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- **Communication of Results and Incidental Findings in Medical Research**
- **Working for Health Equity: The Role of Health Professionals**

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Communication of Results and Incidental Findings in Medical Research – A European Perspective¹



Elmar Doppelfeld

The principle of *free and informed consent* – codified, perhaps for the first time ever, as early as December 29, 1900 [Minister der geistlichen Unterrichts- und Medizinal-Angelegenheiten 1900] by a decree of the Prussian Minister of Education – is considered an essential prerequisite for the involvement of human subjects in medical research. Since World War II, numerous sets of rules – including both legally binding and so-called “soft law” instruments intended to serve as recommendations – have established legal and ethical principles that need to be observed to ensure that “free and informed consent” is obtained. One of them is to provide full and frank information to the potential research participant, or “a proper instruction regarding potential adverse effects that might result from the intervention”, to put it in the words of the aforementioned de-

cree. Thus, the principle of informing participants before the commencement of a research project is well-established and no longer contested.

Less clear, however, is the extent to which a person who participated in a research project is to be informed about the results. Should, or may, the participant be informed at all? Should the information be restricted to “health-related” findings obtained in the course of the project? Who defines what “health-related” means? These questions are all the more important as research projects in all disciplines produce findings that are difficult to interpret – if they can be interpreted at all. But does this entitle the researcher or the physician-researcher to withhold such findings (even if they cannot be interpreted) from the person concerned? After all, an increasing number of incidental findings² can be related to the choice of the research methodology. They, too, raise the question of the research participant’s *right to know* and *not to know*. Can, or may, the decision regarding disclosure of information about such findings be left to the good will or the discretion of the physician-researcher or other researchers?

The right to know and not to know can be associated with the right to informational selfdetermination. Hence, it needs to be established whether the respect for the dignity of the research participant calls for this right to be respected. To this end, the present Chapter will examine the legal standards for the protection of that dignity, particularly the instruments of the Council of Europe.

Interest in the results of medical research

The vast majority of people who agree to participate in a medical research project do not do so to serve as a mere “source of data”. The decision to be part of a research study may be motivated by various interests – interests, which may also give rise to the desire to know the results.

For instance, participants who are patients may hope to learn more about the current status of diagnostics and therapy for their disease, or they may desire to contribute to improvements in these areas. This motivation may be coupled with the need to gain knowledge about the overall results of this disease-specific research and, as the case may be, also about the status of their own disease. It must be borne in mind, however, that a patient may also refuse to be informed about the possibly advanced stage of their disease. Furthermore, unexpected findings may occur during the diagnostic process, which the patient may or may not want to know about. Healthy volunteers may be guided by the idea of making a contribution to research in general, without expecting any personal benefit; there might still be some advantage for them. Furthermore, it should be recognised that patients and test persons (healthy volunteers) alike may also have a legitimate interest when it comes to the future use of findings that have been obtained with their participation. It may not be acceptable to everybody that “their findings” might be used in follow-up studies in areas they do not approve of.

In the context of research projects, we can systematically distinguish between expected or preferred findings and unexpected findings with respect to the applied method, disease status or evidence of a previously

¹ Based on a lecture given at the IMAGEN Meeting of the Ethics Council and Workshop “Incidental Findings and Disclosure of Information in the Context of Research”, September 20, 2010 – Berlin.

² “The term ‘incidental finding’ refers to the unexpected discovery of an abnormality for which there was no recognizable prior evidence and that was not specifically looked for.” [Heinemann et al. 2007].

undiagnosed disease, as well as limitations or new possibilities for therapy. To complete this attempt at classification, we need to add findings discovered in the course of a research project involving healthy volunteers that are not related to the aims of the study.

Communication of results to research participants

When considering how to deal with the findings obtained, respect for the dignity of the persons concerned and for their right to informational self-determination should be given priority. The idea that – from an “ethical” or “medical” perspective – it is unacceptable to inform people about negative findings (especially when they cannot be interpreted) is quite common and understandable. Others argue that unexpected findings pointing to a potential disease should be communicated to a person even against his or her will, so that appropriate measures can be taken to preserve that person’s health if necessary. Such considerations, reasonable though they may seem, find their limits in provisions that, in respect for human dignity, have been established to protect the “right to know” and the “right not to know”. These provisions, which have only been introduced in the past few years, do not differentiate between different categories of findings, as mentioned in the classification proposal above. A systematic distinction is made between rules with a general scope that also extend to medicine and medical research and provisions that, in the form of legal or quasi-legal instruments (“soft law”), pertain specifically to these areas.

General provisions

One example of a legal instrument with a general scope is the German Federal Data Protection Act (Bundesdatenschutzgesetz). This Act stipulates the obligation to inform individuals about recorded data relating to them (Section 34). This obligation is ex-

pressly linked to the person concerned in making a request to be informed about the data. If no such request is put forward, there is no obligation to inform. At the same time, this right granted by Section 34 may not be excluded or restricted by a legal transaction (Section 6), such as an agreement between the researcher and the research participant. The cited provisions – which also apply to medical research without restriction – bind the owner of the data, whether they are a medical researcher or a member of any other scientific discipline, to provide information on request. The waiver of this right to information, which can be found in many contracts with research participants, conflicts with the cited Section 6, and should therefore be considered invalid.

Specific provisions

The current version of the Declaration of Helsinki [World Medical Association 2008] clearly states that “patients” entered into a study are entitled to be informed about the outcome of the study (Paragraph No. 33). The guidelines issued by CIOMS [Council for International Organizations of Medical Sciences 2002] stipulate that the research protocol (Appendix 1, Item 34) must include “plans to inform subjects about the results of the study”. Hence, it can be acknowledged that two prominent and widely accepted instruments of “soft law” postulate an obligation to inform research participants about research findings. In particular, the definition established in the Declaration of Helsinki, which has been developed by the medical profession as a statement of ethical principles for medical research, could help to point the way ahead when conflicts arise between the legal obligation to inform and “ethical/medical concerns” against the disclosure of information. Besides, it remains unclear why the Helsinki Declaration only affirms the *patient’s* right to information, without explicitly including other test persons (healthy volunteers) as well. The CIOMS guidelines use the neu-

tral term “subjects”, without differentiating between the two groups.

On the European level, the primary rule governing the handling of data from medicine and research in the context discussed here is Article 10¹³ of the Oviedo Convention [Council of Europe 1997], which 30 members of the Council of Europe have ratified to date.

According to Article 10, “everyone is entitled to know any information collected about his or her health. However the wishes of individuals not to be so informed shall be observed.” Article 10 further provides that “in exceptional cases, restrictions may be placed by law” on the exercise of the aforementioned rights “in the interests of the patients”. It should be noted that this provision, besides establishing the right to obtain exhaustive information on all recorded data, explicitly codifies the right not to know. No such explicit stipulation is contained in either of the other aforementioned documents. In general, the right not to know is considered as an element of informational self-determination, requiring no specific wording. Article 10 of the Oviedo Convention provides that in exceptional cases, both rights may be restricted for the benefit of the patient, namely on a legal basis. Article 10 grants rights to the persons concerned, without naming those who must comply with them. This suggests that anyone who disposes of the collected information – whether a medical researcher or a member of any other scientific discipline – must ful-

1 “Private life and right to information:

- a. Everyone has the right to respect for private life in relation to information about his or her health.
- b. Everyone is entitled to know any information collected about his or her health. However, the wishes of individuals not to be so informed shall be observed.
- c. In exceptional cases, restrictions may be placed by law on the exercise of the rights contained in paragraph 2 in the interests of the patient.” (Convention on Human Rights and Biomedicine, Article 10).

fil the obligation to provide information on the one hand, and to respect the right not to know on the other. Thus, anyone who deems it necessary to deviate from this principle should (even if there may be good reasons in individual cases) first make sure that there is a legal basis for doing so. It should also be borne in mind that the Oviedo Convention only allows for such deviations if they are in the interests of the patient.

The Additional Protocol to the Oviedo Convention on "Biomedical Research" [Council of Europe 2005], is – like the Convention itself – an instrument of International Law, and hence legally binding in countries that have ratified it. With regard to the right to information, the Protocol specifies the framework conditions laid down in Article 10 by adding more detailed provisions. The Chapter on information for research participants – which makes no distinction between patients and other test persons (healthy volunteers) – explicitly states that it must be made comprehensible to participants how they can get access to information that is relevant to them, as well as to the overall research project results (Article 13.2). The ethics committee must verify that this requirement has been met when evaluating the research project in question. The Appendix to the Research Protocol ("Information to be given to the ethics committee") specifies the details of this requirement by referring to the relevance of the generated information to the present or future health of the research participants and their family members.

The Additional Protocol on Biomedical Research emphasises the research participant's right to be informed in three articles covering different areas. To begin with, Article 26 of the Protocol reaffirms the right of research participants "to know any information collected on their health in conformity with Article 10 of the Convention." The text refers to "research participants", i.e. no distinction is made between patients and test persons (healthy volunteers). Since refer-

ence is made to Article 10, the right not to know is secured, too. Data collected in the course of the project that are not health-related shall be made accessible to the person concerned, in accordance with national law. The main objective here is to guarantee the rights of Third Parties to the results obtained. Article 27 regulates the handling of information on research results that are of relevance to the present or future health or quality of life of research participants. Such information is to be offered to the person concerned within a framework of health care or counselling; confidentiality and the right not to know are to be respected.

The obligation to offer the information to research participants is not limited to a particular profession. Physician-researchers and researchers from other disciplines are equally bound to make this offer; only the disclosure itself shall take place within a framework of health counselling. Since reference is made to Article 10 of the Convention, it is made clear that in the context of information disclosure also, the right to know and the right not to know may only be restricted under the provisions contained therein.

Finally, the conclusions of the research project must be made available to the participants – again, no distinction is made between patients and test persons (healthy volunteers) – on request (Article 28 of the Protocol). Further, Article 28 refers to the obligations to submit a report to the ethics committee on completion of the research, and to take measures to make the results public.

Conclusions

The provisions which have been addressed – whether they are legally binding or "soft law" instruments, and whether they are based on data protection law or have been specifically established for the areas of medicine and medical research – allow for

the statement that everybody has the right to be informed about any data collected on his or her health. To this end, the legal instruments of the Council of Europe provide detailed guidelines pertaining to medical research. The authors deemed it necessary to adopt detailed regulations in order to guarantee right to informational self-determination and to avoid the possibility that researchers circumvent this right by making decisions that may well be morally justifiable in certain cases, but which may also be somewhat arbitrary in nature. Information on collected data relating to health and to the conclusions of a research project is to be provided to the persons concerned on request.

The obligation to offer information to the research participant only applies in the case of findings of relevance to the health of the person concerned. The research protocols, which are submitted to the ethics committee for evaluation, must specify how the process of disclosure will be managed.

When a research participant requests to be informed, he or she exercises his/her right to know. The exercise of this right cannot be restricted or invalidated by means of a waiver signed by the participant – at least not under German data protection law. Here, the right not to know comes into play: It must be respected, even in the case of findings and research outcomes that are of relevance to the health of the person concerned.

From the author's point of view, the creators of these different provisions have set clear standards to substantiate the right to informational self-determination, which is associated with the autonomy of the person. A responsible person must be able to decide for himself/herself what he or she does or does not want to know, since it is this person who has to live with the consequences of, for instance, a disease in an advanced stage that might have been successfully treated if information – which the person refused to obtain – had been given. A re-

sponsible person must also decide whether he or she wants to let the matter rest when a research project produces findings that are difficult or nearly impossible to interpret, or whether he or she desires further clarification. It is the responsible person who bears the risk of a potentially adverse progression of the condition, not the researcher by withholding this information and of acting contrary to law.

Of course, these clear provisions – which do not yet provide for any exceptions in the case of incidental findings or inexplicable findings – give rise to the question of morally acceptable conduct in the physician-researcher. Some rules could be found in “Codes of Deontology” of physicians (in Germany: “Berufsordnungen der Landesärztekammern”). It must be noted, however, that the right to know and the right not to know are regulated by law and cannot be modified or invalidated by any code of deontology. With the exception of the German “*Berufsordnung*”, such codes of deontology are not legally binding in any European State. Hence, they do not really provide a solution to the moral dilemma of either burdening a person by informing them about findings which may be irrelevant after all, or – if the right not to know is invoked – of leaving this person with the risk of a looming disease. But again: This risk is borne by the responsible person alone.

To conclude, a few remarks are warranted concerning incidental findings, which occur more and more frequently in research projects in many areas. Such findings are not given any special status in the provisions discussed above – they are to be treated in the same way as any other “health-related information”, and the right to know or not to know is to be respected. Sometimes it is argued that incidental findings only occur when certain parameters apply to the research project, e.g. the use of imaging techniques, and that it is impossible to draw conclusions about their medical relevance. In the author’s opinion, which is substan-

tiated by the cited provisions, the person concerned must be informed in such cases, at least on request. He or she may then decide whether they want to let the matter rest, or whether they prefer to watch for further developments related to these findings – for instance in the context of a long-term observation, which is sometimes desired by researchers. However, the researcher may not make this decision tacitly or on the participant’s behalf. As regards the requirement that findings which cannot be interpreted with the methods used in the research project should be clarified by means of appropriate medical diagnostics, this is often objected to on the grounds that it would involve excessive costs and administrative effort. However, cost and effort should be considered and budgeted for when such projects are being planned – after all, we are talking about the weal and woe of the research participants. The measures envisaged for a medical clarification of incidental findings must be documented in the research protocol, which is submitted to the ethics committee. It is sometimes argued that, in the context of the research situation discussed here, the doctor and the research participant are not engaged in a typical physician/patient relationship, and that hence there is no obligation to perform further medical diagnostics. Whether this splitting of roles between physicians and physician-researchers is consistent with the requirement contained in Item No. 4 of the Declaration of Helsinki, “The health of my patient will be my first consideration”, is something that everybody must judge for themselves. However, the instruments of the Council of Europe do not allow for such splitting. They refer exclusively to the “researcher”, who has both rights and duties, or, in more neutral terms, to actions, measures etc. to be taken.

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Working for Health Equity: The Role of Health Professionals

*Matilda Allen, Jessica Allen,
Sue Hogarth with Michael Marmot*

Statements for action were written by the following:

- Nurses by the Royal College of Nursing;
- Social workers and social care by the Social Work & Health Inequalities Network;
- Clinical Commissioning Groups by the Royal College of GPs;
- General practitioners by the Royal College of GPs;
- Paediatricians by the Royal College of Paediatrics & Child Health;
- Midwives by the Royal College of Midwives;
- Obstetricians and gynaecologists by the Royal College of Obstetricians and Gynaecologists;
- Hospital doctors by the Royal College of Physicians;
- Psychiatrists by the Royal College of Psychiatrists;
- Dentists and the oral health team by the Faculty of Dental Surgery, Royal College of Surgeons of England; Dental Faculty, Royal College of Surgeons of Edinburgh; Dental Faculty, Royal College of Physicians and Surgeons of Glasgow; Faculty of General Dental Practice, Royal College of Surgeons of England; Dental Schools Council; British Association for the Study of Community Dentistry;
- Medical students by Medsin
- Allied health professionals by the Allied Health Professions Federation with sections on: Music therapists by the British Association of Music Therapy, Dieticians by the British Dietetic Association, Occupational therapists by the College of Occupational Therapists, Physiotherapists by the Chartered Society of Physiotherapy, Paramedics by the College of Paramedics, Radiographers by the Society and College of Radiographers, Speech and language therapists by the Royal College of Speech and Language, Therapists.

Foreword

The Merseyside Fire and Rescue Service made a lasting impression. When conducting the Marmot Review of Health Inequalities, published as *Fair Society Healthy Lives*, we partnered with the North West Region of England. On one of our visits to Liverpool, we were hosted by the fire fighters. Their compelling story was of going outside their core professional practice of fighting fires to preventing them, which entailed engaging with the local community. They then became involved in looking at quality of housing, and at smoking, which are fire risks, to more general issues that benefit the community, including activities for youngsters and older people.

"If the fire fighters can do it, why not the doctors?" was a question I posed to the British Medical Association, during my time as President. Doctors are involved in treating illness but most accept they have an important role in prevention. If illness arises from the conditions in which people are born, grow, live, work, and age – the social determinants of health – should the doctors

not get involved in the causes of illness and, indeed, the causes of the causes. The BMA picked up the challenge and produced a report on what doctors could do about the social determinants of health. But why stop at doctors? Other health professionals have key roles to play on improving the conditions of people's lives and hence could have profound effects on health inequalities. This report builds on the BMA's report and the inspiring work of health professionals.

Fair Society Healthy Lives laid out the evidence and made recommendations of what should be done on the social determinants of health in order to reduce health inequalities. Many of the recommendations were aimed at sectors other than health. But the medical and health professions are well placed to take action on the social determinants of health – they are trusted, expert, committed, and great powerful advocates.

One response to the evidence on social determinants of health is weary reluctance – it is simply all too difficult. The response we have had from colleagues who helped us with this report has been far from that.



Sir Michael Marmot

Nineteen organisations have contributed, including medical Royal Colleges, nurses, midwives, medical students, and several allied health professions. We appear to have struck a chord. And it is hugely encouraging.

The response can be summarised as: not only *should* we be taking action but there

is ample evidence that we *can*. This report shows the evidence base for actions, the case studies present examples of organisations with effective strategies, and the statements for action put forward practical actions.

The report and statements make clear that action on the social determinants of health

should be a core part of health professionals' business, as it improves clinical outcomes, and saves money and time in the longer term. But, most persuasively, taking action to reduce health inequalities is a matter of social justice. The enthusiastic response from medical and health professionals to the challenges of a fairer distri-

bution of health contributes to what I have described as my evidence-based optimism: we are making progress in a good cause. Join us.

*Professor Sir Michael Marmot
Director of the UCL Institute
of Health Equity*

Executive Summary

Those in the health sector regularly bear witness to, and must deal with, the effects of the social determinants of health on people. This report will demonstrate that the health care system and those working within it have an important and often under-utilised role in reducing health inequalities through action on the social determinants of health. The health workforce are, after all, well placed to initiate and develop services that take into account, and attempt to improve, the wider social context for patients and staff.

This report launches a new programme of activities to tackle health inequalities through action by health professionals on the social determinants of health. It draws on many examples of inspiring and excellent practice which demonstrate what can be done. The report describes areas where greater action is necessary and possible and makes some practical suggestions about how to take forward action on the social determinants of health.

The report contains recommendations and analysis in six core areas, described below. It also contains nineteen Statements for Action about actions health professionals can take to tackle the social determinants of health through their practitioner role. These have been written by Royal Colleges and other representative organisations, and set out, for each profession, a rationale for action, practical guidance on what activities to engage in, and relevant case studies and fur-

ther reading. Working with the authors of these statements, and other organisations, the Institute of Health Equity (IHE) will support and encourage health professionals to take greater action to tackle health inequalities.

The report also sets out a series of commitments made specifically for this report and future work programme, from twenty relevant organisations. These cover each of the six priority areas in this report, and display an impressive ambition to take forward action on the social determinants of health. Organisations have committed to work in partnership to implement the recommendations of this report by producing educational materials, developing new research and publications, setting up networks, embedding the social determinants of health in current work and disseminating information to health professionals. These commitments are described throughout the document at the ends of chapters, and a full list can be found on the IHE website (1). They will form the basis for an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges (AoMRC), the British Medical Association (BMA), the Canadian Medical Association (CMA), the World Medical Association (WMA), and other organisations and institutions. These commitments will extend and develop over time, but are included in the full report in their current form in order to give an indication of future steps. As we continue the programme of work over the next few years, these will

be developed, tested and implemented further.

Background

Evidence presented in the Marmot Review 2010 (2), and many other evidence-based analyses of health inequalities (3–6) show a clear social gradient in health outcomes, which closely relates to social and economic factors: the conditions of daily life. Most of the factors influencing health lie outside the immediate reach and traditional remit of the health system – early-years experiences, education, working life, income and living and environmental conditions. The recommendations of the Marmot Review were therefore mainly focussed on actions which could be taken outside the health care system to reduce health inequalities. This report now focuses on actions and strategies that can be developed within the health care system, and particularly the health workforce, where there is great scope. It builds on and learns from other recent initiatives (7–9).

While inequities in access and care within the NHS do exist, they do not account for a large proportion of health inequality, particularly when compared to the powerful influence of social and economic factors on health (10–12). This report demonstrates that there is much that the health system can do to influence these wider social and economic factors, beyond ensuring equity of access and treatment. Those working within the health system have an important, albeit often under-utilised, role in reducing health

inequalities through action on the social and economic factors: the social determinants of health. Tackling health inequity is a matter of social justice; it is also essential in order to provide the best care possible. Preventive measures that improve the conditions in which people live can lengthen people's lives and years spent in good health, improve services and save money (2).

The report is based on literature, case studies, and other evidence about how health professionals and organisations can influence social determinants and tackle health inequalities in a systematic and effective way. Many relevant organisations have had direct input into the report, and this input forms much of the basis for the analysis and recommendations. We organise this analysis into six areas in which actions will be particularly effective: education and training, working with individuals, action by NHS organisations, working in partnership, workforce as advocates, and opportunities and challenges within the health system. These are described briefly below and in greater detail in the main report, where they are also accompanied by case studies, recommendations and commitments.

Part A. Ways for health professionals to take action on health inequalities

1 Workforce education and training

In order for the health workforce to successfully tackle health inequalities and take action on the social determinants of health, the right education and training are essential. Good education on the social determinants of health will not only inform but also empower the health workforce to take action. Changes should take place within undergraduate education, postgraduate education, Continued Professional Development, and other forms of training.

There are two important actions in this area. Firstly, professionals should be taught

about the nature of the social determinants of health, and what actions by those within, and outside, the health system have been successful in tackling them. Education should include information about the graded distribution of health outcomes, how social and economic conditions can help to explain these unequal outcomes, and what practical actions can be undertaken by health professionals to decrease these inequalities. This teaching should take the form of dedicated compulsory and assessed modules, and should be included in other specialised courses, for instance a course on cardiovascular disease should include information on the social determinants of that disease (13).

This first area can then be supplemented by a second action, the teaching of skills: that is, how to reduce inequalities within professional practice areas. Some necessary skills are more general and have broad application – for example, skills of communication, partnership and advocacy are all essential for tackling health inequalities. There are also specific strategies which have been shown to be effective, for example, taking a social history and making patient referrals to external support services. Teaching skills in these specific practice-based areas should be a core element of all health courses.

Seeing the effects of social and economic inequalities will ground and 'realise' the knowledge described above. For this reason, student placements are central to learning. They should take place in a range of non-clinical settings, for example with social services or with a debt advice service, and should be designed to expose students to disadvantaged areas and needs. It is also important that access to health professions is made more equal.

Within England, action across the areas discussed above is the responsibility of Health Education England, Local Education and Training Boards, the General

Medical Council, medical schools, NHS organisations, and professionals and students in advocacy roles. IHE will work with these organisations to embed the recommendations below.

Key recommendations:

Workforce Education and Training

Knowledge

A greater focus on information about the social determinants of health, and information on what works to tackle health inequities, should be included as a mandatory, assessed element of undergraduate and postgraduate education.

Skills

Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and referring patients to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses.

Placements

Student placements in a range of health and nonhealth organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students' knowledge and skills related to the social determinants of health.

Continued Professional Development

Both knowledge about the social determinants of health and skills to tackle these should be taught and reinforced as a compulsory element of CPD.

Access

Universities should take steps to ensure that students from all socio-economic backgrounds have fair access to health care careers.

2 Working with individuals and communities

The Marmot Review showed that if the conditions in which people are born, grow, live, work, and age are favourable, and distributed more equitably, people would have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. Individual health professionals can tackle the social determinants of health by helping to create the conditions in which their patients can have control over their lives.

It is important that health professionals build relationships of trust and respect with their patients. This is good for the patient as control and reducing stress can have direct effects on health (14). It can also improve the uptake of public health messages and other strategies to reduce inequalities. Greater communication and better relationships can also enhance practitioners' knowledge and understanding of their patients and the local community, thereby improving the care that they are able to offer. Techniques such as motivational interviewing, a method that increases communication and collaboration between patients and providers, can help to build these relationships on an individual level. On a community level, professionals should be promoting and engaging in collaboration and communication with the local population.

In taking action to reduce inequalities, health professionals can focus on two key activities: gaining information, and providing information. Gaining information about patients is important in order to understand how social and economic factors are impacting on a patient's health. Taking a social history can enhance a medical history and enable professionals to provide the best care possible. This type of information is also essential on an aggregate basis, as it can help to influence and inform local commissioning and provision, both of health care and of other services within the community.

Key recommendations:

Working with Individuals and Communities

Relationships

Health professionals should build relationships of trust and respect with their patients. They should promote collaboration and communication with local communities to strengthen these relationships.

Gathering information

Health professionals should be taking a social history of their patients as well as medical information. This should then be used in two ways: to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care.

Providing information

Health professionals should refer their patients to a range of services – medical, social services, other agencies and organisations, so that the root causes of ill health are tackled as well as the backgrounds have fair access to health care careers.

Longitudinal social data can also enable organisations to measure progress and the effectiveness of interventions against health equity indicators.

Giving information that can help to improve the social determinants of health mainly consists of referring patients to non-medical services. These should cover a broad range of sectors and issues, beyond lifestyle and disease management programmes. For example, referral to Legal Aid, Relate, CAB, employment programmes or housing advice services can help patients to tackle the sources of ill health. By connecting patients to professional advice about state benefits,

health professionals can ease patient anxiety and stress (15) and improve the context in which they live. Other referrals can help to tackle other social determinants of health. Such activity may reduce the number of consultations with and prescriptions from GPs (16). Referral of this type is particularly successful where the services are readily accessible or medical and non-medical services are co-located – for example, where Citizens Advice Bureaux are situated in GP surgeries.

There will be two types of changes needed: those requiring increased resources of time and money, and those that can be accommodated within existing structures and constraints. In the first case, professionals should be advocating for change and helping to build an evidence base to support the case. However, some changes can and should be made within existing structures and constraints.

3 NHS organisations

In addition to actions taken to improve the health and wellbeing of their patients, NHS organisations have a responsibility to ensure that health inequities among their employed staff are also tackled. The NHS is the largest employer in the country with 1.4 million staff (17), plus staff employed in non-NHS commissioned services. Health professionals have opportunities in their roles as managers, commissioners and employers to ensure that workforce health and wellbeing are central to their activities.

Firstly, NHS organisations should be places of good quality work. Evidence has consistently shown that employment is better for mental and physical health than unemployment. However, this only applies to good quality work (2). Good quality work is characterised by a living wage, having control over work, being respected and rewarded, being provided with good quality in-work

services such as occupational health services, and with adequate support to return to work after absence.

The importance of these areas was recognised by Carol Black's review of the UK's working age population (18), and was applied to NHS workplaces in the Boorman Review (19). Managers should be ensuring that all staff, including contracted staff, are provided with good quality work in line with the recommendations of the Boorman Review. IHE have produced a strategy for Barts and the London Trust which set out how to implement the recommendations of the Boorman Review and the Marmot Review (22). Implementing these strategies across the workforce is likely to reduce inequalities as there is a gradient in quality of work: those from lower socio-economic groups currently tend to experience worse quality work.

NHS organisations, and therefore their staff, have considerable influence through their sizeable purchasing power, both as employers and contractors of staff and as commissioners of services. One literature review found that the health sector often accounts for 15–20% of a local community's employment and income (20). This gives health organisations significant power to affect the health and wellbeing of their local population. Public bodies also have a legal duty to consider how procurement might improve the economic, social and environmental wellbeing of their area (21). Employment should be designed to be particularly beneficial for those from lower socio-economic groups, as this will reduce inequalities. In addition to providing a good quality place of work, this can be achieved by ensuring that there is security and flexibility of employment and retirement age, and that jobs are suitable for lone parents, carers and people with mental and physical health problems (22).

This report outlines many actions that can be taken by individual health professionals.

Key recommendations: NHS Organisations

Health professionals should utilise their roles as managers and employers to ensure that:

- Staff have good quality work, which increases control, respects and rewards effort, and provides services such as occupational health.
- Their purchasing power, in employment and commissioning, is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.
- Strategies on health inequalities are given status at all levels of the organisation, so the culture of the institution is one of equality and fairness, and the strategies outlined elsewhere in this document are introduced and supported.

They can start to take most of these actions straight away. However, in order for action to be comprehensive, systematic and sustained, these actions must be supported at every level. For this reason, managers and leaders should ensure that strategies on organisational health inequalities that incorporate the areas in this report are in place, with dedicated leads and budgets. They should be auditing proposed actions, monitoring progress and sharing good practice.

4 Working in Partnership

In order to take effective action to reduce inequalities, working in partnership is essential. Evidence shows that effective action often depends on how things are delivered, as much as what is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector, or draws on information and expertise from other sectors.

Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of agencies that have the potential to affect social and economic conditions.

Many health professionals work extensively and successfully with other health care staff. These partnerships within the health system often extend across primary, secondary and tertiary care; between nurses, psychiatrists, doctors, surgeons and more; and are a core part of day-to-day business for practising professionals. Partnerships should occur between different organisations, for example hospitals and community health services, and different professionals in the same organisation. They can help to improve patient experience and practitioner knowledge, and reduce inequalities in outcomes.

However, perhaps more importantly, partnerships between health and non-health professionals and organisations should be established, supported and extended. Integrated work should be broad, and include partnerships with local government, other public sector partners, the police and fire service, charities and other third sector organisations, private companies and places of work, and schools (2). There is a legal duty on Clinical Commissioning Groups and the NHS Commissioning Board to integrate services where this would reduce inequalities (23), and other professionals should work to support and extend this. Information-gathering and monitoring systems should be collaborative where possible. Joint planning, commissioning and delivery are particularly important for effective partnerships. Collaborative local strategies can provide effective ways of reaching shared goals and providing excellent services, as well as reducing inequalities, although partnerships must be carefully designed and assessed in order to ensure effectiveness (24).

Early years and childcare health are important examples of the value and necessity of

partnership working. In order to tackle the root causes of ill health effectively, action early on in life is essential. This can change the conditions in which children are born and grow, and the care and opportunities that are made available to them. In order to take action in this area, partnerships should be established between Children's Centres, schools, social care, health visitors, midwives and other health professionals. When these different sectors communicate effectively, deliver joint programmes and tackle individual problems in a collaborative way, outcomes tend to improve (25).

Since the passage of the Health and Social Care Act 2012, a new form of partnership has been established – Clinical Commissioning Groups (CCGs). These are locally based consortia, made up of GP practices, which will commission care for the local community (26). The doctors and nurses

Key recommendations:

Working in Partnership

Within health sector

Partnerships within the health sector should be consistent, broad and focussed on the social determinants of health.

With external bodies

Partnerships between the health sector and other agencies are essential – they should be maintained, enhanced, and supported by joint commissioning, data-sharing and joint delivery. They must, however, be well designed and assessed for impact.

Clinical Commissioning Groups

CCGs should make tackling health inequalities a priority area, and should measure their progress against this aim. They can do this via their role as commissioners, in partnership (particularly with Health and Wellbeing Boards), and as a local community employer and advocate.

who sit on CCGs have three important ways to tackle health inequalities: through their actions as health professionals; in their role on the CCGs, which includes making commissioning decisions; and in the way they use the CCG as a local advocacy and community asset. If CCGs and professionals are aware of and responsive to the social determinants of health in their local area, they will be able to tackle health inequalities while delivering clinical services.

5 Workforce as advocates

Every health professional has the potential to act as a powerful advocate for individuals, communities, the health workforce, and the general population. Since many of the factors that affect health lie outside the health sector – in early-years experiences, education, working life, income and living and environmental conditions – health professionals may need to use their positions both as experts in health and as trusted, respected professionals to encourage or instigate change in other areas. The medical Royal Colleges have a clear advocacy function, and regularly petition government for policy changes on behalf of their members and their patients. However, advocacy is also powerful and important for health students, qualified professionals, CCGs, NHS organisations and other professional bodies such as unions.

Acting as an advocate for individual patients and their families is often particularly helpful to improve the conditions in which people live. Professionals can use their understanding of the factors that are influencing a patient's health, and act as advocate in order to help these patients to access services both within and outside the health service. In a similar way, advocacy on behalf of communities is also important.

The actions proposed in this report will be most effective where they are adopted wide-

ly and supported at all levels – from central to local and individual arenas. This will ensure that strategies are in place to instigate change, to regulate action, to measure and reward progress, and to learn from others. This will require, in some cases, action that is beyond the remit of the individual professional. In these cases, professionals should use their position to advocate for the changes that are necessary, both within their

Key recommendations:

Workforce as advocates

For individuals

Individual health professionals and health care organisations should, where appropriate, act as advocates for individual patients and their families.

For changes to local policies

Individual health professionals and health care organisations such as local NHS Trusts should act as advocates for their local community, seeking to improve the social and economic conditions and reduce inequalities in their local area.

For changes to the health profession Individual health professionals, students, health care organisations such as NHS Trusts and professional bodies such as medical Royal Colleges and the BMA should advocate for a greater focus on the social determinants of health in practice and education.

For national policy change

Individual health professionals, students and professional bodies such as medical Royal Colleges should advocate for policy changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions. They should target this advocacy at central government, and bodies such as the NHS Commissioning Board.

organisation, and within other local bodies or central systems. For example, changes to education, as outlined above, will need the support and backing of health students and professionals.

Health professionals have great authority and expertise, and should also be using this to advocate for policies that will reduce health inequalities and against policies that will widen them. This should be targeted at central government departments as they consider policy change, but also towards newly formed bodies such as the NHS Commissioning Board, which are currently considering what to prioritise and what strategies to adopt. With concerted pressure from health professionals and the bodies that represent them, we have a great opportunity to ensure that tackling health inequalities is a central concern across the policy spectrum, and that all bodies consider the health equity impact of new and existing policies.

6 The health system – challenges and opportunities

The Health and Social Care Act of April 2012 has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within the health system (23). While the changes are challenging and disruptive, there are also new opportunities to tackle health inequalities and to embed an approach based on the social determinants of health across the new system. The new legal duties in the Health and Social Care Act can act as an important lever in encouraging action. In exercising their functions, the NHS Commissioning Board and Clinical Commissioning Groups must have regard to the need to reduce inequalities, both in terms of access and health outcomes of patients. They must also secure integrated provision of services, both within the health system and beyond it, where this would reduce inequalities in access or outcomes. In addition, there are duties on the Secretary

of State, Monitor and NHS Foundation Trusts, all of whom must integrate these duties into their plans and report progress on them annually (23). The Equality Act 2010 states that public sector bodies “must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage.” (27). These duties mean that work by the NHS workforce to tackle health inequalities should be integrated into organisational strategies and plans, as well as being incentivised and monitored. Unfortunately, other mechanisms may make this harder. For example, the Quality Outcomes Framework is a powerful incentive system but tends to measure certain outputs rather than patient outcomes, weakening its potential to reduce health inequalities. On the other hand, the Public Health Outcomes Framework includes important social determinants of health indicators, but is not linked to financial incentives or requirements, decreasing its potential to leverage change and increase impact. There are other mechanisms which may provide opportunities or challenges: the NHS Commissioning Board and the NHS mandate, the NHS constitution, funding and allocation arrangements, monitoring and data-sharing procedures, and various mechanisms that impact on health education. This chapter in the full report sets out some initial conclusions from a working paper, which is available on the IHE website (1). IHE will be developing this analysis as part of the ‘Working for Health Equity’ programme.

Part B. Professions: Statements for action

The analysis set out in this report has been largely welcomed by health professionals and their representative organisations. But there is a need for health professionals to

have brief, practical guidance for tackling health inequalities through the social determinants of health. To inform this report we asked Royal Colleges and other organisations to provide statements for action, to give practical accessible guides for particular professionals to develop and use in their roles. The result of an enthusiastic response, nineteen statements for action by different organisations are set out in the main report. These statements also include a rationale for action, case studies and further reading. During the implementation phase of our programme of work, we will be working with various organisations to drive uptake of these practical actions.

There are statements for each of the following professional groups:

- Nurses
- Social workers and social care
- Clinical Commissioning Groups
- General practitioners
- Paediatricians
- Midwives
- Obstetricians and gynaecologists
- Hospital doctors
- Dentists and oral health teams
- Psychiatrists
- Medical students
- Allied health professionals
- Music therapists
- Dieticians
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Paramedics
- Radiographers

Commitments and next steps

This report also sets out a series of commitments by the health workforce and other organisations to embed and develop action on the social determinants of health. These form the basis of an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges, and the British Medical Association among other organisations

and institutions. The current commitments are placed throughout the document at the ends of chapters. These commitments will be added to over time. Please see the IHE website for an up-to-date list of commitments (1).

IHE will lead a programme of work to disseminate the messages in this report, encourage their practical application across the workforce, and to extend the evidence base. We have been sent many examples of excellent practice already taking place, and the 'Working for Health Equity' programme will be focussed on increasing the systematic and sustained implementation of this activity across the health system. This will be undertaken in partnership with organisations that have already been involved in the project by writing statements for action and commitments. IHE also welcomes other organisations to join the programme and share their experience, working together to achieve greater health equity through actions by health professionals and related organisations.

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Abbreviations

AoMRC	— Academy of Medical Royal Colleges
BMA	— British Medical Association
CAB	— Citizens Advice Bureau
CCG	— Clinical Commissioning Group
CMA	— Canadian Medical Association
CPD	— Continued Professional Development
GP	— General Practitioner
IHE	— UCL Institute of Health Equity
NHS	— National Health Service
WMA	— World Medical Association

www.instituteofhealthequity.org

Great East Japan Earthquake Before and After



Masami Ishii

Introduction

**Great East Japan Earthquake:
14:46 March 11, 2011**

When I returned to my hospital in Iwaki, Fukushima, there was a thunderous roar coming up from below, after which I was assailed by violent shaking like I had never experienced before. The reinforced concrete building creaked as it shook widely with the enormous waves of energy propagating repeatedly up from the bottom of the earth. A tsunami warning was then issued, after which a giant tsunami carrying a tremendous amount of energy transmitted through the ocean water bore down upon one seaside community to the next, from the Tohoku Pacific coast to Ibaraki and Chiba prefectures.

Making matters worse following this natural disaster of a scale seen once in a thousand years, the Fukushima Daiichi Nuclear Power Plant owned by Tokyo Electric

Power Company (TEPCO) experienced a melt-through and explosions starting the following day, March 12. This development robbed 140,000 people from the surrounding communities of their places to live and was a man-made disaster that struck the sharpest fear into many Japanese, including those in the Tokyo metropolitan area.

The disaster victims as well as we who were taking action onsite faced an overwhelming dearth of information that is supposed to be provided by the government during an emergency. The hunger I felt with all my heart while leading all the support efforts that I could, including the Japan Medical Association Team (JMAT), as a disaster victim on the one hand and as the Japan Medical Association (JMA) officer in charge of disasters in the face of this situation is still engraved in my body and soul.

Events Before the Great East Japan Earthquake

**Tokaimura nuclear accident:
10:35 Thursday, September 30, 1999**

The Tokaimura nuclear accident, in which large amounts of neutron radiation and gamma rays as well as fission products were released for about 20 hours with the reactor in criticality, began when alarms were sounded in a conversion test building at the facility operated by JCO in the town of Tokaimura.

Residents who passed nearby the accident site on the Joban railway line and the Joban Expressway made inquire with medical institutions in the city of Iwaki. I received lots of information and many questions at that

time, as I had been the director in charge of emergency and disaster medicine at the Iwaki Medical Association since April 1998.

I immediately reported the situation to then-director of the Health Center, Shogo Asahina, and made an urgent request. As a result, a radiation dose measurement service using a handheld Geiger counter was hastily arranged and provided from the following day at the Iwaki Health Center to residents who requested it. A total of over 800 people came for the service, 10% of them residents from northern Ibaraki.

Although this was an inadequate response, there is no boundary to actions that can be taken for the peace of mind and safety of residents in a radiation disaster. This event made it clear that building disaster prevention schemes based on this truth is fundamental.

This had become my basic stance as someone who participates every year in emergency drills for the group of TEPCO nuclear power plants in Fukushima. It also became the basis for a request I made at a later date for the stockpiling, above and beyond the national regulations, of our own iodine preparation for all Iwaki residents in case of a nuclear accident in the city. This stockpile was created before the TEPCO Fukushima nuclear accident, put in place at the city's health center, and distributed to residents after the accident.

9.11 Terrorist Attacks in NY and WMA 2002 General Assembly in Washington

In April 2000 I was elected president of the Iwaki Medical Association and at the same time continued to be in charge of emergency and disaster medical responses as vice-president of the Fukushima Medical Association, a position to which I had been appointed [1]. The large-scale terrorist

attacks on the World Trade Center buildings in New York and other targets on the morning of September 11, 2001 was an event that once again seared into the breasts of relevant parties worldwide the importance of disaster preparedness against both natural and man-made disasters.

The Scientific Session Program at the General Assembly of the World Medical Association (WMA) held in Washington DC from October 2–6, 2002 took up a wide variety of subjects including preparedness to large-scale disasters, infectious disease, and terrorism under the central theme of “Responding to the Growing Threat of Terrorism and Biological Weapons” in light of the horrific tragedy of the previous year’s international terrorist attacks.

I voluntarily attended the assembly as an associate member of the WMA and was deeply impressed by the stance of the American Medical Association and interested parties who disclosed extremely pragmatic and full contents. I returned to Japan with many documents and a desire to establish the foundation of disaster medicine in Japan.

On the way home, my suitcase had been prized open during the flight from New York and my commemorative WMA’s congress bag with all the documents related to disaster medicine had been stolen. Luckily, my wife Atsuko’s suitcase was fine, and it contained a second set, as she had listened to all the lectures with me.

As I was filing a claim at Narita Airport, I realized that the WMA bag and all the documents had been distributed for free at the meeting venue. So, I ended up filing a claim only for the suitcase whose lock no longer shut. But this incident taught me the important lesson that truly important things are priceless and the importance of backups—things that we have to consider when thinking about life and disaster medicine.

Agreement regarding Medical Relief during a Disaster: January 2004

On January 5, 2004, Fukushima Prefecture and the Fukushima Medical Association signed an Agreement regarding Medical Relief during a Disaster based on repeated discussions on regional disaster prevention planning for Fukushima prefecture during disaster prevention meetings held at the prefectural government office [2].

The Fukushima Medical Association is positioned as a designated local public institution under laws such as the Basic Act on Disaster Control Measures (1961) and what is called the Civil Protection Law (Act concerning the Measures for Protection of the People in Armed Attack Situations, etc.; enacted in 2004 and amended in 2008).

In settling the negotiations, the Medical Association inserted a clause indicating that while it would take responsibility for medical relief planning and medical relief teams, on the flip side, the Prefecture would grant retrospective approval after the dispatch of medical relief teams deemed necessary by the Medical Association when faced with circumstances in which emergency action is unavoidable.

This clause ensures that the government accepts our decisions and actions based on physicians’ professional autonomy as stated in the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence [3].

In addition, the agreement stipulates that the Prefecture shall bear expenses for medical team formation, participation in drills, and for actual deployment, settlement of actual costs such as medical supplies carried, and financial aid if by any chance team members are injured, contract a disease, or die during medical relief efforts.

This arrangement is grounded in the basic concept that team members act as quasi public servants throughout all medical relief efforts. Moreover, a provision has been included indicating the entire agreement shall be reviewed every year, thereby preventing the agreement from becoming a dead letter.

Even before the agreement was signed with the Prefecture, I was an active participant in prefectural emergency drills conducted at Fukushima Airport in disaster scenarios, based on a disaster prevention agreement made directly between the airport and the Fukushima Medical Association.

The annual emergency drill was usually planned for early dawn on a weekday so as to not affect aircraft operations. To ensure that I made it on time from Iwaki, I would take two days to participate, staying at the nearby Bobata hot springs the day before. It was by some curious chance, in relation to radiation exposure medicine, that the inn I usually stayed at on those occasions was well known for its radon hot springs.

In Fukushima prefecture, the majority of hydro-, thermal, and nuclear power generation since the Meiji Restoration (1868) has been conducted under the control of TEPCO and supplied roughly a third of power consumed by the Tokyo metropolitan area.

Additionally, TEPCO also controls the water rights to Lake Inawashiro in the center of the prefecture, creating a special environment in which the prefectural government conducts river administration while the entire water system is under the control of TEPCO.

In other words, the entire prefecture is like a giant backyard for the Tokyo metropolitan area. Within the prefecture, the Hamadori region in particular functioned as one of the world’s leading nuclear energy stations,

having a total of 10 power-generating facilities: 6 reactors at TEPCO's Daiichi Nuclear Power Plant and 4 reactors at its Daini Nuclear Power Plant. After I took charge of emergency and disaster medicine at the Fukushima Medical Association, I had a place prepared for myself in a corner of the prefectural government's medical team stationed at the Fukushima Prefecture Offsite Center in Okuma Town and participated in annual emergency drills.

M6.9 earthquake off the Sanriku Coast: 6:39 November 15, 2005

At 6:46 a tsunami advisory was issued for central part of Hokkaido's Pacific coast and the Pacific coast of the Tohoku region (Iwate, Miyagi, and Fukushima prefectures). Tremors from 3 to 1 on the Japanese earthquake intensity scale of 1 to 7 were observed from Hokkaido to the Kanto region and the largest tsunami, at 0.5 meters, struck the city of Ofunato at 7:35.

This apparently harmless earthquake happened to occur on a morning for which a nuclear disaster prevention drill had been planned at Fukushima's Offsite Center.

Since April 2002, I have participated every time in the prefectural government's medical team during drills at the Offsite Center. On this day I had left Iwaki early and was heading to the center, but arrived a little late because of traffic congestion.

Meanwhile, the Offsite Center was waiting for reserve firefighters, fire corps volunteers and police officers, who had gone to inspect the coast and estuary barrages when the tsunami advisory was lifted at 8:38. I remember that the drill started about an hour late – a little after 9:00 – as a result.

The drill itself proceeded smoothly, but conversation in the center turned to concern that it would likely be hard to re-

spond, including the securing of personnel, in the event of a combined disaster in which a nuclear accident occurred at the same time as an earthquake-induced tsunami. Nevertheless, after completing the planned drill, this concern was not brought up in successive discussion. Consequentially, and unfortunately, the real meaning of this experience was not realized until after experiencing the Great East Japan Earthquake.

1st WMA Asian-Pacific Regional Conference: September 2006

In April 2006, I was elected as an executive board member of the JMA and here too took over emergency and disaster work, where it became one of my heavy duties to be involved in disaster responses for all of Japan.

Since then I promoted the dispatch and putting into practice of information by both national agencies and prefectural medical associations so that the idea behind of the above-mentioned Agreement Regarding Medical Relief During a Disaster signed between Fukushima Prefecture and the Fukushima Medical Association could be shared by all prefectural medical associations as a basic principle of the JMA.

At the same time, I repeatedly talked with the WMA as the JMA's international affairs representative and as the secretary general of the Confederation of Medical Associations of Asia and Oceania (CMAAO), which brought into shape the idea of holding a regional conference of the WMA.

The 1st WMA Asian-Pacific Regional Conference, held at the Hotel Chinzanso in Tokyo on September 10–11, addressed the two topics of earthquake and tsunami countermeasures and infectious disease under the theme of disaster preparedness and response.

The conference also discussed, under the title, "State of the Profession," means of increasing the autonomy of physicians and medical association activities, rooted in professional autonomy.

Other subjects also have significance today, but we narrowed the focus on earthquake and tsunami and looked at responses to the 2004 Indian Ocean earthquake and tsunami, which had earlier struck Indonesia. Discussion started with an unavoidable mechanism of the high earthquake and tsunami risk throughout the entire Asia and Oceania region, and widened to future preparedness and possible responses [4].

JMAT creation proposal: March 2010

Right away I asked that the JMA's Committee on Emergency and Disaster Medicine be composed not only of block representatives of prefectural medical associations and physicians who are specialists in emergency and disaster medicine, but also include the director of the Self-Defense Forces Central Hospital as well as observer participation by the Guidance of Medical Service Division in the Health Policy Bureau of the Ministry of Health, Labour and Welfare (MHLW), the Fire and Disaster Management Agency of the Ministry of Internal Affairs and Communications, and the Japan Coast Guard, plus the participation of Dr. Makoto Akashi, the Executive Director of the National Institute of Radiological Sciences in order to respond to all conceivable situations.

The committee as well as a subcommittee organized under Dr. Toshio Ido (Immediate Past president of Okayama Medical Association) added ex-post verification of experiences during the Great Hanshin-Awaji Earthquake of 1995, the Mid-Niigata Prefecture Earthquake of 2004, the Noto Hanto Earthquake of 2007, and the Niigataken Chuetsu-oki Earthquake of 2007.

This resulted in the committee proposing, on March 10, 2010 – one year before the Great East Japan Earthquake – the creation of the JMAT. A press conference was held the same day and the JMAT creation announced. The nationwide announcement of JMAT creation appeared on the JMA's newsletter the following day, by strange coincidence March 11 [5].

Response to the Great East Japan Earthquake

Support through cooperation in and outside Japan

The purpose of JMAT operations was to provide health support for the approximately 400,000 people who survived in a 150-km sphere in addition to the nearly 20,000 lives lost in the enormous damage of the Great East Japan Earthquake.

I will avoid saying much about this here, as details have been published in the Japanese Medical Association Journal and elsewhere [6, 7, 8, 9, 10].

However, the transport of medical supplies to the afflicted areas, which came about through the US military, the Japan Self-Defense Forces, and the good will of many people, was the pioneering figure of the US's Operation Tomodachi [11].

The JMA set up a disaster response headquarters on March 11, the first day of the Great East Japan Earthquake, and made a collective effort to respond around the clock with nearly 200 people, from officers to office staff.

The JMA aimed to create a system for JMAT operations that could meet changing needs by acting as a coordinator between prefectural medical associations afflicted by the disaster and those dispatching teams. As much as ¥1.9 billion (approx. USD 20million as of April 2013) donated

mainly by sympathizers in medical associations around the country was delivered immediately to afflicted medical institutions through medical associations in the affected areas.

Moreover, in addition to receiving reimbursement from the government for actual expenses of operations conducted under the umbrella of the JMAT and compensation as the an activity of quasi public servants, with the consent of the MHLW, the JMA started up its own accident insurance and established an insurance system in all operations.

The JMA negotiated with the National Police Agency and obtained emergency vehicle stickers that enabled teams to travel to the affected areas.

The JMA also made it possible for teams going on-site during the early phase to get free tickets on Japan Airlines and All Nippon Airways flights and to receive priority supplies of gasoline. Further, the JMA requested the Ministry of Land, Infrastructure, Transport and Tourism to reopen expressways running through the affected areas.

The JMA received support and assistance from many and a wide variety of people and organizations in and outside Japan, such as donations from outside Japan, including from the Taiwan Medical Association, and the stationing of Dr. Maya Arii of the Harvard Humanitarian Initiative at the JMA's office. And the various problems occurring before our eyes were dealt with, from health support for evacuation shelters to cooperation in dispatching autopsy teams, support in establishing temporary clinics, and support in reconstructing afflicted medical institutions.

Thanks to the well-intentioned efforts of medical personnel from throughout the country, JMAT operations reached a total of 1,398 teams on which 6,054 people par-

ticipated, including 2,145 physicians, by the end of operations on July 15, 2011.

Since then, the JMA has continued to be involved in support efforts, given the situation on the ground in the afflicted areas, which have not been able to recover completely from the tremendous damage. Thirty-four medical-related groups (18 organizations) as well as government-affiliated agencies launched the Survivors Health Support Liaison Council, for which the JMA serves as secretariat.

Efforts were switched over to JMAT II operations, which carry on medical support activities that are broader than disaster support. As of February 4, 2013, a total of 763 teams with 2,475 people, including 1,730 physicians, have been dispatched and are carrying on operations even now (Figs. 1, 2).

Efforts for better information sharing

The Japan Medical Association Research Institute, which is the JMA's think tank, also responded to the Great East Japan Earthquake with concerted efforts. These included field investigations in areas damaged by the tsunami, collection of data relating to JMAT operations, and consideration of the problem of compensation for loss relating to the nuclear accident [12, 13, 14, 15].

In order to prepare for potential complex disasters close to home, the JMA held, one year after the earthquake, a training course on JMAT activities in disaster medicine [16] (which will be certified for the JMA's continuing medical education credit) on March 10, 2012 and a symposium on health policy "Disaster Medicine and Medical Associations" the following day [17]. Since then, content has been added and enriched and made available on the JMA's website and other sources.

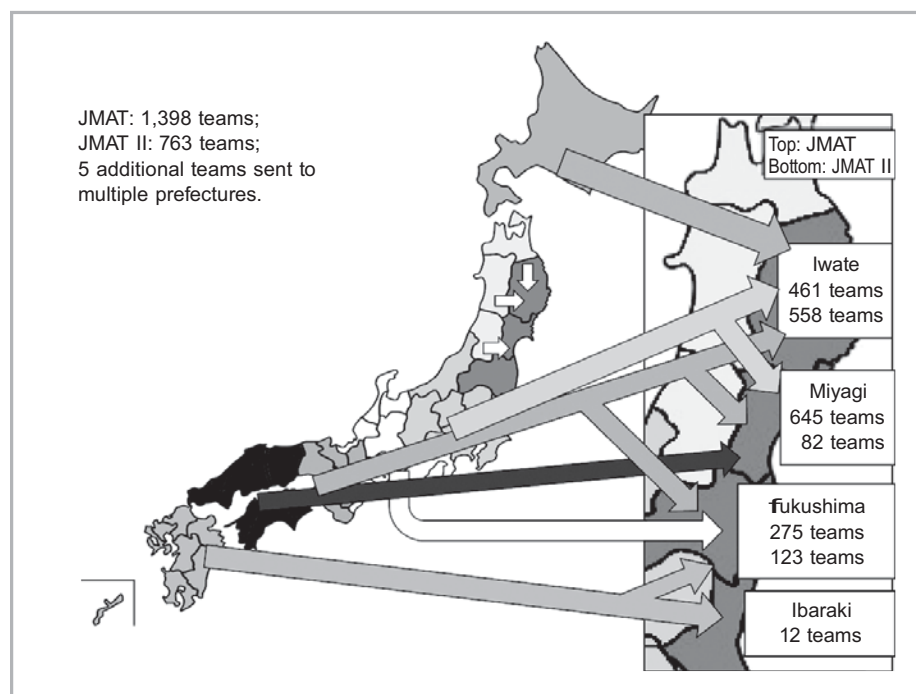


Figure 1. JMAT and JMAT II dispatches (updated as of February 4, 2013)

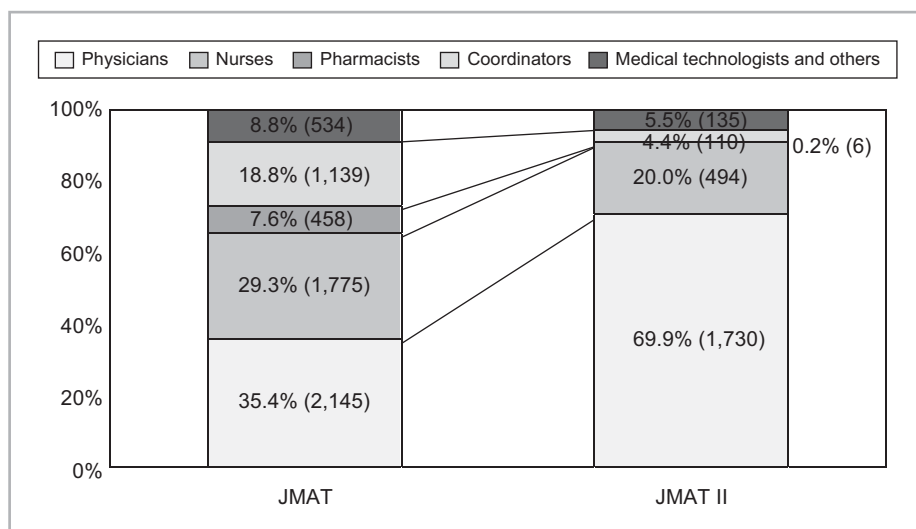


Figure 2. Breakdown by occupation of JMAT and JMAT II participants in the Great East Japan Earthquake (updated as of February 4, 2013). (Numbers of people are represented in parenthesis)

Based on reflections after the disaster of personnel in charge of information, it was agreed that combining multiple information media was realistic, as there is no single medium that can definitively cover many different events, and within that the need to share information became a common view.

That is why in 2012 the Liaison Council of Prefectural Medical Associations on Disaster Medicine conducted an emergency communications demonstration that attempted to link clinical records and evacuation shelter information during a disaster via cloud computing, assuming disaster scenarios such as an earthquake directly beneath the Tokyo Metropolitan area.

The demonstration used the Wideband InterNetworking engineering test and Demonstration Satellite (WINDS) called "KIZUNA" operated by the Japan Aerospace Exploration Agency (JAXA), with which Iwate Prefecture had past results, and also included simultaneous Internet transmission to prefectural medical associations. Based on the demonstration's good results, the JMA and JAXA signed an agreement on demonstration experiments using the satellite KIZUNA in disaster medical activities and held a press conference at the same time on January 30, 2013.

After the Great East Japan Earthquake

The problem of radiation exposure and radioactive contamination

According to Dr. Jose Luiz Gomes do Amaral, president of the WMA in 2012, it is difficult to avoid the fact that disasters of a certain level take on the aspect of a complex disaster in developed societies. It is also a fact that there is no place on Earth that could be called safe with absolute certainty [17]. The problem of radiation exposure and radioactive contamination resulting

from the Fukushima Daiichi Nuclear Power Plant accident following the Great East Japan Earthquake, in particular, emerged at an unprecedented scale. What is more, the spread of contamination brought about a major problem greatly exceeding the conventional administrative framework and predictions and raised widespread anxiety that still has not been brought under control.

Considering the truth of responses that were actually made, although a disaster response headquarters was set up in the Fukushima Prefecture government office during the Great East Japan Earthquake, the prefectural government was utterly negative regarding medical association participation and the building of a cooperative relationship. This is extremely difficult to comprehend, given the point of the already signed Agreement regarding Medical Relief during a Disaster and considering the lives and health support for citizens of the prefecture.

On October 22, 2008, the national government under the Taro Aso Administration conducted a nuclear disaster prevention drill with the scenario that the emergency cooling system failed after the usual reactor cooling system had failed at the Fukushima Daiichi Nuclear Power Plant, releasing radioactive material offsite.

On October 20 and 21, 2010, during the Naoto Kan Administration, disaster prevention drills were conducted with a similar scenario at the Hamaoka Nuclear Power Station. Ahead of the later, a comprehensive disaster prevention drill for the Iwaki region was held in the city of Iwaki in August 2010 with the scenario of a large tsunami triggered by a M7.7 earthquake (intensity 6 lower on the Japanese scale) off the Fukushima coast. Assuming that these kinds of drills were not made use of at all in the actual Great East Japan Earthquake of March 11, 2011, there is a need to create a system for improving skills through effective

drills and ex-post verification, beyond the framework of routine work by the government alone.

International Physicians for the Prevention of Nuclear War World Congress: August 2012

On August 26, 2012, the International Physicians for the Prevention of Nuclear War (IPPNW) held its 20th World Congress at the International Conference Center Hiroshima. I was invited to the congress and gave a lecture on "JMAT Operations in Response to the Great East Japan Earthquake and the Fukushima Nuclear Accident.

"This was an opportunity to present the picture that JMAT activities were the realization of a vision to provide continuous support from the acute phase, when teams work in cooperation with the Disaster Medical Assistance Team (DMAT), until medical care in the afflicted areas has recovered, and convey the fact that the nationwide call for support activities for medical care at first-aid stations for evacuees and for local medical institutions turned into an operation that was Japan's largest medical support effort.

Additionally, I reported on activities on the ground in the disaster-stricken area of Fukushima Daiichi Nuclear Power Plant accident, including original information gathering and disclosure. While there was a tumultuous atmosphere at the venue just at that time, with remarks flying about from an anti-nuclear movement, the program was run with a clear division between determined opposition to nuclear weapons, which are an inhumane use of nuclear power, and discussion of the peaceful use of nuclear power.

I stressed that my report was based on experiences on the ground and also that we physicians, who practice the peaceful use of nuclear power in clinical care, always strive

in future to minimize the risks while maximizing the benefits to patients of radiodiagnosis and during treatment. While there were opinions that completely deny the application of nuclear power and calls for practical information disclosure on the Fukushima Daiichi Nuclear Power Plant accident, those kinds of remarks disappeared as the presentation proceeded.

Conclusions

Need for comprehensive health policy and health support

My heart truly aches at the fact that today, nearly two years since the Great East Japan Earthquake, the communities destroyed by the earthquake and tsunami have not been restored, let alone revived. Still more, the district where the nuclear power plant is located and nearby areas from which whole communities were forced to evacuate due to the nuclear accident in Fukushima prefecture and the subsequent radioactive contamination, have only called for decontamination; the disposal of rubble has hardly even begun, to say nothing of the building of new communities. In such a situation, only the delay in responding to the people of the areas that accepted nuclear power plants in compliance with national policy stands out.

Nuclear power stations, regardless of whether they decommission their reactors or continue operations, need integrated policy making covering everything from fuel refinement through use to final disposal, a scientific basis to underpin those policies, and policy agreement that will carry them out. Considering the Fukushima nuclear accident, which saw explosions and resulted in a major disaster even though the plant was under an emergency shutdown, work processes that are assured to be safe and health support for the workers engaged in that work will most likely be necessities for more than a few decades.

Further, there is a pressing need for comprehensive policy and health support for evacuees from radioactive contamination in addition to health support for evacuees from natural disaster.

Above all, active national involvement is expected in the creation of a long-term support system for young people – especially children – with the elimination of trivialized frameworks that are limited to Fukushima prefecture and the inclusion of evacuees who have scattered around the country and residents of areas with relatively high radioactive contamination that spread from the Tohoku to the Kanto region. I also think that cordial and considerate accountability must continue to be fulfilled for the many members of the general public that cannot get rid of growing anxiety caused by looking at the current situation.

Peaceful use of nuclear power

On my way back from the UNESCO 8th International Conference on Bioethics Education held in Tiberias, Israel on September 2-5, 2012, I had the opportunity to stop by the Israel Academy of Sciences and Humanities and stand face-to-face with the statue of Einstein in the garden. When looking back at the footsteps of Einstein, I am certain that humanity, which obtained new knowledge and a source of energy in the 20th Century, has an obligation and a role to raise its voice in strong opposition to the misuse of science that harmed so many people with atomic bombs and has an adverse effects on the global environment.

On the other hand, however, I reaffirmed my belief that Japan, precisely because it suffered the crippling damage of atomic bombs and experienced the Fukushima nuclear accident, should not abandon its world-leading role in contributing to the field of ensuring the peaceful use and safety of nuclear power based on humanity's wisdom. I believe that because human civili-

zation, which established cultural life using Prometheus' fire, set sail over the open seas, made possible safe transport through the skies, and even bent its steps into outer space, accomplished today's development by sincerely facing unforeseen accidents at every point in time and being cautious about the abuse of new technologies and power.

Lastly, I offer heartfelt condolences for the people who lost their lives in the Great East Japan Earthquake and my sympathies to the survivors. I should also like to express my respect and appreciation to all the medical personnel who were engaged intently in medical operations in the afflicted areas.

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Air Pollution: a New Concern. Polycyclic Aromatic Hydrocarbon Endocrine Disrupting Chemicals in Urban Outdoor Air and Children's Health

A Brief Public Health Overview of Recent Literature



Peter Orris

Polycyclic Aromatic Hydrocarbons

Endocrine disruptors are chemicals that interfere with hormone signaling systems in the human body, potentially affecting reproductive, metabolic, nervous, and immune system functions (1,2). Endocrine disrupting chemicals (EDCs), natural or synthetic, can be found in many different environmental media: food, water, soil, and air. Most identified EDCs are produced by indoor sources, and therefore indoor air concentrations may better predict a person's exposure to EDCs than outdoor air concentrations (3). However, outdoor air is a significant source of exposure to one group of EDCs, the Polycyclic Aromatic Hydrocarbons (PAHs). The health consequences of these exposures for children include neurodevelopmental disruption, DNA damage leading to increased cancer risk, and epigen-



Erica Burt

etic changes that are potentially the basis for other diseases, including asthma.

What are PAHs?

PAHs are a family of chemicals formed as a by-product of incomplete combustion. PAHs are created when organic material combusts, such as when fuel is burned, food is cooked, or cigarettes are smoked. Significant outdoor urban sources are coal-fired power plants, incinerators, furnaces in residential buildings, and the internal combustion engines of automobiles, trucks, buses, and trains. PAHs can be found in gaseous form or adsorbed onto particulate matter, with the tendency of each PAH to do so depending on its molecular weight.

The PAHs which are suspected endocrine disruptors based on animal or human

studies include: acenaphthylene, benzo (a) pyrene, benzo (b) fluoranthene, benzo (k) fluoranthene, 3-methylcholanthrene, chrysene, dibenzo (a,h) anthracene, indeno (1,2,3-cd) pyrene, naphthalene, phenanthrene (1,4,5).

Health Effects of Prenatal and Childhood Exposures to PAHs

Exposure to PAHs is a concern throughout an individual's life; however, gestational and childhood exposures have been the focus of several studies, and have revealed several important health consequences in this population. Perera et al. have studied prenatal PAH exposure and its effects on cognitive and behavioral development for a cohort of children in New York City.

They found that prenatal exposure to PAHs above the median of 2.26 ng/m³ was positively associated with developmental delay at three years, reduced IQ at five years, and symptoms of anxiety/depression and attention problems at seven years (6–9). A similar study in Tongliang, China, did not find an independent association between PAH exposure and impaired IQ, but found an inverse correlation between PAH-DNA adducts in cord blood, a biomarker of prenatal exposure to PAHs, and motor, language, and overall development in children at two years old (10,11).

Studies in Krakow, Poland, similarly found a decrease in IQ for 5 year olds exposed in utero to average air concentrations of PAHs above the median of 17.96 ng/m³ (12). Prenatal PAH exposures in Krakow, New York

City, and Tongliang were also associated with decreased fetal growth: birthweight, length, and/or head circumference in Polish-Caucasian, African-American, and Chinese populations (11,13,14). Studies in the Czech Republic support these associations (15,16).

Human evidence also suggests that despite an approximate 10-fold lower dose of PAHs received by a fetus relative to the mother, the amount of carcinogenic DNA damage caused by the exposure is greater to the fetus (17). This damage is a covalent bond between the PAH and DNA, known as a DNA-adduct, and is a known biomarker for cancer risk. The exact relationship between this carcinogenic damage and carcinogenesis is not clear in humans, but animal studies clearly demonstrate a relationship between in-utero PAH-induced DNA damage and cancer of the liver, lung, nervous system, and lymphatic system of the offspring (17–19).

It is hypothesized that not only is a child's DNA affected by in-utero exposure to PAHs, but his/her gene expression may also be altered. Such changes are associated with cancer and other diseases, and may have transgenerational effects. Evidence for these epigenetic changes have come through studies looking at the methylation and demethylation by PAHs of cord-blood cells (20,21).

One health end-point suspected to be a result of such PAH-induced epigenetic changes is childhood asthma. Asthma is one the most common chronic health problems facing children today, with approximately 14% of 13–14 year olds worldwide experiencing symptoms in the last year (22, 23). PAHs may help to initiate, exacerbate, and hinder treatment of asthma. Initiation of asthma could occur in several ways, one of which is alteration of epigenetics contributing to asthma biomarkers.

A case control study in Saudi Arabia found significant associations between serum

levels of PAHs and biomarkers of asthma (24). Another possible mechanism for initiation of asthma by PAHs, which may also contribute to continued asthma symptoms, is through increasing a child's sensitivity to certain allergens (25,26). There is some evidence for exacerbation of asthma symptoms by PAHs; a study in California of the United States showed a mild trend of increased wheeze in 6–11 year old children with asthma after ambient exposure to PAHs increased, but other studies have not seen an association (26,27). Another New York study showed respiratory symptoms and probable asthma are more prevalent among children exposed to PAHs and environmental tobacco smoke in early childhood (28). Relatedly, prenatal exposures to PAHs are suspected to increase the occurrence and duration of respiratory symptoms (29). Furthermore, in vitro evidence suggests that exposure to PAHs may decrease the responsiveness of lung tissue to asthma medication (30).

Prevention

While this paper has not highlighted the sources of airborne PAHs in the indoor environment, reduction of these is often easier than tackling the job out of doors. Proper venting or reduction of the use of organic fuel use for cooking and heat within living quarters is an important intervention in much of the world where the indoor smoke pollution often rivals that generated communally. The elimination of cigarette smoking by adult family members is well known to reduce the incidence of both asthma and cancer in children.

Minimizing exposure to PAHs outdoors in urban areas is of great importance despite its difficulty. The generation of energy utilizing fossil fuels and the incineration of wastes are major sources of PAHs that are able to be eliminated through sustainable urban planning. PAH concentrations emanating from major roadways train tracks, or water

transportation routes are again susceptible to reduction through urban planning that distance housing units and accommodates the prevailing winds.

Factories and homes themselves are major sources of outdoor PAHs when organic heating fuel is used. Reduction or elimination of this ubiquitous exposure is reachable only through the substitution of wind, water, or solar energy generators. Such a substitution has been demonstrated to be adequate for the world's energy needs through 2030 and at approximately the same cost as allocated today (32). However, there may be some relevant policy solutions, and here is a list of ideas for further exploration and research:

The immediate effect of such an intervention is documented in Tongliang, China, where the closing of a coal fired power plant reduced the health effects associated with prenatal PAH exposure in the community (32).

Conclusion

Through the disruption of the endocrine system and DNA damage, PAH exposure from combustion sources such as power plants, vehicles, and home-heating and cooking systems can cause negative health consequences to the most vulnerable in our community, our children. PAH air pollution is associated with developmental delay, decreases in IQ, behavioral problems, increased cancer risk, and asthma. While indoor exposures can be minimized through family choices, outdoor exposures cannot be reduced with such ease. Community, state, and national policy changes are necessary to reduce community air pollution exposures to this class of compounds.

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Defeating Resistant Bacteria with Knowledge



Marie Wedin

Antibiotics is a foundation for the provision of modern health care but we have to develop strategies to better manage this great discovery. In 2009 the Standing Committee of European Doctors (CPME) adopted a resolution addressing the need to invest in research of finding not only new antibiotics, but also new ways of combining old antibiotics. In the light of the increasing problems with antimicrobial resistance another resolution was adopted in April 2013 encouraging member states to develop strategies for a sustainable use of antibiotics.

Even though Sweden is one of the countries with the lowest consumption of antibiotics Swedes run the increasing risk of developing resistant bacteria. Therefore, rational use of antibiotics is of paramount importance. One of the problems is the big regional differences in prescription rates as there is a lower rate in rural areas and a higher rate in urban areas. In Stockholm, for example, the rate is about 410 recipes for antibiotics per 1000 inhabitants while in a rural area, such as Västerbotten, the rate is about 290. The aim is to decrease the national average rate to 250.

Variation in the prescription rates between countries is substantial. The European Centre for Disease Prevention and Control (ECDC) has revealed that the consumption of antibiotics varies threefold between the countries consuming most compared to those consuming least.

In Sweden we find a similar pattern in the variation of consumption in dental care. In Skåne regional council, where the consumption is the highest, 35 out of 1000 inhabitants received a prescription of antibiotics by a dentist between July 2011 and July 2012. Stockholm had about the same rate while in Västerbotten the rate was only 15.

In animal care and veterinary care in Sweden the consumption has declined from about 20 tons in 1996 to 12 tons in 2012. Antibiotics of the right sort should be used in the right doses and when there is a need in order to decrease the pain of the animal.

Since 2006 antibiotics may not be used in the EU to increase the growth of the animal. It may only be used to treat bacterial diseases. The sale of antibiotics varies a lot between the EU/EEA-countries. For example, the use of antibiotics for animals is 269 milligram per kilo in Hungary compared to 8 milligram in Iceland.

In 2010 about 90% of the sale of antibiotics in the EU was intended for the medication of animals. In Sweden the corresponding share was only 10 %. In many countries more antibiotics are prescribed to animals than to humans which is the case, for example, in Denmark. In countries with extensive use of antibiotics the problems with antimicrobial resistance is rather a rule than an exception.

The key problem concerns the issue of prescriptions. A survey by the CPME earlier this year shows that in several European countries

there is a lack of guidelines for the prescription of antibiotics in primary health care.

Only doctors, dentists and veterinarians are allowed to prescribe antibiotics. It is of major importance that the right to prescribe is not extended to other professions. In livestock farming it is of great importance that a veterinarian makes an examination before antibiotics is used and that antibiotics should be used on a case by case basis.

Doctors, dentists and veterinarians should not be allowed to sell antibiotics, a common practice in some countries. To prescribe antibiotics for earning money from their sale is a harmful incentive when the goal is to decrease the consumption.

The patient's right to choose the doctor or the dentist or the animal breeder's right to choose the veterinarian could also lead to an increase in the prescription of antibiotics. One usually tries to have a good relationship with the patient or the animal breeder. Informed patients and animal breeders are crucial in order for the professionals to have a good dialogue with them regarding the guidelines for a prudent use of antibiotics.

In the basic medical training and the continuing professional development of doctors, dentists and veterinarians there should be more focus on antibiotics, antimicrobial resistance, and prevention of the spread of diseases.

In the EU open labour market a lot of doctors, dentists and veterinarians move across the borders. They have different medical backgrounds and experiences when it comes to antibiotics. As a tool for ensuring qualitative use of antibiotics in Sweden we have proposed a requirement for continuing professional development of doctors, dentist and veterinarians. Higher competence is required to defeat resistance!

Marie Wedin,
President of the Swedish Medical Association

Turkmenistan on the Road to Democracy



Peteris Apinis

On the Eastern shore of the Caspian Sea, between Uzbekistan, Afghanistan and Iran develops the great nation of Turkmenistan, wisely led by Gurbanguly Berdimuhamedow.

I visited Turkmenistan accepting the invitation from the Minister of Health. There are no non-governmental organisations in Turkmenistan, however, President Gurbanguly Berdimuhamedow has recently announced that they will be allowed and it seems the first one to be established is the dentists association with Gurbanguly Berdimuhamedow as honorary president. The Minister of Health hopes that in the nearest future there will be a medical association, a medical journal and post-graduate education.

The Great President of the State Gurbanguly Berdimuhamedow, a dentist by profession, was elected president of the state six years ago when Turkmenistan was in mourning because of the death of the Father of the Nation, President for Life Saparmurat Niyazov (Türkmenbaşy). The for-

mer Minister of Health and Prime Minister Berdimuhamedow had also served as the Dean of Medical University and he was obliged to follow the traditions and rhetoric founded by his predecessor. However, there is a difference – when Niyazov was still alive, his gilded monuments were erected all around the country, it does not take place now and the Constitution stipulates no presidency for life.

I was invited to visit a conference and an exhibition. Almost any stand in the exhibition, including those of *Siemens A.G.* or *Bayer*, was decorated with a large-scale portrait of the Great President of the State Gurbanguly Berdimuhamedow.

More than sixty companies were represented in the exhibition. As it turned out later, there is a portrait of the President in a doctor's white coat in every doctor's office. The July page of monthly calendars reveals the same portrait and I have no reason to think that other pages display different photos.

It was a surprise to see that after the opening speech, delivered by the Deputy Prime Minister at 11 a.m., at 12 p.m. thousands of doctors entered the hall, most of them middle-aged ladies wearing traditional national gowns and bright scarves around their heads. It is almost impossible to inveigle doctors when an exhibition dominated by pharmacy companies takes place in Europe.

All presentations in the conference started and finished with expressions of thanks to the strategic leader, the President of the State. It was widely reported on TV and in newspapers accentuating the thanks not medical aspects of the reports. Along with the exhibition a new six-storey dental centre in the form of a molar tooth was opened. The centre can be reached by a hundred metres long suspension bridge that crosses

the yard. The premises, spacious lobbies and conference halls, are decorated with Turkmen carpets and TV sets.

I had an opportunity to visit the neighbouring health centres. There are at least 15 newly-built centres-hospitals. The first one – cardiological – was built in 1998 by the previous President and its six storeys host 27 beds; it was built for the government needs. Today the President acts as a trustee for a new block of the centre while the cardiology diagnostic is available to everybody.

There is already a 500 beds Maternity Health Centre built, but there is a 600 beds centre planned to be constructed next year (there is also Children Hospital and Maternity Hospital). So it seems that the government is demonstrating its attitude to health issues by enhancing the construction work. Turkmenistan counts 5 million inhabitants while 1.2 million live in Ashgabat.

As it is expensive to transport patients across the deserts, similar centres are being built in all major cities. The principle of reconstruction is to start new buildings after the old ones have been destroyed. The new Emergency Hospital with 400 beds is going to be opened this year, but a significantly bigger Red Cross Hospital is already functioning.

As far as I know, there is no other country in the world with such a ratio of hospital beds per capita. Technologies used are mighty, modern, mostly non-compatible and not effectively used.

The colleagues are open to conversations and genuinely interested in modern medicine, most of them have graduated from Moscow or Minsk University. The white and spacious building of Ashgabat Medical University fascinates with its enormous gilded domes. I am not too modest and ask about the colleagues' personal attitude to their President of the State. Many of them had met him during his doctor's, Dean's or

World Medical Journal



hospital manager's career and remember him being hardworking and friendly, however, demanding. His two theses were supervised by Academician Leontyev (former President of Russian Medical Association and member of WMA) and defended in Moscow.

The foreign language skills of Turkmen doctors are surprisingly good, they speak English, Russian and German. It is contrasting greatly with police officers one can meet on every corner and next to any building, as they do not speak any foreign language.

There are numerous sanatoriums built by the state. To maintain their activities, at least one third of the nation has to visit them yearly and the expenses are covered by the employer (usually a ministry or department). Health is promoted by applying mud, salts and herbs. The method has a proper basis as Academician, Dr.med. and Dr.oec. Gurbanguly Berdimuhamedow has just finished his monograph "Medicative Herbs of Turkmenistan" in three volumes. It has already been translated into English, Russian and six other languages. The directions of health care in the country are determined by the President's monograph "Scientific Principles of Health Care in Turkmenistan".

While the President was Minister of Health, a sixteen storey building for the Ministry of Health was constructed. A really significant part of the state budget (which is not publicized in Turkmenistan) is spent on health issues; doctors are supplied with apartments in a special area close to the Ministry and newly built health centres.

The state health care strategy exceeds extensive building of huge centres and quite chaotic purchases of new technologies. The Great President is also an outstanding sportsman, who personally supports sports and healthy lifestyle. Women in Turkmenistan never smoke or drink alcohol, which

is based on tradition, Islamic laws and the President's instructions. However, they do not do any sports. Either it is the new times or tradition to be blamed, but most women are obviously overweight.

In contrast to other Muslim countries, men in Turkmenistan consume alcohol a lot, which is heritage from the USSR. It is declared that men practice martial arts, horse-riding and football.

Eight new sports stadiums and several ice halls have been built in Ashgabat. As the city is preparing to host the Asian Olympic Games or Asiade in 2017, a new sports stadium with the capacity of 100,000 seats and many other sports premises are under construction. However, one cannot see anybody running or cycling in the city.

There is a special 8.6 km long Health Track, particularly favoured by the President, built in the vicinity of the city; initially you have to climb about 350 metres and the track leads you over the hilltops, then it goes down near town Bagira where a mighty fortress and a temple were erected before Christ. From time to time it was invaded by Alexander of Macedonia, Persian sultans or just Kazakh or Mongolian warriors.

The President is said to walk the track once a month together with all his ministers. The track is covered by a concrete layer; its width is about 1.5 metres, both sides are secured with metallic rails, stairs installed in steeper parts and nice gazebos on hilltops. At the very top of the hill there is a landing field for helicopters in case someone gets faint after ascending the hill. The track is a workplace for several dozens of Turkmen – at least four militia officers guard both ends of it, a group of men work on maintenance compacting concrete, while women carry water from big tanks in buckets.

There are cedars, thujas and silvery pines planted on the hill that are taken care of by gardeners. Actually, I did not meet any

health addicts on the track. It could be because even at 42° Celsius no water is supposed to be supplied on the whole length of 8.6 km.

The main natural resource of Turkmenistan is gas and oil. The economy of the state is based on gas fields that rank the 4th largest in the world. Pipelines transport the gas to the whole world through Russia and Iran.

Every inhabitant possessing a car is entitled to 1.5 tons of petrol a year for free while petrol costs about 25 US cents per litre. Flat rent and public utilities billing is quite symbolic; for a spacious flat it makes about 10 USD per month. Gas is free and heating during winter is free as well. Taxes on income make about 10%; however, mostly for foreigners.

The capital city Ashgabat makes you feel surprised – the construction boom is more impressive than anywhere in the world. Ministry buildings, blocks of flats, universities, schools, factories – all kinds of buildings are being erected everywhere. The streets are as smooth as glass with at least three lanes in each direction.

Actually, there is a new twelve to sixteen storey white marble city standing next to the old one. Architects are French, construction managers and supervisors are Turkish while the buildings resemble the classicism of the 20th century of America in the thirties and Russia of the fifties. There are thousands of snow-white buildings with stained glass windows illuminated at night; at least ten impressive obelisks glorifying independence, neutrality, heroism of ancient Turkmen, the former President Türkmenbaşy Niyazov etc.

The fountains are illuminated at night-time as well. The ever biggest flag is hoisted at the museum building the exposition of which displays the Turkmen nation as one of the largest and most significant in the world.

The city itself is fascinating. If there are no construction works going on, new trees are planted (mostly pines and cedars); each tree gets an individual water supply pipe.

In twenty years Ashgabat will be green and surrounded by forests.

Our hotel is situated on the main road, the other three corners are occupied by the President's Palace, the Ministry and Academy of Defence and the University. Thus, the

priorities of the former President are clearly seen. Every country and nation has its own path to follow. Turkmenistan is aiming at becoming the tiger of Central Asia, mostly through construction and pomposity. However, no one could deny that a great deal of profit from the national land deposits returns to its people.

The President of the State is a doctor and his priority is people's health, the civil service although poorly educated does their

best to implement this priority. Doctors are trained in-service in France and Germany, knowledgeable professionals come to Turkmenistan to perform model operations, new directions in medicine are being developed. I believe that the Medical Association of Turkmenistan will be founded this year.

*Dr. Pēteris Apinis,
Editor-in-Chief of World Medical Journal,
President of Latvian Medical Association*

Helping Put Self-care Center Stage with Patients and Policy-Makers in Combating 21st Century Killer Diseases

Today, Non-Communicable Diseases (NCDs) – cancer, diabetes, chronic respiratory and cardiovascular diseases lead to 63% of annual deaths worldwide. They are recognized as a global killer and major health challenge. They affect individuals as well as society with an economic burden estimated to reach \$30 trillion over the next 20 years. The situation in low- and middle-income countries is no different in this regard; according to WHO data, 80% of NCDs occur in low- and middle-income countries. Part of the solution lies in the fact that NCDs are preventable to a large extent through better *self-care* as up to 80% of heart disease, stroke and type-2 diabetes and over a third of cancers could be prevented.

Self-care is a holistic and very powerful concept well known to doctors and other health practitioners. It involves people making healthy lifestyle choices ranging from regular exercise, healthy eating, good hygiene, avoiding risky behavior such as smoking, but also getting vaccinated, using sunscreen and the rational use of self-care products, services and medicines. This should go hand in hand with improving health knowledge and becoming more aware of physical and mental conditions. If practiced 24/7, self-



Zhenyu Guo

care makes a huge difference to wellbeing and longer life expectancy.

Although there has been some progress in recognizing the crucial role of self-care in the prevention of NCDs, it is still not sufficiently appreciated by the general public globally, to make a tangible difference. Internationally, 1 in 3 people smokes while tobacco is the single greatest cause of preventable deaths in the world today, killing



David Webber

more than 5 million people a year – more than HIV/AIDS, TB and malaria combined.

Part of the problem is that self-care is also not seen as integral part of effective and cost-efficient health care systems, which are currently oriented to disease treatment. Prevention is understood mainly in the context of disease and not encouragement of 'wellness'. We need to look on a global and na-

tional level to reform health systems to shift from treating the citizens as passive victims of diseases to active shapers of their own well-being. We should support behavioural change by creating self-care friendly policies, also outside current health systems – from town planning, through to transport and education. This will not only help to save lives but also to reduce the burden on healthcare systems.

Exchanging and promoting best practices among different countries should be a part of the way forward as well. We already see some optimistic tendencies. Initiatives in support of self-care are taking place around the world. In 2011 the International Self-Care movement, which celebrates 24 July as International Self-Care Day to remind us all of the benefits of self-care, was launched in China and has since spread to Vietnam, Indonesia, Myanmar, and Nigeria. Interest-

ing activities are also taking place in Australia, the United States and in the United Kingdom.

As the challenge is global, the International Self-Care movement is calling on UN to recognize International Self-Care Day on 24 July each year. This could largely help to raise awareness and encourage people to be active participants in their own self-care and also motivate governments to create self-care friendly policies.

In the meantime, doctors and health practitioners have a key role to play in helping their patients understand the need to take responsibility for their wellness. Patients should have a right to health but they also have a responsibility to play their part in it and help avoid becoming a burden to families and society. International Self-Care Day can support health practitioners and

reinforce the message that Self-Care is not difficult.

We invite doctors, nurses and other health practitioners to join the self-care movement by passing on the word to their patients. Combining our efforts, we can not only support a grass roots movement and we can encourage policymakers to turn self-care into an integral part of a new collective compact for managing health, which will help achieve healthier and more productive societies and focus public healthcare budgets in areas where there is the greatest need.

*Dr. Zhenyu Guo, Chairman,
International Self-Care Foundation, initiator
of the first Self-Care Day in China in 2012*

*Dr. David Webber, founding director
International Self-Care Foundation*

IFMSA: Striving Toward an Future that Medical Students Want

IFMSA has been at the forefront of cultural exchange, building friendships, and health action in young aspiring doctors for over

60 years. More than five hundred medical students from around the world, representing collectively as a Federation more than



a 100 nations, gathered at the 62nd General Assembly of the International Federation of Medical Students' Associations (IFMSA), August Meeting in Santiago, Chile to strive toward making a difference in the world. However, this General Assembly was a defining one in IFMSA history as IFMSA has taken milestone steps towards creating a new birth for a Federation, in hopes of creating a Federation that has greater reach into improving the health and well-being of communities around the world.

In this past year, IFMSA has been prioritizing its global advocacy in several key areas, but not limited to: Universal Health Coverage, Social Determinants of Health with a focus on Sustainable Development, Climate Change, Open Access to Essential Medicines and Research, Human Resources for Health and Post-2015 Development Agenda. The Federation has represented the emerging voice of future doctors and actively participated in more than fifty global and regional meetings – not only highlight-

ing the valuable role that young people can have, but demonstrating that young people are leading the innovative drive for social change. For instance, IFMSA hosted the first Pre-World Health Assembly (WHA) workshop for Youth on Global Health Diplomacy – where the Federation brought together more than 40 young health leaders from over 25 countries, six different disciplines to create joint strategy for the world health assembly on health issues that are important to young people. As a result of this multi-disciplinary and strategic collaboration, IFMSA at the WHA66 has had significant increase in meaningful engagement with member states and stakeholders. Moreover, IFMSA held its first-youth hosted side-event at the WHA66 on Investing in Girl's Health, which was co-hosted by the World Medical Association, Norad and UNFPA.

As the global community strives to set the next global agenda on development and health, medical students, as future doctors and health leaders of the world, aspire for creating an IFMSA that has limitless opportunities, so they can achieve more for

their communities. IFMSA at the 62nd General Assembly, a meeting devoted to IFMSA's Reform process, opened with an announcement of a collaboration agreement between IFMSA-PAHO by our key note speaker, the director of PAHO, the WHO regional office for the Americas – Dr. Carissa Etienne – that “it cannot be business as usual” and to “strive for change.” IFMSA President, Roopa Dhatt echoed to IFMSA members to “let us ensure that the Federation that emerges from this reform process to create the IFMSA we want and let us together be the generation that, with dynamism and optimism, with unity amidst diversity, will create a better future for the world's medical students to reach our communities for better health.”

During the assembly students, while participants focused on capacity building, project brainstorming, training and advocacy, they also explored greater questions of transparency, institutional strengthening, financial management, sustainability, and operations to further to the Federation. Additionally, it was all historic in that the World Health

Student Alliance, an agreement between International Pharmaceutical Students' Federation (IPSF) and International Association of Dental Students (IADS) was formalized – creating an alliance between medical, pharmacy and dental students for advocacy and collaboration. At the conclusion, the general assembly, with consensus, adopted the Santiago Resolution on Strengthening IFMSA – a commitment of the Federation to focus on addressing the needs of the Federation to create an IFMSA that the members want.

The world had its eyes on this General Assembly, and more than 100 national members organizations have been awaiting the conclusions that were accomplished in Chile. It was amazing to see how all delegates, from all regions of the world, regardless of cultural background, came together to work on institutional change, to take this dream and strive to create an IFMSA a more sustainable, visionary Federation.

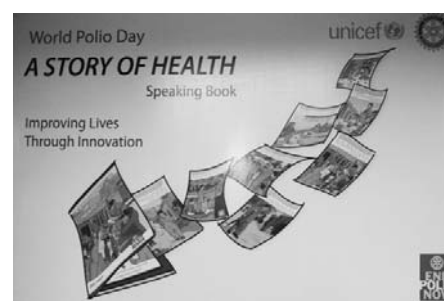
*IFMSA President
Roopa Dhatt 2012/13*

Rotary and UNICEF Launch a Speaking Book to Prevent the Spread of Polio on World Polio Day

Rotary International and UNICEF Pakistan, partners in the Global Polio Eradication Initiative since 1988, launched a Speaking Book titled “A Story of Health” to mark World Polio Day on October 25th. “A Story of Health” or Sehat ki Kehani in Urdu is an educational tool that enables community workers to inform men, women, children on the importance of sanitation, hygiene, and vaccination in preventing the spread of polio. The Speaking Book has been developed for the Pushtun speaking communities across Pakistan.

The launch ceremony, held at Indus Valley School of Art & Architecture, had as Master of Ceremonies, Zubair Anwar Bawany, UNICEF Pakistan's Lead for CSR, Corporate Engagement & Partnerships. Speakers included prominent guests like the Senior Minister for Education, Sindh Mr. Nisar Ahmed Khuhro, who applauded Rotary and UNICEF's initiatives and stressed the need for more of this type of education as key in polio eradication.

The District Governor, Dr. Pir Syed Ibrahim Shah, gave a regional perspective on



having no polio cases in Balochistan since last year versus having three in Sindh. He urged Rotarians to renew efforts to eradi-



cate polio from Pakistan just as they have been instrumental in polio eradication worldwide, particularly taking the lead from efforts in Manila, Philippines which were later expanded to a global initiative.

Dr. Andro Shilakadze, Chief Field Office, UNICEF Sindh, thanked Rotary for their

collaboration on the Speaking Book, saying that UNICEF is proud to be part of this innovative initiative and particularly pleased the launch involved school children. He offered UNICEF's continued support to eradicate polio and educate Pakistani children, commending Pakistanis for their resilience and commitment to education.

The National Chair, Polio Plus Committee, Aziz Memon, discussed the global collaboration effort among partners throughout the development and production of the Speaking Book. He described how the Speaking Book was first pioneered by a South Carolina Rotarian, then sponsored by Rotary International, designed in South Africa, written, illustrated, voiced over in Pakistan, and finally printed in China. The National Chair also pointed out that literacy is the first step towards polio eradication, mentioning Sri Lanka, with 100% literacy level, completely eradicating polio 20 years ago, and other nations with high literacy levels having similar success.

Following the speeches, the National Chair officially launched the Speaking Book and presented it to the Chief Guest and Dr. Altaf Bosan, who then read a few pages from A Story of Health to the children huddled around him in the garden, listening attentively. All of the children from the local school were given polio mobilization items such as pencils, badges, plastic mugs, and books.

The Speaking Books team is thrilled and encouraged by the phenomenal collaboration between Speaking Books, Rotary International, and UNICEF. We understand and promote the power of education in enabling people to live healthier and more productive lives. We see this Speaking Book as another incredible initiative to help improve lives. We're proud to be a part of this effort and look forward to continuing the work to wipe out polio around the world.

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News from the CPME: Up-date on policy developments in the European Union

The Standing Committee of European Doctors (CPME) represents the National Medical Associations of 32 countries in Europe. We are 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 leading a tender on Continuous Professional Development

For this reason, the CPME has recently applied to and won a call for tender issued by the European Commission, concerning the review and mapping of continuous professional development (CPD) and lifelong learning for health professionals in the EU and the EFTA/EEA countries. The final result of the study aims to explore the existing evidence base on CPD practices and identify emerging trends to provide a more comprehensive European overview.

The active participation of every member represented by the CPME and experts in health policy will be fundamental to collect data and information and have a better picture of the situation on CPD in Europe. Another important achievement is the provision of greater transparency and the improvement of mutual understanding of CPD systems and practices in the EU. The CPME, as leader of a Consortium composed of European Council of Dentists (CED), European Federation of Nurses (EFN), European Midwives Association (EMA), European Public Health Alliance (EPHA) and European Group of Pharmacists (PGEU), will be involved in this project for 12 months.

Ethics committees and informed consent under serious threats

The European Union is currently legislating on two major pieces of legislation: the General Data Protection Regulation (2012/0011 (COD)) which aims at securing the processing, storage and exchanges of personal data at a European level – including health and medical data; and the Clinical Trials Regulation (2012/0192 (COD)) which is meant to facilitate the conduct of research and foster the development of medicines in Europe.

CPME has been actively monitoring the development of negotiations and fueled the debates with the views of the medical profession. Both draft regulations have been adopted by the European Parliament, now the next step is for the Parliament to reach agreement with the Council – representing the 28 EU Member States. The objective is for these regulations to be formally adopted in the first half of 2014.

However, even if the legislative process is not over yet, CPME is extremely worried about the orientation of negotiations. We do see a tendency of the legislators to put into question and even weaken the foundations of medical ethics, in particular ethics committees and informed consent in research.

First, the role foreseen for ethics committees in the course of a clinical trial's approval procedure, is being dangerously diminished. Indeed, the current text of the clinical trial regulation limits the function ethics committee to a sole examination role of the trial protocol. In other words, the final decision of the ethics committee based on the assessment of the protocol, is not binding

any longer. We fear that in practice, this will result in clinical trials being conducted despite the negative assessment of the trial protocol by the ethics committee.

Second, the widely agreed ethical standard by which an individual who is about to take part in a medical research study should be substantially informed of the characteristics of the study before he consents to it, is at stake.

This is the case both in the data protection and the clinical trial regulations. In this context, identifiable health data of an individual could indeed be accessed by a researcher while the concerned individual has never given his informed and explicit consent to it. We believe this is a very dangerous step which will without doubt have disastrous effects on research integrity, but also on the patients themselves.

The World Medical Association's Declaration of Helsinki which was renewed at the WMA meeting in Fortaleza, Brazil in October 2013 and which highlights these key ethical principles is to be respected. The CPME together with WMA has lobbied and will continue to lobby in favour of those principles. When research involves human beings, ethical principles are not negotiable.

For further information on CPME's activities and policies: www.cpme.eu

*Dr Katrín Fjeldsted,
President of the Standing Committee
of European Doctors*

*Ms Birgit Beger,
Secretary General of the Standing
Committee of European Doctors*

Memorandum of Understanding European Forum of Medical Associations – World Medical Association Handbook

The European Forum of Medical Associations (EFMA) was established in December 1984, following an invitation from the WHO European Region to a joint meeting with the National Medical Associations to discuss Health for All in Europe and other common issues. From this date until the present, a joint annual meeting has been held, hosted by different NMAs.

Information about participating National Medical Associations, their aims and activities was first collected in a printed handbook (herein “the handbook”), as a joint venture between the Norwegian Medical Association and EFMA-WHO in 1991. The handbook was updated and published by the Norwegian Medical Association every year since then until 2009, when it was transferred to the EFMA website: www.efma-forum.com and www.efma-forum.org.

In 2012, the Norwegian Medical Association decided that they are no longer able to maintain and update the EFMA handbook. At the EFMA Forum in Riga in March 2013, it was decided that this will be taken on by the World Medical Association.

This agreement is between the European Forum of Medical Associations (herein “EFMA”) and the World Medical Association (herein “WMA”).

In consideration of the mutual promises contained herein, the parties agree as follows:

The handbook will be co-branded as the EFMA-WMA handbook and will be posted on the WMA platform. The Serbian Medical Chamber will undertake the upkeep of the handbook and will host

the handbook on their server. The EFMA website, which includes details of EFMA meetings and activities will be separated from the EFMA-WMA handbook and will also be hosted and updated by the Serbian Medical Chamber.

1. The handbook will include all members of EFMA and the WMA, including those who are members of only one of the two organizations. The WMA will work to extend the handbook to include associations from other parts of the world.
2. Both parties, EFMA and the WMA, will appoint representatives to form a review committee. It is the responsibility of each party to ensure that they are involved in the upkeep of the handbook and encourage their members to update their profiles.
3. The handbook will consist of two parts: the names, addresses and contact details of the NMAs and a more descriptive section about the role of each association and its activities. The handbook will also include a section where associations state which international organisations they are a member including but not exclusive to: EFMA, WMA, CPME and UEMS.
4. The WMA will clarify in the handbook that they are listing the true number of doctors in their country and not the declared numbers the WMA asks for in their membership. WMA members will not be penalised if there is a discrepancy between the two figures.
5. The handbook will include the logos of both EFMA and the WMA, and will clearly state that the handbook is the product of joint cooperation between EFMA and the WMA.
6. If the WMA add accompanying sections to the handbook they will receive sole credit for such additions.
7. If either party intends to revise or publish future editions of the handbook, that party hereby grants the right of first refusal to the other association to participate in the modification or editing of the work. If either association does not provide an acceptable revision within a mutually agreed upon reasonable time, or should one of the associations be unable or unwilling to revise the handbook, the other party may revise or edit the future edition. The associations will consult with each other when the handbook is considered for uses other than the ones for which it was produced.
8. If the Serbian Medical Chamber or the WMA decide to end their involvement in the publication of the handbook, EFMA will do its utmost to find a replacement.
9. This Agreement constitutes the entire understanding between EFMA and the WMA with respect to the EFMA-WMA handbook, supersedes any and all prior understandings and agreements, oral and written, relating hereto, and may be amended at any time only in a writing signed by both parties.

Signed by
Dr. Otmar Kloiber
Secretary General, WMA

Adv Leab Wapner
Secretary General, EFMA

New WMA Cooperating Center

The Steve Biko Centre for Bioethics, University of the Witwatersrand, Johannesburg, South Africa has been awarded the title WMA Cooperating Center. WMA Cooperating Centers are academic institutions that support the WMA with scientific advice and on specific projects. The WMA currently has five cooperating centers. The Steve Biko Centre for Bioethics is the first in Africa.

WMA Executive Committee decided to award the title WMA Cooperating Center to the Steve Biko Centre for Bioethics, University of the Witwatersrand, Johannesburg, South Africa. This is remarkable in several ways. Steve Biko was an anti-apartheid activist who died in police custody as a result of torture. The failures of the (white) medical community in South Africa at that time finally led to a split in the World Medical Association. The failure of the Medical Association of South Africa and the WMA to clearly stand up for human rights at that time was certainly one of the serious mistakes of these organizations. Steve Biko's death was one of the critical events that finally led to the isolation of the apartheid regime.

There has been increasing cooperation between the Steve Biko Centre for Bioethics and the WMA for more than a decade. We have continuously worked together on issues of research involving human beings, with a focus on questions of placebo use and research in resource poor settings, and on new ways to empower illiterate communities using speaking books that bring health education to them. Prof. Ames Dhai, the head of the Steve Biko Centre, is currently President of the South African Medical Association. By affiliating ourselves with an organisation bearing this name, we not only pay tribute to an academic partner we have held in high esteem for many years now, but also to a man to whom we owe praise for his sacrifice: Steve Biko.

World Medical Association has, for the first time, issued a joint press statement with the UN Special Rapporteur for the Right to Health, Armand Grover. Following the protests at Gezi Park in Istanbul and in other Turkish cities last summer, the government has now prepared a law that would require special permission and registration to provide assistance in extraordinary circumstances like catastrophes and riots. The intention is very obvious: the government wants to discourage health professionals from providing first aid and medical assistance to government opponents or, if they do register, to be able to easily get hold of them and the names of those they treated. This is an old trick. In the nineties, the Turkish government required those treating torture victims to hand over the names of their patients. Intimidation is a powerful tool for denying access to health care to political opponents.

As then, so too now Turkish doctors are resisting, and we stand by them. The Special Rapporteur and the WMA are extremely concerned about the new law which contains draconian sanctions for those who do not comply. Grover warned that, "Enacting laws and policies criminalizing provision of medical care to people opposing the State, such as political protestors, will certainly deter healthcare workers from providing services due to fear of prosecution".

The Turkish Government is taking an absurd route in fighting its own civil society. We need to stand by our Turkish colleagues in upholding medical neutrality and support their commitment to providing aid in critical situations. We are convinced that we stand on the side of righteousness. But for our Turkish colleagues this is not without peril. As Voltaire put it, "It is dangerous to be right when the government is wrong."



Dr. Ames Dhai Director of the Steve Biko Centre for Bioethics and WMA President Dr. Margaret Mungherera

Human Rights

The World Medical Association has, for the first time, issued a joint press statement with the UN Special Rapporteur for the Right to Health, Armand Grover. Following the protests at Gezi Park in Istanbul and in other Turkish cities last summer, the government has now prepared a law that would require special permission and registration to provide assistance in extraordinary circumstances like catastrophes and riots. The Special Rapporteur and the WMA are extremely concerned about the new law which contains draconian sanctions for those who do not comply. The law is designed to deter healthcare workers from providing services to government opponents due to fear of prosecution.

(09.12.2013) GENEVA – The UN Special Rapporteur on the right to health, Anand Grover, and the World Medical Association

tion (WMA) urged today the Turkish Grand National Assembly (Meclis) to reconsider a draft law that would criminalize the provision of medical care by qualified independent practitioners during emergencies after the arrival of a state ambulance.

“If adopted, Article 33 will have a chilling effect on the availability and accessibility of emergency medical care in a country prone to natural disasters and a democracy that is not immune from demonstrations,” Special Rapporteur Grover said.

“Enacting laws and policies criminalizing provision of medical care to people challenging State authorities, such as political protestors, will certainly deter healthcare workers from providing services due to fear of prosecution,” Grover warned, quoting his latest report* to the UN General Assembly on the enjoyment of the right to health in conflict situations. “Sanctioning such laws and policies will also discourage other segments of the population from seeking health services due to fear of being suspected in the involvement in protests,” he stressed.

“The mere presence of ambulances would be considered grounds not only to prevent emergency medical care by competent, independent physicians, but also to prosecute those medical responders up to three years of imprisonment and a hefty administrative fine for acting under the International Code of Medical Ethics to provide care to those in need,” the WMA’s Secretary General, Otmar Kloiber, underlined.

Dr. Kloiber pointed out that “in times of urgency, from earthquakes to floods to protests and demonstrations, the international standards for emergency medical care are based on the medical need of the wounded and sick rather than the presence of official medical transport.”

The two experts noted that international medical and human rights standards make it clear that it is a humanitarian duty of doctors, nurses, paramedics, and other health workers to give emergency care to those in need. “They must be able to carry out their professional responsibilities without interference or fear of reprisal,” they said.

The Special Rapporteur and the WMA had written individually to the Turkish Government expressing their grave concern about the requirements of Article 33 of the draft health bill. “Now we urge the Meclis to consider the right of the Turkish people to emergency care and ensure the respect for medical ethics and independence health workers in Turkey.”

“We hope parliamentarians will make the right call on the Article 33 and scrap it, as it should be,” the experts said.

Successful Climate and Health Summit in Warsaw

On 16 November the 2nd International Climate and Health Summit took place in Warsaw alongside the official UNFCCC COP19 climate negotiations.

The Summit was organised by the Global Climate and Health Alliance (GCHA) together with the World Medical Association and supported by the WHO. Prof. Vivienne Nathanson (British Medical Association) represented the WMA at the event.

Warsaw 15/11/2013 – Health and medical organizations from around the world are convening in Warsaw this week to emphasize the urgent need to prioritize the protection and promotion of health within global and national policy responses to climate change.

The Global Climate and Health Summit 2013 will take place on 16 November 2013, during the UNFCCC’s COP19 meetings in Poland, and is organized by the Global Climate & Health Alliance (GCHA) together with the World Medical Association and with support from the World Health Organization.

The Summit will highlight the dangerous impacts of climate change on human wellbeing, the health benefits of mitigation and current efforts to make the health system more sustainable. It will build a road-map for the international health community to work towards in the run-up to the 2015 climate negotiations in Paris.

Research shows that climate change already contributes to over 400,000 deaths every year. If there is a continued lack of political will, these figures are expected to increase dramatically as the impacts of climate change worsen:

- Populations at risk of infectious diseases such as malaria may grow to 170 million in Africa by 2030 whilst those at risk of dengue fever may increase to over 2 billion globally by 2080
- Climate change will worsen the impact of urban air pollution which is already directly responsible for over 1.2 million deaths each year
- The impact of coal plant emissions in Europe alone contributes to 18,000 premature deaths and four million lost working days—with all health costs combined totaling nearly 43 billion Euros every year
- By 2080, over 100 million more people each year risk being exposed to coastal flooding by predicted sea level rises.

Human health is profoundly threatened by our global failure to halt emissions growth and curb climate change. GCHA argues that strategies to achieve rapid and sustained emissions reductions and to protect health must be implemented in a specified time frame to avert further loss and damage.

In addition to calling on governments to commit to a binding treaty at the 2015 COP in Paris, GCHA is also encouraging the international community to ensure the resulting political, legislative and financial frameworks reflect the full impacts of climate change on health and ensure public health is protected by governments around the world.

IRCT defines way forward to realise the right to rehabilitation

Beirut, Lebanon, 27–28 June 2013

Victims of torture have a right to rehabilitation. But how can we ensure that this right becomes a reality in which victims enjoy access to appropriate, holistic rehabilitation services that are funded through states?

This was the major question addressed at the pioneering scientific conference The Right to Rehabilitation, co-organised by the International Rehabilitation Council for Torture Victims and Restart Center for Rehabilitation of Victims of Violence and Torture.

The experiences, best practices, lessons learned and priority pathways forward are now available in the conference report.

In collaboration with speakers and participants from 50 countries, the IRCT has gathered the input to move forward on ensuring the right to rehabilitation for all victims of torture. The IRCT recommends that rehabilitation services be:

- **State funded:** Most significantly for the sustainability of the rehabilitation movement, states are obligated to provide or ensure provision of rehabilitation services to victims of torture, regardless of resources or where the torture took place.
- **Victim-centred:** As mentioned by the UN Committee against Torture in their General Comment No. 3, rehabilitation services must consider the totality of the victim's context and needs.
- **Linked to national health and educational systems:** To ensure the continued growth of high-quality care, rehabilitation services must build sustainability and quality through on-going collaboration with current health and education systems. In addition, links with

health systems builds in improved referral systems for victims of torture when they seek treatment through general practitioners.

- **Multi-faceted services:** Rehabilitation treatment should be holistic, or multi-faceted, to encompass the multiple needs of victims, including medical, psychological, legal, social, economic and asylum needs. Furthermore, multi-faceted health organisations for victims of torture may lessen the stigma for those needing to access mental healthcare services.

Call to Action from Bellagio Conference on Protection of Health Workers, Patients and Facilities in Times of Violence

In November 2013, the Center for Public Health and Human Rights of the Johns Hopkins Bloomberg School of Public Health convened 19 experts from the fields of humanitarian practice, human rights, human security, academic research, government, and philanthropy, along with UN representatives and leaders from health professional associations, at Bellagio, Italy to address the problem of attacks on and interference with health care, particularly in times of armed conflict and internal disturbances. WMA President, Dr Margaret Mungherera, was one the experts and a keynote speaker.

Noting that Violations undermine the human security and health of conflict-affected populations, disrupt health systems and undermine equitable access to health care, resulting in avoidable loss of life and human suffering, the experts agreed that urgent action is needed to address the problem and call upon the international community to advance the security of health, particularly in situations of armed conflict and internal disturbances through several actions.

Call to Action

Bellagio Conference on Protection of Health Workers, Patients and Facilities in Times of Violence
Bellagio, Italy
November 19–21, 2013

International humanitarian and human rights law recognizes the obligation and/or the responsibility of governments and non-state actors to respect and protect health workers, facilities, medical transports, and the people they serve. Violations undermine the human

security and health of conflict-affected populations, disrupt health systems and undermine equitable access to health care, resulting in avoidable loss of life and human suffering.

We, the assembled, believe urgent action is needed to address the problem and call upon the international community to advance the security of health, particularly in situations of armed conflict and internal disturbances, through the following actions:

1. States and armed groups at all times, including during armed conflicts and internal disturbances, respect health care workers, facilities, transports, and services, and persons seeking care, by not attacking, interfering with, threatening or obstructing them; refrain from punishing health workers for providing treatment to individuals in need of medical care on account of the patient's ethnic, religious, national, political or military affiliation or other non-medical considerations; and ensure availability of safe and secure access to and equitable distribution of quality health care.
2. States train their military, police forces and other law enforcement agents to adhere to legal standards and assure protection of health services, health workers and people seeking care; armed groups similarly raise awareness among their forces to comply with their international obligations to respect health care workers, facilities, transport, and services, and persons seeking care.
3. States, with the support of the UN, take action to stop attacks and hold perpetrators to account in national and, where appropriate, international courts and/or special tribunals.
4. States make explicit in national law the respect for and protection of the delivery of health care and health workers in times of armed conflict and internal disturbances, and reaffirm and reinforce these norms through the UN General Assembly, the Security Council and the Human Rights Council.
5. States, through Ministries of Health and other relevant agencies and UN bodies, establish, strengthen and provide resources for systematic monitoring and reporting of attacks on health workers, facilities and transports, and individuals seeking care; and support the implementation of ongoing initiatives by the UN Special Representative for Children and Armed Conflict and the World Health Organization designed to collect and disseminate data on attacks on health services and encourage field-based reporting by the High Commissioner for Human Rights.
6. States, through the UN, engage in processes such as Universal Periodic Review, treaty body review and mechanisms for the protection of civilians and children affected by conflict to promote compliance with international law and accountability for perpetrators.
7. States, relevant UN entities, NGOs and professional health organizations and ministries of health promote, disseminate and implement recommendations of the International Committee of the Red Cross Health Care in Danger project to increase security of health care services and health workers in the field.

8. Health professional organizations at the national and global level promote universally accepted standards of professional conduct among health workers in armed conflict and internal disturbances, including training health workers on human rights and medical ethics and advocating for protection and security of health services and health workers.
9. States, WHO and the Global Health Workforce Alliance as part of the UN post-2015 development agenda process incorporate strategies to address the problem of interference with health care and attacks of health workers in the human resources for health agenda and related initiatives.
10. Civil society actors actively engage States and relevant international organizations to advance protection of health care in armed conflict and internal disturbances.
11. States and donors support civil society engagement through capacity building, technical assistance and funding.
12. States and other research funding bodies sponsor and researchers and practitioners conduct in-depth studies on the nature of violations, the perpetrators, as well as the consequences of lack of protection of health care functions on the health and development of the population. Current research gaps are identified in Annex 2 to this statement.

2013 Global Health Forum, Taipei, Taiwan

From WMA Leaders' blogs

WMA Secretary General Dr. Otmar Kloiber travels around the world talking about the WMA's work representing the millions of physicians worldwide. Acting on behalf of patients and physicians, the WMA endeavors to achieve the highest possible standards of medical care, ethics, education and health related human rights for all people. This blog will chronicle these travels and important issues. (www.wma.net).

Taipei, Taiwan to Frankfurt, Germany. Should all ministers be health ministers? For sure, at least in a way...

There is no sector of government that does not have relevance for health and health care. Whether the actions of a ministry have direct effects, such as setting financial budgets for health care or payments, or indirect effects for example upon peace, the availability of work and housing, social protection, road safety, education, occupational and environmental safety, international cooperation, trade and aid, climate change, or research financing, there is virtually no section of government that is not connected in some way with health.

Next generation had a strong representation at the Global Health Forum: Roy Jen-Hsiang Shen, WMA-JDN-Member, Dr. Otmar Kloiber, WMA, Dr. Yung-Tung Wu, Past-President TMA, Dr. Andy Hsieh, (Dental Surgery), Dr. Ray Wu, (Dental Surgery).

But how to get health into the minds of the politicians? This awfully difficult question was debated at the invitation of the Taiwanese government at the 2013 Global Health Forum in Taipei from November 23-24, 2013. In a section on the "Physicians' role and response to promoting Health in All Policies in an NCD era" I stressed our holistic approach to tackling non-communicable disease (NCDs). This has two major pillars: Firstly, the right to health as a human right, and secondly a focus upon the social determinants of health as the underlying causes of many diseases in this world.

The WMA was irritated when in 2011 the World Health Organization went back to the old silo approach of listing four disease areas (cancer, cardio-vascular and lung diseases and diabetes) in their program on NCDs. Just three years previously in 2008, thirty years after the Alma Ata Declaration of the WHO, a ground breaking World Health Report on "Primary Care – Now more than ever" clearly demonstrated that the sectorial approach, tackling a limited number of infectious diseases, had not shown the desired effects. And yet, while finally tackling NCDs after decades of ignoring them, the WHO now falls back on the same old and insufficient strategy.

This is even more startling since, at the same time, the WHO has not only made a new start on primary care (World Health Report 2008) – much more realistic than ever before – and developed a report on Social Determinants of Health ("Closing the Gap in one Generation" WHO 2008) under the chairmanship of Sir Michael Marmot, it has also embarked on health system strengthening and is advocating loudly for universal health coverage.

The challenges are overwhelming - we still don't see enough policies taking account of their effects upon health, whether they are directly related to public health, such as fostering tobacco control, or indirectly, such as providing enough funding for affordable and high quality education for all. While Africa still has a homeopathic average per capita health expenditure of around 100 USD per year, problems of equity exist within all nations, regardless of whether they are rich or poor.

The Taipei conference ended with a call upon the politicians of this world to be aware of their responsibilities regarding health. However, as the conference was mainly attended by experts on public health, this was a bit like preaching to the converted. One positive aspect was the presence of a lot of young people at the conference. Medical students, young physicians and other young health professionals gave the conference a strong youthful perspective, and the

hope that our voices will be heard in the future. And of course it is always good to meet up with members of the WMA Junior Doctors Network (JDN).

The fact that Taiwan, having been a very poor country just few decades ago, is now a leader in health system development, providing comprehensive and efficient health care to all of its people, is really very inspiring. And it is also clear that the health of the nation is not merely a result of strong economic development, but rather a condition for it. For all those who are struggling to build a health care system, the bottom line is: Yes, it can be done, even against all odds.

A big thanks to the Taiwan Government, the Minister for Health and Welfare, Dr. Wen-Ta CHIU for inviting the WMA again and the Taiwan Medical Association for facilitating this!

Meetings

Health care in danger: From consultation to implementation

WMA President Dr Margaret Mungherera gave a key note address on the importance of healthcare in times of conflict and violence at the expert conference organized by the International Committee of the Red Cross (ICRC), together with the Conflict and Catastrophes Forum of the Royal Society of Medicine (RSM) and the British Red Cross on 3 December in London.

197th WMA Council Session, April 2014

The 197th Council session will be held from 24–26 April 2014 at the Hotel Nikko Tokyo, in Tokyo, Japan. The registration is open and higher fee will be applied after 24 March.

WMA General Assembly, Durban 2014

The General Assembly in 2014 will be held from 8–11 October 2014 at the Durban International Convention Centre, in Durban, South Africa. Please save these dates in your calendar.

200th WMA Council Session, April 2015

The 200th Council session will be held from 16–18 April 2015 in Oslo, Norway. Please save these dates in your calendar.

World Health Professions Regulation Conference 2014

To be held in Crowne Plaza Hotel, Geneva, Switzerland 17–18 May 2014. WMA is co-organizer.

International update

Call to end attacks on health workers

On 24 October 2013, the UN Special Rapporteur on the Right to Health, Anand Grover, presented the latest report to the General Assembly, dedicated to the right to health obligations of States and non-State actors towards persons affected by and/or involved in conflict situations. It describes a wide range of abuses against health workers and highlights the need for better monitoring and accountability. The Special Rapporteur's report is the first UN human rights analysis to describe the responsibilities of countries to provide and protect health workers and services in conflict.

Resolution supports torture victims' right to rehabilitation

On 12 November, 193 States of the UN General Assembly adopted a resolution reiterating the absolute prohibition of torture and, significantly, the obligation on states to ensure victims have prompt access to appropriate rehabilitation services. This resolution is particularly important since not all countries around the world have ratified the UN Convention against Torture.

Third Global Forum on Human Resources in Health (HRH)

The Forum, held in Recife, Brazil, emphasized the importance of HRH in implementing universal health coverage and discussed what universal health coverage means for various stakeholders. WHO Member States adopted the Recife Political Declaration, which outlines the type of actions and commitment required at national and global levels to address international HRH challenges.

Education and training for 21st century

WHO has developed a website on "Transforming and scaling up health professionals' education and training". The guidelines are expected to give rise to regional- and country-based policy and technical dialogues with key stakeholders across education, health, finance and labour, on how best to finance health professional training and prepare health professionals for the 21st century.

Green news

WHO calls to phase out mercury from measuring devices

On 11 October 2013, to mark the signing of the Minamata Convention on Mercury, WHO and Health Care without Harm joined forces to launch a new initiative to have mercury removed from all medical measuring devices including fever thermometers and blood pressure by 2020. WHO media release

New UNEP Website of the Minamata Convention on Mercury

The Minamata Convention for Mercury is a global treaty to protect human health and the environment from the adverse effects of mercury.

Publications, courses, conferences, calls for papers

Research Ethics Course – TRREE

Research Ethics Course – Training and Resources in Research Ethics Evaluation (TRREE) in collaboration with the Institute of Health Law, University of Neuchâtel, is available on the WMA website.

The Prince Mahidol Award Conference (PMAC)

The Prince Mahidol Award Conference is an invitation-only conference hosted by the Prince Mahidol Award Foundation and the Royal Thai Government in cooperation with several partners. The Conference, entitled "Transformative Learning For Health Equity," will be held in Bangkok, Thailand, 27–31 January 2014. WMA is part of the conference advisory committee helping develop the conference program.

Ambulance and pre-hospital services in risk situations

Written by the Norwegian Red Cross with support from the International Committee of the Red Cross (ICRC) and the Mexican Red Cross, this report sets out ways to make pre-hospital care and ambulance services operating in areas of armed violence safer.

State of the World Population Report 2013

The State of the World Population Report 2013 “Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy” released by UNFPA finds that more than 7 million girls in poor countries give birth before 18 years old each year with two million of them 14 or younger. The report, which focuses on adolescent pregnancy, highlights its challenges and consequences on the health, education, employment and rights of millions of girls around the world.

Guidance note on disability & emergency risk management for health

The WHO and partners have launched a guidance note on disability and emergency risk management for health – a short, practical guide that covers actions across emergency risk management.

New Detention Monitoring Tool

This tool developed by Penal Reform International (PRI) and the Association for the Prevention of Torture (APT) addressing risk factors to prevent torture and ill-treatment. It aims to provide analysis and practical guidance to help monitoring bodies to fulfill their preventive mandate as effectively as possible when visiting police facilities or prisons.

Recognizing Victims of Torture in National Asylum Procedures

A new report by the International Rehabilitation Council for Torture Victims (IRCT), conducted an 18-country overview of asylum

systems in Europe, North America and the Pacific. It gives a comparative overview of early identification of victims and their access to medico-legal reports in asylum-receiving countries.

Guidelines on Human Rights Education for Health Workers

These guidelines present approaches to be adopted when planning or implementing human rights education for health workers related to six key structural areas: the human rights-based approach to human rights education; core competencies; curricula; training and learning processes; evaluation; and professional development and support of trainers.

New database of health and human rights syllabi

To assist university-based teachers and others teaching health and human rights, the University of Southern California (USA) has created a database of syllabi on health and human rights concepts and methods. In providing these syllabi, the initiators hope to stimulate and support efforts to integrate health and human rights into a wide variety of specific and general curricula.

150th Anniversary of the World Veterinary Association

The 31st World Veterinary Congress (WVC) took place in Prague (Czech Republic) from 17 to 20 September. This year, the WVC was marked by World Veterinary Association's 150 years Anniversary celebrations. This year, the WVA-WHO-OIE-FAO 2nd Global Summit focused on strengthening institutional collaboration and cooperation between animal and public health in education and research.

“A Doctor’s Experience of Injustice in the United Arab Emirates, a Caveat”

Prologue

The United Arab Emirates consist of seven semi-autonomous emirates with three licensing bodies for medical and paramedical professionals.

The Dubai Health Authority (DHA) licenses doctors and other paramedical profes-

sionals to work in the Emirate of Dubai. The Health Authority of Abu Dhabi (HAAD) licenses doctors and paramedical professionals to work in the Emirate of Abu Dhabi and Al Ain city. The United Arab Emirates Ministry of Health (MOH) licenses doctors and paramedical professionals to work in the remaining five emirates namely Sharjah, Ajman, Um al Quwain, Ras Al Khaimah and Fujairah.

The Scene

I am a Nigerian general medical practitioner with thirty-seven year unbroken experience in private medical practice. I desire to retire from hospital practice at age sixty-five, and start a medical tourism business. In pursuance of this, I opted to work in the United Arab Emirates few years before this venture, in order to have firsthand knowledge of the health establishments/institutions relevant to this ambition, gain knowledge of the laws guiding hospital practice and business in the country, be familiar with the coun-

try's financial institutions and know the traditions and customs of its people. Also working in the UAE will give me the much needed base for the take off of the venture, since I already have enough field experience in my country which is to be used as the main field for take-off.

I flew into Dubai in June 2011 to complete the necessary formalities to be a DHA-licensed practitioner. I was scheduled for an academic interview on September 14, 2011, which I passed. I had my result and certificate issued online two days after. I was in Dubai on 14th may 2012 to search and start work. I had non-attractive job offers necessitating my decision to return to my country, after staying in Dubai for two months.

A day before i exited Dubai, precisely on 11th July 2012, I decided to trade in my DHA certification for an MOH certification, a recently introduced and permitted procedure. In pursuance of this, I filled a ministry of health form online and uploaded all requested documents. The third item on the first page of the form was my date of birth which I clearly inserted as May 19, 1951.

Also uploaded on the form was my passport page on which my date of birth was clearly stated.

After waiting for four months, and without any information from the ministry on the application inquired and was told by the ministry that I am yet to pay its application fee of Aed 100! (about \$30). In other climes, the application would have been formally acknowledged as received and request made for the application fee.

By the time the ministry processed the application, my DHA certificate has lapsed and the ministry then claimed it could not use a lapsed certificate to grant me its MOH certification. It requested i sat a fresh assessment by entering for its prometric on-

line examination. It gave me the guidelines for the examination, and also requested I visit its website to peruse its requirements for certification. In all the information it gave to me including that on its website, the word age was NEITHER mentioned NOR appeared on them.

I entered for the ministry's examination and paid the necessary fees. I sat for the examination on 16th February 2013 and passed. It sent me a letter of congratulations the next day. By an email dated 1st April 2013, the ministry requested I visited its customer department to collect my evaluation certificate.

I arrived in UAE on 17th August 2013, collected the certificate on the 21st, instantly and immediately started applying online for jobs. I attended interviews and had good offers. However the procedure in UAE requires an employer to apply to the ministry for the release of the licence of any prospective employee, paying a non refundable fee of AED 2600 (about \$800).

As a precaution not to lose such money, an employer will normally make preliminary enquiry on whether a prospective employee's licence will be released to it or not. Such preliminary enquiries by employers regarding me were not responded to by the ministry. After not responding to my formal enquiry on this behaviour, the ministry head of licensing eventually told me on phone that I am over aged to work in the UAE!

My age was on the application form; likewise the passport page uploaded on the form. Age was not even mentioned in its "conditions for evaluation of physicians/dentists" displayed on its website. In this age of the versatility of the computer, why did the ministry fail to programme its computer to screen off overage applicants? Why ask me to travel all the way from my country to pick up an evaluation certificate when you have already predetermined i wouldn't be

allowed to use it to gain employment? Why collect money for application and examinations? Why make me go through the physical, mental and financial stress of an examination? Four air trips to the UAE, four months stay in UAE idling while searching for jobs, TWO UAE licensing bodies' certifications passed and yet I cannot work? WHAT ELSE IS INJUSTICE IF NOT THIS?

To call this an injustice is an understatement. There are demeaning and appropriate words to describe this action which civility will not allow me to use in this article. It is worse than a swindle! I have written more than two dozen letters separately to the UAE Prime minister, the ministers of health, justice and foreign affairs, without the courtesy of a single reply from any of them. I even wrote to them that I was no longer interested in working in the UAE, but requested compensation for the expenses incurred, time lost and wasted in this venture spread over three years, Through the ministry's administrative incompetence, sheer ignorance, deliberate misguidance or all combined.

I DID NOT HAVE ONE REPLY. At a certain point in time the ministry of health even shut off its computer from accepting my e-mails! This was the same ministry that could not programme its computer to screen overage applicants! I learnt that my experience wasn't the first case. I learnt of a Spanish surgeon that was treated similarly.

I even appealed to the ministry to amend the information on its website to reflect age; it simply ignored the advice. I have made a decision to make colleagues to beware and be aware by writing this article, lest they fall into similar predicament or do we call it the ministry's "trap" if they are intending to work in the UAE. If a government ministry can so treat an individual, what can one not expect or experience with private organisations?

World Medical Journal



Epilogue

The fortune or misfortune of not being allowed to work in UAE is least of my problems. I have done well in life without leaving my country. What I find very repulsive and damning, and which mutates my indifference to the whole saga, is the complacency of the ministry in not accepting its blunder and offering a simple apology;

also its set agenda to continue to mislead and misguide doctors who may want to seek its services. Why did it refuse to amend the wrong information it placed on its website? I write this article in good faith and with an unbiased and unperturbed mind. All assertions in this article are backed by documents which are available on request. Please do not ask me if I intend being in UAE in future? I may in the next world!

Like a friend once remarked. Being referred to as a developed country or nation takes more than skyscrapers and boulevards! Respect for humanity, rights and dignity are key requirements for a nation or country to be labelled and acknowledged as a developed and civil country.

Dr. Francis Olubunmi Ilori

Sri Lanka Medical Association

The Sri Lanka Medical Association (SLMA) is the apex academic medical institution in Sri Lanka and is the oldest such institution in Asia and Australasia. The SLMA has been in existence for 126 years from 1887. The registered address of the organisation is Wijerama House, No.6, Wijerama Mawatha, Colombo 7, Sri Lanka. All doctors registered with the Sri Lanka Medical Council are eligible to become members of The Sri Lanka Medical Association.

The SLMA is a purely academic organisation concerned with Continuous Profes-

sional Development of doctors and policy discussions on all aspects of healthcare. It has also performed an important function in an advocacy and advisory role for the government of the Democratic Socialist Republic of Sri Lanka.

Many of the activities of the organisation are carried out by Expert Committees and Working Groups. The functioning of the institution are overseen by an Executive Committee. The current members of this committee are:

1. President: Dr. B.J.C. Perera
2. Immediate Past President: Professor Vajira H.W. Dissanayake

3. President Elect: Dr. Palitha Abeykoon
4. Vice Presidents: Professor Rohan Jayasekera, Dr. Kalyani Guruge
5. Hony. Secretary: Dr. Samanmaali Sumanasena
6. Hony. Asst. Secretaries: Dr. Shyamali Samaranayake, Dr. B. Kumarendran, Dr. Navoda Atapattu, Dr. Sanjeeva Gunasekera
7. Hony. Treasurer: Dr. Ruvaiz Haniffa
8. Hony. Asst. Treasurer: Dr. Leenika Wijeratne
9. Hony. Social Secretaries: Suriyakanthi Amerasekera, Dr. Gamini Walgampaya
10. Public Relations Officer: Dr. Deepal Wijesooriya

The Association has its Anniversary Scientific Medical Congress in July every year and the Foundation Scientific Sessions in October every year. In addition many Provincial Academic Meetings are organised in collaboration with Regional Clinical Societies. All these are designed to bring state-of-the-art knowledge and the latest developments in medicine to doctors from all over the island. Over the last couple of years the SLMA has expanded its activities to allied healthcare professionals as well.



The SLMA can be accessed at
<http://www.slmaonline.info/>
<https://www.facebook.com/SLMAonline> and
<http://www.linkedin.com/in/slmaonline>

The Physician's Situation in Romania

Over 10,000 professionals from the Romanian health system (doctors, dentists, pharmacists, nurses, psychologists, biologists, biochemists) protested in Bucharest for an increased budget for health and professional dignity. The protest was called *The March of Silence*, and it took place on November 2nd 2013, on a 3 km route – Romanian Government – Romanian Parliament.

Since it was a silent march, protesters only marched and displayed boards with messages such as: "I will deal with the International Monetary Fund," "I want to work in Romania", "I'm a Romanian doctor and I care", "I won't be silent anymore", "6% of GDP for health".

The March of Silence was organized by the Coalition of Health Professionals, after the picketing the Ministry of Health and Ministry of Finance for 10 days at the end of September with 150 health professionals each day, coming from all parts of the country. Following these pickets, we began negotiations with the Ministry of Health, Ministry of Finance and Ministry of Labor, negotiations which are still held.

In Romania, the current situation of health professionals in general, and doctors, in particular, is difficult from many perspectives. One of them is that the number of doctors is not enough for the 19.000.000 people living in Romania. In present, only 39.800 physicians and 14.000 residents are working in the health system. Only 14.487 of them are working in hospitals (in 2011 the number of physicians working in hospitals was 20.648).

Because of the difficult situation, all the health professional organizations decided to gather in the Coalition of Health Professionals, which includes: The Romanian College of Physicians, Sanitas Federa-



tion, The Romanian College of Dentists, The Romanian College of Pharmacists, The Romanian College of Psychologists, the Romanian Order of Nurses and Midwives, the Romanian Order of Biologists, Biochemists and Chemists, the Federation of Physicians "Dr. Ioan Cantacuzino", the Association of Resident Doctors, The Federation of Medical Students, the Romanian Society of doctors working in collectivities of children and young people, the Association of Ambulance Services, The National Association of Pharmacists from Hospitals in Romania.

The Health Professionals Coalition advocates for getting at least 6% of GDP for the health care system, legislation to guarantee the professional independence of those working in the public and health sector, a wage law specific for the health system (increased wages), double wage for the resident doctors, defending the dignity and giving up denigration of professionals by the authorities; organization of medical units with beds in the public system to ensure prompt and

quality services for patients; real consultation with the Health Professional Coalition, regarding any measure which may affect the functioning of the health system.

We obtained the recognition that without health professionals, the health system is unsustainable, scholarship for residents in the amount of 150 Euros, legislative changes (on going) to protect doctors from external interferences, the release accompanied by funding of more than 1200 posts in the health system, the return to the payment of work during the weekends and legal holidays, the refinancing of services in dental medicine (this year the budget of dental medicine covered only two months).

We didn't succeed to obtain the increasing of the salaries for the physicians, we received only promises that the additional funds that occur during 2014 will be directed to Health's budget and that some of them will be used to increase revenues doctors. We didn't obtain an increase of health's



budget to 5% of GDP in 2014, which now is only 4,3% of GDP.

Unfortunately, the announced strike was cancelled because SANITAS Federation (the trade union from the Coalition, made up mostly from Nurses) decided to sign the Collective Labor Agreement, which means they are not allowed to trigger strike. The Federation of Physicians "Dr. Ioan Cantacuzino" is not nationally representative and cannot trigger the strike by herself.

But, maybe the most important gain of this period is the changing attitude of the physicians. If, until now, they were pessimists, they always used to say: we can't win anything, it is no use going on strike, the physician's place is not in the street, now they are



more united and prepared to fight. That is the reason for what in present we are trying to build a powerful physician's trade union, in order to have a better represented cause and to fight for physician's rights.

*Prof. dr. Vasile Astărăstoae
President of Romanian College of Physicians*



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