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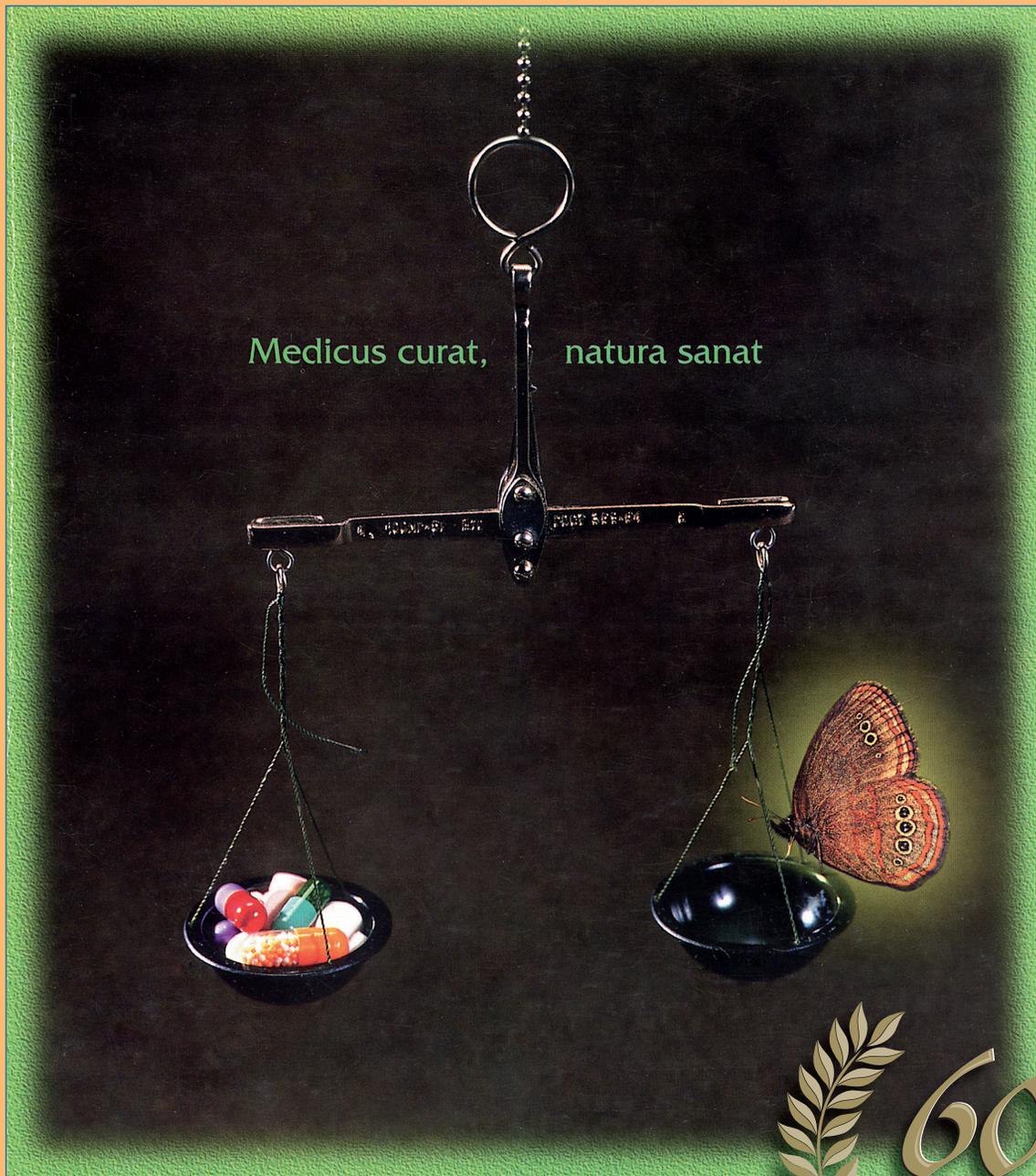
World Medical Journal



Official Journal of the World Medical Association, INC

Nr. 3, September 2014

vol. 60



- World Health Assembly Week
- WMA members

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Katrīnas iela 2, Riga, Latvia

Cover painting: "Medicus curat, natura sanat",
1997, by Latvian graphic artist Guntars Sietiņš

Publisher

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

Publishing House

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

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Business Managers J. Führer, N. Froitzheim
50859 Köln, Dieselstr. 2, Germany
IBAN: DE83370100500019250506
BIC: PBNKDEFF
Bank: Deutsche Apotheker- und Ärztebank,
IBAN: DE28300606010101107410
BIC: DAAEDED3
50670 Cologne, No. 01 011 07410
Advertising rates available on request

The magazine is published bi-monthly.
Subscriptions will be accepted by
Deutscher Ärzte-Verlag or
the World Medical Association

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

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



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

50 Years and Beyond

After 50 years of the World Medical Journal, we have come to a point where a major change must be made: We are going virtual.

For those who love a tangible paper product to hold in your hand, scribble notes in the margins, and file on your bookshelves, this is a sad departure from an old tradition. At the same time, we must acknowledge that an attractive on-line journal can reach more people than our printed journal ever could. New media consumers expect interactive formats with graphics and videos, and better searchability will facilitate more targeted and versatile communications with our members, as well as with other interested persons and institutions. We will take this departure as a step forward, as an opportunity to reach out and create a greater impact.

The recent Ebola outbreak in West-Africa is likewise a signal to change: The health and health care situation in many if not most of the poor countries in Africa is no longer an acceptable situation for this world. The crisis response – our own and that of the

global community – has been poor if not negligent. The countries affected have not invested enough in their health care systems and the international community has done what does best: actively looking away until the problem far away became a threat to the whole world. Meanwhile, the rich countries continue their devastating trend of brain drain from the poor countries of this world.

We must develop adequate response mechanisms to counteract such outbreaks, to contain the spread of these diseases, to care for the infected, to maintain acceptable living conditions in the affected regions during such crisis. But we also have to put more pressure on world leaders and national politicians to address our contribution to the underlying social causes of these disasters: our unequal sharing of resources, our exclusive trade policies, and our arms deals that fuel conflicts in the poor parts of this world. The leaders within these countries will have to address the corruption and the abuse of foreign aid funding, and foster internal commitment to investment in health and health care. Ebola is only one time bomb

that is ticking. Simply hoping that all this resolves itself alone is not a solution.

In Ukraine, we experience a conflict between two nations, which, until very recently in history, we barely discerned as separate nations. In a time of a common European Market, the conflict in Ukraine – without judging who may be right or wrong – strikes us as a wholly unacceptable way of coexisting on this planet. And in other parts of this world, more and more radical groups show blatant disrespect the most basic rules of human behaviour, not to mention respect for those who care for the ill and the wounded.

Twenty-five years ago, we believed the gaps were beginning to close and our global problems seemed to be lessening. But that was a mistake. There is no doubt that our intensive international cooperation as professionals, dedicated to caring, to healing and to relieving suffering, is more necessary than ever. This, in itself, is reason enough to intensify our efforts for cross-boarder collaboration and common standard setting. Our World Medical Journal is just one tool we can use in this most important undertaking.

Otmar Kloiber

Geneva Report for WMJ

World Health Assembly Week



Nigel Duncan

The sixty-seventh session of the World Health Assembly (WHA) took place in Geneva from 19–24 May. It was attended by many representatives from the World Medical Association and National Medical Associations who spoke at scores of side events and other conferences during the week. Dr. Margaret Mungherera, President of the WMA, and Dr. Mukesh Haikerwal, Chair, addressed a number of meetings. As usual, it was often the informal discussions between events that proved to be the most useful. A résumé of some of the formal events follows.

World Health Professions Regulation Conference

On May 17 and 18, the weekend before the WHA opened, the World Health Professions Alliance held another successful conference on regulation at the Crown Plaza Hotel, Geneva. This followed similar events held in 2008 and 2010. The main objectives of the conference were to evalu-

ate the challenges facing health professional regulation and to identify and promote best practices.

A succession of keynote speakers and panellists from around the world addressed the conference of senior physicians, nurses, dentists, physical therapists and pharmacists from more than 45 countries. Among them were Dr. Mungherera and Annabel Seebohm, legal advisor to the WMA.

Dr. Mungherera spoke about the key challenges and experiences of health practitioner regulation in Africa, and evolving scopes of practice and inter-professional collaboration. She said that the challenges in Africa included the perception of governments about professional autonomy, clinical independence and self-regulation of the health professions. Strategies to address these challenges included establishing an enabling legal framework, creating structures that ensured efficient decentralised functions supported by sufficient resources, and continued efforts to ensure all health professionals had an in-depth understanding of their ethical obligations and their rights to professional autonomy and clinical independence.

Dr. Mungherera said that evolving scopes of practice of health professionals and inter-professional collaboration in African countries also created regulatory challenges. Strengthening health systems was one means of achieving universal health care. Efforts to improve health human resources in African countries were increasingly targeted at the primary health care level. She spoke about the provision of effective health care across primary health care, including in situations of armed conflict. She also referred to migration within the African continent and especially across borders

which created a huge challenge for regulation. However this could be addressed, at least in part, by regional collaboration. She added that many other regulatory related challenges needed to be addressed to ensure a sustainable and effective health system in Africa, such as the selection of students into health training schools, curriculum issues especially around the teaching of clinical ethics and ensuring health professionals remained competent through access to CPD – especially for health professionals in remote and rural areas.

Annabel Seebohm spoke about the impact of standardisation initiatives in Europe and the global lessons for health professional regulation and the challenges facing health professional regulation. She said that current initiatives by the European Union affected health professional regulation in several ways and flowed from the European Union mandates in health care and the internal market. European Union competencies were based on the Treaty of Lisbon. After then, the European Union action respected the responsibilities of Member States for the definition of their health policy and for the organization and delivery of health services and health care. The exercise of the health professions, along with all the rules and regulations which applied to their activities affected the organization of health services and health care and was therefore Member States' responsibility. Nevertheless, specific examples showed that health professional regulation was and would be highly influenced by European Union initiatives.

Following the conference, leaders of the main health professions issued a press release urging their members to pay more attention to regulation issues and implement the right systems in order to act in the public interest.

They concluded that in the face of the many challenges facing health professions and their patients globally – changing de-



mography, increased expectations of health services, more mobile professionals – there is a greater need than ever for regulation systems that ensure quality of service and protect the public.

They said that participants at the conference agreed that different systems of regulation suited different national environments, but whatever the model, regulation was a responsibility and a public duty, not an option. Regulation systems should be underpinned by accountability and responsiveness and should observe principles such as checks and balances between stakeholders, and patients and professionals being aware of rights and duties.

There was agreement between WHPA members (the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association) that the goals of health professional regulation should be person-centred, involving patient care, patient rights and patient safety. They should also take into account social and economic welfare and professional practice.

‘Regulation has started to feature more prominently in many policy debates,’ said Judith Shamian, President of the International Council of Nurses. ‘The problem is that in most countries far too few people understand the advantages and disadvantages of different regulatory systems.’

Michel Buchmann, President of the International Pharmaceutical Federation, said: ‘A regulation model that takes into account inter-professional collaborative practice is most likely to be effective. There now needs to be a sustained political commitment to effective regulation by both decision makers and professionals. Professionals themselves, who can be guarantors of compliance, have a leadership role to play in regulation.’

Marilyn Moffat, President of the World Confederation for Physical Therapy said: ‘It is clear that there is no single model for a good regulatory system, but all should ensure that physical therapists and other health professionals provide safe and competent care/services. Regulatory bodies also need to understand the day-to-day realities of the health professions they are seeking to regulate.’

Margaret Mungherera, President of the World Medical Association said: ‘There are significant challenges and obstacles in many parts of the world, such as Africa, where there is a negative perception of governments about professional autonomy, clinical independence and self-regulation. This needs to change.’

Tin Chun Wong, President of the World Dental Federation said: ‘We expect the health professions as well as the public to play a major role whenever professional regulation is under discussion. The WHPA will continue to promote learning and information-sharing on this important subject.’

Meanwhile the WMA’s Junior Doctors Network was holding its own meeting to discuss their response to the various issues being raised during the World Health Assembly week. The issue of medical education was high on their agenda of topics that were discussed.

World Health Assembly

The World Health Assembly opened on the Monday and WHO Director General Dr. Margaret Chan addressed the gathering of representatives from all over the world.

She spoke about the international spread of polio virus and the fact that at the end of 2013, 60 per cent of polio cases resulted from international spread, with strong evidence that adult travellers were playing a

role. She said the causes of this could be found in armed conflicts, civil unrest, migrant populations, weak border controls, poor routine immunization coverage, bans on vaccination by militant groups and the targeted killing of polio workers. These factors were largely beyond the control of the health sector.

She referred to the disruptive effects of rising inequality and economic exclusion on social cohesion and stability, about the warnings on climate change and the health effects of air pollution.

She said there was no good evidence that the prevalence of obesity and diet-related non-communicable diseases was receding anywhere. Highly processed foods and beverages loaded with sugar were ubiquitous, convenient, and cheap. She expressed her deep concern at the increasing prevalence of childhood obesity in every region of the world, with the increase fastest in low and middle-income countries. And she said she had established a high-level Commission on Ending Childhood Obesity. What she expected from the Commission was a state-of-the-art consensus report on which specific interventions, and which combinations, were likely to be most effective in different contexts around the world. She had asked the Commission to deliver its report to her in early 2015 so that she could convey its recommendations to next year’s Health Assembly.

World Health Professions Alliance Reception

On Monday, the WHPA held its annual luncheon reception at the InterContinental Hotel on the theme of ‘Health Care in Danger’.

Dr. Mungherera welcomed the guests with a brief introduction. She made the point that in areas of conflict where health care was attacked, it was largely local health personnel

and facilities that were worst affected. She said that health ministers around the world should be informed about this situation so that they could become involved. In addition, ministers needed the support of all stakeholders. Finally, it was important to put in place indicators to measure and monitor all incidents and the measures taken.

The keynote speaker at the event was Ms Christine Beerli, Vice President of the International Committee of the Red Cross. She said the ICRC had documented 1,809 incidents of assaults or threats against patients, health care personnel, ambulances and health care facilities between January 2012 and December 2013. Yet this represented only the tip of the iceberg. The statistics were that 168 health care personnel had been killed, 267 had been injured, 564 kidnapped or arrested and 212 threatened. The number of patients killed or wounded totalled 545 and 410 healthcare facilities had been attacked or looted. In addition 351 ambulances had been attacked, robbed or delayed.

Ms. Beerli said this was unacceptable and showed the urgency of protecting the medical missions. Local health care providers accounted for 91 per cent of the documented incidents. The perpetrators included state armed forces, such as the military and police and armed non-state actors. However the ICRC 'Health Care in Danger' project, launched in 2011, was on track, first to improve the safety, quality and timeliness of medical services in armed conflict and also to engage the various stakeholders in finding and promoting practical solutions to protect health care. A broad community of concern was being built.

But she said more needed to be done, and she mentioned several specific requirements. Health ministers had to be brought on board because they had an essential role to play and they needed the support of all stakeholders, such as national medical associations, nursing associations and oth-

ers. And finally indicators to measure and monitor the effects of incidents had to be put in place.

WMA/IFMSA Seminar

On the Tuesday the annual WMA lunch-time seminar was held at the Chateau de Penthes on the topic of 'Doctors Fighting Violence against Women and Girls'. The event was jointly organised with the International Federation of Medical Students' Associations and with the support of the Norwegian Agency for Development Cooperation and the Ministry of Health and Welfare of Taiwan.

The first guest speaker was Taiwan's Health Minister Chiu Wen-ta, who told the gathering about his country's efforts to prevent violence against women. He said that Taiwan had made huge efforts to prevent violence targeting women, including passing several acts to regulate and prevent violent crimes targeting women, such as the Domestic Violence Prevention Act of 1998 and the Sexual Harassment Prevention Act of 2005. Taiwan was the first country in Asia to implement the Sexual Assault Crime Prevention Act in 1997.

He said that Taiwan was dedicated to the cause of gender mainstreaming and had had gender mainstreaming policies since 2003. These had focused on assessing the different implications for women and men in legislation and government programs. In addition, Taiwan had signed the Convention on Elimination of All Forms of Discrimination against Women of the United Nations in 2007, and an enforcement act was passed by the Legislature in 2011 to implement the international codes for protecting women's rights passed the enforcement rules.

He said that Taiwan's efforts had paid off, citing figures showing 18 percent of women last year suffered violence at the hands of

an intimate partner, lower than the world average of 30 percent estimated by the World Health Organization. The Ministry of Health had launched a program with 24-hour hotlines, counselling, emergency assistance, and events to raise community awareness of the issue. And according to ministry statistics, in 2013 alone, the program provided 990,000 consultations for domestic violence victims and 180,000 consultations for sexual assault victim

The second keynote speaker was Professor Sir Michael Marmot, Director of University College London Institute of Health Equity, and chair of the World Medical Association's Socio-Medical Affairs Committee. He outlined the extent of domestic violence around the world. It was a global public health concern with one in three women throughout the world experiencing physical and/or sexual violence by a partner or sexual violence by a non partner. In many countries married women believed a husband was justified in beating a wife if she refused to have sex. Education, however, was key, he said. The more educated women were the less likely they were to think that violence from a husband was justified.

Sir Michael said that although domestic violence was evident across all classes, economic and ethnic groups, the statistics showed that this pattern of behaviour was more prevalent among the less well educated. A study among nine countries showed that those women most likely to report having experienced violence were married at a young age, had multiple children and a family history of domestic violence between their parents. As well as resulting in murder and injury, domestic violence also led to suicide, induced abortions, depressive disorders and alcohol problems. And women with mental health disorders were also more likely to have experienced domestic violence.

He said that physicians and health professionals had to be more active in this field.



Staff training in equality and diversity issues should be improved so that physicians and others could detect more easily cases of abuse among their patients and could ask relevant questions. He suggested that physicians should routinely ask their women patients about domestic abuse where they had reason to suspect violence, a leading doctor said today. Physicians should ask about domestic abuse more often so that it normalised the question.

‘For instance, much domestic abuse starts during a woman’s pregnancy and physicians should be aware that asking questions during this time is particularly effective. Previously silent women may come forward because of fear of harm to their baby’. In addition, he said, women and girls should be empowered through education and social support.

Dr. Mungherera, who also spoke, said: ‘Domestic “Gender Based Violence” was only one of the many forms of violence that women experienced worldwide. In conflict situations, sexual violence was common and was often associated with physical violence and abductions. Unwanted pregnancies, HIV/AIDS, mental disorders and traumatic fistula were common complications.

‘In addition, low use of family planning services has also been associated with GBV and hence the need to integrate such services into the reproductive health services. It is also important that GBV is included in the pre-service training and continuing education curricula of physicians and other health workers. GBV services should be integrated into mental health and primary care services and these should be made available universally.’

In a press release about the event, Dr. Mungherera added: ‘The recent kidnapping of young Nigerian girls illustrates in the most horrific way this devastating scourge. It is not enough to deplore the magnitude

of the phenomenon. Urgent, strong and concrete policies must be taken now with the participation of all sections of society, including the health sector, to meet this major global public health, gender equality and human rights challenge.’

WMA Presentations to World Health Assembly

During the week the WMA made several presentations to the Assembly on behalf of the World Health Professions Alliance. Among them were:

Monitoring the Achievement of the Health-Related Millennium Development Goals

‘We would like to commend WHO in its efforts to make sure health remains central in the post-2015 development agenda. In the lead-up to the 69th session of the General Assembly, where the post-2015 development framework will be discussed, we would like to see the following points supported by WHO:

‘The “Health across all stages of life” goal should be clearly stated in the framework and include targets on communicable and non-communicable diseases, mental health, sexual and reproductive health and family planning, maternal and child health, and neglected tropical diseases, as well as the social determinants of health.

Universal health coverage should be acknowledged as a means of achieving health for all, not an end in itself. Only by strengthening holistic health care systems and linking them to the social determinants of health can we improve the health status of all people.

The interdependence of the development goals should be recognized, emphasizing health as critical to their achievement.

Health is particularly important in attaining the goals in education, gender equality, eradication of poverty and environmental sustainability, including minimizing the impact of climate change on people’s health. To demonstrate this interdependence, we suggest that all development goals include the health-related indicators.’

Prevention and Control of Non-communicable Diseases

‘We would like to commend WHO on the progress made in the implementation of the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs following the UN High-Level Meeting in September 2011. We, however, have several concerns with regard to the Terms of Reference (TOR) for the Global Coordination Mechanism and would appreciate your attention to these matters:

‘Structure of the coordinating mechanism – The TOR states that participants will include non-state actors along with the UN funds, programs and agencies. However, the rules and terms of participation for non-state actors are not clear. The term itself “participants” is vague and non-committal. We suggest the use of the term “partners” instead and a clear definition of the partnership requirements and selection criteria.

Definition of non-state actors – We believe that the implementation of the Action Plan will depend on the tireless work and commitment of healthcare workers at the national level. Professional associations are key to facilitating the translation of the global policy into action on the ground. This is particularly important within the context of moving towards universal health coverage and integrating NCDs into the post-2015 development agenda. We propose that the role and expectations of professional associations in the TOR be more clearly defined

instead of merely counting them as “non-state” actors.

Working groups – The eligibility criteria, function and expected outputs of the working groups are not clear. We suggest a more clear definition of their role and functions in the final TOR, and we also suggest making resources available to support their activities.’

The Global Challenge of Violence, in Particular Against Women and Girls

‘We welcome the report addressing the global challenge of violence, in particular against women and girls, which features the magnitude of the global scourge of the phenomenon. We deplore the costs of violence, its devastating health consequences on society as a whole. Violence against women is a manifestation of structural inequalities between women and men. We underscore the crucial need for policies addressing specifically violence from a gender perspective.

‘Furthermore, although we support WHO’s activities to combat violence through multi-sectorial approaches, we believe that there is more to be done. Physicians have a unique role to play in combating this, one of the most severe human rights violations. They see the health problems individuals face in the context of that person, their family, community, workplace and all the other complex factors that affect their health and their recovery from illness. The views of physicians must therefore be incorporated systematically into any comprehensive strategies to prevent and respond to violence.

Physicians and their health professionals’ colleagues are at the frontline in the provision of comprehensive services in support of victims, ensuring that violence is identified, documented and victims reha-

bilitated. We believe that specific, quality and affordable training must be further developed in medical schools and in the framework of Continuing Professional Development. Such a requirement should be reflected by Member States, WHO and other international agencies in their commitments to stop violence.

Finally, given the alarming rate of sexual violence in humanitarian emergency situations, we demand of Member States, WHO and other relevant UN agencies that they strengthen their response to violence against women and girls in situations of conflicts, as a matter of urgency.’

World Medical Association Welcomes Major Step Forward on Palliative Care

At the end of the week, the Assembly unanimously approved a resolution on palliative care and the WMA responded with the following press release:

“The World Medical Association has welcomed last week’s decision by the World Health Assembly to provide greater support for palliative care.

Following years of pressure from the palliative care movement supported by the WMA, the WHA adopted a resolution which aims to ensure that palliative care is integrated into all relevant global disease control and health system plans. This involves including palliative care as an integral part of the education and training offered to care providers.

Dr. Margaret Mungherera, President of the WMA, said: ‘The WMA has long argued for better palliative care for those millions of people who are suffering pain without access to adequate treatment. This must include education of the public and of health-

care professionals, to overcome barriers to effective pain management.

‘We are delighted that the World Health Assembly has now recognised the need for better basic training and continuing education for all undergraduate medical and nursing courses, and as part of in-service training of caregivers at the primary care level. Only in this way can we improve the current level of palliative care required by more than 40 million people around the world.

‘It is the ethical duty of physicians to alleviate pain and suffering. Palliative care is fundamental to improving people’s quality of life and well-being. It is a matter of human dignity and human rights.

‘In too many countries there are no satisfactory palliative care services and I hope that last week’s decision in Geneva will be a major step forward.’”

Africa Project

During the week, Dr. Mungherera addressed many meetings about the Africa Project that she had pursued since becoming President of the WMA. She spoke about progress in involving African national medical associations more in the activities of the WMA with the aim of strengthening the health systems in their countries. She said African NMAs were generally too weak to play their capacity building and advocacy role. Yet with adequate capacity, and networking opportunities from the WMA, NMAs in Africa had the potential to positively influence the quality of health care in their countries by promoting standards in medical education, regulation and clinical practice of doctors. She had visited many of the African NMAs and planned to visit more in the coming months.

*Mr. Nigel Duncan,
Public Relations Consultant, WMA*

Child Abuse & Neglect in India: Time to Act



Narendra Saini

Introduction

The UN Convention on the Rights of the Child (UN CRC) (1989) is the most widely endorsed child rights instrument worldwide, which defines children as all persons up to the age of 18 years [1].

Defining violence and children protection rights, the Convention declares "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." [1,2]

The World Health Organisation (WHO) has defined "Child Abuse" as a violation of basic human rights of a child, constituting all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility,

trust or power. "Child Neglect" is stated to occur when there is failure of a parent/guardian to provide for the development of the child, when a parent/guardian is in a position to do so (where resources available to the family or care giver; distinguished from poverty). Mostly neglect occurs in one or more area such as: health, education, emotional development, nutrition and shelter. "Child maltreatment" sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation [3]. Failure to ensure child right to protection adversely affects all rights. Besides, Child protection is critical to the achievement of Millennium Development goals (MDG). These MDGs can't be achieved unless child protection is an integral part of program & strategies to protect children from child labour, street children, child abuse, child marriage, violence in school and various forms of exploitation. Child Abuse & Neglect (CAN) is a worldwide social and public health problem, which exerts a multitude of short and long term effects on children. The consequence of children's exposure to child maltreatment includes elevated levels of post-traumatic stress disorder, aggression, emotional and mental health concerns, such as anxiety and depression. A well designed epidemiologic, Adverse Childhood Experiences (ACEs) Study [4] revealed a high risk of heart disease in adult survivors of maltreated children, after correcting for age, race, education, smoking & diabetes.

Several developed countries of the world have well-developed child protection systems, primarily focused on mandatory reporting, identification and investigations of

affected children, and often taking coercive action. The burden of high level of notifications and investigations is not only on the families, but also on the system, which has to increase its resources [5]. In these contexts, the problems of child abuse and neglect in India need serious and wider consideration, particularly among the underprivileged rural and urban communities, where child protection systems are not developed – or do not reach.

Magnitude of Problems, Challenges & Types of Child Abuse

India has about 440 million children; they constitute more than 40 per cent of the population. Each year, 27 million babies are born. Many face unsafe birth, and many do not survive them. Many more struggle through childhoods of privation and risk, and fail to reach their full potential. As the poor vastly out-number the non-poor, a large majority of these births are among the underprivileged section of the population, where the parents cannot provide proper care to their children. The situation of the newborn and the periods of infancy and early childhood are particularly critical and the morbidity and mortality rates continue to remain very high. Maternal under-nutrition, unsafe deliveries, low birth weight babies and poor newborn care, lack of adequate immunizations, poor nutrition and unsafe water, neglect of early development and learning opportunities are major issues that need to be appropriately addressed [6]. One can argue that many of these deficits are of under-development rather than of safety, but this is debatable: childhood rights must include protection against neglect and negligent treatment, and the denial of services is negligence. Social and cultural defaults in child-rearing practices reflect social norms and very often adverse traditions are passed from one generation to the next, especially in illiterate and poorly informed communities, and are extremely resistant to change. As guardians of health,

the IMA has to plan and manifest its effort to address child abuse in this reality.

An obvious challenge is that of magnitude

The numbers in need of care and protection are huge and increasing. Extreme poverty, insecurity of daily living, illiteracy and lack of education, result in very little care to the child during the early formative years. Even services that are operating nation-wide, and are mandated to offer free or virtually free services are poorly run and often poorly utilized. The financial allocation for health care is far too small, despite some increases. The allocation of attention to health surveillance and to the social aspects of public health seems even smaller.

The urban under-privileged, large migrating populations and neglected rural communities are particularly affected. In large cities, there is more physical infrastructure and availability of basic services, but major inequalities in access and genuine coverage. Pavement communities, including street children on their own, and child labourers employed in menial and un-protected work are especially at risk and without support. Migrants and their children seem invisible to services that require the so-called "client" to produce proof of a location address. Other children in difficult circumstances such as those shut away in institutions, those affected by disasters, those in conflict zones; refugees, HIV/AIDS-affected, and children with disabilities need appropriate care and rehabilitation [6]. The Central budget allocation for child protection has never even reached 50 paisa (half a rupee) of every 100 rupees pledged for social development. This grave resource challenge calls for re-examination. It also calls for stronger voices from the public and medical constituencies.

Absence of monetary investment and lack of economic capacity are important concerns. But child abuse knows no class or livelihood barriers, or age buffers. It threatens and afflicts children up and down the economic ladder, and up and the 0–18 age

spectrum. The IMA recognizes the need for diagnostic detection of children at risk – and the importance of finding ways to act to help children who appear to be at risk.

A Government of India, Ministry of Women & Child Development (2007) survey showed that the prevalence of all forms of child abuse is extremely high (physical abuse (66%), sexual abuse (50%) and emotional abuse (50%) [7]. A more recent study by the National Commission for Protection of Child Rights (NCPCR), conducted amongst 6,632 children respondents, in 7 states; revealed 99% children face corporal punishment in schools [8].

Indian Medical Association (IMA) perspective

The term "protection" relates to protection from all forms of violence, abuse, and exploitation. This underlines the importance of anticipating and averting what might happen to damage and demean a child – not just response to hurt inflicted. Moreover, it calls for a deeper and wider comprehension of what protection means. Based on our understanding, the Indian Child Abuse, Neglect & Child Labour (ICANCL) group and Indian Medical Association (IMA) has strongly propagated the view that "protection" must also include protection from disease, poor nutrition, and lack of knowledge, in addition to action against abuse and exploitation. This infers that the denial of such safeguards does constitute negligence or neglect, both of which are included in the internationally recognized definition of violence.

The 9th ISPCAN Asia Pacific Conference of Child Abuse & Neglect (APCCAN 2011) conference outcome document "Delhi Declaration" re-affirmed and pledged a resolve to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination. It urged and asserted the urgent need to integrate principles,

standards and measures in national planning processes, to prevent and respond to violence against children [9, 10].

The concept of a "caring community" as children's right, conceived by eminent Indian public health expert Dr. Eric Ram a generation ago, argues that every sectoral entity, every service or infrastructure touching a child's daily life – and every person in any of these – every arm of the State and its institutions – has the potential to be a "caring community" for children. It is an issue of attitude, of not just giving care to the child, but caring about what happens to a child, and thus honouring the ethics that should guide any dealings with any child.

India's Approach to Promotion & Protection of Children

The Government has assigned focal responsibility for child rights and development to the Ministry of Women and Child Development (MWCD). The sectoral management of schemes by this and other central ministries has not given children the convergent attention they deserve. Health care services are in one sectoral portfolio, child development and nutrition in another, youth services affecting older children in another, and education in yet another, and services for children with disability parked in yet another, and projects for children rescued from labour in yet another. The focal point ministry has not so far managed holistic co-ordination of planning, programming and monitoring very effectively. The National Commission for Protection of Child Rights, set up in 2007, enquires, investigates, and recommends but lacks autonomy and any authority to act. The same limitation holds for State-level commissions [8].

NGOs and civil organizations and forums: India has a strong presence of non-governmental bodies, networks, community-based organizations, civic forums and peoples' campaigns. In recent years, these organizations and platform have sharpened their focus on protection issues. The news

media are also increasingly alert in playing a watch-dog role.

Having accepted the treaty obligation of implementing the UN Convention on the Rights of the Child in 1992, the Government of India has reported thrice to the UN on national effort to realize these rights. Its latest (2011) report lists some welcome forward-looking legislations and actions, but unfortunately lacks information on impact of laws and programmes and actual benefits [11]. The official routing of services and communications to the family as the receiving unit fails to address the need to reach children placed in any situation or setting other than a family or household location. Children must be sought and reached where they are, not where they should conventionally be. The IMA can see this is as a working challenge in trying to access children in need – in institutions, in street groups, in work-places, on the move, or even in prisons. Linkage with NGOs connected to such kinds of settings may be considered as an outreach option.

General Measurers of Implementation

To address national child right commitments, several policies, laws and programmes have been introduced. The core commitment is still the one that India enshrined in the Constitution: to safeguard children “against exploitation and from moral and material abandonment.” A new National Policy for Children (2012) has just replaced the 1974 policy [12]. That hallmark expression of commitment recognised children to be “a supreme national asset” and accorded “paramount importance” to their best interests in all situations of dispute. The new policy also expresses firm commitment to children’s rights, but gives their interests “primary” rather than “paramount” status. The past decade has produced some positive official assertions of commitment. (See Note to the report). The challenge predictably lies in translating policy into programmes, and then carrying programmes into practice. The State’s development enterprise in India also urgently needs good monitoring and

regular reporting. Much of the data given in official national reports is old, and some of it is consequently not representative of existing realities. This must improve.

Effective Systems for Child Protection

Whose responsibility is it to ensure the safe, protective and caring environment that every child deserves? Ideally, the parents should be responsible for proper care and protection of their child. Every birth should be planned and all births registered. However, the child must not suffer in case the parents cannot provide care and protection. It is the duty of the proximate community and the Government at large to address the issues of care and protection. In this responsibility, the State and its institutions must function pro-actively at all levels of governance and service.

The UN CRC does not absolve either family or community or society at large of care and protection of children. But it firmly puts the onus on the State. Governments are the ultimate duty bearer. In India, the State should ensure that all vulnerable children have the assurance of the best anticipatory, preventive and restorative protection of their right to life, survival, well-being and dignity. India’s new National Policy for Children [12] reaffirms the promise of the original 1974 policy in pledging protective care to children “before, during and after birth and throughout the period of growth.” In practical terms, this must include access to comprehensive health care and nutrition, learning and play, social welfare and the protecting hand of law. Integrated child protection systems can contribute to breaking the cycle of childhood insecurity and exploitation.

Role of Government

India should not need to be reminded that the ultimate responsibility to protect a nation’s children lies with the State. The Constitution of India recognised and affirmed

this in 1950, by pledging to safeguard children against “exploitation, and moral and material abandonment.” By ratification of international instruments such as UN CRC, by recognising international standards such as UN General Comment #13, the Government should commit appropriate legislative, administrative, social and educational measures to prevent and protect children from maltreatment [13]. In 1992, India accepted the obligations of the UN Convention on the Rights of the Child (CRC). The National Commission for Protection of Child Rights (NCPCR) was established in 2007 with a mandate of enquiry and investigation. However, there is a wide gap between (i) policy and implementation and between (ii) practice and outcome, and millions of children fall through the gaps. Government should assign adequate child protection budgets and its officials should also ensure that Governmental funds are properly utilised. The “child’s voice” must be heard by the policymakers! Both the State and professional bodies must also give more attention to the need for services and schemes to be more than reactive, and become proactively preventive. There may be design faults as well as delivery faults: both require detection and correction. Otherwise health attentions as well as safety attention are only in “response” mode. For many children, this may be too little, and too late.

Role of Non Government Organisations (NGOs)

A large number of NGOs are working in the field of child welfare and child protection, and many have created valuable models of prevention, intervention and rehabilitation. However, because of the huge numbers of children requiring protection, their efforts can make only a marginal impact. The larger and central responsibility falls on the State. It is for the State, as well, to bring together different professions and disciplines to make common cause in defence of children’s safety and security. Professional bodies can highlight this potential by taking the initiative

to make connections and to converge efforts. This the IMA has set out to do.

Role of the community

Wherever the parents are unable to take care and protect the child, the proximate community and their elected representatives must take up more caring responsibility, with due diligence and also due benevolence. Thus, rural *panchayats* (local self government) and urban local councils can ensure that every child is safely born, receives basic health care and nutrition, and protection from abuse or neglect – and can feel secure throughout childhood. India's policy assures this. But in practice, even the first moment of survival can fall prey to abusive neglect. This is where the medical professional must be available, aware and attentive [14–15].

Education, Empowerment and Enabling Mechanisms: Families and the community must be educated, informed and enabled so that they can provide care and protection to their children. All those entrusted with the child's upbringing and development must learn that the best approaches are non-violent. Parental guidance and basic support to vulnerable families must be expanded. In India, the Government cannot afford to separate children from their vulnerable families and place them in institutions. Such approaches are also being challenged in more developed countries as well. What most families need is some extra support to cater for their children, in the form of sponsorship schemes, social protection programmes. Awareness of their rights and information about governmental assistance would ensure proper utilization of various "schemes" [16–17].

Role of Multi-disciplinary professionals, the private sector, religious institutions: In India, there is also an urgent need for appropriately trained multi-disciplinary professionals and human resources to make services for children viable and effective. Besides these professionals, all educated persons, the private sector and religious institutions can do more for child protection

and child welfare. Children are not someone else's responsibility.

Attitudes, Traditions, Customs, Behaviour & Practices: There is need to understand social norms and traditions and their effect on children and their right to safety – and to condemn harmful practices and support those that are positively protective. A major attitudinal change in civil society is called for. Any institution that senses this should make the first move.

Many protective traditions and practices exist, such as strong family values. However, certain stereotypes, attitudes and social norms that violate the rights of the child also persist, such as the use of corporal punishment as a way to discipline children or the social acceptance of child labour. Other harmful practices associated to gender roles, such as child marriage or gender-biased sex selection, manifest a patriarchal and hierarchic attitude towards girls and women, who are still seen by many as a liability or as *paraya dhan* (someone else's wealth or property of the marital family) [18].

The traditional acceptance of caste and occupational divisions, and the perception that they represent a justified socio-cultural ladder has been legally questioned and limited or banned – but it persists, and imposes an identity-based restriction on many children's fair access to rights and opportunities. This constitutes abuse. A better understanding of those norms and attitudes, are necessary to promote social change in the best interest of the child.

Recommendations & Plan for a Way Forward

Professional organisations and their infrastructures must not be found wanting in efforts to make India safe for children. The Indian Medical Association is a nationwide entity, with a large membership of trained professionals not only trained to save and safeguard lives, but pledged to do so. The Hippocratic Oath is already a promise made by every medical practitio-

ner, carrying a pro-active commitment to be healers.

Survival, early child health care, nutrition, education, development and child protection are most crucial child rights. In India, child rights, protection and exploitation are intimately linked to socio-cultural and economic inequalities. The deprived sections of society may not know all their rights, and may not have high expectations. But the State does know, and so do professional bodies that all children have equal rights and entitlement to priority attention and care. Multi-disciplinary professionals should step forward and work together to make such attention and care a reality accessible to every child [19].

It is important for professionals and their institutions to monitor the government efforts in protection of child rights. They should be able to collate available national child health indicators, address key issues and concerns in their spheres of operation, and promote and support necessary research. They must also monitor their own performance of their own chosen duties and responsibilities. We can be proud of our service to the nation. But there is always more for us to do. What we now propose is in keeping with our pledge to be the best medical professionals possible.

The prevention of sickness, the relief of injury, the service of relieving pain and suffering, and of both preventing the loss or breakdown of health and well-being, and of restoring them, is already our chosen vocation. The protection of human dignity in facing and overcoming hurt is a part of medical service.

Addressing the underprivileged, vulnerable families and communities as a priority

In the process of voluntary service in underserved regions of our country, some of our IMA member's learnt some important lessons from the vulnerable families and communities. The most important lesson was that public awareness about child abuse

& neglect has to be raised & society attitudes have to change. Children should have knowledge regarding life skills, child rights and participation.

Consistent implementation & strict enforcement of laws

Adequate Legislative framework and their consistent implementation & enforcement are very important. Beyond rationalization of existing laws, the main challenge in India remains their enforcement and the fact that there is a certain degree of impunity for those violating the law. For instance, if one compares the prevalence of child marriage in India (43% of women aged 20-24 were married before they were 18) and the numbers of people prosecuted for violating the anti-child marriage law (a few hundred per year, at best), it is evident that the law is not enforced [18].

Medical Professionals: Training on Child Rights and Protection

Medical professionals are specially mandated to report cases of child sexual abuse, under the "The Protection of Children from Sexual Offences Act (POCSO), 2012". However, the Indian Medical Association (IMA) is aware that hardly any training is imparted to medical students, doctors and allied child health professionals in India on Child Rights and Protection and how to report cases of Child Abuse? [21]. Therefore, IMA has decided to recommend to the Medical Council of India (MCI) (statutory body with the responsibility of establishing and maintaining high standards of medical education and recognition of medical qualifications in India) to advocate necessary changes in curriculum, teaching, training and practice of medical professionals, undergraduates as well.

Medical Professionals to take a stand against Child Abuse

To take a stand against child abuse is not outside our existing mandate. Children are

already at our door, silently asking us to recognize them as the persons most vulnerable to the loss of well-being, and the least able to avoid it. We have a job to do.

We as an association and as a very large number of people who know their job – intend to take up the task we have chosen. Our theme was not an idle or forgetful choice. Our next report should be able to tell how we worked to live up to it.

Information Note to the Report

New National Policy for Children (2013). It establishes 18 years as the ceiling age of childhood, and details many of the 1974 policy commitments, adding an affirmation of India's acceptance of the UN CRC, thus recognising the UN Convention at policy level. National Policy for Persons with Disabilities (2006). The policy recognises that a majority of persons with disabilities can have a better quality of life if they have access to equal opportunities and effective rehabilitation measures.

Policy Framework for Children and AIDS in India (2007). This policy seeks to address needs of children affected by HIV/AIDS, by integrating services for them within the existing development and poverty reduction programmes.

National Rehabilitation and Resettlement Policy (2007) Under this policy, no project involving displacement of families can be undertaken without detailed assessment of social impact on lives of children

National Urban Housing and Habitat Policy (2007). The policy seeks to promote sustainable development of habitat and services at affordable prices in the country and thereby provide shelter to children from disadvantaged families.

National Plan of Action for Children (2005). The action plan was adopted in response to the UN General Assembly Special Session on Children (2002). It lacked specific activities, and implementation fell short of most stated goals and targets. A new national plan is presently being drafted.

National Legislations

The legislative framework for children's rights is being strengthened with the formulations of new laws and amendments to existing laws. These include the Food Security Act (2013), The Protection of Children from Sexual Offences (POCSO) Act, 2012, Right to Free and Compulsory Education Act (2009), Prohibition of Child Marriage Act (2006), the Commissions for Protection of Child Rights Act (2005), Juvenile Justice (Care and Protection of Children) Act 2000, amended in 2006, Right to Information Act (RTI) 2005, the Goa Children's (amendment) Act 2005, the Child Labour (Prohibition & Regulation) Act, 1986 (two notifications in 2006 & 2008), expanded the list of banned and hazardous processes and occupation) and the Information and Technology (Amendment) Act 2008. In addition, there are new legislations are on anvil, such as HIV/AIDS bill. The two most important legislations meant to exclusively protect children are the following;

The Juvenile Justice (Care and Protection) Act 2000 (amended in 2006) was a key national legislation. It established a framework for both children in need of care and protection and for children in conflict with the law. This law is presently being reviewed for substantive changes, and may be replaced by a new law.

Harmonisation is needed with other existing laws, such as the Prohibition of Child Marriage Act 2006, the Child Labour Prohibition and Regulation Act 1986 or the Right to Education Act 2009. Important contradictions exist among these laws, starting with the definition and age of the child. Conflict with personal laws should also be addressed, ensuring universal protection of children, regardless of the community they belong to.

Protection of Children from Sexual Offences (POCSO) Act 2012

The Protection of Children from Sexual Offences Act, 2012, specifically address the issue of sexual offences committed against children, which until now had been tried un-



der laws that did not differentiate between adult and child victims. The punishments provided in the law are also stringent and are commensurate with the gravity of the offence. Under this act, various child friendly procedures are put in place at various stages of the judicial process. Also, the Special Court is to complete the trial within a period of one year, as far as possible. Disclosing the name of the child in the media is a punishable offence, punishable by up to one year. The law provides for relief and rehabilitation of the child, as soon as the complaint is made to the Special Juvenile Police Unit (SJPU) or to the local police. Immediate & adequate care and protection (such as admitting the child into a shelter home or to the nearest hospital within twenty-four hours of the report) are provided. The Child Welfare Committee (CWC) is also required to be notified within 24 hours of recording the complaint. Moreover, it is a mandate of the National Commission for the Protection of Child Rights (NCPCR) and State Commissions for the Protection of Child Rights (SCPCR) to monitor the implementation of the Act [20].

Telephonic help lines (CHILDLINE 1098) and Child Welfare Committees (CWC) under the Juvenile Justice Act (2000) have been established, where reports of child abuse or a child likely to be threatened to be harmed can be made and help sought.

National Programmes

The Government of India is implementing several programmes on social inclusion, gender sensitivity, child rights, participation and protection. The approach is based on UN CRC and Millennium Development Goals (MDGs). These programmes include: Integrated Child Development Services (ICDS), SABLA Scheme for Adolescent Girls, and Saksham project for adolescent boys; Rajiv Gandhi Crèche Scheme for children of working mothers, scheme of assistance to home for children (*Sishu Greh*) to promote in-country adoption, *Dhanalakshmi*- conditional cash transfer schemes for girl child,

Programme for Juvenile Justice, Child Line (24-hour toll-free telephone helpline (No. 1098), Integrated Child Protection Scheme (ICPS), Integrated program for street children, *Ujjawala* (scheme for prevention of trafficking and rescue, rehabilitation, reintegration and repatriation), *Sarva Shiksha Abhiyan* National programme for school education, National Rural Health Mission (NRHM), Mid Day Meal Scheme, Jawaharlal Nehru National Urban Renewal Mission (JNNURM), Universal Immunization Programme (UIP) and Integrated Management of Neonatal & Childhood illness (IMNCI).

Integrated Child Protection Scheme (ICPS)

The Ministry of Women and Child Development, Government of India has launched an Integrated Child Protection Scheme (ICPS) (2009), which is expected to significantly contribute to the realization of State responsibility for creating a system that will efficiently and effectively protect children. It is meant to institutionalize essential services and strengthen structures, enhance capacity at all levels, create database and knowledge base for child protection services, strengthen child protection at family and community level and ensure appropriate inter-sectoral response at all levels and raise public awareness. *The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society.* The ICPS is an important initiative, but is still in its infancy [22].

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Dr. Narendra Saini
Hon. Secretary General, IMA

Acceptance Speech for the Paracelsus Medal on the Occasion 117th German Medical Assembly on 26th/27th May, 2014 in Düsseldorf



Gerhard Trabert

First of all, I would like to thank Ms. Albrecht, Mr. Bach and Mr. Diehl for immediately agreeing to grant me a little speaking time when I offered to say a few words on the subject of poverty and health.

I see the award of the Paracelsus Medal as an expression of solidarity on the part of the German doctors' association with the people who are particularly close to my heart, and to whom I have devoted my medical work over the last decades. People living on the fringe of society, here and elsewhere.

The debate about the underclass and the precariat has clearly shown that poverty is an issue that raises many concerns and fears amongst the people in Germany. Established findings on the relationship between and the mutual influence of poverty and health or disease have been available in German-speaking countries for over 20 years. And yet this context still attracts too little public and professional interest.

The situation of poor people and their problems is a side issue, it is still given way too little attention, especially since the parties involved

have no influential lobby, their needs are not seen as being or allowed to become a priority. It is this phenomenon of non-consideration, of turning a blind eye, of ignorance which we can also find in the discussions on the health care reform and on the co modification of the health system.

Poverty and its relationship to and impact on health and on the development of disease is still an underestimated and neglected subject in the context of the debate on poverty. Although – particularly in terms of these close correlations – it is clear that poverty in one of the richest countries in the world does not simply mean a lack of consumer goods, or convenience, or social participation, but is often accompanied by physical and mental suffering, by higher morbidity rates, and even a significantly lower life expectancy.

Even Goethe once said: "Empty pocket, sick heart." The relationship between social conditions and disease has been proven by numerous socio-scientific and natural scientific studies.

A concrete connection between social status and disease, with significantly increased disease prevalence could be found for almost all groups of somatic and mental illness. Depression and suicide rates, amongst others, increased significantly, unemployed people show a 20-fold higher suicide rate than the employed. Poverty causes stress and associated illnesses.

In addition to the morbidity, the mortality of people experiencing poverty is also higher in our society. Between the richest and the poorest quarter of the German population, there is a difference in life expectancy of 11 years for men and 8 years for women. 31% of men affected by poverty do not reach the age of 65. In our open medical centre, I more and more frequently experience people with life-threatening diseases being denied adequate treatment because they have no health insurance. In Germany, people are dying because the health care system is no

longer there for them when they need it. Being poor means being subjected to great psychosocial stress, especially in our achievement-oriented society. To make matters worse, there is still a negative culture of defamation and finger-pointing towards socially disadvantaged people which often causes them to seriously doubt their own worth.

The so-called health care reforms – are they really reforms which benefit the people? The changes in the law already made and those planned are at the expense of poor and socially disadvantaged people. High health insurance premiums, additional fees, higher deductibles, the axing of medical services all lead to further health risks and social exclusion. In this context, Amartya Sen addressed the importance of structurally implemented opportunities to access resources, including health care. He speaks of capabilities, of realization opportunities, of being able to use and implement existing individual resources. But it is precisely this that is becoming more and more difficult, sometimes even impossible, for many people in our society today, due to administrative hurdles.

We cannot just silently accept the brutal profit-oriented policies of large sectors of the pharmaceutical industry. When the chairman of a leading German pharmaceutical company publicly stated at the end of last year that the cancer drug Nexavar – and I quote: "was not developed for the Indian market, but for Western patients who can afford it," then this must be strongly condemned. *Mahatma Gandhi* said more than half a century ago: "Poverty is the worst form of violence". Sadly, this kind of corporate behaviour shows that his statement is clearly as accurate today as it was then.

Equally important and necessary is our solidarity with and practical support for people in countries which still have a completely inadequate health care infrastructure, whether these are in Europe – such as Greece – or on other



continents. Countries in which sickness, death and suffering are tragically part of everyday life. And the causes of which, considering, for example, the many AIDS sufferers in Africa and their inadequate health and specifically medicinal care, are to be found also and particularly in the greed for profit of European and German corporations.

In our medical centre without restrictions for people without medical insurance, we are currently constantly confronted with the situation that people who are looking for asylum in Germany are deported. To this respect I must sharply criticize the European Dublin III Agreement under which asylum seekers can at any time be deported to the first European country in which they set foot. It is and must be clear to everyone that deportation to Bulgaria, Greece or Italy results in these destitute people seeking help being "released" into accommodation unfit for human habitation, into homelessness, or often even being imprisoned. Thus, their human rights are not respected, sometimes they are even deported back to the crisis regions and war zones from which they have fled. Numerous scientific studies have shown that a large proportion of the people affected experience severe post-traumatic mental stress disorders. These are often not recognized and acknowledged and then exacerbated due to the repressive and hostile treatment they are subjected to in the countries of refuge. As a doctor I have gathered experience with the suffering of the local people in numerous war zones. Recently, I attended a medical aid mission in the Lebanon for Syrian war refugees. The Lebanon, with a population of only 4 million people, has taken in over 1 million war refugees. Germany boasts of taking in 10,000 Syrian war refugees. A scandalously low admission quota. At the same time it prevents admission of these people who are in mortal danger by imposing repressive regulations culminating in an unacceptable "declaration of obligation" for family members of Syrian refugees. The planned drastic tightening of the asylum law by the Federal Ministry of the Interior will dramatically worsen the situation, especially the health situation, for many people. Conclusion: European regulations and

the associated deportation practices are unjust, unsocial and endanger the lives of many people in need. Germany should also not be thinking about stepping up its military involvement in the world, but its humanitarian efforts. This makes me sad and angry at the same time. We must not remain silent.

Once again we hide behind laws, rules and regulations and don't see the individual suffering that we create through the implementation of these unjust regulations. Abbé Pierre, the French priest who, amongst other things founded the Emmaus movement, once said: "Respect laws if their application shows respect for the people themselves." These legal regulations clearly do not do so. In this regard, we doctors have to make a stand and fight for these people even more actively and vehemently.

The Danish therapist Jesper Juul has "introduced" an interesting term into the German language, the term of "Gleichwürdigkeit" or equal dignity. This term does not exist in the German language, but in other languages. For me, this term expresses a fundamental quality of human relationships and communication. To encounter people with dignity, thus returning to them a little of the dignity they have been robbed of. This dignity is especially reflected in comprehensive health care which is accessible for everyone, regardless of social status. Giving people affected by poverty dignity, respect and appreciation back means finding new approaches in health care. Approaches that take us to the ostracized people in our society. This reminds me of two statements made by famous people from our neighbouring countries. The Swiss philosopher Kurt Matti said: "Where would it take us if everyone said, where would that take us and nobody went to see where it would take us if we went." Franz Kafka, the Austrian of Czech origin, said, very pragmatically: "Paths are formed by walking." We must do something now.

And it is precisely this need to act now, tangibly and practically, that Stéphan Hessel, who died last year, demanded. Hessel, the Berlin-born French citizen and Résistance fighter who survived the Buchenwald concentration camp, co-author of the United Nations Declaration of Human Rights, published a remarkable pam-

phlet in 2010, entitled: "Time for Outrage". In this pamphlet, Hessel criticizes the treatment of poor people in the heart of Europe. He does this by denouncing the deliberate suppression and the loss of human rights and criticizes the power of financial capitalism. He ends with the words: "Creating something new means putting up resistance. Putting up resistance means creating something new."

We should all be outraged at how socially disadvantaged people are treated in our society, at how their circumstances are reported on, inadequately, sometimes ignoring facts, denying causal links. Let's start putting up resistance to anti-social, unjust policies, constructive and consistent resistance, in solidarity and together with the people concerned.

I wish all of us, especially us doctors, that we can summon up the commitment, the courage and intransigence when it comes to the realisation of humane, human rights-based health care for socially disadvantaged people.

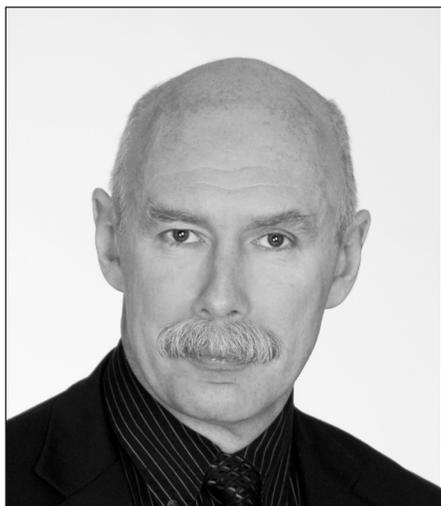
Our work as doctors has always been based on the fundamental philosophy that medical care must be offered regardless of religion, race, ethnicity or social status. It seems that this has to be increasingly complemented by the phrase that we will also treat human beings in need of help, regardless of their health insurance status, whether they are health insured or not, and irrespective of their residence status in our country, in accordance with our medical skills and knowledge. Just talking about it won't remove discrimination and injustice. Contrasting approaches must again be demonstrated more clearly in order to achieve concrete and practical improvements of the situation for the patients concerned.

Finally, let me say this: This acceptance speech is a little out of the ordinary, in terms of time and of content. On the one hand, I see myself as having an obligation and a responsibility to address the situation of poor marginalized people here and now. On the other I am guided by the man who, 62 years ago, first won this award, by Albert Schweitzer. He said: "It is my right to be uncommon – if I can. I seek opportunity – not security".

Prof. Dr. Med. Dipl. Soz.-päd. Gerhard Trabert

What We Can Learn From the Ukrainian Crisis

Kiev-Dnipropetrovsk, August 25–27 (eyewitnessed)



Pēteris Apinis

On August 25, I together with Mr. Renārs Putniņš, Parliamentary Secretary of the Ministry of Health (as at the moment there is no Minister of Health in Latvia according to legislation he is the highest ranking official in the sector) arrived in Ukraine to see the situation in the area of health care, especially paying attention to the wounded soldiers and refugees.

As at that time active warfare was taking place, we were allowed to attend Dnipropetrovsk Region situated next to Donetsk. There are approximately 3.5 million inhabitants in Dnipropetrovsk Region. The city itself, which lies 240 kilometres from Donetsk, can be considered an important industrial, educational and scientific centre.

Dniprodzerzhynsk (a suburb of Dnipropetrovsk) is the birthplace of the former Soviet leader Leonid Brezhnev. During his career Brezhnev was supporting the development of the region by promoting rocketry industry, electrical technologies, metal

industry and establishing a series of universities, including the Medical Academy.

Before our visit to Dnipropetrovsk I had watched Russian TV channels that presented the city as a ruined, economically exhausted and abandoned place. The truth was quite different – the city was well illuminated, the lawns mowed, new apartment blocks being built. Dnipropetrovsk receives daily from a hundred to a thousand refugees from Donetsk Region, mostly women and children.

Obviously, in Donetsk Region, which is under the control of separatists, a human crisis has begun because Dnipropetrovsk is flooded by chronically ill people from there. For instance, now a ward, performing haemodialysis to 120 patients daily, has to manage additional haemodialysis for 78 refugees. All the refugees have arrived after interrupted medical care and can be considered as severe cases.

Patients with diabetes mellitus who need insulin and other antidiabetic remedies have arrived hoping to be rescued. I witnessed myself that to a psychoneurological institution with 60 beds for children from Dnipropetrovsk Region there were hospitalized 50 children with different inborn and hereditary pathologies, mental disorders etc. from Donetsk.

The nurse had injected sopoforic medicine during the transportation and there was no documentation that could contain evidence about their parents or relatives, even the names of most of the children were not known.

The children were taken to Dnipropetrovsk to save them from being killed as separat-

ists tend to believe that they only cause expenses. Practically all pregnant women with pathologies or extrauterine pregnancy have fled Donetsk for Dnipropetrovsk as separatist leaders have announced that all deliveries should take place in equal conditions and the specialized Mother and Child Centre had been turned into a hospital for soldiers.

The flow of refugees is handled by volunteers, mostly students, and the people of Dnipropetrovsk support reception centres by donating food, warm clothing and sanitary items. So far it has been possible to place refugees in different premises, hostels and empty apartments.

The wounded have been brought to Dnipropetrovsk (also Kharkiv) as well. On average, there are about 30 patients with polytraumas. The severe cases are transferred to Mechnikov Hospital of Dnepropetrovsk Region while the milder ones are taken to the military hospital. I must admit that the military hospital is badly equipped, practically plundered and should be closed. Only a nineteenth century military doctor could consider it a hospital. The reanimation ward is as in the fifties of the last century.

Mechnikov Hospital is quite a surprise. The former chief of Health Board had built a spacious emergency ward with diagnostic equipment, operation halls, intensive care units. The hospital already cares for some thirty severe cases simultaneously and the staff has learned to cope with the situation.

When a patient with burn wounds was brought in, cartridges and hand grenades fell out of his pockets. In an intensive unit you can find about a dozen wounded mostly with bullet injured legs and extensive burn wounds. There is an officer whose neck has been hit with a bullet which had passed between esophagus and trachea not touching the major blood-vessels while breaking the lower jaw on exit. Some sol-

diers with milder wounds who have already been treated properly have been placed near the main entrance – to keep safe from provocations.

A week ago a wounded pregnant woman was taken to the hospital and doctors managed to save the child. About one third from the wounded is civilians.

Soon the Ukrainian doctors will become mega-stars concerning caring for wounds and polytraumas – there is no such training practice in other countries. So it seems we have to go to Mechnikov Hospital and a similar institution in Kharkiv and volunteer for experience. The war of today is very different from WWII – every wound is combined with a lacerated wound, crushed bones and internal burns. Unbelievably many traumatic amputations. An anaesthetist we had a cup of coffee together in the emergency ward told me about a patient whose leg just fell off the transportation trolley while being driven from the ambulance van. An experienced nurse fainted at the sight.

It seems to me that the first lesson we get from the Ukrainians relates to the first aid experience, actually the mistakes they are making. Unfortunately, there is no chance for me to reach the front line as separatists have resumed their offensives.

I had a conversation with a young surgeon on his ten-day leave who asked not to reveal his name. He is in his late twenties, used to work as a surgeon in a prominent Dnipropetrovsk hospital, then got mobilized and sent to the battlefield.

Every other day he worked at the battlefield and spent the days in the sanitary vehicle. He had been observing, draining, immobilizing up to 32 wounded patients per day. The biggest problem is that there is no obvious battlefield, most of the soldiers get shot, wounded or killed while they rest in barracks or tents.

Obviously, my companion had been instructed regarding conversations with strangers. There had been no instruction about medical matters, however, and we could discuss medical issues more freely. Those fighting on the Ukrainian side are young men doing obligatory military service – eighteen-year-olds, sooner, cannon fodder. There are also battalions of volunteers – experienced men who have done military service before, but they are unbelievably poorly equipped.

Volunteers are much easier to manage, many of them have graduated from universities and as many there are students. They all receive booklets containing first aid algorithms (neat and easy-to-understand) and they are eager to practise. As a result they are taught how to inject analgetics immediately. First aid kits, however, resemble drivers' first aid kits – a red rubber constrictor that has been kept in a storehouse for years and as a result has become fragile, gauze bandage, iodine or green antiseptic liquid (for a friend to pour on a friend's burns), eye drops that I don't recognize.

The biggest problem is evacuation of the wounded person from the fire zone – at first it is just reaching him, then evacuation by an available vehicle – usually an armoured personnel carrier or a lorry that jolts so heavily that the wounded feels like going through hell. After the transportation the injured person is taken to the sanitary vehicle described above where he is examined by a professional doctor or gets transported to a nearest regional hospital (there is one in every bigger town next to the battlefield), where there is only a local internist or no one at all to treat the wounded.

The most professional institution near the battlefield is a surgical hospital where real help is provided to the wounded. From there they get transported to Kharkiv or Dnipropetrovsk, more often by helicopter than by ambulance car. More severe cases

go to civil hospitals while milder ones – to military hospitals. Sorting takes place in Dnipropetrovsk Airport, and the decision is made by an experienced military doctor, a colonel, Head of the Lung Surgery Department from Odessa. All by himself. He only tells me his name and patronymic, omitting his surname, *as it is not important*.

The person who is not afraid of telling his name and who supervises the process from morning till night and the whole healthcare in the region is Professor Igor Makedonsky, Head of the Regional Health Department. He is a paediatrics surgeon, a well-known professional in the whole country and he has been Head of Dnipropetrovsk Children's Hospital; at the moment he is assigned responsibility for the regional healthcare. Reserved, introvert, polite, but unbelievably confident in his statements and actions. He manages to procure funds both from the region and Kiev.

It is only fair to mention that support from local people is incredibly great. People bring to hospitals food, medicine; local industries have started producing stretchers, hospital equipment, up to vacuum pumps, dermatomes, pulse oximeters that are at least 10 times less expensive than the analogues supplied to Latvia by international companies.

Ludmila Ivanovna Padalko, Head Physician of Dnipropetrovsk Perinatal Centre, tells us that there is enough donated food to feel safe for a week or even two. The Centre is large, there are nearly 400 beds, including gynaecological beds, and the maternity ward. In Ukraine, the number of beds is decisive in healthcare as it determines the money allotment to the hospital. The maternity ward has 12 separate entrances each of which leads to a small separate maternity ward installed with a bed, a maternity table and even a triangle bath. The patient's husband is also welcome. There is a bathroom, resting facilities and even a TV set. The ward is for patients with pregnancy



pathology from the whole Dnipropetrovsk Region.

However, those who want to give birth in civilized conditions come to this hospital as well. According to Ukrainian legislation maternity assistance should not be charged. As a result those who are not eligible but still want to give birth to their children in this wonderland have to pay a donation to the hospital (only by credit card).

It feels strange to hear about the way the donations are spent. Five men from the hospital have been called up – an anaesthetist, two medical assistants and two workers. The hospital has purchased for all chest armour for 4,000 grivnas, helmets for 3,000 grivnas, and special footwear for 2,000 grivnas. It turns out that those who are not provided with such assistance get to the battlefield without any protective means.

There used to be similar exclusive prenatal centres in Donetsk and Luhansk as well, but the separatist government considered that the centres mainly dealt with artificial insemination. At the moment the centres care for at least about one third of patients more than usual.

In Kiev I had a possibility to visit the Ukrainian Ministry of Health and meet the Minister of Health Oleg Musij. It was a holiday – the National Independence Day. Oleg Musij was not wearing a jacket and poured tea himself. He is energetic, talkative and smiles a lot. He is an anaesthetist, long-term President of the Ukrainian Medical Association. He managed medical service on Maidan, spent days and nights on duty, provided first aid, organized evacuation, performed about ten intubations and resuscitations directly on the square or in the Ukrainian House next to it. Once he got shot by a water-cannon at 20 degrees below zero Celsius and nearly turned into a block of ice while performing resuscitation. He is the only minister in the new government who does not belong

to any party and is free of any political influence. However, his deputies have been assigned by several parties. Oleg Musij is getting ready for winter when there will be no heating; they have almost run out of supplies of medicines and dressings. The physicians' salaries are three times lower than in Latvia and ten times lower than in Europe on average. "Были б мне Твои проблемы (If only I had your problems)", he said with a smile. The health budget in Ukraine is 3.5 billion euro for 45 million inhabitants, and that is in a country at war or – the Ukrainian Ministry of Health has 77 euro per capita per year.

To tell the truth, the Ministry of Health manages only 65% of the health funds. Military medicine is managed by the Ministry of Defence. Those working on railways go to Railway Hospitals and sailors go to Marine Medical Centres, miners have their own specialized hospitals. There are fourteen different departments competing among themselves while all of them suffer from the economic crisis. Altogether it makes 118 euro per capita from the state budget. As a result patients almost fully pay for medical care, including their stay in hospitals.

It seems that the biggest problem created by the war in the east of Ukraine is running out of resources – no one knows how Ukraine will survive the winter without energy and the very restricted reserves of fuel.

There is something that is not said aloud, but can be sensed – humanitarian assistance causes only problems. Nothing is said, but you become aware that European countries send what they do not need themselves – old dressings, unidentified pills etc. The logic is simple – when you are at war, you need a month's supply of narcotic painkillers, infusion liquids, antibacterial remedies, respiratory equipment and outer fixation materials including dressings. In fact, the same is true today for any place in Europe. Such reserve is necessary

and it should be a modern one. Of course, this is not the same amount that Ukraine, which is at war, now needs.

What can Latvian medicine do for Ukraine? As a country holding the EU Presidency in 2015, we can convene a conference about a united healthcare system, attracting medical thought from Ukraine, Moldova, Georgia and Belarus. We can help Ukraine to reach the European level not through simplified humanitarian aid, but by all European countries jointly dealing with the consequences of the Ukrainian tragedy.

And there is a tragedy. There are young men with amputated legs. There are officers whose gunshot wounds have turned into osteomyelitis. There is a guy with a bullet stuck in the frontal cavity. It is a strange feeling when you enter a ward with 5-6 war-wounded patients, and each has his own story and now they are bedridden. There are polytraumas that suppurate.

I am the first doctor from Europe who had been so close to the battlefield to see what is going on in healthcare. I was not allowed closer than 100 kilometres from the front line, so I could not see first aid provided to soldiers and I did not see the hospital tents myself. I am ready to return to understand what is going on in reality at the battlefield in the middle of Europe. I took a lot of photos for professional purposes including doctors and patients; however, I cannot publish the photos for ethical and professional reasons.

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Junior Doctors' Work Hours: from regulations to reality

Physicians worldwide are sick. We experience increasing levels of stress, burnout, and mental health disorders compared to our non-medicine neighbours [1]. Dissatisfaction is high, and many of our colleagues would not choose medicine all over again, let alone recommend it to the next generation of our healthcare system [2]. Injured wellbeing, the “phantom limb” of our profession, limits our ability to provide quality of care, reduce health care costs, and improve the health of populations [3–5]. How can we care for the world, if we cannot care for ourselves?

Perhaps caring can begin with our trainees.

In medical school and residency, trainees are more susceptible to dehumanizing traits, mental health disorders, and stigmatizing attitudes that we carry throughout our careers [6,7]. Those we encourage to heal, including women and minorities, are particularly vulnerable [7]. Loss of wellbeing may be due to fear of health workforce crises and safety concerns. Medical errors are often attributed to trainee fatigue and long hours worked. Century-old education models have been called into question. The wellbeing of junior doctors and their patients worldwide is at risk. Members of the Junior Doctors Network have expressed their concerns and offered solutions for consideration.

Workforce

Trainee security is uncertain and threatens the sustainability of our health workforce. In North America and the UK, after hundreds of thousands of dollars of medical education debt, trainees are struggling to find employment [8]. This is amidst predictions for worldwide shortages of health professionals by over 10 million by 2035 [9]. In developing nations, junior doctors are first-line for outbreaks irrespective of training [10] and when under scrutiny are a face for criticism and dismissal. In developed nations, bullying is a concern [7]. To ensure a sustainable health workforce, we need to help nurture the right trainees for the right job for the right place through safe, quality, and accessible medical education. The WMA JDN is working with the World Health Organization and other stakeholders to determine the drivers behind health workforce supply-demand mismatches worldwide and provide our members with the best information possible to support their healthcare systems and ease their minds.

Duty Hours

Longer hours are associated with higher burnout, fatigue, depression, and injuries [11,12], and national regulatory bodies have responded. In 2003, the Accreditation Council for Graduate Medical

Education) in the United States limited work hours to 80 hours per week and the longest consecutive working time to 30 hours for senior residents, and 16 hours for first year trainees. The ACGME mandated teaching hospitals to ensure adequate sleeping facilities for residents. The European Working-Time Directive applied in 2009 limited work hours of employed doctors to 48 hours per week and 24 hours of consecutive work. There is even national variation with Québec (Canada) limiting hours to 72 hours per week and a maximum of 16 consecutive hours per day while Manitoba (Canada) has an 89-hour limit [12]. In Turkey, hours are limited to 40 hours per week.

In regions without enforced restrictions, there is concern that longer hours may be related to poor physician health. In Australia, younger doctors worked more and reported being more psychologically distressed, suicidal, and burnt-out more and are more burnt-out than their older colleagues [7]. According to a Cross Sectional Survey of Hong Kong doctors, physicians working more than 52 work hours per week were at a higher risk of burnout [13]. In Europe, despite the European Working Time Directive there is variability with UK physicians reporting working more than 56 hours due to occupational pressures [14]. In Turkey, doctors are considered a strategic workforce and are not covered by the same 40-hour limits of other workers with average working hours of junior doctors varying between 48–110 hours per week by specialty and reports of having to work under stress to meet service needs [15]. However, in regions with enforced restrictions, there is concern that patient care, medical education, and even junior doctor quality of life are suffering, especially with surgical trainees [16,17].

Instead of focusing on quantity, perhaps we need to focus on the quality of the hours junior doctors spend serving patients and supporting their own wellbeing. This will likely require attention to the comprehensive working and learning environment including how well we communicate with the entire healthcare team, how well we are taught, and how well we take the time to take care of ourselves.

Education

Medicine is becoming increasingly complex. The number of available diagnostic tests, diagnoses, and treatment options has expanded exponentially and contributed to the clinical and educational workload of all physicians [18]. To compensate, the time a patient spends in the hospital has been declining and junior doctors have increasingly needed to meet this service need without the same educational benefit, and without the legal, financial, or social supports as their older colleagues [19]. The healthcare team is also changing, with greater focus on interprofessional care to meet increasing health system needs. However, the insular training of junior doctors may predispose us to burnout and unprofessional behaviours [20]. The average age of a new Junior Doctor from North America is 28 with at least two degrees and a six-figure debt. Our costs have inflated. Our lives have stagnated. Our futures are uncertain. The century-old



medical education system may no longer be able to keep pace. Reform may be needed, including access to quality medical education resources, consideration of new models such as competency-based medical education, and collective education with other professions, sectors, and patients with the wellbeing of healthcare professionals and the safety of patients in mind.

Conclusion

When a physician is sick we should provide care, but we also need sustainable solutions including a global workforce that meets supply and demands, working conditions that balance education and service, and a current medical education system. We need a healthcare system that prevents the suffering of our own by improving the wellbeing of our trainees. Together, with further institutional commitment and collaboration with our stakeholders, we can foster a culture that is safe for both junior doctors and the patients for which they care. It is a culture of wellbeing. It is medicine's culture to care.

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Order of Physicians of Albania

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Membership: By the law No. 8615 date 1.06.2000 "For the Order of Physicians in the Republic of Albania", all the doctors and the dentists to practice the profession must be registered (mandatory) to the Order and have a individual license which is issued for a term of 5 years.

The mission of the Order of Physicians of Albania is the preservation of high standards on the formation and exercise of medical professions and protection of patients and public from the malpractice of health services.

For the accomplishment of this mission the Order of Physicians of Albania, it:

- accomplishes the registration and maintains the doctor's register for the exercise of their profession;
- supervises the implementation of the professional obligations in accordance with the requests of medical sciences, rules of ethics and Medical Deontological Code;
- assures the ethic, moral and deontological guidance of the doctors and dentists communities, the independence of exercising of the medical profession according to the standards and protects the moral interests of this profession;

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- Assemblies; (General and Regional)
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AMA President; Associate Professor Brian Owler, a Neurosurgeon based in Sydney, Australia

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The AMA is the peak representative and advocacy body for all registered medical practitioners and medical students in Australia.

Medical students can join the AMA for free and are supported with advocacy, lobbying and mentoring.

AMA membership provides political representation, political and professional lobbying, media commentary, public health advocacy, workplace representation and advice, career advice and support, industrial relations expertise and craft group representation.

Members shape and debate current issues facing the medical workforce and patients. Policies are developed at the association's annual National Conference

The prestigious Medical Journal of Australia keeps members informed of the Association's work and provides a major commitment to medical research and education. The Medical Journal of Australia celebrated its 100th anniversary in 2014. The monthly publication Australian Medicine also keeps members up to date with the latest in health news.

The AMA keeps in regular contact with a large number of politicians, political parties and government ministers. It frequently presents submissions to, and appears before, committees inquiring into health issues.

It is also represented on a number of government committees, ensuring that the voice of the profession is heard well before decisions are made. It also keeps politicians informed about the views of the profession in order to help achieve better health outcomes for all Australians.

The AMA frequently runs campaigns to influence government decisions, which it believes may not be in the country's best interests. All policies and advocacy by the AMA is in the interests of the medical profession and patients.

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Austrian Medical Chamber

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Membership: According to the Austrian Medical Act, the Austrian Medical Chamber represents the professional, social and economic interests of all doctors engaged in medical activities in Austria. Furthermore, it acts as umbrella association under public law for its nine members, the medical chambers in the Austrian provinces. Membership is obligatory for every doctor wishing to pursue medical activities in Austria.

Activities: Legal responsibilities of the Austrian Medical Chamber include, besides others, admission to and administration of the medical register, as well as recognizing foreign medical qualifications. Furthermore, the Austrian Medical Chamber is the competent authority for issuing medical diplomas and for conducting specialist and GP qualifying exams. The elaboration of concepts, expert opinions and proposals regarding the Austrian health care system, including the right to comment on draft bills or enacting guidelines on medical fees, on the medical code of conduct etc., as well as concluding contracts with social insurance institutions and collective agreements, and executing disciplinary legislation and arbitration also belong to the responsibilities of the Austrian Medical Chamber. Moreover, the Chamber is involved in the elaboration of specialist and GP training programs, and it also has its own institution offering CME/CPD for Austrian medical doctors. Current topics of interest include the reform of primary health care in Austria, the Electronic Health Record (ELGA), and the current shortage of country doctors. Besides various media activities on cur-

rent political issues, the Austrian Medical Chamber lately hosted two events widely covered by the media: A conference in celebration of the 40th anniversary of the "Mutter-Kind-Pass" ("Mother and Child-Health Record Book"), a then revolutionary prevention program for both mother and child, and an international congress dealing with the situation of doctors in rural areas.

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Bangladesh Medical Association (BMA)

Office Bearers (2012-2014):

President: Dr. Mahmud Hasan
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Membership: BMA offers five category of membership i.e. General Membership, Honorary Membership, Life Membership, Associate Membership & Concerned Membership. Bangladeshi residence any medical doctor whose MBBS or equivalent degree accredited by Bangladesh Medical & Dental Council (BM&DC) can join the Bangladesh Medical Association as a General or Life member.

Services provided: Members are entitled to attend meetings of the association where matters of professional interest are discussed. They can also take part in continuing professional development activities and social services provided by the association. They also get copies of journal and other publications of association.

Activities (some examples):

- With Members: as above.
- With the Public: Interactions with the press regarding professional activities and doctor patient relationship are regularly held. Free clinics are run by the association and its members.
- With the Governments: Regular interactions are held with the officials of Ministry of Health, regarding health policy, health service delivery and professional interest of doctors.
- With the Media: Press releases related to health issues of public interest, promotion of debates related to health policies, education on health related issues.

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Activities: The ABSyM/BVAS (Belgian Association of Medical Unions) was created in 1963 as a reaction to the decision of the government to oblige the medical profession to be regulated by the Belgian State. Belgian physicians thought that this system could not match their medical ethics which is based on a doctor-patient relationship of trust implying free choice of a doctor by a patient, doctor's therapeutic freedom as well as secrecy. The rules and legislation established by the State affected those principles.

Quite rapidly, physicians from all over the country get organized and created doctor's associations on the ground. Those associations federated and developed necessary means to deal with conflicting situations. This association that is presently called ABSyM/BVAS was the successor of the former Belgian Medical Federation (Fédération Médicale Belge – FMB) which was unable to organize a resistance movement. The conflict raised the year after, in 1964, with a medical strike that lasted nearly one month and had been very well planned. The medical corps, organized as an emergency doctor service, then proposed nothing more than depersonalized care, according to the modalities and procedures the government wanted to establish. As the conflict got worse and since the government had decided to requisition the physicians, the ABSyM/BVAS launched a "luggage" operation. Most of the physicians went abroad to escape the potential requisitions. This operation brought the government to give in on this issue. The conflict led to some agreements that foresaw an annual collaboration system which allowed the coexistence of a medical private practice and a social financing. This annual or biennial agreements' system is still ongoing although it has been dealing with many problems and had to tackle the evolution of the medical profession in which it is often difficult to fully preserve the Hippocratic principles. Let's think about the control over expenditure, the necessity of teamwork but also the exchange of data which is the inevitable consequence to reach the necessary balance.

The ABSyM/BVAS did not only focus on union defense. It has been firmly committed in the defense of patients' interests and dialogue with them, who have also formed associations. The ABSyM/BVAS has been committed in the quality of care thanks to an incentive system rather than restraints and sanctions. Furthermore, the ABSyM/BVAS gives priority to security and patients' rights and

also organizes direct dialogue with other health care professionals (pharmacists, dentists, nurses, physiotherapists...). It also takes care of the working conditions of physicians and their health. Its sphere of activity is as extended as the one of associations but in the meantime, it also preserves means of action when the negotiation shows no signs of good results. The Belgian "defederalization" which is currently ongoing gives the ABSyM/BVAS new concerns, especially since it remains one of the few unitary organizations in the country. Nevertheless, the strongly professionalized ABSyM/BVAS is looking to the future with confidence.

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www.absym-bvas.be

Brazilian Medical Association (AMB)

Office Bearers (2011–2014):

President: Florentino de Araujo Cardoso

1st Vice-President: Jorge Carlos Machado Curi

2nd Vice-President: Newton Monteiro de Barros

General Secretary: Aldemir Humberto Soares

1st Secretary: Antonio Jorge Salomão

1st Treasurer: José Luiz Bonamigo Filho

2nd Treasurer: Murilo Rezende de Melo

Director of International Affairs: Miguel Roberto Jorge

Junior Doctors Representative: Nívio Lemos Moreira Junior

Membership: Any medical doctor from all States of Brazil can join the Brazilian Medical Association as a regular member if he/she is a regular member of the respective State Medical Association affiliated to the AMB.

Services provided: The main services provided by the AMB to their membership are a Board Certification jointly with the respective Specialty Society as well as its periodical renew, the Brazilian Hierarchical Classification of Medical Procedures and related minimum medical fees, news and scientific publications, representation of their interests in national and international forums.

Activities:

- With Members: a Continuing Medical Education Program, the Evidence Based Medical Guidelines Project.
- With the Public: Salve Saúde (Cheers Health) Campaign to promote healthy habits and the prevention of Non Communicable Chronic

Diseases

- With the Governments: a Law Proposal to increase yearly funding for health to a minimum of 10% of the GDP, lobby at the Ministry of Education for quality control when approving new and inspecting existent medical schools, lobby at the Ministry of Health for adoption of a medical career in the public services.
- With the Media: press releases related to health issues of public interest, promotion of debates related to health policies, education on health related issues.
- With Strategic Partners: special programs with pharmaceutical and health insurance companies, and financial institutions aiming to promote health information to the public as well as to provide free access to scientific publications to Brazilian physicians.

*Rua São Carlos do Pinhal 324, CEP 01333-903, São Paulo-SP, Brazil
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E-mail: rinternacional@amb.org.br; www.amb.org.br

British Medical Association

Chair of Council, Dr. Mark Porter
Chair of Representative Body, Dr. Ian Wilson
Treasurer, Dr Andrew Dearden
Chief Executive, Mr. Keith Ward

Membership is open to anyone registered to undertake a medical undergraduate course leading to a licence with the GMC to practice medicine and to anyone eligible for registration with the General Medical Council, and for those with qualifications allowing registration in the area or region where they work. Applications are normally made online at www.bma.org.uk

The BMA is a trade union, not part of the Trades Union Congress and with no party political affiliation. We are also a voluntary professional association, a medical publisher (the BMJ and its various journals and e learning resources) and a company limited by guarantee. The core membership offering includes free access to the BMJ, to a wide variety of e learning resources, to trade union support if in employment difficulties (and equivalent support for those members who are employers) and to guidance on professional matters including ethics and to an extensive library increasingly available electronically. Many members are actively engaged with the BMA through local, regional and national structures, helping to make policy and to promote that policy to the public and to governments.

The Association is an influential and active advocate, for the health of the public in the UK and elsewhere. This includes advocacy on matters such as tobacco use and alcohol abuse, as well as on the availability of comprehensive health care through the National Health Service. We engage with members on all matters of health

and health care policy, as well as working with and for members on matters such as their employment conditions, and training organisation and opportunities.

We are formally recognised to negotiate contracts of employment, including pay, for doctors with the Government and health service bodies, and are interlocutors with government on legislation, regulation and other actions that will affect the public, patients and their care. We use a social determinants of health approach to public health advocacy, pointing out to the four governments within the United Kingdom the impact of their decisions on health and well being expectations. The Media ask the BMA to express the views of doctors on all and every health issue, including health service organisation and to explain major health issues of the day to the public. We engage in strategic partnerships with many others on matters of interest – including for example social determinants of health, tobacco control, protection and promotion of an integrated and comprehensive health care system and promoting a healthy childhood for all children.

*BMA House, Tavistock Square,
London WC1H 9JP, UK
President, Professor the Baroness Ilora Finlay*

Canadian Medical Association

The Canadian Medical Association is a national, voluntary association of physicians that advocates on behalf of its members and the public for access to high-quality health care. The CMA also provides leadership and guidance to physicians.

The CMA was formed in Quebec City in 1867, just three months after the birth of Canada. It was created by 164 physicians who recognized the need for a national medical body. They selected Sir Charles Tupper, who would later serve as Canada's prime minister, as the first president. Plans are currently underway to celebrate the 150th anniversary of the association in Quebec City in August 2017 at the CMA's annual General Council meeting, which is held every year in August. This meeting is traditionally attended by international guests from the WMA and other national medical associations.

Today the CMA has more than 80,000 members, and lobbies vigorously on behalf of both members and their patients – on Ottawa's Parliament Hill, during federal election campaigns and in the media.

The CMA also takes the lead on public health issues. The CMA's goal is to ensure the survival and robust health of Canada's medicare system in the face of numerous challenges.

The CMA has been an active participant in the World Medical Association since the founding of the WMA in 1947. There have been two Canadian Presidents of the WMA, most recently Dr. Dana



Hanson in 2009 – 2010. The current CMA representative to the WMA Council is Dr. Andre Bernard. The CMA continues to be actively engaged with the work of the WMA on many fronts, including serving as Chair of the advocacy advisory group and the working group on person centered medicine.

Through its Office of Ethics, Professionalism and International Affairs, the CMA contributes to several international initiatives, particularly in the area of medical ethics. It achieves this through its work with the WMA as well as other organizations such as the World Health Organization and the International Committee of the Red Cross. The CMA's previous ethics director, Dr. John Williams, also served in this role at the WMA, while the current Executive Director of the Office, Dr. Jeff Blackmer, now serves as the primary ethics advisor to the WMA.

The CMA's Mission, Vision and Values are as follows:

Mission. Helping physicians care for patients.

Vision. The CMA will be the leader in engaging and serving physicians, and the national voice for the highest standards for health and health care.

Values: We are known for...

- *Professionalism.* Uniting physicians on fundamental tenets important to the medical profession.
- *Integrity.* Honesty in representing our members and conducting our business.
- *Compassion.* Caring for physicians, patients and each other.
- *Community building.* Bringing diverse communities together to pursue common goals.

*Dr. Jeff Blackmer MD MHSc FRCPC Executive Director
Office of Ethics, Professionalism and International Affairs*

Chinese Medical Association

Office Bearers

President: Dr. CHEN Zhu (2010–2015)

Secretary General: Dr. LIU Yanfei

Mission:

Uniting Medical Professionals, Upholding Medical Ethics and Promoting Social Justice Chinese Medical Association (CMA) is a non-profit national professional organization in China. It is an important social force in the development of medical science and technology and a linkage between the government and the medical professionals. Established in 1915, CMA now has 87 specialty societies. CMA has joined 40 International Organizations and in the year 1947, CMA became a member of the World Medical Association. CMA publishes 162 medical journals including online

electronic journals and makes several hundred kinds of audio-visual products. It organizes more than 200 domestic and/or international conferences each year.

42 Dongsi Xidajie, 100710, Beijing, China

E-mail: intl@cma.org.cn

Conseil National De L'ordre Des Medecins (CNOM)

Office Bearers (2008–2014)

President: Mbutuku Mbambi Antoine

Vice-President: Kaswa Kasiama Jean

1st Secretary: Sese Ndele Henri

2st Secretary: Ebondo Ngoie Symphorien

Treasurer: Beya Luiza Marie

Membership: Any medical doctor from all States & can join the DRC Medical Council as a regular member if he/she has an inscription to the CNOM.

Services provided: The main services provided by the CNOM to their membership are a Board Certification jointly with the respective Specialty Society as well as its periodical renew, the Congolese Hierarchical Classification of Medical Procedures and related minimum medical fees, news and scientific publications, representation of their interests in national and international forums.

Activities

- With Members: a Continuing Medical Education Program, the Evidence Based Medical Guidelines Project.
- With the Public: Salve Saúde (Cheers Health) Campaign to promote healthy habits and the prevention of Non Communicable Chronic Diseases.
- With the Governments: with the Ministry of Education for quality control when approving new and inspecting existent medical schools, lobby at the Ministry of Health for adoption of a medical career in the public services.
- With the Media: press releases related to health issues of public interest, promotion of debates related to health policies, education on health related issues.
- With Strategic Partners: special programs with pharmaceutical and health insurance companies, and financial institutions aiming to promote health information to the public as well as to provide free access to scientific publications to Congolese physicians.

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National Medical Union of Costa Rica

Office Bearers (2012–2014)

President: Dr. Edwin Solano Alfaro

Vice-President: Dr. Alexis Castillo Gutiérrez

Secretary of Minutes & Correspondence: Karim Rojas Herrera

Secretary of Labor Affairs: Carlos Delgado Jiménez

Treasurer: Dr. Johnny Rojas Quiros

Secretary of information: Dra. Patricia Nunez Fallas

Secretary of International Affairs Dr. Xinia María Ávila Matamoros

Secretary of education Dr. Manuel Rosales Caamaño

Secretary of organization DRA. Liliana Vargas Pérez

Board Member I Dra. Rita Maria Vargas Arias

Board Member II Dr. Catalina Morales Alpizar

Board Member III Dr. María de los Angeles Rodriguez Masis

Monitoring Member Dr. José Alberto Méndez Elizondo

Membership: Any physician who is enrolled in the Colegio de Medicos Y Cirujanos de Costa Rica can be affiliated as a member on a voluntary basis to Union Medica Nacional, currently 70% of doctors nationwide are affiliated.

Services provided: Legal Counsel in the field of labor law, administrative law, criminal law and mal practice. It boasts a service shop facilities for the affiliate, retirement fund and union related representation in case of conflicts regarding conditions of the medical employment.

Activities (some examples)

Assemblies with affiliates twice a year, two annual national councils of Directors of local councils, lectures nationwide that envelope different labor union issues and information related to the Board of Directors, we have different commissions with Costa Rican government members for the study of problems regarding the medical labor, also specific and follow-up of the Costa Rican legislation regarding issues that will or can affect the affiliates.

- With Members: a Continuing Medical Education Program, the Evidence Based Medical Guidelines Project, also discussion of related affairs, concerning their labor conditions.
- With the Public: weekly program on television with interviews to different affiliates, regarding their experiences of physicians nationwide, as an example doctors working on rural areas and bringing their knowledge and medicines to this areas.
- With the Government: Caja Costarricense de Seguro Social, Instituto Nacional de Seguros, Ministerio de Salud, Ministerio de Trabajo y Seguridad Social, Dirección de Servicio Civil, Asamblea Legislativa, Ministerio de Hacienda, y el Poder Ejecutivo.

- With the Media: Publications in different newspapers and magazines, conferences press, interviews and discussions about trade unionism, live interviews on radio and television.
- With Strategic Partners:: Colegio de Médicos y Cirujanos de Costa Rica, Sindicato de Médicos Especialistas, Sindicato de Profesionales en Ciencias Médicas, Unión Nacional de Empleados de la CCSS, Asociación Nacional de Profesionales en Enfermería, Bancos Estatales, companies.

San José Costa Rica.

Sabana Sur, 100 meters to the East of the Ministerio de Agricultura y Ganaderia.

Phone: (+ 2290-5490)

E-mail: unmedica@racsacosta.cr; www.unionmedica.com

National Order of Physicians of Cote d'Ivoire

The National Order of Physicians of Cote d'Ivoire regulator Medical Corporation has a status Institution of the Republic by the law 60-284 of 10 September 1960.

The law has defined it three (03) main tasks:

1. Administrative, for the registration of doctors all over the country through the Departmental Councils with regional vocation
2. Disciplinary by the jurisdiction to try and punish doctors across the disciplinary courts at both Departmental Councils and the National Council.
3. Aid works and retirement for doctors to preserve the reputation of the Corporation by medical social actions (residential acquisitions, vehicles, various equipments, membership social mutual funds).

Beyond these national activities, ONMCI is mainly engaged in extra-national activities:

- Writing a Harmonized Code of Ethics and Conduct for medical space West African States (ECOWAS), comprising nearly three hundred (300) million people – five (15) countries – three (03) languages (Portuguese – English -French)
- Participation and elaboration in the West African Organization (WAHO) the harmonization of training curricula of general medicine and medical specialties, the presence of ONMCI within the Regional Council for the Training of Health Professionals (RCTHP), Board responsible for developing and issuing accreditation to training structures healthy.

The wish of ONMCI would like that these advances regionally West Africa can inspire the other physicians States in the region of Central Africa, grouped within the Economic Community of Central African States (ECCAS).

AKA Dr. Kroo Florent

President of the National Council of ONMCI



Czech Medical Association (CzMA)

The CzMA is a voluntary and independent organization of medical doctors, pharmacists and other workers in the healthcare services and related fields in the Czech Republic.

The number of our members has been gradually rising since 1989 when the CzMA became a democratic institution with democratically elected president and council. The members of the CzMA are affiliated on basis of their specialities in particular scientific societies. In larger cities the doctors organize local medical clubs. One hundred twenty scientific societies and 40 local medical clubs currently work within CzMA. Both Czech citizens and foreigners may become members of the CzMA. As the CzMA has slowly gained popularity number of its members reached more than 34 000. It represents almost 90 per cent of all doctors in the republic.

The history of the CzMA dates back to 1860 and is closely linked with the founder Jan Evangelista Purkyne (1787–1869), a world renowned scientist in physiology. His name gives prestige to the name of our Association and helps us to hand down the traditions of the humane and scientific legacy. The aim of J. E. Purkyne and his colleagues was, above all, the development and promotion of knowledge in medical sciences and related fields and their application in health care for people. These fundamental aims remain unchanged to the present time.

The CzMA is involved in postgraduate and continuing medical education in almost all fields of medicine, in organizing national and international congresses, symposia, courses as well as in promotion of effective health care.

The CzMA has also close relations with European and medical associations worldwide. Of these the most important cooperation has been with the World Medical Association (WMA). The president of the CzMA has participated in most of its Council meetings and General assemblies. The Helsinki Declaration has been translated in Czech by the CzMA and published in the Czech Medical Journal (both the Seoul and Fortaleza versions).

Thanks to its reputation the CzMA also grants awards and prizes which are received with the respect they deserve.

*Professor Jaroslav Blahoš, M.D., D.Sc.
President Czech Medical Association J. E. Purkyne
Former WMA president*

Danish Medical Association (DMA)

Office Bearers

Dr. Mads Koch Hansen, President
Dr. Jette Dam-Hansen, Vice-President
Dr. Andreas Rudkjøbing, Chair of International Committee
Bente Hyldahl Fogh, CEO

Membership: Nearly all Danish doctors are members of the DMA. The total number of members as on January 1 2014: 27.090. This means that 97 percent of the doctors authorized to practice in Denmark are members of the DMA.

Objectives: The specific objectives of the DMA are to unite Danish doctors in order to protect the interests of the medical profession. DMA serves as the body through which the influence of the medical profession may be exercised in the society on issues related to sickness and health and in general support the medical profession.

Activities: Subjects as better treatment for psychiatric patients, quality in treatment, patient data security, emergency patients and antibiotic resistance among others are right now high on the agenda in the DMA. Related to the doctors we work with CPD, patient complaint systems and autonomy. DMA exerts its influence through various channels, including formal governmental hearings, corporations, representations in committees, partnerships with other organisations, networking and lobbying activities. DMA also works through the media – in an increasing degree the social media (Facebook and Twitter) which gives a direct access to our members and creates an opportunity to interact with the members. DMA also publishes a scientific journal on the website (ugeskriftet.dk) and every second week on paper. It also serves as a channel for information for members and society. DMA supports our members with different kinds of advice and services regarding their daily life as doctors and their obligation to be continuously professional educated.

*Kristianiagade 12, DK-2100 Copenhagen
www.laeger.dk
www.ugeskriftet.dk*

Finnish Medical Association (FMA)

Office Bearers

Dr. Tuula Rajaniemi (President)
Dr. Heikki Pälve (CEO)
Dr. Hannu Halila (Vice-CEO)
Ms. Mervi Kattelus (Health Policy Adviser, International Affairs)

The FMA employs approximately 70 people (including Finnish Medical Journal)

Membership: The Finnish Medical Association, established in 1910, is a professional organization of which almost all (94%) doctors practicing in Finland are members. Membership is voluntary and available for all physicians practicing in Finland. In the beginning of 2014 the number of members was 24 600.

The FMA binds its members together to support common values (advancement of medical expertise, humanity, ethics, and collegiality), and represents their common professional, social and economic interests. Member services include a patient injury and liability insurance, legal advice, membership in unemployment fund, CPD/CME-training, network of trusted physicians, Finnish Medical Network (Fimnet) Internet portal, and grants for training, research and for international co-operation. Members are also offered certain products, discounts and social activities.

Activities

- We involve our members at regional and local level to participate policy-making of the association.
- We negotiate the salaries of the physicians working in the public sector.
- We follow actively health policy issues in the society and do advocacy work towards and together with the ministries in order to develop health and health care system and patient's rights in the country.
- We provide official and reliable data concerning physician work force both to the governmental agencies as well as to the media. The views of the FMA are frequently quoted in the Media. The FMA is a member of the Confederation of Unions for Professional and Managerial Staff in Finland (AKAVA).

*P.O. Box 49 (Mäkelänkatu 2 A)
FI-00510 Helsinki, Finland
www.laakariliitto.fi*

The French Medical Council

The French Medical Council in a nutshell

The French Medical Council brings together all doctors in France whatever their speciality and their mode of practice, defends the honor, protects the independence and represents the medical profession. By taking on a moral, administrative, consultative, mediation and jurisdictional role, the French Medical Council is the guarantor of the doctor/patient relationship. The commitment of the French Medical Council in its everyday activities is being at the service of doctors in the best interest of patients.



*Xavier Deau President
of the International
Relations Delegation
and President-Elect
of the WMA*

*Patrick Bouet
President of the French
Medical Council*

*Walter Vorbauer
Secretary General of
the French Medical
Council and Council
Member of the WMA*

- The French Medical Council is a private body charged with a public service obligation whose existence is established in the French Code of Public Health.
- In France, doctors must be registered to be allowed to provide items of medical service. According to the French Law, the French Medical Council is the one managing the whole process of registration of doctors (including the establishment and maintenance of the official register of doctors), monitoring their conditions of practice as well as taking care of the recognition of their professional qualifications.
- The French Medical Council consists of one Departmental Council per French Department (95 in total), one Regional Council per French Region (22 in total). The French National Council is made up of 54 members (from each Region), elected by the Departmental Councils, a member appointed by the Academy of Medicine, and a Councillor of State appointed by the Minister of Justice.
- Members of the National Council meet in four different sections: Ethics and good medical practice, Professional practice, Medical training and competence and Public health and medical demography.
- The Council write and update the French Code of Medical Ethics, which is an integral part of the French National Code of Public Health.
- The French Medical Council also acts as a disciplinary body for doctors
- The Council has set up 2 Delegations: one for internal affairs (to support and oversee the Departmental and Regional Councils) and one for European and International Affairs (DAEI) (to work with other European and international bodies).

European and International Commitments

- Since 2012, the French Medical Council is an official member of the World Medical Association



- The French Medical Council runs the General Secretariat of:
 - The European Council of Medical Orders (CEOM) which brings together Medical Councils and regulatory bodies from 16 European Countries. It aims at promoting the practice at European level of high quality medicine respectful of patients' needs
 - The Conference of Medical Councils from French-speaking countries (CFOM) which is a collegial forum for discussion among medical regulatory bodies from French-speaking countries.

Brussels representative office

The French Medical Council opened in 2008 a **representative office to the European Institutions in Brussels** in order to closely monitor European legislation on health. Since 2011, this office has been shared with the Spanish, Italian and Portuguese Medical Councils.

Georgian Medical Association

Office Bearers:

Prof. Gia Lobzhanidze M.D., Ph.D., Sc.D. – Chairman of the Directors Board

Gia Tsilosani M.D., Ph.D. – Vice Chairman of the Directors Board

Zaza Khachiperadze M.D. – Secretary-General

Prof. Besarion Kilasonia M.D., Ph.D., Sc.D. – Past Honorary President

Prof. Dimitri Kordzaia M.D., Ph.D., Sc.D. – Honorary President

Tamaz Maglakelidze M.D., Ph.D., Sc.D. – Honorary President-Elect

Lia Kovziridze – Treasurer

Ketevan Medvedskaia – Office Manager

Membership: Voluntary; Total Number of Members: 4017; Number of Junior Doctors: 357; Number of Medical Students (EMSA-TSU): 210

Details of who can join, how many join and what services are available to Members:

All licensed physician practicing in Georgia, living overseas doctors, residents and students of the Faculty of Medicine. The number of members is unlimited.

Georgian Medical Association offers its members: continuing medical education; Professional liability insurance; Protecting the rights of medical personnel; Recommendation-petitions for public, private and non-governmental agencies (in case of necessity); Participation in the conferences and congresses with affordable preferential price, etc.; Printing articles in its journal "Georgian Medical

Journal" at reasonable prices; Active involvement in various social programs and charity events; inclusion and participation in Research and grant programs; provide support to send abroad to work and for internship, and so forth.

Activities:

- With Members: Annual Conferences; Continuing Medical programs; Work on guidelines and protocols; Protecting the rights of medical personnel; Professional help in orientation and the graduate pre- and postdiploma medical education stages.
- With the Public: Introducing the annual number of days/week of celebration by the World Health Organization; Delivering Information on patients' rights in relation to the work performed; Promotion of Healthy Lifestyle and trainings; Providing free medical research and assistance to the population of the regions; Providing benefits to medical personnel and their family members at University Clinic to make Research and treatment.
- With the Governments: Participation in the development and implementation of guidelines and protocols; Participation in compilation test questionnaires and exams in qualification and licensing exams; Participation in different councils' work of medical profile; Legislative initiatives relevant to the committees of Parliament; Providing the Secondary schools with the educational programs dedicated to a healthy lifestyle together with the students of Tbilisi State University (TSU) Faculty of Medicine; The expertise of incidence of medical errors and complaints.
- With the Media: Participation in TV and radio programs to discuss issues related to health; Exclusive weekly radio program broadcast on the topical issues of interest to the population on the actual issues; Intensive cooperation with the Press on the other topical issues.
- Others e.g: Active participation in the rehabilitation victims of torture; Active participation of the development of the systems in Penitentiary institutions; Work of Ethical Council in medical researches; Foundation and management of the University Clinic together with the TSU; The implementation of joint programs with Tbilisi State University Faculty of Medicine; Publishing the 'Georgian Medical Journal' together Faculty of Medicine of TSU; Organizing joint projects with Students of the Faculty of Medicine of TSU; Active cooperation with Georgia-based industry trade associations, societies, and funds; Active involvement in the country's domestic and international grants; Workout and implementation of Professional Liability insurance program across the country.

11 Budapeshti str.
0169 Tbilisi, Georgia

The Hong Kong Medical Association

Office Bearers (2014–2016)

President Dr. SHIH Tai Cho, Louis, JP
 Vice-Presidents Dr. CHAN Yee Shing, Alvin, Dr. CHOW Pak Chin, JP
 Hon. Secretary Dr. LAM Tzit Yuen, David
 Hon. Treasurer Dr. LEUNG Chi Chiu
 Immediate Past President Dr. TSE Hung Hing, JP

To Safeguard the Health of the People

Founded in 1920, the Hong Kong Medical Association brings together all medical practitioners practising in, and serving the people of Hong Kong. The Association is managed by a Council of 28 members elected from the general membership. The Council is assisted by over 50 standing and ad hoc committees to oversee various issues relating to the medical profession, membership welfare as well as public medical education. With a membership of over 10,000 which comprises the majority of registered medical practitioners in Hong Kong, the Association represents the medical profession in the territory both locally and in the international scene. In recent years, the Association promotes healthy life styles such as safe driving, exercise for health, DASH diet, disease prevention by vaccination and "Say No to Drugs" to the younger generation. It also participates in various organ donation campaigns. The HKMA spearheaded the first computerized organ donation registry in Hong Kong in 1994. In order to pool all possible efforts, the job was taken up by the Department of Health by setting up the Centralised Organ Donation Register.

The medical professionals show their concern to the public not only within but also outside their clinics and hospital wards. The Association has been raising funds for community projects over the past 20 years through public performances of the HKMA Choir and Orchestra. The Hong Kong Medical Association Charitable Foundation was founded in 2006 for better promotion and organization of charitable activities for helping the underprivileged with special medical needs.

A Platform for the Members

The Association runs regular continuous medical education (CME) activities in form of lectures, seminars, workshops, discussion group, clinical attachments in hospital and exchange conference. Various Community Networks set up by the Association have also exerted great efforts in the training of doctors.

Every year members have the opportunity to compete with each other on arenas in various sports tournaments including badminton, golf, snooker, squash, table-tennis, tennis, tenpin-bowling and football. The annual Family Sports Day and the Swimming Gala are the major sports events and well supported by members. The Association also

offers a variety of recreational and cultural activities, e.g. photography exhibition, singing competition and gourmet dinner etc.

The Annual Ball, which is mostly held in New Year's Eve, is definitely one of the most joyous occasions of the year. Members relish the good food, fine music and delightful dance with their partners and friends.

Young members, especially students are the future of the profession. The Association organises the Career Seminar for young graduates before they start internship. In addition, medical exchange tours to Mainland China are held annually for young members and medical students for them to know about the healthcare system of China. Besides, monthly Newsletter reporting the Association's activities and commenting on controversial medical issues is published to enhance communication between members and the HKMA Council, and amongst the membership.

A Bridge for the Public

The Association disseminates health information to the public through press releases, radio programmes, TV programmes, public health awareness events, exhibitions, pamphlets and video.

To facilitate the public to find a suitable doctor, the Association develops the Doctors Homepage which contains essential information including doctor's specialty and means of contact of all registered doctors in Hong Kong.

An Active Player in Hong Kong

With the unfailing support from the members, the Association continues to speak for the profession and safeguard the health and welfare of the public. It works closely with the Government, the Hospital Authority (HA) and the Department of Health (DH) on public health issues, for instance, regulation of medical procedures, public-private partnership programme (PPP), revamp of HA, Health Protection Scheme (HPS), nutrition labelling, adult and childhood vaccination etc.

Legislative Councillor who is elected by the Medical Functional Constituency is also invited to serve in the Council of the Association as a representative voice.

Looking outside Hong Kong

The Hong Kong Medical Association and the Chinese Medical Association of Mainland China organize annual exchanges to promote friendly relationship and understanding of medical development in the two localities.

Internationally, the Association joins the medical experts worldwide in the WMA General Assembly and the CMAAO Council Meeting every year.

*5th Floor, Duke of Windsor Social Service Building,
 15 Hennessy Road, Hong Kong
 Phone: (852) 2527 8285
 E-mail: hkma@hkma.org*

Hungarian Medical Chamber

Office Bearers (2011–2015)

President: Dr. István Éger

1st Vice President: Prof. Dr. János Banai; 2nd Vice President: Dr. János Gerle; 3rd Vice President: Dr. Attila Kovács

Secretary General: Dr. Ferenc Nagy

1st Secretary: Dr. Gábor Hollós; 2nd Secretary: Dr. János Lengyel

3rd Secretary: Dr. Zsolt Pataki; 4th Secretary: Dr. Péter Takács

Membership: Any medical doctor from all States of Hungary can join the Hungarian Medical Chamber as a regular member. Since 1994 the Hungarian law says all medical doctor, who is practicing have to join the Hungarian Medical Chamber. Between 2007 and 2011 the membership temporarily was voluntary. In 2011 the law have been reconstructed and since then the membership is mandatory.

Services Provided: The Hungarian Medical Chamber is an independent, democratic body which preserve professional, moral and substantial interest of doctors. Functionally it is a public body as a representative democracy. With an open structure and influence it serves people and people's health.

Activities:

- With Members: A monthly newspaper with scientific and health publications for all member of the Hungarian Medical Chamber.
- With the Public: Serves people's health with the principle of "salvation of patient is the primary law".
- With the Governments: Law proposal and estimate, lobby at the Ministry of Health for better medical basic services.
- With the Media: Press releases and interviews to health issues of public interest and promotion of debates related to health policies.
- With Strategic Partners: Collaboration with Chamber of Nurses, Chamber of Pharmacies health insurance companies and promotion of public health.

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Icelandic Medical Association (IMA)

Board of the IMA (2013–2014): Officers:

Chairman: Þorbjörn Jónsson;

Vice-chairman: Orri Þór Ormarsson;

Treasurer: Magnús Baldvinsson;

Secretary Salomé Á. Arnardóttir;

Directors: Björn Gunnarsson, Guðrún Jóhanna Georgsdóttir, Magdalena Ásgeirsdóttir, Þórarinn Ingólfsson, Ólöf Birna Margrétardóttir (appointed to the board by the Association of General Physicians).

IMA is an umbrella organisation of physicians who are members of the IMA's member associations or who have an individual membership to the IMA. In August 2014 there are around 1100 practising doctors in Iceland. Of these 98,5% are members of the IMA. A total of 229 are members of the Association of Elderly Physicians.

A large proportion of them have retired. Furthermore, several hundred Icelandic doctors are living and working solely abroad, mostly in Scandinavia.

The purpose of the IMA is according to Article 2 of its bylaws:

- To promote the status of the medical profession in Iceland and enhance the professional development of its members.
- To safeguard the independence and interests of the medical profession.
- To work for the enhanced education of doctors of medicine and to encourage their interest in matters pertaining to their work.
- To promote co-operation between doctors on everything conducive to progress in public health affairs.
- To participate in international co-operation between doctors on common issues.
- To contribute to increased public health in Iceland and to promote policy issues in the health sector.

The IMA offers its members various assistance not least pertaining to interpretation of collective wage agreements. Furthermore the IMA offers its member legal assistance on matter related to their work. Through the IMA its members have access to holiday homes, summer houses and flats in Iceland. Furthermore the IMA's Family Fund gives financial support to its members and families when support criterias are met, such as major illness or death as well as supporting leave due to childbirth.

When necessary the IMA voices its opinion on various issues in the health sector both related to health care services, medical ethics and patients' safety. This is done directly with dialogue with the Government or through the media to the general public. IMA further expresses regularly to the Parliament its opinion on draft legislations related to health care, health care issues and patients' safety and care issues.

The IMA is actively involved with cooperation with other Nordic Medical Associations. It further takes part in the works of CPME, UEMS and WMA.

*Hlíðasmári 8, 4th floor,
IS-200 Kópavogur, Iceland*



Israeli Medical Association

President: Dr Leonid Eidelman
Secretary General: Adv Leah Wapner

The Israeli Medical Association (IMA), founded in 1912, is an independent professional organization advocating for the rights of physicians and patients, serving as the official representative body of physicians and acting as an arbiter of health policy and medical ethics in Israel. The IMA is responsible for setting professional norms and ensuring the highest standards of medicine and professional integrity.



Leonid Eidelman

Although membership in the IMA is voluntary, over 90% of publicly employed physicians in Israel are members. The IMA also acts as the umbrella association for 155 scientific associations, societies and workgroups. The IMA's 21,409 members have access to educational courses, medical journal subscriptions, legal, tax and insurance assistance, information about rights and entitlements, scholarships, pension services, welfare activities and more. Israel is characterized by its ethnic diversity; medical doctors in all ethnic groups make up the members of the IMA.

The IMA Scientific Council is responsible for the planning and supervision of all post-graduate training and for continuing education programs in medicine in Israel. Their work also includes approving medical specialist certification in 56 medical fields, accrediting hospitals and clinics for medical specializations, overseeing residency programs, devising curricula, formulating and administering exams, accrediting departments for residency purposes and recommending the award of specialty certificates.

The IMA Ethics Board, comprised of senior physicians from a variety of fields, convenes on a monthly basis to discuss ethical issues arising in the field, and to approve principle decisions concerning medical ethics. The Board disseminates position papers, promotes ethical issues, reviews complaints lodged against physicians and organizes conferences on various issues of interest to physicians and the public. The Ethics Board formulates the physician's code of ethics which is binding following the approval of the national convention. The Ethics Board also takes positions on all major medical issues in Israel, including, most recently, convening a consensus conference to establish a position on treating prisoners participating in hunger strikes.

Since 1995, when the National Health Insurance Act was passed, the IMA has expanded its function to take a greater role in shaping national health policy, influencing the legislative process and promoting public health and quality assurance. Recent related activities include hosting a "Health Day" at the Israeli Parliament and suc-

cessfully co-submitting a bill to ban smoking in public playgrounds and within 10 meters of the entrance to kindergartens.

In 2011, citing a decline in Israel's public health care system, the IMA publicly announced "a mission to save public medicine," demanding additional staff, more beds in hospitals, an increase in physician salaries in the periphery and incentive pay for doctors working in specialties suffering from physician shortages. After many months of a difficult and complex struggle, marked by intensive negotiations and strike action, on 25th August 2011 a breakthrough agreement was signed. The agreement included an additional almost 3 billion NIS in early funding, 1,000 new doctor positions in public hospitals, a limit to the number of resident on-call shifts, significant salary and hourly wage increases and financial incentives for doctors working in the periphery and/or in specialties with severe shortages. The IMA publishes two scientific periodicals, which are disseminated to all IMA member physicians as well as to subscribers in Israel and abroad. Harefuah is a Hebrew medical-scientific periodical that publishes a wide variety of articles written by the most prominent physicians in Israel. The periodical has been published monthly since 1924. The Israel Medical Association Journal (IMAJ) is a medical-scientific periodical in English, which publishes scientific articles in all medical fields, written by renowned physicians from Israel and abroad. The journal has been published monthly since 1999.

The IMA has been an active member of the World Medical Association since its inception, drafting and contributing to statements and declarations and holding key offices within the organization. The IMA sends Israeli doctors on fellowships abroad, and is also closely connected with other NMAs and international medical organizations such as the WHO, the International Committee of the Red Cross and others, and frequently collaborates with medical and humanitarian efforts around the world.

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3566 Ramat Gan, 5213604 Israel*

Japan Medical Association

Office bearers: President; Dr. Yoshitake Yokokura, Vice Presidents (3); Dr. Kenji Matsubara and others, Board Members (13), Executive Board Members (10); Dr. Masami Ishii and others, Auditors (3), Chair and Vice-Chair of the House of Delegates

Membership: Voluntary, 166,000 members. Total number of physicians in Japan is about 300,000. *Types of members:* Founders of clinic/hospital – about 84,000; Employed physicians – about 81,000; Residents – 825 *Affiliated facilities:* JMA Research Institute, Center for Clinical Trials of the JMA, Woman Doctors Support Center of the JMA, and JMA Certificate Authority

Activities: The JMA's activities are extensive.

With Members: Provide CME programs including JMA lecture conferences, training program and symposium. Some of them are e-learning. Provide the up-dated information by publication, video, TV and radio programs. JMA medical library with about 93 thousand books is open to the members. Enhance the awareness and level of medical ethics. Assure a solid financial basis for medical practitioners. Programs to support women doctors for their more positive activities.

Programs for the emergency disaster countermeasures

- *With the Public:* Let the public know the activities of the JMA and provide them with useful medical information about topics such as infectious diseases, disaster medicine and emergency care mainly by Website and TV programs.
- *With the Government:* By being a member of the core committees of the Ministry of Health Labor and Welfare, the JMA has a bigger voice in the government's policy making process. Negotiate with the government for securing the medical fee to ensure the member's professional autonomy for their steady daily practice of medicine. Offer the government the JMA's opinions about important health issues of community health such as the countermeasures against an aging society
- *With the media:* A press conference is regularly held to provide the media with accurate idea of the JMA about national health policy and other important health issues as well as action programs/plans and report of the achievements.
- *Others e.g.: Strategic partnerships:* Serve as Secretariat of the Confederation of Medical Associations in Asia and Oceania since 2001.
- JMA has been collaborating with the Harvard School of Public Health to support the Takemi Program in International Health which was established in 1983.

2-28-16, Honkomagome, Bunkyo-ku, Tokyo, 113-8621 Japan

National Medical Association of the Republic of Kazakhstan

Activities

- Interaction with different ministries and bodies
- Represent the interests of the members of the NMA in governmental, international and nongovernmental organizations
- Protect the rights and interests of their members upon conflict situations, legal proceedings
- Implements publishing activity
- During 1996-2000 - prepared and issued weekly programme "Densaulyk" (Health) on TV for population in Kazakh and Russian

- Initiated establishing of the Almaty Curative Centre, Institute of post-graduate education for psychologists and physicians, Chairs on "Medical psychology" and "Medical right and Bioethics"
- Conducts city, republican, international conferences on actual health problems
- Actively introduces and implements independent expertise in the health system
- Initiates foundation of the avenue "Ave Vitae" in Almaty, devoted to the memory of doctors-solders
- Developer of Ethical codex of physician of the RK, hymn and oath
- Established nominations:
 - The best physician of the NMA (award "Altyn Deriger")
 - The best nurse (award "Meйipim" (Miloserdie))
 - The best clinic of the Year

NMA representatives are members of the National Coordination Council on Health Care under the Government of the RK, on attestation, conflict situations, awards and commissions of local executive bodies.

International collaboration

Close contact with National Medical Associations of Europe and Asia

1994 - Member of the European Forum of Medical Associations

1997 - Member of the Eurasian Forum of Medical Associations

2003 - Member of the World Medical Association

2003 - Member of the EFGCP

Almaty 050000, Kazakhstan,
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Korean Medical Association

President: Dr. Choo, Moojin

Chair, Executive Committee of International Relations: Dr. Shin, Dong Chun

KMA, established in 1908, is a statutory organization in accordance with the Medical Service Act and is the official organization representing all physicians in Korea.



Choo, Moojin



Shin, Dong Chun

World Medical Journal



Under the Medical Service Act, all physicians who obtain a medical license must become a member of KMA and accordingly, KMA currently represents more than 110,000 physicians in Korea.

KMA's top decision-making body is the House of Delegates. Within its organization, KMA also includes the Korean Academy of Medical Sciences with 154 medical societies as its members, the Research Institute for Health Policy, 16 regional medical associations, the military medicine chapter and 2 overseas chapters. It also has councils organized by occupation such as the private practice doctors' council, government-employed doctors' council, hospital doctors' council, intern & resident council and public health doctors' council.

The founding goal of KMA is to contribute to the promotion of people's health and social welfare by enhancing medical ethics and developing medical science and technology.

To achieve this goal, KMA has been providing its members with a code of ethics and has been developing and researching various training and continuing education programs. Also, at the macro-level, KMA has been actively participating in the process of developing government's health policies as a professional organization based on its health policy surveys and research as a part of its efforts to improve Korea's health system.

Furthermore, KMA has been very active in various community activities including medical volunteering, environmental protection, child abuse prevention as well as medical exchange with North Korea. Recently, KMA has been focused on delivering objective and accurate health and medical information to the public by strengthening its public communication efforts in order to prevent people from becoming confused or experiencing harm due to the flood of unverified and inaccurate medical information.

KMA publishes Doctor's News, the official weekly newsletter for actively communicating KMA's activities to the public and members and the professional medical journal, The Journal of Korean Medical Association.

KMA will continue to strive to better serve the public and its members by further enhancing its capabilities and through close international cooperation.

Latvian Medical Association

President Dr. Pēteris Apinis

Vice-presidents Dr. Maris Pļaviņš, Dr. Vilnis Dzērve-Tāluts

LMA is governed by a board composed of 15 people and automatically includes the President of Latvian Junior Doctors association. First medical association in Latvia was established in 1802 in Riga but there has not been any real heredity. During the Soviet occupation (1940–1991) professional organizations were banned. 1988 is considered the founding year of currently existing Medical association when it began operating illegally.

LMA unites all Latvian medical specialty associations (surgeons, anaesthesiologists, gynaecologists, etc.) as well as individual members. Individual members receive professional medical journal "Latvijas Ārsts" (Latvian Physician) monthly, take part in conferences, congresses and other events for reduced price. Journal is a 80–96 page long journal containing only medical articles, mainly reviews. The association publishes medical books on regular basis.

In Latvia medical professionals may practice only when they have acquired a certificate issued by LMA. The certification in each field is entrusted upon a dedicated committee formed by LMA in cooperation with specialty associations. Re-certification is required every five years and it is automatic if the physician can present 250 further education points (60% of them in relevant specialty).

LMA has the right of legislative initiative, thus almost all laws concerning public health (restriction of smoking, alcoholism limitation, trans fat limitation, etc.) are initiated and moved to parliament LMA. A professional court operates under LMA and mainly deals with very complex medical treatment situations. Additionally, LMA also has an ethics committee.

The association organizes nation-wide disaster medicine training events which take place in a different city every year. This year the situation was "capsized and burning train coaches with 50 victims, mostly polytrauma patients".

Every week LMA organizes discussions on important health or medical issues which are always attended by one of the highest officials of the Ministry. Over a year LMA organizes 20–24 conferences covering various subjects (mainly, interdisciplinary). Latvian Congress of Physicians is held every four years. A video documentary is made before these congresses covering the medicine in Latvia in the particular year. LMA is actively involved in the work of WMA, CPME, EFMA.

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Myanmar Medical Association

President – Professor Rai Mra

Vice-President (1) – Professor Aye Aung

Vice –President (2) – Professor Myint Thuang

General Secretary – Professor Saw Win

Joint General Secretary – Dr. Khaing Soe Win

Treasurer – Professor Mya Thida

Academic Secretary – Professor Win Myat Aye

Immediate Past President – Professor Kyaw Myint Naing

Members

Professor S. Kyaw Hla; Professor Kyaw Zin Wai; Professor Thet Khaing Win; Dr. Sein Thuang.

Membership – All medical doctors registered with the Myanmar Medical Council are eligible for membership. Pre-registration house officers are given pre-membership.

Activities

With members – All members are eligible to attend the annual Myanmar Medical Conference and well as all speciality conferences and CME activities carried out by the association at a reduced rate. The quarterly Myanmar Medical Journal and the monthly newsletter are distributed free of charge to members. Members have the privilege to use the facilities of the medical association. All members have the right to vote at the election for the executive council of the medical association. They also can enter the elections as candidates.

With the public – the public is invited to attend the public health talks and health education talks held periodically at the association. Important health issues are discussed and disseminated to the public.

With the government – Myanmar Medical Association takes part in the National Health Committee meetings held by the ministry of health. MMA is also invited by the ministry of health to take part in discussions on important health issues concerning the public as well as policy issues related to all doctors.

With the media – the media is invited to all important activities carried out by MMA. MMA also makes television broadcasts on many important health issues.

Others e.g. Strategic partnerships – The Myanmar Medical Association has strategic partnerships with the Ministry of Health, Global Fund, 3MDG fund, UNFPA and Nippon foundation in implementing public health projects on malaria and tuberculosis, sexual and reproductive health, IUD services, youth programme, and mobile medical services in remote areas.

*No. 249, Theinbyu Road,
Mingalar Taung Nyunt Township,
Yangon, Myanmar*

New Zealand Medical Association (NZMA)

Office Bearers (2013–2015)

President: Branko Sijnja

Chair: Mark Peterson

Deputy Chair: Stephen Child

General Practitioners Council Chair: Kate Baddock

Specialists Council Chair: Harvey White

Doctors-in-Training Council Chair: Sudhvir Singh

Membership: The New Zealand Medical Association (NZMA) is the country's foremost pan-professional medical organisation in New Zealand representing the collective interests of all doctors. The NZMA's members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students.

Services provided: The NZMA is a strong advocate on medico-political issues, with a strategic programme of advocacy with politicians and officials at the highest levels.

The key roles of the NZMA are:

- to provide advocacy on behalf of doctors and their patients
- to provide support and services to members and their practices
- to publish and maintain the Code of Ethics for the profession
- to publish the New Zealand Medical Journal.

The NZMA works closely with many other medical and health organisations, and provides forums that consider pan-professional issues and policies. The NZMA has a close relationship with, and provides support to, the New Zealand Medical Students Association (NZMSA).

The NZMA provides administrative, advocacy and communications activities for the New Zealand Branch of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). It also provides support services to the Medical Benevolent Society.

Activities (some examples)

- **With Members:**
 - Revision of the profession's Code of Ethics, which lays down principles of ethical behaviour, applicable to all doctors. It also includes recommendations for ethical practice.
 - Representing member practices in employment negotiations with the nurses' union.
- **With the Public:** *Tackling Obesity: a policy briefing*—this publication recommended a suite of measure to be considered as part of an approach to tackling New Zealand's obesity epidemic. This was a major piece of work for the NZMA, with several months' research into the latest evidence of the harms associated with obesity and on the successful ways in which these can be addressed.
- **With local and central Government:** Advocacy on: local alcohol policies; support for plain packaging for tobacco products; a new national drug policy; non-medical prescribing; health equity and social determinants; health structure and funding, with particular reference to primary care
- **With the Media:** Press releases related to health issues of public interest (obesity etc); promotion of debates related to health policies (fluoridation of community water supplies; alcohol policies etc);
- **With Strategic Partners:** Submissions to the Medical Council of New Zealand on reviews of advertising, cultural competence, registration of foreign-trained doctors. Advocacy to the national



funding agency for pharmaceuticals (PHARMAC) on its approach to managing hospital devices, as well as various individual drug funding proposals; advocacy to the Pharmaceutical Society on the draft National Pharmacist Services Framework; workforce planning and sustainability (with Health Workforce New Zealand and other agencies)

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Norwegian Medical Association (NMA)

Office Bearers: Hege Gjessing, President, Geir Riise, Secretary General

Who can join: All physicians with a Norwegian licence as well as Norwegian medical students can join. At present NMA has 31 131 members.

Services available to members are: Central and locally negotiated agreements concerning salaries and working conditions both for physicians in private practice and employed physicians, provision of legal assistance to members, advice on educational matters, leadership training as well as other courses, training and guidance for local representatives, Internet based medical courses, projects on quality improvement, health policy documents, reports on various health issues etc.. The members also receive NMA's Medical Journal twice a month. Our Institute for Studies of the Medical Profession produces research on physician's career choices, psychological, ethical and social aspects of doctoring, and the physician role in general.

Activities:

- With Members – NMA works close with the members on most areas that are of importance for physicians. NMA is organised in seven occupational branches, one student association and 45 medical societies. Locally NMA is organised in 4 regional and 19 county branches. The branches and the societies are consulted on matters that are of importance for them.
- With the Public – Articles of public interest published in our journal are distributed to media to be used to inform the public about various health issues. NMA also actively raise political, medical and societal issues considered of importance for public health.

- With the Government – NMA cooperates closely with various governmental bodies on subjects concerning our members such as education, health politics, organisation of health care services, health legislation etc. The organisation is also widely consulted on governmental proposals concerning health related topics, medical education and health legislation.
- With the Media – NMA has a constructive and professional relationship with the media. Media is a possibility, not a threat. Our strategy is to be visible in media to show our engagement in health policy both as a professional association and as a union. We give support to members that are negatively exposed in media and organise courses in how to cooperate with media for representatives on various levels.
- Others e.g.: Strategic partnerships – NMA has strategic partnership with Federation of Norwegian Professional Associations, Association of Pharmaceutical Industry, various health professional organisations and the labour union.

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Philippine Medical Association

National Officers

President: Dr. Maria Minerva P. Calimag
Vice President: Dr. Irineo C. Bernardo III
National Treasurer: Dr. Benito P. Atienza
Secretary General: Dr. Marianne L. Ordonez-Dobles
Asst. Secretary General: Atty. Jose C. Montemayor

Board of Governors

Dr. Harry G. Soller, Dr. Raul E. Echipare, Dr. Francisco B. Ranada III, Dr. Salvador G. Silverio, Dr. Ma. Realiza G. Henson, Dr. Evangeline F. Fabian, Dr. Rebecca W. Deduyo, Dr. Eduardo F. Chua, Dr. Rufino A. Bartolabac, Dr. Ma. Cristina C. Danac-Delfin, Dr. Victor Alan A. Torre Franca, Dr. Ethel A. Lagria, Dr. Ma. Gay M. Gonzales, Dr. Ruben O. Go, Dr. Maria Lourdes G. Monte Verde, Dr. Karen Conol-Salomon, Dr. Angelo L. Dimaano

Membership: The PMA has 118 component medical societies, 8 Specialty Divisions, 73 Specialty Societies, and 39 Affiliate Societies

It's mission: A dynamic, responsive and united PMA, committed to serve its members, through increased benefits, enhanced professional development, and the promotion and defense of the rights

and privileges of the Medical Profession. These efforts, in partnership with other organizations and the Government, shall contribute to excellent healthcare delivery and the community at large.

“PMA: In a dedicated selfless and humane service of the Medical Profession for a healthy Philippines and for the Glory of God”.

It's vision: Our vision in the Association is to have a fellowship of Physicians united in the common goal of acquiring the highest levels of medical knowledge and skills through continuing education and research, and to promote the healing ministrations of the physicians in the delivery of health care of patients. The PMA is a co-founder of the Confederation of Medical Associations of Asia and the Oceania (CMAAO). It is also a co-founder of the Medical Associations of Southeast Asian Nations (MASEAN).

Services Provided: Board certification through its 8 Specialty Divisions; Subspecialty Training through its Specialty Societies, Annual Conventions, symposias supervised by the PMA-CME Commission; Quarterly Newsletters, Bi-Annual Medical Journals; holding of International Conventions.

Advocacies: Supports all government bills as the Clean Air Act, Sin Tax Bill, and the Reproductive Health Bill. The PMA also supports tree planting, waste management, pest control, pollution control, as well as the safety of food and consumer products.

Activities and Events

- With the members: Continuing Medical Education through its Regional Assemblies, Annual Conventions by its specialty divisions, specialty and affiliate and component societies.
- With the Public: Health Information on vital health issues, Lay Fora on Nutrition, Non-communicable diseases, and emergency and disaster information. Adopt a Barangay Project of component medical societies, nutrition feeding programs and lectures.
- With the Government: supports the government on all bills advantageous to public health and to the community, supports programs of the Department of Health, Philippine Health Insurance Corporation and the Professional Regulation Commission.
- With the Media: regular media releases and press conferences on health issues and health policies of the Association.
- With Strategic Partners: special programs with Pharmaceutical Companies and Allied Professionals, in reaching out to all communities, and to our members.

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Polish Supreme Chamber of Physicians and Dentists

(Naczelna Izba Lekarska)

Office Bearers (2014–2018)

President of the Supreme Medical Council: Maciej Hamankiewicz
Vice-Presidents: Romuald Krajewski, Zyta Kaźmierczak-Zagórska,
Agnieszka Ruchała-Tyszler (dental practitioner)
Secretary: Konstanty Radziwiłł
Deputy Secretary: Anna Lella (dental practitioner)
Treasurer: Wojciech Marquardt

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

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

There are 23 regional chambers and a separate chamber of military physicians and dentists that has legal status of the regional chamber although it is active in the entire country.

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

Currently the joint self-government associates 178 000 physicians and dentists in Poland, including appr. 125 000 practicing physicians.

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

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

Scope of activity

The field of activities of the self-government of physicians and dentists, as laid down in the Law of 2 December 2009 on Chambers of Physicians and Dentists, include:

- supervising the proper and conscientious exercise of the medical professions;
- determining the principles of professional ethics and deontology binding all physicians and dentists and looking after their compliance;



- representing and protecting the medical professions;
- integrating the medical circles;
- delivering opinion on matters concerning public health, state health policy and organization of healthcare;
- co-operating with scientific associations, universities and research institutions in Poland and abroad;
- offering mutual aid and other forms of financial assistance to physicians and dentists and their families;
- administering the estate and managing the business activities of the chambers of physicians and dentists.

The chambers of physicians and dentists:

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

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Singapore Medical Association

55th SMA Council

President A/Prof Chin Jing Jih

1st Vice President Dr Wong Tien Hua

2nd Vice President Dr Toh Han Chong

Honorary Secretary Dr Chan Teng Mui Tammy

Assistant Honorary Secretary Dr Lim Kheng Choon

Honorary Treasurer Dr Lee Hsien Chieh Daniel

Assistant Honorary Treasurer Dr Lee Yik Voon

Members:

Dr Abdul Razakjr Omar, Dr Chong Yeh Woei, Dr Loo Kai Guo Benny, A/Prof Tan Sze Wee, Dr Tan Yia Swam, Dr Wong Chiang Yin, Dr Woon Yng Yng Bertha, Dr Anantham Devanand, Dr Lee Pheng Soon, Dr Noorul Fatha As'art, Dr Tan Tze Lee, Dr Toh Choon Lai, Prof Wong Tien Yin

Formed in 1959, the Singapore Medical Association (SMA) is the national medical organisation representing the majority of medical practitioners and medical students in both the public and private sectors. The SMA is a not-for-profit, non-government funded, members-based professional body for medical doctors in Singapore. Our ordinary membership is opened to every medical practitioner registered or provisionally registered in the Register of the Medical Council in Singapore.

While the Ministry of Health and the Singapore Medical Council are tasked with the regulation of the medical profession, the SMA, as neither the extension of the Ministry nor part of the Singapore Medical Council, aims to maintain the honour and interest of the medical profession. To this end, SMA vigorously represent its members' views and engage in a good and transparent practice of feedback, which comprise questions, discussion and dialogue. Representing the medical profession, SMA raises concerns and questions, presents feedback from the medical profession, and suggests alternatives to the relevant policy-making bodies. Even though there were times when SMA's views and suggestions were not accepted by the policy-making bodies, the subsequent explanation and education that the medical profession received by these bodies on the decisions made have helped to shape a more inclusive and collaborative healthcare landscape. A strong and well-represented SMA is necessary to maintain the honour of the medical profession and to represent its interests, as well as to advocate the overall well-being of patients in Singapore.

With over 6,800 current members and growing, SMA has over the years experienced a healthy increase in membership numbers, which attests to increasing recognition and support of our mission and values by the medical profession at large. SMA Membership offers various professional services, medical resources and lifestyle benefits via avenues such as the SMA Forum, Locum Listing, and Directory of SMA Doctors, which help provide a reliable platform for doctors to discuss and explore healthcare issues, have their voices heard, search prospective contacts and make their profiles (including their specialisations and qualifications) searchable to enable easier patient access.

SMA Centre for Medical Ethics and Professionalism (SMA CMEP) was formed in 2000 and since then, it has been instrumental in promoting continuing education and academic training in

Clinical Ethics, Health Law, Professionalism and Medical Practice. SMA CMEP aims to provide leadership in the areas of academic training, discussion, resource development and research, so as to support a high standard of medical professionalism.

Key statistics for 2013:

- 20 Council Members
- 110 doctors in 21 standing committees serving 6905 SMA members
- 27 membership events with >2000 attendees
- 83 courses conducted for 2572 participants with S\$36,000 course subsidies disbursed
- 43 citations in various local media
- 228 articles published in the Singapore Medical Journal
- 110,671 hits on PubMed LinkOut

*2 College Road,
Singapore 169850*

Swedish Medical Association

Swedish Medical Association is the union and the professional organisation for medical doctors working in Sweden. Patient safety, work environment, salaries, working hours, training and research are some of the issues that are of great importance.

We are 46 000 members; medical doctors and medical students. The Swedish Medical Association enters into collective agreements in areas such as general employment conditions, which includes salaries, working hours, holidays, sick and parental leave and pensions.

Membership entitles you to:

- Advice and support in matters relating to your salary, contract, and general working conditions as well as insurance and pensions.
- Help with salary negotiations, and up-to-date salary statistics.
- Legal assistance on disciplinary matters, such as negligence claims or probation, and on general matters of healthcare and labour law.
- Peer support for doctors undergoing personal crisis.
- Swedish Medical Association is a strong voice in Swedish media and we work continuously with the politicians in power as well as in opposition.

*P.O. Box 5610
SE-114 86 Stockholm, Sweden
President Heidi Stensmyren*

Swiss Medical Association (FMH)

Leaders: Dr Jürg Schlup (President), Anne-Geneviève Bütikofer (Secretary-General)

As a professional association representing the medical profession in Switzerland and an umbrella organisation for more than 70 core and specialised organisations, FMH defends the interests of doctors throughout Switzerland. Both economically and politically independent, FMH has more than 38,000 members, representing more than 95% of all doctors currently practising in Switzerland. Only doctors who hold a federal medical diploma or an equivalent diploma who are currently practising or have practised in a particular field in the healthcare sector may join FMH. Ordinary members are simultaneously members of one of the core organisations.

In order to facilitate the professional activities of its members, FMH offers a wide range of services, including access to the online myFHM platform, as well as the list of downloadable documents (contract templates and practical guides in particular), an information service for points of law and questions about prevention, training about rates, and a support network for crisis situations (ReMed). Many of these services are also made available to external partners, journalists, and the general public, especially the annual medical statistics, press releases, the doctorfmh.ch search engine, and advanced patient directives, which are frequently consulted.

FMH does everything in its power to ensure that the entire population of Switzerland can access high-quality care with sustainable funding. To achieve this objective, it attaches great importance to the dialogue with the other partners in the healthcare sector and makes doctors' voices heard in the political and legislative decision-making process through policy statements and consultations. FMH also participates in the development and updating of rate structures and has taken on the role of spokesperson for questions about prevention and quality in the medical field that are raised at the national level.

FMH is currently focusing on the following topics: interprofessionality in the healthcare system related to the acute fragmentation of care and the need for clarification of responsibilities; the lack of training places for medical students and the resulting shortfall in certain regions and disciplines; and barriers to the free practice of the profession and the increase in administrative tasks.

*Elfenstrasse 18, case postale 300,
3000 Bern 15, Switzerland*



Taiwan Medical Association (TMA)

Office Bearers

President Dr. Ching-Chuan SU
Chairman of board of supervisors Dr. Tsung-Cheng KUO
Secretary General Dr. Ming-Chung TSAI

Membership

Details of who can join, how many join

There are 5 special municipality, 16 county and 3 city medical associations in Taiwan. All of them are entitled to join Taiwan Medical Association. According to Physicians Act, all practicing physicians are required to join the local medical association. Therefore, Taiwan Medical Association has 43,318 physician members as the end of June, 2014.

What services are available to Members

TMA serves as a role of intermediate between physicians and government.

All members are available to free subscription of Taiwan Medical Journal.

Free group life insurance for all physician members.

CME courses are opened to all members without charge.

Activities

- With Members: Supervising local medical association by holding regional seminars or workshops.
- Schedule monthly nationwide Video Conference on patient safety and healthcare quality.
- Annual Golf outing, Tennis tournament and Ping-pong game nationwide for members.
- With the Public: Donate or finance vulnerable groups and charities.
- Hold blood donation activities and social welfare concerts.
- With the Governments: Advocate amending for "Health Care Act" to protect health professionals and patients' safety by ensuring a zero-violence health care environment.
- Legislate for "Long-term Care Act and Long-term Care Insurance Act".
- Promote for "Medical Practice Dispute Resolution and Compensation Act".
- With the Media: Periodical press conference for announcing TMA policies.
- Collaborated with cable TV network to produce health related programs.
- Others e.g.: Strategic partnerships: Strategic alliance with human resource agency and with commercial bank.

9th Floor, 29, Section 1, An-Ho Road, Taipei 10688, Taiwan

Medical Association of Thailand (MAT)

Office Bearers (2014–2016)

President: Assoc. Prof. Dr. Prasert Sarnvivad
President Elect: Prof. Dr. Saranatra Waikakul
Vice-President: Prof. Dr. Teerachai Chantrarojanasiri
Secretary General: Prof. Dr. Ronnchai Kongsakon
Deputy Secretary: Major Dr. Chanrit Lawthaweesawat
Treasurer: Group Captain Dr. Paisal Chantarapitak
House Master: Dr. Sawat Takerngdej
Scientific: Prof. Dr. Wachira Kochakarn
Publication: Prof. Dr. Amorn Leelarasamee
International Relations: Major. Gen. Assist. Prof. Dr. Kidaphol Wadhanakul
Medical Education: Assoc. Prof. Dr. Yothin Benjawung
Ethics: Prof. Dr. Orawan Kiriwat
Public Relations: Dr. Sakda Arj-ong Vallipakorn
Registration: Dr. Komgrib Pukrittayakamee
Welfare: Dr. Nithiwat Gijisriurai
Special Affairs: Assoc. Prof. Dr. Juvady Leawpairat
Chief Executive Officer: Prof. Dr. Somsri Pausawasdi
Members of Committee
Pol.Maj.Gen. Dr. Chumsak Pruksapong
Dr. Pinit Hirunyachote
Dr. Kavirach Tantiwongse
Assoc. Prof. Dr. Apichat Asavamongkolkul
Dr. Somchai Thepcharoennirund (Regional Rept.)
Dr. Varaphan Unachak (Regional Rept.)
Dr. Thongchai Triviboonvanich (Regional Rept.)
Dr. Banjerd Sukapitpanont (Regional Rept.)

Membership: Any Thai medical doctor can join the MAT as a regular member.

Services provided: The main services provided by the MAT to their membership are the Annual Academic Meeting as well as news and scientific publications, representation of their interests in national and international forums and participating as a member of World Medical Association.

Activities (some examples)

- With Members: Receiving life long access to Journals of the Medical Association of Thailand
- With the Public: Through Medical Knowledge programme for Thai People as FAQs disease problem TNN TV Channel monthly by the Famous MAT speakers
- With the Governments: As a Medical Counselor to support the Ministry of Health for adoption of a medical career in the public services.



- With the Media: Press releases related to health issues of public interest, promotion of debates related to health policies, education on health related issues.
- With Strategic Partners: special research aiming to promote health information to the public as well as to provide happiness working and safety to Thai physicians.

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Romanian College of Physicians

Executive Board

Prof. Dr. Vasile Astarastoae – President
Dr. Gheorghe Borcean – Vice-President
Dr. Constantin Carstea – Vice-President
Dr. Calin Bumbulut – Vice-President
Dr. Viorel Radulescu – Secretary General

Members: who can become a member, how many members are registered and what services are available for the members:

Any doctor who wants to practice medicine in Romania, according to the law, may become member of the Romanian College of Physicians. The Romanian College of Physicians has 10,000 members. They can:

- vote and can be elected,
- be informed about any action performed by the College,
- use all infrastructure belonging to the College,
- take part in any of the actions carried out by the College,
- litigate any sanction applied by the College,
- request material help from the College, for special situations, for them and their family.

Activities:

- with the members
- with public
- with the government
- with the media
- other, strategic partnerships

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Turkish Medical Association (TMA)

Central Council (2014–2016)

President: Bayazit İlhan
Vice President: Raşit Tükel
General Secretary: Özden Şener
1st Treasurer: Filiz Ünal İncekara
2nd Treasurer: Hande Arpat
Members: İsmail Bulca, Hüseyin Demirdizen, Deniz Dülgeroğlu, Nilay Etiler, Şeymus Gökalp, Fatih Sürenkök

Membership: Obligatory for physicians working in private health institutions including private offices. Physicians working in public health institutions can also become members and most of them are already members of TMA.

Services provided: Turkish Medical Association mainly promotes and struggles for the professional autonomy and the values of the profession. TMA publishes monthly or bimonthly journals in the fields of Health Policies, Occupational Health and Continuous Medical Education. In addition to publications, educational activities, certification programs, accreditation of continuous medical education and scientific congresses, provides to its members identification cards, protocol notebooks, etc.

Activities (some examples):

- With Members: TMA arranges continuous education programs in various topics, such as “health of the health care workers”, “Sports Medicine, Tourism and Health”, “Occupational Medicine in Workplaces”, “Legal Medicine” and “Health Care in Disasters” courses. TMA struggles for the rights of physicians and cooperates with the unions and associations of other health professionals in Turkey.
- With the Public: Based on the legal establishment of TMA, it prepares reports on emerging public health issues and tries to raise public awareness on these matters. Radiation, environmental pollution, right to access to clean water, communicable diseases, critics about health reform, struggle against tobacco are some of the examples of these studies.
- With the Government: TMA is a direct member of Turkish Ministry of Health Central Ethics Committee and Committee of Specialty in Medicine. Additionally, TMA tries to form public opinion on medical profession, informs the National Assembly and the other institutions in legislative procedures. It exchanges views with the institutions such as Turkish Ministry of Health, Social Security Institution that determine the health policies in which many physicians work.
- With the Media: TMA uses mass communication tools, web sites for public information. There is a press bureau at the central

building of TMA. It provides information for press organizations and journalists.

- With Strategic Partners: In recent years TMA conducted many studies with partners especially on the prevention of torture, forced feeding in hunger strikes, the health of prisoners around the world. In 1997, due to these studies, PHR (Physicians for Human Rights) awarded TMA with human rights award. In 1991–1992, TMA has made a common project with Canadian Public Health Association about public health care and provided support for multidisciplinary projects. In 1995–1996–1997, it has performed a project about Forensic Medicine that supported by EU. TMA was a partner in Istanbul Protocol training programs throughout Turkey related to reporting issues on torture and inhumane treatment from government forces, patient rights, examination of prisoners. TMA was nominated for 2014 Human Rights Prize of Parliamentary Assembly of European Commission (PACE).

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Synopsis of Vietnam Medical Association

Vietnam Medical Association (VMA) is the biggest of non-government organization in medical sector in Vietnam is founded in April 15, 1955. VMA is constituent member of World Medical Association since 2006 (in the General Assembly of WMA in Imperial Hotel – Tokyo, Japan) and constituent member of Medical Association of South East Asian Nations (MASEAN) since 1995 (in MASEAN conference – Singapore).

In 2014, VMA has 44 national specialities associations (Cardiology, Surgery...) and 52 regional associations (Hanoi, Hochiminh city, Danang medical association,...). VMA published 4 medical revues, medical magazines in French, in English and in Vietnamese. VMA organized many MASEAN meetings in Vietnam. VMA has good relations with many national medical associations on the world since 60 years ago.

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In memoriam: Bernard Mandel

Born: 22 May 1927, Passed away: 17 July 2014



Dr. Bernard Mandel, was elected President-Elect at the 47th General Assembly of the World Medical Association in Bali, Indonesia and he was inaugurated as President of the World Medical Association at the 48th General Assembly in Somerset West, South Africa. He served as President for one year 1996–1997.

Dr. Bernard Mandell was co-opted onto Border Coastal Branch Council in 1992 and served on Council until 2002. He served as Border Coastal Branch Federal Councillor from 1993–2000. He served as President of Border Coastal Branch in 2001. He was awarded The South African Medical Association Gold Medal in 1996.

The Evolution of Research Ethics in South Africa

The history of health research dates as far back as the 1800's in South Africa, when Cape Town, Grahamstown, Durban, Pietermaritzburg and Kimberley were large thriving towns in with many doctors in practice. They formed their own associations as branches of the British Medical Association. By the 1920's, these branches had spread throughout South Africa and in 1927, they joined to form a national association, the Medical Association of South Africa (MASA). The MASA later joined the WMA when it was established. The MASA was replaced by the South African Medical Association (SAMA) on the 21st May 1998. The SAMA as we know it today is the result of the unification of the fragmented pre-democracy medical groups. Although medical research had been conducted in South Africa since the 1800's, and despite oversight mechanisms being set up at individual institutional levels, there was no national guideline or policy until 1979. Even this document was limited in scope in that it applied only to researchers affiliated with the MRC, either as recipients of funding from the MRC or as researchers within its institutes, units or groups. Despite there

being no safeguards for participants in research at a national level for many decades, doctors involved in research were bound by the World Medical Associations guidelines and declarations.

Following the publication of a paper by Beecher on unethical research being conducted by leading and respectable scientists in the United States, the Committee for Research on Human Subjects (Medical), the first Research Ethics Committee (REC) in South Africa (SA), was established at the University of the Witwatersrand, Johannesburg in 1966. From the seventies, tertiary institutions at which health research was conducted established local RECs. In 1979, the Medical Research Council (MRC), SA produced the first set of guidelines at a national level. The protections espoused in those guidelines applied to any research being funded by the MRC or conducted by researchers affiliated to the MRC. These guidelines have undergone several revisions. While an important milestone in the participant protections endeavours in South Africa, the MRC guidelines did not have regulatory authority for non

MRC associated research. Furthermore, there was no uniformity of functioning between the local institutional RECs that had been set up. Standards of review ranged from exceptionally high at some RECs to very poor at others and some RECs even served as mere "rubber-stamping" committees. Hence, ethics "shopping" was not uncommon in the country. The promulgation of the National Health Act (No 61 of 2003) brought about far-reaching changes, with research participant protections and the functioning of RECs now being regulated by the country's statutory laws which require the registration and audit of RECs by the National Health Research Ethics Council, a statutory body established to determine the standards for participant protections in health research.

The importance of the principles in the Declaration of Helsinki in shaping South Africa's ethico-regulatory framework in health research must be highlighted. The Declaration has greatly influenced our national guidelines from both the National Health Research Ethics Council and the Health Professions Council as well. A breach of ethics in health research could result in sanctions by both these bodies.

*Ames Dhai
President SAMA*

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