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- The Future of Global Health
- Physicians in Turkey

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Instead of Editorial

June is graduation month and approximately 700,000 young doctors throughout the world will receive diplomas. These medical degrees may be quite variable. In some countries non-traditional practitioners, local medical specialists and dentists are counted as doctors, whereas in others, physicians must undergo six years of rigorous medical education before they get medical doctorates. Nonetheless, they will all join the pool of doctors in the world and will become serious players in the medical field within ten years.

Most of these doctors will greet the turn of the next century. In 2100 life expectancy is expected to be much longer than it is today. Continuing population growth will add further stress to the healthcare system, though eventually continued population growth will not be sustainable. The number of old people, many of whom will have chronic illnesses, will grow exponentially and the burden to society will be tremendous. Most countries will be unable to support all the retirees, so the retirement age will increase faster than the lifespan. Doctors who graduate this year will probably have to work until they are 80 to 85 years old. Just a century ago, no one thought that

it would be normal to be working at age 70, as is common today. During these years, medicine will change so dramatically that much of what graduating students have learned in medical school will be obsolete. The rate of change is increasing, and there are projections that in the 21st century the philosophy of medicine will change completely every 20 years. In the beginning of the 20th century a sick patient was committed to bed rest and fed a calorie-diet rich. In the beginning of the 21st century, the same sick patient is mobilized and the calories may be restricted. If aging genes or cancer-predisposing genes are discovered in the next 20 years, medicine will go in a completely new direction. The most important questions in medical ethics will be related to business issues – expensive medications, gene therapy and cell transplantation will not be accessible to everyone. While it might be possible to extend life indefinitely, this will not be available to everyone. Welcome, young doctors, to the medical profession. Welcome to the World Medical Association.

Editor in Chief, WMJ
Dr. Pēteris Apinis

On May 30, in the third and final reading the Latvian Parliament unanimously adopted amendments to the law “Protection of the Rights of the Child” which among other things contain the following: “Physical abuse is intentional application of force that threatens the health or life of a child in contacts with the child, including deliberate exposure of a child to the effects of harmful factors, including tobacco smoke.”

Latvia has become the first country in the world where smoking in the presence of a child regardless of the environment, a street or a private apartment, is a violation of the law and will be considered a criminal act. In Europe, 700 000 people every year die of direct effects of smoking, but tens of millions of smokers die prematurely of cardiovascular diseases, cancer or lung diseases. More than 60% of smokers in Europe acquired the habit because their parents were smokers, smoked in the presence of children and left the cigarettes unattended. Moreover, when smoking in the presence of their children, parents send an implied message that smoking is not to be condemned as mom or dad does it.

Recent studies reveal that the foetus can become addicted to nicotine if a pregnant woman smokes or has to breathe in tobacco smoke regularly.

Unfortunately, children are dependent on their parents or other adults and do not have sufficient information and life experience to assess the dangers of smoking. Similarly, disabled people and those who do not possess decision making capacity should be protected from smoking in their presence.

The Ministry of Health of Latvia together with the Latvian Medical Association put forward further legislative proposals to reduce smoking, especially among children and youth. Currently the Latvian Parliament is reviewing amendments to the law “On Restrictions Regarding Sale, Advertising and Use of Tobacco Products”. Latvia aims at legislation providing that any non-smoker has the human right to breathe clean air instead of smokers having the right to smoke. Hence, the next amendment to the Law will stipulate that in Latvia smoking in the presence of other people (on the street, in a park, public places, private territories) is permissible only after receiving their consent. In Latvia smoking is already prohibited in cafes, restaurants, clubs, sports stadiums and halls, workplaces and public premises. Now balconies, terraces, staircase and many other places where smoking can inconvenience other people will be added to the list.

Latvia supports designing plain cigarette packets like in Australia, namely, 100% of the packet's design informs about the harmful effects of cigarettes. However, understanding the different experiences of European countries, Latvia's proposal is a draft law providing that 75% of the packet's design carries information on the dangers of smoking, and calls on all European countries follow suit. Latvia's proposition: Smoke free Latvia in 2020, smoke free Europe in 2025.

Dr. Ingrida Circene,
Minister of Health of Latvia
Dr. Pēteris Apinis,
President of Latvian Medical Association

The Future of Global Health. Reasons for Alarm and a Call for Action



C. D. Butler

The future of global health depends far more on fundamental ecological and social determinants than on progress for health technologies, whether surgical, pharmacological or immunological. There is a growing gap between the optimism in official forecasts of development and global health and the trend of the most important health determinants. Without fundamental change to these, in turn requiring a global shift in culture and measurements of progress, the prospects for global health look bleak. "Peak health" in the past has generally referred to humans in their prime of fitness; in the future it may be seen to refer to the time when global life expectancy reached its maximum. That time may be within a decade – but, if we can change sufficient practices, then we might still improve global health through this century.

"The prospect for the human race is sombre beyond all precedent. Mankind is faced with a clear-cut alternative: either we shall all perish, or we shall have to acquire some slight degree of common sense. A great deal of new political thinking will be necessary if utter



P. Weinstein

disaster is to be averted." Bertrand Russell, 1945 [1].

Introduction

It is a truism within public health circles, in contrast to much of the common understanding of health, that underlying "determinants" are more important than health technologies in explaining phenomena such as life expectancy. For example, mortality from infectious diseases such as tuberculosis decreased, decades before antibiotics, in industrialising countries of Europe from the second half of the 19th century. This has been widely credited to improvements in housing and nutrition [2]. More recently, however, there has been increased appreciation that some medical factors, especially smallpox vaccination, also contributed to better health outcomes [3, 5].

In the 18th century, in the UK, civil society also generated an expanded number of hos-

pitals, a trend which abated in the early 19th century, when life expectancy declined in England, the leading industrialised country in the world, during a time when an extreme form of capitalism often called *laissez faire* dominated [5]. In this period, before widespread labour organisation, inequalities and squalor increased along with industrialisation. In Glasgow, faith in market forces also contributed to a decline in state-supported smallpox vaccinations from about 1820 [4, 6]. Ironically, this was just as Glasgow was becoming known as the "second city of the British empire".

The surge of technical developments in recent centuries is very impressive; from electricity to satellites and the internet. Most of them have health applications. Technologies specific to health have also been revolutionised, and the ambition of human health interventions has greatly expanded. A global highly organised campaign led to the eradication of smallpox, and insecticides and good public health have greatly reduced the burden of malaria [7]. For patients with funds, organ transplants are routinely available in some countries, if needed. The list of such medical contributions to improved health is very long, and their cumulative impact is a powerful reason for the general belief that technology is now more important than deeper health determinants – and will continue to do so.

However, while antibiotics have been discovered, synthesised and used in great quantities, resistance to them is also increasing. Increased resistance to insecticides also looms. Optimism for important vaccine breakthroughs, from malaria to dengue, far exceeds reality, though some progress has been made, such as with a partly effective defence against rotavirus [8].

But problems far worse than antibiotic and insecticide resistance shadow future global health. Especially fundamental are ecological and social determinants, the severity of which underpin the growing gap

between the optimism in official forecasts of development and global health and our concern.

Because of these determinants, an increasing number of scientific papers declare openly that civilisation is at risk [9–12]. This article focuses on these underlying ecological and economic determinants, and then links them to future health prospects.

We assert that, without fundamental reform, associated with a shift in global culture and measurements of genuine progress, the prospects for global health look bleak. “Peak health” in the past has generally referred to humans in their prime of fitness; in the future it may be seen to refer to the time when global life expectancy reached its maximum [13]. That time may be within a decade – but, if we can change sufficient practices, then we might still improve global health through this century.

Hubris, Economics and Recession

Much of southern Europe is in severe recession, and unemployment also remains high in the U.S. Tent cities sheltering the homeless have appeared in the most militarily powerful nation on Earth [14]. These are the modern equivalent of “Hoover-villes” – shanty towns common in the 1930s, named after U.S. President Herbert Hoover, who was in power on Black Friday, October 29, 1929, at the onset the Great Depression.

There are disturbing similarities between the 1930s and the present time, and we should not forget that earlier decades saw the nurturing of fascism in Europe and culminated in an even bloodier conflict than the “War to End Wars”. Perhaps the most important similarity between the time leading to the Great Depression and our own is the economic and cultural hubris of those in power [15]. The U.S. stock market

boom of the 1920s was considered by the herd of bankers, investors and politicians in control at that time to be never-ending. Sceptics who recalled the long history of booms and busts, the best known of which may be the Tulip Mania of 1636–37 [16], were disregarded in what became a stampede to lock in profits, and then a rout, as people were left holding near-worthless bulbs, when they had formerly possessed a house.

For a while, the series of global catastrophes and tragedies that unfolded between 1914 and 1945 – two World Wars and the Great Depression – seemed to offer hope of a new, fairer world order [17]. International idealism was evident at high levels, fostering the birth of the United Nations institutions and declarations, including for Universal Human Rights, a new ideal for which former U.S. First Lady, Eleanor Roosevelt, had been instrumental [18]. Post war U.S. President Harry Truman, who had ordered the atomic attacks on Japan, quickly became troubled by the awful potential of nuclear weapons and took steps to reduce their control by the U.S. military. Truman is said to have recoiled from their further use, argued by some to be justified by the Korean War [19]. Yet, within another few years the U.S. administration was openly contemplating the conventional use of tactical nuclear weapons (including in limited wars) and the Cold War was heating up [19].

About this time, the Canadian-born economist JK Galbraith was warning of the likelihood of future speculative financial bubbles:

No one can doubt that the American people remain susceptible to the speculative mood—to the conviction that enterprise can be attended by unlimited rewards in which they, individually, were meant to share. A rising market can still bring the reality of riches. This, in turn, can draw more and more people to participate. The government preventatives and controls are ready. In the hands of determined government,

their efficacy cannot be doubted. There are, however, a hundred reasons why a government will determine not to use them [20].

Galbraith wrote this in 1955. Although numerous economic bubbles burst in the following decades [20], the next great global economic crash was delayed until 2008, more than fifty years later. This precipitated today’s Great Recession, which to date has persisted for five years, with no end yet in view. Soon after the crash, English Queen Elizabeth II visited the London School of Economics, where she asked why so few experts had predicted this second great financial crash it. A response stated in part:

“Financial wizards” managed to convince themselves and the world’s politicians that they had found clever ways to spread risk throughout financial markets – whereas “it is difficult to recall a greater example of wishful thinking combined with hubris” [21].

Developmental and Environmental Hubris and the 2015 Hunger Targets

Even less well-recognised than the risks of economic hubris, civilisation today faces dangers grounded in the interaction of planetary environmental and social factors [22–24]. Nevertheless, living conditions, and life expectancy for the more privileged global middle class or “second caste” [17] may be protected for some decades, even if these trends remain unaltered.

There are many components to this risk (see box), and many ways that these dimensions can be described. Importantly, the risks to global health extend far beyond climate change [25]. Above all, it is their *systemic* nature which is the most troubling. For example, an important response to the growing scarcity of cheap oil has been to convert food crops to ethanol and biodiesel. Almost



40% of the U.S. maize crop (and over 16% of the global crop) is now used for ethanol [26, 27]. A non-trivial fraction of other foodcrops are also used for fuel, from palm oil to sugar cane and cassava. This diversion of food to fuel adds appreciably to global food prices, and José de Silva, the newly appointed head of the FAO, has recently called on the US to lower the percentage of maize diverted to ethanol, so as to lower global food prices [28]. The diversion of food to fuel also threatens biodiversity (because of the associated replacement of native forest with monoculture, for example oil palm), and as we shall see below a loss of biodiversity in itself poses serious threats to human health.

Only a few of these elements can be discussed in any detail in this article. Fundamental to most analyses, however, is the principle common to all currently dominant economic systems, whether based on redistribution (i.e. leftist or socialist) or market forces (i.e. rightist), which is the failure to properly account for two forms of hazards. These hazards are the depletion of natural resources (both non-renewable and renewable) and the accumulation of waste. The failure to measure either harm is especially pronounced when the damage accrues to people who are far away, whether in physical distance, culture, or time, including future generations.

Depletion of non-renewable natural resources, such as oil and other fossil fuels impacts directly on global health. The rising cost of energy not only lifts the price of food, but also makes it harder and more costly for civilisation to develop the infrastructure which may one day free us from dependency on these dangerous and polluting fuels. Depletion of renewable natural resources, especially biodiversity and intact forests is also problematic. We are dependent on healthy, sustainable ecosystems for food, water, fibre, and fuel. While *provisioning* ecosystem services (such as for food and fuel) continue to increase, this

is at the expense of *regulating* ecosystem services [29], which are vital for a stable climate, for adequate fresh water, and to reduce runaway growth of unwanted species population increases, such as jellyfish swarms [30].

It is also becoming increasingly clear that indirect effects of biodiversity decline include epidemics of emerging infectious diseases: When biodiversity is lost, the likelihood is increased of disease vectors becoming increasingly prevalent [31–33].

The second problem – the failure to account for waste – may result from the long evolutionary human experience as “patch disturbers” [34]. For millennia, humans were migratory, and our numbers small compared to the resources and landscape. Our species could disrupt its local environment and then move on. Even after the development of settlements, local pollution was generally manageable; most wastes were organic, and

quickly broke down – though the failure to safely dispose of human faeces and in some cases urine did contribute to various infectious diseases, including cholera, hookworm and schistosomiasis. The close proximity of humans and animals living together also resulted in a number of ‘host jumping’ events, wherein animal pathogens crossed into human populations.

Economic systems are fundamental, because they supply incentives, operant at multiple levels, including global in the form of price signals, to act in ways that either hinder or facilitate the sustainability of civilisation and thus the chance of reasonable global health. Today, most financial incentives operate to deliver short-term benefit for those who are privileged, but to pile on disadvantage and risk to those who are already poor and vulnerable.

The complacency and misunderstanding which are generating these risks is re-

Major under-appreciated risks and solutions to global health

- A global lack of leadership, bolstered by a retreat from aspirations of global civilisation by the first and second “clastes”.
- Climate change, especially its impact on food security, migration and conflict.
- Rising energy costs.
- Impending phosphate scarcity.
- Limits to yield growth of major crops in Europe, the U.S., China, and India.
- Biodiversity loss.
- Diminishing returns to increasing complexity.
- Youth bulges and the risk of conflict and declining governance on the “front-line”.
- The awakening of “sleeping” infectious disease pandemics in the threatened new milieu of chaos.

Potential solutions

- New technologies, especially solar, which make fossil fuel uncompetitive.
- Revived global leadership, especially a re-awakening of aspirations for education and health for all.
- Improved human rights, especially for women.
- Better treatment of parasitic and other neglected diseases.
- Less wastage of food, pre and post-harvest.
- Greater care to recycle phosphate and reduce its waste.
- The ascendancy of ecological economic systems.

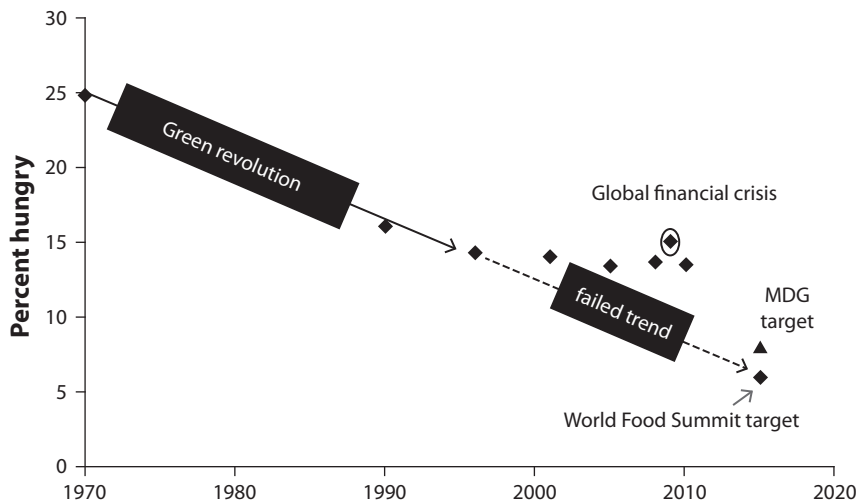


Figure. From 1960 until about 1996 great progress was made in reducing global hunger. A failure to understand the reality of limits to growth led to wildly optimistic targets for 2015. Raw data FAO, to 2011. FAO data in 2012 revised these data, making the target look less out of reach [36].

vealed by global attitudes towards hunger targets. At the time of the World Food Summit in 1996, great progress had been made in reducing the fraction of the world population classed as chronically undernourished. The proportion of hungry people globally almost halved between 1970 and 1996, due to the success of the Green Revolution (see Figure). At that summit, it was announced that the hunger target for 2015 would be to reduce the number of people classed as chronically hungry in 1990 (850 million) by half (to 425 million) [35]. This number represents 6% of an estimated global population of 7.2 billion in 2015. This promise will not be kept; its failure cannot principally be attributed to climate change, though that is now of growing importance.

Full discussion of this little-noticed failure to reduce global hunger are complex and is not possible here. One factor includes the intransigence of Catholic teachings on contraception; a ruling whose power seems inversely proportional to the distance from Rome. Slowing population growth enhanc-

es economic growth, and makes the problem of food distribution easier [37].

Many commentators on the political Left, certainly since Karl Marx (a trenchant critic of Malthus) [38] have argued that the problem with food-poverty is primarily one of distribution, rather than supply. However, the decline in hunger between 1970 and 1996 coincided with a large increase in per person food supply, especially of grain [39]. In recent years, total food supply, when adjusted for biofuels (food which cannot be eaten), has been either static or in decline [36]. Irrespective of the wishes of idealists, world hunger is unlikely to be substantially solved by redistribution, though reduced food waste in low-income countries, especially India, could surely reduce rural hunger.

The 2015 hunger targets could have been on track (and could still be reached, even starting from today) by sufficient redistribution of food and the other resources needed to enable secure food entitlement [40]. However, to argue that the failure of

the hunger goals lies primarily in the failure of redistribution is very unrealistic. It is also very unlikely that the framers of the 1996 World Food Summit goals thought that their target could be thus achieved by redistribution. Rather, they most likely believed that the progress made between 1970 and 1996, in greatly expanding food supply per person, could simply continue. But the chance of such additional food was in reality no more likely at possibility had no more credibility than that stocks would keep rising, predictions made by economic pundits at the height of stock market booms.

This statement may sound too harsh, but not to those who signed or studied the World Scientists Warning to Humanity, now two decades old [41]. Signatories included more half of the Nobel Prize laureates for natural science then alive. The list included Norman Borlaug, who had been awarded the Peace Prize in 1970, for his work in developing the Green Revolution. The collective statement warned:

We the undersigned, senior members of the world's scientific community, hereby warn all humanity of what lies ahead. A great change in our stewardship of the earth and the life on it is required, if vast human misery is to be avoided and our global home on this planet is not to be irretrievably mutilated.

The reasons for the failure of the 1996 and 2000 food targets (for 2015) lie far more with wishful thinking and a failure to understand limits to growth than with a failure of redistribution. The success in reducing hunger in the heyday of the Green Revolution was not primarily because of redistribution, but because food supply per person expanded dramatically in that period.

Probably the single most important reason for the failure to reach the 2015 hunger goals is that the crop and technological improvement which led to the enormous



increase in yield facilitated by the Green Revolution (albeit dependent on energy-intensive fertilisers, pesticides and water) had largely been achieved by about 1990. Yields continued to increase, but at diminishing rates. In some cases, including rice in China, wheat in India, and irrigated maize in the U.S, they have entirely flattened [42]. Indeed, Borlaug broadly forecast these developments in his Nobel Peace Prize acceptance speech, in 1970, in which he also called for the kerbing of population growth [43].

Since about 1990 considerable effort has gone into trying to replicate the Green Revolution's success, using genetically modified crops. The effort in promoting GMOs has not been well spent [44]. Much this research has been to improve weed control through the development of crops such as canola and corn modified to be resistant to the herbicide glyphosate. But, as predicted at least as early as 1996 [45], selection pressure has driven the evolution of glyphosate resistant weeds [46].

Some work has attempted to develop genetically modified crops for use in the Third World that are resistant to drought and disease; however, the results have so far fallen far short of their promise. At the same time, complex factors have prevented the Green Revolution from penetrating far into Africa [47]. The Millennium Development Goal (MDG) for hunger, set in 2000, was slightly less ambitious than the 1996 target [48]. Neither has much progress been made towards it. Furthermore, since the onset of the Great Recession, little noticed by wealthy populations, famines have returned to the African countryside, to Somalia, Sudan and Niger. At least some of the causation for the famine in the Horn of Africa is due to human-induced climate change [49, 50]. There is also increasing recognition that the chronic food insecurity in Niger is related to that nation's high population growth. Half of the people in Niger are aged under 15 [51].

Economics, Energy and Recessions

Our dominant economic systems, whether capitalist or communist, evolved and became dominant in the last two centuries, at a time when global resources were abundant and generally increasing, even on a per-person basis. The price of energy was historically low in most of this period, as was the price of food [52]. Despite the warning of one of the most eminent fathers of economic theory, John Stuart Mill [53], "steady state" systems, which preferred qualitative to quantitative growth were scorned.

The discipline Mill helped establish, most commonly called ecological economics [54, 55], remains as marginalised today [56]. as the analysis of the rare critics who (correctly) questioned the wisdom of making "sub-prime" loans to impoverished U.S. house buyers in 2007. This is the case even though a major component of the seemingly intractable global recession is the persistently high price of energy. Despite claims disputing the reality of "peak oil" [57], energy prices remain very high globally, even during the current deep recession [58]. The former U.K. chief scientist, Sir David King, recently co-authored a paper in *Nature* which pointed out that consumers in the European Union and the U.S. each spend \$1 billion dollars per *day* importing energy, greatly reducing the money circulating in the local economy. These funds could stimulate domestic employment [59].

Optimists have predicted that the discovery of large supplies of shale gas and new technologies that allow increased recovery of "tight" oil mean that a new global energy glut is unfolding with a consequent impending price drop. Others dispute this, including the Post Carbon Institute [60].

A major report underlying this optimism [57], completely ignored the concept of "net energy", or "energy return on energy

investment" [61]. One way to conceptualise this is by thinking of stocks and flows. The total stock of fossil fuel has expanded, but the rate at which it can be withdrawn has altered little, so that total annual supply remains constrained. A medical analogy is the birth of twins. A uterus may have two fetuses, but they can only be delivered one at a time, even by Caesarean.

A major reason for this is that much "unconventional oil" is extremely energy-intensive to extract, such as the Canadian tar sands. At least a fifth of the energy contained in these fields is required to extract the remaining energy, giving an energy return, at the best case, of 4:1 [61]. Off-shore wells from Brazil are so remote that helicopters must be refuelled in mid-air in order for drillers to reach their platforms [58]. These discoveries and new technologies may mean that the world oil production experiences a "bumpy plateau" rather than a sharp peak, and it seems also likely to delay really steep price rises (e.g. above \$200/barrel), partly because high prices generate a deepened recession, temporarily lowering demand [61].

A sustained decline in the price of liquid fossil fuels appears unlikely. But even if fossil fuel prices fall substantially, relief to the global economy is likely to be only temporary, unless that energy bonus can be used to build the technological and energy revolution that is so badly needed, which can wean civilisation from "Earth poisons" such as coal and radioactivity. But without greatly improved leadership, humanity is likely to squander that chance. High energy prices may in fact be the best way to drive the creation of new technologies (such as new-generation photovoltaic), because the constrained supply acts as a *de facto* carbon price, applicable globally except in those few countries which export abundant oil, and which continue to heavily subsidise the price of fuel, often at the same time creating high traffic density and localised air pollution.

Moving from Social to Eco-Social Health Determinants

Recently there has been a welcome revival of interest in the “social determinants” of health. In short, this thinking points out the impossibility of good health when people are poor, either materially or relatively. Inequality appears to be an important health determinant, perhaps rivalling undernutrition in some societies. The core solution to inadequate social determinants is either to redistribute the existing “cake” or to bake a bigger cake, perhaps preferentially distributing the increment to those who are only receiving crumbs.

However laudable these approaches are, they do not contribute sufficiently to solving the problem of limits to growth. The case of energy and food has been extensively discussed above. While redistribution of existing energy supplies would alleviate fuel poverty for many, it would neither lower the price of electricity nor increase the supply of oil. The same analysis applies for phosphate, an essential element which must be mined or recycled and which like oil is declining in quality and quantity [62].

Therefore, there needs to be commensurate awareness of the environmental health determinants, including ecological ones. These may be renewable – such as fish stocks, biodiversity and fresh water – or non-renewable, such as fossil fuels, phosphate and arable land.

Also necessary is a greater recognition of the links between social and environmental factors, such as between conflict, migration and resource scarcity. The co-mingled causation of many eco-social phenomena is contested, sometimes bitterly. For example, the Rwandan genocide of 1994 – together with many other conflicts in Africa and elsewhere – are often analysed as purely social events rather than interactions between ecological events. This is especially true for resource scarcity, most

often of land and social factors. An excellent rare exception was published in the *Journal of Economic Behaviour and Organization* [63].

Most wars concern the struggle for resources, but this purpose is often disguised. The invasion of Iraq in 2003 had much to do with the struggle to control that nation's oil supplies. Rupert Murdoch forecast that oil would fall to \$20 per barrel [64]. However, the link to oil was vigorously denied by the leaders of the U.S., U.K. and Australia.

A more recent example is the displacement of about 400,000 people in the northeastern Indian state of Assam in 2012 [65]. This is generally characterised as a clash between Muslims and the indigenous people, the Bodo, who are largely Christian or animist. Depending on their bias, pundits discuss different events as triggering factors. However, too few analysts, including academics, consider that the problem is one of insufficient land and other resources for the wants and needs of the population. True, some people in such areas could voluntarily live in more extreme poverty, thus enabling a higher population density. But that strategy becomes self-defeating, because such poverty leads to increased weakness and vulnerability, creating the potential for displacement by more powerful groups or populations. In practice, each of the main groups in Assam has sought to increase its living standard by means such as improved technology, better fertiliser, remittances and also by utilising all available resources, including fertile land. This competition creates dry tinder, requiring only a small spark for violence to catch fire.

An increasing number of social scientists recognise the links between earth system limits (including planetary boundaries) and human well-being [66, 67]. At the same time, a slowly increasing number of health workers also recognise these links [22, 24, 68, 69].

Migration

Migration, including the seeking of political asylum, has recently been most frequently characterised as having an “economic” causation, that is, purely social; in the sense that the economic problem could be solved by enough social cleverness. However, economic factors are associated with elements that are both material (food, shelter) as well as social (freedom of association and speech, psychological security).

Despite growing understanding of the interactions, wealthy populations are reluctant to accept this argument. In countries such as Australia the fiction of purely economic refugees is used widely in the media to reduce feelings of guilt and responsibility, including about climate change, with its spectre of rising sea levels and other contributory drivers of migration.

Australia, a signatory to the refugee convention, *does* eventually settle – usually after years of confinement – most people who seek asylum and who are able to reach an Australian territory. However, the entrepreneurs who are paid by asylum seekers to bring them to Australia (a lawful act) are universally vilified as “people smugglers”. Would a sympathetic German helping someone escape from Auschwitz to Switzerland be denigrated this way?

Health

We have written here much more about the determinants of health than health itself. Clinicians are familiar with the art and science of diagnosis and treatment, but rarely consider why their patients may suffer a chronic disease or engage in such risk-taking behaviour as smoking. If clinicians do start to ponder this, then they venture into public health territory, a field in which practitioners routinely consider population-scale factors that influence health, such as calorie intake and cigarette advertising. In



this paper we have only sketched the numerous links between the planetary environmental determinants mentioned and health.

The most important mechanism is unlikely to be a sudden ecological catastrophe that ends food production, though an intensified loss of pollinators, vital for food, is occurring [70]. More plausibly, as limits to growth tighten, competition among people and between human groups will increase, leading to intensified regional scarcity, conflict and misery.

A recent spate of self-immolations in Bulgaria has been driven by poverty and inequality. Conflict over resources in Chechnya can have ramifications in Boston. Rising prices of food and oil in Egypt threaten to deepen unrest there. Globalisation links diverse populations via trade; but unless the wealth it creates is shared equitably – at least to a minimum standard, then resentment and occasional terror will also be exchanged [71].

Climate change is expected to impact on human health in numerous ways, classified by Butler and Harley as primary, secondary and tertiary [25, 72]. In brief, these include direct (“primary”) effects (such as from heatwaves or extreme weather events), less direct “secondary” effects such as from changes in insect vector populations or the rate of growth of parasites within vectors in warmer environments, and “tertiary” effects. These occur when climate change acts as a “risk multiplier” for events such as conflict, famine and large-scale migration. Some analysts think that the Syrian conflict has been worsened by climate change [73].

Even without conflict, rising food prices increase the risk of undernutrition and (perhaps paradoxically) also of obesity, as populations strive to conserve calories at the expense of micronutrients. Chronic under- or unemployment can be devas-

tating for self-esteem and mental health. Resultant poverty can stress families and reduce the intergenerational transmission of love and nurturing that is essential for population health to flourish. Although we have not argued that health care is the major health determinant, it is a factor. Recessions make it harder for the poor to pay for health care. In many locations illnesses are an important cause of impoverishment.

From Describing the Problem to Outlining the Solution

These problems may seem intractable but solutions exist. The mainstream approach has two main prongs. The first strategy is to deny the existence of any fundamental problem, such as a limit to growth or consumption, and trust that ingenuity, investment and market forces will find a solution. This approach has had isolated success, most notably the “Green Revolution” described above. Today, civilization is like a man falling to Earth without a parachute, regarding his velocity as the chief indicator of progress.

The second strategy is scarcely discussed. That is to fortify the walls, moats and electronic surveillance mechanism that separate and try to protect wealthy populations from the masses. This approach can be seen at the border between Europe and North Africa, the U.S. and Mexico, and Australia and Asia. It also is evolving between India and Bangladesh, which can now be called the world’s “biggest human cage”, due to the fence that India has been constructing along most of its border.

Neither of these solutions is tenable over the long run. The solution instead must lie in an intellectual and social revolution which overturns our dominant ways of thought. We must collectively develop the new ways

of thinking called for by such visionaries such as Bertrand Russell, Albert Einstein and Martin Luther King.

Some of these visionaries have worked in health, including Albert Schweitzer, René Dubos and Frank Fenner. Health organisations including The International Physicians for the Prevention of Nuclear War (IPPNW), Physicians for Social Responsibility (PSR) and the International Society of Doctors for the Environment (ISDE) exist, and collectively can work to reduce the threats we face. Perhaps the leading medical aid group, Médecins Sans Frontières, will also take a more active role in calling for improved health determinants.

Another, alternate, solution has emerged: the accelerating power of the internet. An example of how it can be used as a force for change is the use of low-cost mobile phones for internet access in Kenya, which could provide a model for other African countries [74]. Many traditional authorities lament the demise of print media, but some optimists think that the rise of social electronic media may be more democratizing than newspapers have been in recent years, controlled by oligarchs such as Rupert Murdoch.

Academics can contribute by greater recognition of the dangers that exist and by writing about solutions. A recent special issue in *The Lancet* was devoted to human population numbers and health [75]. Melinda Gates has also recently spoken of the need to slow global population growth [76, 77]. A meeting to commemorate the 350th anniversary of the Royal Society accepted the peril we face is real, and warned of the risk of pessimism as a response [68]. The Royal Society report *People and Planet* will also serve to relegitimise discussion of family planning and limits to growth [51].

The fact that such reports are seen as groundbreaking shows how far we have to come. These themes were widely recognised



in the 1970s, a decade which experienced the first Earth Summit in Stockholm, publication of the report to the Club of Rome called *The Limits to Growth* [78] and the coining of the phrase “development is the best contraceptive” [79]. It still is.

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World Health Assembly Week

The 66th session of the World Health Assembly (WHA) took place in Geneva from 20–28 May. It was attended by many representatives from the World Medical Association.

In the days leading up to the Assembly, the WMA had joined organisations from the Safeguarding Health in Conflict Coalition in sending a letter to Dr. Margaret Chan, Director General of the World Health Organisation, urging her to use her opening address to the Assembly to condemn the continuing violence against health personnel in Syria.

So when the Assembly was opened on the Monday by Dr. Chan, the WMA leaders welcomed her words condemning violence against health personnel.

Director General's Opening Address

Dr. Chan declared: 'WHO is aware of reports of assaults on health personnel and health care facilities in conflict situations. We condemn these acts in the strongest possible terms. Conflict situations sharply increase the need for health care. I cannot

emphasize this point enough. The safety of facilities and of health care workers must be sacrosanct.'

In other issues referred to in her address Dr. Chan spoke about two new diseases currently facing the world, human infections with a novel coronavirus and the first-ever human infections with the H7N9 avian influenza virus. 'These two new diseases remind us that the threat from emerging and epidemic-prone diseases is ever-present', she said.

She went on to talk about the place of health in the post-2015 development agenda and the need to ensure that health occupied a high place on the new development agenda.

'Investing in the health of people is a smart strategy for poverty alleviation. This calls for inclusion of non-communicable diseases and for continued efforts to reach the health-related MDGs after 2015.'

She talked of the success in treatments for HIV and encouraging progress on tuberculosis and malaria. The past two decades had seen dramatic improvements in health in the world's poorest countries, but she added that WHO would never be on speaking terms with the tobacco industry. However, she did not exclude cooperation with other industries that had a role to play in reducing the risks for NCDs.

Junior Doctors Network

The WMA leaders who travelled to Geneva for the Assembly began by attending a highly successful meeting held by the Association's Junior Doctors Network. This discussed the issues likely to be raised at the Assembly as well as the various projects being pursued by the JDN, including a white paper on physicians' wellbeing, a policy paper on the ethical aspects of global health education and an environmental scan of post-graduate medical education examining conditions for junior doctors in training in countries around the world.

WHPA Luncheon

On the first day of the Assembly, the World Health Professions Alliance held a luncheon at which it issued a major new statement on collaborative practice.

The global bodies for the five leading health professions, representing more than 26 million health professionals worldwide, called for a new emphasis on collaborative practice. They said that health professions working together around the world can lead to improved health services and a more effective use of resources.

The Alliance, bringing together the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association, informed that health service users around the world can experience duplication, gaps and discontinuity in the health system. Yet, effective collaboration between different professions and service can prevent this and lead to improved access to services, more user involvement in decision-making, more responsive services, better use of resources, reduced incidence of disability and increased job satisfaction of health professionals.

WHPA called on governments to fund structures which supported interprofessional collaborative practice (ICP). The structures of health systems around the world should enable ICP, educational systems should promote shared learning, and health professionals needed to respect each other's expertise.

Dr. Cecil Wilson, President of the WMA, underlined that once the individual contributions of all professionals are recognised, there is more likely to be appropriate referral and a good matching of competencies to a person's needs. 'High quality patient care is most likely to be achieved when health professionals work together as a team. In an increasingly complex and fast-moving medical world, it is safer and more efficient when health professionals collaborate to the full extent of their training and experience.'

Rosemary Bryant, President of the International Council of Nurses, said: 'Health professionals strive to deliver high quality services within their scope of practice and with respect for the expertise of other members of the team. This is a challenge that health professions can address positively together and with other agencies.'

Michel Buchmann, President of the International Pharmaceutical Federation, said:

'Evidence shows that effective interprofessional collaborative practice leads to a comprehensive, coordinated and safe health system that better meets the needs of people and their communities.'

Marilyn Moffat, President of the World Confederation for Physical Therapy, stated: 'Effective interprofessional collaborative practice brings benefits in every area of health services – from health promotion, through injury prevention to condition management. Working together, professionals can effectively address pressing societal health needs such as the growing burden of non-communicable diseases and their risk factors.'

Orlando Monteiro da Silva, President of the World Dental Federation, assured: 'The World Health Professions Alliance will promote interprofessional collaborative practice through advocacy, by example and by promoting educational, legislative and health system changes that bring about and strengthen interprofessional collaborative partnerships.'

WMA Luncheon Seminar

The following day the WMA held its annual luncheon seminar on the theme 'Influenza: We can do better!'

Dr. Cecil Wilson highlighted the unacceptably low level of immunization rates among health care professionals. He said that seasonal flu might seem a harmless infection that people got every year and then got over it within a week or so. But, in fact, it was a significant global health threat that was frequently overlooked.

'Flu is harmless only at first glance. According to the World Health Organization, influenza outbreaks cause about 250,000 to 500,000 deaths per year globally. The US Centers for Disease Control and Prevention

(CDC) estimate that an average season of influenza results in tens of thousands of deaths and as many as 200,000 hospitalizations due to influenza-related causes in the US alone.'

Dr. Wilson stressed that the risk of complications associated with influenza is the highest among older persons, young children, patients with underlying medical conditions and pregnant women. These are the populations that frequently are around health professionals by virtue of attending clinics, hospitals and doctors' offices.

He added: 'Therefore, healthcare professionals play an important role in both transmitting and preventing the virus. The good news is that a safe and affordable vaccine is available against influenza. But the bad news remains that healthcare professionals' immunization rates are unacceptably low, even in developed countries.'

According to the CDC, the healthcare workers' vaccination coverage used to be around 40 per cent in the US. However, that changed in 2010 when the Veterans Health Administration healthcare facilities vaccinated 64 per cent of employees through the system-wide "Infection: Don't Pass It On" campaign.

'We have peer-reviewed evidence that as the percentage of immunized healthcare professionals goes up, healthcare-associated influenza goes down. We also know that educational campaigns in immunization work.'

Dr. Wilson said that with the support of the International Federation of Pharmaceutical Manufacturers and Associations the WMA had launched a global campaign to promote influenza immunization among physicians as a means of protecting their health and the health of their patients. Before launching the campaign, the WMA had surveyed its member associations, representing 102 countries worldwide, and all the respon-

dents had stressed the need for more information and global advocacy on the need for immunization of healthcare professionals. Seventy seven per cent of respondents had asked for toolkits with facts and figures as the most useful advocacy material, followed by web-based resources and draft letters to governments.

He said that getting a flu shot is a routine task that every healthcare professional should be performing every year. Physician vaccination practice also has the extra benefit of encouraging patients to follow their doctors' lead, as physicians are the best role models for healthy behaviours.

'Immunizing physicians against influenza represents a standard of quality care. We, as an organization speaking on behalf of more than 9 million physicians globally, are saying today that we can do better!'

The first guest speaker introduced by Dr. Wilson was Dr. Ingrida Circene, Minister for Health of the Republic of Latvia. The title of her speech was 'Influenza: The policies on immunization and health systems' role in ensuring health workers vaccination'.

She said that illness from influenza resulted in hospitalisations and deaths, mainly among high risk groups. There were three to five million cases worldwide of severe illness. But among healthy adults, influenza vaccine could prevent between 70 to 90 per cent of influenza-specific illness. Among the elderly, the vaccine reduced severe illness and complications by up to 60 per cent and deaths by 80 per cent.

Dr. Circene continued about the situation in Latvia and the legislation requiring monitoring, investigation and response plans. Referring to influenza prevention among health care professionals, she said that monitoring was not carried out, awareness was low and there was low immunization take up as a result of poor communication globally.

She concluded by saying that wider, carefully planned and well communicated immunization campaigns at a national level would promote vaccination.

The final guest speaker was Dr. Cornelia Betsch, a psychologist from the University of Erfurt in Germany. She began her address starkly: 'Imagine you visit your doctor with your new-born child or grandchild and the doctor can't stop sneezing and coughing during the whole consultation. Imagine a friend with cancer who has to go to hospital to undergo the next chemotherapy. And the nurse, just after she took blood samples, gets diagnosed with influenza. Imagine that you are unsure if you should get the flu shot and so you ask your doctor if she is vaccinated against influenza. And she says 'no'.

'These are situations that many people have to face because vaccination rates are low among health care workers.'

Dr. Betsch asked why many health care workers refused vaccination? She reminded that a 2009 overview study summarized the most important reasons. 'Isn't it surprising to learn that across a large number of studies HCWs' most important reason against vaccination was their fear of side effects?'

She said that the other reasons included low perceptions of risk of infection and a lack of concern, potentially because they believed that the risk to transmit influenza to their patients was low. But this was wrong.

Dr. Betsch shared her belief that the more people get immunized in society, the more difficult it gets for a disease to spread. People who are too young or ill to get vaccinated will be protected by a firewall of immunized individuals around them. With a sufficient number of people immunized, diseases can be eradicated.

She said that in the Global Vaccine Action Plan, which was endorsed during the last

World Health Assembly, immunization is recognized as a core component of the human right to health. Mandating vaccination would be like forcing people to drink clean water. Thus, if we do not want to mandate vaccination, health care workers need to be better educated. They need to know where there is a risk and where there isn't. They need to know that they can infect their patients and their families. They need to be aware that they are role models and highly trustworthy sources of information for their patients.

Side Events

Palliative care was among the side events jointly supported by the WMA during the week of the World Health Assembly. The meeting was sponsored by the permanent missions to the UN of Panama, Uganda and the United States, and organised by the WMA together with the African Palliative Care Association,

Asociacion Latino Americana de Cuidados Paliativos, Hospice Africa Uganda, Human Rights Watch, International Association for Hospice and Palliative Care, Kenya Hospice and Palliative Care Association, Open Society Foundations and the Union for International Cancer Control.

Among the speakers was Dr. Mary Cardosa, a Malaysian consultant anaesthesiologist and pain specialist and Immediate Past President of the Malaysian Medical Association. She spoke about the prejudice and

fears of healthcare professionals about using morphine to relieve pain which she said were causing millions of patients to suffer unnecessarily.

She stressed that tens of millions of people around the world suffer from significant pain and other debilitating symptoms related to illnesses such as cancer, advanced diabetes, heart disease, other non-communicable diseases and HIV and TB.

'These patients require palliative care, a health service that can restore or maintain their quality of life and allows them to live with dignity. Despite this great need, palliative care services remain sparse in much of the world,' Dr. Cardosa told the meeting.

Dr. Cardosa went on: 'Apart from having national policies on pain and palliative care, efforts must include education of the public and of healthcare professionals in order to overcome barriers to effective pain management and palliative care.

Among the big challenges are the prejudices and fears of healthcare professionals regarding the use of morphine which is the mainstay of pain relief in patients with acute pain as well as those with advanced cancer and other painful conditions.

Morphine provides cheap and effective analgesia to such patients, but is often not accessible because of legal barriers or, worse still, because of healthcare professionals' fear of addiction and side effects

as well as lack of knowledge on the appropriate prescription of morphine and morphine-like substances for pain relief in these patients.'

Dr. Cardosa told that the Worldwide Palliative Care Alliance estimates that about one hundred countries worldwide do not have any palliative care services available, while in another 74 countries such services are limited to isolated locations and reach only a small proportion of patients in need.

She said the Executive Board of the World Health Organization (WHO) and the World Health Assembly (WHA) are expected to discuss palliative care needs and barriers next year. The present WMA meeting, organised with other bodies, including the Human Rights Watch and the African Palliative Care Association, was designed to discuss successful palliative care models from different world regions and exchange views on how a potential WHA resolution could most effectively promote palliative care.

Dr. Cardosa suggested that building a global coalition for palliative care was a means to ending unnecessary suffering from treatable symptoms for the millions affected, especially those in the countries where palliative care services were not readily available.

*Mr. Nigel Duncan,
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How Much Independence is Necessary?

The politicians of the European Member States spend a lot of time and resources on health services, planning, controlling the medical profession and revising infrastructure, issuing laws and regulations

instead of trusting doctors to continue developing the services patients need. For example, on the European level there has for years been a lot of work on cross border health care, and then it turns out

that only about 1% of medical services actually are cross border. Patients like to be treated near to where they live. I am not saying that cross border health care shouldn't have been looked at, and CPME certainly has been an active stakeholder, but wouldn't it have been more beneficial for all that effort to be put into coming



Katrin Fjeldsted

to grips with the financial world and the banks?

The medical profession is in my opinion to be trusted. There are fewer bad apples to be found in medicine than in any other field that I know. The patients know this too. Therefore there is a relationship between doctors and patients unlike any other. At present, trust in the Icelandic Parliament is less than 10% and no one trusts the banks!

There are not many professions that have a background of 10–15 years of study and specialist training as we have and therefore it is not surprising that doctors prefer to have a say in the structure and running of their own work. Our closest ally is the patient and to my mind it is the right of each patient to have a well trained doctor in times of illness.

In many countries the relationship between doctors and politicians is based on trust. On the other hand there are visible trends in some of our countries for the politicians to think they know better. I realised this rather late in my professional life, after having spent time myself as a politician.

What is Professional Autonomy?

A multitude of terms is used to discuss professional autonomy, all of which contribute to the description of the framework of doctors' professional practice. These derive from a wide range of sources: national and EU laws, ethics codes, regulations of professional bodies, societal expectations and medico-technical requirements. While some concepts can be seen to overlap in meaning, others can also be considered as a balance to each other.

Professional autonomy is applicable both to the medical profession as a whole and to each professional individually. In both concepts, the right of autonomy implies a freedom to practice without interference (be it administrative, political or other) counterbalanced by the obligation and responsibility for those actions. With relation to the profession as a whole, professional autonomy is closely linked to the concept of "liberal professions". This concept is also acknowledged at EU level, e.g. in the Professional Qualifications Directive 2005/36/EC. On an individual basis, professional autonomy is closely linked to clinical independence.

As a principle, the compliance with clinical guidelines is seen as one of the fundamentals of high quality medical practice; CPME policies uphold this principle continuously. They enshrine an evidence-base for effective and efficient clinical treatment decisions and provide a reference point for demonstrating the decision-making process both to patients and peers. However, in certain situations a guideline's application would not help to achieve the best possible outcome for that specific patient. It is in these situations that the concept of clinical independence becomes a tool to comply with the objective of delivering the best possible care for the individual patient. Clinical independence is therefore directly linked with professional autonomy insofar as this

"dictates that a doctor shall deviate from a guideline whenever she/he feels that is in the best medical interest of the patient". Professional autonomy is however necessarily counterbalanced by the need to ensure accountability for a decision. Professional responsibility brings professional autonomy to an equilibrium. This responsibility is not only relevant in terms of its relation to guidelines, but in particular as a tool of accountability to patients. In addition to this, it also is relevant in relation to accountability towards peers, professional bodies and in a further step towards the legal framework of professional practice, as regards professional liability.

Professional responsibility therefore acts as a safeguard for the exercise of professional autonomy. As such it is important to ensure a coherent and sound framework for its exercise.

The Framework

The framework therefore must ensure that autonomy and responsibility are in balance. In a CPME position paper of November 2009, it is stated that "professional autonomy, properly defined and used, can help to preserve a balance between needs, demands and responsibilities of the parties involved with a priority for patients needs".

To achieve the best possible coherence for this framework, self-regulation is a preferred policy tool. With the EU competences on the organisation of healthcare, including the organisation of the profession's practice, limited by the Article 168 TFEU, the principle of subsidiarity applies to give Member States the power to allocate self-regulatory competences to the professions.

Across the various Member States, the degree of self-regulatory competence varies, as does the legal context the profession

may act in. In some cases self-regulation is complemented by significant governmental regulation to create a situation of co-regulation.

For CPME the safeguarding of professional autonomy and the self-regulation of the profession are two sides of the same coin. In the 2009 position paper it is recalled that “rules drawn up by the medical profession and instruments to enforce their application have always served to ensure medical care of the highest possible professional and ethical standards.” It is this objective that shows that essentially professional autonomy is not primarily a professional privilege, but rather a patient right.

As can be seen, the patient and the possibility to make a decision in a patient’s best interest is the ultimate consequence of professional autonomy and therefore substantiates the need to safeguard the principle.

Working With Patients

If departing from the point of view of the patient, the right to high quality healthcare, as enshrined in national and European laws, is dependent on the best possible quality of medical training and practice, an objective which lies at the core of CPME’s mission. In order to achieve this, the principle of professional autonomy is essential. The element of trust in the patient-doctor relationship is directly related to professional autonomy: If professional autonomy in making clinical decisions is undermined and quality healthcare outcomes are not achieved, trust diminishes. Conversely the exercise of clinical independence also pre-necessitates a degree of trust between patient and doctor.

A trustful patient-doctor relationship is therefore one of the pillars of professional autonomy. The importance of reciprocal trust and commitment to the patient-

doctor relationship, the shared interest and value of safeguarding the relationship is recognised by both patients and doctors. Indeed in the Joint Principles CPME adopted in 2008 with the European Patients’ Forum (EPF), both parties highlight patient empowerment and professional autonomy as key areas for cooperation by declaring: “..information to patients, medical ethics, Information Communication Technology and health, continuous professional development, patient’s empowerment and physician’s autonomy (are) identified by both EPF and CPME as significant areas where our joint work at EU level could make an impact”.

The commitment to cooperation between patients and doctors also reflects the changing environment of the patient-doctor relations. This relationship is very much a dynamic one and the changing role particularly of the patient entails also a changing environment for the delivery of healthcare. In order to indeed achieve a model of patient-centered healthcare, professional autonomy is a vital tool to ensure quality of care for each patient.

Recent years have seen the parallel developments of increased patient empowerment and health literacy. This is in part due to a more active participation of patients in the management of their condition, especially in the case of chronic diseases. CPME is very supportive of the empowerment of patients, as enshrined in the Joint Principles adopted with the European Patients’ Forum. It must therefore be made clear that clinical independence is a complementary rather than contradictory tool in achieving the best patient care.

Technology

The rapid developments in health technology contribute significantly to the changing environment of professional practice.

Developments in pharmaceutical care, both as regards organisation of care and scientific progress resulting in technological innovations, offer many examples of situations in which professional autonomy is challenged. The issue of decision-making on generic substitution has been debated for some time: in 2000 CPME recommended that “prescribing doctors must have the right not to allow pharmacists to dispense a different generic from that prescribed, or a generic instead of a branded pharmaceutical prescribed, where they judge it in their patients’ interests to do so “. The more recent discussion on biosimilars has included similar questions.

The increased use of telemedicine and eHealth technologies has changed the clinical decision-making process and consequently redefined the context of professional autonomy. CPME is closely involved in EU-level policy initiatives and projects on eHealth and telemedicine technologies, in recognition of their vast potential to improving access to an delivery of care. One of CPME’s priority principles in eHealth is however safeguarding the trust and confidentiality of the patient-doctor relationship regardless of the medium through which healthcare is delivered. As stated in the “ CPME guidelines for telemedicine”, adopted in 2002: “The use of telemedicine must not adversely affect the individual patient-doctor relationship which, as in all fields of medicine, must be based on mutual respect, the independence of judgement of the doctor, autonomy of the patient and professional confidentiality”. Therefore innovative eHealth technologies should only be used if these principles are respected. An even more recent technological development is the creation of computer-programmes which assist clinical decision-making. Their potential impact on clinical independence is vast, a discussion on the status of professional autonomy and professional responsibility in light of such technologies therefore of significant interest.

Changes in healthcare systems as such also have significant implications for professional autonomy. The organisation, regulation and training of the health workforce is subject to constant policy changes in all Member States. These changes are driven as a response to budgetary pressures, shortages and changing requirements as to the skills and knowledge of professionals as well as new systemic models of care, the definition of the different healthcare professions' tasks, the influence of other actors, such as payers and administrators. The process for clinical decision-making and therefore also the status of clinical independence and professional responsibility is often affected. One example is task-shifting, especially when motivated by reasons other than improving quality of care. In its policy on task-shifting adopted in 2010, CPME recommends that "In order to guarantee the safety of patients, (task -shifting) should always take place under the condition that the responsibility for diagnosis and therapeutic decisions cannot be divided and remains with a doctor, even if (s)he has shifted a task as described above".

The Budget

Cost-effectiveness drives are one of the most direct challenges to professional autonomy. CPME fully recognises the need to respect budgetary restraints and take into account not only the effectiveness but also the efficiency of treatments and has acknowledged this repeatedly. However, the patient's best interest must be the main criterion for the decision taken, be it policy or treatment related. Challenging or disincentivising the exercise of professional autonomy as cost-containment policy must therefore be opposed. Examples for such action can be found i.a. in the incentivising of generic prescriptions through financial rewards to doctor; this was discussed by CPME in 2006 on the basis of a case in the Netherlands.

Patient Mobility

Patient mobility has now been codified in the Directive 2011/24/EY on the application of patients' rights in cross-border healthcare. This legislation also addresses the importance of transparent safety and quality standards to ensure access for well-informed patient decisions. CPME very much welcomed the clarification of patients' rights in accessing healthcare services outside their home Member State and repeatedly highlighted the need to establish "a clear framework of safe, high quality and efficient healthcare throughout the EU which will be beneficial both to patients and to physicians". The need to be able to demonstrate and be accountable for quality, must however not be seen as eliminating professional autonomy, neither at an organisational nor individual level.

Government Regulation

Lastly trends in government regulation can undermine the basis for professional autonomy by challenging the self-regulation of the profession. This may be motivated by political preference for centralised regulation or taken with a view of cost-containment. In many Member States developments can be observed in which the legislative framework shift decision-making competences from professional bodies to the government thus eradicating the substance of autonomy. CPME has lent support to number of members which have faced challenges by their governments and confirmed its belief of the importance of professional autonomy also at organisational level for the best interest of the patient.

The Future

The future holds new technologies for certain. The financial crisis has reinforced and renewed pressure for cost containment in health workforce and services in general.

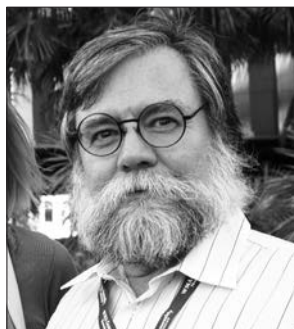
We must always bear in mind that the patient-doctor relationship must be central to the introduction of new technologies. There are also some moves towards standardisation at EU level and the possible increase in cross-border healthcare makes demands on greater harmonisation of clinical practice and may seek to constrain professional autonomy.

Conclusions

Professional autonomy both at organisational and individual level is a vital tool for the achievement of high quality healthcare and as such a patient right. So as to retain its place in medical practice, professional autonomy must strike a balance between safeguarding its core values, such as the observance of ethical codes and the trustful patient-doctor relationship, and the evolving environment of professional practice and healthcare systems. This could include better communication of the regulatory framework, in which professional autonomy is exercised, in order to provide better information to patients and other stakeholders. It must also include a continuous review of professional guidelines to safeguard an adequate response to the changing environment of healthcare delivery and scientific progress. The existing and new challenges arising from governmental regulation, but also societal and commercial developments must be addressed sustainably. Support should be lent to those whose governance model is challenged to the detriment of professional autonomy and thus patient care.

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Physicians and Hunger Strikes in Prison: Confrontation, Manipulation, Medicalization and Medical Ethics (part 3) (part 1, 2 vol. 59 N 1, 2)



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In a previous publication¹, various actions have been suggested for the physician to implement during this quality time with the hunger strikers. The initial encounter with the hunger striker, for the history and exam, and initial evaluation, is the starting point. It is essential that the physician conveys from the start that he is *not* there as a prison official to try to convince them to stop their protest. He is there as their physician, to see to their health, to answer any questions they may have, to explain how fasting and metabolism work, but above all he is there to listen and maintain a constant line of communication with them. The physician has to convey genuine concern for health, and for providing professional care. This in most cases should counterbalance any qualms or legitimate fears the hunger striker may have about the doctor's role.

Without respect for the dignity of the patient, any medical practice is severely handicapped. In the case of a hunger strike, the physician should see to it that the patient is not placed automatically in a bleak or

demeaning environment by the authority wanting to punish him. This is an aspect often neglected by doctors. If there is to be communication, and this is the key to a positive way forward, the patient has to be treated with respect. At the very least, the physician should clearly demarcate himself from any abusive attitude by the custodial staff and hierarchy. This is particularly important in settings where torture is occurring or is likely to occur.

The physician has to ensure his own clinical independence and autonomy. He has to firmly establish, with the custodial hierarchy, that he must have a free hand in dealing with all matters relating to health, in the broad sense of the term, as well as any medical interventions. If he is to try to influence the hunger strike so that extreme situations are not reached, he cannot be taking orders that go against medical common sense, let alone medical ethics.

This is easier said than done in many contexts. It is beyond the scope of this paper to examine the issue of "doctors, serving the state first and their patients second", as this easily spills over into "cultural", "traditional" and "political" discussions. The status quo of hunger strikes and forced feeding will likely continue unless there are deliberate steps to

ensure respect of medical ethics². National medical associations need to provide support for physicians confronted with such ethical dilemmas, and if necessary appeal to supra-national entities such as the WMA for guidance.

During the initial history, often a key moment for establishing the role he wants to play, the physician must ensure confidentiality, as in any doctor-patient relationship. This means there should be no presence of a guard during the discussion in private between the hunger striker and the doctor. This is easier said than done, and in recent situations, this was out of the question from the start because of "SOPs" not allowing such privacy. This has to be accepted. If security is a non-negotiable concern, then a guard should be at the very least out of earshot, so that privacy of exchanges between the hunger striker and the doctor are guaranteed. If there are microphones or other devices to monitor conversations, the physician should be transparent and tell the hunger striker that he, the doctor, is not in a position to impose their removal. Such communication can be achieved, if there is a common language, if necessary by scribbling on a pad.

Once this trust has been, however precariously, established, it is then up to the physician to use the four weeks ahead of them to assess the seriousness of the situation. How resolute exactly is the hunger striker? How determined is he to push his protest through? Can he accept a compromise solution that would allow the fasting to stop? What is behind the protest? Is

1 Allen S., Reyes H. *Clinical and Operational Issues in the Medical Management of Hunger Strikers*. In: Interrogations, Forced Feedings, and the Role of Health Professionals; ed. Ryan Goodman and Mindy Roseman, Harvard University Press, February 2009.

2 Annas, G. J. 'Dual Use,' *Prison Physicians, Research, and Guantánamo*, American Vertigo; Case Western Reserve J. International Law 2011; 43: 631-650.

there some misunderstanding that could be easily corrected so as to defuse the situation? Is there peer pressure from other prisoners? ...Or from within the group of hunger strikers themselves when it is a collective action?

During these first few weeks, a physician dedicated to his task should have sufficient time to determine whether the hunger striker is alone in his decision, or whether he is under pressure. For public consumption the solution the hunger striker wants to find may be a political statement, often a realistically impossible proposal... However, and this is what the physician should be able to pin down, the hunger striker will often be prepared to accept a fall back position, accepting much less than initially asked for. If he somehow, however indirectly, admits he does not really "want to die" then the door is open for the physician finding a solution. *What* solution, depends on a multitude of factors. It may be to convince the hunger striker to lower the bar of contention so that a compromise can be reached with the hierarchy. It may be to persuade the hunger striker to take vitamins and perhaps other nutrients, so as to allow plenty of time for negotiations. In extreme cases, which are rare, the hunger striker may agree to receive artificial feeding – thus allowing him not to lose face (by quitting the hunger strike) while getting him out of danger while a solution is found. If the patient is under pressure, moral or potentially physical from his peers, the physician may simply arrange for the hunger striker to being transferred to the sick bay, where (voluntary) "therapeutic feeding" may be undertaken. In most cases, this feeding will simply mean that the hunger striker quietly starts to eat again.

In a collective hunger strike, the situation may be more complex, a small number of "hard liners", or sometimes even just one leader, making it impossible for any other hunger striker to get out of line. The group may adopt an intransigent position – and

the individual hunger striker may not be in a position to back out individually, even though he would like to. The key here is for the physician first to get to talk to each hunger striker individually. If the relationship of trust has been attained, some at least of the group will admit **in confidence** that they do not want to "go all the way". If the physician can get to know this, it is most of the time half the battle won. The next step will be to separate the hunger strikers from one another. This does not mean isolating them, putting them in solitary confinement, let alone punishing them actively or worse humiliating them (as has been the case these recent years in a well-known hunger strike.) Once the peer pressure relieved, the road to reconciliation is open.

Perhaps even more important, the physician has to strive to avoid the development of a clash between the custodial or judicial authorities and himself or his medical superiors. This will be over untoward medical intervention, and ultimately about force-feeding. In the first stage of a hunger strike, he has to calm things down so that there is no "hasty" decision to force a naso-gastric tube down the hunger striker's throat when there is absolutely no need for any medical intervention. The hunger strikers should be informed, officially, or perhaps "less officially" in some contexts, that the doctor is **not** going to force a naso-gastric tube into their throat. The physician should persuade the authorities that there is no risk before at least four weeks of total fasting. If the situation is one of non-total fasting, this limit can be pushed back even further. He has to convince the non-medical authorities, sometimes "itching for a fight" with the "hostage takers", that he will do his best to reach a way out well before that limit is reached. It may be at this stage counter-productive for the physician to brandish his ethical banner and declare that he will refuse to force-feed whatever the authorities decide. The physician *knows* his duty, and when the moment comes, he will know what to do, In the meantime, the point is

not to push the "trigger-happy" custodial/judicial authorities to pull the force-feeding trigger. An open clash is also to be avoided at all times.

All the high publicity hunger strikes in the recent years have been very badly managed in this respect. Physicians have found themselves to be the instruments of the high-spirited and interventionist non-medical authorities. Some physicians, not having a solid ethical education, have simply "obeyed orders". Others, thinking to help the situation, have loudly protested and clashed openly with the non-medical authorities, which has poisoned the general atmosphere and often provoked a crack-down, with subsequent orders being given to force-feed, when there was no medical need whatsoever, thus dashing any hopes for a compromise.

The first month of a hunger strike eliminates all the "food refusers", and becomes premium time for the physician to genuinely play his role and to try to preserve life and dignity, and find the best solution for compromise. He has to have the trust of the hunger strikers, and also that of the custodial authority. He has to persuade the latter not to be hasty, and above all not to make decisions that are unwarranted, unsound and unethical. Prison Governors have been known to *up the ante* by taking decisions, or implementing new constraints that make it much more difficult for a prisoner to reflect and stop fasting, by withholding medical care for example. There have been concrete cases of **physicians** themselves knowingly giving out false "medical" information, so as to frighten prisoners into stopping their fast. In one specific case, a medical officer of a prison in the Middle East "let it be known" that going on hunger strike "caused impotency in the young male, which could be long-lasting." This was obviously deceitful information, and the use of medical authority in such a way obviously undermines any trust with the prisoners, already so difficult to obtain.

The physician has to stretch out a hand to the hunger striker, to allow him to confide in the doctor, and in the majority of cases find a way out of what should never become an inextricable situation.

In the very rare event of a hunger strike in a Bobby Sands-type situation, where intransigence on both sides is impossible to break, the physician must know when to back off himself. As clearly stated and explained in "Malta 2006" and its comprehensive background paper, it is never ethically acceptable to force-feed anyone. The physician should never lend himself and his medical skills to such abusive practice. In the specific case of Guantánamo Bay, Navy reservist physicians were "vetted" before being sent to the Base. Any doctor strongly against force-feeding was not sent there¹.

Conclusions: Medical Ethics

In managing hunger strikes, no one seems to realise exactly how counter-productive the confrontation between the custodial/judicial authorities and the medical doctors can be towards the goal of resolving the hunger strike. By shining the spotlight of publicity on this clash between professionals, both sides are helping to paint the hunger striker into a corner. They also prevent the physician from playing a crucial role during the first weeks of the strike, when there is time and no danger. The hunger striker thus finds himself in the limelight, which may "force his hand". The hubbub around his case, the fact that his "determination" becomes common knowledge, the fact he is placed on the pedestal of "heroism" or "martyrdom," may well end up pushing him into actually wanting to become one.

Management of fasting, possibly taken to its extreme limits, will seem to involve a conflict between the duty of health professionals to preserve life and the right of the

patient to make an informed refusal of a medical intervention². The main point we have tried to make here is that there has been far too much focus on the "Endgame"³, and "saving lives", when in the vast majority of cases, hunger strikers do not intend to get that far and most often need only to obtain some of their goals. Time is wasted, and, worse, radical positions are taken and hunger strikers can be thus "painted into corners" when it becomes extremely difficult to get out of. That there are many weeks before a situation warranting *any* medical intervention will arise, is just not grasped by most physicians, let alone the non-medical authorities.

The Declaration of Malta does not categorically forbid resuscitation. There may be room for some legitimate debate in individual cases when the health of the hunger striker is so critical that death is imminent, and the individual's real intentions are not clear. But this is a decision for the physician, not the prison officials. Policies, however, of force-feedings of groups of hunger strikers *en masse* before clinically indicated for reasons of intimidation or punishment, as have been reported at Guantánamo, is without question in violation of basic human rights, including the provisions against cruel and inhuman treatment in the Geneva Conventions.

The use of emergency restraint chairs for force-feeding can never be ethically, legally, or medically justified. A patient who must be forcibly restrained in such a device to be fed is certainly strong enough to be in little or no health danger from continuing a fast. The primary justification for the use of this device for force-feeding would seem to be for punishment, control and humiliation rather than for legitimate medical care.

The main conclusion is that medical ethics is consistent with a type of *ethical pragmatism* in dealing with the vast majority of hunger strikers. This means doctors treating each one as a patient and finding a way to establish at least a minimum of trust in the context of what will always be a difficult and confining the doctor-patient relationship. To this end, we have drawn up here a series of practical recommendations which would most certainly "calm things down" and encourage an ethical, pragmatic and humane way to defuse the vast majority of difficult hunger strikes. The WMA "Malta 2006" is very clear in its prohibition of any form of **force-feeding** of a competent patient, but it gives generous leeway for the bedside clinician, and **only** that physician, to address the situation and take the final best decisions for the patient.

Finally, in the specific case, again of Guantánamo Bay, President Barack Obama's Executive Order (EO) of March 7, 2011, unfortunately makes it at least likely that the detention facility there will remain open indefinitely. The EO ignores the whole hunger strike issue and the ongoing force-feedings of at least some prisoners. Solutions and approaches based on the patient trust in the military clinicians are by now impossible because of the past practices. For the reasons stated, the issue is **not**, at the present time, how to end the on-going force-feeding, but rather how our suggestions and observations could be useful to prevent another Guantánamo force-feeding scenario in the future, there or elsewhere.

Recommendations

→ *Conform to established medical ethics*

The WMA's Declaration of Tokyo very clearly anticipates the exact scenario of hunger strikes undertaken at places like Guantánamo Bay, and the declaration represents the established ethical guidelines for

2 Allen S., Reyes H., *op. cit.*

3 *Doctors attack US over Guantánamo*; BBC NEWS; <http://news.bbc.co.uk/1/hi/world/americas/4790742.stm>, accessed March 2012.

1 Okie S. *op. cit.*

physicians. The use of torture during interrogations, or in cases where the very conditions of confinement constitute a form of torture, were envisaged when writing up “Tokyo”, as a central and direct cause for the initiation of the hunger strikes. As mentioned, it was this that ultimately led the WMA to specifically condemn force-feeding itself. In 2006 in an editorial explaining the AMA’s endorsement of the WMA’s Declaration of Tokyo, Duane M. Cady, MD, chair of the AMA’s Board of Trustees quoted from the WMA itself “... where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially.”¹

In addition, efforts to circumvent medical ethics by pre-deployment screening of health professionals to exclude those who might object to the policy of force-feeding at Gtmo does not excuse ethical misconduct by either the health professionals or the detaining authority.²

Physicians deployed to provide detainee and prisoner care should be appropriately trained in the ethical management of hunger strikes, as well as international standards of medical care for detainees and prisoners. Credentialing for work in detention facilities should emphasize and address humane treatment and familiarity with the accepted standards of care in prison and detention facilities.

→ *Don't undermine detainee trust in physicians*

The foundation of effective medical practice is trust between the doctor and the

patient. This is especially true in the scenario of hunger strikes where the doctor’s ability to engage with the patient to find an acceptable resolution to the hunger strike is entirely dependent on the patient’s ability to trust the physician. For that reason, practices that may undermine the trust between the patient and the physician must be eliminated. These include the practice of assigning some health professionals to support the interrogation procedures. These health professionals quite obviously did *not* act in the detainee’s interest (that wasn’t their assignment), and their presence in support of interrogation clearly undermined any detainee’s trust in the clinicians working outside of the interrogation setting. In a 2005 Memo, DoD Assistant Secretary for Health Affairs William Winkenwerder established differential ethical duties for “clinical”, as opposed to “non-clinical”, medical personnel. This goes against the very essence of medical ethics: a physician is a physician is a physician! In addition, the use of medical personnel or even psychologists for activities such as identifying psychological vulnerabilities so as to advise interrogators, constitutes a serious breach of medical ethics.³ Moreover, failures of health professionals to document and report evidence of abuse and torture undoubtedly undermined the trust between the detainee and the health professionals.⁴ Trust between health professionals and patients in custodial settings is unavoidably challenging from the outset. Effective correctional health professionals overcome structural barriers to trust slowly by developing trust with the patient over time largely by the integrity of their actions in treating the patient. Policies that ask health professionals to undermine

their own credibility and integrity must be avoided. Making physicians force-feed detainees destroys any possible trust between the doctor and the patient.

→ *Respect clinician autonomy (clinical decisions to be made by clinicians)*

Key clinical interventions such as whether or not to use forced naso-gastric feeding must be left exclusively to the treating clinician. While there will unavoidably be a role for non-medical chain of command and courts, the clinical approach must be determined by the treating clinician within the frame of accepted ethics and clinical practice.

→ *Minimize coercive practices that infringe on patient autonomy*

From a psychological perspective, it is important to understand the act of a hunger strike as an act by the patient to assert his or her autonomy over the basic act of eating. This is not only an act of autonomy as an ethical issue, but as a practical issue. The reason food refusal is often chosen as the act of assertion of autonomy is that often all other areas of autonomy have been removed as options. In the case of Guantanamo, the development of widespread hunger strikes cannot be separated from the authorization and widespread application of practices that infringed on the autonomy of the prisoners and have now been recognized as ill-treatment and torture.

→ *Develop alternative means of addressing grievances*

“Indefinite detention” as applied in Guantanamo Bay is the major grievance, and as has been stated, one of major reasons the internees initiated hunger strikes there – a situation that hopefully will not be repeated in most hunger strike cases. Fundamentally, the act of hunger striking is a form of stating a grievance. It is more likely to be employed as a means of stating a grievance

1 O'Reilly, Kevin B. *Physicians Speak out on Prisoner Force-feeding* <http://www.ama-assn.org/amed-news/2006/04/03/prsc0403.htm>; April 3, 2006., last accessed March 2012.

2 Okie S, *op. cit.*

3 <http://www1.umn.edu/humanrts/OathBetrayed/Winkenwerder%206-3-2005.pdf>

4 Iacopino, V., Xenakis, S. *Neglect of Medical Evidence of Torture in Guantánamo Bay: a case series*. In: PLoS Medicine. 8(4): e1001027. doi:10.1371/journal.pmed.1001027. Available at: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027>

when alternatives to resolution of grievances are not available. Here it should be noted that the custodial authorities hold “all of the cards,” so to speak. The non-medical officials have the power and authority to negotiate, address and where possible resolve all prisoner grievances (and do not require a medical intervention to do so).

→ Individualize care

Develop emphasis on individualized resolution of the hunger strike before clinical deterioration occurs. The rapport established between the bedside clinician and the hunger striker can be a crucial element starting to resolve the conflict and developing a dialogue between the authorities and the prisoner- patients.

→ De-medicalize the early stage

Hunger strikes are predicated on the assumption that the assertion of autonomy by the detainee will result in a response from the authority. In societies where it is known that the authority will not intervene, hunger strikes are rare to non-existent. One way to reduce incentive to a hunger strike is to avoid intervening too early. The earliest hours and days of a hunger strike pose little or no health risk in the patient without significant underlying health problems. In fact, from a clinical perspective, there is little or no justification to monitor or intervene in any way during the first 72 hours of a hunger strike. Accordingly, in the case of the U.S., its Department of Defense Standard Operating Procedures should be redrafted to emphasize clinically appropriate care. Health professionals must not be exploited to assert control over the patient even for national or prison security purposes.

→ Reduce peer pressure

In settings such as Guantanamo, the potential for a prisoner to undertake a hunger strike as a result of peer pressure from other prisoners is a genuine concern. Ideally, peer

pressure must be reduced or eliminated. Removal or transfer of the prisoner to a health setting may provide some mitigation of peer pressure issues. Allowing access to family and community supports would, of course, be another.

→ Don't punish or further limit other areas of autonomy

Efforts by the detaining authority to limit and control other areas of personal autonomy make it all the more likely that the detainee will use food refusal as a means of asserting some autonomy and as a form of grievance. In this equation, the detaining authority actually has almost all the control over the other areas of autonomy and must not lose sight of that fact. Such broad control provides options for creating alternative paths for the detainee to food refusal. Accordingly, routine use of the restraint chair cannot be justified and must be discontinued.

→ Improve conditions of confinement

Conditions of confinement are often a leading cause for grievance. Indefinite detention and prolonged social isolation often are the drivers of the kind of desperation that produces hunger strikes.

→ Employ outside expert clinicians

No matter how good the facility medical staff is at establishing trust with the detainee, access to a doctor who can offer impartial and independent expert advice to the patient is essential in developing options for resolving a hunger strike. There should be no prison in the world that does not permit a prisoner to be seen and examined by an outside medical consultant at their request or the request of their family.

→ Involve family, clergy, and community

Outside community supports can be effective in providing support needed to achieve

a successful resolution of a hunger strike. In addition to dissipating a sense of isolation and entrenched conflict, community and family influences can counter-balance peer pressure from fellow detainees.

→ Develop honest informed consent procedures and advance directives

It is essential for the clinician to know the intentions of the hunger striker. To formalize it early on in a written declaration, however, may be the start of painting him into a corner. More important is the reverse of the coin, which leaves the *final decision* in the hands of the bedside clinician, who is to act ethically (and not follow any diktat from Judges, prison authorities or any others) but also take into account the situation he has assessed in his bedside care of the patient. Knowing this, and it is carefully spelled out in “Malta 2006”, the clinician can devote all his time and efforts to find the proper, individual, ethical solution best suited to the patient, including death.

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Intervention Program for Addictive Diseases. Hamburg State Chamber of Physicians



Klaus Beelmann

Generally one does not like to talk about addictive diseases and in particular if it concerns physicians. The Intervention Program of the Hamburg State Chamber of Physicians breaks this taboo and assists physicians with addictions in therapy, organization of the doctor's office and postcare. Addiction to alcohol is still underestimated in our society as a whole.

The percentage of apparent addiction to alcohol in the general population ranges – depending on the source – between 3 to 5%, i.e. 2.5 to 5 million people in Germany. Assuming the frequency of addiction among doctors to be the same as in the total population these are small figures. We have 15 thousand members in the Hamburg State Chamber. If you estimate that 2% suffer from addiction the Intervention Program should be offered to 300 Doctors. We treat about 10 doctors a year.

Although we started the Program 20 years ago and have gained some experience we are still at the beginning. All over the pe-

riod the main slogan of the Program has been: "Support rather than punishment" and it still sails under this flag. Let us now examine the specific conditions that could be the cause of physicians' addictive diseases and the specific problems existing before intervention.

1. Among the causes are

- unfavorable work conditions
 - great demands from hierarchical structures
 - irregular and too long working hours
 - unfavorable working contents
 - high emotional stress due to frequent involvement in patients' fates
 - pharmacological practice as a catalyst for addicted behavior

The usage and availability of drugs act in synergy with the professional everyday life and the doctor's supposedly precise knowledge about the risks often lead to a faulty estimation in the "self-experiment" or "use".

2. Among the problems prior to the treatment are

- the idealized self-image of the doctor. Basically the doctor has to be an invulnerable helper who himself does not become sick. Hence, the doctor never loses his self-control, and he excludes all possibilities of doubt in every situation about the fact that his consumption of addictive substances is no longer manageable by himself. Moreover, the effect of the substance increases the inability to think critically. The high doctor's ideal contrasts with the real medical personality, which is exhaustible. The so far unselfish helper requires help for himself;
- the fear of the consequences of the addictive disease's disclosure. This fear has two components:

- the immediately felt distress because of the possible loss of the professional existence (by revoking of the license or other arrangement by the authority);
- the shame and fear of stigmatizing in the personal and professional surroundings;
- another disadvantageous effect for the affected person: the repression of the problem by his surroundings. We often find an extensive and misunderstood colleagueship of medical and also paramedical employees concerning not only the legally established addictive drugs, which are tolerated up to a certain threshold value, but also with drugs and opiate abuses. It is often accompanied by a like-minded private-familial tolerance. Ignoring the addicted colleague's weakness and growing illness leads to co-dependency and for the addicted to a chronic disease.

What makes physicians so vulnerable? We should be aware that many factors work together.

1. Hierarchy-pressure
2. Extended working time
3. Fatal destinies of patients, they have to cope with
4. Easy access to substances
5. Professional experience that leads to the misapprehension that he could control the risk he takes by consuming addictive substances.

The Intervention Program is mostly initiated in the following way. First of all the Chamber is informed about the suspicion of an existing addictive disease. Different sources are considered.

We get information from

1. affected physicians,
2. their patients,
3. their partners or spouses,
4. their colleagues – usually rather late because of co-dependency,
5. pharmacies, telling us about suspicious prescriptions,
6. media as we saw it at the beginning,

7. the court about criminal cases – this information is regulated by law and is received if matters of professionalism are touched upon;
8. anonymous advice.

The physician is directly confronted with the fact if the suspicion is serious enough and if it seems to be proven that the physician suffers from an addictive disease. If the addiction is not obvious and the physician agrees with the evaluation, it is possible to discuss the different necessary rehabilitation measures.

The Chamber itself becomes a kind of Emergency Room. It offers

- First examination
- Crisis intervention
- Possibility to change the treatment
- Accompaniment of the cured “patient doctor”.

The path from the willingness to change is exhausting and usually needs a clinical hospitalization (initial) therapy to show the drastic results. The regeneration and conservation of the doctor's health and the protection of the patient's interests are essential. In the beginning we often have to face conflicts and resistance against the diagnosis.

It is not so easy to verify the suspicion of an existing addictive disease. We start by referring the member to a specialist for further examination. If the physician does not agree, the Chamber informs him that the documents are to be forwarded to the competent supervising authority. There is also information included if the physician does not take part in the agreed plans for the protection of his medical activity without drugs.

Reporting on the addicted Chamber member to the authority is mandatory, even if the Chamber member is cooperative. So transparency and compliance are essential for the Program.

According to the agreement with the supervising authority the implementation of

the Intervention Program is approved and judicial steps regarding the revoking of the license to practice are not initiated in case of positive improvement. This creates a stable base for the attempt of co-operative reintegration of addicted doctors into the daily medical routine. Informing of the authorities does not cause any disadvantage for the doctor who trustfully contacts the Chamber.

The conversation with the affected doctor takes place immediately after informing the Chamber, possibly also on the ground, e.g. in the doctor's practice. Usually the physician is in a desolate, often also in an intoxicated condition. Often the employees of the Chamber face reactions of protective behavior and denial. In spite of the initial aggression we mostly succeed in clarifying the purposes and contents of the Program, such as help and necessary support. It also includes providing room for cooperation and maneuver to be used constructively for decontamination and rehabilitation. If there is no cooperation in the cases of clear addictive diseases, the physician is informed that the existing documents are to be forwarded to the competent supervising authority within the next day. Notwithstanding the partly emotional and aggressive atmosphere it is nearly always possible to reach cooperation with the addicted person at the beginning of such an intervention.

In case of doubt concerning the existence of an addictive disease an examination is carried out by a doctor experienced in rehab medicine, if necessary with a recommendation for a therapy.

So the Intervention Program consists of three major steps. The first step: clarification, starting with a conversation with the doctor concerned, usually an examination by an expert. The second: usually in-patient therapy for two months. The third: the follow-up program running for two years, including

- curricular post care – usually offered by the clinic
- psychotherapy

- participation in self-help-groups
- laboratory tests
- meetings at the Chamber with physicians

If the addictive disease is not to be doubted, a stationary withdrawal therapy paying attention to the person's habits will usually follow. It takes about 6 to 8 weeks average. The problems that often appear in the clinic involve the acceptance of the patient's role by the addicted physician, the capacity to understand and emotionally accept the disease and the relapse management. The Chamber of Physicians helps with the choice of an adequate institution, finding replacement in the affected physician's practice and also with the clarification of costs to make the therapy in the clinic possible.

After the decision on treatment is made the Intervention Program is carried out based on a yearlong support. If a relapse occurs within the period, the time line of the curriculum is adapted accordingly and the need of another stationary therapy will be evaluated.

The postcare follow-up program – as mentioned above – is laid down in a “volunteer's agreement”. It begins after the discharge on the basis of the agreement reached with the addicted person. This usually contains five items and initially covers a period of two years:

1. Implementation of a monthly examination including the psychopathological results and objective lab parameters. We try to arrange an alternative regular control in case the clinic offers no curricular postcare.
2. Weekly sessions of psychotherapy on which the Chamber is only informed in case of missing appointments (in respect of secrecy obligations).
3. Regular visits of self-help groups (e.g. Alcoholics Anonymous) once a week.
4. Random abstinence controls by the Chamber (hair/blood/urine and field sobriety tests). The frequency differs in relation to the type of test and the recommendation of the involved expert. So

it could be three times a week for breath tests or once in a half year for hair analysis. To obtain valid results the Chamber arranges these controls which are performed under the supervision of the local forensic institute.

5. A fixed appointment as a follow-up in the Chamber to discuss the situation and the results once a month to complete the Program. For this interview we claim a monthly record of the proceedings.

The Chamber of Physicians is committed to the fact that participation in a structured treatment is to be a success. It is important to involve the addicted person in therapy and at the same time to protect his patients in the phase of the disease against possible negative consequences of the treatment. The

rate of effective abstinence throughout the Program is about 70–80%, the dropout is 10%.

The legal framework for the Intervention Program in Germany is as follows – the Chamber of Physicians is supported by the local Ministry of Health that provides our members with the license to practice medicine. As a result of a long persuading process our Ministry of Health supports the Program explicitly.

Usually untreated addiction leads immediately to the loss of license. Due to the Intervention Program there is a chance offered to continue working after the treatment.

In general our addicted doctors have a lot of emotional stress. The practice is usually in

a deplorable economic state. Therefore it is very important to clarify the financial situation first. The decontamination and withdrawal is financed by the health insurance and in Hamburg the retirement fund joined in to bear the costs for the weaning.

So what is the key message? Looking closer instead of looking away is in the interests of the concerned, both: doctors and patients. To conclude we want to encourage to act when people may have an addiction. In this situation we are a partner of the patients and a partner of the doctor as a patient to support his successful restart.

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The Greatest Motivation: Assurance of Practicing the Profession with Dignity. Motivational State of Physicians in Turkey



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This article will try to illustrate the motivational state of physicians in Turkey based on the well known Guidelines "Incentives for Health Professionals".

The main data sources are three separate web based researches carried out by the Turkish Medical Association.

The fixed income of physicians is below the poverty line. Physicians are not happy with Pay

for Performance. They are not able to use their rights to rest sufficiently. Their reasonable financial expectations focus on providing themselves with modest human life.

The health care environment starts to destroy the autonomy of physicians and the professional values alienate from the practice of medicine. In the last decade not a single law has been adopted to ensure professional autonomy.

Physicians consider the managerial structure of their work places as a stress factor. They are working long hours. Physicians demand secure work and secure future.

There is not an effective, participative management of occupational health and safety. The violent atmosphere of health care in Turkey tremendously demotivates physicians and other health care staff.

The status of the Association concerning its freedom is reflected in the ILO reports and unfortunately it is in the black list. There is no paid leave for Continuous Medical Education.

Physicians' sense of belonging has weakened and the expectation of future decrease. Physicians in Turkey as honorable members of a profession dedicated to the good of society do not want to be actors in a commercialized health care.

Introduction

What motivates a health care worker or a physician? What ensures that physicians perform at their best all the time? What is the driving force of physician's efforts for the wellbeing of the individual and society? What should it be? Have the motivating factors for physicians been the same since the past up to nowadays? How can we achieve and maintain motivation?

Does the quality of health care differ according to the motivating factors? What is it especially under the hegemony of the pharmaceutical industry? If everything is a commodity, can we expect from physicians to work only for the wellbeing of the individual and society? What physicians' motivation do people expect to provide good health care? Which motivating factor is the most reassuring for the patient who is expecting a qualified health care? Is it making more money or the value associated with health and physicians and the privilege this value provides?

The health of individuals and society is something very special. In the capitalist and neoliberal world and in the era of trivialization and commodification of health, how can we talk about a trustable health care? Turkey is a laboratory... The annual number of admissions increased fourfold in the ten year period 2002–2012. What is the motivating power behind this increase? What is the main reason of this "success" in the

era of increased violence against physicians, including killing? Is this a real success in terms of a qualified health care?

Maybe the reader could find these questions unnecessary, confusing, meaningless.

We will try to illustrate the motivational state of physicians in Turkey based on the well known Guidelines "Incentives for Health Professionals" [1]. By closing our eyes to the recent health care, we hope for the situation described in the guidelines, knowing that such a World is possible.

Method

This article is based on the data of three separate web based researches carried out by the Turkish Medical Association (TMA) in 2007–2008, 2009 and 2010.

The first research was carried out by the TMA Ethics Committee and evaluated the attitude of the physicians towards Pay for Performance (PFP). The Questionnaire was on the website in 2007/2008 for seven months. Random sampling method was used. The total number of participants was

Table 1: *Types of incentives*

Financial incentives	Non-financial incentives
Terms and conditions of employment <ul style="list-style-type: none"> • Salary/wage • Pension • Insurance (e.g. health) • Allowances (e.g. housing, clothing, child care, transportation, parking) • Paid leave 	Positive work environment <ul style="list-style-type: none"> • Work autonomy and clarity of roles and responsibilities • Sufficient resources • Recognition of work and achievement • Supportive management and peer structures • Manageable workload and effective workload management • Effective management of occupational health and safety risks including a safe and clean workplace • Effective employee representation and communication • Enforced equal opportunity policy • Maternity/paternity leave • Sustainable employment
Performance payments <ul style="list-style-type: none"> • Achievement of performance targets • Length of service • Location or type of work (eg. remote locations) 	Support for career and professional development <ul style="list-style-type: none"> • Effective supervision • Coaching and mentoring structures • Access to/support for training and education • Sabbatical and study leave. Access to services such as • Health • Childcare and schools • Recreational facilities • Housing • Transport
	Intrinsic rewards <ul style="list-style-type: none"> • Job satisfaction • Personal achievement • Commitment to shared values • Respect of colleagues and community • Membership of team, belonging

1567. Due to missing data 98 respondents were excluded, 1469 respondents were evaluated and reported on [2].

The second research focused on the working conditions of physicians and their approach to insecure modes of working. This cross-sectional study was carried out in 2009 when the government was preparing new legislation on the working conditions of physicians. 2224 physicians participated, 16 of the respondents were excluded due to repetitive entries. The answers of 2208 physicians were used [3].

The third research had the title "Consensus on the working conditions, workload and labor force of physicians, 2010". 4354 physicians participated in this web based research. The report was based on the entries of 2316 physicians since they had filled in all the compulsory items for the evaluation. This corresponds to 2.6% of the physicians.

Factors Affecting the Motivation of Physicians

According to the Guidelines "Incentives for Health Professionals" the incentives are classified into two main groups: financial and non-financial incentives [1].

Incentive mechanisms as a whole have a multidimensional content and structure. One of the most important features of this approach is the combination of financial and non-financial incentives. Literature on the application of incentive schemes in health care acknowledges that financial incentives alone are not sufficient to retain and motivate staff. Research has confirmed that non-financial incentives play an equally crucial role.

While the importance and potential of non-financial incentives is widely recognized, it is important to note that there are limitations to what can be achieved with non-financial incentives alone.

Effective incentive schemes share the following characteristics: they have clear objectives, are realistic and deliverable, reflect health professionals' needs and preferences, are well designed, strategic and fit-for-purpose, are contextually appropriate, are fair, equitable and transparent, are measurable and incorporate financial and non-financial elements.

Results

1. Financial Incentives

Salary/wage

In general, salaries are low for all kind of personnel. In 2011 the minimum net wage was € 291.73. For a family of four the food poverty line was € 365.03, while the poverty line was € 1189.06 [5].

In 2011 the fixed income for physicians working in the public sector was € 803 for specialists and € 643 for GPs. The fixed income is the salary which will affect what they receive after retirement and is guaranteed to be paid every month. In addition to the fixed income physicians get PFP which is variable, not guaranteed. The fixed income of physicians is below the poverty line. The expectations of physicians are very clear concerning their salaries. 94.8% of the physicians request an income that does not require doing extra job, 99.3% expect that their salary should affect what they receive after retirement. 97.6% claim that the unpredictable, variable income policies affect their future plans negatively [3].

Physicians demand 6000 Turkish Lira which makes € 2921.56 per month if it does affect what they receive after retirement. But they demand 10 600 Turkish Lira which makes € 5161.42 per month if it does not affect what they receive after retirement [4]. It shows that the financial expectations

of the physicians are not very high, they are reasonable in order to provide themselves with modest human life.

Pension

Nowadays a retired physician would get 1600 Turkish Lira or € 779.08 per month in Turkey. This level of income is below the poverty line. Under this condition a physician cannot live modest human life and cannot survive without doing another job. For that reason 67% of the GPs, 77% of the specialists stated that under these conditions they do not want to retire [4].

Paid leave

The right to rest is of vital importance in order to prepare for another productive working day. Only 27% of the physicians admitted that they can afford spare time to spend with their families. Physicians are not able to use their right to rest sufficiently. Only 19% of the physicians stated that they can afford a break from work. The majority of the physicians could not use the one month vacation time [4].

Performance payments

PFP started in 2004 in public hospitals and in 2011 in university clinics in Turkey [6, 7]. PFP is not an incentive, it is rather a principal way of payment in Turkey. It is paid for the active working days only. Illness, pregnancy, holiday leaves are not paid, it does not affect what they receive after retirement and related social rights.

90.1% of the physicians find the criteria of PFP insufficient. 64.6% consider that PFP increases the cost of health care and 83.3% think that PFP damages the work environment [3]. 54.9% of the physicians believe that PFP destroys their relationships with their colleagues, 56.1% – that professional solidarity has been damaged. 52.7% stated

that the doctor – patient relationship was negatively affected [2].

Since PFP is based on individual evaluations it has a negative effect on team work and the quality of care and makes physicians compete with one another [8].

Educational activities are very badly affected by PFP. The training time has been reduced – 70.9% of the physicians underlined the time decrease for skills training, 66.6% – for bedside training, 69.6% – for theoretical training of RAs and 64.4% – the time for Continuous Medical Education (CME)[2]. Thus, preconditions for professional development are not met in Turkey.

According to the report of the Turkish Surgery Association in specialty training the balance between educational activities and health care is destroyed. Training hospitals have lost their educational functions. The number of clinical meetings, seminars and case discussions has decreased. In order to use time efficiently operations are performed by specialists [9].

2. Non-financial Incentives

Work autonomy

In Turkey the Social Security Institution intervenes seriously in professional autonomy of physicians through changes in regulations on reimbursement of health care services. The reimbursement rules affect the PFP rules. The reimbursement rules indirectly determine in what way physicians will carry out their professional activities. In the determination of reimbursement rules no participative mechanism is involved either in the form of specialty associations or the Turkish Medical Association. Therefore health care environment starts to destroy the autonomy of physicians and the values of profession alienate from the practice of medicine.

Job security

Job security is vital for professional autonomy and elimination of job security makes physicians open to the influence of political authority. In the last decade two approaches were used systematically eliminating the job security of the health care workers. Legislation was amended in the following way:

- secure employment was replaced with contract based, insecure modes of employment, such as subcontracting [10, 11], contract based working [12,13,14];
- limitations to the freedom of physicians' work in terms of fields and places; limiting the number of physicians in private hospitals [15], promoting the opening of private clinics [16], compulsory service [17], obstructing the independent self-employment [18], work bans [19, 20, 21], licence auctions [22], free trade zones for health [23, 24].

In the last decade no single legislation has been adopted to ensure professional autonomy. On the contrary, the public and private health care institutions have been reorganized according to the expectations of the sector.

The report of the UK House of Commons reveals that in the Queen Alexandra hospital 700 health workers, including the physicians, were fired in order to overcome the financial difficulties [25]. We can assume that the health workers in Turkey will be forced to work longer, harder under the threat of unemployment.

Access to literature and new technologies

It is hard to believe that 71% of the GPs, 54% of the specialists, 20% of the RAs do not have access to literature in their work places. 95% of the physicians stated that they are under stress trying to keep their knowledge up to date and 91% of the physicians are under stress caused by access to new technologies [4].

Supportive management

Supportive management is one of the critical elements in motivation. 45% of the GPs, 30% of the specialists and 37% of the RAs admitted that they do not have supportive management in their workplaces [4]. 92% of the physicians evaluated the managerial structure of their work places as a stress factor. On the other hand, 41% of the physicians experienced oppression, even violence from their managers [4].

Manageable workload and effective workload management

According to the laws in Turkey the working time is 40 hours per week in the public, 45 hours in the private sector. But there is not an upper limit of the working hours. Physicians are working for long hours.

Figure 1 shows the working hours of physicians. Most of the physicians are working more than 40 hours per week. Nearly one third of the RAs admitted that they work more than 95 hours per week [4]. They stated that they work nonstop 33 hours which is a threat to public health. RAs demand limitation of working hours to 56 hours per week and 220 hours per month and leave of absence after the night duties [26].

51% of the physicians have compulsory duties. In addition to the compulsory duties physicians have on-call duties – 26% of the physicians in the public sector and 41% in the private sector [4].

Physicians demand secure work and secure future. 90% of the physicians demand the right to strike and collective bargaining agreements. As concerns contract based work, 71.2% consider that it decreases control over work, 72% – that it does not improve productivity, 79.3% – that it leads to job insecurity [3].

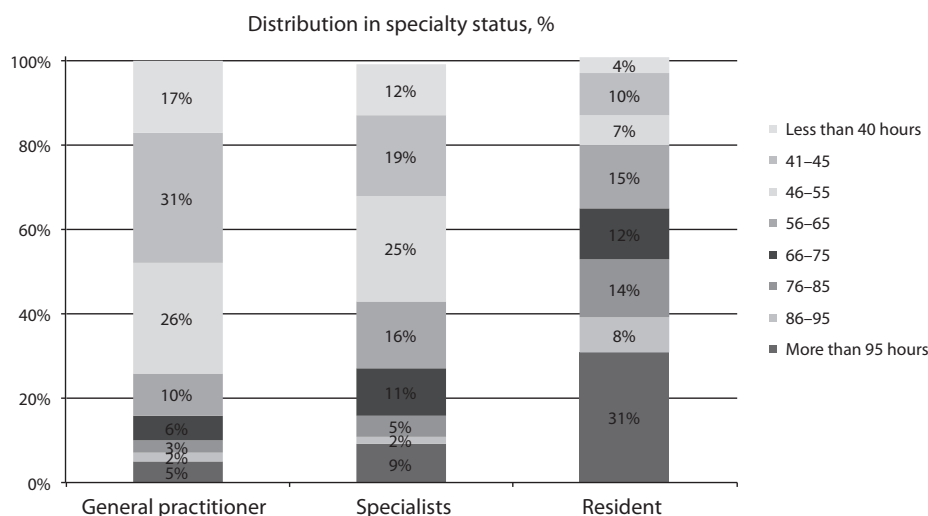


Figure. Weekly working hours including duty and overtime. Consensus on the working conditions, workload and labor force of physicians, 2010

Effective management of occupational health and safety risks

There is not an effective, participative management of occupational health and safety. The most important issue is violence against health care personnel and physicians. 28% of the physicians are exposed to violence from other health care staff, 36% – from their colleagues, 41% – from their managers, 66% – from their patients [4]. The violent atmosphere of health care in Turkey has tremendously demotivated physicians and other health care staff. Unfortunately, one surgeon was stabbed to death in 2011.

Physicians' suicides have not been the subject of scientific research yet, but it cannot be ignored. In Erzurum in 14 months three young physicians committed suicide. The TMA committee has prepared a preliminary report:

"It is hard to establish a connection between deaths but there is an increase of depression, psychological disorders, physical problems due to very heavy work load and even the substance use. There is a social pressure on physicians. Compulsory service creates broken families. Physicians have worries about future. These cases cannot be defined as individual cases" [26].

Effective employee representation and communication

The status of freedom of the Association is reflected in the ILO reports and unfortunately it is in the black list. Only the trade unions close to the government are supported, while being a member of other trade unions is a serious risk. The long detentions in prison and penalties have been reflected in the European Commission Progress Report on Turkey in 2012 [27].

Maternity/paternity leave

Women physicians have 4 months of paid leave after delivery. But PFP is cut during this period. Since the fixed income is around the poverty line physicians are having difficulties in using maternity leaves.

Women physicians have a nursing leave for one year. They are relieved of shift work and duties during this period, but they face difficulties in the unions of private hospitals and public hospitals in terms of restrictive interventions. There are not enough well organized nursery and day care units for the children of health care workers.

Access to/support for training and education

There is no paid leave for CME activities. 95% of the GPs, 68% of the RAs and 33% of the specialists state that they cannot afford time for CME [4]. The total time devoted to CME is extremely negligible – 24 hours by the GPs, 36 hours by the specialists and 31 hours by the RAs per year [4].

75% of the GPs, 65% of the specialists and 66% of the RAs stated that their managers are not aware of the importance of CME and educational activities are not paid for [4]. 75% of the GPs, 64% of the specialists and 74% of the RAs stated that their requests for further training resulted in cuts from their earnings [4]. This is limiting the participation of physicians in the CME activities. On the other hand, since participation in the educational activities is not supported financially, physicians might have unethical financial relationships with pharmaceutical firms.

Intrinsic rewards

In the WHO report "Successful health system reforms: the case of Turkey", the discontent of the health professionals has been highlighted: "The SABIM telephone hotlines have significantly empowered patients and resulted in a considerable change in the power relationship between doctors and patients. This led to discontent among health professionals." [28] The investigations triggered by SABIM became another form of violence against physicians and resulted in suicide of one young RA in 2012.

Conclusion

In addition to the health policies of the last 30 years, the last decade created a wreck of health professionals and physicians. Physicians' sense of belonging has weakened and the expectation of future decreased. This situation has been reflected even in the publi-

cations of the Ministry of Health. The government has lost physicians. This is tangible and visible. The profession is falling into an ordinary status. This needs serious, radical, sincere precautions and interventions [26].

Physicians in Turkey as honorable members of a profession which is dedicated to society, do not want to be an actor in a commercialized health care.

We would like to conclude with a quotation from what Dr. Otmar Kloiber, Secretary General of the World Medical Association, has said in relation to the Turkish government's attack to dismantle physician self-governance.

"...The profession has a lot to lose. Being regulated by a bureaucratic administration that does not understand medicine and the work of physicians is difficult. Being regulated by an administration that is not only disconnected from medicine and care but that has only cost-savings on its radar is even worse. And while these frustrations and difficulties are not to be underestimated, the ultimate threat is to be downgraded from a respected profession to a technical service.

Professional self-governance is not merely a means for physicians to exercise control to serve their own interests; it serves a critical patient-centered purpose and we must make that understood to all stakeholders. In health care, the objective of self-governance is to provide better medical care to the patients and services to our people, to protect the dignity of patients, and to improve public health in our communities. We must be able to demonstrate to our societies that it is to their advantage to have physicians who can freely exercise their duties according to professional standards and ethical rules rather than to be under the control of a government, or an insurance or a managed care company. When physicians are forced to follow third party orders, the interests of the patients will always come last" [29].

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Plagiarism in Scientific Publishing



Izet Masic

Introduction

Scientific publishing is the end product of the scientific work. The number of publications and their citations are measures of scientific success, while unpublished researchers are invisible to the scientific community and as such are non-existent. Researchers in their work rely on precedents, so the use of works of other authors is the verification of their contribution to the growing knowledge of mankind. If the author published an article in a scientific journal, this article should not be published in any other journal, with little or no modification without quoting parts of the first article [1, 2, 3, 4, 5].

Why do scientists publish? Apart from the already mentioned, there stand out three main reasons [1]:

- Profit, money incentives, grants;
- Personal promotion, fame, recognition of society;
- Quest for sponsors.

According to K. Gowrinath [3], plagiarism is one of the ways of scientific misconduct,

besides there is also data fabrication, falsification, and specifying nonexistent references or literature references. Plagiarism is defined as “intentional or unintentional use of other people’s thoughts, words, or ideas as their own without clear attribution to their source”. Stealing someone else’s intellectual work and its appropriation is cheating of the public.

Violation of copyright occurs when the author of a new article, with or without mentioning of the author whose work has been used, is using parts of previously published articles, including tables and figures. In accordance with the principles of good scientific practice (GSP) and Good Laboratory Practices (GLP) scientific institutions and universities should have a center for monitoring, security, promotion and development of quality research. Setting rules and abiding by the rules of good scientific practice are obligations of each research institution, university and each individual researcher, regardless of the field of science that is being investigated. In this way, internal quality control ensures that the research institution, such as a university, is responsible for creating an environment that will promote standards of achievement, intellectual honesty and legality.

Common reasons of intellectual dishonesty are as follows:

- Persisting “publish or perish” mantra;
- The personal ambitions of poorly educated individuals;
- Vanity;
- Financial pressure.

Therefore, all the reasons could be classified into two categories: a) human nature (the desire for status, power and glory without the ability to perform the research in a proper way), or b) a feverish competition among researchers, under the pressure for better results and lack of proper supervi-

sion at the workplace (“publish or perish” culture).

As mentioned above, the worst forms of scientific misconduct and intellectual dishonesty are:

- Falsification of information obtained;
- Fabrication of data;
- Plagiarism of ideas and words (stealing other people’s ideas, data, texts).

Although the truth should be the goal of scientific research, it is not a guideline for all scientists. The best way to reach the truth in the study and to avoid methodological and ethical mistakes is a constant application of scientific methods and ethical standards in research.

Plagiarism – Terms and Definitions

The term “plagiarism” originates from the Latin word *plagium* which means “to kidnap a man”. Literally it means “stealing, taking someone else’s work and presenting that material as the work of someone else” [1, 2]. Plagiarism of words and ideas can be unintended and deliberate. It is “the tendency of literary theft and illegal appropriation of spiritual ownership of other people”, or generally “presenting someone else’s work as own”. According to Miguel Roig (St. John’s University, USA), “Plagiarism can take many forms, from the presentation of someone else’s work as the own work of the author, to copying or paraphrasing substantial parts of another’s work without attributing the results to a survey conducted by others” [1]. In all its parts, plagiarism includes unethical behavior and it is unacceptable.

According to the World Association of Medical Editors (WAME), plagiarism is repetition of 6 consecutive words, or overlapping of 7–11 words in a set of 30 words. Although variously defined, plagiarism is basically a method that is intended to mislead the readers about one’s own scientific contribution [1].



Types of Plagiarism

There are distinguished different forms of plagiarism. The most common ones are given below [1]:

1. Plagiarism of ideas: the inclusion of others' ideas, methods and results in one's own work without acknowledging the original author.
2. Text plagiarism: copying materials from other researchers and its inclusion in the own work without any acknowledgment or quotation. Inclusions comprise:
 - a. Not quoting the sources: the inclusion of the text, or any material by other authors without accurate citing of the sources.
 - b. Para plagiarism: inclusion of the text of other authors with minor changes or additions to someone else's text without recognizing the source text.
 - c. Pure copying: not using quotation marks when the exact wording is copied from other authors, even if the source is indicated.
 - d. Incorrect paraphrasing: the text of other authors is used with small changes, but using the same word or sentence structure, even if the source is indicated.
 - e. Violation of copyright: exact copying of others' words is a violation of copyright.
3. Self-plagiarism
 - a. Duplicate publication: publishing the same article with similar content to that which has already been published.
 - b. "Salami" publication: publishing several papers based on the results of one study. However, the number of papers that can be published based on the results of a study has not yet been fixed.
 - c. Recycling texts: publication of the same paper in different journals or in different languages.

Adverse effects of plagiarism include unnecessary utilization of space in journals,

spending time of reviewers and editors, the risk of professional liability and infringement of copyright, inflating the importance of research subject and awarding lies. Today the availability of abundant materials of the same or similar subject through a simple internet search results in an increase in the incidence of plagiarism. At the same time the internet makes the detection of plagiarism easier with the help of detection software [3].

Plagiarism Prevention

According to M. Roig [4], since 2005 until today the number of published articles containing the word "plagiarism" is higher than in all the years up to 2004. The author also argues that plagiarism is manifested in various forms and describes self-plagiarism and its other forms.

There is no general regulation of control for scientific research and intellectual honesty of researchers that would be absolutely applicable in all situations and in all research institutions. In the case of substantial plagiarism (copying more than 25% of the published sources), the redundant text should be withdrawn from the publication and measures should be taken to inform the respective institutions. If plagiarism is detected only after publication, editors should withdraw the article and inform readers about the abuse.

According to the Office of Research Integrity USA (ORI), plagiarism is on the top of the list of the three largest research fraud offenses. In Bosnia and Herzegovina, plagiarism is not yet listed in the law as a criminal offense and therefore appropriate penalty for plagiarism is not defined.

The ethical aspect of publishing is especially important for small and developing countries. The participation of scientists from Bosnia and Herzegovina in the global scientific communication implies the obligation

of accepting international standards for citing the sources used.

The authors should:

- Always follow the proper rules of citation references, acknowledging that the ideas were heard at conferences and in formal or informal discussion;
- References must contain full bibliographic information;
- Each source cited in the text must be listed in the bibliography;
- Quotation marks should be used if more than 6 consecutive words are copied;
- Obtain permission of other authors/publishers for reproduction of protected figures or text.

K. Gowrinath [3] recommends the following steps to prevent plagiarism:

- All data that have already been published by other researchers should be quoted with appropriate references and all the sources of information used in the preparation of the document should be recognized in the appropriate format;
- Provide footnotes and use inverted commas whenever necessary;
- Written approval of other authors should be obtained prior to the incorporation of their figures or tables in the article.

Specific form of plagiarism is self-plagiarism. Scientists need to take into account this form of plagiarism, because at the moment there is an attitude that their own words can be used without fear of plagiarism. If an author cites his/ her own article that has already been published, then this should be listed as a quote and cite the source in which the article is published.

Conclusion

Science should not be exempt from disclosure and sanctioning of plagiarism. In the struggle against intellectual dishonesty, education on ethics in science has a significant

cant place. General understanding of ethics in scientific research and in all its stages had to be acquired during undergraduate studies and is to be improved further in later years. The ethical aspect of publishing industry is as important, particularly in small and developing economies, because the publisher has an educational role in the development of the scientific community that wants to enjoy it.

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Cooperation Between Medical Profession and Pharmaceutical Industry



Roland Lemye

Like every industry, pharmaceutical industry develops a product, medication in this case, which purpose is to draw the best possible benefit.

To do that, it aims for the highest possible prices in accordance with the purchasing power in each country it targets.

As much as possible, pharmaceutical industry avoids the reentry of a medication from a country where it has a low price to another where its price is high.

Pharmaceutical industry attempts to extend the duration of patents by introducing galenic or chemical improvements of sometimes low usefulness.

It tries to increase demand by raising the conscience of a need or by creating a need where there is none.

To achieve that, it works on:

- General public by publishing something which is not always an advertisement but is related to information;
- The prescribing practitioner.

And, indeed, what makes pharmaceutical industry different from other industries, is the fact that it is not the customer who pays or chooses his product (at least for prescribed medications). That is why pharmaceutical industry creates a relationship with the prescribers.

Pharmaceutical industry needs doctors who will prescribe its products.

Therefore, a doctor must be well informed about a pathology. That is why pharmaceutical industry spends substantial money in continuous medical education of doctors.

It also makes tremendous efforts to inform about its products.

On the other hand, competition between firms which develop related medications for the same pathologies and the ineluctable deadline of the end of patent protection incite the firms to develop a high research activity because innovation only allows growth and durability.

The firms need the cooperation of doctors to do that. The use of new molecules cannot, actually, happen without periods of trial combined with an intense monitoring of the patients who undergo these tests.

The policy of pharmaceutical industry is not guilty in itself. Search for profit is the driving force of progress and provides us, doctors, in therapeutic means which allow us to relieve or heal our patients more often than before. What other product could be more useful to mankind?

That remains true as long as these therapeutic means are used advisedly in the patients' only interest and in complete transparency towards them.

Yet, the boom of expenses in the field of medications, the accidents, sometimes caused by an excessive use, too much promotion from the firms, the taboo on their unwanted side-effects and the bad results of research have led to mistrust from general public towards the industry as well as towards the prescribers.

How was it possible to come as far as suspecting WHO to have been swindled or bribed by pharmaceutical industry about the risk of a H1N1 pandemic and the necessity to vaccinate the world's population? The reason is quite simple: in public view, pharmaceutical industry seemed to have unlimited abilities and doctors were entirely compliant to its messages.

How many abuses made this possible?

The most visible part was conviviality, festive invitations, presents, which amount grew exponentially because they found place in a climate of competition.

Doctors did not feel like they were being bought without being aware of it, since they cared most for the content of communications from those who had made up the atmosphere of conviviality.

So it was about time to restore a climate of credibility for both parts.

Speaking for medical ethics, medical organizations have defined, in statements, what was acceptable and what was not in the context of relationship between practitioners and industry.

The Standing Committee of European Doctors (SCED) has taken it further by negotiating a charter with the European Pharmaceutical industry (EFPIA). Its advantage is, as long as it is signed by all parties, to impose on doctors as well as on firms. Many countries have done the same or even preceded these measures.

It must be said that the pharmaceutical industry has hesitated for a long time before it decided to commit itself but finally did so when it was confronted to two unavoidable outcomes of its policy:

- The exponential cost of conviviality and
- The receding decision-making power of doctors to the benefit of pharmacists.

For all that, all problems are not solved yet even if progress is evident.

The problem which is currently focused on is that of transparency and conflict of interest.

Everybody knows now how tobacco industry has fought against medical efforts to eradicate that plague, by corrupting famous scientists so that they wrote articles which minimized or denied some of tobacco's harmful effects. That strategy was particularly used against the idea of passive smoking in public places.

Methods used by pharmaceutical industry are not always very different.

A spokesman, chosen by the firm (preferably a pacesetter in his field) makes a scientific speech, using the firm's slides, to a public invited by the firm itself.

Industry sponsors medical reviews which are sent for free to the practitioners, in which professors claim the benefits of a given product.

Conflicts of interests are obvious in this case, but what about those who exist in decision-making instances (Drug Agencies, Repayment Commissions, and so on)? It appears clearly that a doctor who has taken part in clinical tests about a given medication can only be influenced by his knowledge of the medication itself, which he gained during the tests (is that a bad thing?), but also by the fact that he is often offered clinical tests and that he does not want to lose that source of income.

If doctors who have that knowledge were by-passed, would a medication be considered with more impartiality by people who do not know it?

Conflict of interest can also occur in the opposite way. Is the person in charge of expenses more neutral, who has to decide over

the conditions of repayment of a medication which is useful but expensive?

The problem is complex but must be solved. The Platform on Ethics & Transparency, which has recently published a list of guiding principles promoting good governance in pharmaceutical sector, is dedicated to that.

The intention is that the patient, finally, receives the most appropriate treatment with relevant information that goes with it.

In order to achieve that, all parties must establish relationships based on mutual trust and transparency.

Transparency implies that all parties reveal all their relationships and potential conflicts of interests. As for companies, they must provide complete information, particularly to the competent authorities.

By introducing all partnerships, not only industry and practitioners but also patients' associations, caregivers, consumer associations, society, hospitals and competent authorities of all levels into debates, the Platform on Ethics & Transparency has given the discussion a new dimension which allows hope in a better future.

*Dr. Roland Lemye,
President of Association Belge
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A Call for Quality Improvement in Medical Education



Jean-Marc Bourque

Medical education has evolved beyond the traditional didactic way of teaching. Dr. William Osler put into practice a learning process that extended beyond the classroom and to the patient's bedside. From the first day of medical school, students are quickly exposed to the experiential concept of "see one, do one, teach one," and all can agree that a considerable amount of learning in medicine happens through observation. Nonetheless, we need to be innovative in changing the way we learn and teach as the quantity of material has significantly increased in recent decades.

Will sitting through numerous lectures throughout medical training and attending scientific meetings implicitly make one an expert in designing lectures? Will it enable future physicians to optimize the transfer of knowledge, and will it aid in understanding the true meaning of Bloom's Taxonomy and fundamental theorists of pedagogy and andragogy such as Beinstein, Freire, or Knowles? What are the principles of medical education in relation to learning and teaching?

Many efforts have been made to advance residency education such as the development of the CanMEDS roles which are meant to promote "better standards, better physicians, better care." These were formally adopted by the Royal College of Physicians and Surgeons of Canada in 1996 and are in place to help guide educators to better define the competencies of well-rounded physicians should possess at the end of his training. The CanMEDS Scholar role encompasses the role of physician as a teacher. Additionally, the imperative to teach others is intrinsic to most descriptions of the constituents of professionalism in medicine. Physicians must not only be lifelong learners, but also lifelong educators; however, there is a paucity of formal training preparing them for either role. A greater emphasis should be placed on the manner and context in which these competencies are attained within a training program to ensure residents and trainers are adequately equipped with the fundamentals of education in order to properly acquire them.

Physicians are trained as medical professionals and generally do not receive formal pedagogy training. There is a gap in the medical community between knowledge and understanding contemporary, effective strategies of delivering the material. The educator is a facilitator of learning; they need to have some understanding of how people learn as well as how to teach. As an effect, the trainer does not drive the curriculum, but facilitates it for proficient and efficient learning.

Communicating the science can be very difficult in a multifaceted and humanistic field such as medicine where a plethora of factors continuously shape the psychology of education. Basic principles of education should be further explored, integrated, and rein-

forced within post graduate medical education. Furthermore, in order to see a change in its culture, a stress on faculty development is vital and an auditing of the education and teaching should be imperative, particularly in the delivery of material. A high-ranking measurable is the transfer of knowledge and skills to equip physicians with a certain capacity for critical thinking. Consequently, learners would be given a greater sense of inquiring about the material being delivered, especially with the relevance of their socio-political context.

There is a call for a culture of continuous quality improvement in medical education. This would allow physicians to not only identify weaknesses and strengths in their scholars, but to guide them on how to act in response. Increasing awareness for the importance and need of adult education must be a priority among stakeholders as it has a direct impact on patient care. Globally and in itself, medical education is a fragmented system with a lack of commitment to excellence from many political leaders. Recognition from the latter for the aforementioned competencies could translate into higher standards in medical education with the aim of increasing the quality assurance and preventing harm to patients.

The World Medical Association encourages the highest possible standards not only in medical ethics, but also in medical education by way of "helping physicians to continuously improve their knowledge and skills." Through its declarations, resolutions, and statements, the World Medical Association and their partners and alliances, have the potential to positively impact how medical competencies are being transferred. Medical education is an ongoing and dynamic process. In modern medicine, it is essential that efforts are made to provide both junior physicians and senior faculty with the skills to evolve into educationalists.

*Jean-Marc Bourque,
Deputy Chair of the Junior Doctors Network*

Healthy Ageing. A Socio-Medical Perspective

The role of European doctors



Jacques van der Vliet

Introduction

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. CPME is committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.

- CPME believes the best possible quality of health and access to healthcare should be a reality for everyone. To achieve this, CPME promotes the highest level of medical training and practice, the safe mobility of physicians and patients, lawful and supportive working conditions for physicians and the provision of evidence-based, ethical and equitable healthcare services. CPME offers support to those working towards these objectives whenever needed.
- CPME sees the patient-doctor relationship as fundamental in achieving

these objectives and are committed to ensuring its trust and confidentiality are protected while the relationship evolves with healthcare systems. Patient safety and quality of care are central to our policies.

- CPME strongly advocates a 'health in all policies' approach to encourage cross-sectoral awareness for and action on the determinants of health, to prevent disease and promote good health across society.

CPME's policies are shaped through the expertise provided by our membership of national medical associations, representing physicians across all medical specialties all over Europe and creating a dialogue between the national and European dimensions of health and healthcare.

CPME's involvement in healthy ageing goes back to the 1960s with policies addressing demographic change and the elderly including recommendations on health care for the ageing population. In 2010 a statement on Mental health in older people/healthy ageing was adopted (*CPME 2010/105*), in 2011, a statement regarding the European Innovation Partnership on Active and Healthy Ageing (EIPAH) (*CPME 2011/066*). The latter, EIPAH is coordinated by the European Commission, which gives high priority to initiatives in this area. Three European Commissioners strongly support EIPAH which aims to add two extra healthy life years to citizens by 2020 and adopted in this sense a Strategic Implementation Plan in November 2010. Within the implementation plan, CPME committed itself to Prevention, early Diagnosis of Functional and cognitive decline.

Doctor's role in Healthy Ageing

The role of doctors in healthy ageing is to tackle both the physical and cognitive components of frailty/functional decline, to contribute to raising awareness within the medical profession as well as partner with patients and citizens and their social dimension for a life-long approach to health. This includes maintaining functional capacity, participation and social inclusion, independent living and caring environment as well as a healthy work environment and leadership.

Healthy ageing will be one of the most important topics for European doctors in the coming decade(s) with a specific focus on maintaining, restoring and improving the functional capacity of patients and citizens. Hence, the role of doctors can be seen in two components. One is the **physical** component in which expert knowledge is needed on physical fitness, on nutrition and on chronic conditions management including polypharmacy and overmedication followed by functional capacity assessment and evaluation. Important to mention here, is to concentrate not only on the disabilities of patients but above all on the existing abilities. (**ability vs. disability**). Wrong judgments in this area can easily lead to social exclusion of people. Next is the **psychological** component in which expert knowledge on social and psychological well-being is needed, including knowledge on a healthy lifestyle. Patients and citizens should be engaged in meaningful activities and get physical support and easy transportation when necessary.

Very important is the need for a **health literacy program** in which dissemination of knowledge is channelled into the capillaries of the population through doctors and other stakeholders, also through educational programmes, e-learning modules, web

based applications, all of which must be focused on the caregiving network and the patients and the public.

Important Elements of Healthy Ageing

Maintaining functional capacity can be achieved through healthy eating and physical activity also including a healthy work environment and lifestyle, a proper work-life balance and smoking cessation. Avoidance of drugs and controlled drinking are also part of this topic. Avoidance of drugs, alcohol and smoking cessation have the most significant impact when introduced at an early stage of one's life. Healthy childhood habits will bring health profits 40 years later. Finally, coping skills and resilience to live with daily pressure and stress are needed as well as one must furthermore respect heterogeneity, autonomy and differences in people.

Functional capacity assessment and evaluation can be reached through use of tools that measure subjectively and objectively a person's functional condition. In the objective tool a doctor looks at personal and social functioning and at adaptation to physical demands. This leads to an outcome in which the result is either normal, limited or limited to a certain extent. The Workability Index is a subjective judgment by an individual (see figure). As the figure above illustrates, the subjective judgement engages the individual in a progressive follow-up ob-

tained from answering a set of 10 questions that, dependent on the score, indicate either the need to intervene and redress functional capacity or assures the individual of his/her functional capacity. The functional capacity status may be observed through yearly evaluations done by the occupational physician at the workplace.

Participation and social inclusion can be realised through staying active in society, either in work or in a social environment. One should be well protected from getting in an isolated position or facing the loneliness which can be a threat for many people in the later stage of their lives. The position of family, relatives, social workers or even neighbours is of key importance. People are entitled to a meaningful place in society and most people want to continue to contribute having a lifetime of knowledge and experience. One must keep older people stimulated and engaged through employment or through learning and promote fiscal benefits and cheap transportation to prolong flexibility. A basic idea of how to extend the social residency of the elderly is through increasing their literacy in technologies (computer skills, special phones with bigger screens or buttons and phone applications for caregivers) Furthermore courses and social clubs for the older members of society could include musical and artistic activities.

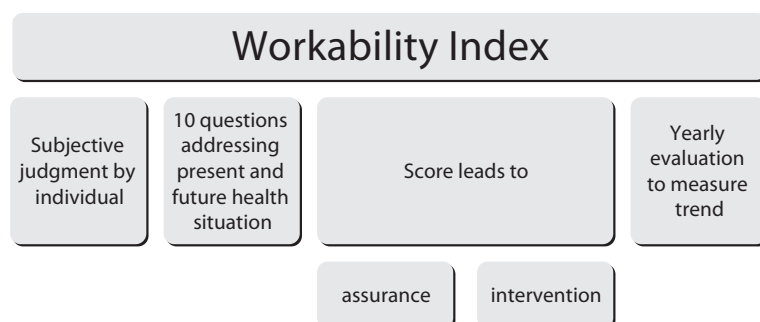
Independent living and caring environment is implemented by promoting independence and offer support where nec-

essary. One should stay in his/her own environment as long as possible and create a network of formal and informal carers, such as family, social workers, GPs. Physical support (like vacuuming the house or doing repairwork and or cooking meals) will help people stay in their original setting. Also organising shopping services with transportation and support can be of immense help.

Good **Working conditions** are important since demographics show that in an ageing population people will have to work longer. Evidence shows that work is good for your (mental) health, provided that proper working conditions are in place. A healthy working environment is implemented through a stimulating and inspiring leaderships or management style. There is a need for a special focus on senior employees, providing them with a stable psychosocial environment and good working atmosphere including clear communication and clarity about goals and objectives, changes and results in the organisation. Training on IT and increasing the technological literacy, as mentioned previously, could aid not only in making the older employee stay integrated in the team but also giving them a constant intellectual stimulus. Human resources management must be active, enabling senior employees to use their potential to the full and contribute to their ability including permanent education.(and task shifting) Skills and experience should be passed on to the next generation with seniors as coaches or mentors.

Likeable Organisations

In order to optimize the working environment for individual employees, employers should promote *likeable organisations*. David Kerpen, CEO of two companies (*Likeable Local* and *Likeable Media*) and author of two books, (*Likeable Social Media* and *Likeable Business*), describes a likeable organisation



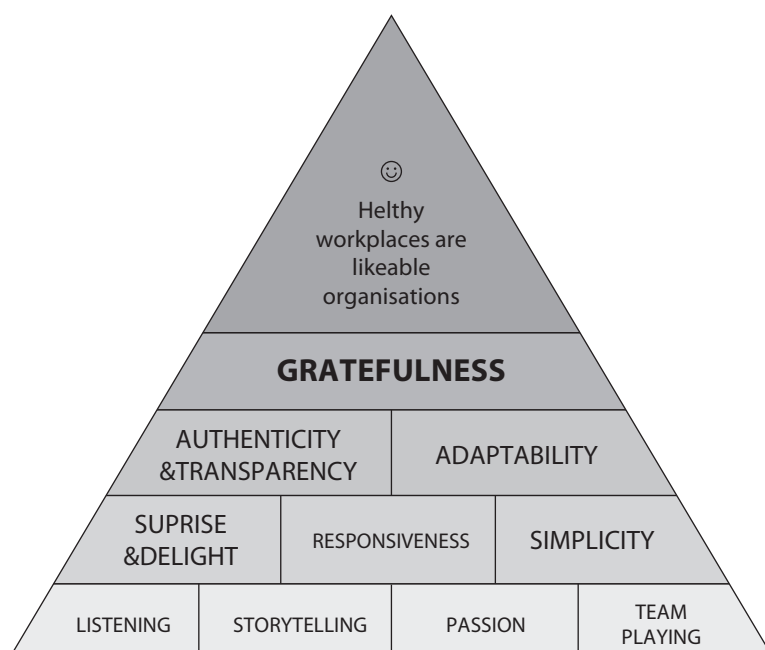


Figure. Adapted from David Kerpen. Likeable social media and likeable business. <http://www.likeablebook.com/>

in 11 elements in a triangle (see figure). Key elements would include:

- **Listening:** “When people talk, listen completely. Most people don’t listen”, Ernest Hemingway;
- **Storytelling:** “Storytelling is the most powerful way to put ideas into the world today”, Robert McKee and “if you tell me, it is an essay, if you show me, it is a story”, Barbara Greene;
- **Authenticity:** “I had no idea that being your authentic self could make me as rich as I’ve become, if I had, I’d have done it a lot earlier”, Oprah Winfrey;
- **Transparency:** “As a small businessperson you have no greater leverage than the truth”, John Whittier;
- **Teamplaying:** “individuals play the game, but teams beat the odds”, SEAL team saying;
- **Responsiveness:** “Life is 10% what happens to you, and 90% how you react to it” Charles Swindell and “your most unhappy customers are your greatest source of learning”, Bill Gates

- **Adaptability:** “When you’re finished changing, you are finished”; humility and willingness to adapt mark a great leader, Ben Franklin
- **Passion:** “The only way to do great work is to love the work you do”, Steve Jobs
- **Surprise and delight:** “A true leader always keeps an element of surprise up his sleeve, which others cannot grasp but which keeps his public excited and breathless” Charles de Gaulle; likeable leaders underpromise and overdeliver.
- **Simplicity:** “Less isn’t more, just enough is more” Milton Glaser
- **Gratefulness:** I would maintain that thanks are the highest form of thought, and that gratitude is happiness doubled by wonder” Gilbert Chesterton
- **The Golden Rule:** “Above anything else, treat others as you’d like to be treated”

Source: David Kerpen. *Likeable social media and likeable business*. <http://www.likeable-book.com/>

Blue Zones

Maintaining functional capacity, social inclusion and a stimulating working environment are crucial to healthy ageing, acknowledging the potential of the older person. Research has shown that where all these elements are in place, people live longer and happier.

Healthy Ageing

Blue zones (adapted from Dan Buettner, USA):

- Still at work
- Physical activity
- Healthy nutrition
- Participation and social inclusion
- Purpose in life
- It starts with good genes of course

For example, Dan Buettner, a journalist/researcher from the USA and connected to the National Geographic Journal describes 5 areas in the world where people reach on average a higher age. What do all these people have in common? Firstly, it starts with good genes, of course. Then, they are still at work most of the time. Thirdly, they are engaged in some kind of physical activity. They eat healthily. Never cease being well integrated with a group. They participate one way or another in social activities. Last but not least, they have a very well –marked purpose in life (a reason to get up in the morning; In Japan: *ikigai*). What we also see here is that a basic thought is to avoid the disease instead of curing it. Moreover, in our society we see that people tend to be preoccupied about a lot of issues, very often worrying solely about themselves. Let us find out what we can do for someone else who might be in need. This could mean looking at our closest environment including family, friends, and neighbours. A small piece of advice could be to try a change in attitude by being kind to other people and smile at one’s neighbour. People in most societies work

towards retirement as a purpose in life, for people in blue zones the word pension often does not exist in their language.

In conclusion 11 steps towards healthy ageing are worth mentioning.

Here they come:

- *“take the stairs,*
- *drink more water,*
- *eat a big breakfast,*
- *snack on fruit,*
- *have a cup of coffee every now and then,*

- *breathe more deeply,*
- *exercise your eyes,*
- *stretch regularly,*
- *take a walk after lunch,*
- *take a powernap,*
- *be more optimisticand*
- *smile at your neighbour”*

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*Jacques van der Vliet,
(with the kind support
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and Olga Rostkowska, (EMSA))*

Rapid Qualitative Assessment of Maternal and Newborn Health Care (MNHC) Speaking Book in Two Districts in the Amhara Region, Ethiopia

Background

The Health Extension Program (HEP) is an important institutional framework developed to achieve the goals of the Health Sector Development Program (HSDP) at community level [1]. It aims to improve access and equity of services by providing health interventions at kebeles and the household level, with a focus on sustained preventive health actions and increased awareness [2] by covering all rural kebeles with the HEP. The HEP focuses on four key areas: (1) Hygiene and Environmental Sanitation, (2) Disease Prevention and Control, (3) Family Health Services, and (4) Health Education. These packages address proper and safe water/waste management and disposal systems; HIV/AIDS, malaria or tuberculosis prevention and control; first aid; maternal and child health, family planning and reproductive health. The Speaking Book is used as an additional health promotion tool particularly for community health promoters with low levels of literacy and for health extension workers (HEW) to use for existing projects related to community-

based maternal, newborn, child and family health. As such, the research study has the following objectives:

- Assess use and effectiveness of MNCH Speaking Book in selected kebeles by HEWs and HDA.
- Understand care-takers' perception of the Speaking Book and the potential impact of this initiative on caretakers' knowledge and practice.
- Assess effectiveness of Speaking Books as a health promotion tool in general and for future initiatives.

Speaking Books

The first Speaking Book in Ethiopia was developed in 2010 by the Federal Ministry of Health (FMOH) in partnership with United Nations International Children Fund (UNICEF), the Integrated Family Health Program (IFHP), and the Last Ten Kilometers /JSI. The Speaking Book is an educational tool containing 16 key messages on community based maternal and new born health presented through

text, pictures, and a recorded soundtrack in Amharic.



Health extension workers (HEWs) and the health development army (HDA) utilize the books as a supplement to the Family Health Card during interactions with the community (mothers, fathers, grandparents, aunts, care-takers and others) regarding

antenatal care, safe delivery, postnatal and new-born care (including early and exclusive lactating), recognition of danger signs, care-seeking and immunization.

Process

The aim of the study was to assess the effectiveness, acceptability and relevance of the Speaking Book as a health promotion tool. As the use of Speaking Books as a communication tool is still in the development phase in this region, the pool of potential participants for this study was too small to fill both the intervention and the control group. However, the study can be valuable by providing:

- Information on who is being served by this program.
- Information that suggests whether anticipated changes are occurring.
- Information on whether anticipated changes are occurring in some subgroups and not others [3].

A total number of 1500 Speaking Books were distributed to the Amhara region during March, 2012. The field research was conducted between May and July 2012. Structured interviews, focus group discussions (FDGs) and observations (use of book during home visits, outreach and at health posts) in the woredas of Dembia (North Gondar) and Dembecha (W/Gojjan) were conducted to provide qualitative reports on the appropriateness, contribution, and challenges of the Speaking Books. Interview participants included:

- 18 health extension workers (HEWs),
- 29 health development army members (HDA),
- 27 care-takers (10 breast feeding mothers and 17 pregnant women),
- 4 focus group discussions with 21 pregnant and 15 lactating mothers.

Transcripts were prepared for analysis through: (1) transcription from voice recorder to paper, (2) translation from Amharic to English, and (3) manual test analysis.

Findings

In some locations, it was found that both HEWs and HDAs were using the Speaking Book as a job aid on daily basis in health posts, for home visits and during outreach programs. It was also found that HDAs were using Speaking Books once a week during home visits, local meetings, market days and local holidays. The book was also used for health promotion during local gatherings including coffee ceremonies, pregnant women's conferences and in churches.



HEWs and HDA made the following observations:

- The book was a good communication tool to strengthen messages of the Family Health Card.
- The book helped HDA and HEWs gain community acceptance.
- The book enabled health workers to provide essential MNCH information in an organized, structured and creative format suitable for small groups.
- The book assisted and simplified health education efforts of health workers and made more efficient use of health workers time and energy.
- The intended audiences trust the messages and consider the Speaking Book information as 'expert advice or as a professional delivering the message'.
- Mothers claimed to learn new information including the importance of avoiding harmful traditional practices and importance of calling HEWs to attend delivery.
- The book is a good communication tool for the illiterate – the majority of the intended audience.

The following are key takeaways from interviews with health workers:

- Showing pictures followed by hearing sound messages was an effective way to deliver the message.
- Speaking Books were useful during conferences for pregnant women, home-visits, outreach programs, and at church.
- It is worth noting that the number of new attendees in antenatal care in April and May 2012 were double that of February and March, 2012.

Interviews with care-takers revealed that:

- The Speaking Book is a good tool to deliver full information.
- The voice was clear and understandable and was the most informative aspect of the Speaking Book.
- They trust the messages from the Speaking Book.
- They appreciated the commitment of the responsible parties for the provision of

Speaking Book and hoped such programs will continue.

- Women showed interest in having frequent and repeated learning through the Speaking Book and preferred to have available at least one book at household or community level during their pregnancy and lactation period.

Focus groups with pregnant/lactating mothers, none of whom could read or write, revealed that:

- All FGD participants claimed to learn something new. Information found to be particularly useful included: importance of antenatal care visits; danger signs during pregnancy and labor; birth preparation; attending a health facility; delivery; new born colostrum feeding; breast feeding; not washing a new born before 24 hours post-delivery; and feeding of infant after 6 months.
- Participants claimed the book provided the opportunity to ask HDA questions during book use for additional information (i.e. availability of delivery service in the health posts; stretcher to carry laboring women from home to health post; solution to those infant with throat and tooth problem if it is not extracted or cut; and type of complementary food they need to give to their children, etc.).
- The voice was the most informative aspect of the book and the pictures were also found to be clear and understandable.

There were very few challenges or obstacles in using the Speaking Books. Some challenges that were identified included failing battery/replacing the battery, un-adjustable volume and protecting the book from water/rain damage.

Recommendations

Due to the limited availability, rotating Speaking Books between HEWs and HDA would result in more efficient use and in-

creased exposure in the community. As suggested by pregnant and lactating mothers and HDA/HEWs, it would be highly beneficial to create Speaking Books to cover other health areas such as: malaria, sanitation, and hygiene. Speaking Books can be used in someone's home, in community and social gathering forums, church programs, development forums and even during informal meetings. Clear training by instructors should be provided on how to replace the battery of the Speaking Book. Alternatively, instructions to replace the battery could be added to the Speaking Book in a picture format. Adding adjustable volume to the Speaking Books would make it useful to distribute to larger groups or in larger venues. Finally, advocacy for resource mobilization at federal and regional levels is needed to provide communities with effective health promotional tools.

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Letters to Prime Minister of Turkey Recep Tayyip Erdoğan

4 June 2013

I am writing to you on behalf of the World Medical Association (WMA), the global federation of National Medical Associations representing millions of physicians worldwide. Acting on behalf of patients and physicians, the WMA endeavours to achieve the highest possible standards of medical care, ethics, education and health-related human rights for all people. As such, the WMA plays a key role in promoting good practice, medical ethics and medical accountability internationally. The Association supports doctors at risk worldwide.

The purpose of this letter relates to the current demonstration that started peacefully in Gezi Public Park in Taksim Square–İstanbul on 27 May. The Turkish Medical Association (TMA) has drawn our attention to alarming violence with excessive force used against protestors. TMA reports hundreds of cases of injury and detention following police confrontations with protestors in Ankara as well as in other provinces including Adana, Eskişehir and Gaziantep. According to our sources, the majority of the injuries were caused by the use of water cannon and tear gas.

The WMA condemns strongly crowd control or riot prevention technology – such as tear gas and water cannon – that is misused, including to perpetrate human rights abuses or that is used in a manner out of proportion with the need, or against populations with particular vulnerabilities.

We therefore call on you to immediately end the excessive use of force against peaceful protestors and to ensure the right to freedom of expression and assembly. We also urge initiation of an independent and impartial investigation into the excessive use of force and bringing to justice law enforcement officials found to have ill-treated demonstrators or other members of the public. I thank you for your attention.

*Dr. Cecil Wilson, President
World Medical Association*

11 June 2013

I am writing to you on behalf of the World Medical Association (WMA), the global federation of National Medical Associations representing millions of physicians worldwide.

We sent you last week a letter expressing our deep concerns on the use of excessive force against protestors in Ankara as well as in other provinces including Adana, Eskişehir and Gaziantep.

The Turkish Medical Association, one of WMA members, reported cases of violence these last days that were directed at health-

care workers and medical students taking care of wounded people in houses, restaurants, and mosques that were converted into temporary infirmaries. Mobile clinics were disrupted and 13 doctors and students were detained in Ankara.

The WMA notes with serious concern that health-care services are threatened, violating the principle of medical neutrality. According to this principle – deriving from international human rights law, medical ethics and humanitarian law – health professionals must be allowed to care for the sick and wounded, regardless of their political affiliations. All parties must refrain from attacking

and misusing medical facilities, transport, and personnel.

We therefore urge you to ensure that medical neutrality is fully respected and that all health personnel is protected regardless of whom they help.

Furthermore, we reiterate our call to immediately end the excessive use of force against peaceful protestors and to ensure the right to freedom of expression and assembly.

I thank you for your attention.

*Dr. Cecil Wilson, President
World Medical Association*

Urgent Call From Turkish Medical Association

Since May 31st 2013 the peaceful and legitimate demonstrations are tried to be suppressed by the police. The police forces are using chemical gases savagely on the unprotected civil masses.

Before complete blockage of health assistance to the injured people and the preclusion of the functioning of health services by the police attacks, that took place once more again on the night of June 15th, Turkish Medical Association was started a web based survey in order to disclose the dangerous health effects of these gases targeted at defenceless people and in one week period, over 11 thousand of people declared that they have been effected by the gas.

65% of the repliers were between 20–29 years of age and professional protecting mask usage was only 13%. The total duration of exposure was evaluated among 11.164 replies. 53% declared that they have exposed to the chemical gases 1–8 hours where 11% exposed more than 20 hours. Exposing the chemical gases more than one day increases the prevalence of the systemic symptoms, especially cardiovascular symptoms. These data shows the dimensions of the problem.

Before the 15th of June disaster the total number of injuries were 788 (7%). These data shows that the gas bombs were targeted the people. Many of them were the injuries of head, face, eyes, thorax and abdomen which could be fatal. 20% of the injuries were open sores and fractures.

Only 5% of the people were admitted to hospitals. The tagging of the people who are admitting to the hospitals is preventing people from going to the hospitals in order to ask medical assistance. Ministry of Health opened an investigation about Istanbul Chamber of Medicine which is organizing the volunteer physicians' work. In Istanbul one physician and one medical student handcuffed and detained. There are many other information about the detaining of health care staff. These data shows the witch-hunt in Turkey.

Turkish Medical Association making calls to the government to act responsibly and stop the barbaric violence immediately. As Turkish Medical Association it is our responsibility to inform the international community. We urgently call the international community to act against brutal suppression of democratic demands.

Turkish Medical Association

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