Contents

The General Assembly in Moscow  ................................................................. 41
200th WMA Council Session, Oslo, April 2015  ............................................ 42
WMA Council Resolution on Trade Agreements and Public Health  .................. 52
World Health Assembly Week  ...................................................................... 53
Global Epidemics. Industrialised Nations Must Develop Global Strategies
to Counter Epidemics  ............................................................................ 57
WMA Roles for Climate Action  ...................................................................... 58
The Art and Heart of Medicine  ................................................................. 60
One Health: A Concept for the 21st Century  ............................................. 62
Pros and Cons of the Over-the-counter Sales of Antimicrobials  ..................... 64
Medicines Shortages: Global Problems
Need Global Solutions  ........................................................................... 69
Do Ethics Need to Be Adapted to mHealth?
A Plea for Developing a Consistent Framework  ........................................... 72
Health Apps – Sound and Trustworthy?  .................................................. 75
Interview with Vytenis Andriukaitis, EU Commissioner for Health and Food Safety .... 78
Position of Israeli Medical Association in Forced Feeding Issue  ............... 82
An Invitation

The World Medical Association was founded in the wake of World War II. After a two-year preparation period, 27 medical associations met in Paris in September 1947 to found a new association. Since then, medical ethics and socio-medical affairs have been at the core of our work and we are proud to have shaped major international medical guidelines and regulations over the past seven decades.

Of course, physicians have had many other interest groups both before and since, but the WMA became, and still is, an advocacy group striving to make the best health care possible for all, including through health education, prevention, rehabilitation and palliative therapy, aside from curative care and public health.

Over past years, aspects of human rights and social determinants have become more prominent and important for the work of the association. The spectrum we deal with stretches from equitable access to treatment through to issues of human rights violations in medicine right up to the challenge of preserving medical neutrality.

We are now working more closely than ever on human rights issues with partners like the International Committee of the Red Cross, Amnesty International and Physicians for Human Rights, to name just a few.

We support member associations in making their case for the ethical practice of our profession, we call upon governments to allow physicians to perform properly and we advise on how to stay within the rules. We are searching deeper for the causes behind the causes of diseases, and we often find very simple mechanisms that determine our health and our chances of dealing with disease.

The WMA has become a strong voice for physicians and their patients worldwide and we need to stay that way: able to raise questions, willing to find answers, and able to speak out. We invite our members – Constituent and Associate Members – to join us in Moscow from 14–17 October for the Council Session and the 2015 General Assembly. Please register on our website now. We need every single one of you!

Dr. Otmar Kloiber
WMA Secretary General

October 14–17, 2015


An Invitation

The World Medical Association was founded in the wake of World War II. After a two-year preparation period, 27 medical associations met in Paris in September 1947 to found a new association. Since then, medical ethics and socio-medical affairs have been at the core of our work and we are proud to have shaped major international medical guidelines and regulations over the past seven decades.

Of course, physicians have had many other interest groups both before and since, but the WMA became, and still is, an advocacy group striving to make the best health care possible for all, including through health education, prevention, rehabilitation and palliative therapy, aside from curative care and public health.

Over past years, aspects of human rights and social determinants have become more prominent and important for the work of the association. The spectrum we deal with stretches from equitable access to treatment through to issues of human rights violations in medicine right up to the challenge of preserving medical neutrality.

We are now working more closely than ever on human rights issues with partners like the International Committee of the Red Cross, Amnesty International and Physicians for Human Rights, to name just a few.

We support member associations in making their case for the ethical practice of our profession, we call upon governments to allow physicians to perform properly and we advise on how to stay within the rules. We are searching deeper for the causes behind the causes of diseases, and we often find very simple mechanisms that determine our health and our chances of dealing with disease.

The WMA has become a strong voice for physicians and their patients worldwide and we need to stay that way: able to raise questions, willing to find answers, and able to speak out. We invite our members – Constituent and Associate Members – to join us in Moscow from 14–17 October for the Council Session and the 2015 General Assembly. Please register on our website now. We need every single one of you!


Dr. Otmar Kloiber
WMA Secretary General

October 14–17, 2015

An Invitation

The World Medical Association was founded in the wake of World War II. After a two-year preparation period, 27 medical associations met in Paris in September 1947 to found a new association. Since then, medical ethics and socio-medical affairs have been at the core of our work and we are proud to have shaped major international medical guidelines and regulations over the past seven decades.

Of course, physicians have had many other interest groups both before and since, but the WMA became, and still is, an advocacy group striving to make the best health care possible for all, including through health education, prevention, rehabilitation and palliative therapy, aside from curative care and public health.

Over past years, aspects of human rights and social determinants have become more prominent and important for the work of the association. The spectrum we deal with stretches from equitable access to treatment through to issues of human rights violations in medicine right up to the challenge of preserving medical neutrality.

We are now working more closely than ever on human rights issues with partners like the International Committee of the Red Cross, Amnesty International and Physicians for Human Rights, to name just a few.

We support member associations in making their case for the ethical practice of our profession, we call upon governments to allow physicians to perform properly and we advise on how to stay within the rules. We are searching deeper for the causes behind the causes of diseases, and we often find very simple mechanisms that determine our health and our chances of dealing with disease.

The WMA has become a strong voice for physicians and their patients worldwide and we need to stay that way: able to raise questions, willing to find answers, and able to speak out. We invite our members – Constituent and Associate Members – to join us in Moscow from 14–17 October for the Council Session and the 2015 General Assembly. Please register on our website now. We need every single one of you!


Dr. Otmar Kloiber
WMA Secretary General

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. Donchun SHIN
WMA Chairperson of the Finance and Planning Committee
Korean Medical Association
46-gil Ichon-ro
Yongsan-gu, Seoul 140-721
Korea

Prof. Dr. Frank Ulrich MONTGOMERY
WMA Vice-Chairperson of Council
Bundesärztekammer
Herbert-Lewin-Platz 1 (Wegelystrasse)
10623 Berlin
Germany

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

Dr. Joseph HEYMAN
WMA Chairperson of the Associate Members
63 Middle Street
West Newbury, Massachusetts 01985
United States

Dr. Masami ISHII
WMA Treasurer
Japanese Medical Assn
2-28-16 Honkomagome
Bunkyo-ku
Tokyo 113-8621
Japan

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

Dr. Donchun SHIN
WMA Chairperson of the Finance and Planning Committee
Korean Medical Association
46-gil Ichon-ro
Yongsan-gu, Seoul 140-721
Korea

Dr. Ardis D. HOVEN
WMA Chairperson of Council
American Medical Association
AMA Plaza, 330 N. Wabash,
Suite 39300
60611–3885 Chicago, Illinois
United States

Dr. Margarete Apinis, Latvian Medical Association, Skolas street 3, Riga, Latvia
Phone +371 67 220 661
peteris@arstubiedriba.lv, editorin-chief@wma.net

Co-Editor
Prof. Dr. Frank Ulrich MONTGOMERY
WMA Vice-Chairperson of Council
Bundesärztekammer
Herbert-Lewin-Platz 1 (Wegelystrasse)
10623 Berlin
Germany

Assistant Editor
Izeta Švitriņš, wmj-editor@wma.net

Journal design and cover design by
Pēteris Gricenko

Layout and Artwork
Latvian Medical Publisher “Medicīnas apgāds”, President Dr. Maija Šetlere, Katrīnas street 2, Riga, Latvia

Publisher
Latvian Medical Association “Latvijas Ārstu biedrība”, Skolas street 3, Riga, Latvia.

ISSN: 2256-0580

Opinions expressed in this journal – especially those in authored contributions – do not necessarily reflect WMA policy or positions
200th WMA Council Session, Oslo, April 2015

The 200th WMA Council meeting, was held at the Hotel Bristol in Oslo, Norway. The meeting was opened by the Secretary General Dr. Otmar Kloiber, who began by reminding delegates that this was a confidential meeting and that tweeting should not take place. There were no apologies for absence. He welcomed three new members of Council, Dr. Heide Steenwyken from Sweden, Prof. Rutgers Jan Van Der Gaag from the Netherlands and Dr. Carlos Jurez from Argentina. He also welcomed delegates from more than 35 national medical associations, Past Presidents, observers and guests and in particular the return of one of the WMA’s founding members, the Italian Medical Association.

Council Elections and Appointments

The Council began with an election for Chair of Council. Two nominations were received – from the sitting Chair Dr. Mukeh Haikerwal (Australian Medical Association) and from Dr. Ardis Hoven (American Medical Association). Both candidates briefly addressed the meeting. Dr. Haikerwal, a former President of the Australian Medical Association, spoke of his achievements as a leader of the medical profession throughout his career and talked about his vision for the future of the WMA to build on his work of the past four years. Dr. Hoven, Immediate Past President of the American Medical Association, spoke of the great opportunity the WMA had to influence and strengthen its voice. In the vote, Dr. Hoven was elected unopposed as Chair of the Committee.

Emergency Resolution

A proposal was put forward by the British Medical Association that the meeting should consider an urgent Resolution about the several trade agreements being negotiated throughout the world and their impact on the provision of health. The Council accepted this as an urgent matter which should be discussed in committee. The Council then adjourned for the committee meetings.

Finance and Planning Committee

Dr. Dongchun Shin (Korean Medical Association) was elected unopposed as Chair of the Committee. The Committee received a report on membership dues payments and on the Financial Statement for 2014. The Committee approved the document as an interim financial statement. A debate took place on a new dues structure.

Alcohol Session

The Committee meeting then adjourned to hear two invited speakers talking about the alcohol policy in Norway. Ms Øystein Bakke, Senior Advisor, FORUT, Campaign for Development and Solidarity and Secretary of the Global Alcohol Policy Alliance, spoke about Norway’s 40 years of experience with a ban on alcohol advertising. She said that increasing amounts of evidence showed that alcohol advertising and other marketing efforts had an impact on consumption. Marketing was a dominant feature of the global alcohol trade, and drinks companies spent massively towards “investments in the brands”. Advertising and marketing had the strongest impact on young people, speeding up onset of drinking and increasing the amount consumed by those who already drank. The alcohol industry looked for new markets as the traditional markets of the West were becoming less profitable. In these emerging markets in Africa and Asia, marketing was effective in recruiting new consumers from the non-drinking population.

The alcohol industry’s response to calls for marketing regulations was “self-regulation”. This approach to alcohol marketing had been ineffective in several studies, but the alcohol producers and their so-called “social aspects organizations” still referred to this as the best way forward. He said that, marketing restrictions existed in many countries around the world and not only in Norway. Almost 50 countries had a total ban on alcohol advertising on national television in 2012, while another 50 had some sort of partial restriction on TV advertising. That added up to about half the world’s countries. Advertising bans were effective measures, particularly in reducing the impact on underage and young consumers. The second speaker, Lily Sofie Orntsen, Deputy Director General of the Unit for Alcohol and Illicit Drugs Policy at Norway’s Ministry of Health and Care Services Department of Public Health, spoke about 40 years’ experience of the alcohol ban in Norway. She said the ban, which was introduced in 1975, was very strict and probably the most comprehensive in Europe. It covered all the media and all expressions associated with alcoholic beverages. Phrases such as ‘happy hour’ and ‘cold one’ were even covered, as well as the mere use of a neutral picture of a beverage and alcohol sponsorships such as beer brands on football shirts and on boards at sport venues. The aim of the ban was twofold – to reduce directly the demand and thereby the consumption and harm of alcohol, and secondly to reinforce the effect of other alcohol policy measures and to contribute to the support for the alcohol policy as a whole.

Addressing the question of whether the ban was working, Ms Orntsen replied that it was. Alcohol consumption in Norway was pared to the rest of Europe and there was evidence to back up the assumption that the ban reinforced other alcohol measures. Public support for the ban had grown in recent years. There had been challenges to the ban from the alcohol industry, but there was now a broad political consensus that Norway should keep the ban.

She concluded: “We believe that it is important to maintain a strict and media-neutral advertising ban. We do not see any reason for the ban as such, but as there will always be changes in society, communications and industry, and we must make sure that the ban and its exceptions adapt to those changes. This, along with an efficient control and sanction system, is important to safeguard the support for the ban also in the years to come.”

Finance and Planning Committee (resumed)

Dr. Kloiber had presented a lengthy written report to Council about the secretariat’s activities. In his oral report he highlighted two issues to illustrate the WMA’s influence and impact. The Association had received an invitation from the United States Defence Health Board to advise the US Defence Secretary and the US military on issues relating to health and the military. The WMA was invited to take part in a session on medical ethics. Past President Dr. Cecil Wilson represented the WMA at this meeting and the Board came out with 16 recommendations. Dr. Kloiber then quoted from a letter from the Vice Chair of the US Senate Committee on Intelligence, Senator Diane Feinstein, to the US Defence Secretary referring to the WMA’s Declaration of Malta on the issue of ending the forced feeding of detainees at Guantanamo Bay.

The second development illustrating the WMA’s impact related to the issue of scheduling the drug Ketamine some weeks ago by the United Nations Commission on Narcotic Drugs. The WMA had asked its members to argue against this scheduling as many people would have suffered from the absence of the drug. Eventually it was decided to postpone the decision for a year and Dr. Kloiber thanked those NMAs who had lobbied on this issue.

Dr. Margaret Mungherera, the Immediate Past President, said that the largest threat to global health were the African health systems, but there was not enough attention being paid to this. She said the WMA needed to keep this issue on the agenda. The WMA had done a lot of work to reduce the draffing silence of NMAs in Africa on this issue, but it had a moral authority to do more and could not afford to sit back.

Chair’s Report

In his report, Dr. Haikerwal reported on the WMA’s increased foot-print on the global health map. He referred to the first “H20” Health Summit in Melbourne, adjacent to the G20 World Leader’s Summit. He said ethical guidance and ensuring access to health and healthcare remained core and key. He and the WMA’s leaders continued to remind people that health was a core component of a successful fair and just society, that health was a wise investment and that health brought human, political and economic dividends. Physicians were part of the solution in health and healthcare research planning implementation.
Future Meetings

The Committee considered the planning and arrangements for future WMA statutory meetings. The Taiwan Medical Association suggested that at the Assembly meeting in Taipei in October 2016 the scientific session should be on ‘Healthcare System Sustainability’ with two sessions, the first on ‘Health System Performance’ and the second session on ‘Health’. This was agreed.

The Secretary General reported that as in previous years, a WMA luncheon in Geneva would again be held during the WHO World Health Assembly period. The main theme this year would be public health issues, including health and investments. Dr. Hauke R. reported that a second H20+ Health Summit was also being planned following the success of the Melbourne meeting.

Associate Members

The Committee received an oral report from the Chair of the Associate Members, Dr. Joe Heyman. He informed the Committee of his plans to draw more commitment from individual associate members by promoting membership through introducing life membership. An international conference call was planned for May and he also spoke about holding regional, on-site meetings when statutory meetings were held and linking up with the Junior Doctors Network and the Past Presidents and Chairs of Council Network.

Junior Doctors Network

The Chair of the Junior Doctors Network, Dr. Ahmet Murt, gave an oral report on the JDN’s activities. Among the current topics it was working on were physicians’ wellbeing, medical work force, medical education, Ebola and social media.

Past Presidents and Chairs of Council Network

Delegates received a written report on the activities of the Past Presidents and Chairs of Council Network. Dr. Cecil Wilson had reitated the need for medical students to be involved in the process of improving the quality of medical education and practice. He expressed the hope that the WMA would be able to continue to work with the International Committee on Education to promote the needs of medical students.

World Medical Journal

The WMJ Editor, Dr. Peteris Apinis, in his oral report, said the transition producing a digital edition of the Journal had been completed. The first digital edition would be published in April.

Public Relations

The WMA’s Public Relations Consultant, Mr. Nigel Duncan, spoke about the importance of social media and the advantages this presented for the WMA. He said there was a need for some guidelines and rules for a more efficient and productive use of social media.

IFMSA Memorandum of Understanding

Dr. Klieber reported on a new Memorandum of Understanding with the International Federation of Medical Students Associations. Dr. Agostinho de Sousa, President of IFMSA, explained that IFMSA had been cooperating with the WMA since the 1960s, and that the official MOU would facilitate future collaboration. The Committee agreed to recommend to the Council to accept the new Memorandum of Understanding.

Internship and Secondment

The Committee received an oral report from the Secretary General on internships and secondment to the WMA. He reported that two bioscience students from the University of Pennsylvania and medical students from the IFMSA had been interning at the WMA Secretariat in Bern for the last year. He invited NMA’s to consider secondment for intensive contact with the WMA for mutual benefit.

Violence Against Doctors

The meeting heard a report from the Indian Medical Association about increasing incidents of assaults on doctors by patients in India. Dr. Klieber agreed that this was a very pressing issue that had arisen in countries around the globe. He had received reports in recent months from every continent, from Asia, Eastern Europe and from Latin America. The WMA had recently issued a press release about the case of a surgeon murdered in a Boston hospital in the USA. There had also been a recent case in Germany. He added that this was a second line of violence in addition to the violence taking place in areas of armed conflict, about which the WMA was working with the International Committee of the Red Cross. He told the meeting that the WMA would need to step up its work on violence against doctors not connected with armed conflict.

Socio-Medical Affairs Committee

Elections

The proceedings began with a contested election for Chair of the Committee, following the decision of President Elect Sir Michael Marmot to stand down. Two candidates were nominated, Prof. Miguel Roberto Jorge (Brazilian Medical Association) and Dr. André Bernard (Canadian Medical Association). After both candidates had addressed the meeting, the Committee elected Prof. Jorge, Associate Professor of Psychiatry and Chair of the Research Ethics Committee, at the Federal University of São Paulo.

Social Determinants of Health

The Group had examined a proposed revision of current WMA policy on Ethical Issues Concerning Patients with Mental Illness adopted in 2006. This revision would reflect doctors’ concerns about recent policy developments in this area and reaffirm medical ethics principles in relation to patients in psychiatric centres. It was proposed that the revision be submitted to the Committee for consideration.

Violence Against Women and Girls

Sir Michael Marmot reminded the Committee of the very successful WMA lunch held in Geneva in May 2014 alongside the World Health Assembly that was dedicated to violence against women. He said that one in three women globally would experience physical or sexual violence. This was a huge public health issue.

It was now proposed that the British Medical Association would host a discussion meeting of interested NMA’s in London about how the WMA could continue working on this subject.

Social Determinants of Health

A report on the successful BMA symposium that was held in March was organised jointly by the British Medical Association, the Canadian Medical Association and the Institute of Health Equity was given by Sir Michael Marmot. He updated the Committee on his plans for following up the conference. The first aim would be to continue strengthening global networks and building a social movement. The next would be to increase the visibility of the WMA Statement on Social Determinants of Health and build on the best evidence to produce a report. The third aim would be to develop educational tools for physicians to learn what they could do to tackle the Social Determinants of Health through online courses and training workshops.

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

It was reported that experts on the topic had been consulted over recent months. However, having not received enough material or responses, it had so far not been possible to submit a paper to the Work Group. It was hoped that the Work Group would be in a position to submit a draft policy in October 2015. It was decided to postpone further discussion until the next committee meeting in Moscow.

Proposed Statement on Physicians’ Well-Being

A new draft Statement on Physicians’ Well-Being was presented to the Committee by the Work Group. There was a brief debate about the need for doctors with disabilities to be enabled to return to work by making the necessary adaptations to the workplace. It was also argued that the paper should contain a more expanded section on physicians at risk from alcohol abuse. It was agreed to recommend to Council that the paper should be re circulated to NMA’s for comments.

Revision of the WFME Standards for Post-Graduate Education and Continuing Professional Development

A report was received on the activities of the Work Group on Medical Education. The Group had made comments on revising...
the World Federation of Medical Education Standards for Post-Graduate Education. The revision was considered thorough and comprehensive.

Dr. Kloiber reported that he has been consulted by the WFME in a personal capacity on the revision of standards for Continuing Professional Development. He thanked those members that had sent comments on the proposed revision and he expected there would also be an open consultation with the opportunity for NMAs to submit further comments.

Statement on Providing Health Support to Street Children
New guidelines for National Medical Associations on providing health support to street children were set out in a revised Statement on Providing Health Support to Street Children. The revised Statement was introduced by the Conseil de l'Ordre on Providing Health Support to Street Children. The revised Statement was then introduced by the Conseil de l'Ordre

health support to street children were set out in a revised Statement on Providing Health Support to Street Children.

Statement on Riot Control Agents
It was proposed that the title of the paper be changed to Statement on Riot Control Agents. It was proposed that the title of the paper be changed to Statement on Riot Control Agents.

Statement on Chemical Weapons
The Committee considered the proposed revision of the WMA Statement on Chemical Weapons which deals with the appropriate use of riot control agents. It was proposed that the title of the paper be changed to Statement on Riot Control Agents.

Proposed revision of WMA Statement on Child Abuse and Neglect
It was decided that this proposed document should be withdrawn.

Statement on Chemical Weapons
The Committee considered the proposed revision of the WMA Statement on Chemical Weapons which deals with the appropriate use of riot control agents. It was proposed that the title of the paper be changed to Statement on Riot Control Agents.

Proposed revision of WMA Statement on Child Abuse and Neglect
It was decided that this proposed document should be withdrawn.

Statement on Chemical Weapons
The Committee considered the proposed revision of the WMA Statement on Chemical Weapons which deals with the appropriate use of riot control agents. It was proposed that the title of the paper be changed to Statement on Riot Control Agents.

Proposed revision of WMA Statement on Child Abuse and Neglect
It was decided that this proposed document should be withdrawn.

Proposed Declaration on Alcohol
The Australian Medical Association introduced a draft Declaration on Alcohol which recommends priority legal and regulatory mea- sures as well as social policy interventions to address alcohol-related harm. The document was welcomed by a succession of speakers and after a brief debate it was agreed that with two minor amendments it should be sent to Council for forwarding to the General Assembly for approval and adoption.

Mobile Health
A proposed new Statement on Mobile Health was presented to the Committee by the German Medical Association. Delegates were told that National Medical Associations had commented on the pa- per and many of their suggestions had been included. Speakers welcomed the document on what they said was a very important issue. There was one suggestion that the Statement should include more about secrecy and confidentiality. This led to a debate during which many speakers argued that the guidelines should remain as broad and as general as possible. The meeting decided to reorder the wording of the document and the Commit- tee agreed that the proposed Statement, as amended, be approved by the Council and be forwarded to the General Assembly for approval and adoption.

World Day for Eliminating Violence Against Health Professionals
The Turkish Medical Association introduced a revised Statement on a World Day for Eliminating Violence against Health Professionals. This would be in memory of all those health professionals who had died in the course of duty, including the young Turkish surgeon Dr. Erzin Arslan who was stabbed by a relative of his pa- tient while on duty in his hospital three years ago.

Several speakers questioned whether there was a need to adopt new policy and it was suggested that this proposal should be referred to the WMA Advocacy Group. Other speakers supported the idea for a special day. It was reported that the Conseil de l'Ordre National des Medecins had set up an observatory to monitor physician safety and a form had been devised for physicians to report physical and verbal attacks. In 2014 they had noted a major increase in incidents of violence. In France it was not as usual for physicians to report such attacks and therefore the known figures should be multiplied to get a correct picture of what was going on.

Speakers also said that one of the reasons for violence was the lack of resources for hospitals and doctors when it came to working conditions, and the public sometimes reacted violently as a con- sequence. Doctors felt helpless when confronted with this type of problem and often resorted to defensive medicine. It was said that in Mexico over four years more than 60 physicians had died at the hands of the drug trafficking industry. The Committee agreed that the proposed Statement be forwarded to the Advocacy Group for considering possible action.

Nuclear Weapons
The Committee considered the proposed Statement on Nuclear Weapons requesting all National Medical Associations to join the WMA in urging their respective governments to work to ban and eliminate nuclear weapons.

Members of the Committee welcomed the Statement and recom- mended that it be sent to Council for forwarding to the General Assembly for approval and adoption.

Proposed new Statement on Mobile Health was presented to the Committee by the German Medical Association. Delegates were told that National Medical Associations had commented on the paper and many of their suggestions had been included. Speakers welcomed the document on what they said was a very important issue. There was one suggestion that the Statement should include more about secrecy and confidentiality. This led to a debate during which many speakers argued that the guidelines should remain as broad and as general as possible. The meeting decided to reorder the wording of the document and the Committee agreed that the proposed Statement, as amended, be approved by the Council and be forwarded to the General Assembly for approval and adoption.

World Day for Eliminating Violence Against Health Professionals
The Turkish Medical Association introduced a revised Statement on a World Day for Eliminating Violence against Health Professionals. This would be in memory of all those health professionals who had died in the course of duty, including the young Turkish surgeon Dr. Erzin Arslan who was stabbed by a relative of his patient while on duty in his hospital three years ago.

Several speakers questioned whether there was a need to adopt new policy and it was suggested that this proposal should be referred to the WMA Advocacy Group. Other speakers supported the idea for a special day. It was reported that the Conseil de l'Ordre National des Medecins had set up an observatory to monitor physician safety and a form had been devised for physicians to report physical and verbal attacks. In 2014 they had noted a major increase in incidents of violence. In France it was not as usual for physicians to report such attacks and therefore the known figures should be multiplied to get a correct picture of what was going on.

Speakers also said that one of the reasons for violence was the lack of resources for hospitals and doctors when it came to working conditions, and the public sometimes reacted violently as a consequence. Doctors felt helpless when confronted with this type of problem and often resorted to defensive medicine. It was said that in Mexico over four years more than 60 physicians had died at the hands of the drug trafficking industry. The Committee agreed that the proposed Statement be forwarded to the Advocacy Group for considering possible action.

Nuclear Weapons
The Committee considered the proposed Statement on Nuclear Weapons requesting all National Medical Associations to join the WMA in urging their respective governments to work to ban and eliminate nuclear weapons.

Members of the Committee welcomed the Statement and recommended that it be sent to Council for forwarding to the General Assembly for approval and adoption.
media and particularly twitter might fit into WMA’s proceedings. He said a task group would be set up to draft some guidelines and bring them back to the next meeting of the Advocacy Commi-
te. He also referred to the need to follow up the advocacy training session held at the Assembly in Durban and said that the Council would explore how to advance the various initiatives discussed. Finally he said the Committee was considering how advocacy fitted with the Association’s policy making process. There was a need to have clear messaging and to consider what levers for advocacy communication were available for each piece of work produced by the WMA.

Resolution on Trade Agreements and Public Health The British Medical Association submitted a proposed urgent Resolution on Trade Agreements and Public Health. It was re-
ported that there were a large number of trade agreements moving towards finality. It was very difficult for individual NMAs to have a significant impact on these agreements because of the secrecy surrounding the negotiations. But it was possible to get concerns heard if it was handled collectively. The key issue was that the WMA wanted to protect the ability of governments to make deci-
sions about promoting health and well-being and health equity in each country. It did not want to have those policies damaged or stopped because it was felt by some companies that their trading rights had been infringed and to use the new trade agreements to either stop the policy changes or even worse to make governments not want to have those policies damaged or stopped. A small drafting group was invited all constituent members to contact experts in their country to produced a draft policy paper and an open public consultation had been pro-
duced. It is now possible to get concerns heard if it was handled collectively. The key issue was that the WMA wanted to protect the ability of governments to make deci-
sions about promoting health and well-being and health equity in each country. It did not want to have those policies damaged or stopped because it was felt by some companies that their trading rights had been infringed and to use the new trade agreements to either stop the policy changes or even worse to make governments not want to have those policies damaged or stopped.

Person Centred Medicine The Committee received an oral report about the activities of the Work Group on Person Centred Medicine which had begun its work in 2012. It was reported that a white paper would be de-
veloped for the next meeting in October explaining the different existing concepts and their challenges. The language had evolved over the different definitions of person centred medicine. The white paper would address the difficulty in balancing the patient focus of medicine and public health and the physicians’ perspective. A WMA Work Group on Person Centred Medicine would be set up to develop the white paper. This led to a brief debate in which speakers elaborated on the defi-
nition of person centred medicine and the reason why the name of medicine and public health and the physicians’ perspective. A WMA Work Group on Person Centred Medicine would be set up to develop the white paper. This led to a brief debate in which speakers elaborated on the defi-
nition of person centred medicine and the reason why the name

Health Databases and Biobanks The activities of the Work Group on Health Databases and Bio-
banks were outlined to the Committee in an oral report. It had pro-
duced a draft policy paper and an open public consultation had been started, which would run until 5 June 2015. The Work Group in-
vited all constituent members to contact experts in their country to comment on the draft paper or to send the WMA Secretariat sug-
gestions of who to contact for this process. A small drafting group would incorporate the comments received at a drafting meeting in Berlin later this year. The Work Group then proposed to hold an open meeting with additional experts at the beginning of Septem-
ber 2015. The Danish Medical Association had offered to host this meeting in Copenhagen and the Work Group would report back at the next meeting of the Committee. Speakers emphasised that this was an ever changing topic and even when a paper was produced it would only be a work in prog-
ress. The topic was a core issue for the profession of patient con-
fidentiality.

Declaration of Geneva The German Medical Association put forward a proposal that it should form an informal workgroup to explore the potential revi-
sion of the Declaration of Geneva. The Declaration was due to be re-
vised in 2016 and the German Medical Association said it would like to express its support for re-exploring this crucial document from a 21st century perspective. This would be to ensure an appropri-
ate level of careful preparedness for when the official revision pro-
cess began. The informal work group would create an initial draft to serve as a basis for the final revision next year. Some speakers agreed with this approach and said the Declara-
tion needed a thorough revision. This led to a lengthy debate dur-
ing which many other speakers questioned whether such a working group would be set up to revise the Declaration or simply to review whether the Declaration should be revised. Several speakers were doubtful whether the Declaration needed revising at all, although there was general agreement that any work group set up should be a formal and not an informal group. The Committee concluded by recommending to the Council that a formal WMA Work Group be set up to review the Declaration of Geneva and come back to the Committee with recommendations. The Committee considered the status of several policies which were adopted or last revised 10 years ago. It was proposed that the State-
ment on Physician-Assisted Suicide, rather than being automati-
cally reaffirmed, should undergo a major revision. The Canadian Medical Association volunteered to do this. This prompted a brief debate when it was pointed out that in responses from NMAs, the majority opinion was that this policy should not be revised. On a vote, the Committee recommended that the Statement on Physi-
cian-Assisted Suicide and three other policies be reaffirmed: • The Declaration of Lisbon on the Rights of the Patient • The Declaration on Euthanasia • The Resolution on Academic Sanctions or Boycotts It recommended that the Statement on Non-discrimination in Pro-
fessional Membership and Activities of Physicians be reaffirmed 
with a minor revision by the Secretariat and be submitted to the
Committee and Council at the next meeting.

Medical Ethics Health Databases and Biobanks The Committee considered how advocacy fitted with the Association’s policy making process. There was a need to have clear messaging and to consider what levers for advocacy communication were available for each piece of work produced by the WMA.

Person Centred Medicine The Committee received an oral report about the activities of the Work Group on Person Centred Medicine which had begun its work in 2012. It was reported that a white paper would be de-
veloped for the next meeting in October explaining the different existing concepts and their challenges. The language had evolved over the different definitions of person centred medicine. The white paper would address the difficulty in balancing the patient focus of medicine and public health and the physicians’ perspective. A WMA Work Group on Person Centred Medicine would be set up to develop the white paper. This led to a brief debate in which speakers elaborated on the defi-
nition of person centred medicine and the reason why the name

Health Databases and Biobanks The activities of the Work Group on Health Databases and Bio-
banks were outlined to the Committee in an oral report. It had pro-
duced a draft policy paper and an open public consultation had been started, which would run until 5 June 2015. The Work Group in-
vited all constituent members to contact experts in their country to comment on the draft paper or to send the WMA Secretariat sug-
gestions of who to contact for this process. A small drafting group would incorporate the comments received at a drafting meeting in Berlin later this year. The Work Group then proposed to hold an open meeting with additional experts at the beginning of Septem-
ber 2015. The Danish Medical Association had offered to host this meeting in Copenhagen and the Work Group would report back at the next meeting of the Committee. Speakers emphasised that this was an ever changing topic and even when a paper was produced it would only be a work in prog-
ress. The topic was a core issue for the profession of patient confi-
dentiality.

Declaration of Geneva The German Medical Association put forward a proposal that it should form an informal workgroup to explore the potential revi-
sion of the Declaration of Geneva. The Declaration was due to be re-
vised in 2016 and the German Medical Association said it would like to express its support for re-exploring this crucial document from a 21st century perspective. This would be to ensure an appropri-
ate level of careful preparedness for when the official revision pro-
cess began. The informal work group would create an initial draft to serve as a basis for the final revision next year. Some speakers agreed with this approach and said the Declara-
tion needed a thorough revision. This led to a lengthy debate dur-
ing which many other speakers questioned whether such a working group would be set up to revise the Declaration or simply to review whether the Declaration should be revised. Several speakers were doubtful whether the Declaration needed revising at all, although there was general agreement that any work group set up should be a formal and not an informal group. The Committee concluded by recommending to the Council that a formal WMA Work Group be set up to review the Declaration of Geneva and come back to the Committee with recommendations. The Committee considered how advocacy fitted with the Association’s policy making process. There was a need to have clear messaging and to consider what levers for advocacy communication were available for each piece of work produced by the WMA.
The Financial Statement for 2014 was approved.

Financial Statement

The Financial Statement for 2014 was approved.

Proposed Declaration on Alcohol

The Council considered the proposed Declaration on Alcohol which had been brought forward by the Australian Medical Association. It was proposed that there should be an amendment to the document’s wording on reducing the impact of harmful alcohol consumption in at-risk populations, such as children and young people, alcohol-dependent, pregnant and breast-feeding women, and minority groups. It was proposed that the words ‘and minority groups’ be deleted because in some countries minority groups did not see themselves at risk. This led to a lengthy debate and opposition from the Australian Medical Association on the grounds that it was imperative to highlight Australia’s indigenous population. Two further amendments were proposed, one to reword the statement to read ‘and some minority groups’ and the other to ‘vulnerable groups’. Other speakers argued that the document should not list particular groups, which led to a lively debate. The meeting eventually decided to amend the document to read ‘Reduce the impact of harmful alcohol consumption in at-risk populations’ and the Council approved the Declaration as amended for forwarding to the General Assembly for approval and adoption.

Proposed Statement on Physicians’ Well-Being

The Council agreed that the proposed Statement on Physicians’ Well-Being be recirculated to NMA for comments.

Statement on Providing Health Support to Street Children

The Council agreed that the proposed Statement on Providing Health Support to Street Children be forwarded to the General Assembly for approval and adoption.

Statement on Riot Control Agents

The Council agreed to send the renamed Statement on Riot Control Agents to the General Assembly for approval and adoption.

Mobile Health

The Council approved the proposed Statement on Mobile Health and agreed that it be forwarded to the General Assembly for approval and adoption.

Resolution on Trade Agreements and Public Health

The Council approved the emergency Resolution on Trade Agreements and Public Health without debate.

World Veterinary Association

The meeting concluded with an address from Dr. René Carlson, President of the World Veterinary Association. Dr. Carlson, a general private practitioner, said she wanted to share two very important messages with the WVA. The first was the common ground on which the two organisations could collaborate. These included zoonotic diseases, such as rabies. Rabies still killed around 60,000 humans every year primarily through exposure to unvaccinated and infected dogs. It killed more people every year than Ebola had killed over several decades. Yet rabies was almost one hundred percent preventable. If the WMA and WVA worked together to strengthen health care systems, and advocate to the appropriate governmental agencies to establish policies that would protect their own citizens’ lives, they could have a large impact on improving human and animal health by eliminating dog-mediated human rabies. A second area of collaboration was animal welfare, which directly affected human well-being in many cases. Healthy and well-cared for animals produced a safer, more nutritious, more abundant, and more economically profitable and affordable food supply.

A third area was good quality education which improved the knowledge and core competencies of veterinarians around the world as it did for physicians, and which benefited the global public good. Finally, was pharmaceutical stewardship. According to the World Health Organization, antimicrobial resistance was the next major global public health threat. Physicians and veterinarians must be part of the solution and must work together to move toward keeping people and animals healthy in the first place, rather than depending on medicines to treat the consequences of poor management and illness, especially with excessive use of antimicrobials.

Her second message was that the WMA and the WVA were hosting the Global Conference on One Health in Madrid shortly, along with the Spanish Medical and Veterinary Associations. This meeting could be a real turning point and was receiving a lot of attention worldwide. This was their opportunity to move past the usual rhetoric and the continuing justification that One Health issues were important from both their perspectives. But they must define how they could truly bridge the gap between the two professions to strengthen collaboration as these diseases became more prominent in the future. Dr. Carlson concluded: ‘The continuing good collaboration between our two organisations is both important and beneficial in many ways. People are intricately interconnected to animals as fellow members of the animal kingdom. We know why we should work together, so now how do we work together to more effectively protect and improve the health of humans, animals, and plants? That is the question we want to answer next month in Madrid. For that to happen, it is important that both physicians and veterinarians attend that meeting. If we continue to work jointly on many of these common issues, we will become a working model for national and regional collaboration between our two professions leading to a much greater impact on improving human, animal, and environmental health’.

Mr. Nigel Duncan, Public Relations Consultant, WMA
Preamble
Trade agreements are sequelae of globalization and seek to promote trade liberalization. They can have a significant impact on the social determinants of health and thus on public health and the delivery of health care.

Trade agreements are designed to produce economic benefits. Negotiations should take account of their potential broad impact especially on health and ensure that health is not damaged by the pursuit of potential economic gain.

Trade agreements may have the ability to promote the health and wellbeing of all people, including by improving economic structures, if they are well constructed and protect the ability of governments to legislate, regulate and plan for health promotion, health care delivery and health equity, with- out interference.

Background
There have been many trade agreements negotiated in the past. New agreements under negotiation include the Trans Pa- cific Partnership (TPP), [1] Trans At- lantic Trade and Investment Partner- ship (TTIP)[2], the Trade in Services Agreement and the Compre- hensive Economic and Trade Agreement (CETA) [3].

These negotiations seek to establish a global governance framework for trade and are un- precedented in their size, scope and secrecy. A lack of transparency and the selective sharing of information with a limited set of stakeholders are anti-democratic.

Investor-state dispute settlement (ISDS) provides a mechanism for investors to bring claims against governments and seek compen- sation, operating outside existing sys- tems of accountability and transparency. ISDS in smaller scale trade agreements has been used to challenge evidence-based pub- lic health laws including tobacco plain pack- aging. Inclusion of a broad ISDS mecha- nism could threaten public health actions designed to effect tobacco control, alcohol control, regulation of obesogenic foods and beverages, access to medicines, health care services, environmental protection/climate change and occupational/environmental health improvements. This especially in na- tions with limited access to resources.

Access to affordable medicines is critical to controlling the global burdens of communi- cable and non-communicable diseases. The World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) established a set of international rules governing the protection of intellectual property in- cluding the patenting of pharmaceuticals. TRIPS safeguards and flexibilities includ- ing compulsory licensing seek to ensure that patent protection does not supersede public health. [4].

TTIP may impact on eHealth provision by changing rules in licensing and telecoms. Its impact on the delivery of eHealth could be substantial and damage the delivery of com- prehensive, effective, cost-efficient efficient health care.

The WMA Statement on Patenting Medi- cal Procedures states that patenting of diag- nostic, therapeutic and surgical techniques is unethical and "poses serious risks to the effective practice of medicine by potentially limiting the availability of new procedures to patients."

The WMA Statement on Medical Work- force states that the WMA has recognized the need for investment in medical educa- tion and has called on governments to “… allocate sufficient financial resources for the education, training, development, recruit- ment and retention of physicians to meet the medical needs of the entire popula- tion…”

The WMA Declaration of Delhi on Health and Climate Change states that global cli- mate change has had and will continue to have serious consequences for health and demands comprehensive action.

Recommendations
Therefore the WMA calls on national gov- ernments and national member associations to: Advocate for trade agreements that pro- tect, promote and prioritize public health over commercial interests and ensure wide exclusions to secure services in the pub- lic interest, especially those impacting on individual and public health. This should include new modalities of health care pro- visions including eHealth, Tele-Health, mHealth and uHealth.

Ensure trade agreements do not interfere with governments’ ability to regulate health and health care, or to guarantie a right to health for all. Government action to protect and promote health should not be subject to challenge through an investor-state dispute settlement (ISDS) or similar mechanism.

Oppose any trade agreement provisions which would compromise access to health care services or medicines including but not limited to:
• Patenting or patent enforcement of diag- nostic, therapeutic and surgical techniques;
• “Evergreening”, or patent protection for minor modifications of existing drugs;
• Patent linkage or other patent term ad- justments that serve as a barrier to generic entry into the market;
• Data exclusivity for biologics;
• Any effort to undermine TRIPS safe- guards or restrict TRIPS flexibilities in- cluding compulsory licensing;
• Limits on clinical trial data transparency.

World Health Assembly Week
Geneva, May 18–26, 2015
The Sixty-eighth session of the World Health Assembly, the supreme decision- making body of the World Health Organ- isation, was held in Geneva May 18–26. As usual it attracted to the city an array of world leaders, health ministers, chief medical officers, global leaders from the health professions and countless lobby- s. More than 3000 delegates from the WHO’s 194 Member States, including the many side events and unofficial meet- ings held simultaneously that proved just as beneficial.

During the weekend before the Assembly opened, the World Health Professions Alliance held a successful Leadership Forum, bringing together representatives from the nursing, pharmaceutical, physi- cal therapy, dental and medical associa- tions. The Forum held two sessions, one devoted to discussing human resources as a health component in all WHO policies and the other concerning issues around ageing populations and the ageing health workforce.

Participants discussed the fact that health workforce implications were often largely ignored when public health goals were set, as was the case when targets were set for both the Millennium Development Goals and the Sustainable Development Goals.

On the issue of ageing populations, the Fo- rum considered the challenges that would be faced as the number of citizens over 65 increased to almost 30 percent by 2060, while those over 80 would nearly triple. During this time, health and health care services would need to adapt to a growing demand.

At the same time as the WHA Forum meeting, the WMA’s Junior Doc- tors Network was gathering to prepare its activities for the week. It organized a two-day workshop at the WMA office in Ferney-Voltaire which was attended by more than twenty JDN members from four continents. The focus of the work- shop was on preparing JDN delegations for the Assembly.

JDN members met with Dr. Xavier Deau, WMA President, and Dr. Otmar Kloiber, WMA Secretary General. Highlights in- cluded discussions on the International Recruitment of Healthcare Personnel, im- mune preparedness with Dr. Julia Seyer from the WMA, Emergency and Disaster Risk Reduction, Air Pollution and Climate Change, advocacy at the WMA and trade and health.

REFERENCES
1. TPP negotiations currently include twelve par- ties: the United States, Canada, Mexico, Peru, Chile, Australia, New Zealand, Brunei, Singa- pore, Malaysia, Japan and Vietnam.
2. TTIP negotiations currently include the Euro- pean Union and the United States.
3. CETA negotiations currently include the Euro- pean Union and Canada.

World Health Assembly Week
Geneva, May 18–26, 2015
The Sixty-eighth session of the World Health Assembly, the supreme decision- making body of the World Health Organ- isation, was held in Geneva May 18–26. As usual it attracted to the city an array of world leaders, health ministers, chief medical officers, global leaders from the health professions and countless lobby- s. More than 3000 delegates from the WHO’s 194 Member States, including the many side events and unofficial meet- ings held simultaneously that proved just as beneficial.

During the weekend before the Assembly opened, the World Health Professions Alliance held a successful Leadership Forum, bringing together representatives from the nursing, pharmaceutical, physi- cal therapy, dental and medical associa- tions. The Forum held two sessions, one devoted to discussing human resources as a health component in all WHO policies and the other concerning issues around ageing populations and the ageing health workforce.

Participants discussed the fact that health workforce implications were often largely ignored when public health goals were set, as was the case when targets were set for both the Millennium Development Goals and the Sustainable Development Goals.

On the issue of ageing populations, the Fo- rum considered the challenges that would be faced as the number of citizens over 65 increased to almost 30 percent by 2060, while those over 80 would nearly triple. During this time, health and health care services would need to adapt to a growing demand.

At the same time as the WHA Forum meeting, the WMA’s Junior Doc- tors Network was gathering to prepare its activities for the week. It organized a two-day workshop at the WMA office in Ferney-Voltaire which was attended by more than twenty JDN members from four continents. The focus of the work- shop was on preparing JDN delegations for the Assembly.

JDN members met with Dr. Xavier Deau, WMA President, and Dr. Otmar Kloiber, WMA Secretary General. Highlights in- cluded discussions on the International Recruitment of Healthcare Personnel, im- mune preparedness with Dr. Julia Seyer from the WMA, Emergency and Disaster Risk Reduction, Air Pollution and Climate Change, advocacy at the WMA and trade and health.

REFERENCES
1. TPP negotiations currently include twelve par- ties: the United States, Canada, Mexico, Peru, Chile, Australia, New Zealand, Brunei, Singa- pore, Malaysia, Japan and Vietnam.
2. TTIP negotiations currently include the Euro- pean Union and the United States.
3. CETA negotiations currently include the Euro- pean Union and Canada.
Dr. Calone Mattar, Chair of the JDN’s Pre-WHA Organizing Committee, provided attendees with an introduction to the WHA and what to expect for the week to come. In addition, JDN members joined the International Federation of Medical Students’ Associations’ Pre-WHA workshop at the Graduate Institute in Geneva for a successful panel discussion and collaborative issue-based small group sessions on human resources for health, climate change and antimicrobial resistance. These sessions prepared participants for the Assembly and provided the opportunity to learn more about WHA agenda items.

Representatives from both the JDN and IFMSA helped to prepare the various interventions to be made by JDN and the WHPA to the Assembly during the week.

On the Monday morning, while thousands of delegates gathered for the opening of the Assembly, leaders of the World Health Professions Alliance were meeting a group of African journalists to brief them on the events of the coming week. Organised by the World Health Editors Network and its founder Franklin Apfel, the gathering allowed the Presidents and CEOs of the five WHPA professions to talk to the African media about their priorities at the Assembly and their respective plans to create a single new WHO professional body.

Delegates adopted the draft global action plan on antimicrobial resistance on this year’s Assembly agenda.

Dr. Peña said that the Thai Health Professional Alliance Against Tobacco brought together more than 21 different associations, most being healthcare professional bodies. It had initiated many projects covering different areas such as public promotion of smoking-free environment, education, and national health policy. It was also the pioneer in starting educational centres on tobacco hazard in 12 provinces of Thailand.

The WHPA award was received by Prof. Dr. Somsi Pausawasdi, President of the THPAAT and CEO of the Medical Association of Thailand. She said that THPAAT was established in 1994 on the vision of the Medical Association of Thailand and at the time when the King of Thailand, Bhumibol Adulyadej, had expressed his wish to reduce the growing problems of cigarettes addiction in Thailand. The Medical Association of Thailand had responded to the King’s wish and to the WHO campaign by initiating the THPAAT with the goal of recruiting a mixture of health professionals for an anti-smoking campaign.

She went on: “It was clear that the best way to accomplish our goals was to create a collaborative interprofessional team and thus the Medical Association collaborated with the Thai Health Foundation and recruited four more organizations including the Pharmacy Council, the Nurses’ Association, the Dental Association, and the Public Health association to join the team. Over the years, our network has expanded and we currently comprise 21 different health professional bodies under the support of the Thai government. The goals of our team are to generate knowledge, and develop and enforce the smoking free society as national health policy.”

She said the Alliance’s activities included the aim of improving the awareness of children and should use their trusted positions and skills to reintegrate these children back into society. He also said that national medical associations had an important role to play in educating their members about what they could do to help.

Dr. Deau quoted WMA policy deriving from the Declaration of Ottawa on World Health adopted in 1998. This stated that children needed to grow up in a place where they could thrive, spiritually, emotionally, physically and intellectually. This was necessary to create a safe and secure environment, the opportunity for growth and development, health services when needed and monitoring and research for evidence-based continual improvement.

He said that assisting street children required a method, such as a multi-professional team including health professionals, social workers, drivers, teachers and police.

Finally, Dr. Deau said that at the WMA’s General Assembly in Moscow delegates would consider a new Statement for adoption, calling for all street children to be provided with care and where necessary returned to a living environment. He said that remaining indifferent towards street children was not an option.

During the Assembly, the JDN and IFMSA delivered a number of interventions they had drafted on behalf of the WMA and/or World Health Professions Alliance. These were based on the WMA policy and
in collaboration with the WMA staff and leadership and included interventions on antimicrobial drug resistance, polio, non-communicable diseases, climate change and Ebola.

On the Global Action Plan on Antimicrobial Drug Resistance the WMA said that antimicrobial resistance was a threat to all countries without regard for geographical boundaries. A commitment was needed from both member states and the WHO to ensure financial sustainability to implement interventions in LMICs. The WMA’s intervention emphasized that the Global Action Plan could not be separated from strengthening healthcare systems, building on lessons learned from the Ebola epidemic. A focus on access to primary care, availability of diagnostic tools and rapid diagnostic methods and surveillance systems was needed to fight the spread of resistant pathogens. The Assembly went on to agree on resolutions to improve access to affordable vaccines.

On polio eradication, the WMA said, it had condoned in the strongest terms the recent killing of five health care workers in Pakistan while providing polio immunization to the citizens of Pakistan. This tragedy had underscored the urgent need to ensure the protection of health care workers in conflict areas. It urged the WHO and member states to ensure adequate security for the healthcare workers to enable effective implementation of immunization protocols, to develop systems sensitive surveillance and immediate notification to the WHO of any detected poliovirus transmission and to implement adequate immunization training for health professionals. The WMA also wanted to see an increase in effective public awareness and education to prevent and dispel myths.

The IFMSA spoke about the need to tackle, prevent and control the global burden of noncommunicable diseases (NCDs), and reduce the worldwide morbidity and mortality related to cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, as well as reduce the four shared risk factors. It strongly recommended that interventions aimed at reducing the burden of NCDs must include: addressing risk factors during childhood and adolescence.

The IFMSA also spoke on the issue of health in the post-2015 development agenda asking the WHO to focus its attention on supporting the development of realistic targets and clear indicators, which would remain a main topic of discussions in the following months. However, it referred to the absence of several important health areas, such as recognizing primary health coverage and the importance of health literacy, patient centered care and patient empowerment.

On the issue of the International Recruitment of Health Personnel, the IFMSA raised a concern that the current Code was mainly focused on regulating the migration of health personnel. It was important that member states tackled fundamental factors that caused the migration, such as poor or unsafe practice environments, poor education and excessive workload. Medical students were facing mental and physical strain, harming their practice, decreasing patient safety and exponentially increasing the costs of healthcare systems, and sometimes even leading to suicide. Health workers and students must be protected from violence, discrimination and exploitation in the workplace, and be allowed to operate within a positive practice environment that guaranteed occupational safety and health.

The Assembly passed several landmark resolutions on air pollution, on epistemy and the next steps in finalizing the framework of engagement with non state actors.

Among the many side events attended by WMA representatives and JDN delegates was one which the JDN co-hosted with the International Committee of the Red Cross on the Healthcare in Danger. This focused on the role of education and training in addressing healthcare in danger and featured a panel discussion including Dr. Ahmed Berzig (Head of Health Unit, ICRC), Prof. David Gordon (President, WFME), Dr. Bruce Esayeh-Chauvin (Medical Ad- viser, Healthcare in Danger) and Dr. Ahmet Murt (Chair, JDN).

At the end of the Assembly, IFMSA President Agostinho Souza said: “The voices of medical students, and of youth more generally, have been recognized several times during this World Health Assembly. Addresses by Dr. Margaret Chan, Director General of the World Health Organisation, and references made by numerous Ministers of Health or their representatives, have shown the crucial role that future health professionals play in shaping the global health agenda.”

In March 2014, the Ebola virus was identified as the force behind a wave of illness in Guinea. According to the latest figures from the WHO, there have been nearly 27,000 cases of Ebola reported in West Africa and 11,120 deaths. The approach taken in response to previous outbreaks of the Ebola virus (i.e. quarantining patients and monitoring their immediate social circles) proved to be inadequate in this case due to the mobility of the population and the prolonged duration of the disease. As a result, major cities in West Africa had to contend with large numbers of victims for the first time.

One particular problem facing the affected countries was the lack of appropriately trained professionals needed to contain the virus. In Germany, the German Medical Association teamed up with the Federal Ministry of Health and the German Red Cross, as well as the national professional associations of physicians, to promote voluntary efforts in the affected regions. On an international level, the World Medical Association and the Standing Committee of European Physicians (CPME) called for concrete measures to contain the virus. The necessary structures must be developed on a national and international level in order to combat epidemics more efficiently in the future. Providing protection for physicians before, during and after they engage in relief efforts is a key component of this. Protection must include, for example, guarantees for the physicians in the case of infection, access to comprehensive medical and psychological care upon their return, as well as sufficient life insurance.

In hindsight, we must concede that governments, the scientific community and relief organisations underestimated the severity of the Ebola crisis in West Africa for far too long. Although the situation appears to be largely under control and the Ebola epidemic is now only a passing reference in the media, we cannot fall back into the old habit of ignoring and avoiding the problem. The Ebola outbreak continues to demand the full attention of the international community.

At the same time, it demonstrates by example that in a globalised world, epidemics not only have the potential to wipe out entire populations, but also that they do not stop at national borders, nor are they confined to certain continents. We must work to develop effective global strategies to ensure that diseases can be contained early going forward. These strategies must incorporate elements of prevention, as well as rapid response facilities.

The Ebola outbreak made it clear that vaccines, a sensible tool for combating epidemics, were initially not developed by the pharmaceutical industry because the market was not deemed profitable enough. Although there are promising trials in progress, there is still no approved vaccine available. The World Medical Association and the CPME have demanded that adequate funding really be made available for immunization programmes and for vaccine research and development. The Declaration of Helsinki asks the WHO to focus its attention on the crucial role that future health professionals play in shaping the global health agenda.

The IFMSA also spoke on the issue of the International Recruitment of Health Personnel, the IFMSA raised a concern that the current Code was mainly focused on regulating the migration of health personnel. It was important that member states tackled fundamental factors that caused the migration, such as poor or unsafe practice environments, poor education and excessive workload. Medical students were facing mental and physical strain, harming their practice, decreasing patient safety and exponentially increasing the costs of healthcare systems, and sometimes even leading to suicide. Health workers and students must be protected from violence, discrimination and exploitation in the workplace, and be allowed to operate within a positive practice environment that guaranteed occupational safety and health.
Climate changes

West Africa’s Ebola epidemic demonstrated the consequences of uncontrolled outbreaks of infectious disease. For this reason, this year’s 118th German Medical Assembly in Frankfurt deliberated the most pressing issues relating to civil protection under the heading “Medicine in times of global epidemics”. The discussion was initiated by presentations meant to shed light on the domestic and international aspects of battling global epidemics. Dr. Tankred Stöbe, chairman of the board of the German chapter of Médecins Sans Frontières (Doctors Without Borders), drew attention to the preconditions and challenges of establishing a preventive medical infrastructure in regions affected by epidemics. He reported on practical measures taken to stem the disease, which included educating the population and increasing public awareness about infectious disease and safe burials, as well as efforts to strengthen countries affected by epidemics. From the perspective of an international non-governmental organisation, it is also essential to address what is needed to protect and safeguard medical and non-medical personnel and their employment rights during their deployment abroad.

Following this talk, Prof. Dr. René Gottschalk, Director of the Public Health Office of the city of Frankfurt/Main, discussed the domestic and European aspects of the fight against global epidemics. Prof. Dr. Gottschalk addressed options for reducing greenhouse gas emissions to limit global warming within 2 °C. That is why some are even calling it the “historic two weeks.”

Due to the earth’s feed-back mechanism, any change, once gaining enough momentum in a certain direction, becomes extremely difficult to reverse. Even if all emission of greenhouse gas is stopped now, it would still be difficult to completely prevent global warming. The goal of limiting global warming to 2 °C is the minimum measure necessary to prevent the worst case scenario.

Health needs to be given the greatest priority in efforts to minimize climate change. Climate change causes change in temperature, wind, and precipitation with profound effects on all natural systems. These, in turn, have effects on the health, safety, and livelihoods of people—especially the poor.

We have already seen previews of the health impact that lies ahead if extreme weather events continue to increase. Heat waves like the one that hit Chicago in 1995, killing some 750 people and hospitalized thousands, and the 2003 European heat wave, killing 21,000 to 35,000 people in five countries, are becoming more common.

But even more subtle, gradual climate change still can harm human health. Elevated carbon dioxide levels promote the growth and sporulation of some soil fungi, and diesel particles help deliver these allergens deeper into our alveoli and present them to immune cells along the way.

Mosquitoes, which can carry many diseases, are very sensitive to temperature changes. Warming up their environment—even within its viable range—boosts their rates of reproduction and prolongs their breeding season, and shortens the maturation period for the microbes they disperse. Extremely wet weather may bring its own share of illness. Floods are frequently followed by disease clusters. Major coastal storms can also trigger harmful algal blooms (“red tides”), which can be toxic, help to create hypoxic “dead zones” in gulfs and bays, and harbor pathogens.

These are only a few examples of what is in store. The impact of climate change comes in many shapes and sizes from not only damage from increase in harmful substances or chemicals in the air but also the increase in prevalence of various contagious diseases, which are all major public health challenges. In particular, the detrimental effects of climate change on health are far more serious among the more vulnerable population such as children, the elderly and people in less developed countries.

WMA has continuously expressed its concern over the health impact by climate change, and has worked to raise awareness regarding the benefits of putting health in the center of the climate change agenda. As a way to tackle the issue in the WMA, the Environment Caucus was organized. It aims to exchange opinions among WMA members and related bodies regarding WMA future activities related with health and environment.

The main activity of the Environmental Caucus is sharing global trends and concrete information regarding environment and identifying common topics of interest and to discuss follow-up measures. It encourages free exchange of opinions by adopting an informal setting. Major themes discussed at the Environmental Caucus with regards to the direction of future WMA activities include the role of physicians and of constituent members in greenhouse gas reduction, promoting research on the health co-benefits of countering climate change and expansion of green hospitals and clinics.

At the last meeting of the Environmental Caucus held in Oslo, Norway, during the 20th Council Session of WMA, participants all agreed on the importance of forming a coordinated voice representing the entire medical community in anticipation of COP 21 and shared ideas about what we can do.

The discussion can be summarized into the following approaches:

1. Recognition of co-benefits of dealing with health issues in climate action
2. Getting involved in liaising with each government’s negotiation representatives
3. Active media coversages and journal exposure
4. Collaboration with other professional organizations and NGOs on joint initiatives on the issue
5. Promoting awareness of members on green policies for daily operation of health facilities.

As described by LANCET, climate change is “the greatest global health challenge of the 21st century.” It is a battle cry for all physicians to take on a more active role in tackling climate change, and for us to feel a greater sense of responsibility starting from our everyday lives and also at a national level through each NMA, and at an international level through the WMA.

Much is at stake as COP21 approaches, and hopes are high that we will be able to deliver our voices effectively so that COP21 will find a meaningful framework to prevent and resolve health problems caused by climate change.
The Art and Heart of Medicine

The Art and Heart of Medicine

The Art of the conversation between a physician and their patient, is at the heart of medical practice [1]. It is a dialogue between a person seeking help and a physician who possesses the relevant medical knowledge and skills. This patient/physician relationship is founded on trust and respect — trust within which two-way communication is key. The physician’s professional service to their patient must be conducted within a professional code of ethics which has been enshrined within the World Medical Association International Code of Medical Ethics 1949 et seq.

This statement includes the requirement that “a physician shall be dedicated to providing competent medical service in full professional and moral independence with compassion and respect for human dignity.”

Trust

Trust can only be assured if the patient believes the physician respects them as individuals, will act only in their best interests, avoid ‘harm’ where possible, be truthful and treated equally with others according to their needs.

The physician also has a duty of care to their patients and should keep their medical records secret within applicable national laws. These ethical principles need to become ‘internalized’ as the individual physician’s ‘professional’ conscience and act as a compass through the complex scientific, medical, psychological, social, cultural and spiritual scene. These principles relate both to the individual health care professional as a basis for the ‘trust’ given by the patient as a person to them and to society in general where they form part of the essential ‘contract’ between the healthcare professions and society allowing the physician to work as an independent clinician whose primary duty is to their patient. Only in this ‘trusting’ culture will a patient’s inner worries and secrets be gradually shared with their physician.

A person’s narrative

A patient’s own story is the key to the physician finding out what may be right and what may be wrong during a professional consultation. A narrative approach encompasses an open awareness of health and disease within a storied structure from which the meaning and purpose in both an illness and the experience of recovery emerge. Diagnostic labels become secondary to the life of the individual person. A story is recounted in a complicated narrative of illness told in words, silences, gestures, physical observations, overlay not only by the objective findings but also with the fears, hopes and implications associated with it [2].

The narrative is a therapeutic central act because finding the words to contain the disorder and its attendant worries gives shape to and control over the uncertainties of the illness. As the physician listens to the patient, he or she follows the narrative thread of the story in all its existential, cultural, familial, biological, social, psychological and spiritual dimensions.

The act of listening, so essential to the process, enlists the physician’s interior sources—memories, association, curiosities, creativity, interpretive powers and allusions to other stories by the person and others to identify meaning. Only then the physician can bear and confront the person’s narrative questions “What is wrong with me? Why is this happening to me? And what will be the result?” [3]

Listening to stories of illness and recognizing that there are often no clear answers to patients’ narrative questions demands courage and generosity to tolerate and bear witness to unfair losses and random tragedies [4]. Accomplishing such acts of witnessing allows the physician to proceed to his or her more recognizable clinical narrative tasks: to establish a therapeutic alliance, to generate and proceed through a differential diagnosis, to interpret physical findings and laboratory reports correctly, to experience and convey empathy for the patient’s experience [5], and, as a result of these, to engage the patient for effective care.

If the physician cannot perform these narrative tasks, the patient might not tell the whole story, might not ask the most frightening questions, and might not feel heard [6].

The resultant diagnostic workup might be unfocused and therefore more expensive than need be, the correct diagnosis might be missed, the clinical care might be marked by noncompliance and the search for another opinion, and the therapeutic relationship might be shallow and ineffective. The narrative is absorbing. It engages the listening physician and invites an interpretation. It gives him or her the experience of “living through”, not simply “knowledge about” the character and events in the story.

The Art and Heart of Medicine

The Art and Heart of Medicine

The tendency of even experienced family physicians not to seek the patient’s complete agenda is similar to the finding of Beckman and Frankel 15 years ago. Despite the concern that a patient-centered approach will take more time, the study further reinforces that exploring all of the patient’s concerns does not decrease efficacy. Using a simple opening empathic enquiry, such as “What concerns do you have?”, then asking “Anything else?” repeatedly until a complete agenda has been identified appears to take 6 seconds longer than interviews in which the patient’s agenda is interrupted. Agenda setting is a teachable and learnable skill that deserves emphasis and reinforcement.

A few verbal affective remarks can be effective and this is not necessarily time consuming [12]. In one study it took only 38 seconds to make a difference! The affective statements that caused this reduction were related to emphasizing being there for the person—the sense of a physician’s duty of care—providing reassurance of continuing medical support. These points have been defined as fundamental for effective patient-physician communication. Whilst one of the most difficult tasks for physicians is to tell bad news, physicians who are emotionally supportive can influence patients’ emotional functioning with little effort and time [13].

Affective communication may have the power to elicit beneficial effects in clinical encounters as it enables patients to adjust better to the emotional and cognitive impact of medical information [14]. Indirect effects might also be present. When patients remember more about treatment procedures and their consequences, this may affect adherence to treatment or medication regimen. A few affective statements can have a large impact on patients’ anxiety, uncertainty and recall. Affective communication allows physicians to temper patients’ emotional responses and improve their ability to remember medical information.

Conclusion

A person-centered approach involves a renewal of our ethical commitment both to each person as a patient and to society as a whole in a wide biomedical, psychological, social, cultural and spiritual framework. It attends to both ill health and positive health and focuses on the diagnostic
Some of the greatest discoveries in the history of medicine have been zoonotic in origin [1]. Ninety percent of emerging infectious diseases develop in wildlife, livestock, and pets cannot be adequately addressed without meaningful wildlife, livestock, and pets cannot be adequately addressed without meaningful communication about HIV risk. Ann Intern Med. 1995;125:435-442.


James Appleby MD, FRCPC
President, International College of Person centered medicine
Dr. Hubii, Blissen
Commonwealth CTZ 9J UK
E-mail: jimappleby25@gmail.com

One Health: A Concept for the 21st Century

One Health is a new term, but an ancient concept that recognizes the inherent links between human, animal, and environ- mental health. Humans and animals cannot be healthy if the environment in which they live is sick. The One Health concept seeks to foster improved understanding and collaboration between human, animal, and environmental health professionals.

The One Health concept is important for many reasons. Zoonotic disease risks from wildlife, livestock, and pets cannot be ad- equately addressed without meaningful collaboration and cooperation between veterinary medicine and public health practitioners. Microbes do not necessarily recognize the differences between species and could infect across them if given the right conditions. Indeed, approximately 75 percent of emerging infectious diseases and approximately 60 percent of all human pathogens are zoonotic in origin [1].

Some of the greatest discoveries in the histo- ry of medicine and public health were made at the intersection between human and ani- mal health. For example, Dr. Edward Jenner, an apprentice surgeon, learned from dairy- maid’s that they were immune from smallpox because they had had cowpox. He applied this concept to the practice of vaccination and developed the world’s first vaccine for smallpox, which became the basis for all subsequent vaccines against other infectious diseases. Jenner’s vaccine was used to eradicate smallpox from global human populations [3].

Dr. Louis Pasteur and Robert Koch, a French chemist who studied chicken cholera and a German physician who studied anthrax, respectively, discovered that an arthro- mectomized cells carried immunity and developed the world’s first vaccine, and Dr. Koch developed “Koch’s Postulates” for establishing this concept. In the late 19th century, before the discoverer of ticks as vectors of disease. The world’s last endemic case of smallpox: surveillance and control. Wien Klin Wochenschr. 2002 114 (13-14): 479-81. http://www.ncbi.nlm.nih.gov/pubmed/12162602


Laura H. Kahn, MD, MPH, MPP
Research Scholar
Lisa Conti, DVM, MPH
Princeton University
E-mail: lishua@princeton.edu

The author would like to acknowledge
Dr. Lisa Conti, DVM, MPH
For Small Animals, a Fleck of a Life

The author would like to acknowledge
For Small Animals, a Fleck of a Life

References


Most antimicrobial use is probably inappropriate. It has been estimated that up to 50% of human antibiotic use and up to 80% of veterinary antibiotic use could be eliminated without serious consequences [1]. The inappropriate use of these drugs increases the risk of selection of resistant bacteria and may contribute to antibiotic resistance [2]. Antibiotic resistance has become a global health problem and is responsible for significant morbidity and mortality, and therefore, restriction of antibiotic use and marketing regulations are among many important strategies to control this problem [3,4].

The sale of antibiotics and other antimicrobial medicines without prescription remains widespread, with many countries lacking standard treatment guidelines; thereby increasing the potential for overuse of antimicrobials. However, implementation of the policy is clearly established. Southern Europe, Asia, and North America have the highest prevalence of over-the-counter policy with antimicrobials, which are considered as prescription-only medicines in Finland, were purchased by 41% of the immigrants who admitted having bought an antimicrobial at the pharmacy was only 4% [6].

Prevalence

The prevalence of over-the-counter sale of antibiotics varies across countries, being common outside Northern Europe and North America [5]. The percentage of non-prescription access to antimicrobials is often underestimated, and also depends on the methodology used to estimate it. In 2013, the European Commission published a questionnaire-based study (Eurobarometer), carried out in 28 European countries, including 27,680 respondents, in which 35% admitted having taken at least one dose of antibiotic in the previous 6 months [6]. The large majority of those who had used antibiotics during the time covered by the survey had got them from a healthcare provider, but 3% of users reported to have obtained them without prescription and 2% more stated that they used the leftovers from a previous course. However, when more reliable methods are used the results are much higher. One of the most reliable ways to estimate how frequent the sale of antibiotics is included simulated-client-method pharmacy studies in which actors simulating certain infectious diseases manage to obtain antibiotics at community pharmacies. Table 1 describes the 30 studies published so far and applying this methodology.

In 2007 in Spain, making use of a mystery shopper who presented at community pharmacies requesting an antibiotic for one of three different clinical scenarios, our group observed that these drugs were sold in 45.6% of the pharmacies without a medical prescription [7]. This percentage was slightly higher at 54.1% when the study was repeated in 2014 using the same methodology [8]. However, according to the Eurobarometer, the percentage of Spanish people who admitted having bought an antimicrobial at the pharmacy was only 4% [6].

By contrast with Northern Europe and North America, non-prescription access to antimicrobials is common in the rest of the world [5], as shown in Table 1. In a nice study carried out in a Finnish community with the results are much higher.

Type of simulated patient (D, direct: the patient him-/herself; I, indirect: simulating having a relative or friend with an infectious disease); URTI=upper respiratory tract infection (including sinusitis, sneezing, with or without fever); OM=otitis media; Sin.=sinusitis; LRTI=lower respiratory tract infection; Dia.=diarrhoea; UTI=urinary tract infection; STI=sexually transmitted infection

Various infectious diseases considered; “Mystery shoppers requested ciprofloxacin (33% of success) and amoxicillin/clavulante (100% of success).” Related to a 9-month-old baby with an upper respiratory tract infection and fever; “40% in case of a 6-month-old child and 92% when an adult with this infection was simulated.” Case of a male urethritis; “98% in case of a male urethritis and 65% when a vaginal discharge was simulated;” The direct simulated patient corresponded to the case of UTI; the indirect case corresponded to his 5-year-old son with diarrhoea.
terms of the consumption of antibiotics, as described in the last report issued by the European Surveillance of Antimicrobial Consumption Network (ESAC-Net) [10]. Indeed, over-the-counter sale of antibiotics is reported as common in countries such as Italy, Greece, and Spain [5]. In a study on pharmaceutical surveillance in Spain, Campos et al. observed that about 30% of the outpatient antimicrobials purchased was not identified by reimbursement data, largely because over-the-counter sales were not tracked [11].

Self-medication with antimicrobials is also widespread, occurring among the population in the same countries where over-the-counter sale is available [12]. Antibiotics available at home have been found to be an important risk factor for this practice [13], and leftover medication may later be considered for self-medication, leading to inappropriate usage of these drugs. In a study carried out in 2006, the prevalence of antibiotic storage in Spanish households was 37% [14]. This in-home antibiotic storage might also increase the risk of self-prescription of antibiotics to families and friends. In a population survey conducted in 19 European countries, covering 15,438 respondents, Grigoryan et al. found that the main reason for self-medication was a previous medical prescription of the same medication [15]. Thus, the over-the-counter sale of antibiotics encourages self-medication and the storage of leftover antimicrobials, creating a vicious circle that increases the consumption of antimicrobials (Figure 1).

Public awareness of the issue is low, with many people still believing that antibiotics are effective against viral infections. According to the last Eurobarometer available, carried out in November 2013, 84% of respondents would take over-the-counter antibiotics if they were available [16]. However, many people still believe that antibiotics can be used to cure viral infections, which is related to the related to health or resistance issues in only 30% of the cases and pharmacists only asked about possible allergies, or potential side effects in less than half of the cases [17]. Another inconvenience is the pressure of antibiotic use in its member countries, by promoting the European Antibiotic Awareness Day on the 18 November [16]. Nevertheless, concerns have been raised that such campaigns are not having their anticipated effect [17]. In addition, the recent Eurobarometer stated that 60% of respondents had taken at least one course of antibiotics in the previous year for flu, acute bronchitis, colds, or sore throat [6].

Another factor is patients’ non-adherence to antibiotic therapy. Our group observed an intentional non-adherence to antibiotic regimens of 35% for respiratory tract infections with the use of Medication Event Monitoring System or MEMS contain- ers [18], resulting in the presence of some leftover drugs that might be used on future occasions by the members of the household. Although a relationship between intentional non-compliance and the storage of antibiotics has not been proven, the fact that approximately one third of individuals store antibiotics in their households and a similar percentage intentionally do not take them as requested makes this association very likely.

Over-the-counter sale of antimicrobials often leads to a wrong choice of these drugs. For instance, in our study carried out in 2007, thromboconolones, which are considered as critically important antimicrobials by the World Health Organization as also are third- and fourth-generation cephalo- sporins and macrolides [19], accounted for 40% of the antibiotics sold for urinary tract infections [7]. Similarly, essential anti- bacterial drugs are available without prescription in many areas, with streptomycin, rifampicin and isoniazid being sold for indica- tions other than tuberculosis as over-the-counter antimicrobials [20,21]. This easy access and inappropriate use of these drugs clearly constitute risk factors for further development of multidrug resistant tuberculosis, which is nowadays challenging due to the associated high morbidity and mortality [22]. Over-the-counter sale without a prescrip- tion may also lead to the use of insufficient doses, with lower doses dispensed being more common when the antibiotic is sold at the pharmacies compared to other healthcare facilities [23].

Safety issues associated with non-prescrip- tion use also include adverse drug reactions and masking of underlying infectious pro- cesses (Table 2). Antibiotics frequently cause side effects, despite most being mild; however, side effects accounted for nearly one fifth of all visits to the emergency room for adverse drug events in a US study [24]. Linked to this, low-quality and counterfeit antimicrobials have been more frequently reported among antimicrobials sold without a prescription, mainly in developing countries, resulting in a possible direct harm and treatment failure [25]. Another concern of the non-prescription status is the possibility of drug interactions, partic- ularly in children, elderly patients and preg- nant women. In another study carried out in Taiwan, patients with detectable antibiotic concentrations in urine were nearly twice as likely to have a missed diagnosis of a true bacterial infection compared to the patients without any antibiotic detected [26]. Proper diagnosis of an infectious disease can also be challenging in a pharmacy. Di- agnosis is often even more difficult in the primary care clinic and to distinguish between bac- terial and viral aetiology is even more so, mainly in respiratory tract infections.

Another inconvenience is the pressure of the population on both the pharmacist and the physician. In the first case this pressure is related to the selling of the antimicrobial and in the second, to obtaining the pre-


21 Richard Price, Ana Moragas, Primary care physicians, Primary Healthcare Centre, Via Rama, Barcelona, Spain

Is there a health system in the world at this moment not suffering from the impacts of medicines shortages? With strong docu- mentation of the problem in such coun- tries as the USA [1], Australia [2], South Africa [3], Canada [4] and elsewhere, to the understanding of the pan-European dimensions of the problem was recently added the publication of the report by the European Association of Hospital Phar- macists “Medicines Shortages in European Hospitals” (November 2014) [5].

Distributed across Europe by the net- work of 34 EAHP national country associ- ations [6], over 600 hospital pharmacists from 36 countries responded to a call for information about the problems being faced in practice as a result of medicines shortages. A definitive answer was re- turned: 80% responded in the affirmative that, yes, medicines shortages are a current problem in the hospital the responding pharmacist works in, in terms of delivering the best care to patients and/or operating the hospital pharmacy. Indeed, no country surveyed responded with less than 60% agreement that medicines shortages are a current problem. 88% of the respondents experience medicines shortages at least monthly, with 66% expressing it as a daily or weekly problem.

But what kinds of problem are being cre- ated? The report sheds some further light on the nature of the negative impacts entailed for pharmacists, but above all, patients, when a medicine prescribed for the patient simply becomes unavailable.

For pharmacists, enormous amounts of time can suddenly be absorbed into the pressing task of finding a new source of supply for the medicine. In the European context, this might often be from other countries, with all the delay, and potential knock-on im- pacts for supply in the source country that can be involved [5]. EAHP’s 2014 report finds that 55% of hospital pharmacists in Europe say that up to 5 hours of staff time a week is being diverted from other tasks in order to deal with shortages problems, with a further 32% indicating that more than 5 hours a week is consumed with managing the situations caused by shortages. Indeed, some respondents reported the need to em- ploy full-time equivalents dedicated solely to locating new sources for out-of-stock medicines.

As suggested by the title, however, simply drawing attention to the problems caused by medicines shortages is not enough. Ef- fort, energy and awareness must be drawn to potential solutions. With the cases of shortages acknowledged to be so multi-fac- eted, as well as situation and region-specific, it need hardly to be mentioned that it is a list of mitigating policy actions that are re- quired, rather than any single answer.

The reflections of the International Phar- maceutical Federation (FIP) and, indeed, the regulatory action advocated for by our colleagues at the American Society of Health System Pharmacists (ASHP) have certainly informed the outlook of the European Association of Hospital Phar- macists on the matter of potential solutions to the medicines shortage problem.

In 2013 FIP brought together pharmacy professionals from across the globe in an in- ternational summit on medicines shortages

Richard Price

Ana Moragas, Primary care physician, Primary Healthcare Centre, Via Rama, Barcelona, Spain

E-mail: carlos.llor@mail.com

BACK TO CONTENTS
Approximately how often do they affect your hospital pharmacy experience shortages?

Most hospital pharmacists responded that they are affected by shortages on a weekly basis. Hospital pharmacists are affected by shortages on a daily basis, with 21.1% (n=111) replying that they experience a shortage of a medicine every day. The situation for the majority of those who replied was that they experience shortages at least weekly. 54.2% (n=238) selected this response. 21.2% (n=112) replied that they are affected by shortages on a monthly basis with 12.4% (n=65) stating that they are affected occasionally.

This resulted in a combined 87.6% (n=112) of the respondents replying by saying that they are affected by medicines shortages at least monthly.

Figure 1.

Which type of medicine do you most commonly experience to be in short supply?

According to the respondents they most commonly experience originator (patented) products to be in short supply. 51.8% (n=221) reported them as the most common category of shortage. The situation for the majority of those who replied was that they experience shortages at least weekly, with 45.2% (n=200) reporting a shortage at least weekly.

Meanwhile, in the United States, some case study examples of what can be achieved, at least as interim steps, have been provided via the FDA Innovation Act (FDASIA) of 2012 [9]. This legislation not only clarified the statutory remit of the USAs medicines agencies involved in resolving medicine shortages problem, but also addressed problems in relation to the legal responsibilities of manufacturers to report likely disruptions to supply at an early stage in order to enable better contingency planning. Some early monitoring results from the University of Utah has suggested such action, whilst by no means eliminating the problem, it has proven effective in so far as reducing the difficulties [10].

Drawing inspiration, EAHPs 2014 report on medicines shortages in European hospitals ends with a set of policy calls to political decision makers:

- Improved collection and sharing of information about medicines shortages in Europe, by both national medicines agencies and the European Medicines Agency;
- Clarification and enforcement of legal responsibilities on manufacturers of medicines to report disruptions to supply;
- An inquiry at the European level into the primary factors causing medicines shortages;
- Criteria for a fair distribution of supply in cases of shortage, based on primary consideration of patient need.

EAHPs is now working with counterparts in healthcare professional and patient organisations at the European level to promote this much needed policy agenda [11] and hope that in time a positive European example of response to the shortages problem may yet be provided to our colleagues elsewhere in the world. That work, however, remains ongoing. A new European Commission settlement into its 5 year term of office could provide the opportunity required [12].

References


Richard Price, Policy and Advocacy Officer at the European Association of Hospital Pharmacists (EAHP) E-mail: richard.price@eahp.eu

The countries with highest records prevalence of originator (patented) shortages are Belgium (28.3%, n=49), Spain (24.5%, n=42), Austria (23.3%, n=15) and Slovakia (28.6%, n=14). The pharmaceutical markets of Bulgaria, Ireland, Switzerland, Italy, Norway, France, and Poland also expressed that patented products were the most common category of shortages.

Figure 2. Nature of the shortages reported from all of the responses. N=427

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>51.8%</td>
<td>221</td>
</tr>
<tr>
<td>Generic</td>
<td>36.5%</td>
<td>156</td>
</tr>
<tr>
<td>Originator</td>
<td>5.3%</td>
<td>23</td>
</tr>
<tr>
<td>Unlicensed</td>
<td>11.7%</td>
<td>50</td>
</tr>
</tbody>
</table>

The countries with highest records prevalence of originator (patented) shortages are Belgium (28.3%, n=49), Spain (24.5%, n=42), Austria (23.3%, n=15) and Slovakia (28.6%, n=14). The pharmaceutical markets of Bulgaria, Ireland, Switzerland, Italy, Norway, France, and Poland also expressed that patented products were the most common category of shortages.

The countries with highest records prevalence of originator (patented) shortages are Belgium (28.3%, n=49), Spain (24.5%, n=42), Austria (23.3%, n=15) and Slovakia (28.6%, n=14). The pharmaceutical markets of Bulgaria, Ireland, Switzerland, Italy, Norway, France, and Poland also expressed that patented products were the most common category of shortages.
Do Ethics Need to Be Adapted to mHealth?
A Plea for Developing a Consistent Framework

The rapid development of technology does not stop at mobile devices: For most people, these sophisticated gadgets have become an integral part of their daily life. Smart phones and tablets as well as various wearable devices, e.g. smart watches, perform their duties in an unobtrusive way but still provide users with impressive functionalities that would have been unthinkable of only a few years ago; the sensor technology included in most of these devices can record data relating to many different aspects of the user’s life and these data can easily be stored and evaluated either by the devices themselves or be sent to some remote location for further processing and storage.

At first gaining great popularity with businesspeople as well as private users who feel they can rarely do without their constant mobile companions, the devices have also become accepted in other sectors, including the medical field. Part of this stems from the fact that economists as well as politicians have come to realize that mobile devices along with the (public) health related apps running on them offer great potential for the medical field, not only by improving the quality of care for patients, but also from an economic point of view. Their use in the medical context is manifold. For example, they are regarded as invaluable for prevention, e.g. for monitoring chronic conditions such as high blood pressure or diabetes [1, 2] and improving adherence to therapies. For patients, the main aspect is the added comfort of such mobile solutions compared to conventional methods, while from a professional point of view the difference to a prescribed regimen as well as meticulous monitoring may serve to prevent long-term damages that might be caused as a result of a more careless approach. Nevertheless, despite the perceived benefits mobile technologies can offer in healthcare, the highly sensitive nature of this field of application raises a number of ethical questions that need to be answered [3].

People who use health related apps for recreational purposes, training or other health related tasks are usually considered to be those who provide the apps (vendors as well as developers) follow the unwritten rules with respect to how personal data should be handled or not. They are not necessarily ignorant or careless, but often, they like to think that datasets recorded by the mHealth applications they use are deleted as soon as they are no longer needed or that only they themselves can gain access to their data because they do not suspect anything else. However, there are divergent interests involved that may lead some providers of mHealth apps to collect data and use them for purposes that the users are not aware of (and would never or only hesitatingly acquiesce to if they were told), e.g. marketing. The consequences of this ‘misinterpretation’ of the other party’s goals are not trivial. This is not about whether people should clap hand in the British House of Parliament or not – it is about serious issues regarding autonomy, participation, personal health, economy and public interest. Different interests and different notions about what should be done cause tensions and conflicts of goals and norms. Conflicts like these are well known to medicine at large, but mHealth in its ubiquity, availability and accessibility may provoke a new and enhanced debate about some ethical aspects that are already being discussed in medicine in general. The power of mHealth apps to medicalise the behaviour of individuals causes us to start a debate about ethics in mHealth. Users often make excessive use of mobile technologies when it comes to monitoring their health because they have been told this may help to reduce their risk for disease. Also, they believe that being well informed may also serve to mitigate potential risks. At the same time apps have already proven to be effective tools for boosting adherence to therapies (for example, via text messaging reminders) or for disease management [5]. However, these developments go hand in hand with technical challenges and ethical concerns: Above all, the medicalisation of apps results in limited consumer choices. This refers as much to using the apps by themselves as to targeted advertising users may receive which is specifically adapted to their “health-related data or their health profile. Consumers may be led to think that they need certain apps or commercialized products for their well-being. Having these radical examples in mind, we believe that it is essential to transparently describe what people using mobile devices for mHealth can expect from mHealth providers. Thus, mHealth ethics is not so much about finding out which rules people want mHealth providers to follow, but about which rules mHealth providers promise to follow in the future.

Our objective in this article is to provide some starting points for the clearly needed discussion about ethics in mHealth. Therefore, after an introductory definition of what constitutes ‘mHealth’, we outline how the fundamental principles of medical ethics as they are described in several standard codices can be transformed in order to make them applicable to mHealth. In a nutshell, we propose mHealth specific ethical principles to be developed that – while they are still based on established principles and guidelines – also take the specific requirements of mHealth under consideration.

What Constitutes mHealth?
As specified by the WHO’s Global Observatory for eHealth (GOe), mHealth, also known as mobile health, can be seen as the ‘medical and public health practice supported by mobile devices, such as mobile phones, personal monitoring devices, personal digital assistants (PDAs), and other wireless devices’. [6] However, considering the rapid technological evolution that of course does not stop at mobile devices, this definition (dating back to 2011) falls short of what is possible nowadays. Even sensors commonly found in mobile devices but developed with entirely different fields of application in mind are often used for medical and health related purposes. Apart from applications making use of sensor based data, there are also those that aim at providing users with health related information, while even others target bio-medical research or can be used for (preventive) healthcare. Often, it is impossible (and not even desirable) to clearly distinguish between these areas, since they all make use of monitoring, recording as well as surveillance functionalities and there are many overlaps. A ‘definition’ guideline has been provided, for example, by the FDA in their guidance ‘Cautions for Industry and Food and Drug Administration Staff – Priority Review of Premarket Submissions for Devices’ [7] revised on February 9, 2015. Also, the manner in which mHealth is or shall be understood means that the access to health related services is no longer restricted to time or location, i.e. getting to a doctor’s office or a hospital at a specified time. Instead, by using mHealth technologies, users can gain access to an impressive number of health related services whenever they need them [5].

Evaluating Existing Biomedical Principles and Codes
Due to the vast number of imaginable areas of application for mHealth solutions, starting with their use in private settings in the patient’s home and further extending to remote monitoring of various data as well as large scale collection of health related data for biomedical research (the so called “big data” approaches [8, 9]), many different levels of ethical norms are affected and must be considered. For example, as soon as data originally recorded in a care context (additionally evaluated in a research project, research ethics need to be included in the equation. On the other hand, if mobile devices are employed to record physiological parameters (independent of whether this patient care or research in mind), patient autonomy as well as the patient’s right “not to know” must be respected. Also, sometimes, the target oriented approach commonly used in medicine, namely, research vs. treating patients, stands in the way of applying the value-rational principles of medical ethics as would be appropriate. And lastly, the use of mHealth may also influence the relationship between patients and their physicians. A striking example is the reference to the traditional issue of confidentiality: mHealth app users might use them to communicate their disease specific parameters with their physician, either actively, for example, via text messaging or passively by having their data monitored. This communication can only be frank, truthful, true and free of manipulation if confidentiality is a crucial element of patient-physician relationships, is guaranteed. For both sides, confidentiality is of utmost importance and this also holds true for third parties because this is essential for guaranteeing mutual respect, full disclosure of symptoms to the physician, and may also want to influence the behavior of consumer in one or the other direction. Here, specifically the above mentioned traditional concepts like autonomy, confidences, beneficence and nonmaleficence are at stake. At the same time and on another level, a consumer using mHealth may have the impression that the promise of confidentiality commonly applied in medical contexts also extends toward mHealth settings in general and, his or her health related data are also protected similarly. However, many mHealth providers have a more or less legitimate interest to simply make use of the data they obtain. Additionally, the interest in data does not stop with researchers. Public health officials, “a medical police”, insurers or employers might also have interest in these data to increase their chances on the market by choosing the clients or employers with the best risk profile. Transparency usually has a good reputation, but from a patient perspective, mHealth transparency interpreted in this manner may go too far.

As a first approach, we would therefore suggest to follow the classical codes of medical

Codes of ethics that are already available and deal with issues related to the consequences of using technologies, public health [11], research [10, 12], or telemedicine both as well as the general use of internet based services [14] or other subject areas such as medical informatics [15] also need to be scrutinised with respect to their applicability to the mHealth sector.

However, such an analysis reveals that there are certain dimensions that might be in conflict with each other. For example, while a user may simply want to have his or her data monitored to stay healthy and an employer may want to be able to participate in public, mHealth providers may rather have the collection of data for research or marketing purposes in mind and may also want to influence the behavior of consumer in one or the other direction. Here, specifically the above mentioned traditional concepts like autonomy, confidence, beneficence and nonmaleficence are at stake. At the same time and on another level, a consumer using mHealth may have the impression that the promise of confidentiality commonly applied in medical contexts also extends toward mHealth settings in general and, his or her health related data are also protected similarly. However, many mHealth providers have a more or less legitimate interest to simply make use of the data they obtain. Additionally, the interest in data does not stop with researchers. Public health officials, “a medical police”, insurers or employers might also have interest in these data to increase their chances on the market by choosing the clients or employers with the best risk profile. Transparency usually has a good reputation, but from a patient perspective, mHealth transparency interpreted in this manner may go too far.

As a first approach, we would therefore suggest to follow the classical codes of medical
Health Apps – Sound and Trustworthy?

The App Market, Health Apps and Medical Apps

The smartphone and app hype really started in 2008 when 500 apps were made available on one app store [3]. In May 2015, the number of offered apps had already grown to the formidable number of 3,730,000 [4] for four mobile platforms in five app stores. The continuing growth of the app market in general also applies to apps for health and fitness and, in fact, some analysts predict that this part of the app market will have the largest percentage change [5]. Recent estimates are that there are about 100,000 mHealth apps [6] with an estimated growth of about 1,000 apps per month [7]. An exact number for mHealth apps cannot be determined since the app stores only offer very basic rules for assigning apps to one category or another. Rather, this is left to the manufacturers, who will often choose a category that promises better sales. To clarify the classification and to give users a better understanding, we recommend the following to clearly differentiate between health apps and medical apps [8]. While, following the WHO’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” [9] – the term “health apps” encompasses a wide range of health related apps, “medical apps” are primarily intended for treating or preventing illnesses or injuries.

Risks and Limitations

The relevance of this categorization becomes apparent when one considers the potential risks and ramifications that may arise in the intended field of application. For medical apps, the inherent risks of causing harm are considerably greater, since their focus is primarily on diagnosing or treating patients – supported by the app and the mobile devices they run on – whose health is already compromised in some way. However, desired success may either fail to materialize or, in a worst-case scenario, it may come to an excruciating or additional health problems. Of course, this outcome is highly undesirable.
not only for the patients themselves but of- ten also for the medical staff, their employ- ers, as well as the manufacturers. There exist many possible sources of risks and the fol- lowing paragraphs will mention the most obvious ones – the list is by no means ex- haustive. Roughly speaking, two areas where problems can arise is discerned:

1. The app does not do what is supposed to do? This sentence and other simi- lar utterances, often voiced by discon- tented users, for example in user com- ments that they leave on the stores, is often caused not only by shortfalls in performance that may for example be caused by technical limitations of the devices used to run the app, but also by programming errors, deficiencies of the content or simply bad usability.

2. “The app does more than it should!” This is often caused by non-obvious “features” of an app, for example when data protection and data security or the user’s right to self-determination are compromised. This may be caused either with or without intent, e.g. by failing to observe due security measures when dealing with this highly sensitive type of data, lack of providing users with adequate information regarding data handling, as well as unclear, secret and illicit data transmission and evaluation.

The App as a Medical Device

Although many aspects of the app business seem to be like a “wild west” scenario at least some apps, namely, those where the manufacturers have specified that they are a “medical device”, have to conform to the of- ficial regulatory requirements that apply to such products. However, whether these re- quirements apply also depends on whether the manufacturer has assigned a medical pur- pose to his product, in this case the app. Going through the processes is often time-con- suming and costly. Thus, although some apps can be medical products and would therefore have to comply with regulations for such products, manufacturers often avoid or ignore this due to the considerable hurdles raised by the necessary regulatory processes. Currently, compared to the number of available apps, only a relatively small number of apps have so far gained approval by a federal authority (e.g. by the Food and Drug Administration in the USA) or passed an assessment following the federal laws of other states (e.g. conformity assessment for European countries). The im- possibility of closer scrutiny of all apps by the authorities, which would be appropriate, can also be easily explained by the sheer number of apps and additionally contributes to the uncertainties in this area, although the intent of regulation is to protect patients as well as users of these products. An exhaustive over- view of the subject of “apps and regulations” can be found in [10].

Available Information Is Not Always Reliable and Information Is Only Rarely Available

Users often rely on comments made by other users on the distribution platforms. Such com- ments can be easily created and publicized. The more “stars” and positive comments an app has received, the greater its influence towards presenting it to users as well as for the search algorithms of the stores. However, these comments and ratings are not subject to any review and do not follow any standards. They can be freely assigned and given pseudonymously. Their quality is often questionable, but still they are generally the main source of information for those interested. Other information can usually only be found via time-consuming searches: blogs, evaluations done by (private) initiatives or databases containing specific in- formation provided by the manufacturers that are often not widely known. If available, peer reviews of apps or corresponding scientific studies provide more reliable information, but finding this information often requires con- siderable effort on the user’s part.

Which Information Is Important for Making a Decision?

For users, the situation is quite chaotic due to the vast number of available apps. Identifying apps that match the desired use and are trustworthy is like a mixture between finding a needle in the haystack and playing Wheel of Fortune. The emphasis of available information is often on marketing aspects and infor- mation that can support the claimed credibil- ity and trustworthiness can rarely be found. Alternative sources of information need to be identified and are often only available some time after an app has been published. Certifi- cations are also rare and they often suffer from questionable credibility. There are even fewer apps conforming to regulatory standards. What can be done to make things work?

Sensitizing Users as well as Manufacturers Combined With Standardized Information

Users need reliable applications, especially where either their own health or that of the patients they treat is concerned. This is not only an ethical imperative, but also a strict requirement. Users first of view (buzzword: “medical device”). Imprudent use of apps can cause serious harm. There is no alternative to requiring manufacturers to actively provide reliable and trustworthy apps and corresponding information. Ex- erting pressure will work best if sales are af- fected. In order to enable users to use their power in this context, they need tools that can support them in their decision whether to purchase an app or not. Information to be used towards this end may be gained from a number of different sources. For example, it may be based on standardized reporting mechanisms of such as an app synopsis [4, 10] which covers all important aspects and provides the crucial information in a single location. Information covered by the synop- sis includes, but is not limited to, that the manufacturer or distributor of an app and his associates as well as the experts involved in the development, as well as the ratings behind the app, i.e. its intended purpose(s) and target audience. It also makes provi- sions for aspects such as functionality and reliability of the app as well as data acquisition, data transmission and storage and, of course, also calls for information on how data protection and privacy are handled. A more exhaustive description of the app syn- opsis can be found in [8, 13, 14].

Transparency as an Added Value

The situation in the market can be improved as soon as manufacturers acknowledge that providing transparent information about their product can significantly contribute towards an app’s perceived quality. Users will appreci- ate the added value they receive via this trans- parent reporting. For manufacturers, it is an easy task to compile the information point by point and to publish it, for example on the app stores, since they already possess the necessary knowledge. Thus, users have a fair chance to inform themselves about an app even before they download it. For users, this is only possible since they are also affected by the potential consequences of using the app. This can serve both as an important confidence building measure as well as towards improving sales. Just providing this information does not suffice as in addition users must be made aware of the inherent risks of apps that are to be used in a health context and they must also learn to ask the right questions. Educating users towards this goal is imperative.

Conclusion

One objective of the article was to present aspects relevant for assessing the trustwor- thyness of a health related app, while also sensitizing readers to what needs to be in- cluded when developing the development phase of a trustworthy app. Only based on trust- worthy apps will it be possible to fully re- alize the potential apps offer for healthcare without risking to lose the trust users place in them – only an app that can be used without any problems will be a success.

References

Interview with Vytenis Andriukaitis, EU Commissioner for Health and Food Safety

By Dr.Petris Apinis. June, 2015

Vytenis Andriukaitis

Q. The half year of the Latvian Presidency of the Council of the European Union has come to an end. As to healthcare, we have organised a number of European-level conferences on the topics of healthy lifestyles and nutrition for children, tuberculosis, eHealth, popular sports, healthcare financing as well as addressed a number of other important issues. How do you evaluate Latvia’s performance in its half a year of presidency?

A. I would like to congratulate Latvia for achieving its objectives in delivering results on a set of priority issues during its Presidency of the Council of the EU. Latvia took up the Presidency at a very important moment and at a crucial time in the development of the European Union. The Presidency has contributed to the discussions on how to create efficient, equitable health systems.

Q. Currently there is a tendency all across Europe that patients obtain information about diseases and health from the Internet or magazines. Over 80% of Internet portals and social sites which are dedicated to health topics are financed by businesses: drugs, dietary supplements or a special method. More often than not, it is difficult for patients to discriminate between the truth about health and surreptitious advertising. As to Latvia, is there even a publication, the magazine As joti tev Nenostas (What Doctors Don’t Tell You), advertising dietary supplements, Ayurveda, unjustified diets, and at the same time discouraging people from vaccination and explaining about the dangers of vaccinations? What could the European Commission do in order to present information on the need of vaccination in an equally attractive manner from the visual and informative point of view? Is there a common immunization calendar in Europe? This issue is more and more topical due to the increasing labour mobility in Europe. Children are moving along with their parents. Each single country in Europe has its own vaccination calendar, which is the reason why many children do not get adequate vaccination and immunization. Shouldn’t such vaccinations as against diphtheria, polio meningitis, tetanus and some more be declared as mandatory, to be administered according to strictly defined time schedule, whereas the rest (rotavirus, German measles, pneumo-cocci) could be left on the national level? Isn’t it high time that we have a mandatory requirement to vaccinate all immigrants from third countries because their earlier vaccination is unreliable?

Q. In Europe, the manufacturing and distribution of dietary supplements is becoming increasingly widespread. Contrary to drugs, the supervision of manufacture, distribution and advertising of dietary supplements is much more lenient. As a rule, dietary supplements contain chemically active substances: vitamins, minerals, and their derivatives. As to Latvia, there is even a publication, the magazine As joti tev Nenostas (What Doctors Don’t Tell You), advertising dietary supplements, Ayurveda. In Latvia, there is even a publication advising people to vaccinate their children against diseases, which is the reason why many children do not get adequate vaccination and immunization. Shouldn’t such vaccinations as against diphtheria, polio meningitis, tetanus and some more be declared as mandatory, to be administered according to strictly defined time schedule, whereas the rest (rotavirus, German measles, pneumo-cocci) could be left on the national level?

A. Isn’t it high time that we have a mandatory requirement to vaccinate all immigrants from third countries because their earlier vaccination is unreliable?

Q. More often than not, the pharmaceutical business in Europe would not supply all countries with drugs on equal terms, and the prices vary significantly across the countries. If there were a common pharmaceutical policy for Europe, would what be the effect be like?

A. At EU level, prices of medicines are under the responsibility of Member States. The only field of EU regulatory intervention is the so-called “transparency directive” (Directive 89/105/EEC) which lays down rules for regulating prices of medicines and their inclusion in the scope of health insurance systems. I am keen to foster discussions and support co-operation between Member States in this area so as to make medicines more affordable and accessible to patients. I am encouraged by recent developments including new conclusions whereby Member States have agreed to exchange information about the prices of innovative medicines; about on-going discussions on this issue, as well as emerging pilot project amongst some Member States. Other challenges of pharmaceutical policy in Member States that also gained attention lately at EU level relate to the optimal use of current regulatory framework, the Member States in all relevant cases and the bilateral agreements between member states. Such issues also relate to the efficiency of pharmaceutical spending, i.e. the capacity to get the most value from today’s expenditure while keeping appropriate incentives for future innovation, associated with challenges for affordability in some countries. It is agreed in the Council that further cooperation between Member States is needed in such areas and the Commission is ready to further cooperate based on an integrated approach and a long term agenda.

Q. Today, health and of polypragmasia in senior citizens is becoming an ever increasing problem all across Europe. On average, each senior citizen in Europe consumes 6.4 various drugs daily. Doesn’t the pharmaceutical business have a too heavy influence on the healthcare system?

A. Demographic and epidemiologic trends, together with a range of other factors as pharmaceutical industry’s own dynamics, changes in medical practice and pharmaceutical policies influence pharmaceutical spending, which is an important component of healthcare expenditure in Member States. In addition, changes in the therapeutic mix of medicines used that occur with new treatments can also influence the share of the overall pharmaceutical bill accounted for by hospitals. The use of multiple medications in elderly increases the possibility of adverse reactions to drugs, increases the risk of hospitalisation, of medical errors caused by these medicines and may question the quality of healthcare in general. This is an area of Member States competence; however, the Commission supports Member States to exchange experience and in particular on developing of tools and methodologies to assess the quality of care.
tion resists to introduce the third sports class per week. Could the European Com- mision be more active in making the national governments to introduce daily sports classes for children? I regret to report that the figures are even worse. One out of three children in Europe in 2010 was overweight or obese. This is a major increase compared to 2008 when one out of four children was overweight or obese. Member States play the key role in providing education for school children in relation to nutrition, physical activity, overweight and obesity – and this is something most are addressing. I am ready to use all the tools at my disposal to support them in their efforts to promote healthy lifestyles. The Commission is working with Member States in this regard within the High Level Group on Nutrition and Physical Activity. In 2014 this group adopted an Action Plan on Childhood Obesity with the aim to prevent the increase in obesity in children by 2020. A Joint Action on Nutrition and Physical Activity will start after the summer period to further support Member States in the implementation of this Action Plan.

Q. In Latvia, the attitude of the Minis- try of Education to children's health is quite an issue. Since 2002, health educa- tion is no longer in the school curricula. The situation (i.e., no health education for children) is similar in many countries in Eastern Europe. Could the Commis- sion consider that making the Eastern European governments more active in regard to educating children in the basics of health? Again, the competence in the field of educa- tion lies with the 28 EU Member States. However, under the EU Strategy on Nutri- tion, Overweight, and Obesity-related Health Issues, the Commission is working closely with the national governments to promote healthy lifestyles in children. The High Level Group on Nutrition and Physical Activity brings together governmental experts that promote and exchange best practices in this area. The promotion of healthy environments, especially at schools and pre-schools, is one of the key areas of the 2014 Action Plan on Childhood Obesity.

Q. In terms of percentage of GDP, Latvia has the highest healthcare expenditure in Europe; it is less than 3%. Could the European Union make a pressure on na- tional governments that the accessibility to healthcare services for population is a priority and thus healthcare financing throughout Europe should be at least 4.5% of GDP? The Commission acknowledges that healthcare systems need to be reformed to provide accessible and quality health- care through efficient structures. Sustainable- challenges of healthcare systems in the EU are assessed and monitored within the process of the European Semester.

Under the 2014 European Semester Latvia received for the first time a country-specific recommendation (CSR) calling for the reform of its health system with concrete, targeted areas including the quality and acces- sibility. Since then, the Latvian govern- ment increased the health budget by € 31.2 million in 2015 compared with 2014 and approved a € 30.6 million increase each year until 2017. But even with this additional funding, still below 3% of GDP, the finan- cial burden on patients in Latvia remains very high and accessibility is still a prob- lem. Therefore, in 2015 the Commission once again proposed the same health CSR to Latvia, and we will closely monitor its implementation.

The Commission provides help and sup- port, which is what countries are facing difficulties need. For example, Member States can make use of the European Strategic and Investment Funds (ESIF) for health investments. I welcome the commit- ment made by the Latvian authorities to use ESIF for better access to healthcare, especially for those socially and territori- ally excluded. For the years 2014–2020 the health infrastructure allocation for Latvia exceeds €152 million and further allocati- ons have been programmed for measures such as health promotion and prevention, enhancing qualifications of the medical staff and health.

Position of Israeli Medical Association in Forced Feeding Issue

Hunger strikes have been used as a means of non-violent resistance by political prisoners throughout history in an effort to achieve specific objectives. Famous examples include Mahatma Gandhi, British and American suffragettes, and the Irish Republican hunger strike of 1981. In Israel, Palestinian detainees and prisoners have used the hunger strike as a tool for soliciting acquiescence to their de- mands. Over one thousand hunger strikes have occurred in Israel to this point. In general, these hunger strikes began in the facilities of the Israeli Prison Services (IPS), and, when the prisoners’ medical condition deteriorated, this stage was followed by hos- pitalization in public hospitals. The hunger strikes lasted everywhere from several days to weeks and months, during which most, though not all, prisoners drank and agreed periodically to undergo tests, and take vita- mins and carbohydrates intravenously. Each time, the duration and extent of cooperation with IPS and/or hospital physicians varied. No detainee or prisoner in Israel has ever died during a hunger strike.

In the early months of 2014, the Israeli Medical Association (IMA) became aware of legislation being prepared in Israel that would allow the forced feeding of prisoners. The IMA immediately requested a meeting with the Ministry of Health and the Minis- try of Justice, in which we expressed, in no uncertain terms, our complete opposition to such a bill and the fact that we would in- struct our physicians not to cooperate with it. We followed this letter with a letter to then Justice Minister, Tzipi Livni, explaining our strong ethical position.

Our objections notwithstanding, the Minis- try of Justice continued work on the bill and brought it before our Parliament (the Knesset). We sent a letter to the Knesset members before the bill was considered in the Knesset, but unfortunately it passed this commit- tee. Although we urged those Ministers

References

Q. Shouldn’t public health issues override the national level? For example, isn’t it the time for the European Union to declare that it has a common policy as to pesticides and other substances which inhibit the de- velopment of hormonal system? Isn’t it the time to have a common European strategy in place for reducing the consumption of alcoholic beverages and tobacco products, and for prohibiting trans fatty acids? The overriding principle of EU health pol- icy is that human health is well protected and accounted for in the development of all EU policies and activities. All EU policies are required by the EU treaty to follow this “Health in all Policies” (HIA) approach. Taking some of your specific examples: Endocrine disruptors are already regulated in some sectors. Currently, the European Commission is working on an impact assess- ment to analyse different options for defining the criteria for the identification of endocrine disruptors in the context of the plant protection products and biocidal products regulations. The decision at EU level concerning the criteria will be made once the impact assessment is concluded.

On alcohol, whereas the main responsibility for public health interventions lies with Mem- ber States, the Commission will continue to support them in reducing alcohol related harm. This will be done based on the objec- tives of the 2006 Strategy and by making use of existing structures like the Committee on National Alcohol Policy and Action. In line with the Commission’s “Health in all policies” approach, we will further consider how to en- shrink alcohol harm into a holistic approach to reduce the burden of chronic diseases.

Q. Would you agree that the vast dif- ference as to the availability of medical services is actually a shame for Europe? Maybe it is the time we start considering a common European health strategy, uni- fied health tax, unified standards for emer- gency medical care and first aid? At present there is no unified health sys- tem policy in the EU: it is for Member States to decide which services to provide to their citizens and how this should be funded. However, the EU does have a role in supporting Member States and we are actively working on ways to try to help them increase availability of services. The cross-border healthcare Directive makes it easier for patients to access services in other Member States. We are in the pro- cess of setting up European Reference Networks which will bring together cen- tres of expertise for conditions or treat- ments where expertise is rare: these will act as a resource for all Member States. We are working together to deliver the consider- able potential benefits of Health Technol- ogy Assessments and eHealth. And we are increasingly looking at the question of collaboration in border areas can improve the delivery of health services.
who opposed the bill in the Committee to appeal the decision, the bill continued to a first review in the Knesset plenum, where it passed.

Seeing that the bill was progressing, and against the backdrop of a mass hunger strike in the Israeli prisons in June 2014, the IMA and its Ethics Bureau convened an emergency consensus conference, under the title “Treatment of prisoners/detainees on hunger strikes – the medical challenge.” Participating in the conference were representatives of the IMA scientific associations, members of the IMA ethics bureau, representatives of the Ministry of Health, the National Council for Bioethics, IPS physicians, representatives of the International Committee of the Red Cross and others.

At this conference, IMA officials made it clear that the law does not change a doctor’s ethical obligations not to coerce feeding on a competent individual. At the end of the conference, all parties agreed on a list of principles which can be viewed on the IMA website [1].

Recently, Gilad Erdan, the new Israeli Minister for Interior Security, announced plans for the provision of medical care and/or nutrients (including force-feeding through a tube) despite the active opposition of the physician.

In our view, the proposed law is both unethical and unrealistic and does not help solve the problem. It creates an illusion that forced feeding will prevent medical harm to the patient, whereas the opposite may in fact be true. We cannot approve a law that puts physicians at the forefront of a policy – both as a group and as individuals – which is against their professional and ethical obligations.

The fundamental change underlying this proposal is in contradiction with and contrary to the accepted medical ethics in Israel and throughout the world, including the IMAs ethical Code and the WMA’s Declaration of Tokyo and Declaration of Malta, which recognize it as a form of inhuman and degrading treatment.

The IMA is strongly opposed to the intended force feeding law. Our opposition was expressed to the government offices and representatives of the attorney general at every possible opportunity. We are prepared to continue to protect the doctors at all levels, including in the public sphere and parliamentary level, in order to thwart the legislative process.

We know our hospital doctors will be presented with ethical dilemmas and be placed in an impossible position professionally. Therefore, we have established a hotline for these physicians to call with any questions they may have, as well as professional and ethical guidelines that we released in a handbook following last year’s mass hunger strikes.

Our concern is that the proposed law will move quickly through the legislative process and we are taking measures to ensure that it does not materialize. The IMA took out paid announcements in major Israeli newspapers (in addition to regular press coverage on the matter) explaining our opposition to the proposed law.

The World Medical Association (WMA) has also been a steadfast partner in our struggle against this unethical bill. On June 22, Drs. Deau and Hoven sent a letter to Prime Minister Benjamin Netanyahu explaining the WMA’s position and its support of the IMA, and the inevitable international condemnation that would follow the passage of such a law.

In its letter, the WMA stated the following:

“Over the past four decades there have been clear directives developed on what physicians can do, and from what they must refrain. Clearly torture, inhuman and degrading treatments are nothing with which a doctor should be involved in any way. Force-feeding is violent, very painful and absolutely in opposition to the principle of individual autonomy. It is a degrading, inhumane treatment, amounting to torture. But worse: It can be dangerous and is the most unsuitable approach to save lives.

The evidence from many cases around the world that our colleagues have been working on over the past four decades shows that the best results are obtained when the patient/physician relationship is maintained, even under the difficult circumstance of a hunger strike. This includes patient confidentiality, proper medical care and advice by the physician, but also respecting the free will of the patient. Force-feeding is completely incompatible with this and destroys any patient/physician trust.”

We are determined to prevent force feeding in Israel and we will continue to support our physicians and remind them of their ethical obligations.

References

Dr. Leonid Eidelman, President, IMA
Malke Borow, Director, Division of Law and Policy, IMA
E-mail: malkeb@ima.org.il