer treat-

ments continuously and carefully so that patients receive the best chances of a therapy.

### Introduction

Treatment of cancer disease remains one of the greatest health challenges, and although great strides have been made in some treatments, the prognosis for many patients remains poor. Cancer patients often turn to complementary (CAM) therapies because they believe these will improve their body's strength to fight cancer and therefore their chances of survival. Many consider that CAM therapies will improve their emotional or physical well-being, help to avoid aggressive treatment, or at least make it more easily tolerated.

The poor prognosis of many cancer patients and their desire to participate actively in any therapy which might ameliorate their condition have motivated CAM therapists

to search for new therapeutic approaches. Many CAM practitioners are integer and their intentions are entirely honourable. However, others appear to be less principled. They seem to view CAM practice as a way of making easy money and exploit the fact that some patients with a poor outlook may try anything, often ignoring the expense, if they think it might help them. These practitioners of dubious motivation often justify their activities with claims that they are pursuing "therapeutic freedom" and that conventional medicine is often unable to cure the disease.

Conventional medicine has always had difficulty in knowing how to judge and evaluate CAM methods, and how to deal with CAM therapies and therapists. Mainly it has chosen to ignore it. Meanwhile the US- American National Academy of Sciences regards being informed on CAM methods with frequent usage as an "obligation" for physicians (<http://www.nap.edu/catalog/11182.html>; Ethical Framework for CAM). This means that experts on CAM in oncology recommend physicians to inform patients on data concerning safety and efficacy. Physicians should point at the missing proof of efficacy of CAM as well as the relation of chances and risks of conventional therapy [6].

Adams [1] denotes aspects of ethical decisions: Severity and acuteness of disease, chance of cure by conventional therapy, side effects of conventional therapy, existence, quality and evidence for efficacy and safety of CAM, patient's understanding of risks and usefulness of CAM and the voluntary consent of patients to accept the risks. "If evidence (concerning the CAM therapy) supports both safety and efficacy, the physician should recommend the therapy but continue to monitor the patient conventionally. If evidence supports safety but is inconclusive about efficacy, the treatment should be cautiously tolerated and monitored for effectiveness. If evidence supports efficacy but is inconclusive about safety, the therapy could still be tolerated and moni-

tored for safety. Finally, therapies for which evidence indicates either serious risk or inefficacy obviously should be avoided and patients actively discouraged from pursuing such a course of treatment” [1].

Figure 1 shows 4 possible ways how to manage CAM use based on its safety and evidence [4]. If patient and physician consent to an alternative therapy, omitting or delaying a conventional therapy a close follow up has to be done (Ernst 2001, Cohen 2002). In order to do this he has to have profound knowledge on remission, progression and time intervals and the diagnostic measures to take in order to provide maximum security for the patient. Only experienced oncologists with thorough knowledge on oncology as well as CAM will be able to follow this rule.

There is another obstacle to this rule: patients who adhere to complementary and alternative medicine are likely to omit follow-up visits at their oncologists. One reason for this is inherent with their seeking for alternatives: the oncological setting does not provide the holistic approach they are looking for. Another reason might be that they want to avoid any testimony of failure of alternative therapy and therefore prefer diagnostics done by healers or other persons. Finally, patients are told by their dubious protagonists that they should avoid contact with conventional oncologists. This is one reason why patients should be actively informed about CAM in the first place. Regarding communication on CAM in oncology [5] developed a guideline for such discussions with patients. This guideline is based on a systematic review of the literature concerning patient-doctor communication in general and on CAM. 10 steps are recommended in this guideline (table 1).

Why a guideline for CAM use is needed

All above mentioned recommendations and guidelines focus on the discussion with the

Table 1. 10 steps as a guideline for discussing Complementary and alternative medicine with patients [5]

1. Elicit the person’s understanding of their situation
2. Respect cultural and linguistic diversity and different epistemological frameworks
3. Ask questions about CAM use at critical points in the illness trajectory
4. Explore details and actively listen
5. Respond to the person’s emotional state
6. Discuss relevant concerns while respecting the person’s beliefs
7. Provide balanced, evidence-based advice
8. Summarize discussions
9. Document the discussion
10. Monitor and follow-up

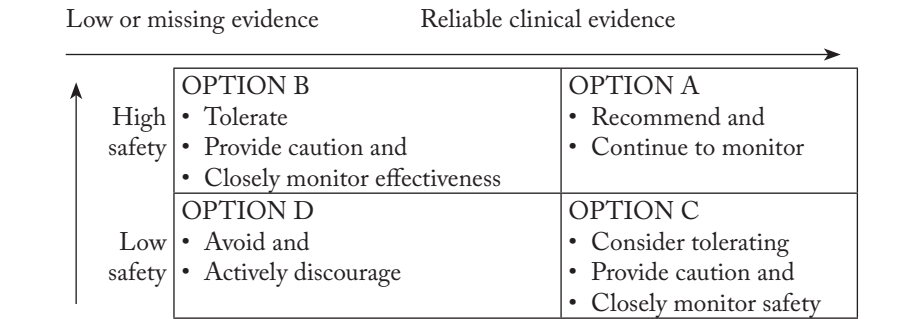


Figure 1. Possible options how to cope with CAM based on its safety and evidence et al. [3, 5]

patient and not on the treatment itself. Indeed, many CAM methods can be applied by the patient himself. So the discussion may lead to the decision on what the patient will do. But there are methods which the patient cannot apply without the aid of his physician. These are likely to be based on technical devices (f. e. bioresonance, hyperthermia) or are medical therapies with substances with side effects. Here the patient has to rely on the physician and in such a situation the physician has to accept a higher medical as well as ethical responsiveness than in a mere discussion on CAM. Thus it is important to establish ways which assure that treatments are given which are both well founded on medical knowledge and also in accordance with ethical values. The problem is that specific guidelines which have been issued for some tumour entities do not meet the individual situation of the patients. Since most patients also want that their etiologic concept behind the development of cancer is considered, it is important to suggest ways

for such individualized treatments without the risk of composing something totally irrational. Such a guideline is missing. It would, once established, not only improve individual counselling but also regulate treatment decisions and allow addressing the problem of “charlatans and quacks”.

Advancing to a guideline on CAM use by physicians:

- We have to consider three constellations:
1. Administration of CAM in conjunction with conventional treatments in a curative or palliative situation
2. Administration of CAM after completion of adjuvant therapy in a curative situation
3. A highly palliative setting with a patient facing death asking for an alternative

For all three situations we have to ask for the benefit and risks for the patient. In order to define benefit we should look at the scientific

**Table 2.** Problems in studying CAM. Up to the present, studies on CAM in oncology have limited themselves to a very general exploration

1. CAM literature is not always published in mainstream journals and listed in f.e. Medline.
2. Articles often are written in native language and only accessible as abstract in English.
3. Mostly it is not clear whether a CAM method is applicable to every type of tumour and medical condition or is only suitable for certain settings.
4. Most studies on supportive treatment issues do not look for long term safety as follow-up of the studies is too short.
5. Reviews are often out of date soon after they have been published.
6. Published reports are not revisited and updated regularly and frequently enough.
7. Not all CAM methods are covered and in the meantime, new ones are invented or old ones modified.
8. Furthermore most reviews rely on only few studies if any and therefore tend to be narrative reviews instead of systematic.

data concerning influence on disease, quality of life and side effects. Strength of evidence regarding CAM, aspects of safety and the comparison of chances and risks between conventional medicine and CAM has to be scrutinized thoroughly. In the past, several problems have been encountered in studying CAM. These are summarized in table 2. But the inherent problem of CAM is missing evidence – if we had evidence, it would be easy to define a method as conventional or alternative. Thus we have to set up rules how to confer recommendations on an insecure fundament. In this context it seems appropriate to define a set of principles which will enable the development of the guideline. These principles are based on logical and ethical considerations.

## Ethical fundament for a guideline: Principles for CAM in oncology

**Definition:** There is a clear distinction between complementary and alternative medicine, the former being part of scientifically based treatment strategies the latter suggesting an “alternative” way to cure. Only the complementary approach is scientifically evaluable and can thus be discussed.

**Principle 1:** Any method in complementary medicine has to be tailored to the in-

dividual. This means that benefit only can be defined if it has been proven in a setting similar to the situation of the patient.

**Principle 2:** In cases of unknown benefits, as is typical for most methods of complementary medicine, safety is the most important issue.

**Principle 3:** Cancer is a deadly disease with points of no return; therefore use of any experimental treatment is unethical as long as a proven treatment option exists. In cases of advanced palliative settings, palliative medicine is the standard with which any other treatment has to be compared. It is unethical to deny or delay palliative care in this setting.

**Principle 4:** Conventional medicine and CAM must be assessed equally. This means that both must prove their efficacy and effectiveness following the rules of evidence based medicine.

**Principle 5:** In case of missing evidence both in conventional as well as complementary therapy in a given setting the physician should make his recommendations according to principle 1 and 2. Shared decision making is the recommended way of communication in this situation.

**Principle 6:** Physicians giving advice on CAM must adhere to honesty and sincerity.

No undue hope should be evoked by false promises.

**Principle 7:** Patients' autonomy has to be considered. Complementary medicine should be a means to strengthen autonomy and should not be abused to enhance dependency.

These seven principles follow the ethical rules of Beauchamp and Childress:

- Autonomy – patients have the right to choose, but not obligation to choose
- Nonmaleficence
- Beneficence
- Honesty

## Developing a guideline by synthesis from the principles and the evidence based recommendations concerning discussion on CAM

A synthesis of the ethical principles presented above and the recommendations from Shoffield and others which sum up the evidence on counselling patients on CAM in oncology is the fundament for a guideline on CAM use.

A comparison of both shows, that they are complementary to each other as they focus on communication on the one side and action on the other. There is only a small overlap in the field of patient's autonomy. Table 3 provides a comparison of the recommendations [5] and the principles suggested in this article. In order to achieve maximum safety and efficacy in CAM, ten steps can be identified. They describe the whole process of counselling, decision making and administration of CAM. Each step is accompanied by requirements which are mandatory for its realization. These steps are explained as follows:

### 1. Counselling

All patients with cancer should be counselled about CAM, especially about the methods most frequently used, so that they are able



**Table 3.** Comparison of the principles suggested in this article to the recommendations of Shoffield et al. [5]

Principle	Recommendation of Shoffield et al.
1: Therapy has to be individualized	No equivalent
2: Safety is of highest importance	No equivalent
3: Do not deny therapies with known benefit	No equivalent
4: Evidence on CAM follows the rules of Evidence based medicine	7. Provide balanced, evidence-based advice
5: In case of missing evidence in conventional as well as complementary therapy follow principles 1 and 2	No equivalent
6: Ethical principles to follow are honesty and sincerity	No equivalent
7: Respect patient's autonomy	1. Elicit the person's understanding of their situation 2. Respect cultural and linguistic diversity and different epistemological frameworks 6. Discuss relevant concerns while respecting the person's beliefs
No equivalent	3. Ask questions about CAM use at critical points in the illness trajectory
No equivalent	4. Explore details and actively listen
No equivalent	5. Respond to the person's emotional state
No equivalent	8. Summarize discussions
No equivalent	9. Document the discussion
No equivalent	10. Monitor and follow-up

to judge critically any promises and offerings of dubious therapists and can thus avoid any potentially harmful influences of the method itself or when it is given in combination with other treatments. If desired, patients should be advised about methods which are likely to have beneficial effects. Counseling should be done according to the recommendations of Shoffield and colleagues.

*Underlying requirements:* Oncologists need greater knowledge of CAM therapies. There must be ongoing education in CAM, beginning with undergraduate medical training and continuing during specialisation.

## 2. Evidence in CAM

Selection of a treatment method must take into the account the levels of evidence and

the credibility of the data and its authors. Both have to be evaluated critically. The levels of evidence and grades of recommendations apply as much to CAM as they do to conventional medicine. Generally, the method which has yielded best results should be the one be selected.

*Underlying requirement:* There must be continuing reviews in the field of CAM, aiming to identify new and perhaps rational treatment approaches and also potentially risky or ineffective methods.

## 3. Selection of CAM treatment

Selection of CAM methods must be done rationally and objectively. Only methods which have been investigated in clinical trials and have shown positive effects should

be chosen. Methods based on philosophical or pseudo-religious beliefs can not be accepted unless their efficacy has been proven in such trials.

If this clinical proof is missing, preclinical data should not be the bases for an active recommendation, yet they can be used as a reference to inform patients who are actively asking about a certain method.

CAM is used in two intentions: as supportive agent or as antitumor agent. Since there is no universal cancer "drug" in conventional medicine, the selection of antitumor treatment should focus on methods which have been tested in the type of tumour being treated.

CAM should only be used if it has been studied in a setting similar to the one discussed with the patient.

*Underlying requirement:* Therapeutic concepts for treating different tumours in various treatment situations or supportive situations should be developed.

## 4. Applying CAM methods

In a curative setting and during active treatment, the use of any CAM therapies should be restricted to those methods which have high clinical evidence. In a palliative situation and after all reasonable conventional treatments have been tried more poorly investigated, other methods may be used if patients actively demand for them. However, there always must be some rational to support the use of a method. If this is only based on preclinical data the same rules of counselling as in informing patients on a phase I study must be applied.

*Underlying requirements:* Physicians informing patients on CAM use in advanced palliative care without clinical data or with the intention of using a method's anticancer effects must have excellent knowledge



of all preclinical data of the method. Inclusion of patients in ongoing clinical studies could also be discussed as a true alternative for the patient.

## 5. Safety

CAM methods must have proven benefits and must be safe in relation to drug interactions. If drug interactions are suspected, the CAM treatment must be discussed critically and patients must be advised not to use it. These considerations refer to all kinds of conventional treatments (chemotherapy, radiotherapy, hormonal and immunological therapies).

*Underlying requirement:* Checklists should be developed which can help to exclude the most common causes of drug interactions in oncology.

## 6. Costs

There must be a reasonable relationship between expected benefits and costs. Poorly studied methods should only be considered when costs are low. Patients should be advised to avoid expensive CAM treatments unless they have proven efficacy.

*Underlying requirement:* A list of CAM methods with evidence which fulfils the rules for reimbursement should be set up and funding by a defined process discussed with stakeholders. It must be made sure that this discussion will not open the process to the reimbursement of methods with low evidence.

## 8. Shared decision making, informed consent and documentation

The whole process of counselling and therapy has to be discussed thoroughly with the patient. The principles of shared decision making should be obeyed. Any communication which increases patients' dependence on the physician must be avoided.

Patients should provide written informed consent to their records being used for research purposes. Monitoring of patients during CAM use assessing the course of the disease and adverse effects as well as quality of life is mandatory.

*Underlying requirement:* The physician must have sound knowledge about the course of the disease and the use of adequate diagnostic means. He must also know the side effects of ongoing conventional therapy as well as the CAM method selected and he must be highly sensitive to any sign of interaction.

## 10. Generating Evidence: Studies and Publication

Case reports and case series on CAM methods should be published once a conclusive situation was reached. Practitioners with experience of certain CAM methods should be encouraged to analyse their data. Furthermore, CAM therapists should collect data on certain methods for subsequent analysis.

*Underlying requirements:* As most practitioners do not have experience with publication cooperation with scientists could be helpful. A consented reporting system with defined data sets would enable scientists to find all necessary information in order to decide whether the case report gives hints at the effects of the CAM method used. Case reports and case series can be important when they refer to new medical situations or report new side effects. Clinical studies on CAM must be encouraged. Also trials in conventional medicine should assess the prevalence of CAM methods in order to detect possible positive or negative effects.

There also must be greater awareness of CAM, including the willingness to grant money to support studies in the field and to cooperate with the scientific study groups. Studies should be published in peer-reviewed journals.

## Conclusion

These recommendations represent a framework which should enable the safe application of CAM methods in oncology. Adopting recommendations such as these seems particularly important for cancer patients since they, unlike patients in other areas of medicine, will not perhaps have a second chance. Wrong decisions taken during primary treatment of most types of cancer can not be compensated for later on. This very reason makes it important to monitor cancer treatments continuously and carefully so that patients receive the best chances of a cure. Furthermore, only a rational and evidence based approach to CAM in oncology can make this field more generally respected.

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## Healthcare System Reform in China

Missions set in the three-year plan for China's healthcare reform from 2009 to 2011 have been completed on schedule. Now, please, allow me to introduce you to the basic facts of the current healthcare reform in China.

### I. By achieving periodical goals as scheduled, the three-year healthcare reform achieved remarkable effect

In April 2009, the central government initiated the new round of healthcare reform. In the past three years, we have been sticking to the philosophy of providing basic healthcare system to our people as public goods. Guided by the principle of ensuring the basic, strengthening the grass-roots and establishing the mechanism, providing methodology for coordinating arrangements, emphasizing the priorities, and advancing in a stepwise manner, we intensified leadership, increased input, innovated the working mechanism and improved policy support. The key priorities of the health care reform have been pushed forward and obvious progress has been achieved.

Firstly, residents in urban and rural areas have benefited as seen from the National Health Indicators. Maternal mortality rate dropped from 34.2/100,000 to 26.1/100,000, infant mortality rate went down from 14.9‰ to 12.1‰, and average life expectancy has also increased. Urban and rural residents have access to 41 basic public health care services in 10 categories. The out-of-pocket medical payment for rural residents who have joined the New Rural Co-operative Medical Scheme (NRCMS) decreased from 73.4% three years ago to 49.5% in 2011. The accessibility and affordability of medical care service has been improved. Secondly, health

care resource allocation and utilization have been optimized. With preferential public finance policy towards the grass-roots, rural areas, and public health, the gap of medical care and health development between urban and rural areas has been narrowed gradually. There emerges the tendency of increased utilization of primary healthcare services, and research and science are developed in the health sector. Thirdly, the framework of basic healthcare system has been preliminarily established. Medical insurance for urban employees, urban residents and the NRCMS have covered over 95% of the population, which forms the largest basic medicare security and safety net. The national essential drug system has been implemented in all government-run medical and health institutions at grass-roots level, thus meeting the people's basic needs for essential medicine. Primary health delivery system has been enhanced with improved service quality. Public hospital pilot reform has been pushed forward actively in good order. Access to basic public health services has been enhanced by institutional arrangements with emphasis on prevention. Traditional Chinese Medicine (TCM) plays a more important role in health care and prevention. Fourthly, major structural changes have taken place in total health expenses. Proportion of individual health expenditure dropped from 40.4% in 2008 to 35.5% in 2010 due to more reasonable health financing and led to enhanced health care equity. Excessive growth in public hospital expenses has been effectively controlled, as calculated in comparable price, the annual rise of in-patient and out-patient expenses in public hospitals have been brought down by 3–4% average.

In the past three years, five reform priorities have been promoted and great improvements have been achieved in the healthcare field.

### 1. Basic medical insurance system has been established and consolidated, being a critical step forward to the goal of universal access to health care service

Universal access to medical insurance is the top priority in the healthcare reform. It plays an important role in safeguarding people's health and providing healthy workforce for sustainable development. At present, medical insurance for urban employees, urban residents and the NRCMS have covered 1.3 billion people (over 95%), and the coverage of the NRCMS reached 97.5%. The NRCMS fund pooled has reached 243 RMB Yuan per capita, out of which 208 RMB Yuan is subsidized by governments of various levels. This year, the per capita fund will reach 290 RMB Yuan and the subsidy will be 240 RMB Yuan. In rural areas out-patient expenses have been covered by the NRCMS, and maximum in-patient compensation has been set 6 times higher than rural per capita net income and no lower than 50,000 RMB Yuan. In 86% of the rural areas covered by the NRCMS, the reimbursement rate within the scheme has reached over 70%. Medical insurance pilot on catastrophic diseases also advances. Since the initiation of including leukemia and child congenital heart disease in 2010, till the end of 2011, 93% of the NRCMS areas have started pilot work. In some areas, 6 more major diseases including holergasia, tuberculosis, cervical cancer, breast cancer, end-stage renal disease and HIV/AIDS are also covered, having benefited more than 200,000 patients.

### 2. National essential drug system has been preliminarily established, grass-roots level health care service operated under new mechanism

In accordance with the reform plan, by implementing essential drug system, comprehensive reform of the grass-root level medical and healthcare institution has been



carried out. It aims to build a public management system, to set competitive employment and incentive distribution mechanism, to adopt regulated drug purchasing and long-acting multi-channels compensation mechanism.

Under joint efforts, essential drug system has been implemented in government-run grass-roots medical and healthcare institutions, where essential drugs are distributed and sold with zero markup. The practice of subsidizing medicine services with drugs sales profits has been eliminated. Essential drug system also extends to county level health care institutions and non-governmental grass-roots healthcare institutions. A total of 307 kinds of drugs have been included in the national essential drug list, while additional drugs are added by provinces (autonomous regions, municipal cities). Average 210 kinds of drugs have been added and 29 provinces (autonomous regions, municipal cities) have adopted new measures for the purchase of essential drugs.

Meanwhile, we promote the comprehensive reform of the grass-roots level medical and healthcare institutions. Government-run grass-roots level medical and healthcare institutions are defined as public institutions, provided with special fiscal subsidy and regular balance of payment subsidy. Staffing system of total amount control and dynamic management is adopted while staffing checking and posts adjustment has been carried out. Hence a new employment mechanism is founded offering employees entry and exit, promotion and demotion. In government-run grass-roots level medical and healthcare institutions, comprehensive quantified performance evaluation and performance-based salary system have been implemented, linking the evaluation results with the government subsidy and the income of the healthcare staff. Preliminarily, the compensation channel mainly supported by fiscal investment and health care insurance payment has been formed in grass-roots medical and health care institutions.

The subsidy to village doctors for providing public health services has been realized and essential drug system is promoted in village clinics.

### **3. Healthcare delivery system at grass-roots level has been effectively consolidated and the goal of “strengthening the grass-roots” has been preliminarily realized**

During the past three years of the reform, the central government had invested 47 billion RMB Yuan to support 35, 000 housing construction programs of the grass-root medical and health care institutions. Grass-roots healthcare service delivery system has been strengthened; poor medical facilities and weak service capability in rural and remote areas has been greatly improved; qualification, knowledge and the number of personnel recruited are all improved. By initiating the general practitioner cultivation plan, 36,000 health workers in grass-roots medical and health institutions received on the job training to become general practitioners. Through the central/western rural area-oriented cultivation plan, more than 10,000 medical students were trained free of tuition for grass-roots health institutions in central and western rural areas. In the three years, visits to township hospitals, community health centers or stations, village clinics amounted to 10.81 billion person times, 61.4% of the total number of visits to medical institutions at all levels.

### **4. Equal access to basic public health services has been enhanced**

In the past three years, the coverage of the basic public health services has been expanded and planned mega public health programs have been accomplished ahead of schedule. Major communicable disease prevention has been improved with the principle of prioritizing prevention put into good practice. The basic public health ser-

vice fund reaches unified standard in both urban and rural areas and is increasing year by year, from 15 RMB Yuan in 2009 to 25 RMB Yuan in 2011 per capita. A total of 982,000,000 residents now have health records and 62.9% of them have standardized electronic health records. Mega public health service programs in total have covered nearly 0.2 billion people.

### **5. Public hospital pilot reform is advancing systematically, experience in institutional reform has been accumulated**

The reform exploration has been carried out in 17 national pilot cities, 37 provincial pilot cities and 2000 public hospitals, and positive progress has been achieved in service delivery, institutional innovation, internal management and diversified pattern of hospital running. Through reducing the eliminating drug markup, payment mode reform and separation of revenue and expenses, we are exploring ways to separate medical services from drug sales. By improving the supervision system and emphasizing the government's function in supervision, we are actively searching for an effective model of administration reform in public hospitals. Comprehensive pilot reform of county-level hospitals has started, featuring eliminating the practice of subsidizing medical services with profits from drug sales, and advancing comprehensive reform in management system, compensation system, human resource system, purchasing mechanism and pricing mechanism. All these measures aim to gradually set up a new public hospital operation mechanism that maintains the public welfare nature, motivates health professionals and ensures sustainable development.

## **II. Reflection of the three-year healthcare reform**

The three-year health care reform practice proves that the guiding ideology, principle



methodology and basic pathway set out by the central government are fully in line with our national circumstances, health care development rule, and the wish and needs of our people. We summarize our experience and reflection as follows:

## 1. Strengthen the policy implementation and promote the establishment of basic healthcare system

The guiding documents on healthcare reform of the central government explicitly stipulated that basic medical and healthcare services be provided to the people as public goods. This demonstrates the significant change of our health development from ideology to mechanism. It shows the determination of the Party and the government to improve people's well-being by taking measures in the health sector. The health system carries out the deployment from the party central committee and the State Council unswervingly, follows the principle of the central government document with perseverance. These are the fundamental guarantees to achieving the expected results of the healthcare reform.

## 2. Increase input and promote institutional reform

Institutional reform has a comprehensive, fundamental and long-term influence on the development of the health sector. In order to obtain success, we must not only increase input, but also pay attention to institutional transformation in order to reform the old improper interest pattern.

## 3. Insist on the leading role of the government and promote inter-department coordination

As the healthcare reform is a critical transformation in society, powerful leadership

and working system secure its smooth progression. Leading groups and inter-department coordination mechanism set up by the central and local government have played an important role in overall planning, consensus building and the reform promotion.

## 4. Highlight top-level policy design and advance each reform task in a coordinated manner

Adhering to the masterstroke of the healthcare reform document from the central government, insisting on the five key reform priorities, we promulgated series of guiding policy measures. Every slight move may affect the work as a whole. Hence we must make an overall plan and take all factors into consideration. We must gradually carry forward the work with the supporting policy, through close coordination, by highlighting the key points.

## 5. Enhance policy implementation and motivate medical professionals

Whether we can accomplish the reform and make breakthrough in the key tasks or not depends on arousing the enthusiasm, creativity and activeness of medical professional to let them devote to the reform with heart and soul. Therefore, we must improve the relevant policies and set up salary system, performance evaluation system and incentive distribution system compatible with the features of this profession. Related issues as welfare and benefits, career development and practicing environment should also be addressed appropriately.

## 6. Strengthen the joint actions of central and local governments and respect the local pioneering spirit

Along with the implementation of healthcare reform policies of the central govern-

ment, local experiences have been drawn and transformed into national policy. This leads to the interaction between the guidance of central government and the practice of local health departments. This three-year reform journey reveals that the driving force and sources of practice are at the grass-roots level. Thus, we shall emphasize that local governments should explore to make breakthroughs, and experiences in this regard can lead to central-local interaction and make national breakthroughs.

## III. Continuously promote the healthcare reform

The twelfth five-year period serves as a linkage between the past and the future in the healthcare reform. Guided by the healthcare reform spirit and principles enshrined in the address of Vice Premier LI Keqiang at the National Working Meeting on Deepening the Healthcare Reform, we shall intensify our efforts in the three priorities stipulated in the twelfth five-year plan of the healthcare reform, namely, accelerating the construction of the basic medical insurance system, improving essential drug system and enhancing new operation mechanism in grass-roots medical and health institutions. We shall focus on medical insurance, medicine and medical services and take well-coordinated action jointly in these three aspects so as to achieve greater progress in the healthcare reform.

### 1. Accelerate the construction of the basic medical insurance system

**Firstly, consolidate the coverage and enhance the basic medical insurance level.**

On the one hand, a stable fund increase mechanism should be set up. With the rising income of urban and rural residents, subsidy from the government shall rise accordingly. By 2015, yearly subsidy for urban residents' medical insurance and the

NRCMS shall have reached above 360 RMB Yuan per capita. On the other hand, with the increased funding, insurance package shall be expanded and the compensation proportion shall be raised, featuring about 75% of the in-patient expenses paid within the urban employee medical insurance, residents' medical insurance and the NRCMS and the out-of-pocket medical payments for residents shall continue to be reduced.

**Secondly, promote reform in medical insurance payment.** The payment system reform is an important way to control expenses. In order to replace the current pay-by-item, such payment methods as total prepaid, diagnosis-related grouping, fee-for-service and/or capitation shall be adopted. New ways of payment will further regulate the medicare service, control the expenses and promote the comprehensive reform of the medical institutions.

**Thirdly, improve basic medicare management and service.** Information management should be forwarded to avail resident health card, realize immediate accounting in overall planned regions and speed up trans-regional immediate accounting. We are also to level up the overall planning of the NRCMS and increase fund risk resistance. The NRCMS funding is encouraged to be used for purchasing commercial medicare insurance as complementing the medicare insurance system.

**Fourthly, explore to build medical insurance for catastrophic diseases.** By linking the NRCMS fund and medical aid, the compensation rate for catastrophic diseases shall reach 90%. By the end of this year, the insurance scheme of 8 major diseases including child congenital heart disease and leukemia will be implemented entirely and in 1/3 of the overall planned regions, 12 kinds of diseases including lung cancer, acute myocardium infarction, hemophilia and hyperthyroidism will also be included to maximally prevent disease-led poverty

and disease-led back to poverty for the NRCMS peasants.

## 2. Consolidate and improve essential drug system and new grass-roots operation mechanism

**Firstly, consolidate national essential drug system.** Based on the previous 3-year work, the system shall be expanded to all village clinics this year. In the meantime, essential drugs shall be given priority in terms of distribution and use in other medical institutions. The national essential drug list shall be improved, local essential drug list amendment, drug use by medical institutions and purchase mechanism shall be further regulated in order to ensure safety, efficacy and timely supply of essential drugs.

**Secondly, keep promoting comprehensive reform in grass-root medical and healthcare institutions.** Improve the long-term stability of the multi-channel compensation mechanism and implement the fiscal input policy to the letter. Carry out the general consultation fee and medical insurance payment policy and ensure a long-term stabilized operation of grass-root medical and health care institutions. By means of improving the performance evaluation system, salary and distribution system in line with medicare character, there should be a reasonable gap in salary in order to motive health professionals.

**Thirdly, improve grass-root medical and healthcare service.** Standardized construction of grass-root medical and health care institutions will be supported continually, aiming to cover more than 95% of them by the end of the twelfth five-year period. General practitioner (GP) team building will be promoted to cultivate over 150 000 GP by 2015, featuring more than 2GPs for each 10 000 urban residents and a GP in every health clinics in towns. Free medical students orientation training and GP spe-

cial duty plan will also be continued to encourage talents serve in grass-root areas. The issues of rural doctors in terms of function positioning, working environment, compensation and pension should be properly addressed to build a solid foundation for rural healthcare system.

## 3. Advance comprehensive public hospital reform

Public health reform shall focus on the county level. Efforts should be made to promote institutional reform and to provide convenient and accessible health services to the people. According to the recently issued *opinion on comprehensive pilot reform in county level public hospital* by the General Office of the State Council, the reform should follow the principle of joint action of the central and local governments with inner vitalization and outer thrust. According to the requirements of the reform to separate administration from service, management from running, medicare from medicine, the for-profit from the non-for-profit, we shall eliminate the practice of subsidizing medical services with profit from drug sales as the key link, the compensation system reform and independent management of hospitals as the breakthrough points. We shall promote reforms in the administration, compensation, personnel distribution, pricing, medical insurance payment, purchasing and supervision systems.

**Firstly, eliminate the practice of subsidizing medical services with profit from drug sales,** a compensation mechanism formed under special historical conditions. At present, this mechanism has cast negative influence, hurt the public nature of public hospitals and become a malady need to be eliminated in the healthcare field. Public hospital is the main body to provide medicare services in China while issues of accessibility and affordability mainly occur here. Unless we eliminate the malady, it is



hard for us to eradicate the prescription of excessive and costly drugs, and to suppress the improper increase of medicare expenses from the root. This mechanism hurts not only the interests of the people but also the doctor-patient relationship. With its existence, it is hard to form the mechanism of grass-root gatekeeper, dual referral, prevention-treatment combination, acute-chronic separation and inter-institution coordination.

**Secondly, improve comprehensive compensation mechanism.** Income reduced by eliminating the practice of subsidizing medical services with profit from drug sales should be compensated by setting up multi-channel compensation mechanism of medicare insurance-finance joint action. We need to properly adjust the medicare service pricing system, to improve cost accounting of public hospitals, to increase general service fee, nursing fee and operation fee that give expression of the medical professionalism and to fully respect the professional dedication and values of medicare service. At the same time, we should control the total amount and adjust the structure, and reduce large equipment examination fee to achieve total balance. Since medical insurance has become the main funding for public hospitals, we must give full play of its compensating function, to promote payment reform, to include the increasing expenses into insurance reimbursement and to avoid adding burden to the people. Meanwhile, governmental investment shall be increased, including subsidies for public hospital infrastructure construction, large medical equipment purchase, personnel training, key discipline development, pension and policy-related loss.

**Thirdly, motivate the medical professionals.** As medical professionals are the major driving force of the healthcare reform, a salary system in which special features of this profession are taken into consideration should be set up. To ensure an income in-

crease after the reform, we should explore to reform the current total wage limit in public institutions and raise the expenditure ratio on personnel over operation. In the meantime, to provide medicare staff a promising career development, we should create a good environment, improve professional qualification system and develop key clinical disciplines. Furthermore, to build a harmonious doctor-patient relationship, we should adopt more training on humane care, enhance mutual trust and build the third-party negotiation mechanism.

**Fourthly, improve medical care services in public hospitals.** We will strive to recruit talented personnel, and formulate favorable policies on staffing administration, professional qualification appraisal, salary and welfare, so as to attract the talents to practice in public hospitals. By enhancing performance evaluation and incentive mechanism, implementing standardized resident-training and on the job training for medical professionals, we shall improve the overall medicare services in public hospitals. A special post will be set up in county level hospitals and badly-in-need high level talents will be recruited. In the meantime, central-local government's joint action will continue to target support at designated areas, and first diagnosis at primary health facilities, graded diagnostic and treatment, and dual referral system will be developed.

#### 4. Promote other healthcare reform work in a coordinated manner

**Firstly, improve equal access to public health service.** We shall proactively respond to population aging and disease model transformation, strengthen chronic non-communicable disease management, innovate working methods and enrich the services we provide, gradually expand the package of basic and mega public health services and benefit more people. The role of

Traditional Chinese Medicine (TCM) shall be given full play in preventive medicine while proper TCM preventive technique shall be promoted. By 2015, expenditure on basic public health service shall reach 40 RMB Yuan per capita.

**Secondly, accelerate the process of encouraging multi-sectors to run medical institutions.** We are to further improve medical practicing environment and implement the policy encouraging private sectors to run medical institutions. Priority support will be given to private nonprofit medical institutions which are encouraged to develop towards higher level and larger scale. Qualified medical professionals are encouraged to open private clinics. By 2015, non-public medicare institutions beds and service shall take up 20% of the total.

**Thirdly, innovate personnel cultivating and utilization system.** Standardized resident training system shall be built and continuing medical education system shall be improved. Meanwhile special talents in urgent need and high level personnel shall be cultivated. Improvement is also expected to be made in doctor multi-site practicing and in medical insurance perfection as well as in the third-party negotiation mechanism settling medical disputes.

**Fourthly, promote health informatization.** We shall further promote the creation of electronic resident health record and electronic medical record, based on which to promote examination results recognition among different medicare institutions, remote consultation and in-time supervision over medical practice. Meanwhile, resident health cards will be spread to facilitate seeking medical service and health management.

*Chen Zhu, Health Minister of China  
Report at the China Bio-industry  
Convention, June 28, 2012*



# World Medical Journal



## Never Say Never, Uganda!

*This is a story with pictures of my visit to Kampala, the capital city of Uganda, to find out more about how and where the President Elect of WMA, Margaret Mungherera, lives and works.*



On 27<sup>th</sup> December, 2012, I flew into Entebbe airport from Kenya, and in just a couple of days I was able to visit Margaret's home, her parent's home, Butabika Hospital, a mental hospital where she worked for 19 years and Mulago National Referral Hospital where she currently works as Senior Consultant Psychiatrist. I also visited the Ministry of Health headquarters, her primary school, her medical school, Makerere University main campus and Kampala International University, a private institution where she serves as Council member.

I also had an opportunity to meet her husband, Richard, her parents and some of her siblings, co-workers, students and Rotary club members. I was driven around in a car which though provided for her by the Ministry of Health, she has to pay for the driver's salary and the fuel.

When European or American doctors think of Uganda, usually two stereotypes cross their mind. The first – medicine in

Africa is very charlatan, they use frog's skin to treat burns, and soil – to get rid of diarrhoea, but a very ill person gets visited by a shaman who dances around the patient six times first. The other stereotype – well, if you are a doctor and, god forbid, went to Cambridge, then you are just like all of us, so go ahead and pay the same conference fees as we do, start giving your patients all the necessary drugs and stop those excuses! Something like this can be heard from colleagues who read in the business news that each year the economic growth of Uganda is 3.5%. But what they can't read among the lines is that just a couple of years ago, the economy of Uganda which was about a hundred times behind the leading economies, and even now is still far behind, is rapidly growing due to coffee and fish as the major exports and that Southern Sudan relies on Uganda for its food and basic essentials.



There are only 4700 physicians for a population of approximately 32 million people! In rural areas of the country, the health centres are mainly headed by nurses and in some places by clinical officers who are known elsewhere as medical assistants or physician assistants. A large part of the population can only have access to a nursing assistant who is someone who has had a few weeks of basic medical training. The number of pharmacists is very low and so drugs are often dispensed by lay people.

Every year, about 250 young doctors graduate from the four medical schools in the country with most of them shunning employment in the public hospitals opting to join the private sector or leave the country with the hope of finding better working conditions. In the past, the majority of Ugandan doctors migrated to the Republic of South Africa, but more recently many are migrating to neighbouring Rwanda and Southern Sudan. Some of those who manage to obtain employment in South Africa have moved on to the USA, Canada and Australia.

Margaret's brother, Andrew works as an orthopaedic surgeon in South Africa and her youngest sister is doing her PHD in Public Health in Australia while she does her Family Medicine residency in Auckland, New Zealand. Another sister, Lydia, also a physician, is a well known HIV/AIDS activist. She returned to Uganda from South Africa where she worked as a Medical Officer for about 20 years. Margaret herself chose to stay in Uganda where she has made her name in the field of mental health.

Margaret Mungherera was born in Jinja, a town located on the shores of the largest lake in Africa, Lake Victoria, and the source of the River Nile which is the longest river in Africa. Uganda or Kenya is the place where 2 million years ago our ancestors got off a tree and sharpened a stick to chase leopards away. Now that is what actually started our way to space travels in the 20<sup>th</sup> century and a rapid spreading of the Internet in the 21<sup>st</sup>.

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About a million years ago, here in Kenya (or Uganda) our ancestor learned how to start a fire and had the first “barbeque”, and in another half million years packed his backpack and went ahead to explore the rest of the globe – Europe and Asia at the beginning, then Australia, Americas and Antarctica. Being at Lake Victoria in the city of Jinja makes it easy to imagine how it actually happened when our ancestor got up, stretched, took his axe and said he was going away to see and explore other countries. Uganda should be the Holy Land to come to feel your roots.

Uganda is full of contrasts. Just next to a fancy colonial building with lots of marble is a simple and tiny shack where the owner sells live chicken to be able to make a living.

The side roads in Kampala are like arteries – full of life. They sell everything – drinking water, meat, fish, bananas, vegetables, fruits, beds, reclining chairs that are being made right there in front of your eyes. They sell fire wood, construction materials, gasoline, paints, but considerably more than anywhere else in the world – fashion goods. Nearly every store is proudly showing off gorgeous and fancy dresses. I have to admit that never ever on Europe’s streets will you

see as many women dressed in long evening gowns as I saw here in Uganda. Ugandan women go to church dressed up like European women would do for, say, a presidential reception. And I have to admit those dresses are absolutely wonderful, designed with such taste! Local designers are lost to the rest of the world, Armani and any other top fashion designer would just die of jealousy seeing what Africa’s colours have to offer.

Margaret Mungherera is a true patriot, and carries her WMA brooch attached to a blouse of all shades of yellow, orange and red.

We all come from different families. I am very lucky to have met Margaret’s parents, Seth and Joyce Mungherera. They live approximately 6 kilometres outside the city.



Two sons and a daughter still live with them, a son, Dan is a graphics artist, the other, Peter a journalist trained in Zambia and with many years of working experience in Germany, speaks fluent German. The family itself is very conservative and carries strong traditions – the father plays the piano, while the daughters sing.



Margaret’s mother keeps all Margaret’s local and international awards which include a certificate of her Honorary Doctor of Science degree and another from the Ministry of Health in recognition of her advocacy efforts. Since the Ministry of Health does not have enough funds to adequately pay Margaret for the work she does as Senior Consultant she has been assigned an official vehicle which she fuels herself.





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Margaret's father is a retired public servant and her mother worked for more than 40 years as General Secretary for Uganda YWCA and for several years was executive member of the World YWCA representing Eastern, Central and Southern Africa. She is therefore widely travelled. The family belongs to the Anglican Church, so Margaret and I visited St. Paul's Cathedral, very beautiful, simple, spacious and mighty, and located on top of a hill.

We found the choir singing in a manner that will make any organist plain jealous. Mendelssohn would have been quite surprised to know how vocally rich, polyphonic, beautiful and rhythmic his Wedding March can be. However, the choir sang it faster than we are used to hear it in Europe (a wedding ceremony was being held in the cathedral during our visit).



Most Ugandans are either Anglican or Catholic with a small number belonging to the Moslem faith. Each of the three religious groups has its main house of worship situated on a hill.

We visited the primary school which Margaret had attended and it had formerly been known as Kampala European Primary School.



During the whole time she was there, there was only one black teacher. We found extensive renovation work being done, but the old school bell is still in its place though no longer used. More than 50 year old tradition of holding an assembly for the whole school is being continued. It was introduced during the time of an English headmaster who was strict and insisted on punctuality. The current headmaster believes punctuality should not be instilled by using a school bell. Children should simply use their own watches to learn to keep time. The lawn around the school is neatly mowed, bushes carefully trimmed.

Margaret had her secondary school education at a famous girls school, Gayaza High School, approximately 10 km from Kampala city centre. Then she was admitted to Makerere University Medical School, the oldest

medical school in Eastern and Central Africa known for its research and training. At one time it was the only medical school for Kenya and Tanzania.



Naturally, a lot has changed since the time Margaret graduated. There are now four medical schools in Uganda. Margaret was very instrumental in founding one of them, Kampala International University (KIU). We visited the main campus of KIU which has several large buildings and the grounds are green and clean.



Burglar proof windows and doors and security guards are common in public buildings and homes, a reminder of the insecurity often experienced by the population during the times of Idi Amin.

Margaret started her working life in Butabika Hospital, the only mental hospital for a population of more than 30 million people.



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She worked there for 19 years before she requested to be transferred to Mulago Hospital where she is currently based. Butabika Hospital is a 700 bed hospital located about 9 kilometres from Kampala city centre and has a beautiful view of Lake Victoria. The Hospital is incredibly clean, has beautifully kept green lawns, decorative bushes, flower gardens and gravel walkways. The male and female wards are separated by the office buildings. The environment reminds one of a European resort. Margaret's former co-worker, David, now acting as Executive Director, gave us a brief tour of the Hospital.



Margaret and David are 2 of the small number of psychiatrists, 34 to be exact, for a population of 35 million people. Yet, mental health problems such as depression are common in Uganda with approximately 40% of the population affected. This may be the reason why Margaret is in high demand, constantly receiving referrals and consultation from colleagues all over the country. When she responds to the calls in Luganda, the most commonly spoken vernacular, I am only able to pick up names and doses

of common antidepressants and antipsychotics. In addition to the severe shortage of mental health specialists, there are often inadequate supplies of drugs and hospital beds in the rural parts of the country where the majority of people live.

On the other hand, Uganda has made impressive progress in fighting HIV/AIDS with the prevalence dramatically going down from 30% in the 1990s to the current 7.3%. Maternal mortality is still a huge problem and so is malaria and TB. Yet, according to the UN, Ugandans are amongst the most optimistic people in the world. They see a lot more light and hope in the world than people in rich European countries and North America.

Margaret got married to her husband Richard who is a retired banker. On our way to the Hospital she pointed out to me the house they lived in for 9 years.

Although she left the Hospital 9 years ago, many people in the nearby trading centre still recognize her and wave to her. Store owners are eager to welcome us in their stores.



Margaret Mungherera now works at Mulago National Referral Hospital as Senior Consultant Psychiatrist in the Department of Psychiatry.

She also has additional administrative responsibilities of the Clinical Head in charge of the Departments of Internal Medicine, Psychiatry and Community Health. She still maintains an office in the Department of Psychiatry, but the emptiness of the office shows that she hardly spends time there. All the doctors we met seemed free to consult her which is a sign that they consider Margaret more as a friend than an administrator.



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Her main administration office is located in the offices of the Department of Internal Medicine because it is the largest of her three departments. It is not too big and has a maroon sofa set, four chairs and one table.



There are several files on the shelves, some for the Hospital, others for the Uganda Medical Association of which she is President and others are for the Commonwealth Medical Association where she was once Vice-president and is now Treasurer.

Other documents are from the Medical Associations of Uganda, Kenya, Zambia, Rwanda and Burundi. These countries form the East African Community and the national medical associations (NMA) have been working together to ensure quality

standards in training and health care. The NMAs have accomplished much as regards bringing their regulatory bodies together to harmonise the training of doctors including the curriculum. As a result there is joint inspection of medical schools in the five countries with reciprocal recognition of qualifications so doctors graduating from a medical school in any country in the region can work in any of the other four countries without doing pre-registration exams. Margaret has been at the forefront of this development.

One of many problems that Margaret had to solve during our tour round the city is evidence of the state of affairs as regards the political governance of the country. The government is investigating the death of an outspoken member of the Parliament and a member of the ruling party. A pathologist acting on behalf of the family and the Parliament was arrested by the police as he tried to leave the country to take the specimens to South Africa. As President of the NMA, Margaret has had to make statements in the media about the opinion of the medical profession.

I am not saying Parliament members die every day in Uganda, but when they do, questions like this do come up.



It is obvious from her conversations with doctors, nurses and other medical staff that Margaret Mungherera is a strict boss, there is none of that sparkling humour we are used to at the WMA meetings. Although I do not understand the local vernacular, I can sense from her tone dissatisfaction about the care of patients, the wet floor and the conditions of the wards. The wards are congested with some patients sleeping in the hallways. Visiting relatives, many with young children, of patients sit patiently outside on the grass, waiting to see their beloved ones. The hospital grounds are beautiful – plenty of trees, bushes, long legged marabou storks walking around. My seemingly innocent question about correlation between the Pathology Anatomy unit and those marabou storks on the roof went by unanswered.

Meanwhile, the marabou storks at the Makerere University main campus have decided to build their nests in the trees of the alley right in front of the main building, making the trees dry due to the many nests in the tree.

The exodus of physicians from Uganda to elsewhere is determined by two important aspects – first of all, an experienced senior doctor working for government is paid approximately USD 1000 per month, while their colleagues in Kenya make about 4-5 times more, and the situation is even better in Rwanda where the salaries are 5-6 times better. This means doctors



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have to supplement their meagre pay by doing private practice. Margaret is not an exception. She supplements her income by seeing private patients in the evenings at a clinic owned by a friend who is a paediatrician.



The second aspect is the incredible workload due to the lack of physicians. More than 60% of the population receives health care from the government hospitals and health centres. This covers tuberculosis, cancer and HIV/AIDS. This is a huge workload for the few doctors available.

Though free, still the services often lack drugs and investigative facilities. This means patients often have to be prescribed drugs so they procure them at their own expense from local drug shops. This makes doctors feel uncomfortable because the majority of patients are poor.



As I watched her friend examining a small child, I was reminded of the infant mortality rate which is still alarmingly high and is largely due to diarrhoeal diseases, malaria, malnutrition and HIV/AIDS. Being a large city, Kampala is very different from the other parts of the country. This is because the health care services are more accessible. Uganda has very few medical specialists if compared to the United Kingdom for instance that is approximately the same size.

That being said, the average life expectancy is approximately 45 years mainly because of HIV/AIDS and the high maternal mortality rate which is around 490 women dying for every 100,000 live births and the high infant mortality rate. Indeed, healthcare has to come first, then statistics. There are many private clinics in Kampala and outskirts, but primary care is still in high demand.

All these issues seem to be important enough for us to go visit the Ministry of Health of Uganda. I do have to tell, it was an early afternoon of December 27, when the rest of the world is stuck between celebrating Christmas and New Year's.



Unfortunately, the security measures at the Ministry of Health headquarters seem more relaxed than elsewhere where anyone coming in has to be searched or scrutinised by the security guards. Here, the doors are open and anyone is free to go in and out. The doors of the Minister of Health and her deputies are locked which as Margaret points out is because of the Christmas season. We run into a Commissioner who politely advises us to come back the following week when the holiday season is over. But here is the good news – it is nice to watch Margaret Mungherera walk freely into the Ministry, a sign that the President of the National Medical Association means a lot to the country. Of course, it would have been nice to see the Minister of Health jump out of her chair to welcome Margaret but she just was not there... And I do understand that she does not always have to just sit in her office signing documents. There is so much work to be done away from the Ministry head offices.

Meanwhile, an Irish doctor who came to work in Uganda as a missionary several years ago, has built a state-of-the-art hospital near the city centre. Even though he has been elected as one of the four mayors of the city, he still has time to spend some time at his hospital even during the holiday season.



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Rotary is a very important part of Margaret's life. During her time as Country Chair, she was able to have a total of nine new Rotary clubs formed. Rotary has supported the equipping of hospitals and Rotarians are even constructing a new Cancer Ward at one of the Catholic church-run hospitals. My personal impression was that Ugandan Rotarians are generally not wealthy people compared to the average European but they are keen to be involved in charity work and to donate generously.

Everywhere we go, we are greeted by many people who know Margaret and are eager to talk to her. These include members of her Rotary Club, lawyers, bankers and government officers. A few people introduce themselves as her former patients or family members of her former patients and respectfully greet her from a distance.

I enquired of Margaret as to her priorities during her term as President of the WMA. Her interest is increasing access to health care. A patient should be able to see a doctor regardless of his/ her status, age or where in the country they live. She is concerned that Africa suffers from human resources for health crisis. She is however quick to add that the crisis is also affecting other parts of the world, including Europe.

As a doctor working in Africa, Margaret is concerned about the high maternal mortality and infant mortality rates in many of the African countries. Infectious diseases continue to be the major cause of morbidity and mortality. However, non-communicable diseases (NCDs) including hypertension, cardiac diseases, cancer are on the rise in Africa. This is largely due to the changing life style including increased consumption of alcohol and tobacco products. Many Ugandans are not able to access a doctor and in the best scenario may be able to see a nurse.

Margaret is participating in the process to revise the Declaration of Helsinki (DoH).

These important ethical guidelines for research involving human subjects will be clocking 50 years during her term as President of the WMA.

She recently attended an experts meeting in Cape Town, South Africa, and will be attending review meetings to be held in Tokyo and New York. Her brief discussion about the DoH shows that she is concerned about the adverse effects the DoH is likely to have on poor countries.

There is a large resort hotel on the suburbs of Kampala city and on the shores of Lake Victoria where the Commonwealth Head of Government Meeting (CHOGM) was recently held. It is a popular venue for international meetings with ample conference facilities and a scenic view that according to Margaret can easily host a General Assembly of the WMA.



To my mind the costs would be too high but Margaret believes the government and international organisations would be willing to support a meeting that attracts medical professionals from all over the world.

To date, South Africa is the only country in Africa that has hosted a WMA event, moreover, only two WMA presidents have ever visited Uganda.

I put it to Margaret that the Uganda Medical Association might not be able to afford such an event and asked her about the Association's financial situation. For the last few years the government has not supported the Association financially as it used to do in the past. Occasionally some departments sponsored doctors in rural areas to attend the annual meetings of the UMA.

Government regional hospitals have sometimes provided the UMA with space for CPD seminars. A few District Health Officers have sponsored their doctors to be able to travel to Kampala and occasionally paid the conference registration fees. Some of the costs are covered by the fees pharmaceutical companies pay to exhibit at the conference venue. Every so often a corporation will offer to sponsor such events, for instance, the electricity distribution company has recently offered the UMA support for CPD seminars for doctors in remote areas.

The members of the Association recently registered a savings and credit society for its members and have already received a small contribution from the President of Uganda. The Association is a shareholder in the society and will use funds obtained from savings to put up the UMA House.

The office block which was given to the UMA by President Idi Amin in the 1970s was repossessed by the previous owners in the early 2000s. Since then the Association has been renting offices.

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The biggest more recent accomplishment of the Association has been the almost 300% raise in salaries of junior doctors working in remote areas. The salary of those doctors is now higher than that of a specialist working in the national referral hospital in Kampala. Margaret believes that the number of doctors working in the rural areas where the majority of people live needs to be increased. Increasing access to doctors in rural areas will have a significant impact on the morbidity and mortality of people living there and lead to economic growth and development.

Margaret witnessed the signing of the memorandum of understanding by the WMA and the World Veterinary Association. As a result the WMA and the Uganda Veterinary Association will be holding a One Health Conference in Kampala. The theme of the conference is "Disease Eradication: What will it take?" and the areas to be covered include disease surveillance, policy, advocacy, communication, disease prevention and control. The conference has received tremendous support from the WHO, UNICEF, USAID and the University of Minnesota, USA. Margaret plans to spend her year as President encouraging the NMAs in low income countries in Africa and the Middle East to participate in the WMA activities. She would like to see stronger NMAs twinning with and mentoring the smaller NMAs. Her specific areas of emphasis will be the human resources for health crisis, maternal health, mental health, HIV/AIDS and non-communicable diseases (NCDs).

On the 28<sup>th</sup> December, I briefly visited the apartment complex where Margaret lives with her husband Richard.

The apartment complex is located in the eastern part of the capital city, Kampala, and is near the shores of Lake Victoria. Right across from where Margaret lives is an elementary school for Moslem girls. Islam is commonly practised in Uganda especially with the large influx of refugees from

Eritrea and Somalia. The large mosque on one of the hills of Kampala was donated to Uganda by Muammar Gaddafi and was named after him.



She collects wooden mementoes from all the African countries she visits. I laugh because I believe they are made in China which she says is not true.



Margaret's husband Richard has a firm handshake, a low voice, a friendly smile and a keen interest in Margaret's activities.



He knows the names of all the leaders of the WMA, what they look like and what they do. He sits in the passenger seat by the driver in the car, Margaret sits behind him. Our destination is the source of the River Nile, where it comes out from Lake Victoria. I have "googled" Jinja and so I am aware the distance is approximately 80-90 kilometres. They rush me saying that the term "highway" has a whole different meaning in Africa....

The traffic made of passenger minibuses, large trailers on their way to Kenya, occasionally pedestrians and large herds of cattle, sheep and goats and even chicken crossing the main road make our travel much slower than it should be on a highway. Toyota minivans rule the road – they are the most popular mode of public transportation in Uganda.



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Where in Europe oncoming cars would slowly pass by each other, here it's common to see two cars in one lane pass each other with the side mirrors colliding. Wherever there is a speed limit of 20 km/h, there is a hawkler trying to sell some food through the window. The sides of the road are also popular meeting places for motorcyclists.

Margaret's driver Ibrahim is also Moslem and is very polite and calm. One can learn a lot from him on the highway of Uganda. Driving here is not as difficult as it is for instance in India where there seems to be no traffic rules.

Many of the roads are of bad quality and there are traders on the sidewalks often on both sides narrowing the roads even more.

It is not unusual to find a truck parked by the roadside with the driver selling pine-apples from it.

Normally, there are three people on a motorcycle but sometimes the kids are seated on top of it. And their riding makes me worry about Uganda as an organ donor country...



We drive through woods (even there are a lot of pedestrians).



It is a broadleaf forest – Uganda is more than 1 km above the sea level and the air temperature is not burning hot. Information available for public states that Uganda is constantly planting new forests, but Margaret disagrees – she thinks that even the existing ones are very poorly maintained.

Also, she is not happy about Uganda's results in preserving gorillas and chimpanzees, let alone savanna animals. Especially hard is her take on military's destructive actions against preserving forests and animals. Being green is just another Margaret's interest amongst many, she is ready to fight the global warming because in her opinion, rain forests play an essential role in the climate change and producing oxygen. In general, Uganda is a very green country – there are big trees in the cities, a beautiful lawn and bushes surround every house.



After a two hour ride, we arrive in Jinja, where Margaret was born in the local hospital. Jinja was once the most industrious town in the country but all this changed with the coming of Idi Amin. Some of the areas still look clean while others are run down and there is evidence of rehabilitation.



There is evidence that there are ongoing efforts to improve the sanitation standards of the town. The reconstruction is a common sight in many of the towns in Uganda in between large residential houses with beautiful gardens.

We get out of the car, pay the parking fees, then go down to the River Nile where we eat delicious fried tilapia fresh from Lake Victoria accompanied by a cold Nile Gold beer.

As we take in the cool breeze from the source of the longest river in Africa, the President Elect continues to share her aspirations for the WMA. I wish her the best knowing that with her energy and charisma, the Annual General Assembly will come to Uganda sooner than later.

*Dr. Peteris Apinis  
Editor in Chief, WMJ,  
President of Latvian Medical Association*



Susceptible Healthcare Professionals



Alley Ronaldi

The vaccination rates among healthcare professionals are shockingly low. Yet, these are individuals who are most frequently exposed to communicable diseases. Our member organizations should be informed about these inconsistencies among healthcare professionals.

Even in the developed world there are significant inconsistencies in vaccination rates

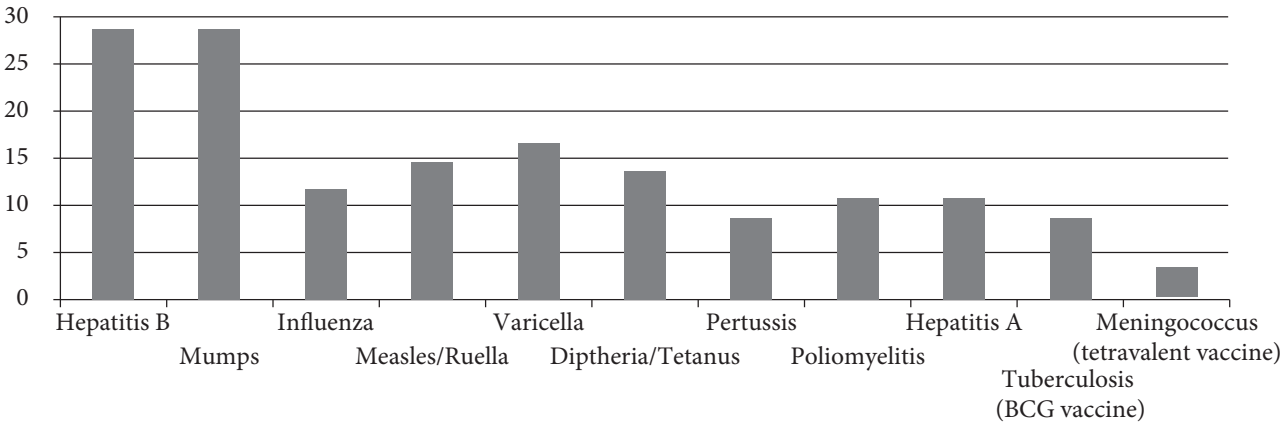
of healthcare professionals (HCPs) [1, 3, 4, 5]. For example, according to a survey conducted at a major teaching hospital in France, the rate of fully immunized HCPs and other healthcare workers (HCWs) was around 30 percent [4]. In some developed nations, statistics regarding the vaccination rates of HCPs were unavailable despite the policy encouraging specific vaccinations for HCPs [1, 5]. These disparities are mostly due to a considerable lack of understanding of specificity of vaccines, fear of the vaccination itself, and inconvenience in obtaining vaccinations [2, 4, 6, 9].

Even the policy recommendations for HCPs and HCWs vary greatly between countries. Thus, in the European Union the vaccination recommendations for HCPs and HCWs were nearly universal for seasonal influenza, as well as hepatitis B, but only 9 of the 27 member states recommended pertussis vaccination [5]. It would be reasonable to assume that the policies regarding HCPs protection are relatively comprehensive in comparison to recommendations for the general population of these states. It would also be expected that

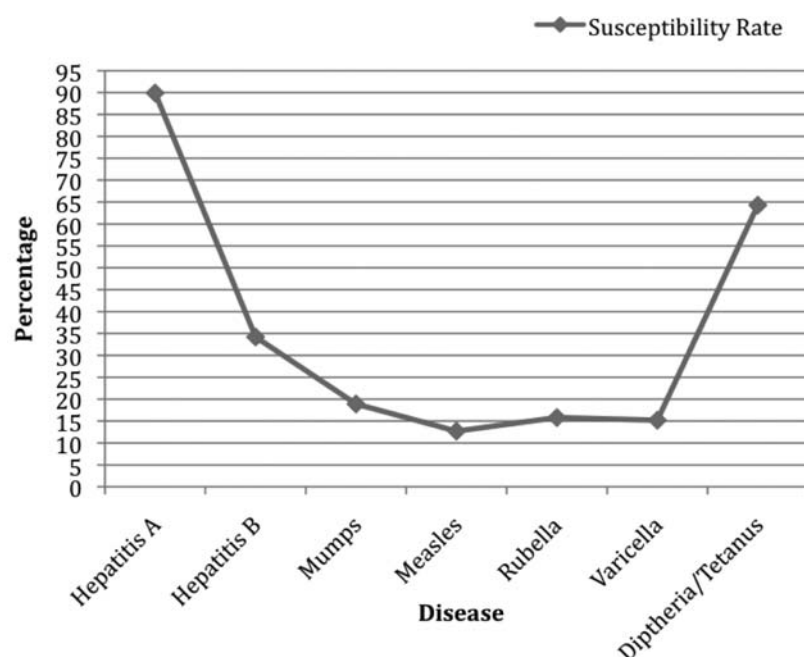
HCPs as well as their employers would monitor such policies closely. As it has been demonstrated, neither is the case with many developed nations.

The reasons for HCPs to be fully vaccinated are not just the obvious ethical reasons pertaining to the concept of “do no harm,” but also for the economic reasoning of avoiding aggregate productivity losses associated with illness. This is true in both developed and underdeveloped nations. For instance, productivity loss of USD 1.2 billion could be avoided in the decade preceding 2020 in LMEs if caretakers alone were updated on vaccinations [10].

The fluctuation in vaccination rates in the underdeveloped world due to lack of knowledge, convenience, or understanding is secondary. These variables do still affect the vaccination rates of HCPs and HCWs in the underdeveloped world, and should be addressed. However, the deficits in immunization rates are primarily due to low political commitment by respective governments, civil unrest, weak health delivery infrastructure, underfunding, poor development, and low levels of further research and development of vaccines needed for these nations [11]. In addition to these problems, there are matters of standardizing the injection



**Figure 1.** Number of Countries with Vaccine Recommendations for Healthcare Workers (by disease). Source: “Vaccination policies for health-care workers in acute health-care facilities in Europe.” (Vaccine): 27 EU member countries as well as Norway, Russia, and Switzerland surveyed



**Figure 2.** Self-Reported Susceptibility Rates (Tertiary-Care Hospital Employees).

Source: "Attitudes towards mandatory vaccination and vaccination coverage against vaccine-preventable diseases among health-care workers in tertiary-care hospitals" (Journal of Infection): Survey taken in Greece

tion safety itself. Nearly half of the vaccines administered in Sub-Saharan Africa are believed to be unsafe [11].

The administration problems, as well as the data inconsistency have resulted in reported outbreaks of specific preventable diseases in the least developed nations of the world. According to WHO's 2010 monitoring system report, between the years 2008–2009, the number of reported cases of measles, mumps, and rubella actually increased significantly among the general population of the least developed nations. Since this is the case for the general population, and because data regarding the vaccination rates of HCPs are nearly non-existent in such countries, it can be assumed that the HCP vaccination rates are correspondingly lower in developing nations.

The dangers of HCPs not maintaining vaccinations while spending most of daily life exposed to communicable diseases are obvious. There are not only personal risks involved for the HCPs, but also risks to their

patients. Physicians should do everything in their power to make healthcare settings safe for their patients. It is their ethical duty as professionals. Hospitals and other stakeholders could work to ensure that high levels of vaccination rates among their employees are maintained to ensure a safe setting for the provision of healthcare. Such actions could also serve to protect their organizations from large productivity losses from incapacitation of HCPs due to vaccine-preventable illnesses. As is the case with many public health dilemmas, physicians should be made aware and use their leadership positions to help augment discussions regarding HCP vaccination policy.

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Alley Ronaldi

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## Implementing Surgical Care at the National Level: The WHO Integrated Management for Emergency and Essential Surgical Care Toolkit

Under the umbrella of the WHO Emergency and Essential Surgical Care program aimed at strengthening surgical care systems, WMA participated in a global forum called the Global Initiative for Emergency and Essential Surgical Care. This Forum was established with multidisciplinary stakeholders – professionals, academic institutions, societies, NGOs – interested in collaborative activities to reduce death and disability from injuries, pregnancy-related complications, congenital anomalies and other surgical conditions.

### Introduction

The *WHO Integrated Management for Emergency & Essential Surgical Care* (IMEESC) e-learning toolkit (CD) has been developed by the WHO Emergency & Essential Surgical Care program with input from members of the Global Initiative for Emergency and Essential Surgical Care. The target audience is policy-makers, managers, and health-care providers (especially surgeons, anaesthetists, non-specialist doctors, health officers, nurses, and technicians). This toolkit contains WHO recommendations for minimum standards and best practice protocols in emergency, surgery, trauma, obstetrics and anaesthesia at first-referral level healthcare facilities. Also contained are WHO best practice protocols for minimum standards in disaster management and equipment at first-referral health facilities. Training tools, a trainer's guide, teaching slides, self-evaluations, needs assessments, quality and safety tools, and a planning tool for district-level managers complete the toolkit.

The *WHO Integrated Management for Emergency & Essential Surgical Care* toolkit has

been introduced in 38 low- and middle-income countries (LMICs) through WHO and Ministry of Health partnerships, to identify and address development needs in national and district-level surgical capacity. The tool has also been used to teach safety during clinical procedures, infection control and HIV prevention as well as management of disaster situations.

### Training and educational tools

The *WHO IMEESC* toolkit aims to address the healthcare workforce shortage in much of the developing world through its training materials. The most comprehensive tool provided in the toolkit is the *WHO Surgical Care at the District Hospital*, which covers the full compendium of first-referral level surgical practice and procedures. This manual is a practical resource for frontline providers and also a potential teaching instrument at the undergraduate and post-graduate levels.

In addition, the toolkit offers training workshops which are geared towards equipping frontline health care providers with the appropriate skills to address surgical emergencies and routine procedures. Teaching and reference materials are available for the workshop leader, including a Trainer's Guide, a workshop agenda, and teaching slides. Following the training, participants can evaluate the workshop through a formal assessment and can assess their own knowledge through a self-learning module. The toolkit also contains seven practical videos on general principles of wound management, head and back injuries, and fracture management along with special topics such as fractures in children.

### Implementation of best practices at the point of care

An integral component of the IMEESC toolkit are the *Best Practices Protocols*. These protocols are in the form of posters to be displayed throughout hospitals and health facilities. Messages for the best practices is informed by WHO standards and represent the basic skills and trainings for practicing emergency, obstetrics, trauma, anaesthesia and other surgical procedures. There are eleven protocols which cover diverse topics including safety and sanitation, wound and burn management, post-operative care, female genital injury management, intensive care settings, and emergency resuscitation.

### Disaster management guidelines

In relation to Clinical Procedures Safety for disaster planning, guidance is offered to determine trauma team responsibilities, perform a disaster-centered needs assessment, manage anaesthesia, and treat gunshot and landmine injuries.

### Equipment lists & quality/safety management

Equally important to training surgical care professionals is the availability of high quality, safe resources. The *Essential Emergency Equipment* list offers a guideline for the minimum equipment needs at the first referral health facility in LMICs. This generic list outlines both capital outlays as well as renewable items. A similar list is provided for anaesthesia materials, including access to general supplies, medicines, and infrastructure-based resources such as oxygen. Both these equipment lists can serve as inventory tools at higher level facilities to improve quality and safety, through a careful assessment of the quantity and functioning of available equipment.



## Research tool

Health facilities can easily assess their surgical capacity through two components of the *Integrated Management for Emergency & Essential Surgical Care* toolkit – the *Situational Analysis Tool to Assess Emergency and Essential Surgical Care* and the *Needs Assessment for Essential Emergency Room Equipment*. Both tools enable health care providers and hospital managers to conduct research on potential gaps in surgical care provision. The Needs Assessment evaluates human and physical resources, quality and safety of available resources and also policy measures in place at the facility. The Situational Analysis Tool takes a comprehensive approach to identifying personnel capabilities, procedural breadth, and material resources at the health facility.

## Policy management

*Aide-Memoire:* Well-organised surgical, obstetric, trauma care and anaesthetic ser-

vices are essential within the framework of a country's and a district's health care infrastructure as they substantially reduce the death and disability from trauma and pregnancy-related complications. The overall responsibility of establishing and maintaining effective district surgical services requires government support and national policies.

*Planning Tool:* The *WHO Planning Tool for Emergency and Essential Surgical Services* provides advice for first referral level facilities on how to develop a national plan for district-level surgical services.

## Quality and Safety

Establishing quality and safety of emergency and essential surgical care is tantamount to its appropriate delivery. The *WHO Integrated Management for Emergency & Essential Surgical Care* toolkit provides documents on safety protocols for anaesthesia

and obstetrics – a step-by-step guide for components of safe practice.

A *Monitoring and Evaluation* tool is also available to measure the progress and the impact of various trainings in health facilities. It relates to those that address personnel, infrastructure, equipment functionality and availability, continuing education opportunities, and Best Practice Protocols for Clinical Procedures safety.

More information about the IMEESC toolkit and its resources is available at <http://who.int/surgery>.

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## Health Care Reform: Does One Size Fit All

Health is considered a basic human right. Each country in the world is trying to provide health care “for all” its citizens. In 2006 the European Council outlined the aims for its member states: universal coverage, solidarity in financing, equity of access and provision of high quality health care. On the other hand health care is getting more expensive every year in connection with developing technology and increasing life span. These huge health spending costs must be somehow funded. Realistically, there are only a few recognized ways to cover the health care costs. They can be funded by the state from general tax revenues or by a mandatory health insurance program backed by a payroll tax. Health care funding can also be based on private sector health insurance plans as in the

USA, and in many countries there are systems where these are combined. Personal out of pocket spending far exceeds private pooled and government health spending in low income countries [1].

As beginning with the 1970s the “welfare state” developed problems with funding, a new wave of privatization began. It was claimed that the state provided services, including health and education, should be run by the private sector because the state run services were inadequate, ineffective, prone to corruption, and resistant to new technologies and developments. Moreover, money spent for health and social security was regarded as going into a “big black hole” and thus creating a great burden for the government budgets.



A. Ozdemir Aktan

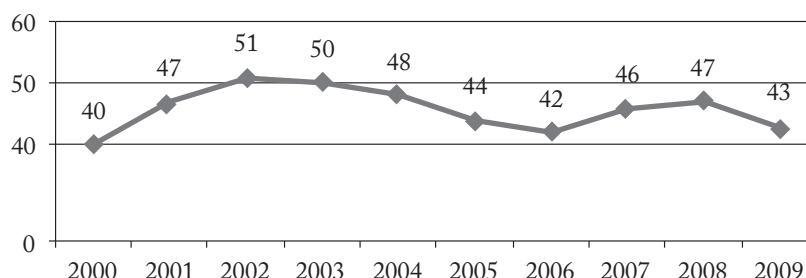
The United Nation's Millennium Development Goals are focused on improving overall health outcomes, securing financial protection against impoverishment and

ensuring long-term sustainable financing. In the developing countries steps to be taken to accomplish these are framed and funded by the World Bank and the International Monetary Fund (IMF).

The biggest problem in financing is obviously its long term sustainability. Continuous economic growth is necessary to maintain the percentage of health spending at an acceptable percentage of the gross national income (GNI). On the other hand, for fiscal sustainability public revenues should be gradually increased. The model implemented by the World Bank to accomplish this for East European members of the European Union (EU) (some of them being former Soviet States) and Turkey (which is not a member of the EU) and many other countries is to establish a mandatory health insurance system financed by payroll tax, as well as encourage private insurance and increase cost sharing (user charges). At the same time, privatization of the government health care system is encouraged including the state run medical facilities [2].

In Turkey, the first step in this process was taken when the legislation on establishing a payroll tax financed mandatory health insurance fund was passed in 2006. This fund, run by the Social Security Institution (SSI) is the only state financier of health. Turkey spends 6.0% of its GNI for health while the average for 31 OECD countries is 9.0%. Per capita health expenditure in Turkey is USD 767 which is the lowest among the OECD countries. This breaks down as 69% for the state and 31% for the private sector. In comparison, in the USA government and private expenditures are 45.5% and 54.5% respectively as reported in 2010 OECD report and the WHO database.

As of June 2010, the unemployment rate in Turkey was 13.6% and it is estimated that roughly 50% of the working population is unregistered and pays no tax. This obviously is a very big problem to finance the health



**Figure.** Collected Premiums/Social Security Health Payment (%)

care system through the SSI. At present, the premiums collected can only support less than half of the total SSI spending (see Fig) [3]. The rest comes from the state budget. The current Social Security Law defines as "poor" anyone with an income less than 1/3 of the minimum wage which is around USD 400. With these figures, the best estimate is that less than 50% of the population can receive the SSI provided health care. Private health insurance covers only one million in a population of 72 million. In Turkey, the uninsured and poor are covered by a "green card" which enables the holder to access health care through the SSI and run by the government. However, in this ill defined and politically manipulated system, the number of green cards increases to 11 million just before elections, and drops to 5 million thereafter.

A new law which is expected to go into effect soon will open the way to privatization of all state hospitals that are now run by the Ministry of Health. These activities are being pursued in nearly all developing countries in a standard fashion. General Agreements on Tariffs and Trade (GATT) aimed at increasing and regulating international trade prohibit the states to form monopolies on any service given and encourage privatization.

Privatization of the health care system has certain advantages such as effective and timely implementation of new technologies and a better quality health care in addition to decreasing the burden on the

general budget. On the other hand, overall health spending and population unable to receive health care increase while premiums required for health care rise. In Turkey and similar countries spending on health care has been steeply rising. When the governments can no longer compensate the health deficit, someone must pay. This means more out of the pocket spending and charging more, accompanied by reduced health care coverage. In private health care systems, spending must be lowered to increase profits that lead to reduced fees for physicians and other health professionals.

President Obama's health care reform in the USA was aimed at providing health care to around 50 million who could not afford health insurance. Through a state owned insurance fund financed by taxes, health care will be provided to those who cannot afford it, which essentially is a great turn back from a completely private system. Another aim of the health care reform is to decrease the prohibitively high health care costs in the USA. Among other steps taken, the most prominent is to reduce the physician fees. The USA is the biggest economy in the world, while the GDP is about five times that of Turkey. If a completely private health system cannot work effectively in a country like the USA, how can anyone expect it to be successful in developing countries?

In Turkey overall infant mortality rate has been constantly decreasing, down from 52.6 in 1993 to 20.7 in 2007 per 1000 live births.

However, in 1978, 1.2 infants died in rural areas for every one infant from urban areas. This ratio rose to 1.7 in 2007 [4]. The same trend is observed when the richer western part of Turkey is compared with the poorer eastern part, being a clear indicator of the poor not receiving proper health care. The big problem is that the rich are getting richer every year and the gap between the rich and the poor is increasing.

Health care should not be completely privatized, especially in developing countries, and one single model of health care reform will not solve health care problems. Primary health care is essential in these countries

and must be provided by the state. In addition to the poor, the combination of unregistered labor force and high unemployment rates form a large group of population that cannot afford private health care. This fact alone makes a payroll tax financed system unrealistic. Health care in these countries should be provided mainly by the state at least until these countries join the “developed” countries.

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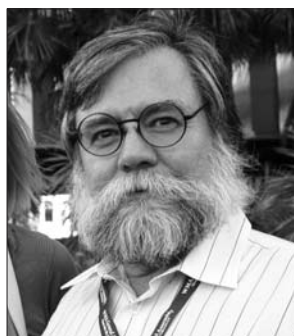
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## Physicians and Hunger Strikes in Prison: Confrontation, Manipulation, Medicalization and Medical Ethics (part 1)



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### Introduction

The act of *fasting for a prolonged period of time as a form of protest* goes back more than a century. It has been used since the suffragette movements in the UK and the US in the early 20<sup>th</sup> century. Hunger strikes occurred sporadically in Ireland during the long protracted struggle between the Irish Nationalists and the British authorities. In the first half of the last century, Mahatma Gandhi, in Britain's Imperial India, went on and off hunger strikes many times, both when in and out of prison. It was Gandhi

who perhaps actually gave hunger strikes their *lettre de noblesse* as a means of making the protest known to the general public. Hunger strikes attracted world-wide attention in the late 20<sup>th</sup> century in Belfast and Turkey. Ten much politicized deaths in Northern Ireland and several dozens deaths in Turkey put hunger strikes back in the news. In this century, the vast media attention given to hunger strikes by the inmates at Guantánamo Bay did not center on the phenomenon of the protest, but of the very controversial “solution” applied – force-feeding the hunger strikers. There have also

been other, less highly publicized, hunger strikes in Europe, the Middle East and elsewhere, which have attracted particular media attention, and have raised different controversies.

The 21<sup>st</sup> century hunger strikes put the spotlight onto the high-level, often heated arguments between two antagonistic authorities. On the one hand, there are the Prison authorities, responsible for keeping prisoners confined, and also legally responsible for their welfare. Then there are the judicial authorities, judges and lawyers that apply and process the rule of law in the wide sense of the term, including appeals and demarches, for sentenced and remand prisoners. Both prison and “judicial” authorities are non-medical entities. To simplify the text, both shall hereafter come under the generic term of “custodial authorities”, unless one of the two needs to be specified. On the other hand, there are the “medical authorities”, the physician(s) in charge of caring for prisoners who go on hunger strike, and by extension the national medical association, and further up the World Medical Association.



tion (WMA). The recent confrontations on hunger strikes have been between these two groups of authorities, “custodial” and “medical”. In some cases, it has almost been as if the actual hunger striker, as an individual person, has become an afterthought. The conflict has been mainly around the “custodial” authorities who have decreed and imposed force-feeding, and those who are the only ones who can perform it, the actual physician(s), who often object, with the implicit support of the WMA. The controversy has in fact not been so clear cut, as there have been physicians willing to perform force-feeding of hunger strikers, taking sides with the “custodial” authorities, and, as shall be seen, against their ethical principles.

The controversy around this force-feeding, which has essentially been a major issue in just one context – Guantánamo Bay – but has been the Damocles sword in many others, is a major issue, but it is just the tip of the iceberg. As shall be shown, the force-feeding controversy is indeed a serious bone of contention for the medical profession. However, the true role of the physician has been corrupted and co-opted. By “medicalizing” the situation with the contentious solution of force-feeding, the “custodial” authorities have shifted the onus onto the doctors to “solve the issue”, i.e. to make the protest fasting cease. Physicians have been *ordered* to intervene, artificially feeding fully conscious and mentally competent prisoners *against their will*. This is what constitutes the force-feeding which shall be one of the focal points of this paper. The *real* role the doctors should be playing in the vast majority of cases will also be defined and illustrated. From an ethical, practical and clinical perspective, in many if not most cases, there are better options than force-feeding available in the competent management of a hunger strike. We will describe them in this paper.

The reason the “custodial” authorities have shifted the responsibility for making the hunger strike stop is obviously because prolonged fasting is undoubtedly not good for

health. The physician’s role, however, is not just about monitoring calorie intake (or the lack thereof), controlling blood pressure and weight-loss – and ultimately inserting a tube down a hunger striker’s throat to deliver nutrients by force. As shall be demonstrated, the physician can and should play much more important role, which in most cases will facilitate to avoid getting close to the need for any feeding. This role, however, requires having a relationship of trust, as there should be in any doctor-patient relationship. Imposing any solution perverts this relationship, perhaps irretrievably, and prevents physicians from carrying out their task of intermediary, towards a compromise, and a solution acceptable to all. This is the practical basis for the ethical prohibition of force-feeding. Forced treatment against the competent informed consent of the patient destroys trusting and functioning doctor-patient relationship. The practical consequence of that destruction is the elimination of almost all non-coercive solutions to the hunger strike. Furthermore, the practice of force-feeding corrupts the already fragile foundation of trust between all correctional physicians and their patients, and may have the effect of undermining the efficacy of the profession in the prison at large.

## Ethical framework: the “WMA 2006 Malta declaration”

The World Medical Association (WMA), is the “international organization created in 1947 to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians, at all times”<sup>1</sup>. At the time of writing this, it comprised about one hundred national medical associations, including the American Medical Association (AMA), one of its founding members. The WMA issued specific medical ethical principles relating to hunger strikes in its Declaration of Malta of 1991 (“Malta 1991”), updating them in

2006<sup>2</sup> (“Malta 2006”), together with an accompanying Background paper and Glossary<sup>3</sup>. The WMA guidelines recognize that hunger strike situations are complex and require the physician to make individualized clinical judgements. Discussions around the WMA guidelines for dealing ethically with hunger strikes have led to heated confrontations between custodial and judiciary authorities, on the one hand, and physicians on the other. In some cases local medical authorities, not familiar with the WMA guidance, of choosing not to follow it, have added to the confrontation. Heated arguments, sometimes in the full spotlight of the media and general public, have even distracted from the plight of the actual hunger striker(s). As shall be seen, these confrontations may in some cases have pushed fasting prisoners into adopting positions more radical than they initially intended to take. It is this phenomenon, and how to avoid it, that this paper ultimately intends to document and so to provide practical recommendations for constructive action.

How and why “Malta 2006” evolved from the original “Malta 1991” relates directly to the complexity of hunger strike management, and is discussed in the second section of this paper.

## Definitions: what are hunger strikes – and what they aren’t

There is a vast literature on hunger strikes, making it almost futile to ask, “what a hunger strike is.” Nonetheless our experience around the globe has shown time and again that many fundamental misunderstandings and misconceptions about hunger strikes

2 <http://www.wma.net/en/30publications/10policies/h31/index.html>

3 *WMA Declaration of Malta – A Background Paper on the Ethical management of Hunger Strikes*, In: World Medical Journal, Vol 52, N° 2, June 2006, hereafter WMJ. One of the authors of this paper was co-author of the background paper, together with the British Medical Association (AS).

1 [www.wma.net](http://www.wma.net) *What we do*

persist. It is first necessary to recall what is meant by a “hunger strike”, what is *not* meant... what benchmarks need to be defined, and finally how such fasting is intended to “work.”

Hunger strikes fundamentally are a form of protest against the custodial authority where the hunger striker is attempting to draw attention to a grievance by creating an urgent situation that may bring unwanted attention or shame upon the authority as a means of moral leverage.

Perhaps the earliest recorded hunger strike, in the sense of a political protest against the custodial authority, was that of the revolutionary Vera Figner in Czarist Russia in 1889. At the beginning of the 20<sup>th</sup> century, in the UK, countless suffragettes suffered ignoble force-feedings ordered by the British judiciary authorities, widely reported and vehemently criticized at the time. Eloquent posters showed how these brave women were submitted to force-feeding, a tube being inserted by a doctor into their stomachs while they were held down, struggling. It was however Mahatma Gandhi, protesting against the government of his Majesty “Emperor of India” who gave hunger strikes their *titre de noblesse*, in the first half of the 20<sup>th</sup> century.

There have been many hunger strikes in the past thirty or so years. However, not all prisoners “who-refuse-to-eat” should be considered hunger strikers. The generic term “hunger strike” is used to cover a variety of very different situations in which a prisoner refuses to take nourishment as a form of protest. Two main types of fasting protesting prisoners can be distinguished, differing essentially by their *modus operandi*, the “food refusers” on the one hand, and the (true) “hunger strikers” on the other. The vast majority of what prison directors, lawyers, judges, the media and even most physicians call “hunger strikers”, are in fact *food refusers*. The difference, as shall be seen, is a major one, as in the case of the “refusers”, those prisoners do not have the slightest in-

tention of hurting themselves by fasting “to the brink” so to say. Therefore, there will be no question of forcing them to take food, force-feeding them, and hence little or no ethical dilemma involved at all.

Food refusers are what a senior medical colleague working in the prisons of Northern Ireland used to call “*the blokes who give hunger strikes a bad name!*”... These are prisoners who for any motive, great or small, justified or not, important or petty, *declare themselves* to be on “hunger strike”; make a big fuss over it; ensure that the prison director, the prison staff, the doctor, if possible their families, and above all the media, *know* they are “on strike”. The key concerns here are that this type of the so-called “hunger strike” is always short-lived. Food refusal as defined is quite common amongst common-law prisoners, generating a “lot of noise”, but most often not much else. Such prisoners trumpet whatever their complaints are, but in fact they have not the slightest intention of hurting themselves by their fasting. Medical staff who are used to this category of prisoners call them the “*professional* hunger strikers” – “who go on strike at the drop of a hat”... Others less kindly call their action “nuisance fasting”, as it generates extra work for the medical staff, but essentially for no purpose.<sup>1</sup>

Who, then, is a “true” hunger striker? Are there different “categories” of hunger strikers? Are there “real” hunger strikers and “phoney” hunger strikers, as some authorities have asked<sup>2</sup>. Before the Turkish protests at the end of last century, hunger strikers were often classified as “serious”, when like Bobby Sands, they were effectively ingesting **only** water, and thus posed a risk to

their lives by their action. Any other form of fasting was deemed “not-so-serious”. These other forms were by far the most common among prisoners who were fasting, but who also took nourishment “on the side” and were thus deemed to be “cheating” on their strike. This vast majority had their strikes catalogued as “not-so-serious”. One of the authors of this paper fell into that trap at the time. While the Irish hunger strikers fasted totally and died after eight to ten weeks from acute malnutrition, the Turkish hunger strikers obviously *did* take some nourishment on the side, as they survived much longer than the Irishmen. The Turks did this to make their protest last as long as possible, to extend the moral pressure put on the authorities, and on public opinion. A great many of them died anyway, from prolonged and not acute malnutrition, after up to several months. Thus, simplistic distinctions cannot be made when dealing with this complex issue.

A “hunger striker”, as we use the term here, is thus a prisoner who uses fasting as a way of protesting, and is willing to place his health – and perhaps his life – “on the line”, so as to be heard by an authority that does not allow any other meaningful way for him to make his grievances known. The masculine form is used here to ease the reading of this text, as the great majority of hunger strikers in the world are indeed males, with all due apologies and respect to the suffragettes, and even more so to the Irish and Turkish women hunger strikers who died. The determination of a hunger striker to carry through with his actions is subject to many factors and pressure from many sides. It is therefore unfair to judge the “seriousness” of a hunger strike on any one criterion alone. Each context, and each individual, must be judged on its, or his, own merits.

It is paramount to realize that the hunger striker, in the vast majority of cases, does *not* fast with the intention of dying! Thus, to compare hunger strikes to “suicidal behaviour” is a major error, made by many,

1 Owing to the fact that most of these actions are short and self limited, optimal management often involves little to no response by either custodial or medical authorities for the first 72 hours assuming the patient is healthy at baseline. The clinical rationale for this approach will be explained later in this paper.

2 The author’s own personal experience of twenty-eight years working as a doctor with the ICRC...

including judges and senior physicians who should know it better. Going on a hunger strike is not an attempt to commit suicide. A hunger striker wants to make his case known, to protest, and to change his situation or perhaps change the world. He wants to *live* better in that world, not to *die* in it. Bobby Sands was as determined as any hunger striker could be, yet if he had obtained from Margaret Thatcher a concession to his demands the day before he died, he would have taken nourishment. The Greenpeace activists who used to sail their boats into the atoll where French nuclear tests were being carried out in the Pacific Ocean, in the early and mid-1990s, were not seeking to get themselves blown up. They were most certainly *not* suicidal. They *were*, however, willing to risk their lives as a last resort, in order to publicize their protest against nuclear weaponry. Indeed, soldiers often enter the battle with full knowledge that their mission carries with it the high risk of death. But they are not suicidal. Death is a risk of the form of protest called “hunger strike.” It is not the goal, and therefore, a death by hunger strike is not suicide.

As will be developed further on, this comparing determined hunger strikes to “suicide” is a common misunderstanding through lack of knowledge in many cases, but also through “bad faith”. In the case of the hunger strikes at Guantánamo Bay, Department of Defence (DoD) directive 2310.08e *specifically* classifies any hunger strike as an “attempted suicide” or an attempt to “self-harm.” This is an improper and inaccurate classification that has persisted in the face of efforts by a number of outside health professionals to correct the Department’s policy.

In most cases when the term “hunger striker” is used, there is a political connotation to the protest fasting. The common denominator between Emily Pankhurst, suffragette; Bobby Sands, IRA leader and member of Parliament; Holger Meins, member of the German “Baader-Meinhof” group in Ger-

many in the 1970s; and the already mentioned Turkish hunger strikers, is that all of them evoked political motives for ceasing to take nourishment, and steadfastly “stuck to their guns”. Less well-known prisoners have to consider the probability of their protest being heard, and how far they really want to go to get attention.

To conclude, a prisoner who goes on a hunger striker, determined to pursue the fasting for a certain length of time, does so because s/he feels, rightly or wrongly, that such an action is a “last resort” to be heard. The demands will vary considerably according to the time and context, but the protest fasting most often seen as the “only way” to be taken seriously. As shall be seen, it is up to the physician to determine “*how seriously a hunger striker wants to be taken seriously*”...

## Clinical Framework: Diet and Time

The benchmarks that need to be clearly defined concern diet and time frame. It may seem a bit ludicrous to define any “diet”, since it would seem that hunger strikes imply a lack of any intake of nutrition. However, as shall be seen, a majority of the so-called “hunger strikes” involve less-than-total fasting. Therefore some definitions are called for. The time frame will define when a hunger strike should attract attention, and how long a span of time one can actually last.

### Diet

There are different kinds of fasting and different concepts of “eating”, but for our purposes only three are important.<sup>1</sup>

- The **dry hunger** striker takes no food or water of any kind. This is often put for-

ward, by the hunger striker wanting attention, or by the authority to justify intervention, as a “very dangerous” form of hunger strike, as a body cannot survive very long without any water. No “dry hunger striker” will survive more than a few days at most, depending on climate and temperature. Hunger strikes need time if they want to exert any effect, thus this kind of strike is by definition counterproductive. It may be either a “gimmick” to attract publicity, or the manifestation of a possible psychological problem. There is no known record of a hunger striker dying on a “dry” strike.

- **Total** fasting means no solid food, and **only** ingestion of **water**. This differs from the US definition, which uses the term “total fasting” for what has been defined above as “dry hunger strike”. This is unfortunate because the concept of “Voluntary **Total Fasting**” is in fact what a hunger strike is all about. Two litres of drinking water a day is the suggested quantity, with or without salt, preferably mineral water... In a “rigorous”, i.e. *strict* hunger strike, à la Bobby Sands, there would be no other addition to the water, no sugar, no vitamins and certainly no nutritive concoction. **Non-total** fasting simply means a “less rigorous” hunger strike, and includes practically any other type of fasting, e.g. with vitamin and mineral intake; sometimes liquid nutrients taken in addition to plain water; or other supplements. The term is not strictly defined, as it also includes a supposedly strict, “total”, hunger strike – with *unofficial* (“on the sly”...) intake of food. The physician must know what type of a hunger strike the prisoner is on as this will change the approach he may have in dialogues with the prisoner(s).

The determination and hence “seriousness” of a hunger strike depends on its duration and not alone on its being total or not. A non-total hunger strike may be just as determined as a total one – and lead to deaths as well, only at a much later stage, as was the case in Turkey in the nineties.

<sup>1</sup> See WMA Internet Course for Prison Doctors. *Hunger Strike*, Chapter 5; accessible at <http://www.wma.net/en/70education/10onlinecourses/20prison/index.html>



The fact that a non-total hunger strike allows more time for negotiations is a positive – not an inconsistent – position. Physicians need to keep this in mind, as prison authorities tend to malign non-total fasting as “cheating”. Some even may deny a declared hunger striker any access to food as if they were “calling his bluff”. Although this may “break” some hunger strikes, it may radicalize others and may uselessly lead to loss of life. Denying access to nutrition is of course unacceptable as a medical intervention.

These distinctions are emphasized here as a question of credibility for medical staff, as terms of reference. Anyone, claiming that hunger strikers have been on total fasting for six or nine months, *de facto* proves that the fasting was not total. This in itself is *not* a problem, and the physician should abstain from the arguments some prison authorities, or the media, would like to get him into – whether the fasting is “genuine” or not... A physician needs to clearly state that any form of fasting can indeed be prejudicial for health, and that the doctor’s role is to see what the best solution is in each case. He should not fall into the trap of “confirming” a hunger striker is indeed “eating on the sly” as this will destroy his credibility for negotiating both with the hunger strikers and those around him. Any partial fasting for a lengthy period of time will provide much more time to perhaps finding a face-saving solution for all involved – and thus be instrumental in avoiding fatal outcomes.

## Timeframe

“When does a hunger strike begin”? Skipping several meals may well be a form of food refusal – and therefore a form of protest – but such short-lived, often episodic, fasting certainly does not qualify for the term hunger strike. There are no set criteria for the minimum duration for protest fasting, so reference can be made to physiology. A healthy, normally nourished adult, without any medical contra-indication to

prolonged fasting, should have no problem whatsoever **fasting totally** (i.e. taking only water) for around 72 hours. This is when the onset of ketosis, the presence of metabolites known as “ketone bodies”, usually occurs, for physiological reasons<sup>1</sup>.

Ketosis is discernible clinically on the breath by what has been described a “pear-like smell”. Ketosis subdues the voracious sensation of hunger, “hunger pangs”, experienced during the first 2–3 days of total fasting. It could thus be argued that, as a simple “rule of thumb”, **total fasting** (i.e. taking water only) for **longer than 72 hours** qualifies on metabolic grounds for the term hunger strike. The appearance of ketone bodies in the breath will depend on many factors, including body mass and fat, but this rule of thumb has been found to work in the majority of cases. Strictly fasting for 72 hours does absolutely no harm to anyone in good health, but does need *some* determination, and thus allows separating so to say “the wheat from the chaff”.

The purpose of this “test” is to eliminate any confusion with **short-lived fasting**, which should not even qualify as “food refusal” – most cases petering out by themselves before 72 hours. It will not be relevant – and may even be counter-productive – to insist on distinguishing between somewhat more determined food refusers (but food refusers nonetheless) and hunger strikers immediately after the 72 hours. Such food refusers will not want to lose face by appearing to be less determined than real hunger strikers.

At the other end of the spectrum, there can be another rule of thumb. The fatal outcomes of terminal total fasting were medically documented during the 1981 hunger strikes in Northern Ireland. **Death** occurred during these total hunger strikes anytime between 55 and 75 days. During the 1981 Irish hunger strikes one of the “Ten Men” died at 46 days, according to one account

because he could no longer ingest water<sup>2</sup> only one exception at 46. Similar experiences have confirmed this time bracket – the three-week span being due to differences in initial physical constitution, and individual adaptation. It is not possible to precisely predict when, within this time span, death may or is “most likely” to occur.

Death caused by ingesting only water does not occur before six weeks, and usually later if the person was in good health at the start of the fasting, and *after* a specific phase of the total hunger strike, called the “ocular motility” phase<sup>3</sup>. The clinical manifestations during this phase last about a week, roughly between 35 and 42 days according to the very few contexts where it has been medically observed, and are troubles of ocular motility due to progressive paralysis of the oculo-motor muscles:

- uncontrollable nystagmus
- diplopia
- extremely unpleasant sensations of vertigo
- uncontrollable vomiting
- extremely difficult to swallow water
- converging strabismus

The onset of this phase has been described as the most unpleasant stage by those who have survived prolonged fasting, and is the one most dreaded by prisoners who envisage beginning a hunger strike.

What is essential for the clinician to know here is that the beginning of the final stages of fasting occur *after* the “ocular” phase”, hence roughly from six–seven weeks onwards. It is during the weeks following the ocular phase that the hunger striker may progressively become no longer capable of clear discernment. Survival any time after ten weeks of total fasting is practically impossible.

2 Walker R.K. (2006) *The Hunger Strikes*. Belfast: Lagan Books; p. 126

3 See WMA Internet Course for Prison Doctors, Chapter 5, [www.wma.net](http://www.wma.net)

1 WMJ; *op. cit.* p.32

In short, the “72–72” rule holds: seventy two hours should be the minimum for any fasting to be taken seriously; and 72 days are the maximum a hunger striker taking *only* water can hope to last. This knowledge is indispensable for the physician so he can realistically modulate his interventions as needed. Total fasting is the form of hunger strike that can pose a vital threat as early as six weeks into the hunger strike; and death occurs between the 8<sup>th</sup> and 10<sup>th</sup> week.

Physicians should not be overly obsessed by these benchmarks. On the one hand, they should be alert to the global clinical situation, as it has been mentioned. On the other hand, and they should remember that the vast majority of hunger strikers do not come anywhere close to the “ocular phase”. The main point is that there is time before things *theoretically* can become alarming, and the physician will need to use this time constructively for the benefit of all.

## Understanding how hunger strikes “work”

Hunger strikes in prisons can become effective forms of protest only in countries where there is some respect for basic human rights values<sup>1</sup> or at the very least a *desire to appear* to have such respect. If such values do not exist, or are flouted, hunger strikes will either be repressed, or all and any knowledge about them be stifled. If a hunger strike is to have any effect, by “shaming” the authorities into action, it is necessary for it to become public knowledge. If it does not, “protest fasting” is unlikely to have any impact at all and custodial authorities may well choose to ignore it – rendering any such fasting moot.

Confrontations between the custodial/judicial authorities and the medical staff thus imply a hunger strike that is in the public eye. Such a clash does not always occur. The hunger strikes in Northern Ireland in the 1980s and in Turkey in the 1990s created vociferous confrontations – but not with the physicians. Force-feeding was not an issue either in Northern Ireland, as the authorities and physicians decided to acknowledge patient Autonomy. If a prisoner refused to take food, it was his or her right, and as long as that person was capable of discernment in taking the decision, it was to be respected. In Turkey, the situation was very much more complex, but force-feeding was not an option either. Hunger strikes in other contexts have been a mixture of different models, the vast majority of them “benign”, with short-lived confrontations.

A hunger strike is a way to protest against the detaining authority. A prisoner may feel, rightly or sometimes wrongly, that all means of making his or her grievances known have been thwarted. By refusing to eat, such a prisoner tries to retain, or regain, some “control” over what is left to him or her – the body and its nourishment. A hunger striker thus uses *control over bodily integrity* as a “last resort” for protesting. Any custodial authority, with the support and all the weight of the judicial (or in the case of Guantánamo Bay, “military”) authority, will attempt to control all aspects of prisoners’ lives. In a (real) hunger strike, the authorities consider this protest fasting tantamount to a “hostage situation”, where hostage taker and hostage is one and the same person. They consider it as a form of “blackmail”. This is what they find intolerable and cannot accept. It has to be stated here clearly that a competent prisoner, that is to say, capable of discernment, and not submitted to any pressure or coercion, direct or indirect, has the right to autonomy. This includes accepting or refusing any treatment, once informed of the pros and cons. This also includes fasting as a way of protest, as this can be considered as a last resort the pris-

oner has to make a message known or to make a demand. As has been mentioned, the maximum authority on medical ethics has decided that patient autonomy trumps beneficence in such a case, and that a physician should respect not to force a hunger striker to eat. Some voices have tried to circumvent the right to autonomy by stating that prisoners are *never* in a position to take any decisions freely. This is not tolerable. As is generally accepted<sup>2</sup>, “prisoners are sent to prison *as* punishment, not *for* punishment”, and this includes prisoners still having the right to make decisions about their welfare.

As prolonged fasting can arguably become a medical problem, the “custodial” authorities often medicalize the issue by order force-feeding. Their argument is that the reason physicians should intervene is to “save lives”. They thus “throw the hot potato”, so to say, into the medical camp, and ordering the physician to solve their problem and thus quell the protest. The counter argument to this is relatively simple, as the weight of the ethics is in favour of the physicians. The physician’s role is not to “resolve the problem” with an unethical invasive procedure against the patients informed refusal. The power to “resolve the problem” lies with the authorities; only they have the power to engage in negotiations regarding the grievances of the hunger striker. The physician’s role is to counsel the patient about the health effects of the various options and even make recommendations for what would be best for the health of the patient. In addition, the physician must communicate the general health status of the patient to the authorities as needed. While not the mediator for the grievances *per se*, the physician, as a professional, has the ability to calm the situation by injection of reason and rationality as an intermediary regarding the *health status* of the patient as well as the various permissible clinical options. However, there needs

1 Reyes, H. *Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture* (1998) In: Maltreatment and Torture, Oehmichen M. (ed.) Lübeck: Schmidt-Römhild; J. P. Restellini (1989) *Les grèves de la faim en milieu pénitentiaire*. Staempfli (ed) In: Revue Pénale Suisse (Bern), Geneva, Vol. 106

2 Reyes H. (1996) *Doctors at Risk*. In: Healthy prisons: A vision for the future. Report at the 1<sup>st</sup> International Conference on Healthy Prisons. Liverpool

to be a full and careful assessment in every case, as shall be seen.

Second, and more important still, the vast majority of hunger strikers, as has been stated, do *not* want to “die”. Hence, there should be no need to use force to feed them. During the first weeks of the hunger strike there is time. The physician needs to obtain their trust, by talking to them and having them accept the physician in an additional role of confident, mediator, neutral intermediary or something similar as the case may be. The physician should never appear as the one who is there to implement the will of the custodial authority.

Some, very few hunger strikers, may have sufficient motivation to pursue their fasting, and will not allow the physician to intervene. They constitute a very small minority. The physician responsible for the patient, and not an “outsider” who only arrives once a critical stage has been reached, should then act according to the guidance provided by “Malta 2006”. This shall be discussed in detail further on with reference to examples from the field.

The majority of controversial cases are precisely in between these extremes – and the controversy is most often due to custodial authorities clashing with the physicians.

## Role of the Physician spelled out

The physician has a role to play when a prisoner decides to fast for longer than 72 hours. Whether the prisoner is a “food refuser” as defined above, or a real hunger striker, the physician has to determine whether any initial medical factors need assessment or intervention. An insulin-dependent diabetic, or a prisoner with a history of gastric ulcer should not be fasting, whether seriously or “food refusing.” If the physician has the trust of the prisoner, in most cases the prisoner will understand, and relent from fasting.

The physician has a more crucial role to play when caring for a prisoner who decides to go

on a serious hunger strike. In this case, the physician has certain ethical principles to respect, as set down in the guidelines established by the World Medical Association<sup>1</sup>. Even more important however – the physician has a different role to play, if s/he has the trust of the hunger striker, as stated previously. The physician is in an ideal position, and has the time, to try to find a compromise solution, calm everyone down and ultimately defuse the conflictual situation. In the very few hunger strikes involving die-hard or desperate hunger strikers – respecting the ethics of the situation will be paramount. In the majority of cases, the situation gets out of hand by the blundering and often bad faith of custodial or judicial authorities – and sometimes of those physicians who do not follow the ethical guidance. An ethical physician is able to act constructively – but only if she or he knows how to avoid the many pitfalls involved, and defends the ethical high ground against the non-medical authorities who may try to force unethical conduct. Finally, the physician needs also to know that prisoners, the hunger strikers, can *also* attempt to manipulate him. Here the physician needs to stand firm, and defend “physician autonomy” as well as “patient autonomy”<sup>2</sup>.

Thus, the physician’s role is twofold. First, there is the clinical and “technical” evaluation of the situation, initially after 72 hours, and on an on-going basis. Second, there is the ethical framework within the doctor-patient relationship, the essential element here being that of trust between the hunger striker and the physician. It is this second aspect that has been skewed in recent well-publicized hunger strikes, for reasons that shall be illustrated with examples.

## The doctor-patient relationship

Any hunger strike fasting should be a voluntary action undertaken by a prisoner as

an individual without coercion from anyone. This is not always easy to determine in a prison setting. Pressures on hunger strikers come from many directions<sup>3</sup>. The prison authorities; the prison officers; family members; often the media; other prisoners; and even sometimes medical staff, all have some sort of influence, and can exert pressure on the hunger striker(s). The physician responsible for caring for the fasting prisoner should appreciate this fact, and be prepared to deal each entity as the case requires. The *voluntary* nature of the hunger strike is thus an imperative factor to determine. Whatever decision a hunger striker makes has to be his or her own. The prisoner’s bodily integrity is involved, and the physician has to be certain that no outside coercion is exerted on the prisoner. It is not uncommon for prisoners to be “volunteered” to go on a hunger strike, by their peers or by an unofficial prisoner hierarchy. In extreme cases, such hierarchy may even “force” a prisoner to keep fasting way beyond whatever moment he or she would have stopped. The physician has a duty to detect such a case, so as to help him or her break loose from such coercion.

Thus during on-going discussions between doctor and patient, it will be necessary to find out how serious the prisoner is about not taking any nourishment for how long a period of time. The physician and the medical team need this information to act efficiently in the best interests of all<sup>4</sup>.

Physicians should not let their overall view of the situation be obscured by the *obsession* of the hunger striker dying in the early stages of a hunger strike. Even considering the shortest time frame, there is at least a month, thirty full days, before the afore-mentioned “ocular” phase which flags the passage to the

3 WMA Internet course for prison doctors; *op. cit.*; Chapter 5.

4 Gravier B., Wolff H. *et al. Une grève de la faim est un acte de protestation – Quelle est la place des soignants? In: Bulletin des Médecins Suisses 2010 N° 39, pp 1521-25.*

1 Malta, *op. cit.*

2 Allen S. *dixit.*



more dangerous second stage of a prolonged total hunger strike. During these 30 or more days there is plenty of time for the physician to play a constructive role. All too often, and because of the hubbub around "V.I.P." (very important prisoner) hunger strikes, it is the authorities who become nervous and make decisions or issue feeding orders that are unwarranted and premature. The physician thus has a duty to inform the custodial, and if need be the judicial, that there is no medical emergency looming.

The doctor-patient relationship in any context implies that the patient, in this case the prisoner hunger striker, trusts the physician. This is not a moot point. Relations between prisoners and medical staff are always fraught with uncertainties, and a degree of mistrust. If the physician is seen as part of the coercive system any prison of necessity is, then any relationship of trust will be in jeopardy. In prisons, inmates cannot choose their physician; nor can the doctors choose their patients. Conscientious prison doctors know this and do their best to demonstrate they are there to care for prisoners, and not to enforce discipline. In many countries, unfortunately, this principle has yet to be accepted, and is seen still as foreign to local culture.

It should further be anticipated here that any bond of empathy between the doctor as healer and his patient is obviously skewed, if not eliminated altogether, if physicians have participated in abusing prisoners or in military cases (e.g. Guantánamo) participated in interrogations. Whether the methods used for interrogation "qualify" as ill-treatment or torture is beyond the scope of this paper – what matters is their being perceived as such by the prisoners. In such cases, developing a relationship of trust may just not be realistic. In such cases, prisoner access to outside physicians may be the only solution. This type of case will be considered in the final recommendations.

The main point to make here, in discussing the doctor-patient relationship is upstream

from such intervention. It is to draw the prison doctors' attention to the fact that they are the ones who can make a difference, and can in most cases avoid getting into the force-feeding controversy. The vast majority of prisoners neither want to die nor "hurt themselves", as it has been stated. The custodial authorities resent the protest, and want it ended. Furthermore, they do not want any prisoner to die "on their watch" because they are on hunger strike. The physician obviously wants also to avoid any fatal outcome of the hunger strike. One wonders, then, how it is that heated confrontations do ensue, though everyone agrees to the essential fact that deaths must be avoided.

The answer is a complex one, and has many facets that are not acknowledged by one or the other of the participants. The custodial authorities cannot accept that a prisoner holds him/herself – and therefore the whole system – hostage, by threatening to fast to death. In addition, judges and prison governors most usually have no knowledge about the medical evolution of total fasting, and fear "losing" a prisoner on their watch. Finally, the custodial authorities have no ethical obligation to respect the principle of patient autonomy, not to mention physician autonomy and usually do not understand this medical position.

Physicians, hold the key to solving the impasse in most cases. Before entering into considerations about exceptional cases of "diehard" hunger strikers, one should consider the much more frequent case that has been mentioned. A physician, if s/he can have a meaningful discussion in private with the fasting prisoner, should be able to determine what exactly the hunger striker is prepared – and is not prepared – to do. Once it becomes clear that the prisoner does not intend to go "all the way", the issue becomes that of serving as useful intermediary between the hunger striker(s) and the custodial authorities.

This is not necessarily an easy matter. A physician may be able to convince a hun-

ger striker to accept an intravenous drip, for example, with or without nutrients, but at least with minerals and vitamins. Or even a naso-gastric tube in some cases. The point is, if the hunger striker has declared (not necessarily publicly) that s/he does not want to die, the whole issue of "force-anything" becomes moot. An agreement, even only tacit and unspoken, between the hunger striker and the doctor takes the latter off the hook, and allows for any and all measures to be taken. The physician then has the "diplomatic" task of weighing the sensitivities of both sides, and trying to avoid any side losing face as much as possible. This may entail, for example, inserting an intravenous line, while "allowing" the hunger striker to declare vociferously that the "hunger strike continues..." The physician may have to calm down a cantankerous prison governor, assuring him that all is for the better, and that the measures taken will eventually deflate the conflict and end the fasting.

The key element here is time. Hunger strikes only "work" if there is enough time for negotiation and for communication. (This is the main reason why a "dry" hunger strike is an aberration, leaving no time at all for any appeasement to be found.)

What the physician then has to do is maintain this relationship of trust – both with the hunger striker and with the nervous custodial authorities who are itching to "do something" to make the protest stop.

Hunger strikes *à la Bobby Sands*, i.e. going all the way with strict total fasting are an extremely rare occurrence. The reason the whole argumentation about hunger striking and force-feeding has inflated to what it has is mainly because of the custodial authorities increasing tendency to enforce force-feeding, leaving the physicians no leeway at all to act as intermediaries. In the case of military physicians, they may be less than knowledgeable about the ethical guidelines that were being flouted, or they agree on principle to follow superior orders whatever they entailed.

If indeed a hunger striker is adamant about not giving in at any cost, then the physician must theoretically weigh the principle of patient autonomy (informed consent and the right to refuse treatment) against that of beneficence before deciding what to do. In fact, this discussion has already taken place within the World Medical Association, and the guidance given for doctors in "Malta 2006" is quite clear.

When such a conflict exists, it is the *autonomy* of the informed, competent patient that is the governing principle. Beneficence, in the words of the WMA, "includes respecting individuals' wishes as well as promoting their welfare..." Avoiding harm "means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not involve prolonging life at all costs, irrespective of other values."<sup>1</sup> Thus, a competent individual who is informed and able to understand the implications of his/her choice cannot be treated against his/her will. They can refuse contemporaneously or in advance of losing mental capacity<sup>2</sup>.

Examples shall be given in the second part of this paper that fully illustrate the correct ethical conduct of a hunger strike, in the event that it does go to its final resolution. What is perhaps infinitely more important is that the physician most often has the power to *avoid* the conflictual situation getting anywhere near death by starving. This will be developed in the "Way Forward" section below.

## The clinical role of the physician when caring for hunger strikers

The medical evaluation of the prisoner on hunger strike requires an accurate assessment of both his/her physical and mental

health, and first of all a precise and candid history. Any ailments or diseases should be diagnosed and if necessary documented. The prisoner should be given accurate clinical information about the foreseeable effects of fasting in his or her particular case. The fasting prisoner needs to be aware that heretofore-unknown underlying health problems may come to the foreground *because* of the total fasting, and should indicate whether they accept treatment or pain relief for these. Some diseases, such as gastritis, any kind of ulcer, duodenal or gastric, diabetes, other metabolic diseases, to mention but the most obvious ones, should be contra-indications to going on hunger strike. As previously stated, if the physician can explain this to the prisoner convincingly and so s/he does not get the (false) impression that it is all merely a ploy to get the hunger strike to stop, in most cases the hunger strike will quickly desist.

This first evaluation should also determine the mental state and competency. If refusal of food is a manifestation of some mental disorder, such as severe depression, psychosis, or anorexia, then the situation is *not* that of a hunger strike. The authors of this paper have argued that most mental disorders disqualify a prisoner from the "status" of hunger striker, and make him a full-fledged patient requiring medical attention. A prisoner, refusing to eat because of a mental affliction, may be reasonably declared incompetent to refuse treatment. A psychiatrist may even prescribe medically prescribed feeding, if and when such feeding is necessary to sustain such a patient's life. To the extent that individual competency assessment has been properly conducted, this may be medically indicated. The physician should direct care at treating the underlying mental disorder or illness. For this reason, when in any doubt, a full psychiatric assessment of the fasting person is an essential feature of the evaluation.

An examination of the hunger striker's psychiatric and medical history may reveal

factors affecting decision-making abilities and cognitive processes<sup>3</sup>. It has already been mentioned above that a hunger striker, almost by definition, does *not* want to die, s/he is *not* trying to commit suicide by fasting to death. There is often confusion in the minds of prison authorities and judges, who are steadfastly determined against any prisoner "killing himself" or "escaping justice by committing suicide".

The psychiatrists M. Wei and J.W. Brendel have stated, "*Most commonly, hunger strikers do not have mental disorders...*". The distinction is paramount between behaviours intended to kill oneself and behaviours undertaken to protest as a last resort. A politically motivated hunger striker may pursue a total fast with a very positive goal in mind, for himself, or his community – so as to "live better", even risking death if his plea not be heard<sup>4</sup>. The Turkish prisoners who went on repeated and prolonged hunger strikes in the late nineties did not want to die – even if though they were vociferous in declaring they were on "death fasts". The suicide excuse does not apply to prisoners at Guantánamo, even though some could arguably have multiple reasons to feel desperate and hopeless. As Major General Jay W. Hood, the camp's commander, told a group of visiting physicians in the fall of 2005, "the prisoners at Guantánamo are protesting their confinement; they are not suicidal"<sup>5</sup>.

The already mentioned more difficult role for the physician is the all-important task of acting as medical intermediary if consistent with the patient's wishes. This does not mean negotiating the terms of the hunger

1 Malta, *op. cit.*, Article 19

2 *Medical Ethics Today*, 2<sup>nd</sup> ed. (2004) British Medical Association, London; pp. 602-607, 623-625

3 Wei M., Brendel J.W., *Psychiatry and Hunger Strikes*. In: Harvard Human Rights Journal, Vol. 23, 2010.

4 WMJ Case example 1; *op. cit.*; Wei M. Brendel J.W., *op. cit.*, Footnote 16

5 Okie, S *Glimpses of Guantánamo – Medical Ethics and the War on Terror*. In: N Engl J Med 2005; 353:2529-34.

strike, nor interceding on behalf of either party. It may imply determining what possible alternatives to harm-causing, prolonged total fasting can be acceptable. In this way the physician acts in the hunger striker's best interests, while respecting freely taken decisions. This will, again, require a relationship of trust.

The custodial authority sometimes sees the physician as being the "final umpire – the one charged with informing the hunger striker that fasting "to the end" can result in irreversible harm and death. This limited role of the doctor misses the main point. Too much is focused on what should be done *late* in the fasting, and not enough on what should be done during the less pressured time *earlier on* in the fasting – where

better solutions exist. In fact, in the collective experience, the best opportunities to de-escalate and resolve a hunger strike occur long before there is any real risk of serious harm or death. The more technical and monitoring roles for medical staff in the supervision of hunger strikes, concerning laboratory exams, weight monitoring, electrolyte intake are fairly straight-forward have been largely documented elsewhere<sup>1</sup> and shall not be repeated here.

*To be continued...*

<sup>1</sup> *Assistance in Hunger Strikes: a Manual for Physicians and Other Health Personnel Dealing with Hunger Strikers.* (1995 ) Johannes Wier Foundation for Health and Human Rights; Amersfoort, Netherlands, ISBN 90-733550-122

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## Ian Trevor Field

*Ian Field, a past Secretary General of the World Medical Association died on 23 December 2012 after a long illness.*

Ian was born in Rawalpindi, then in British India (now in Pakistan) in 1933. His father was a Regular Army Officer, not medically qualified, serving there during the dying days of the British Raj. Ian childhood and early education were in India. During the second World War he remained in India, while his father was reported killed in action but was in fact captured by the Japanese and held in Changi for 3 years. During this time Ian was admitted to a military school in Poona alongside the younger sons of maharajas. He had been given the aristocratic Hindu caste of a warrior to fit with the princely hierarchy.

When his father was eventually freed the family returned to the UK and settled in Bournemouth where Ian completed his school education. After school he undertook national service in the Royal Engineers, starting an interest which remained all his life.

Having decided to study medicine Ian applied to medical school. His choice of Guys Hospital, University of London was cemented when they presented him with tea in a china cup when he attended his interview in military uniform.

Guys was the ideal choice; not least as he met there Christine who was to become his wife for 52 years.

After qualifying and the usual round of house posts Ian entered General Practice, becoming a GP principal. He joined the BMA staff as an assistant secretary in 1964, rising to Undersecretary before leaving in 1974/5 to work in International Health first with the Department of Health (then DHSS) and later with the Overseas Development Agency (ODA) where he rose to Chief Medical Adviser. Ian rejoined the BMA in 1985 as Deputy Secretary for National Medical Services, the trade union "arm" of the BMA, and became BMA Secretary in 1989.

Amongst many other significant achievements while working at DHSS and the ODA Ian was responsible for relationships with the WHO and with the Council of Europe. At that time the latter in particular was emerging as an important voice that would influence health policy within the UK, and Ian's deep understanding of the processes and politics as well as of the policies was invaluable.

In the ODA Ian was advising ministers on how the UK could use its influence, and money, to improve the health lot of the poor in developing countries. This included work on some of the great killers of those, and indeed of these, times. He chaired the WHO Global Advisory Committee on Malaria; he was the only member who had personally had malaria and he remembered the toll it took from his childhood in India.

Along with those roles came exotic travel. I was exciting to visit China officially, to be taken to Bokhara and Samarkand by the Russians and to be wine and dine with the Japanese. But alongside the fun of meeting new people and exploring new places he



never lost his commitment to health in developing countries. In Zanzibar he zoomed in on a maternity ward that had been given modern incubators for premature babies but had no electricity or oxygen to put them to use. The survival of the babies still depended on loving care and their isolation. On the mainland of Africa he noted how bedsores were treated with honey and exposure to sunlight.

In this work Ian was using his childhood experiences, which were far more diverse than the average senior civil servant or British doctor, to see further and to connect better with the people his department were seeking to help.

Returning to the BMA Ian inherited an organisation expanding rapidly and consolidating its member-facing services, helping doctors in employment difficulties. At the same time relationships with the UK government were going through a difficult phase with changes to the National Health Service that were deeply unpopular with most and to which the BMA was vocally opposed. The Association needed a steady hand at the top, keeping diverse interests together, and that is what Ian delivered.

The BMA had always had strong international links; many of the medical associations in the former British Empire were now independent bodies in their own independent countries. But many remained then (and now) attached to memories of working with the BMA and Ian was always delighted to meet and host colleagues from around the world. His genuine respect and affection for people from all over the world shone through.

Ian's knowledge of the way international organisations worked, including WHO, was especially helpful as the BMA increased its public health lobbying internationally on matters such as tobacco control. Help in identifying the right routes to influence were invaluable and always available.

By the time he retired the BMA had raised its membership to over 100,000 for the first time and was continuing to expand both its political and professional activities. In recognition of his service the BMA appointed Ian a Vice President, one of its most senior honours.

As a broader recognition of his service to health, including his enormously important work while at the Department of Health and the ODA Ian was honoured by Her Majesty the Queen who made him a Commander of the Order of the British Empire (CBE).

As soon as Ian left the BMA he was snapped up by the World Medical Association. He and Christine moved to Ferney Voltaire and Ian set about persuading lapsed members to rejoin, and to take an active part in developing WMA policy and direction.

A number of member associations had left the WMA in the early 1980's in protest at a number of matters, including voting systems. Ian cajoled them back into active membership promising that, as always, he would listen to their concerns and ensure real

problems were fairly addressed. This was a significant period of growth for the WMA. Ian also encouraged engagement, and many more members began to develop new policies for the WMA. As always Ian was a strong source of advice as well as encouragement; new members knew he was always there to

help with drafting, or with help in understanding how to get policies through the byzantine and confusing processes of the WMA. Ian loved the opportunity to travel with the WMA, and was a popular visitor at national medical association meetings where he never failed to promote membership of and engagement with the WMA.

After Ian retired his many friends hoped he would have a long period in which to enjoy life, including his family. His involvement in the Worshipful Society of Apothecaries, a livery company in the City of London that had long had the right to grant medical licences, culminated in its highest honour when Ian became master.

Sadly Ian suffered a stroke in the late 1990s which severely curtailed his ability to travel, but he remained active in his community. Among other things Ian enjoyed helping Primary School children with their reading.

Ian was, throughout his life, a committed Christian. Raised in the Jesuit tradition he later embraced the Benedictine traditions. As a community activist Ian played an important part in both local church management and in Ecumenism. His faith was a part of everything he did.

Ian was also a family man. He was devoted to his partner, wife Christine, their three sons and daughters in law and 8 grandchildren. All took part in his funeral showing their deep love for their devoted grandfather.



*(With grateful thanks to Sir Colin Imray whose Eulogy offered great help in compiling this obituary.)*

Vivienne Nathanson  
29 January 2013

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# EFMA meeting March 21–22, 2013 Riga, Latvia

EFMA (European Forum of Medical Associations) meeting will take place in the capital city of Latvia – Riga on March 21–22, 2013. Already for 30 years EFMA has organized this meeting together with Regional Office for Europe. The 2010 EFMA meeting took place in St. Petersburg, 2011 in Brussels and 2012 in Yerevan.

Meeting is organized by the EFMA President Lea Wapner from Israel and Latvian Medical association.

The EFMA meeting 2013 is supported by the World Health Organization, Ministry of Health of the Republic of Latvia and World Medical Association

The Medical Associations, Unions and Chambers of the European Union, the Medical Associations of the Economical Zone of Europe are going to participate in EFMA.

EFMA is the only forum where not only European Union members and medical organizations which belong to countries based on classical European values comes together, but also medical associations from former Soviet Union countries like Belarus, Tajikistan, Turkmenistan, Moldova, Armenia and Albania, Kosovo, Israel are represented. This is an opportunity to discuss among different systems, traditions and possibilities.

The goal of Latvian Medical association for the meeting in Riga is to create a dialogue or a kind of bridge between different medical organizations in Europe and putting emphasis on exchange of experience among medical associations of Western Europe, Central Europe, new participants of European Union, CIS countries, Israel and perspective members.

There is quite different experiences among European countries regarding issues concerning possibilities of medical NGO's to solve problems connected to public health in their respective countries.

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