

# World Medical Journal



Official Journal of the World Medical Association, INC

Nr. 4, December 2014

vol. 60



- Council Session and General Assembly. South Africa, Durban
- Anniversary of the Declaration of Helsinki

# World Medical Association Officers, Chairpersons and Officials

**Dr. Xavier DEAU**  
WMA President  
Conseil National de l'Ordre des  
Médecins (CNOM)  
180, Blvd. Haussmann  
75389 Paris Cedex 08  
France

**Dr. Margaret MUNGERERA**  
WMA Immediate Past-President  
Uganda Medical Association  
Plot 8, 41-43 circular rd., P.O. Box  
29874  
Kampala  
Uganda

**Sir Michael MARMOT**  
WMA President-Elect  
British Medical Association  
BMA House, Tavistock Square  
London WC1H 9JP  
United Kingdom

**Dr. Mukesh HAIKERWAL**  
WMA Chairperson of Council  
2/174 Millers Road/PO Box 577  
Altona North, VIC 3025  
Australia

**Dr. Leonid EIDELMAN**  
WMA Chairperson of the Finance  
and Planning Committee  
Israel Medical Association  
2 Twin Towers, 35 Jabotinsky St.  
P.O.Box 3566, Ramat-Gan 52136  
Israel

**Joseph M. HEYMAN, MD, FACOG**  
WMA Chairperson  
of the Associate Members  
163 Middle Street  
West Newbury, Massachusetts 01985  
United States

**Dr. Heikki PÄLVE**  
WMA Chairperson of the Medical  
Ethics Committee  
Finnish Medical Association  
P.O. Box 49  
00501 Helsinki  
Finland

**Dr. Otmar KLOIBER**  
Secretary General  
World Medical Association  
13 chemin du Levant  
01212 Ferney-Voltaire  
France

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

**Prof. Dr. Frank Ulrich  
MONTGOMERY**  
WMA Treasurer  
Bundesärztekammer  
Herbert-Lewin-Platz 1  
(Wegelystrasse)  
10623 Berlin  
Germany

[www.wma.net](http://www.wma.net)



## Official Journal of the World Medical Association

**Editor in Chief**  
Dr. Pēteris Apinis  
Latvian Medical Association  
Skolas iela 3, Riga, Latvia  
Phone +371 67 220 661  
[peteris@arstubiedriba.lv](mailto:peteris@arstubiedriba.lv)  
[editorin-chief@wma.net](mailto:editorin-chief@wma.net)

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

**Assistant Editor**  
Velta Pozņaka  
[wmj-editor@wma.net](mailto:wmj-editor@wma.net)

**Journal design and  
cover design by**  
Pēteris Gricenko

**Layout and Artwork**  
The Latvian Medical Publisher  
"Medicīnas apgāds",  
President Dr. Maija Šetlere,  
Katrīnas iela 2, Riga, Latvia

**Cover painting** by Latvian graphic artist  
Guntars Sietiņš, 1994

**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

**Producer**  
Alexander Krauth

**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](http://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



## Editorial

The Declaration of Helsinki (DoH) translates the willingness of the World Medical Association and its Founding President, Eugène Marquis, French Physician, to bring the ethics of medical practice and research at the highest level with a twofold goal:

- to ensure a universality of ethics in research on human beings as well as the protection of people subjected to these researches.
- to make definitely impossible the horrible abuse of Medicine encountered during the thirties and forties.

These ethical principles are often translated into the codes of Ethics of each country or laid down in the resolutions of international organisms which are usual partners of the World Medical Association (WHO, UNESCO, UNITED NATIONS, ICRC..)

And Governments felt encouraged to include the DoH principles into their legislation.

This Declaration conciles with pragmatism and wisdom “primacy of the individual” dear to and the “societal primacy”. This raises awareness of the physician to the fundamental importance of the



*Xavier Deau*

informed consent and information of the patient, the secrecy of personal and especially patient data, and the value of the professional autonomy of the physician., Under the aegis of independent research committees, the DoH rigorously codifies the scientific studies and trials, and in particular, the protection of the research subjects against dangerous experiments and exploitation. The declaration commands the application of the necessary scientific rigor, including the usage of placebos when necessary.

The sustainability of the DoH is a shining example of universality of medical ethics. Even if its drafting seemed to be laborious, our Declaration of Helsinki has the merit to be a historical and yet modern document, compiling the cultures of more than 100 medical associations. Thus, it is an

authentic factor of peace and union between medical professions around the world in full respect for the patients for who we care.

The DoH ensures a rigorous application of sciences as well as the ethics on the grounds of a genuine respect for the patient and human rights we are caring for.

*Dr. Xavier DEAU*  
*WMA President*

## WMA 2014 General Assembly Report

Durban, South Africa, October 8–11

### Wednesday October 8

At the invitation of the South African Medical Association, delegates from 46 National Medical Associations met at the International Convention Centre in Durban, South Africa from October 8–11.

### Council

Dr. Mukesh Haikerwal AO, Chair of the WMA, opened the 198<sup>th</sup> Council session.

The Secretary General, Dr. Otmar Kloiber, welcomed a new member of the Council, Dr. Steven J. Stack (American Medical Association) and gave apologies from delegates from Austria and Brazil, welcoming their replacements, Dr. Reiner Bretten-thaler (Austria) and Dr. Miguel R. Jorge (Brazil).

### President's report

The President, Dr. Margaret Mungherera, reported on her activities since April, visiting many national medical associations. She said she had attended several mental health meetings and many countries did not have mental health policies or laws. In addition no mention had been made of mental health in the post 2015 sustainable development goals. On the African development initiative, she said the findings from a survey carried out among African NMAs justified the need for a capacity building programme. She spoke about the importance of strengthening NMA activities and continuing professional development and the need for training. There was also a need to work on universal health coverage and the social determinants of health.

She said there were now twinning arrangements between the New Zealand Medical Association and Tanzania, the Danish and Rwanda, and Japan and Malawi.

Finally, she referred to the fact that there were 33 African NMAs that were not members of the WMA. The plan was that every year at least four NMAs joined and this year four had applied to join – Zambia, Kenyan, Rwanda and Lesotho.

### Influenza

Dr. Julia Tainijoki-Seyer, WMA medical adviser, updated the meeting about the next stage of the WMA's influenza campaign, which was to be launched the following day. This was based on encouraging physicians to become role models and to meet their ethical obligations to protect their patients. The evidence was that if physicians got vaccinated they were more likely to ask their patients to be vaccinated. She said a micro site as part of the WMA website had been developed to enable greater use of digital and social media to get this message across. The micro site was being launched the following day.

### Chair's report

Dr. Haikerwal reported briefly on his activities over the past year, including the successful Council meetings in Bali, Indonesia and Fortaleza, Brazil. The year had proceeded with the usual full, diverse and intense agendas pursued with consideration and in a timely way. He emphasised three important thoughts – that health was a core component of a successful fair and just society, a wise investment bringing human, political and economic dividends and that physicians were part of the solution

in health and healthcare research planning implementation.

### Resolution on Ebola Viral Disease

Professor Vivienne Nathanson (British Medical Association) introduced an emergency Resolution on Ebola. She said this was a global problem, but some governments had been treating it as a local problem for a few countries in West Africa. However, because of air travel every country was affected. At the moment Ebola was disproportionately affecting countries with the least money to deal with it and the poorest infrastructures because of their relative poverty. She said that although some countries had been doing a lot, there were many countries who could do more to help. There were also many health staff who were trying to deal with this crisis who were not being given the facilities to do this safely. Nor did they have the contact tracing facilities to help them shut this epidemic down. She said the WMA should be supporting their colleagues in Sierra Leone, Guinea and Liberia and saying something to force governments to recognise that this was a global.

This led to a lengthy debate, with several proposals being suggested for amending the proposed Resolution. Dr. Ardis Hoven (American Medical Association) suggested an amendment urging all countries, especially those not yet affected, to educate health care providers about the current case definition. In addition they should be educated about strengthening infection control methodologies and contact tracing to prevent transmission in their countries. She said it was important for everyone to 'gird up their borders'. Her proposed amendment was accepted by the Council.

Dr. Ames Dhali (South Africa) suggested including support for the use of unproven interventions for the treatment of patients with the Ebola virus. However, Dr. Nathanson said the proposed Resolution was

about providing resources to manage the epidemic. She was not sure that unproven treatment should be part of the recommendations. It was an extraordinarily complex issue that required a much longer explanation. Dr. Ajay Kumar (India) also opposed introducing the issue of unproven treatment, while Dr. Heikki Pälve (Finland) agreed that it was outside the scope of the resolution.

The amendment proposed by Dr. Dhai was eventually withdrawn.

Dr. Pälve proposed an addition that national medical associations should urge their governments to act on the WMA's recommendations in the Resolution. The President, Dr. Mungherera, said she would like to see a recommendation that international agencies work with the medical experts on the ground. These experts and local physicians felt they were being ignored, she said. These suggestions were accepted.

Dr. Xaviour Walker, Past Chair of the Junior Doctors Network, wanted to see a reference in the Resolution to the special role that junior physicians faced with inadequate protection equipment and supervision. However, this did not find support.

Dr. Juan Rodriguez Sendin (Spanish Medical Association) reported on the situation in Spain where a nurse had been infected after being in contact with a patient suffering from Ebola. Other speakers complained about the inaccurate information appearing on social media. Dr. Yoshitake Yokokura (Japan) reported on activities in his country, while Dr. Mungherera suggested that the issue of prevention and health promotion should be considered. She was particularly concerned that these fevers were common in Africa and there was a need for joint animal-human disease surveillance.

Eventually, the emergency Resolution, as amended, was approved.

Council was then suspended for the three committee meetings

## Socio Medical Affairs Committee

Sir Michael Marmot, Chair of the Committee, in his opening remarks, referred to progress on the social determinants of health. He reported that a joint letter had been sent to UN Secretary General Ban Ki-moon from the British Medical Association, the NCD Alliance, the International Planned Parenthood Federation and many other concerned organisations drawing his attention to the fact that most of the sustainable goals impacted on health and that, as a consequence, social determinants of health should be fully mainstreamed in the process. The WMA leadership had signed the letter.

He also raised the opportunity of developing collaboration with the World Psychiatric Association with a view to making mental health a public health issue. The newly-elected President of the WPA, Dr. Dinesh Bhugra, whom he met with recently, welcomed future such collaboration with the WMA.

Finally, Sir Michael informed the committee that three WHO regional offices (Europe, PAHO and EMRO) had made health equity a main objective within the framework of their activities. As a consequence, a process for health equity and social determinants of health has been set up.

Dr. Kloiber, Secretary General, reported on three items of interest to the committee. The first was the trial of the Turkish Medical Association, which had begun the previous week in Turkey, following the health care given by doctors during the Gezi Park demonstrations. Dr. Kloiber said he had attended the opening of trial on behalf of the WMA. The Standing Committee of European Doctors and Physicians for Human Rights were also present. But unfortunately

the court did not dismiss the case as requested, but postponed the trial until December 23.

The second item was that, on the initiative of the government of Norway, a group of countries had been working on a draft resolution on the protection of health care personnel in situations of armed conflicts and other emergencies for submission to the United Nations General Assembly. The WMA had been consulted about this.

The final issue was the fruitful cooperation with the World Veterinary Association (WVA). The WMA was currently working with the WVA on an international conference on zoonosis in Madrid in 2015.

## Health Care in Danger

Dr. Nathanson (British Medical Association), Chair of the Work Group on Health Care in Danger, reported on the activities of the group. Dr. Bruce Eshaya-Chauvin, of the International Committee of the Red Cross, had presented a detailed report on the HCiD project. Members of the group agreed to reflect further on how the WMA and its members could bring forward issues at the national level.

The group had also discussed the issue of violence against health care workers outside of armed conflicts, in particular in the area of mental health. It was now working on a revision of the current WMA policy on Ethical Issues Concerning Patients with Mental Illness and planned to consult the World Psychiatric Association.

Dr. Nathanson concluded by informing the committee that she was working on the development of a booklet for doctors in situations of violence.

## Violence against Women & Girls

Sir Michael Marmot reported on the successful seminar organized by the WMA

and the International Federation of Medical Students Associations in Geneva during the World Health Assembly last May. The event was very well attended, reflecting the strong interest of the health community to engage further in this area. In terms of follow-up, the Chair proposed convening a small meeting of interested NMAs at the BMA in London to consider how the WMA could continue working on addressing violence against women. Medical associations from the Netherlands, India and South Africa had expressed an interest in attending.

## *Role of Physicians and NMAs, SDH and Health Equity*

The committee received a report of Dr. Jeff Blackmer (Canadian Medical Association) on the international meeting on social determinants of health which would take place on March 24–25 at the British Medical Association in London. Invitations had been sent out and many medical associations had already confirmed their participation or expressed an interest. Dr. André Bernard (Canadian Medical Association) underlined that this was expected to be a high level meeting, providing a real opportunity for NMAs to explore potential actions in terms of SDH.

## *Medical Education*

Dr. Andreas Rudkjoebing (Danish Medical Association) reported on the activities of the Work Group on Medical Education on providing guidance to the World Federation of Medical Education on their revision of their global standards for post graduate medical education. He thanked group members (South Africa, Netherlands and JDN) for their useful input.

## *Role of Physicians in Preventing the Trafficking with Minors and Illegal Adoptions*

Dr. Fernando Rivas (Spain), Chair of the Work Group, informed the committee that

a new draft of a Resolution on the Role of Physicians in Preventing the Trafficking with Minors would be submitted at the next Council meeting in Oslo in April 2015.

## *Physicians' Well-being*

Dr. Robert Wah (American Medical Association), Chair of the Work Group on Physicians' Well-being, reported that the group had been busy since being set up last April. It had held a meeting the previous day, during which it worked on a first draft proposal. It hoped to have a final proposal ready for the next Council meeting in Oslo.

## *Non-Commercialization of Human Reproductive Material*

The committee considered the proposed revision of the WMA Resolution on the Non-Commercialization of Human Reproductive Material, which called on NMAs to urge their governments to prohibit commercial transactions in human ova, sperm and embryos and any human material for reproductive purpose. Following further informal discussions the committee agreed several amendments and recommended that the document be sent to the Council for adoption by the Assembly.

## *Aesthetic Treatments*

The committee considered the proposed WMA Statement on Aesthetic Treatments, a document that combined draft documents originally submitted by the Israeli and Swedish medical associations. The statement expressed concern that in many countries aesthetic procedures were not adequately regulated and it set out new guidelines, primarily for physicians, warning that many treatments involved risks and might potentially harm the health of patients. There was a brief debate about prohibiting advertisements showing patients before and after operations and it was agreed to strengthen the

document to read that 'unrealistic or altered photographs showing patients before and after treatments must not be used in advertising'. Suggestions were put forward for stating that only 'qualified' physicians should be allowed to carry out these treatments. However, this was opposed and instead it was agreed to amend the document to read that 'aesthetic treatments must only be performed by practitioners with sufficient knowledge, skills and experience of the interventions performed'.

The committee recommended that the proposed Statement, as amended, be approved by the Council and forwarded to the General Assembly for approval and adoption.

## *Air Pollution*

The proposed Statement on the Prevention of Air Pollution Due to Vehicle Emissions was submitted by the Austrian Medical Chamber for discussion. This called for the introduction of more stringent emission standards for all new diesel vehicles to limit the concentration of soot particles in the air. After a brief debate it was agreed to make it clear in the document that there were also other ways of reducing the volume of harmful emissions. The committee decided to recommend that, as amended, the Statement be approved by the Council and be forwarded to the General Assembly for adoption.

## *Solitary Confinement*

The committee considered the proposed Statement on Solitary Confinement, introduced by the Finnish Medical Association. This urged those authorities responsible for overseeing solitary confinement to take account of an individual's health and stated that solitary confinement should not be imposed when it would adversely affected the medical condition of prisoners with a mental illness. An amendment was proposed by the British Medical Association and accepted that doctors had a duty

to consider the conditions in solitary confinement and to protest to the authorities if they believed that they were unacceptable or might amount to inhumane or degrading treatment. A further debate took place on whether prolonged solitary confinement, without the will of the prisoner, must be avoided and the recommendation that physicians should never participate in any part of the decision-making process resulting in solitary confinement.

The committee agreed that as amended, the Statement be approved by the Council and forwarded to the General Assembly for approval and adoption.

### *Protection of Healthcare Workers*

The German Medical Association put forward a proposed Declaration on the Protection of Healthcare Workers in Situations of Violence. This called on those in power and all parties involved in violence to ensure the protection of healthcare workers and facilities and to respect their neutrality. It was argued that this document was needed to focus on the responsibilities of governments and others in positions of authority to provide the necessary protection for health care workers. Some speakers argued about whether such a document was needed or whether it replicated other WMA policy documents.

After agreeing on several detailed amendments, the committee recommended that the Declaration be sent to the Council for forwarding to the General Assembly for adoption.

### *Street Children*

A proposed Statement on Providing Health Support to Street Children presented by the Conseil National de l'Ordre des Médecins was considered by the committee. It was suggested that although good will was often expressed about helping these children it was not followed by action. Yet

thousands of children over 14 were compelled to work, while thousands more were subjected to trafficking and sexual abuse or were involved in armed conflict. Several speakers argued that the Statement was not yet ready for adoption and that further work was needed to incorporate comments from members.

The committee recommended that the document be re-circulated among constituent members for comments.

### *Water and Health*

The committee considered several minor revisions to the WMA Statement on Water and Health, adding the words that an adequate supply of fresh water was 'central to living a life in dignity and upholding human rights' and supporting 'the promotion of the universal access to clean and affordable water as a human right and as a common good of humanity'.

The committee agreed these and other amendments and recommended that the revised Statement be sent to the Council for forwarding to the General Assembly for adoption.

### *Chemical Weapons*

A proposed Statement on Chemical Weapons presented by the Turkish Medical Association was considered by the committee. This recommended strongly to States to refrain from using riot control agents because of the potential grave impact on the health of those exposed.

The committee agreed to recommend that the Statement be circulated among members for comment.

### *Declaration on Alcohol*

A draft International Declaration on Alcohol was proposed by the Australian Medical Association. The document outlined the

main objectives of alcohol harm-reduction, and recommended priority measures to address alcohol-related harm.

The committee decided to recommend to Council that the document be circulated for comment.

### *Mobile Health*

The committee considered a proposed Statement on Mobile Health proposed by the German Medical Association. The document drew attention to the opportunities and risks associated with mobile health and called for appropriate regulation to protect patient safety and user data. Speakers from several NMAs welcomed the document and said this had become a very important issue.

The committee recommended that the Statement be circulated among members for comment.

### *World Day for Health Professionals*

A proposal for a World Day of Combating Violence against Health Professionals on April 17 was suggested by the Turkish Medical Association. Its draft Statement said this would be in memory of the young Turkish doctor Dr. Ersin Arslan who was killed by a patient's relative in hospital. The idea was to increase public awareness of what the medical association said was a worldwide problem. An amendment was agreed to change the title of the document to 'preventing' violence and the committee recommended that the document should be circulated to members for comment.

### *Migrant Workers' Health in Qatar*

The committee considered a proposed Resolution on Migrant Workers' Health in Qatar. The Resolution, from Finland, demanded that FIFA as the responsible organization of the World Cup take immediate



action to secure the life, safety and freedom of movement of migrant workers in the World Cup construction sites in Qatar or change the venue as soon as possible. During a debate that followed, it was said that workers elsewhere were being similarly treated. It was decided to strengthen the Resolution by amending it to read that FIFA should take immediate action *and* change the venue.

The committee recommended that, as amended, the Resolution be sent to the Council for forwarding to the General Assembly for adoption.

### *Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies*

The committee considered a document on proposed Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies. This was submitted within the framework of the Health Care in Danger Project of the International Committee of the Red Cross. It was explained that different organisations had different sets of principles and the document was a common denominator of ethical principles of health care applicable in times of armed conflict that has been agreed by the WMA, the International Committee of Military Medicine, the International Council of Nurses and the International Pharmaceutical Federation.

The committee agreed to recommend that the document be forwarded to the Council for adoption by the Assembly.

### **Medical Ethics Committee**

The committee met under the chairmanship of Dr. Heikki Pälve.

#### *Person Centred Medicine*

Dr. André Bernard (Canada), Chair of the Work Group, informed the commit-

tee about the development of the group's work and highlighted discussions about the meaning of the terms 'person centred' and 'patient centred' healthcare. The group did not have a clear enough understanding of these terms and further consensus building was needed. He said the group would invite advice from outside experts and would submit a further paper to the committee.

### *50<sup>th</sup> Anniversary Celebration of the Declaration of Helsinki*

Dr. Leonid Eidelman (Israel), Chair of the Work Group, reported on the event to be held in Helsinki, on November 11 due to be attended by the President of Finland.

#### *Health Databases*

The committee heard that NMA comments had been received about the draft policy paper circulated by the Work Group on databases. The recent Work Group meeting in Copenhagen in August had focused on the links between this document and the Declaration of Helsinki, on broad consent, anonymity, pseudo-anonymity, medical transfer agreements and the recently adopted CMAAO (Confederation of Medical Associations in Asia and Oceania) policy on health databases. The group had also discussed initiating an open consultation outside of NMAs, similar to that carried out during the recent revision of the Declaration of Helsinki.

The committee decided to recommend to Council that the Workgroup be authorized to continue drafting policy and that the Executive Committee be mandated to approve the start of an open consultation as soon as the Workgroup considered that it had a draft version appropriate for sharing.

#### *Human Rights*

Clarisse Delorme, WMA Advocacy Advisor, reported that the WMA had met the newly appointed United Nations Special

Rapporteur on the right to health, Dr. Dainius Pūras from Lithuania. Dr. Pūras was the first physician to hold this position. The WMA was considering further collaboration with him.

### **Finance and Planning Committee**

The committee met under the chairmanship of Dr. Leonid Eidelman.

#### *Financial Statement*

The Audited Financial Statement for 2013 was considered and the committee recommended that it be approved by Council and forwarded to the Assembly for adoption.

#### *Budget and Membership Dues Payments*

The committee considered documentation on the Budget for 2015 vs. Actual 2013 Expenditures and membership dues payments for 2014 and agreed that the documents be sent to Council for approval and forwarding to the Assembly for information.

#### *Statutory Meetings*

The committee considered arrangements for future WMA meetings – the Council Session in Oslo in April 2015, the 2015 General Assembly in Moscow, the April 2016 Council in Buenos Aires and the 2016 Assembly in Taipei, Taiwan. No invitation had yet been received yet for the Council meeting in 2017, but the committee recommended that the 2017 General Assembly be held in Chicago from 11–14 October.

#### *Special Meetings*

The Chair of Council, Dr. Haikerwal, reported on three meetings – the pre-G20 Health Summit in Melbourne in November, the One Health conference with the World Association of Veterinarians in Spain in cooperation with the Spanish



Medical Association and a possible conference on eHealth/Telehealth in Italy.

## *Membership*

The committee considered applications for membership from the Kenya Medical Association, the Lesotho Medical Association, the Zambian Medical Association and the Rwanda Medical Association and agreed to forward these to the Assembly for adoption.

## Thursday October 9

### Associate Members Meeting

Dr. Joseph Heyman (American Medical Association), a gynaecologist from Massachusetts, was elected unopposed as Chair for 2014–16. He succeeded Dr. Guy Dumont.

### *Junior Doctors Network*

The meeting received an oral report from Dr. Nivio Moreira, immediate past Chair of the Junior Doctors Network, who spoke about the Network's activities. He said that a meeting had been held at the beginning of the week in Durban, attended by 23 junior doctors. Dr. Ahmet Murt from Turkey had been elected JDN Chair for 2014–15.

### *Past Presidents and Chairs of Council Network*

A report was also received on the Past Presidents and Chairs of Council Network. Dr. Jon Snaedal said this new group would have a vital role within the WMA in future.

### *Proposed Revision of WMA Statement on Nuclear Weapons*

Dr. Xaviour Walker, former Chair of the Junior Doctors, said the JDN would like to propose revisions to the Statement on

Nuclear Weapons on the basis that the threat of a limited nuclear war was more likely. The revisions included new advice to all governments that even a limited nuclear war would have catastrophic effects on the world's food supply and would put a significant proportion of the world's population at risk from a nuclear famine. A further amendment would urge NMAs to use available educational resources to educate the general public.

The meeting agreed to forward the amendments to the Assembly for adoption.

### *Destruction of smallpox virus stockpiles*

Dr. Walker also proposed a Statement on the destruction of smallpox virus stockpiles. This recommended that the World Health Assembly pursue an international witnessed destruction of the remaining stockpile of smallpox virus, that the World Health Organization have access to adequate smallpox vaccine and antiviral stockpiles and that governments had appropriate emergency pandemic planning for outbreak for smallpox virus. It also encouraged the urgent outlining of robust international laws and guidelines to stop the use of recombinant laboratory technology to recreate the smallpox virus.

The proposed Statement attracted some criticism that it needed more work and it was agreed the document should be sent to the Assembly with a suggestion that further consideration should be given to the issue.

### *Investments*

A suggestion was made that future potential investments of the WMA should exclude fossil fuel based energy companies. The Secretary General, Dr. Kloiber, said that the Association did not have any investments in stock shares, but the Chair promised that he would present the suggestion to the General Assembly.

## Scientific Session

### *"Health Determinants Beyond the MDGs"*

The Chair of the first session, Dr. Mungherera, opened the proceedings by asking what the priorities post 2015 would be. She said physicians would have a role to play in providing the professional leadership that would be required. Their role was to motivate others and to ensure communication between with those they led.

Dr. Mzukisi Grootboom, Chair of the South African Medical Association, said it was 350 days before they started taking stock of what the nations of the world had achieved on MDGs. These goals had achieved universal support because they were ambitious. But they now needed to address the post-MDG agenda and the social determinants of health.

The first speaker in the Scientific Session was Sir Michael Marmot, Research Professor of Epidemiology and Public Health at the University College London. He said doctors needed to concern themselves with sustainable development and people concerned with sustainable development should bother about health. What happened with the draft Millennium Development Goals post 2015 would have a profound impact on health and the fair distribution of health between countries and within countries. Health and wellbeing should be the outcome, the mission and the overarching goal of sustainable development. And doctors and the WMA should be advocates of health and wellbeing. Physicians were the advocates of the poor.

Sir Michael spoke about the work going on to draft new goals, but said there appeared to be no focus on equity. He said universal health coverage was required as well as concerted action on the social determinants of health. They were complementary.

Measurement and monitoring could drive equity and although many countries said they did not have the systems, they had to start with what was feasible.

He looked at what had been happening with MDGs in eradicating poverty. In sub Saharan Africa 48 per cent of people were still in poverty, living on less than \$1.25 a day. Here there had been a colossal failure to bring about a sufficient reduction. There had been a decline in poverty in Southern Asia, although the figure was still 30 per cent. Less than a quarter of the world's poor lived in low income countries and half the world's poor lived in India and China.

He spoke about the importance of education for women and said this was a health issue. He said we had the resources to improve global health but those resources were so inequitably distributed that they were making things very difficult.

Answering questions he said that health was getting better and global poverty was coming down.

The next speaker was Prof. Hoosen (Jerry) Coovadia, a Director at MatCH Health Systems (Maternal, Adolescent and Child Health), with a speech entitled 'Countdown to 2015: the global situation'. He spoke about progress in achieving the MDGs. There had been monitoring of MDG goals and many of them had been met. But people had not analysed whether the MDGs from 2000 had made a substantial difference. The problem was that the difference made by MDGs could not be easily measured. Throwing money at things it might not always make a difference.

Malebona Precious Matsoso, Director General of the South African National Department of Health, spoke about South Africa and the MDGs. She said that in 2008, eight years after the MDGs were adopted the world faced three crises – a financial crisis, a food crisis and a fuel crisis, the three Fs. But

over and above these crises, in some parts of the world they had conflict which was still continuing. Lately they had seen what happened in post-conflict countries when systems had failed, when countries were unable to thrive and when health systems were fragile. West Africa was a reminder to all of them that post-conflict, if they failed to develop countries, they could not talk about development.

She said there were some countries that had shown progress. There was a widespread feeling among policy makers that progress against hunger, poverty and disease was notable and that MDGs had played a role in a world that had been undergoing the three Fs. Referring to South Africa's achievements she said that the proportion of the population living below \$1 a day in 2000 was 11.3 per cent and in 2011 was down to four per cent. But even that four per cent was not acceptable. There had also been an improvement in education. However one survey undertaken had shown that in early school entrants about 89,000 of the children had learning disabilities, such as sight problems. Others had serious hearing problems and others were suspected TB cases.

She went on to say that investments in South Africa required that they dealt with social determinants of health and also promoted inter-sectoral collaboration. It was not enough to say they had a ministry of water affairs or a ministry dealing with sanitation because where other sectors had failed health had to serve as a safety net. If the water ministry did not do its work there would be problems with diarrhoea. If the ministry of trade did not create employment they would have to ensure they had got psychologists and psychiatrists to look after people with depression because they could not look after their families. So they were setting up inter-ministerial and social clusters that could specifically look at the social determinants of health. She was pleased to say that with the interventions

they had made they were seeing an increasing life expectancy, improvements in under five mortality and in infant mortality rates. But these improvements would not be sustainable if they did not address the social determinants of health. As the countdown to post 2015 MDGs continued, they had identified 15 interventions that could help them save 10,000 more lives between now and 2015. She would like to see this unfinished business continue.

In the next session, entitled 'Is Universal Access and National Health Insurance the same concept?' Professor Diane McIntyre, Professor of Health Economics in the School of Public Health and Family Medicine at the University of Cape Town, said the simple answer to the question in the title of her presentation was 'No!' She said that often the concept of universal access was equated with health insurance. But the misconception that universal coverage might equal health insurance was quite dangerous and allowed government to abrogate its responsibility. Speaking about terminology – universal health coverage, universal coverage or access – she said she preferred universal health system. This definition drew on the most common definition put forward by the World Health Organisation which had said it was about everyone having access to needed care, of sufficient quality to be effective as well as financial protection from the costs of using health services. A universal health system realised the right and entitlement.

She spoke about the key things needed from the health care financial perspective, including funds coming from mandatory pre-payment sources. People should be paying in advance, but government revenue was also a form of pre-payment through taxes. She drew on international data to illustrate the importance of this and the importance of large quantities of government revenue going towards health. There was an onus on governments to make sufficient revenue available. If they were going

to pursue a universal health system they could not do it without adequate government revenue.

Some people asked how much was enough. The Chatham House health care financing discussions, recently published, looked at the relationship between government spending on health as a percentage to GDP and the conclusion was that government spending on health should be at least five per cent of GDP. Some people might ask why it should be as a percentage of GDP and not 15 per cent of government expenditure. The answer was that the target of 15 per cent was nothing if government expenditure was small. If it was expressed as a percentage of GDP pressure was applied on government to raise revenue and to how much it spent. From the social determinants perspective high levels of government spending was needed in all social sectors. One of the discussions happening internationally was a growing call that governments should be seeking to generate revenue and have expenditure in the region of 35 per cent of GDP in order to achieve the sustainable development goals.

Prof. McIntyre went on to talk about the pools of funds in South Africa and fragmentation within the pools and the issue of strategic or active purchasing. They were not going to have universal access unless they started getting purchasing right. South Africa had said it intended to introduce a national health insurance fund. But would this proposed NHI and the way it was being rolled out actually promote progress to a universal health system? They were in the preliminary phases of these reforms and these reforms focused on the service delivery and management side. She said the current reforms would create the conditions for efficient and equitable provision of quality services within the public sector. There had been a lot of debate around the National Health Insurance Fund and a lot of confusion. A lot of people thought that it would be just a big

insurance scheme. But her understanding was that it would be fully tax funded. Although it was called the National Health Insurance Fund it was not going to be on a contributory basis where only those who contributed would benefit from it. It was going to be universal and would create a universal entitlement to services and would be tax funded. So why were they going to create the national health insurance fund? Her understanding was that the primary role of that institution would be to undertake strategic purchasing. If they created a good institution that was a strategic purchaser it would take them an enormous distance towards a universal health system.

In conclusion she said that the proposed reforms had the potential to move them towards a universal health system. The intention was that the majority of health care funding would be from mandatory pre-payment tax funding. There would be reduced fragmentation in the funding pools. The majority of funds would be in a single pool and lastly they would strive to get strategic purchasing through an independent public institution.

The final speaker, Professor Olive Shisana, Chief Executive Officer of the Human Sciences Research Council, spoke about South Africa's journey to National Health Insurance and traced the history of its development. She compared the proposals first made in 1935 with the 2011 green paper. For almost 50 years from 1944 and 1994 there was no action. In 1994 the ANC took the decision to have a NHI review. The green paper now in the public domain had several principles, one of which was the right to access to health care and the transformation of the health care system in such a way that it would be evidence based.

She compared the differences between the proposals from the past and today's green paper. Previously it was planned to include employers and employees only and the pro-

posals would cover only the urban working population. Those that were poor or lived in rural areas would not be included. In other words, it was a racially based system. In 2011 the plan envisaged was for a comprehensive universal entitlement programme in which everyone would be included except migrants not resident in South Africa.

Quality control under past proposals lay with the doctors. Now it was proposed that an independent body would be responsible for compliance.

There were now many key stakeholders who were not involved years ago. While many of the health professionals and political parties were ambivalent towards NHI, the public said they supported the proposed reforms.

She said there had been missed opportunities since the 2011 green paper had been published. A wide consultation had taken place with further proposals being made. But she said that the system of NHI was not being piloted. What was now needed was strong stewardship. Consultation must continue with stakeholders and there would have to be more changes. It was also important that pilots took place.

The session ended with a panel discussion involving Prof. Yosuf Veriava and Prof. Alex van der Heever, both from the University of the Witwatersrand, and Dr. Jonathan Broomberg (Discovery Health).

In the afternoon there was a session on advocacy entitled 'Can Physicians be activists for change?'

The first speaker, Dr. Nivio Moreira (Brazil), Past Chair of Junior Doctors Network, spoke about the role of the junior doctors within the WMA and the way they could become more active within the Association. He stressed the way in which the JDN used social media, through the use of twitter and Facebook.



Dr. Jeff Blackmer, Director of Ethics at the Canadian Medical Association spoke about physicians as activists for change and explained why physicians should become activists. He posed the question – was this an option or an ethical obligation? He gave several examples from Canada of where doctors had become involved actively on behalf of their patients and said doctors had the power individually and collectively to act on their social conscience. They had certain rights, but along with these came certain responsibilities. Putting patients above all else was one of these. Another was to advocate on behalf of patients. Doctors were in a unique situation to influence policies, particularly health policies and WMA policy made it clear that doctors had an ethical obligation to undertake advocacy activities.

The final three speakers gave examples of how effective advocacy could be. Dr. Cecil Wilson (American Medical Association), Past President of the WMA, and Dr. André Bernard (Canada), Chair of the WMA's Advocacy Advisory Group, spoke about the advocacy activities of the WMA, giving recent examples of successful media campaigns. Dr. Bernard said that advocacy was key to everything the WMA did and had to be mainstreamed into all NMA activities. And Bruce Eshaya-Chauvin, Medical Advisor with the International Committee of the Red Cross, and head of the Health Care in Danger Project, spoke about the way the project had been developed.

## Friday October 10

### Council

The Council resumed under the Chair Dr. Haikerwal to consider reports from the three committees.

#### Medical Ethics Committee

The report from the committee was approved. The report from the Finance and

Planning Committee was approved after Dr. Haikerwal reported on plans to hold a pre G20 meeting in November in Melbourne on health as an investment.

The Council also agreed to recommend to the Assembly that four new members be admitted from the national medical associations of Kenya, Lesotho, Zambia and Rwanda.

#### Socio Medical Affairs Committee

##### *Environment*

An oral report was received about a meeting of the Environment Caucus. The caucus meeting had heard about the greening of hospitals and clinics and the issue of disinvesting from fossil fuel.

##### *Street Children*

The French Medical Association raised again the issue of the UNESCO International Day for Street Children on November 26 and said it hoped that the WMA would support the day. Meanwhile the Conseil National de l'Ordre des Médecins would continue to fine tune its document on proposals for assisting street children around the world.

##### *Alcohol*

The Australian Medical Association explained further how its International Declaration on Alcohol had emerged. A similar document had been pursued in Australia. Alcohol was a scourge and the harmful effects of alcohol killed about two and a half million people every year, almost four per cent of all the deaths worldwide.

It was significant burden of disease. The Australian Medical Association had worked with a strong coalition in Australia to develop this statement. They accepted that it would be a long campaign, and it was one that should not be joined by the alcohol in-

dustry which did not have the best interests of patients at heart. The Council approved the Socio Medical Committee report.

### Assembly Ceremonial Session

Prof. Ames Dhali, President of the South African Medical Association, officially welcomed delegates to the 65<sup>th</sup> General Assembly. She said it had been an honour for South Africa to host the WMA Assembly for the second time since 2006. She said that one of the most important issues which the WMA was in an excellent position to address was the importance of strong national medical associations. At a time when healthcare was under so much pressure from a number of conflicting interests NMAs had to take up the role as the conscience of the medical profession. It was also important to maintain the unity of medical professionals at both national and international levels. Keeping a united front was absolutely necessary as it was the only way NMAs could have the necessary positive impact to bring about the changes needed to make the world a better place. NMAs were particularly important as vital components of national health systems. The current Ebola crisis had demonstrated again what they had known in advance that badly managed and poorly supported health systems lead inevitably to disaster. If they compared the current Ebola outbreak to the SARS outbreak a few years ago it became apparent how much of a difference adequate health systems made.

Dr. Haikerwal then paid tribute to the retiring WMA President, Dr. Margaret Mungherera. He said she had been a very powerful leader who led from the front and had travelled widely during her Presidency. Dr. Mungherera delivered her valedictory speech and was given a standing ovation.

Dr. Xavier Deau, a general practitioner from France and President of the European and International Delegation of the French Medical Council speech, was then installed

as the 65<sup>th</sup> President of the WMA to serve in 2014/15.

He took the oath of office as President and delivered his inaugural speech, speaking partly in French, partly in Spanish and partly in English.

The ceremonial session ended with a presentation from Bruce Eshaya-Chauvin, Medical Advisor with the International Committee of the Red Cross, and head of the Health Care in Danger Project ICRC, who spoke about plans to launch an e learning module on the project. This would be a simple tool explaining physicians' rights and responsibilities.

## Saturday October 11

### Plenary Assembly Session

#### *President 2015/16*

Professor Sir Michael Marmot, Research Professor of Epidemiology and Public Health at University College London, was elected unopposed as President for 2015/16 after the only other candidate, Dr. Osahon Enabulele (Nigerian Medical Association) withdrew his nomination.

Thanking the Assembly Sir Michael said he was on a mission to promote health equity in the world through action on the social determinants of health.

'I chaired the WHO Commission on Social Determinants of Health. When we published, one government as a form of criticism said our report was ideology with evidence. That was meant as a criticism I took it as praise. I do have an ideology. Health inequalities that are avoidable are wrong, unjust, unfair. That is an ideology.'

He said what he brought to the debate was a deep respect for the evidence. Good intentions were not enough. Since that WHO report he had been talking to governments

making the case that there needed to be action right across government on social determinants of health. He said he would like to represent the voice of the world's doctors in those discussions.

'Who cares more about health than we do. We should be the voice for health. We want action from the whole of government. The doctors are absolutely key. Of course, the WMA represents the interests of doctors and that's absolutely right. But we have a key ethical role to play in representing the interests of our patients and indeed of populations.'

He said he had been asked what advice he would give to young doctors considering working the field of social determinants of health. 'What I would say to young doctors is what a privilege it is every day to know that your work is trying to improve the health of the most disadvantaged.'

#### *Committee Reports*

The Assembly adopted the following policy documents:

- Declaration on the Protection of Health-care Workers in Situations of Violence
- Statement on Aesthetic Treatment
- Statement on the Ethical Guidelines for the International Migration of Health Workers (Revised)
- Statement on the Prevention of Air Pollution and Vehicle Emissions
- Statement on Solitary Confinement
- Statement on Water and Health (Revised)
- Resolution on Ebola Viral Disease
- Resolution on Unproven Therapy and the Ebola Virus
- Resolution on the Non-Commercialization of Human Reproductive Material (Revised)
- Resolution on Migrant Workers' Health and Safety in Qatar

#### *Financial Report*

The Treasurer, Prof. Dr. Frank Ulrich Montgomery, gave an oral report on the past two

years, thanking NMAs for their prompt payment of their dues. He also spoke about the budget for 2015 and said the positive financial development he could report on was due to the frugal use of budgetary means, efficient cost control and a risk free investment policy. The Assembly approved the Financial Statement for 2013 and the 2015 Budget.

#### *Meetings*

The Assembly agreed that the 2017 General Assembly be held in Chicago, USA (Oct 11–14) and that the 2018 Assembly be held in Reykjavic, Iceland.

#### *New Members*

The Assembly approved an application for constituent membership from the Ordre National des Medecins de Guinée and approved four new members from the national medical associations of Kenya, Lesotho, Zambia and Rwanda.

#### *Ebola*

Dr. Haikerwal reported that the Council had approved an emergency Resolution on Ebola on Wednesday and he asked the Assembly to adopt this. Dr. Mark Sonderup (South Africa) suggested amending the Resolution to give more emphasis to honouring those working in dealing with the Ebola crisis. He also wanted to see a paragraph inserted on the use of untested therapies. The WMA was the author of the Declaration of Helsinki and given the debate around the use of therapies and untested therapies which was referred to in the Declaration he believed the WMA should re-emphasise this.

The Assembly voted in favour of amending the Council Resolution by re-ordering the recommendations to give more priority to honouring those fighting the Ebola crisis.

But Prof. Nathanson opposed putting the issue of untested therapies into the Council Resolution. The use of unproven therapies

was extraordinarily complicated. She said the WHO had got this issue right and had referred to Declaration of Helsinki. To insert something on untested therapies in the Council Resolution would require a great deal of information and it would distort the Resolution which was about supporting people in West Africa with the resources they needed to safely care for patients with Ebola. She suggested the issue should be included in a separate statement.

Prof. Montgomery (Germany) also argued against changing the Council Resolution, as this had already been publicised and would cause confusion. He agreed that a second statement could be issued.

Dr. Grootboom (South Africa) said all that was being proposed was an addition to the Resolution. But Dr. Deardon (British Medical Association) believed changing the Resolution would dilute its effectiveness. Dr. Mungherera supported leaving the Resolution unamended and said the most important thing was to try to engage with the communities affected by Ebola. She said the difference between the Nigerian response and that of others was community engagement.

Dr. Sonderup said he had heard the objections to his proposal and still wanted to add to the Resolution. He proposed inserting the words 'The WMA draws attention to the ethical principle that given that proven interventions currently do not exist and that the case fatality rate for EVD is high, the WMA supports the use of unproven interventions if in the physician's judgment it offers reasonable hope of saving life as expressed in the Declaration of Helsinki'.

Dr. Kayode Obembe (Nigeria) said the experience of Nigeria was very important because they had controlled and contained Ebola completely. Other countries had a lot to learn from Nigeria in terms of mobilization, quick response, community epidemiologists and all other aspects. This was a disease that was global and must be con-

tained. He said if they prevented other interventions which had not been proven they would open their practice to the possibility that may occur in the future. He said the Resolution should be left as it was but they should emphasise that physicians' judgment should be taken into consideration.

Dr. Joyce Banda (Zambia) urged caution. What they had been standing for all along was the Declaration of Helsinki where they said they should not use unproven interventions. Now what were they saying? Were they going back on that?

Prof. Montgomery suggested that the Council Resolution should not be amended but that a second emergency Resolution should be considered. He proposed that this would read: 'In the case of Ebola the WMA strongly supports the intentions of Article 37 of the newly revised Declaration of Helsinki which reads "Unproven interventions in clinical practice: In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician's judgment it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available".'

Dr. Sonderup said the suggested Resolution would be acceptable.

Prof. Montgomery's proposed emergency Resolution, slightly amended, was adopted by the Assembly.

## *Associate Members*

Dr. Joseph Heyman, newly elected Chair of the Associate Members, reported on their

meeting and brought two recommendations for consideration by the Assembly, one on nuclear weapons and the other on smallpox.

## *Nuclear Weapons*

The first, the proposed Revision of the WMA Statement on Nuclear Weapons, was introduced by Dr. Xaviour Walker. He explained that the Junior Doctors Network wanted to update the statement to highlight the effect that even a limited nuclear war would have on the world's food supply. He also wanted the Statement amended to focus on how NMAs could educate their physicians and the general public about this threat and he wanted the WMA to join a coalition urging governments to advocate a ban on nuclear weapons.

Prof. Montgomery said this was a paper of high importance and he suggested that it should be circulated to NMAs for further consideration.

Dr. Walker said he wanted to see the proposed revision adopted by the meeting. But the Assembly decided that the proposal be sent to Council for further consideration.

## *Smallpox*

Dr. Walker also proposed a Statement on the destruction of smallpox virus stockpiles. He said smallpox was eradicated in 1980 but live samples were still retained in the United States and in the Russian Federation. He said he would like a proposal for the destruction of the remaining stockpile to be sent to the Council for further consideration. This was agreed.

## *Bioethics*

Dr. Yoram Blachar (Israel) delivered a presentation on the new curriculum for medical ethics to be taught at medical schools and the annual conference to be held by the UNESCO Chair in Bioethics in Jerusalem in January 6–8 2015, sponsored jointly by WMA and others.



## *Ebola*

The Assembly then heard an address from Dr. Andrew Medina-Marino, an epidemiologist with Medecin sans Frontieres, on his recent experiences dealing with the Ebola outbreak in Liberia. Dr. Medina-Marino, Head of the research unit of the disease surveillance and laboratory systems, Foundation for Professional Development, said that the virus was first identified in Zaire in 1976 and until recently all previous outbreaks had occurred in east and central Africa.

The current outbreak was unprecedented and was already 20 times greater than any previous outbreak. Ebola was a zoonotic disease and one of its reservoirs was bats. He spoke about how the infection spread. Currently in West Africa many individuals had been exposed due to certain types of burial traditions. This was not specific to one religion. But unfortunately, at least in Liberia, there were particular communities that had found it difficult to break with certain burial traditions. The current outbreak in West Africa was first identified in the south east region of Guinea in March this year. It was inevitable that this disease would be transmitted across borders and by late March cases had been reported in Liberia. The first wave started in March and ended around mid-April, or so people thought. Local and national governments took their foot off the pedal and did not continue to provide the extensive contact tracing and isolation of individuals. So a second wave flared up, starting at the beginning of May, and this was the current outbreak. He explained how MSF had responded by sending additional support to the affected countries. But their resources had become very strained and in mid-June MSF urged the international community to mobilise resources. Unfortunately this did not materialise and certain international organisations were well behind the curve in identifying this as an international emergency.

He then spoke about his own personal experiences in Liberia. When he arrived there were 231 cases against a background of a recent conflict and hostilities. It was a degrading situation, with significant resistance to the government entering communities because of the recent civil war. As a result MSF personnel were often attacked either because of fear and ignorance. The government was overwhelmed during this period. Civil war had decimated the leadership and the health structure in the country. The Ministry of Health was unable to cope with the situation which was not surprising and this was coupled with a lack of international response. This response was still lagging. The World Health Organisation had a mandate to co-ordinate activities but unfortunately at this stage it had not stepped up to the plate. There was an extreme impact on healthcare workers and to date there had been more than 200 healthcare workers in Liberia alone who had become infected, of whom more than 94 had died. This included 11–12 doctors who had died, 10 per cent of the country's total number of medical doctors. By the time he left Liberia in August there were 768 cases, a tripling over a period of a month. And between the time he left the country and that moment there were nearly 4,000 cases alone in Liberia. The situation was still quite dire.

He said the international community's slow response had been quite deadly. Support had often not materialised and donations without proper co-ordination had gone unutilised. He challenged the WMA to ask their members to urge their national governments to provide an organised response to the West Africa crisis.

## *Moscow General Assembly*

The Russian Ambassador to South Africa, His Excellency Mikhail Petrakov, then formally invited delegates to the next WMA General Assembly in Moscow in October 2015.

## *Nuclear War*

Dr. Ira Helfand, Co-President of the International Physicians for the Prevention of Nuclear War, spoke about the threat of nuclear war. Such a possibility was looming so large that it should demand people's attention as much as Ebola as the medical consequences would be catastrophic. There were more than 16,000 nuclear warheads held by nine countries, the vast majority by the United States and the Russian Federation. The use of even only a small percentage of these warheads would be a global catastrophe. He described the horrific consequences of nuclear warfare, even limited nuclear warfare, and set out what he thought the medical profession could do to prevent this eventuality. Physicians were not speaking out at the moment, but he said they should speak out to terminate these weapons. He asked Assembly delegates to engage with their national medical association to take action.

## *Polio*

Dr. Kenneth Collins AM, former Director of Rotary International from Western Australia, talked about Rotary's involvement in the global partnership to eradicate polio. He charted the start of the project in the Philippines and its spread to other parts of the world. The eventual worldwide campaign led Rotary to raise sufficient funding for 606 million children to be vaccinated. A total of \$1.3 billion had been raised during this period. National governments and the Gates Foundation joined the campaign and in 1991 national immunization days were started. He spoke about the campaign in India and said there were now just three endemic countries, Pakistan, Afghanistan and Nigeria. Pakistan was the only country where the number of cases was escalating. As a result of the global polio eradication initiative 10 million polio cases and 1.5 million deaths had been averted. He urged the WMA and its members to do what they could to help the campaign.

## Open Session

During this session NMAs had the opportunity to present any profession-specific problem they believed the WMA should know about. Several delegates took the opportunity to address the Assembly.

### Costa Rica

Dr. Alexis Castillo Gutierrez (Union Medica Nacional Costa Rica) spoke about what he called 'the dearth of medical services in Latin America'. He spoke particularly about the importation of Cuban medical manpower which was affecting Brazil, Venezuela and other countries and was leading to a health crisis. He said he was speaking on behalf not only of Costa Rica but also of the Latin American Confederation of medical colleges, of Uruguay, Argentina and Brazil and supported by Spain and Portugal who were partly responsible for the training of millions of their colleagues.

He said his Peruvian colleagues could not attend because of their very fragile situation. He appealed to the WMA on behalf of Peruvian physicians in their conflict with their Government. They had been taking strike action since May 2014. The Peruvian Medical Association had not found a way out of the difficulties despite a great number of consultations with the Government. In May the Latin American Forum issued a statement supporting the Peruvian Medical Association. Several appeals had been made to the Government and to the President of Peru, but with no positive outcome. In September a new statement was made regarding the right to strike and non-violence due to acts of violence perpetrated by the Peruvian police against doctors. Dr. Gutierrez said they had brought evidence of this violence to the WMA Assembly and he urged the WMA to get involved in this conflict, by denouncing the violent treatment against physicians and requesting the Peruvian Government to find a solution to the conflict.

Dr. Kloiber responded by saying that the WMA would certainly support the Peruvian physicians.

### India

Dr. Narendra Kumar Saini (Indian Medical Association) talked about the emergency declared by WHO on MDR tuberculosis. There were 9.3 million cases every year and 1.8 million deaths. Of the nine million cases, one million were multi drug resistant tuberculosis. He said that according to the WHO there were three million missing cases. One undetected case gave rise to between ten and 15 more cases. So this was a very grave statistic. He said 70 per cent of affected patients went to the private sector for treatment. Unfortunately many countries did not have the capacity to diagnose cases. Airborne transmission was very high and people often did not complete their course of treatment. He said this was a very grave situation and as grave as Ebola and he urged NMAs to help detect these three million cases.

### Turkey

Dr. Bayazit Ilhan (Turkish Medical Association) raised the issue of problems following the Gezi Park Demonstrations. Thousands of people had been injured as a result of police force and tear gas. There were difficulties in accessing health care services. The Turkish Ministry of Health had failed to organize health services and did nothing to stop the violence. Injured people being treated were asked to give their personal details. As a result many people were afraid to go to hospital. Physicians ran to help the injured. But the Ministry of Health then began inquiring about those healthcare workers who were involved.

He said the Turkish Medical Association reconfirmed its commitment to give first aid care to all without any distinction. It gathered information about the health status of demonstrators and it had conducted a web

based scientific study of health problems experienced by people exposed to tear gas. It had also issued a statement on the use of riot control agents.

The Ministry of Health had since appealed to the court for the dismissal of members of the Ankara Chamber of Medicine saying they gave unauthorized and unsupervised medical care. There was a pre-trial hearing in September, attended by the WMA Secretary General, but the judge had refused to dismiss the case, but postponed it until December 23.

There had also been trials against individual physicians. Now new legislation had been introduced about delivering unauthorised health services, a new type of offence with sanctions of one to three year prison sentences and fines of up to \$900,000 dollars.

### USA

Dr. Cecil Wilson, Past President of the WMA, gave a report on a meeting he had held with the US Defense Health Subcommittee on the subject of "medical professional practice policies and guidelines". The purpose was to have the Defense Health Board deal with the challenges faced by military medical professions in their dual-hatted positions as a military officer and a medical provider.

Dr. Wilson said the Board had asked two questions – how could military professionals most appropriately balance their obligations to their patients against their obligations as military officers to help commanders maintain military readiness? And how much latitude should military medical professionals be given to refuse participation in medical procedures or request excusal from military operations with which they had ethical reservations or disagreement?

He said the Defense Health Board was a civilian-appointed body responsible for providing guidance on ethics to the De-

partment of Defense under Secretary of Defense Chuck Hagel and the current president of the Board was Nancy Dickey, Past President of the American Medical Association.

Dr. Wilson said that to the question as to whether the issues for the military related to dual responsibility were increasing the response was, perhaps. However in 98 to 99 per cent of cases the situations were worked through without problem. However in the cases that did involve a conflict meant that for that one individual professional the consequences for his or her life's work were catastrophic.

He gave two examples. One concerned a young female primary care physician deployed in Afghanistan who was directed to perform physicals on male detainees prior to their interrogations.

Female physical exams performed on male Muslims were considered highly embarrassing. She refused and was threatened with a court martial. She subsequently did the physicals, fearing the risk of a court martial and serving a two-jail term. This doctor had a young daughter and did not want to miss time with her daughter.

The second example related to a team physician for critical care transport stationed outside the US who was directed to transport four critically ill civilians to another hospital. The team physician on boarding the plane determined that the facilities of the newer hospital were not able to provide care and the civilians would die. He directed the aircraft pilot to return the plane. The pilot refused – he had different orders. There was potentially a court martial.

Dr. Wilson said he had also discussed the WMA's Tokyo Declaration and the issue of forced feeding as there was interest in how the WMA representing physicians saw the problems with forced feeding worldwide. He said the discussions for the day had gone well and he was hopeful that problems were being assessed.

#### Cote d'Ivoire

The meeting also heard an appeal from the Ivory Coast medical profession for physicians to do more to protect themselves from Ebola. Some simple medical practices were not being abided by and routine measures were not being applied. Physicians were not washing their hands regularly after attend-

ing patients. They were not wearing gowns or gloves when examining patients. In the case of confirmed cases the request was for all physicians to incinerate all the materials and equipment used.

#### Germany

Dr. Armin Ehl (Germany), Executive Director of Marburger Bund, the trade union of employed doctors in Germany, invited delegates to attend the first congress of medical trade unions to be held in Berlin in June 2016. The conference would deal with physicians' working conditions and with the migration of doctors.

#### Council

The WMA Council briefly reconvened to consider the two motions sent to it by the Assembly on nuclear war and smallpox.

It was agreed that both motions should be sent to the Socio Medical Committee for consideration.

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





## Valedictory address

**Dr. Margaret Mungherera,  
President of the World Medical Association 2013-2014**

The Guest of Honour, the Chair of the World Medical Association Council, Dr. Mukesh Haikerwal. The Immediate Past President, Dr. Cecil Wilson. The President Elect, Dr. Xavier Deau. The Secretary General, Dr. Otmar Kloiber. Council Members, delegates, observers, ladies and gentlemen,

I want to begin by again thanking our hosts, the South African Medical Association for having accorded us such warm hospitality.

Then I want to pay tribute to those physicians and other health workers who are on ground working very hard to overcome the Ebola outbreaks in Sierra Leone, Guinea, Liberia and until recently, Nigeria.

As is the African culture, I ask for a moment of silence to remember all those physicians who have succumbed to the Ebola haemorrhagic fever since the outbreaks started in West Africa.

Over the last one year I have listened carefully to physicians, speak of their work and the issues that confront them. What strikes me is that the challenges of physicians working in high income countries are the same as those of physicians working in poorer countries. The only difference is the scale. Physicians everywhere are concerned about the increasing burden of chronic diseases and the need for something to be done about the lifestyles of people. Physicians everywhere are faced with an increasing plethora of stakeholders inside and outside the health sector and the challenge of finding ways of engaging more effectively with them. Everywhere you go, physicians are concerned about the increasing work load, the wider scope of work, the bureaucracy and fears of litigation. Physicians all over the world have recognized the need to

strengthen inter- professional collaboration and team work.

And In Low and Middle Income countries in Asia, South America and Africa, physicians are particularly concerned about the massive brain drain resulting in a human resource for health crisis and unsatisfied with the response of governments and the lack of priority given to health especially when allocating funding. In many areas of the world, physicians are confronted with harassment and their right to clinical independence is threatened by governments which should be protecting them. Unfortunately, in many places, these incidences do not get reported because the physicians themselves fear the repercussions of reporting or have nowhere to report.

What is encouraging however is the resolve, the commitment and the passion with which physicians all over the world regardless of the challenges they face, continue to do their work. It is for instance inspiring when you hear of the courage shown by the Turkish Medical Society in protecting their physicians.

One important challenge facing physicians is the Information Age. Physicians indeed need to play their part in contributing to the global movement to build what is referred to as the Information Society. WMA should be at the forefront of advocacy for instance in Africa against the negative perceptions policy makers have towards ICT and especially social media and lobby strongly for the cost of ICT infrastructure to come down. These are among the major causes of the lack of or underdevelopment of e-health approaches that you find in Low and Middle Income countries.

The Information Age, global security and the global economy are among the key chal-

lenges for global health in the 21<sup>st</sup> Century. The physicians of the 21<sup>st</sup> century therefore are likely to face challenges that are very different from those that were faced by the physicians of the 20<sup>th</sup> Century. Physicians of the 21<sup>st</sup> Century will be required to be more effective change agents, stronger human rights advocates, patients' advocates, more effective communicators with patients and communities they serve. They will also increasingly be expected to play a larger role in convincing governments and other stakeholders, as to why it makes economic and development sense to invest more in health. NMAs of the 21<sup>st</sup> Century therefore must play different roles from the NMAs of the 20<sup>th</sup> Century. NMAs must speak out against violence and other injustices their physicians face. They must be at the forefront of civil society advocacy campaigns. And they must advocate more strongly for the right to health of the communities they serve.

The WMA will continue to provide opportunities for NMAs to develop their leadership capacity by providing guidelines, training modules, networking opportunities and the leadership development course at the INSEAD in Singapore. NMAs must make an effort to access these resources and use them to build the capacity of their physicians so they are able to do the action and advocacy required

The WMA must be more proactive in reaching out especially to those NMAs in poor countries. In response to requests by the membership, WMA has embarked on a process to strengthen the advocacy capacity of NMAs.

Over the last one year, I have played my role and represented WMA at a total of 15 global meetings, speaking about the role of WMA and the potential roles for NMAs in addressing issues of brain drain, regulation, medical education, access to quality health care for patients and protection of health workers in armed conflict and other emergencies, the Social Determinants of Health, Mental Health, Violence against Women, Violence in the Health care setting, Pa-

tient Safety, ethical issues around health care, post 2015 priorities and health system challenges in Low and Middle Income countries. And as a Rotarian, I am eager to see that WMA works closely with Rotary International and that NMAs participate actively in the campaign to eradicate polio from this planet.

What has made a big impression on me however, are the discussions we have had during my interaction with many of you. Many NMAs have extended to me an invitation to visit them and as a result, I have spoken at a total of 10 annual general meetings in a period of only 12 months and have visited a total of 20 countries in 6 continents, some of them more than once. I have also had the pleasure to be invited by several of you to participate in your NMA activities – like the Medical Mission in Benin City in Nigeria, where I looked at the expressions of relief on the faces of mothers of ill children which made me even more convinced that this is what NMAs are supposed to do. The reception I received at the studios of Radio New Zealand further convinced me that the media can be an effective partner for NMAs in promoting health.

The WMA is making an effort to address many of these issues in the working groups and through collaboration with other organizations. The WMA of the 21<sup>st</sup> Century however cannot be the same as the WMA of the 20<sup>th</sup> Century. The roles are different and so are the expectations of the NMAs, physicians and other stakeholders. This requires the WMA to review its institutions with a view to strengthen them based on the needs. The Council has introduced the idea of Round Table conferences as a means of fundraising. However, these efforts must be improved.

Two groups of people will be useful in propelling NMAs to cope with the new challenges of the 21<sup>st</sup> Century. These are junior doctors and medical students. They are truly the future of the profession, the NMAs and the WMA. And through my own interac-

tion this year with the Junior Doctors Network and the International Federation of Medical Students Associations, I have become more and more convinced that these 2 groups are ready to take on the mantle of leadership. As NMAs therefore, let us open our doors, provide them space to participate effectively in the NMAs and invite them to get involved in the leadership.

As far as Leadership is concerned, in 2015 the world celebrates 20 years since the Beijing Conference on Women. We shall be celebrating the achievements of the world in terms of empowerment of women in many areas including leadership. The very first speech I made after my election as WMA President was the keynote speech at the Congress of the Medical Women International Association last year in Seoul, Korea. I spoke at great length about the roles that women physicians can and should play in influencing the health agendas in their countries and in strengthening the roles of their national medical associations. As I move around the world, I have been impressed by the work women physicians do in their national medical associations.

There are several NMAs that do not have or have very few women in their leadership. Yet there are benefits of allowing women to participate in the NMA leadership. I have met and interacted with vibrant and committed women NMA Presidents in the US, in UK, in Ethiopia, in Sweden and in Rwanda and in South Africa. Having a woman as the NMA President is a good thing but what is even better is to have more women and achieve a gender balance within the leadership of the NMA. We are encouraging NMAs to involve themselves more in issues around women's health and Violence against Women. Women leaders can more easily become actively involved in such programs because they are more likely to appreciate the related socio-cultural issues. It also encourages more women to join the profession and more importantly more women will be encouraged to take up positions of leadership within the profession.

Our NMAs must therefore reflect what we would like to see in other public and private institutions and in society as a whole. Good examples of NMAs where I found gender balance in the governance structure were the Philippines Medical Association and the Ethiopian Medical Association. Maybe WMA should consider taking up the responsibility of leading the way and setting an example for NMAs.

Every WMA President gets to choose a theme around which he or she will do their advocacy work. I chose Africa as my theme. I set out to increase the focus of WMA on the African continent and particularly on the African NMAs. The reason contrary to what some people may think is not because I am an African. It is because Africa is part of the world and in fact, 11% of the world's population lives on the African continent. Africa's health therefore impacts on global health. And as has now finally been realized with the Ebola outbreaks, the world's survival depends on Africa's survival.

The African continent is the continent with the largest disease burden, one that is disproportionate to its population. For instance, with 11% of the world's population, Africa has 45% of the world's women dying from childbirth related complications and 62% of the world's HIV patients. This huge disease burden can be attributed to natural disasters, wars, political instabilities etc. But the most significant causative factor is the weak health systems that African countries have especially those that are in the Sub Saharan region.

It is however, unfortunate that it has taken the recent Ebola outbreaks for the world to realize that it is the weak health systems of Africa that are the biggest threat to global health. Millions have been dying from Malaria and other diseases as a result of these weak health systems. And yet there is little done to strengthen these systems. In fact, the main problems that are making overcoming the Ebola outbreaks difficult is not lack of hospital beds or health workers but the lack of disease surveillance systems,

epidemic preparedness and an effective epidemic response.

African Governments have responded to the challenge of weak health systems by ratifying several international and regional declarations with several countries further developing national policies and health sector strategic plans and incorporating them into national development plans. Subsequently, massive amounts of funds from donor and foreign sources have been pumped into African health sectors for the purpose of implementing these policies. It is however estimated that 20-40% of these funds are wasted largely due to massive corruption and due to implementation that is not in line with the policies. The major cause of Africa's weak health systems therefore is not a shortage of policies or road maps or funding. It is effective leadership to implement the policies and road maps. Let us hope however that it will not need many more Africans and others to die before the world realizes that the key solution to strengthening these systems lies in effective leadership from within Africa rather than from outside the continent.

A good leader has followers. A Malawian proverb says "A leader without followers is simply taking a walk". Africa has too many leaders without followers, leaders simply taking a walk. A common example is the delay in the local response to the Ebola outbreaks by the governments affected, the African Union and others on the continent, clearly showing a lack of effective leadership. Developing leadership capacity should therefore be the main emphasis of any effort aimed at strengthening health systems and reducing Africa's disease burden.

The solutions for Africa's health problems lie within the African continent. The international community must allow Africa to take charge of their health sector by helping Africa to develop its professional leadership. So during my term as WMA President, I have spearheaded the WMA Africa Medical Initiative. The Initiative set out to assess the strength of African NMAs. A capacity needs assessment has been carried out this

year consisting of 4 regional consultative meetings held in Kenya, Nigeria, Tunisia and South Africa and as a result 8 key thematic areas have been identified. These are Organizational Strengthening, Migration and Retention, promoting quality Medical Education, improving physicians' access to Continuing Professional Development, Social Determinants of Health, Universal Health Coverage, Research and Publication. Over a period of 5 years, African NMAs irrespective of whether they are members or not) will be offered capacity building opportunities to enable them more effectively influence their health systems. We have introduced the WMA Initiative to the African Union, the African Development Bank and to 44 African Ministers of Health who I spoke to explaining the potential role of their NMAs in strengthening their health systems in their countries.

The next stage is for the identified Lead Facilitators to design the Program basing on the findings and then work with resource persons who have been identified from among NMAs outside Africa and from among African physicians in the diaspora in the UK. And anyone or NMA interested is welcome to participate.

The Program will involve online discussions, skills training workshops and conferences. Twinning is also being encouraged between strong NMAs outside the African continent and African NMAs. I want to therefore appreciate those NMAs outside the Africa region who have offered to twin with African NMAs- the New Zealand Medical Association, h will twin with Medical Association of Tanzania, the Japan Medical Association with the Malawi Medical Association and the Danish Medical Association with the Rwanda Medical Association. African NMAs that have not yet joined the WMA have been invited to join. Our target is to see that at least 4 new African NMAs join WMA every year. This target has been met this year with NMAs of Kenya, Zambia, Rwanda and Lesotho applying to join. However, we still have 29 of the 54 coun-

tries in Africa which are not represented in the WMA. This is half, so we have a long way to go.

At this juncture I wish to thank the Danish Medical Association for offering to support the Chair of the Kenya Medical Association and the President of the Rwanda Medical Association to attend this meeting as observers. We shall need more of such support from other NMAs.

We again look forward to many more of you participating in this important initiative because again I say when the health of Africa is threatened, global health and survival is also threatened.

This flight of WMA 2014-15 took off on the 19<sup>th</sup> October 2013 in Fortaleza, Brazil. Some of you looked uneasy seeing an African woman from one of the poorest nations in the world taking charge and yes, the flight did experience some turbulence from time to time. Generally, it was a smooth flight. And as I was assured from the beginning by my good friends Vivienne and Ardis and Mzukisi, I have had tremendous support. I have had an excellent co-pilot, Mukesh you have taught me a lot, and Otmar, you have been an excellent flight engineer, and the crew, Julia, Clarisse, Sunny, Anna, Lamine, Annabel and the volunteers, Salma and Stintje have been very supportive, and more importantly the passengers, that is you the constituent members have been exceptional. Well now, a new Captain takes over. Xavier mon ami, I wish you all the best in this important and prestigious position. I pledge my support to you. I am very confident that with your commitment, and you being calm and clear headed you will take the WMA to greater heights.

I want to end by expressing sincere appreciation to my husband Richard and the rest of my family for their patience and unwavering support.

To all of you again, I say, thank you for this wonderful opportunity to serve. It has indeed been a wonderful year and thank you all for listening to me.



## Inaugural speech

**Dr. Xavier Deau,  
President of the World Medical Association 2014-2015**

It is a great honour and pleasure for me to be here in Durban to take on the Presidency of the World Medical Association in front of all of you and to represent the 106 Medical Associations of our Association. I'm sure you will understand that it is with some emotion that I address you today.

Allow me first to pay tribute to our Past President, Dr Margaret Mungherera, whose great amount of work over the past year has contributed to promoting the ethical standards of our Association at the highest level, particularly on the African continent through the African Forum project.

Let me introduce myself:

I am a medical specialist in general medicine, and since 1976 I have been working in Epinal (in the Eastern part of France) in a multi-professional medical practice located in a socially disadvantaged area (which includes a re-housing centre, a children's home and social housing...). I founded this multi-professional and multidisciplinary medical practice in order to optimize the quality of healthcare and answer the specific needs of a precarious population in a coordinated manner.

Having lived in Lorraine, 20 meters from the German border, for the first 25 years of my life, I have always been sensitive to multiculturalism, to the importance of respecting difference, and to the construction of a Europe in the spirit of peace and understanding so dear to Robert Schuman, the founder of the European Union who was born in the same region. Therefore, I have always held within me great faith in a world of peace, fraternity and joy.

This spirit of peace, respect and understanding has led me to take on professional responsibilities within the French Medical Council as an Elected Representative, first

at Departmental level, then at National level as Vice-President, then as President of the European and International Relations Delegation, and lastly as Secretary General of the European Council of Medical Orders and of the Francophone Conference of Medical Orders gathering of 22 countries, including 15 from the African continent. I would like to express my gratitude to the French Medical Council for making all these commitments possible.

During my studies, I was fortunate enough to get to know Doctor Bernard Kouchner and Doctor Xavier Emmanuelli, founders of Doctors without Borders and of the SAMU Social International, who have been outstanding examples of the universality of medical ethics for me.

Lastly, I could never forget my daily source of energy: the affection of my wife who is here with us today, as well as my 5 children and 12 grandchildren, who are not physically present, but who are in my heart and soul.

Therefore, you will understand that, as is true for each of us, my path has been marked by my own family and my own cultural determinants. I would like to thank all of those who have helped me to be here with you today.

All your actions within the World Medical Association have allowed me to continue along this path.

The question I am now asking myself is probably the same one that you have in mind:

Why did I accept the role of the Presidency of the WMA?

I would first like to call to mind one of the fathers of the WMA, the French doctor Eugène Marquis, who, following the atrocities of the last World War, showed along

with many of his colleagues a very strong willingness to work for peace by raising the ethical standards of medical practice to the highest level through the foundation of the WMA.

Since its creation in 1947, the WMA has been constantly affirming loud and clear through its declarations and statements the universality of essential ethical values for practicing our profession.

I want to maintain continuity with my predecessors; it is with humility that I will head our Association.

Therefore, throughout the coming year I will endeavour to enhance our ethical values even further because, beyond the deontology proper to the legislation in each of our countries, these ethical values should sway the mind of each and every doctor, regardless of his or her culture, religion or skin colour.

Along with you, I will seek to protect and further develop:

The independence of the medical profession, which should be duly respected by political, administrative, military as well as religious authorities. The independence of doctors' decision-making forms the basis of the trust indispensable to the doctor-patient relationship.

Professional secrecy: in all circumstances, including during armed conflicts, professional secrecy must be respected along with all information on patients and their consent to the health care proposed to them.

A high-level, good quality education is the cornerstone of the competence of doctors, and it is essential that the WMA be one of the effective players in this field, especially through the development of the worldwide junior doctors network. The JDN has demonstrated its role within the WMA. The WMA should remain at the service of the education of the doctors of tomorrow.

Let us not forget the protection of our patients' personal data at this time of new technologies, e-health and m-health. The protection of these sensitive data should be enhanced as rigorously as possible without

jeopardizing the evolution of our medical science.

At the same time, in a world where everything tends to have a monetary value, we should remain very watchful of all potential conflicts of interest. Human values must always prevail over financial considerations, bearing in mind that the well-being of humans cannot be dissociated from financial contingencies. The WMA has to participate in finding a balance between the "primacy of the individual" and "societal primacy".

All of these ethical values have been underlined in the latest version of the Declaration of Helsinki, which is a shining example of the universality of medical ethics. Even if its drafting seemed laborious at times, our Declaration of Helsinki has the merit of compiling the cultures of 106 medical associations, and thus is an authentic factor in promoting peace and the union between medical professions around the world in full respect for patients and their care.

Nonetheless, these ethical values cannot exist without a structured and organized society, taking into account the social determinants of health in order to optimize health equity.

This coordination should include all the different players around patients, both in care and prevention, as well as in health education, in one single, all-encompassing and dynamic vision within a given territory.

The WMA should contribute to a genuine revolution in primary care by promoting holistic and personalized medicine, coordinated between the different health professions.

In this respect, I would particularly like to praise the work of Sir Michael Marmot for his contribution towards this goal, both in his own country and worldwide.

Taking account of our cultural differences necessarily raises the level of care requirements, particularly at a time when viruses like Ebola have no more borders and require a maximum level of coordination from all health care professionals and politicians. In this regard, the role of the WMA becomes

indispensable. We must all mobilize ourselves.

Working through their constant perspective of multiculturalism, I would like to pay tribute to the efforts of our WMA leaders: our Chairman of the Board, Mukesh Haikerwal, our Secretary General, Otmar Kloiber, as well as the rigorous and careful vigilance of our Treasurer, Frank Ulrich Montgomery, not forgetting our legal advisor, Annabel Seebohm and ethical advisor Jeff Blackmer. I would also like to thank all the members of the WMA's Executive Committee, not forgetting the efficiency of the entire Secretariat and those who support their work (Sunny, Clarisse, Anne-Marie, Roderic, Rosie, Julia and Lamine, and of course...Nigel, always looking out for the latest news).

I am French and my country, France, is not only a country with a strong human rights record, but also a republic which has been based on the triptych: liberty, equality, fraternity since 1789 (and the French Revolution).

I will therefore strive during this mandate to promote healthcare equity for every human being regardless of his or her language, culture or religion.

To conclude, I have one final wish: our world is currently going through a dramatic increase in armed conflicts, which are seeing the values of our Association permanently violated. Impartiality remains an inescapable ethical value, as much in our schools as in our administrations and our hospitals. This impartiality guarantees a deep respect for all cultural differences and the rejection of all forms of fundamentalism.

That is why I am asking everyone to act as peacemakers by strictly observing these values within your Associations, towards your governments and also with respect to each of your patients.

Today marks the 12<sup>th</sup> World Day Against the Death Penalty, and I would like to stress the importance of this issue for the WMA. This gives me an opportunity to

pay tribute to the work of our association in this field through its policies aimed at supporting doctors working in prisons to promote human rights and ethics. I refer in this regard to the Declaration of Tokyo, which provides Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, the Declaration of Malta on Hunger Strikers and the Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases.

On this special day of my election, I would also like to underline the crucial action of two South African Nobel Peace Prize Laureates, Nelson Mandela and Archbishop Desmond Tutu. These two men have managed to be drivers for peace and impartiality beyond the borders of South Africa.

Let us be the actors and also the builders of a healthier, fairer and more equitable society, in which human rights, but also liberty, equality and fraternity, as well as high quality health care, enable each person to grow and live in peace.

Let us be doctors acting towards peace in the name of the universality of the ethics of our Medical Association...!

*Seamos médicos actores de paz en nombre de la universalidad de la ética de nuestra asociación...!*

I thank you all.

## WMA Declaration on the Protection of Health Care Workers in situation of Violence

*Adopted by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

### Preamble

The right to health is a fundamental element of human rights which does not change in situations of conflict and violence. Access to medical assistance for the sick and wounded, whether they have been engaged in active combat or not, is guaranteed through various international agreements, including the Geneva Convention and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials of the United Nations.

The primary obligation of physicians is always to their patients, and physicians have the same ethical responsibilities to preserve health and save life in situations of violence or armed conflicts as in peacetime. These are as set out in the WMA Regulations in Times of Armed Conflict and Other Situations of Violence.

It is essential to ensure the safety and personal security of healthcare workers in order to enable the provision of the highest standard of care to patients. If healthcare workers are not safe, they might not be able to provide care, and patients will suffer.

In situations of violence, the delivery of healthcare is frequently obstructed and the sick and wounded deprived of essential treatment through:

1. Medical workers being prevented from attending to the injured;
2. Interference by the state or others in positions of power through intimidation, detention or other legal measures;
3. Patients being denied access to medical facilities;
4. Targeted attacks upon medical facilities and medical transport;
5. Targeted attacks upon medical personnel, including kidnapping;
6. Non-targeted violent acts which result in the damage to or destruction of facilities or vehicles, or cause injury or death to medical personnel.

Such actions have serious humanitarian implications and violate international standards of medical neutrality as set out in the provisions of international human rights and humanitarian law and codes of medical ethics.

Attacks on the fundamental ethical principles of the medical profession, such as attempts to coerce medical professionals into pro-

viding details regarding those under their care, can undermine the confidence of patients and discourage injured people from seeking necessary treatment.

### Recommendations

The WMA calls upon governments and all parties involved in situations of violence to:

1. Ensure the safety, independence and personal security of healthcare personnel at all times, including during armed conflicts and other situations of violence, in accordance with the Geneva Conventions and their additional protocols;
2. Enable healthcare personnel to attend to injured and sick patients, regardless of their role in a conflict, and to carry out their medical duties freely, independently and in accordance with the principles of their profession without fear of punishment or intimidation;
3. Safe access to adequate medical facilities for the injured and others in need of medical aid should not be unduly impeded;
4. Protect medical facilities, medical transport and the people being treated in them and provide the safest possible working environment for healthcare workers and protect them from interference and attack;
5. Respect and promote the principles of international humanitarian and human rights law which safeguard medical neutrality in situations of conflict;
6. Establish reporting mechanisms to document violence against medical personnel and facilities as set out in the WMA Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence.
7. Raise awareness of international norms on the protection of healthcare workers and cooperate with different actors to identify strategies to tackle threats to healthcare. The collaboration between the WMA and the International Committee of the Red Cross on the Health Care in Danger project provides one example of this.

## WMA Resolution on Ebola Viral Disease

*Adopted by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

### Background

A number of viral diseases have caused occasional health emergencies in parts of Africa, with local or wider spread epidemics. These



include Lassa, Marburg and Ebola Viral Diseases (EVD). The 2013–14 outbreak of EVD in West Africa has proven far more difficult to control than previous epidemics and is now present in Sierra Leone, Liberia and Guinea with more than 2000 deaths. This epidemic appears to have a case related mortality of approximately 55% against a range for EVD of 50–95%.

Following infection, patients remain asymptomatic for a period of 2–21 days, and during this time tests for the virus will be negative, and patients are not infectious, posing no public health risk. Once the patient becomes symptomatic, EVD is spread through contact with body fluids including blood. Symptoms include diarrhoea, vomiting and bleeding, and all these body fluids are potentially sources of infection.

Management is primarily through infection control, the use of personal protective equipment (PPE) by health care workers and those disposing of body fluids and of bodies, and supportive care for sick patients including using IV fluids and inotropes. Contact tracing is also important but may be difficult in many of the communities currently affected. Vaccines are in development as are some antivirals, but they will arrive late in this epidemic if they are proven successful.

Evidence from those treating patients in affected communities is that a shortage of resources, including health care workers and PPE, as well as poor infection control training of health care workers, caregivers and others at risk are making epidemic control difficult.

Some governments have indicated that they will build new treatment centres in affected areas as a matter of urgency, while others are directly providing personal protective equipment and other supplies.

## Recommendations

The WMA honours those working in these exceptional circumstances, and strongly recommends that national governments and international agencies work with health care providers on the ground and offer stakeholders training and support to reduce the risks that they face in treating patients and in seeking to control the epidemic.

The WMA commends those countries that have committed resources for the urgent establishment of new treatment and isolation centres in the most heavily burdened countries and regions. The WMA calls upon all nations to commit enhanced support for combatting the EVD epidemic.

The WMA calls on the international community, acting through the United Nations and its agencies as well as aid agencies, to im-

mediately provide the necessary supplies of PPE to protect health care workers and ancillary staff and reduce the risk of cross infection. This must include adequate supplies of gloves, masks and gowns, and distribution must include treatment centres at all levels.

The WMA calls on all those managing the epidemic, including local and national governments and agencies such as WHO, to commit to adequate training in infection control measures, including PPE for all staff and caregivers who might come into contact with infective materials.

The WMA calls on national and local governments to increase public communication about basic infection control practices.

The WMA calls upon WHO to facilitate research into the timeliness and effectiveness of international interventions, so that planning and interventions in future health emergencies can be better informed.

The WMA strongly urges all countries, especially those not yet affected, to educate health care providers about the current case definition in addition to strengthening infection control methodologies and contact tracing in order to prevent transmission within their countries.

The WMA calls for NMAs to contact their national governments to act as described in this document.

## WMA Resolution on Migrant Workers' Health and Safety in Qatar

*Adopted by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

### Preamble

Reliable reports indicate that migrant workers in Qatar suffer from exploitation and violation of their rights. Workers basic needs, e.g. access to sufficient water and food, are not met. Less than half of the workers are entitled to health care. Hundreds of workers have already died in the construction sites since 2010 as the country prepares to host the 2022 FIFA [1] World Cup. Workers are not free to leave when they see their situation hopeless or health endangered since their passports are confiscated.

Despite the pleas of international labour and human rights organizations, such as ITUC (International Trade Union Confederation) and Amnesty International, the response of the Qatar government to solve the situation has not been adequate. FIFA has been inefficient and has not taken the full responsibility to facilitate the improvements to the worker's living and working conditions.

The World Medical Association reminds that health is a human right that should be safeguarded in all situations.

The World Medical Association is concerned that migrant workers are continuously put at risk in construction sites in Qatar, and their right to freedom of movement and right to health care and safe working conditions are not respected.

## Recommendations

The WMA calls upon the Qatar government and construction companies to ensure the health and safety of migrant workers.

The WMA demands the FIFA as the responsible organization of the World Cup to take immediate action by changing the venue as soon as possible.

The WMA calls upon its members to approach local governments in order to facilitate international cooperation with the aim of ensuring the health and safety of migrant workers in Qatar.

[1] Fédération Internationale de Football Association

## WMA Resolution on the Non-Commercialisation of Human Reproductive Material

*Adopted by the 54<sup>th</sup> WMA General Assembly, Helsinki, Finland, September 2003 and revised by 65<sup>th</sup> WMA General Assembly, Durban, South Africa 2014*

### Preamble

The rapid advances in biomedical technologies have led to growth of the reproductive assistance industry, which tends to be poorly regulated. Despite the fact that many governments have laws prohibiting commercial transactions of reproductive material, most

have not been successful in universally preventing the sale of human ova, sperm and embryos on the internet and elsewhere. The market value of human material, including cells, tissues, and cellular tissue can be lucrative, creating a potential conflict for physicians and others between economic interests and professional ethical obligations.

For the purposes of this resolution human reproductive material is defined as human gametes and embryos.

According to the WHO, transplant commercialism "is a policy or practice in which cells, tissues or organs are treated as a commodity, including by being bought or sold or used for material gain." [1]

The principle that the "human body and its parts shall not, as such, give rise to financial gain"[2] is laid down in numerous international declarations and recommendations.[3] The 2006 WMA Statement on Human Organ Donation and Transplantation and the 2012 WMA Statement on Organ and Tissue Donation call for the prohibition of the sale of organs and tissues for transplantation. The WMA Statement on Assisted Reproductive Technologies (2006) also states that it is inappropriate to offer financial benefits to encourage donation of human reproductive material.

The same principles should be in place for the use of human reproductive material in the area of medical research. The International Bioethics Committee of the United Nations Educational, Scientific and Cultural Organization (UNESCO IBC) in its report on the ethical aspects of human embryonic stem cell research states that the transfer of human embryos must not be a commercial transaction and that measures should be taken to discourage any financial incentive.

It is important to distinguish between the sale of clinical assisted reproductive services, which is legal, and the sale of the human reproductive materials, which is usually illegal. Due to the special nature of human embryos, the commercialization of gametes is unlike that of other cells and tissues as sperm and eggs may develop into a child if fertilization is successful.

Before human reproductive material is donated, the donor must give informed consent that is free of duress. This requires that the individual donor is deemed fully competent and has been given all the available information regarding the procedure and its outcome. If research is to be conducted on the material, it is subject to a separate consent process that must be consistent with the provisions in the WMA's Declaration of Helsinki. There must not be any inducement or other undue pressure to donate or offers of compensation.

Monetary compensation given to individuals for economic losses, expenses or inconveniences associated with the retrieval of donated

reproductive materials should be distinguished from payment for the purchase of reproductive materials.

## Recommendations

National Medical Associations (NMAs) should urge their governments to prohibit commercial transactions in human ova, sperm and embryos and any human material for reproductive purpose.

Physicians involved in the procurement and use of human ova, sperm, and embryos should implement protocol to ensure that materials have been acquired appropriately with the consent and authorization of the source individuals. In doing so, they can uphold the ethical principle of non-commercialization of human reproductive material.

Physicians should consult with potential donors prior to donation in order to ensure free and informed consent.

Physicians should adhere to the WMA Statement on Conflict of Interest when treating patients who seek reproductive services.

- [1] Global Glossary of Terms and Definitions on Donation and Transplantation, WHO, November 2009
- [2] European convention of human rights and biomedicine – Article 21 – Prohibition of financial gain
- [3] Declaration of Istanbul guiding principle 5

## WMA Resolution on Unproven Therapy and the Ebola Virus

*Adopted by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

In the case of Ebola virus, the WMA strongly supports the intention of Paragraph 37 of the 2013 revision of the Declaration of Helsinki, which reads:

In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available.

## WMA Statement on Aesthetic Treatment

*Adopted by the 65<sup>th</sup> World Medical Assembly, Durban, South Africa, October 2014*

### Preamble

Aesthetic treatments have become increasingly common in recent years as society appears to have become more preoccupied with physical appearance. These treatments are performed by practitioners with widely differing clinical and educational backgrounds.

For the purpose of this statement, aesthetic treatment is defined as an intervention that is performed not to treat an injury, a disease or a deformity, but for non-therapeutic reasons, with the sole purpose of enhancing or changing the physical appearance of the individual concerned. In this statement, the individual undergoing treatment is referred to as the patient. The treatments available include a great variety of interventions, ranging from surgical procedures to injections and different kinds of skin treatments. This statement focuses on interventions that are methodologically similar to those performed in conventional health care. Tattooing, scarring and similar interventions are therefore not considered in this statement. Body image affects a person's self-esteem and mental health and is an integral part of a person's overall health and well-being. However, media images of "perfect bodies" have become the norm, causing some people, to develop unrealistic and unhealthy body images. Many aesthetic treatments involve risks and may potentially harm the health of the patient. Minors [1] are particularly vulnerable, as their bodies are often not fully developed. In order to protect persons considering or undergoing aesthetic treatment the WMA has developed the following basic principles regarding aesthetic treatments.

Reaffirming the medical ethics principles laid out in the WMA Declaration of Geneva, the WMA Declaration of Lisbon on the Rights of the Patient and the WMA International Code of Medical Ethics, and consistent with the mandate of the WMA, this statement is addressed primarily to physicians. However, the WMA encourages other practitioners performing aesthetic treatments to adopt these principles.

### Principles

1. The patient's dignity, integrity and confidentiality must always be respected.
2. Physicians have a role in helping to identify unhealthy body images and to address and treat disorders when these exist.

3. Aesthetic treatments must only be performed by practitioners with sufficient knowledge, skills and experience of the interventions performed.
4. All practitioners providing aesthetic treatments must be registered with and/or licensed by the appropriate regulatory authority. Ideally, the practitioner should also be authorized by this authority to provide these specific aesthetic treatments.
5. All aesthetic treatments must be preceded by a thorough examination of the patient. The practitioner should consider all circumstances, physical and psychological, that may cause an increased risk of harm for the individual patient and should refuse to perform the treatment if the risk is unacceptable. This is especially true in the case of minors. Practitioners should always choose the most appropriate treatment option, rather than the most lucrative one.
6. Minors may need or benefit from plastic medical treatments but pure aesthetic procedures should not be performed on minors. If, in exceptional cases, aesthetic treatment is performed on a minor, it should only be done with special care and consideration and only if the aim of the treatment is to avoid negative attention rather than gain positive attention. All relevant medical factors, such as whether the minor is still growing or whether the treatment will need to be repeated at a later date, must be considered.
7. The patient must consent explicitly to any aesthetic treatment, preferably in writing. Before seeking consent the practitioner should inform the patient of all relevant aspects of the treatment, including how the procedure is performed, possible risks and the fact that many of these treatments may be irreversible. The patient should be given sufficient time to consider the information before the treatment starts. Where the patient requesting the treatment is a minor, the informed consent of his or her parents or legally authorized representative should be obtained.
8. All aesthetic treatments performed should be carefully documented by the practitioner. The documentation should include a detailed description of the treatment performed, information on medications used, if any, and all other relevant aspects of the treatment.
9. Aesthetic treatments must only be performed under strictly hygienic and medically safe conditions on premises that are adequately staffed and equipped. This must include equipment for treating life-threatening allergic reactions and other potential complications.
10. Advertising and marketing of aesthetic treatments should be responsible and should not foster unrealistic expectations of treatment results. Unrealistic or altered photographs showing patients before and after treatments must not be used in advertising.
11. Advertising and marketing of aesthetic treatments should never be targeted to minors.
12. Practitioners should never offer or promote financial loans as a means of paying for aesthetic treatment.

[1] For the purpose of this statement minor is defined as a person who, according to applicable national legislation, is not an adult.

## WMA Statement on Ethical Guidelines for the International Migration of Health Workers

*Adopted by the 54<sup>th</sup> WMA General Assembly, Helsinki, Finland, September 2003 and revised by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

### Preamble

The WMA acknowledges that temporary stays of physicians in other countries help both the receiving and the sending countries to exchange medical knowledge, skills and attitudes. The exchange of medical professionals is therefore beneficial for the development of medicine and healthcare systems and in general deserves the support of national medical associations as well as governments.

The WMA Statement on Medical Manpower – 1 (1983, 1986) called upon all National Medical Associations to work with their governments towards solutions to the emerging problems related to the medical workforce.

The WMA Resolution on the Medical Workforce (1998) identified the major components of the medical workforce situation that need to be taken into account when developing a national workforce policy.

For several decades many governments, employers and medical associations have misinterpreted demographical data regarding the number of physicians that are required. Young people seeing employment as physicians have often been seriously affected by poor medical workforce planning.

In many countries, including the wealthiest ones, there is a shortage of physicians. A major reason for the shortage is a failure to educate enough physicians to meet the needs of the country. Other reasons for the net loss of physicians are the recruitment of physicians to other professions, early retirement and emigration, and the problems of combining professional and family responsibilities, all of which are often due to poor working conditions for physicians.

Some countries have traditionally solved their need for physicians by recruiting medical graduates from other countries. This practice continues today.

The flow of international migration of physicians is generally from poorer to wealthier countries. The poorer countries bear the expense



of educating the migrating physicians and receive no recompense when they enter other countries. The receiving countries gain a valuable resource without paying for it, and in the process they save the cost of educating their own physicians.

Physicians do have valid reasons for migrating, for example, to seek better career opportunities and to escape poor working and living conditions, which may include the pursuit of more political and personal freedoms and other benefits.

## Recommendations

National medical associations, governments and employers should exercise utmost care in utilizing demographic data to make projections about future requirements for physicians and in communicating these projections to young people contemplating a medical career.

Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians.

Every country should do its utmost to retain its physicians in the profession as well as in the country by providing them with the support they need to meet their personal and professional goals, taking into account the country's needs and resources.

Countries that wish to recruit physicians from another country should only do so in terms of and in accordance with the provisions of a Memorandum of Understanding entered into between the countries.

Physicians should not be prevented from leaving their home or adopted country to pursue career opportunities in another country.

Countries that recruit physicians from other countries should ensure that recruiters provide full and accurate information to potential recruits on the nature and requirements of the position to be filled, on immigration, administrative and contractual requirements, and on the legal and regulatory conditions for the practice of medicine in the recruiting country, including language skills.

Physicians who are working, either permanently or temporarily, in a country other than their home country should be treated fairly in relation to other physicians in that country (for example, equal opportunity career options and equal payment for the same work).

Nothing should prevent countries from entering into bilateral agreements and agreements of understanding, as provided for in international law and with due cognizance of international human

rights law, so as to effect meaningful co-operation on health care delivery, including the exchange of physicians.

The WHO Global Code of Practice on the International Recruitment of Health Personnel (May 2010) was established to promote voluntary principles and practices for the ethical international recruitment of health professionals and to facilitate the strengthening of health systems. The Code takes into account the rights, obligations and expectations of source countries and migrant health professionals. The WMA was involved in the drafting of the Code and supports its implementation.

The WHO Code states that international recruitment should be "conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries."

The monitoring and information-sharing system established by the WHO should be robustly supported with the goal of international cooperation. Stakeholders should regularly collate and share data, which should be monitored and analysed by the WHO. The WHO should provide substantive critical feedback to governments. Information should be shared about how to overcome challenges encountered.

## WMA Statement on Solitary Confinement

*Adopted by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa, October 2014*

### Preamble

In many countries substantial numbers of prisoners are held at times in solitary confinement. Prisoners are typically kept in isolation for most of the day, and are allowed out of their cells only a short period of time of solitary exercise. Meaningful contact with other people (prisoners, prison staff, outside world) is kept to a minimum. Some countries have strict provisions on how long and how often prisoners can be kept in solitary confinement, but many countries lack clear rules on this.

The reasons for the use of solitary confinement vary in different jurisdictions. It may be used as a disciplinary measure when a prisoner does not respond to other sanctions intended to address his or her behaviour, for example, in response to seriously disruptive behaviour, threats of violence or suspected acts of violence.

The legal authorities in some nations allow individuals to be held in solitary confinement during an on-going criminal investigation or to be sentenced to solitary confinement, even when the individual poses no threat to others. Individuals with mental illness may be kept in high-security or super-maximum security (supermax) units or prisons. Solitary confinement can be imposed for hours to days or even years.

Reliable data on the use of solitary confinement are lacking. Various studies estimate that tens of thousands or even hundreds of thousands of prisoners are currently held in solitary confinement worldwide.

People react to isolation in different ways. For a significant number of prisoners, solitary confinement has been documented to cause serious psychological, psychiatric, and sometimes physiological effects, including insomnia, confusion, hallucinations and psychosis. Solitary confinement is also associated with a high rate of suicidal behaviour. Negative health effects can occur after only a few days, and may in some cases persist when isolation ends.

Certain populations are particularly vulnerable to the negative health effects of solitary confinement. For example, persons with psychotic disorders, major depression, or post-traumatic stress disorder or people with severe personality disorders may find isolation unbearable and suffer health harms. Solitary confinement may complicate treating such individuals and their associated health problems successfully later in the prison environment or when they are released back into the community.

Human rights conventions prohibit the use of torture, cruel, inhuman or degrading treatment or punishment. The use of prolonged solitary confinement against a prisoner's own will or the use of solitary confinement during pre-trial detention or against minors can be regarded as a breach of international human rights law, and must be avoided.

## Recommendations

The WMA urges National Medical Associations and governments to promote the following principles:

1. Solitary confinement should be imposed only as a last resort whether to protect others or the individual prisoner, and only for the shortest period of time possible. The human dignity of prisoners confined in isolation must always be respected.
2. Authorities responsible for overseeing solitary confinement should take account of the individual's health and medical condition and regularly re-evaluate and document the individual's status. Adverse health consequences should lead to the immediate cessation of solitary confinement.
3. All decisions on solitary confinement must be transparent and regulated by law. The use of solitary confinement should be

time-limited by law. Prisoners subject to solitary confinement should have a right of appeal.

4. Prolonged solitary confinement, against the will of the prisoner, must be avoided. Where prisoners seek prolonged solitary confinement, for whatever reason, they should be medically and psychologically assessed to ensure it is unlikely to lead to harm.
5. Solitary confinement should not be imposed when it would adversely affect the medical condition of prisoners with a mental illness. If it is essential to provide safety for the prisoner or other prisoners then especially careful and frequent monitoring must occur, and an alternative found as soon as possible.
6. Prisoners in isolation should be allowed a reasonable amount of regular human contact. As with all prisoners, they must not be subjected to extreme physical and mentally taxing conditions.
7. The health of prisoners in solitary confinement must be monitored regularly by a qualified physician. For this purpose, a physician should be allowed to check both the documentation of solitary confinement decisions in the institution and the actual health of the confined prisoners on a regular basis.
8. Prisoners who have been in solitary confinement should have an adjustment period before they are released from prison. This must never extend their period of incarceration.
9. Physician's role is to protect, advocate for, and improve prisoners' physical and mental health, not to inflict punishment. Therefore, physicians should never participate in any part of the decision-making process resulting in solitary confinement.
10. Doctors have a duty to consider the conditions in solitary confinement and to protest to the authorities if they believe that they are unacceptable or might amount to inhumane or degrading treatment.

## WMA Statement on the Prevention of Air pollution due to Vehicle Emissions

*Adopted by the 65<sup>th</sup> World Medical Assembly, Durban, South Africa, October 2014*

### Preamble

There are a number of ways in which the volume of harmful emissions can be reduced. These include encouraging fewer road traffic journeys, active transport for individuals undertaking relatively short journeys, the use of mass public transit in preference to individual vehicles, and alternative energy sources for vehicles, includ-

ing electric and hybrid technologies. Where vehicle use is essential, means of reducing harmful emissions should be used.

Physicians around the world are aware of air pollution. It impacts the quality of life for hundreds of millions of people worldwide, causing both, a large burden of disease as well as economic losses and increased health care costs. According to WHO estimates, in 2012, urban outdoor air pollution was responsible for 3.7 million annual deaths, representing 6.7% of the total deaths (WHO, 2014).

Especially, diesel soot is acknowledged as a proven carcinogen (IARC, 07/2012). Furthermore, it has many other toxic effects, most prominently in the cardiovascular (Brook et al., 2010) and respiratory systems (ERS, 2010). Moreover, in the context of global warming, soot, along with methane, is identified as the second most important greenhouse driving force substance after CO<sub>2</sub> (Kerr, 2013).

Despite the fact that new vehicles will have to comply with stricter emission standards which take into account most harmful ultra fine particles too, a high-polluting in-use fleet, including off-road vehicles such as construction engines and ships, will continue polluting for many more years.

## Background

In many densely populated cities around the world, fine dust concentrations measurable as aerosols exceed up to 50 times the maximum WHO recommendation. High volumes of transport, power generated from coal, and pollution caused by construction machinery are among the contributing factors. People living and working near major (high density volume traffic) streets are most affected by pollutants.

For fighting the health risks mentioned above, there exist a variety of highly efficient and reliable filter systems on the market (Best Available Technology (BAT) filters[1]). They are applicable to all internal combustion engines and they reduce even most harmful ultra-fine particles by a factor of over one hundred.

As soon as 90% of heavy duty vehicles, both, new and upgraded ones, satisfy this standard, health problems attributable to emissions of heavy duty traffic will be greatly reduced, and no further tightening of emission standards will be possible or even needed at all because of an almost total elimination of the pollutant as such.

In a variety of countries on different continents and under varying conditions retrofit or upgrading programs have been successfully performed. The UN's Working Party on Pollution Prevention and Energy in Geneva has just proposed a technical standard for regulation in their member states, which will be applicable worldwide.

The WMA supports these efforts and calls on policy makers in all countries, especially in urban regions, to introduce regulatory restrictions of access for vehicles without filter, and/or to provide financial assistance to support the retrofitting of in-use vehicles.

## Recommendations

The WMA therefore recommends that all NMAs should encourage their respective governments to:

- Introduce BAT standards for all new diesel vehicles (on road and off-road)
- Incentivise retrofitting with BAT filters for all in-use engines
- Monitor and limit the concentration of nanosize soot particles in the urban breathing air
- Conduct epidemiological studies detecting and differentiating the health effects of ultrafine particles
- Build professional and public awareness of the importance of diesel soot and the existing methods of eliminating the particles
- Contribute to developing strategies to protect people from soot particles in aircraft passenger cabins, trains, homes and in the general environment. These strategies should include plans to develop and increase use of public transportation systems.

## Abbreviations:

- EPA: Environmental Protection Agency (US)
- ERS: European Respiratory Society
- IARC: International Agency for Research of Cancer
- BAT Standards: Emission standards for passenger cars, heavy-duty vehicles and off-road machinery, based on count of ultrafine particles rather than mass and aimed at the protection of human health from the most hazardous soot particles, the lung and even cell membrane penetrating ultra-fines.

## References:

- Brook, Robert D. et al. (2010): AHA Scientific Statement: Particulate Matter Air Pollution and Cardiovascular Disease. An Update to the Scientific Statement from the American Heart Association. *Circulation* 121: 2331-2378.
- ERS (2010): The ERS report on air pollution and public health. European Respiratory Society, Lausanne, Switzerland. ISBN: 978-1-84984-008-8
- IARC (2012): "IARC: Diesel Engine Exhaust Carcinogenic". Press Release No. 213. [http://www.iarc.fr/en/media-centre/pr/2012/pdfs/pr213\\_E.pdf](http://www.iarc.fr/en/media-centre/pr/2012/pdfs/pr213_E.pdf). (access: 14/02/14)
- Kerr, Richard R. (2013): "Soot is Warming the World Even More Than Thought". In: *Science* 339(6118), p. 382.

- WHO (2014): "Burden of disease from Ambient Air Pollution for 2012." [http://www.who.int/phe/health\\_topics/outdoorair/databases/AAP\\_BoD\\_results\\_March2014.pdf?ua=1](http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1) (access: 26/08/14)

[1] Euro 6/VI, US/EPA/CARB, Chinese and equivalent standards.

## WMA Statement on Water and Health

*Approved by the 55<sup>th</sup> WMA General Assembly, Tokyo, Japan, October 2004 and revised by the 65<sup>th</sup> WMA General Assembly, Durban, South Africa 2014*

### Preamble

An adequate supply of fresh (i.e. clean and uncontaminated) water is essential for individual and public health. It is central to living a life in dignity and upholding human rights. Unfortunately, over half of the world's population does not have access to such a supply, and even in those places where there is an abundance of fresh water, it is threatened by pollution and other negative forces.

In keeping with its mission to serve humanity by endeavouring to achieve the highest international standards in health care for all people in the world, the World Medical Association has developed this statement to encourage all those responsible for health to consider the importance of water for individual and public health.

### Considerations

Water-borne diseases account for a large proportion of mortality and morbidity, especially in developing countries. These problems are accentuated in times of disasters such as wars, nuclear and man-made accidents with oil and/or chemicals, earthquakes, epidemics, droughts and floods.

Anthropogenic changes to ecosystems, lowered retention by the earth's surface, and the limitation of the inherent capacity of nature to filter dirt from the water are causing increasing damage to the natural environment, especially the water environment.

The commodification of water, whereby it is provided for profit rather than as a public service, has implications for access to an adequate supply of drinking water.

The development of sustainable infrastructure for the provision of safe water contributes greatly to sound public health and national well-being. Curtailing infectious diseases and other ailments that are caused by unsafe water alleviates the burden of health care costs and improves productivity. This creates a positive ripple effect on national economies.

Water as a vital and necessary resource for life has become scarce in many parts of the world and therefore has to be used reasonably and with care. Water is an asset that is shared by humanity and the earth. Thus, water-related issues should be addressed collaboratively by the global community.

### Recommendations

Physicians, National Medical Associations and health authorities are encouraged to support the following measures related to water and health:

- International and national programmes to provide access to safe drinking water at low cost to every human on the planet and to prevent the pollution of water supplies. International, national and regional programmes to provide access to sanitation and to prevent the degradation of water resources. Research on the relationship between water supply systems, including waste-water treatment, and health.
- The development of plans for providing potable water and proper wastewater disposal during emergencies. These will vary according to the nature of the emergency, but may include on-site water disinfection, identifying sources of water, and back-up power to run pumps.
- Preventive measures to secure safe water for health care institutions after the occurrence of natural disasters, especially earthquakes. Such measures should include the development of infrastructure and training programs to help health care institutions cope with such crises. The implementation of continued emergency water supply programs should be done in conjunction with regional authorities and with community involvement.
- More efficient use of water resources by each nation. The WMA especially urges hospitals and health institutions to examine their impact on sustainable water resources. Preventive measures and emergency preparedness to save water from pollution. The promotion of the universal access to clean and affordable water as a human right [1] and as a common good of humanity.

[1] In 2010, the United Nations General Assembly and the Human Rights Council explicitly recognized the human right to water and sanitation, derived from the right to an adequate standard of living as stipulated in article 11 of the International Covenant on Economic, Social and Cultural Rights and other international human rights treaties. Hence, it is part of international human rights law.



## Anniversary of the Signing of the Declaration of Helsinki

11 november 2014

The 50<sup>th</sup> anniversary of the signing of the Declaration of Helsinki in 1964 was celebrated in style at a day-long seminar in Helsinki on November 11. The event, attended by around 200 people, was held in the magnificent Pörssitalo building in the city and hosted by the Finnish Medical Association (FMA).

The audience was welcomed by Dr. Tuula Rajaniemi, President of the FMA, and the morning session was entitled “The Declaration of Helsinki in a real world – The Implementation of the Declaration”.



*Ramin Parsa-Parsi*

The first speaker was **Dr. Ramin Parsa-Parsi**, from the German Medical Association, who chaired the WMA workgroup on revising the Declaration in 2013. He said it was in Helsinki that, 50 years ago, the 18<sup>th</sup> General Assembly of the WMA adopted the very first Declaration of Helsinki setting out “recommendations guiding doctors in clinical research”. It was therefore fitting that they should return to Helsinki five decades later to celebrate the anniversary of

its adoption and to reflect on its abiding role in providing the highest ethical standards for medical research involving human subjects.

He went on: “Many changes have taken place in medical science since the promulgation of the first version of the Declaration in 1964, and it has been repeatedly revised to take account of these. The most recent revision lasted two years and was the most comprehensive and inclusive revision process yet undertaken.

During the revision process, national medical associations, international organisations and other key stakeholders were invited to provide their input at expert conferences on four continents, as well as during an international online public consultation, which attracted responses from 36 countries and regions of the world. It was the task of the workgroup members to examine all of the arguments put forward and to evaluate their merits. Our shared goal was to revise the document in such a way as to promote good quality clinical research, while at the same time ensuring the utmost protection for research subjects. The workgroup was very pleased that it could be completed in time for this anniversary year.

“The current, eighth version of the Declaration of Helsinki, was adopted by a large majority at the WMA General Assembly in Fortaleza in October 2013. The result was an altogether more comprehensive, methodical and usable document. Despite the new structure of the revised Declaration, five decades after its original promulgation it still retains its unique character as a concise set of ethical principles drawn up by physicians for physicians. This is a tes-

timony to the strength of the Declaration and to the dedication of the World Medical Association as its guardian.

“The importance of having an internationally recognised global ethical standard for physicians has again been underlined during the current Ebola crisis. For example, when concerns were raised about the ethical acceptability of using unproven interventions to treat Ebola patients, the WMA was able to react immediately by referring to Paragraph 37, which permits the use of an unproven intervention with the informed consent of the patient, where no proven intervention exists and if it offers hope of saving life. The WMA General Assembly referred to this in an emergency resolution this October.”

He concluded by saying: “I am sure that these anniversary celebrations will raise further awareness of the importance of this guideline and the ethical responsibilities of physicians and researchers to promote progress in medical science without compromising the health, well-being and rights of research subjects.”



*Jeff Blackmer*

He was followed by **Dr. Jeff Blackmer**, Director of Ethics at the Canadian Medical Association and medical ethics adviser to the WMA, who spoke about the imple-

mentation of the Declaration in North and South America.

Dr. Jeff Blackmer, said the Declaration was not a legally binding document under international laws. However, it exerted authority through the extent to which it had directly and indirectly influenced national and international legislation and regulations. In some cases, it had been codified into those laws and regulations. It was important to always keep in mind, however, that the Declaration was *morally binding* on physicians, and that this obligation was generally considered to override any national or local laws or regulations.

Among international documents, the DoH was relatively unique in that it represented a set of ethical principles combined with some degree of proscriptive detail, while many of the other documents were more technical in nature. However, their presence had meant that a number of national regulatory bodies had decided to make reference primarily to **one** particular document or standard.

For some, this has meant “choosing” between using the DoH as a standard versus another more static and/or technical document. He went on to consider how the Declaration was viewed in the United States and in Latin America.

In April 2006, the United States Food and Drug Administration (FDA) had published a regulatory change ending the need for clinical trials conducted outside of the US to comply with the Declaration of Helsinki.

Previous to this, the FDA had already rejected the 2000 version of the DoH and all subsequent revisions, recognizing only the 1989 version in its regulations. These decisions were made largely over the question of whether placebos should be allowed in clinical trials in resource-poor settings (and to a lesser extent on the issue of post-trial

access). Representatives from the FDA had actively engaged on the placebo issue with the WMA, including during the DoH revision processes and as part of the placebo-control meetings held in Sao Paulo.

He said that what the FDA said was: “We didn’t think the World Medical Association understood you really do need placebos to learn something in a lot of cases. Fundamentally, in a lot of symptomatic conditions, it’s common for studies that compare a new drug with placebo to fail. If doing the right design, or doing an informative design would mean denying somebody a therapy that would really save their lives, then you just can’t do the study at all. Everybody agrees on that. But if it’s just a matter of symptoms, having a headache a little longer, being depressed for a few more days, I would say most people and certainly we believe that you could ask a person to participate in a study [using placebos]. But it’s not unethical to do a trial like that.”

Dr. Blackmer also outlined the concerns in the pharmaceutical industry and fears that the new obligations, to use a comparator other than placebo, would make it harder to prove the efficacy of a new drug and would drive up the costs of development. He referred to one observation that pharmaceutical companies ultimately looked to see what were the regulations and laws they must comply with in whatever countries they were going to seek approval to market a particular product. To the extent that it was easier and perhaps less costly to conduct their research in settings that appeared to have looser standards or less rigorous ethical processes, then we’ve seen a trend in which they had been moving more towards doing research in that setting.

He said that the FDA’s adoption of less morally stringent guidelines could encourage pharmaceutical companies to take ethical short cuts. It could also have practical consequences for trial ethics in developing

countries, especially where research ethics committees might not be promoting high standards of protection for participants in clinical trials, due to lack of financial and human resources. Pharmaceutical companies might also pressurise research ethics committees to relax guidelines and legislation, in order to facilitate future clinical trials in developing and emerging countries that lack the resources to conduct their own clinical research on epidemics such as HIV/AIDS, which have devastating effects on their populations.

Turning to the position in South America, Dr. Blackmer said that in Uruguay the Declaration was used as the main research ethics guideline by which all researchers must abide. National legislation had incorporated the 2000 revised version of the document. But later modifications on the use of placebo were not part of the legislation. In Brazil, following the 2008 revision, the position adopted by the WMA concerning the use of placebo in research involving human beings was immediately contested. According to the position advocated officially by the Brazilian government, through a Resolution from its National Health Board, “the benefits, risks, difficulties and effectiveness of a new method should be tested by comparing them with the best present methods”.

He said there remained in some parts of South America a concern about a “double standard” for research that they felt was not fully addressed by the DoH. Subjects in resource-poor settings might be exposed to placebo controls or to controls that are less than standard of care in more developed countries. Research might not be responsive to the needs of the community in which it is conducted. While revisions of the DoH had attempted to address some of these concerns, they had not done so to the satisfaction of all of those involved.

Finally Dr. Blackmer referred to the Declaration of Cordoba. He said that in November

2008, the Congress of the Latin-American and Caribbean Bioethics Network of UNESCO (Redbioetica) had approved the *Declaration of Cordoba on Ethics in Research with Human Beings*. This document proposed that Latin American countries, governments and organisations should refuse to follow 2008 version of the Declaration of Helsinki, which was approved in Seoul, South Korea. It recommended instead as an ethical and normative frame of reference the principles of the *Universal Declaration on Bioethics and Human Rights*, proclaimed in October 2005 at the UNESCO General Conference.

He concluded by saying that the use and implementation of the DoH in the Americas was, to say the least, inconsistent and controversial. In the United States, the FDA did not endorse the document, and only referenced the 1989 version. In South American countries, there remained a concern that the DoH did not contain sufficient safeguards when it came to the issues of placebo controls and post-trial access.



*Dominique Sprumont*

The next speaker, **Professor Dominique Sprumont**, a health lawyer from the University of Neuchatel, Switzerland, said that the original Declaration was not meant to reinforce the Nuremberg Code, but had

rather been adopted in opposition to the Code. To a large extent, the Nuremberg Code was not well accepted within the research community and was often disregarded by the same countries that contributed to its promulgation. The Helsinki Declaration was originally drafted to allow the medical profession to maintain its control of the conduct of biomedical research. The main purpose was not so much the protection of human participants but an attempt to accelerate research involving human participants.

He went on: "The medical profession was facing a number of challenges. There was not only a proposal from a human rights lawyers' organization to develop an international treaty on biomedical research, but some countries such as the US were considering adopting legislation in the field. The DoH was an attempt to prevent such a move toward the end of research self-regulation. It was also supported by the industry that looked for a more user-friendly regulation than the Nuremberg Code and what was planned by the US and EU drug authorities. Ironically, it is worth mentioning that WMA was suffering from certain financial difficulties in 1964 and the support from the industry seems to have been welcome. This may also explain why the document adopted in Helsinki in 1964 did not contain the same level of protection for research participants than earlier draft documents such as the one from 1962".

Prof. Sprumont added that the drafting of the DoH coincided with the emergence of bioethics as new discipline of applied ethics. At that time society was going through important changes. The years after WWII were characterized by unprecedented economic growth, but people were becoming more aware of the negative consequences for society and the environment. In the 60s people started to question that model.

The medical profession did not escape this reality. It was also under pressure to change

its paternalistic attitude. This resulted in the development of a more equal relation between doctors and patients based on the rule of informed consent. The right of self-determination became the rule in society in general and in medical practice in particular. The medical profession realized the need to be more receptive to the patients' wishes. Ethics gained a new role in medical education and practice. This "moralization" of medicine also served the previous objective, namely to avoid unnecessary intervention from the State to regulate the profession. The DoH was the product of this movement.

"Today, as we are celebrating the DoH 50<sup>th</sup> anniversary, we can only be impressed by how the WMA managed to develop this document, one among many others to become what is often coined the "constitution of research ethics". The fact that the DoH is playing such a central role in research ethics, promoting high ethical principles in the field seems partially in contradiction with the fact the DoH has been revised seven times (or even nine if one includes the two notes of clarification concerning the placebo rule). A closer look at those revisions shows that the core elements of the DoH were never altered, but that the main changes were adaptations to the law and also improvement in the structure and the formulation of some provisions."

He said the DoH had evolved in parallel with legislation and the fact that it managed to stay in line with the legal framework at a time when many countries adopted legislation in favour of the protection of research participants could explain its success. The WMA changed its original attitude that was primarily to facilitate research. Since the late 90s, the DoH clearly focused on the protection of the participants, their dignity, rights and welfare. Another important element was that until the late 1990s, laws and regulation of biomedical research were mostly limited to developed countries. To-



day, the situation had changed as a growing number of countries in the South and in the North had recently adopted new laws and regulation in the field. On one hand, this had modified the status of the DoH as today researchers would primarily refer to their national laws on biomedical research in the conduct of research, but on the other hand, the DoH was often cited in the laws and regulation as the main source of inspiration concerning the principles of research ethics.

Prof. Sprumont went on to ask why there was a need to formulate rules on fundamental freedoms and human rights, and said it was because the rules were violated. "It may seem a contradiction but if everyone would act according to the highest ethical and legal standards, there would be no need to specify them. For instance, if doctors would always spontaneously inform their patients before asking their consent, there would be no need to specify the rule of informed consent."

He went on: "It is a fact that the DoH is limited to ethical principles or, in other words, ethical norms of the highest rank that makes it a universal document that can be used and applied in all regions and cultures of the world. There is a famous statement from Confucius "seeking harmony within difference" that describes well what the DoH is all about. The DoH allows differences in its implementation while defending a universal and harmonious understanding of the highest ethical principles in the protection of research participants".

He said that the DoH was not merely an academic document. It was the product of history, lobbying from various stakeholders, of the development strategy of the WMA, its adaptation to the laws, etc. Its present structure and content was the expression of a carefully built consensus within the medical profession and also the research community, the RECs and the competent authori-

ties worldwide. In fact, they should salute the last two revisions as a true attempt from WMA to conduct broad consultations and seek consensus on difficult issues related to research ethics worldwide. During the last decade, the ethics and regulation of research involving human participants had experienced some important changes, moving from broad principles to detailed regulation, from self-regulation to legislation and to the bureaucratization of research. For the WMA, this meant both challenges and opportunities. The DoH was bound to remain an essential document in the field as it offered a clear statement of the accepted and applicable principles in the field.

He concluded: "The WMA should maintain the DoH as it stands: a document of principles focusing on the protection of human participants. If people have a clear understanding of their responsibilities in view of the ethical principles, there is less need for specific regulation. This is an essential barrier against the present bureaucratization of research ethics. The system should be able to rely more on responsible actors able to interpret and implement fundamental principles of research ethics, rather than on technicians applying check lists".



*Lasse Lehtonen*

The next speaker, **Prof. Lasse Lehtonen** from the University of Helsinki, spoke

about the impact of the Declaration on European human rights development. He said that from a purely legal perspective, the authority of the Declaration was limited. It was a professional recommendation in nature. The original wording stated that the standards set by the Declaration were only a guide to physicians all over the world. Doctors were not relieved from criminal, civil and ethical responsibilities under the laws of their own country. Even the current version of the Declaration stated that it was addressed primarily to physicians. However, the WMA encouraged others who were involved in medical research involving human subjects to adopt these principles.

Prof. Lehtonen went on to compare the Declaration with the Conventions of European Council and with European Union regulation on clinical trials, which had recently been approved and which was applied in all Member States of the European Union from May 2016 onwards. In Europe the postwar development in the field of human rights had most notably been guided by the Council of Europe and the European Convention on Human Rights. In 1992 the Council of Europe had set up a specific Steering Committee on Bioethics which had led to the Convention on Human Rights in Biomedicine and in this way the ethical principles set out by the Declaration of Helsinki had found their way into binding European Human Rights regulations. The standards created by the Council of Europe and the Court had had a major impact on the legislation of European Union. He went on to compare some of the recommendations set by the DoH to the regulations in European Conventions and in the European Union law.

He referred at first to the general principle that the interests of the subject must always prevail over the interests of science and compared that to the totalitarian ideologies of the 1930s when it was common to claim that the interests of society overrode



the interest of an individual also in relation of research. It could be concluded that more or less the principle of primacy of the human being as presented in the Declaration in 1975 had been adopted by both the Biomedicine Convention and by the EU regulation on clinical trials.

He discussed the fact that the requirement for an independent review before an experiment could start was a safe-guarding procedure that had truly been invented by the WMA in its Declaration. There was no mention of that in the Nuremberg code or in any preceding ethical document. The 1975 revision of the Declaration also further emphasized the oversight of research protocols by an independent committee and the transparency and independence of these committees. He compared the informed consent requirements of the different documents. The requirement for voluntary consent for human subject research was a key part of the Nuremberg code, but the DoH put much more emphasis on the necessary information that was given the research subject prior to the study. In its current form the Declaration required that each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it might entail, post-study provisions and any other relevant aspects of the study. Furthermore, the potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. The Declaration also supported the requirement of consent for research with identifiable human material or data and the consent requirements for research in the Convention on Biomedicine were more or less identical to those in the Declaration.

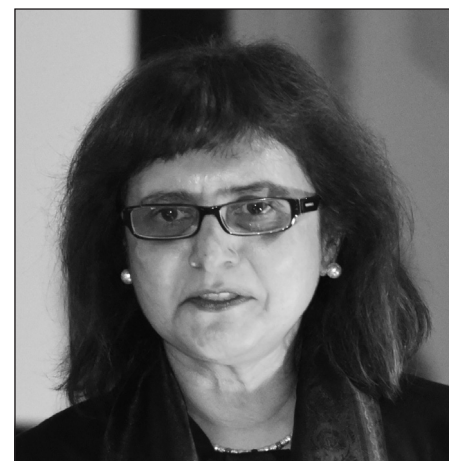
Finally, Prof. Lehtonen made some comparisons about the status of incapacitated subjects and minors. One of the recom-

mendations of the original Helsinki Declaration was to substitute the consent of the research subject with the consent of the legal guardian in cases of legal incompetence. The Nuremberg code did not have this option and it mandated that medical research could only be carried out with a *legally competent subject*. This would have prevented valid research, such as in the field of paediatrics. The Convention of Biomedicine found research in subjects not able to consent possible. However, it could be carried out only for his or her direct benefit. The requirements in the Convention were thus clearly stricter than in the current Declaration. Paragraph 20 of the Declaration, however, stated that medical research with a vulnerable group was only justified if the research was responsive to the health needs or priorities of this group and the research could not be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research. The EU clinical trials regulation, on the other hand, set even more stringent rules for trials in incapacitated subjects or in minors. For incapacitated subjects, the trial should bring direct benefit for the research subject in comparison to risks or at least some benefit for the population represented by the incapacitated subject concerned, if the trial related to a life-threatening or debilitating medical condition. Similar rule applied for trials in minors. Furthermore, the trial might impose only minimal burden on the research subject concerned in comparison with the standard treatment of the condition.

In conclusion, he said that the influence of the Declaration had been far-reaching for the development of national and international guidelines and regulations. The principles of the Declaration had more or less directly been implemented to the Convention on Biomedicine of the Council of Europe and many principles of the Declaration could be found also in the regulation concerning clinical trials in European Union.

However, information technology made it easy to gather information on patients without their consent and there might be new problems arising with the availability of whole genome-sequencing both in research and in the treatment of patients. It was noteworthy that the science community was very committed to follow the principles of the Declaration, but it was by no means clear that the business community developing new technologies was that well acquainted with these principles.

"Thus far the Declaration has followed the development of science and is likely to be updated, when times and conditions change. It is, however, important that the compliance of the research practices with the principles is actively monitored not only by physicians, but by the society as a whole."



Ames Dhai

**Professor Ames Dhai**, immediate Past-President of the South African Medical Association, and Director of the Steve Biko Centre for Bioethics at the University of the Witwatersrand in Johannesburg, spoke about the DoH from the perspective of the developing world. She said the moral authority of DoH was intricately linked with respecting the human dignity of participants in research. The principles of the DoH accentuated

that research participants were not to be treated as a means to answer a hypothesis posed or as mere things, and every wrong done to them infringed their human dignity. Respecting dignity was both implicit and pervasive in the Declaration. She illustrated from a developing world perspective how this respect for dignity translated to safeguards in particular for participants with vulnerabilities. In Africa there were large numbers of vulnerable populations and individuals, little or no health care, failing and failed health systems, low levels of literacy or no literacy, and an acceptance of authority without question.

She referred to the references in the DoH that appropriate compensation and treatment for subjects who were harmed as a result of participating in research must be ensured, as well as the issue of unproven interventions in clinical practice. In South Africa sponsors for clinical trials ranged from pharmaceutical companies to research organisations, such as the US National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC). A typical statement from an informed consent document for an NIH-sponsored clinical trial read "If you are injured as a result of being in this study, you will be given immediate treatment for your injuries. The cost of this treatment will be provided by the Department of Health in a referral hospital or your insurance company. There is no program for compensation either through this institution or the National Institutes of Health. The investigators will provide you with reasonable medical care as is available at the... hospital".

"At first glance this statement seems fair, but human research ethics committees in South Africa do not agree. The consent statement is such that the overburdened and under-resourced health system that is trying to provide care to poor vulnerable populations without medical insurance will

have to cover for research injuries caused by research sponsored by a wealthy developed-country institution.

Naturally, research ethics committees have questioned this practice. The NIH response is that US federal regulations do not allow payment for treatment of research injuries, nor do they allow inclusion in NIH grants of funds sufficient for local researchers to take out suitable insurance or pay for suitable care. Indeed no agency within the US federal health system has a formal compensation policy for research injuries".

"Vulnerability" was now understood as extending beyond an inability to consent or to protect one's own interests. In addition, using "wrong" recognised that participants who were harmed as a result of their involvement in research were not necessarily always wronged. "Wrong" denoted greater moral burden and significance as compared to "harm". It indicated a moral transgression. The strength of the DoH was that it considered vulnerable individuals as well as groups. Vulnerability could differ between individuals. For instance, in South Africa a white Constitutional Court Judge from an advantaged background with HIV infection had far less of a chance of being wronged as compared to a black, illiterate woman from a township or rural setting who had HIV infection. With her, wrongs ranged from physical, social, psychological, consent, to justice.

Finally, Prof. Dhai referred to the relevance of the Helsinki Declaration to the outbreak of the Ebola virus. There were several paragraphs within the DoH that were applicable to the outbreak, in particular the provision that the duty of the physician was to promote and safeguard the health, well-being and rights of patients, including those involved in medical research, that research should be conducted only by individuals with appropriate ethics, and scientific education, training and qualifications and the

issue of unproven interventions in clinical practice.

"Because no cure or vaccine exists for the disease, the WHO on the 11<sup>th</sup> August convened a special consultation to assess the ethical implications of the use of unregistered interventions which existed in the laboratory in small quantities at that time and a day later put out a statement that in the face of the EVD threat, it was ethical to offer unproven interventions with as yet unknown efficacy and adverse effects as potential treatment or prevention. The ethical criteria to guide the provision of such interventions should include transparency regarding all aspects of care, ensuring freedom of choice and informed consent, respecting confidentiality, human dignity and involving the community.

"The WHO decision is in line with the Declaration of Helsinki which in section 37, on "Unproven Interventions in Clinical Practice" states: "In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorised representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available."

She said the Ebola virus continued to spiral and external sources had now come forward to assist the affected countries. However, for as long as governments in these countries did not commit to strengthen their health-care systems and improve the underlying social determinants of health attempts at combatting the Ebola crisis and other crises that followed could end up being ineffective.

During the afternoon session, speakers focused on “Ethics as a Foundation of Research”.

The session was opened by **Dr. Xavier Deau**, President of the WMA. He said the Declaration of Helsinki had translated the willingness of the WMA and its Founding President, Eugène Marquis, a French physician, to bring the ethics of medical practice and research to the highest level with a twofold goal - to ensure a universality of ethics in research on human beings as well as the protection of people subjected to this research and to make definitely impossible the horrible abuse of medicine encountered during the thirties and forties. These ethical principles were now translated into the codes of ethics of many countries or laid down in the resolutions of international organisations, such as the WHO, UNESCO, United Nations and the ICRC. Governments also felt encouraged to include the DoH principles into their legislation.

He continued: “This Declaration combines pragmatism and wisdom with the “primacy of the individual”. This raises awareness of the physician to the fundamental importance of informed consent and information of the patient, the secrecy of personal and especially patient data, and the value of the professional autonomy of the physician. Under the aegis of independent research committees, the DoH rigorously codifies the scientific studies and trials, and in particular, the protection of the research subjects against dangerous experiments and exploitation. The Declaration commands the application of the necessary scientific rigour, including the use of placebos when necessary. The sustainability of the DoH is a shining example of universality of medical ethics. Even if its drafting seemed to be laborious, our Declaration of Helsinki has the merit to be a historical and yet modern document, combing the cultures of more than one hundred medical associations. Thus, it is an authentic factor of peace and

union between medical professions around the world in full respect for the patients for whom we care. The DoH ensures a rigorous application of science as well as the ethics on the grounds of a genuine respect for the patient and human rights we are caring for”.



*Urban Wiesing*

**Professor Urban Wiesing**, ethics adviser to the WMA on the Helsinki Declaration and Director of the Institute for Ethics and History of Medicine at the University of Tübingen, was the next speaker. He said that delegates attending the WMA Assembly 50 years ago could hardly have imagined the historical significance of their decision to adopt the Declaration of Helsinki. “One tiny step had been taken by the delegates that would later turn out to be a giant leap”. But the road to the Declaration was neither straight nor smooth. The work took more than a decade, with discussions starting following the Nuremberg Code.

“The Nuremberg code was meant to prevent crimes like those committed by Nazi doctors in the concentration camps. Therefore it demanded to obtain participants’ voluntary consent without any exception. In addition, the code set a limit on reasonable risks and demanded that subjects have the right to leave the experiment at any time. However, the code attracted little

interest at first. How could it? It served to justify the judgment of an American military court. It was a secret document in some countries. What authority could such a Code claim to have? This was a difficult question to answer. The Nuremberg Code was an important document, but it did not serve as an influential answer to the demanding situation in medical research. Another answer was needed.”

He said it was in 1953 that a first proposal for a position paper was submitted to the Medical Ethics Committee of the WMA, published a year later as the “Resolution on Human Experimentation”. Seven years later, in 1961, the Medical Ethics Committee presented the first draft of the Declaration. Three additional years of intense and controversial debates had to pass until it was adopted.

“The Declaration is what it is because it gives an answer, an answer to a question that is desperately needed to be answered in modern medicine; an answer to the fundamental ethical question of research involving human subjects, an answer to a dilemma. What is the dilemma modern medicine is confronted with? On the one hand, modern medicine knows that precise knowledge concerning the “efficacy and safety of interventions can only be gained from research involving human subjects. Animal or laboratory experimentation is necessary and a prerequisite to clinical research. On the other hand, research involving human subjects is fraught with ethical conflicts that cannot be completely prevented. If one conducts research on human subjects, there will always be the risk of harming them. Exposing the patients to such risks is inconsistent with the medical professional’s obligations, especially with the old Hippocratic principle *primum nil nocere*, do no harm. However, harmful effects are inevitable in research. If the researcher knows beforehand that the patient will not be exposed to any risks because the intervention is effective and does not inflict any harm, then no fur-

ther research is needed. Research involving human subjects is controversial because of the risks.”

But abstaining from conducting research to avoid ethical conflicts would mean treating future patients with previously untested drugs. This would significantly lessen the quality of medical practice. Yet clinical research was ethically critical because it violated the principle “do no harm”. The Declaration stressed the protection of the participants on the one hand and medicine’s need for research on the other.

“After the adoption of the Declaration the inevitable happened. The Declaration was debated. It was classified from the very beginning as too permissive by some commentators and as too restrictive by others. The debate on whether the Declaration is too “research-friendly” or too restrictive persists up to the present day. But if a document is criticized to be too liberal and also criticized to be too restrictive it may very well be a balanced compromise.”

He said the Declaration was now a living document that had been adapted to a changing environment and improved. Thanks to the Declaration and others this research no longer had an exclusively negative image. The Declaration not only limited research on human beings, but it also legitimized it. The Declaration not only protected the participants but the researchers as well. This not only stabilized the medical profession but gave the system of research hope that the people would accept it.

And he added: “The Declaration was created and adopted by an organization of physicians for physicians, thus creating a close relationship to the profession and the professionals. The Declaration remains an expression of professional self-reflection. It is living proof that a profession can regulate not only scientific but also ethical aspects responsibly. The adoption and the successful efforts of the World Medical Association

for self-imposed regulations confirm the fundamental willingness and ability to learn as a professional self-organization. Thus, the Declaration is an expression of responsibility”.

Looking to the future scientific and technological development of modern medicine, Prof. Wiesing said: “They will confront us with new challenges. I only have to remind you of some of the latest medical projects like individualized medicine, system medicine, new developments in genetics or bio-banks. And I am sure there are more to come and are already coming. I am speaking in particular of the Ebola crisis. In the case of Ebola, we can see how adequate the ethical principles of the Declaration are. We do not need a new ethics in the case of Ebola. However, we do need to make new decisions in the face of such a global crisis, but these decisions must be made on the basis of existing ethical principles. The ethical principles laid down in the Declaration remain valid. They are applicable to the current situation and indeed helpful. The Declaration stresses the importance of protecting participants on the one hand and medicine’s need for research on the other. Both must be balanced. This holds true when it comes to Ebola as well. A balance between exposing current patients to potential risks for their own benefit as well as the benefit of future patients is absolutely crucial in order to prevent a pandemic”.

The Declaration allowed the “treatment of an individual patient, where proven interventions do not exist” under certain conditions”. The case of Ebola illustrated just how appropriate the ethical principles of the Declaration were.

The main question now was not how often the Declaration should be revised. It was how the Declaration could keep providing the ethical principles for research involving human subjects in the face of rapid developments in science and society. While the frequency of revisions should be low, they

should also be appropriate to keep up with scientific and ethical progress”.

“As long as the Declaration remains the most important answer to one of the fundamental challenges of modern medicine I have no doubt that there will be good reasons to meet again in 10, 25, in 50 years for the next anniversaries. And where should a meeting take place? There is no doubt- in the city, where it started, in Helsinki, where else?”



*Sauli Niinistö*

An official greeting was then given by the **President of Finland, His Excellency Sauli Niinistö**, who said the Declaration had been described as the most widely accepted guidance worldwide on medical research involving human subjects.

“During the past 50 years theory has turned into practice. Guidelines and principles contained in the Declaration have been enshrined in national and international law and conventions regulating medical research today. For instance, in Finland ethical committees have been statutory since the late 1990s. Regardless of their field of study, researchers have a great thirst for new knowledge. However, the pursuit of knowledge is never without risk. But we will have no new knowledge without active research. Clinical medicine has made immense progress in the



last 50 years. This would not have been possible without countless studies.

“In general, ethical principles do not adapt in step with the opportunities offered by medicine to examine and treat patients. Modern methods for the management and analysis of information are at a completely different level than in the 1960s. These days, we place a particular emphasis on the right of individuals to control personal information. Despite the speed of development in medical science, the World Medical Association has managed to keep the Declaration up-to-date. And the Association has found a well-functioning compromise both in terms of manner and pace of updating. The Declaration provides a valuable guide for all parties involved in research”.

He said that continuous, open discussion on the ethics of medicine and its basis in research was necessary to ensure the sustainable well-being of societies and people. The Declaration had proved to be a well-functioning cure, but they had to continue with this treatment. He hoped the Declaration would continue to play a key role in enabling medical advances of a high standard in the years to come.



Laura Rätty

The final speaker was **Dr. Laura Rätty**, Finnish Minister for Health and Social Affairs.

As a politician and a physician, she asked whether there was room for physician's ethics in political decision-making. She said there were six main principles in medical and care ethics: respect for life, respect for human dignity, self-determination (autonomy), caring, justice (fairness) and maximizing of benefit. She addressed each of these principles and said they could be reflected against the political decision-making that had been and was being carried out in Finland, on one hand, at local government level and, on the other hand, in central government policy.

In addition there was the essential principle in the work of a physician of confidentiality. The basic condition for a good doctor-patient relationship was that the patient could be confident that his or her information could not be accessed by others than the health care professionals that participate in the care of the patient.

Returning to the title of her address “Is there room for physician's ethics in political decision-making?” her answer was “There is and there must be”.

She concluded: “We in Finland are aware that all those conditions where people are born, grow up, live, work and age contribute to wellbeing and health. Therefore we consider that the different sectors of society must in their decision-making evaluate the impact of their decisions on wellbeing and health. *Health in all policies* has been on the agendas of international forums at Finland's initiative for about ten years, and in spring this year the World Health Organization (WHO) adopted a resolution on the issue. Integrating health and wellbeing extensively into societal decision-making can bring concrete benefits to citizens. For instance the systematic and consistent tobacco policy conducted in Finland has reduced smoking, and the nutrition policy has improved the composition of nutrition among the population. The cardiovascular disease mortality in working-age men has

fallen by 80 per cent in 40 years. The improved level of education and working conditions and the improved living conditions in general have had a favourable impact on the population's health.

“When treating patients as a physician I have been well aware of the responsibility I have for the health of an individual. As a politician I have a broader responsibility to influence the population's health and wellbeing. I see this responsibility not only as a political but also as an ethical issue. We must all act ethically so that the citizens' interests are taken into account.

The slogan of the Finnish Medical Association – my own association – is: “For the patient's best with physician's skills.” I am convinced also on the basis of my own experience that a physician can help a patient even in the field of politics – and a politician can help a patient without having medical education. Health in all policies is our – physicians' and politicians' – joint ethics.

Yes – there is room for physician's ethics in political decision-making”.

Dr. Mukesh Haikerwal, Chair of the WMA, concluded the day's proceedings with a vote of thanks to the speakers and all the participants.

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



## Melbourne Health Summit Memoranda

### Health Care in Danger

The H20 Health (Melbourne 2014) Summit urges the Worlds' Leaders, including those at the G20 Australia, to be aware of the mortal danger of those providing and receiving health care across the world and the resulting effects on peoples' health.

We commend the efforts of the International Committee of the Red Cross to secure safe access to Healthcare and call on Governments to legislate and not tolerate infringements against health facilities and personnel.

<https://www.icrc.org/eng/resources/documents/event/2014/violence-against-aid-workers-future-of-humanitarianism-overseas-development-institute-htm.htm>

### Climate And Health

The H20 Health (Melbourne 2014) Summit urges the Worlds' Leaders, including those at the G20 Australia, to prioritise action on the Climate as a matter of urgency in the interest of the Health of the Public.

Human influence on the climate system is clear, and recent anthropogenic emissions of greenhouse gases are the highest in history. Recent climate changes have had widespread impacts on human and natural systems. [http://www.ipcc.ch/news\\_and\\_events/docs/ar5/ar5\\_syr\\_headlines\\_en.pdf](http://www.ipcc.ch/news_and_events/docs/ar5/ar5_syr_headlines_en.pdf)

The environment influences human health in many ways — through exposures to physical, chemical and biological risk factors, and through related changes in behaviour in response to those factors. According to the WHO, 13 million deaths annually are due to preventable environmental causes. Mitigating environmental risk could save as many as four million lives a year in children alone, mostly in developing countries. <http://www.wma.net/en/20activities/30publichealth/30healthenvironment/10climate/>

### Health is a Wise Investment

The H20 Health – Health People, Successful Economy (Melbourne 2014) – Summit wishes to emphasise to the Worlds' Leaders, including those at the G20 Australia, that health and health care are core components of a fair, just and successful economy.

We urge that there be meaningful dialogue with the Health Sector to progress better health outcomes across Nations.

We note that:

- Concerns about health costs exist in all nations.
- Health of Nations is a core component of the Wealth of Nations.
- Good health systems are a marker of a fair and just society.
- The Health Sector employs significant numbers of people.
- A productive society depends on a healthy, engaged and
- Confident workforce.
- People participating and contributing in the economy continue to do so if kept healthy. "Health is the greatest social capital a nation can have".

### Non-Communicable Diseases

The H20 Health (Melbourne 2014) Summit urges the Worlds' Leaders, including those at the G20 Australia, to work constructively and meaningfully with the Health Sector to address the catastrophic effects of unresolved "Non-Communicable Diseases".

WMA asserts all NCDs need to be addressed and in a systematic, coordinated and sustainable way: the work is more urgent now. <http://www.wma.net/en/20activities/30publichealth/10noncommunicablediseases/>

The spread of non-communicable diseases remains a socio-economic and development challenge of "epidemic proportions." Governments in 2011 pledged to work with the United Nations to adopt before the end of 2012 targets to combat heart disease, cancers, diabetes and lung disease and to devise voluntary policies that cut smoking and slashed the high salt, sugar and fat content in foods that caused them. <http://www.un.org/press/en/2011/ga11138.doc.htm>

### Social Determinants of Health

The H20 Health (Melbourne 2014) Summit has resolved that addressing the Social Determinants of Health is a core strategy for a fair and just Society. We stand prepared to work with the Worlds' Leaders, including those at the G20 Australia, to act on and address the Social Determinants of Health and request that the G20 Australia secretariat progress this.

"The Social Determinants of Health, Health inequality among people between and within countries is significant and constitutes an urgent issue of social justice. It is clear that these health inequalities are the result of differences in living conditions; the environment in which a person is born, grows, lives, works, ages, and dies. The International community including the health sector, must redouble our efforts to address these and reach a more fair and just society." <http://www.wma.net/en/20activities/30publichealth/80socialdeterminants/>



## 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 Kováts  
 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.

Szondi street 100., Budapest 1068, Hungary  
 Phone: +36-1/302-0065  
 E-mail: [elnok@mok.hu](mailto:elnok@mok.hu)  
[www.mok.hu](http://www.mok.hu)

## Somali Medical Association (SMA)

### Office Bearers (2014–2016):

President: Prof. Mohamed Yusuf Hassan  
 Vice-President: Dr. Shafii Mohamed Jamale  
 General Secretary: Dr. Hassan Mohamed Habibullah  
 Finance Secretary: Dr. Mohamed Mohamud Omar  
 Public & International relations Secretary: Dr. Nor Abdullahi Karshe  
 Social & Emergency Secretary: Dr. Lul Mohamud Mohamed  
 CPD & Research Secretary: Dr. Mohamed Abdulrahman Jama

**Membership:** Any registered medical or dental practitioner in Somalia is eligible to join SMA.

**Services provided:** The main services provided by SMA to their members are: Continued professional development (finding scholarships for junior doctors), Welfare services, and representation of their interests locally and internationally.

### Activities:

- **With Members:** Support for newly qualified doctors, Continued professional development Programs including scholarships, welfare,
- **With the Public:** Emergency relief programs for displaced people, Mobile clinics for areas where low socioeconomic people live, Education of the public on the prevention of infectious and Non Communicable Chronic diseases with the help of MOH.
- **With the Government:** develop protocols and guidelines for hospitals and district hospitals with Ministry of Health. Advise the ministry of Higher education for improving the quality existing medical schools.
- **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:** on the process of establishing relations with worldwide medical associations to get assistance of continued professional development. Also on the process of creating access to E-Libraries with the help of WHO to provide free access to scientific publications to the Somali doctors.

KPP, Wadnaba Street,  
 Hodon district, Mogadishu-Somalia  
 Phone: +2521652641  
 E-mail: [Intl@sma.org.so](mailto:Intl@sma.org.so), [Info@sma.org.so](mailto:Info@sma.org.so)  
[www.sma.org.so](http://www.sma.org.so)



## Trinidad & Tobago Medical Association (T&TMA)

**Motto:** *Teach, Treat, Mentor, Advocate (TTMA)*

**Origin:** *Originally formed as a branch of the British Medical Association 1891. Formally created by an act of Parliament in 1974.*

### Office Bearers: (2014)

President: Liane Conyette  
1<sup>st</sup> Vice President: Muhammad Rahman  
Secretary: Stacey Chamely  
Treasurer: Edmund Chamely  
Public Relations Officer: Austin Trinidad  
International Liaison Officer: Solaiman Juman

**Membership:** All medical doctors registered with the Medical Board of Trinidad and Tobago to practice medicine in the country are eligible to be members of T&TMA

### Services Provided:

- The T&TMA is the official agent of the Medical Protection Society (MPS) of the United Kingdom.
- The Caribbean Medical Journal (CMJ) – a peer reviewed journal continuously printed since 1938 – is distributed to all our members.
- We are the biggest provider of Continuous Professional Development (CPD) activities for doctors in the country.
- We have been approved by the American Academy of Continuing Medical Education (AACME) to provide AACME credits for eligible activities in the Country
- The T&TMA does regular outreach clinics and activities to underserved areas.

### Affiliations

- University of the West Indies (UWI). We work closely with UWI (the largest Medical School in the Caribbean) to provide high quality CME activities.
- Medical Board of Trinidad & Tobago (MBTT). We are working in an ongoing project with the MBTT to ensure and facilitate the implementation of mandatory CME requirements for all doctors to obtain annual registration.
- Ministry of Health (MOH). There is ongoing discussion and communication with the MOH
- International Associations. We are active members of the World Medical Association and the Commonwealth Medical Association

- Other Professional Medical Organizations and Societies. We are developing links with other medical bodies to strengthen the medical lobby in our country.

#1 Sixth Ave.,  
Xavier Street Ext., Gardens,  
Chaguanas, Trinidad  
Tel: (1-868) 671-7378  
Tel/fax: (1-868) 671-5160  
E-mail: [medassoc@tntmedical.com](mailto:medassoc@tntmedical.com)  
Website: [www.tntmedical.com](http://www.tntmedical.com)

## German Medical Association

### Office Bearers:

President: Prof. Dr. Frank Ulrich Montgomery (Hamburg)  
Vice-President: Dr. Martina Wenker (Lower Saxony)  
Vice-President: Dr. Max Kaplan (Bavaria)

The German Medical Association (*Bundesärztekammer*), based in Berlin, is the umbrella organisation in the system of physicians' self-governance in Germany. As the joint association of the 17 state chambers of physicians (*Landesärztekammer*), it represents the professional interests of the 470,000 physicians in Germany at the national, European and international level.

The structure of physicians' self-governance in Germany reflects the federal nature of the German healthcare system, which is administered at the State (*Land*) rather than the national level. The GMA's Executive Board is comprised of the presidents of all state chambers of physicians and two further physician representatives. Its president and two vice-presidents are elected every four years by the 250 delegates of the annual German Medical Assembly (*Deutscher Ärztetag*). Individual physicians are only indirectly members of the GMA via compulsory membership of the state chamber of physicians in the State where they work.

In addition to its politically representative function, the GMA also promotes the exchange of experiences and coordinates the activities of the state chambers of physicians. Among other things, it draws up model guidelines intended to facilitate uniformity in medical regulation across the country. Once adopted by the German Medical Assembly, it is up to the boards of the individual state chambers to determine the extent to which these guidelines will be implemented at the state level. The GMA also hosts numerous expert committees and advisory boards, which provide the medical profession with information and advice relating to specific areas of medical science, ethics and healthcare policy.



The GMA arose from the Working Group of West German Medical Associations, which was founded in 1947. Following the reunification of Germany in 1990, the system of physicians' self-governance was extended to the former East German states, where state chambers of physicians were also established. As corporations under public law, the state chambers of physicians have responsibility for the following main areas:

- Physician registration
- Organisation and regulation of specialty training and continuing medical education (CME)
- Upholding professional ethics and monitoring adherence to their Professional Code
- Maintaining ethics committees to assess clinical research projects

- Establishing expert commissions and/or arbitration boards to promote the out of court settlement of conflicts between physicians and patients over malpractice claims
- Representing the interests of the medical profession in the political and public sphere, including in the media.

The GMA has been representing the physicians of Germany as an active member of the World Medical Association since 1951. The maintenance of close relations with the international medical community has always been an important aspect of the GMA's work, and is listed as one of its functions in its statutes.

*Bundesärztekammer/German Medical Association  
Herbert-Lewin-Platz 1  
10623 Berlin, Germany*

## Contents

Editorial .....	121	WMA Statement on Aesthetic Treatment .....	144
WMA 2014 General Assembly Report .....	122	WMA Statement on Ethical Guidelines for the International Migration of Health Workers .....	145
Valedictory address .....	136	WMA Statement on Solitary Confinement .....	146
Inaugural speech .....	139	WMA Statement on the Prevention of Air pollution due to Vehicle Emissions .....	147
WMA Declaration on the Protection of Health Care Workers in situation of Violence .....	141	WMA Statement on Water and Health .....	149
WMA Resolution on Ebola Viral Disease .....	141	Anniversary of the Signing of the Declaration of Helsinki ...	150
WMA Resolution on Migrant Workers' Health and Safety in Qatar .....	142	Melbourne Health Summit Memoranda .....	159
WMA Resolution on the Non-Commercialisation of Human Reproductive Material .....	143	Hungarian Medical Chamber .....	160
WMA Resolution on Unproven Therapy and the Ebola Virus .....	144	Somali Medical Association (SMA) .....	160
		Trinidad & Tobago Medical Association (T&TMA) ....	III
		German Medical Association .....	III