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

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

Assistant Editor
Maira Sudraba, Velta Pozņaka; lma@arstubiedriba.lv

Journal design and cover design by
Pēteris Gricenko

Layout and Artwork
The Latvian Medical Publisher, "Medicīnas apgāds", President Dr. Maija Šetlere, Skolas street 3, Riga, Latvia

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Clean Technologies Can Change the World

As I reflect on the activities surrounding COP 21 – the United Nations Climate Change Conference, currently being held in Paris – what disturbs me most is the manner in which climate change is being presented and discussed.

We hear forceful declarations from stakeholders in the debate that climate change is a huge and expensive problem and that we have to act for the sake of future generations.

How in the world can you motivate people by asking them to pay to solve a huge problem with no immediate benefit? Rather than hearing about expensive problems, people are looking to be inspired by solutions that provide an immediate economic reward. And this is exactly what fighting climate change can offer today if we accept to modify our understanding of the situation.

When I was trained as a medical Doctor, I learned that a 'problem' is called a 'symptom'. Every symptom has an origin, and by studying that origin, we can find a treatment. In the case of climate change, CO_2 is not the problem; it's only the symptom – the symptom of our crazy manner of using and wasting energy.

Nevertheless, we see people continuing to fight against the symptom, citing CO_2 emissions as the source of the problem. We have the ecologists who are advocating that we decrease our mobility, our comfort, our economic development and our growth. But really, who would want that? Then, we have those who resist measures to reduce CO_2 emissions for the sake of employment and profit. Having two camps fighting each other will not solve the climate change issue. It will continue to polarize the debate and lead to paralysis.

Looking at how we consume energy and in particular the resulting waste will go a long way in helping us better understand the real issues at stake. The technologies we use today are 100 years old! They present a complete lack of efficiency compared to the clean technologies available: our combustion engines are three times less efficient than electrical ones; light bulbs create more heat than light and in turn require cooling devices; poor insulation of buildings and single glazed windows continue to run up our monthly electricity bills; and, heating and cooling systems, as well as industrial processes produce more losses than efficiency. Why are we so demanding about modern information technology and so relaxed about energy efficiency? Could Paris be the first Climate Conference that looks at energy efficiency as a solution for climate change?

Bertrand Piccard

When I initiated the Solar Impulse project to fly a solar powered airplane around the world without a drop of fuel, it was precisely to demonstrate that clean technologies can achieve the impossible. We can reach more with renewable energy and energy efficiency than with fossil fuel. And all the technologies we use in the sky could be used today to run a cleaner society.

Unfortunately, our world continues to react to the issue of wasted energy by trying to produce more and more energy, either fossil or renewable, instead of opting for efficiency. Is this rational? Would you fix a leak in your bathtub by turning up the water faucets or would you call a plumber to try and identify where the leak is coming from?

This means governments should start to focus on how to replace these old polluting devices with clean technological solutions. Our society has regulations for hygiene, health, taxes, justice and education, but nothing prevents us from wasting energy with outdated technology. Can you imagine how many jobs would be created, and how much profit made, if everyone rallied behind this new market? Lets stand up against those who say that solving climate change will jeopardize our economic development. It›s precisely the opposite!

My fear for COP 21 in Paris is that climate change stakeholders will look at taking measures, which will be unacceptable. Developed countries will be asked to pay for the pollution they have caused, while poorer countries will be asked to renounce on economic development to which they are entitled. The result will be wide-scale resistance! Targets for CO_2 reduction and minimum temperature increases become wishful thinking if they are not addressed with profitable solutions that will help reach them. That's where the focus of the debate is needed: discussing which clean technological solutions are the most relevant and directly profitable for which region of the world and what type of economy?

Can you imagine the motivation of every country that could then trade a costly sacrifice for a profitable investment? Clean technologies impact climate change while at the same time being profitable, creating employment and stimulating economic development and growth. This is why we should choose the clean technology revolution, even if we were not facing any climate change issue at all...

Dr. Bertrand Piccard, Initiator,
Chairman and Pilot of Solar Impulse, http://www.solarimpulse.com

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Valedictory speech

Dr. Xavier Deau, WMA General Assembly, Moscow 16 September 2015

Dear Presidents and Chairpersons,
Dear Colleagues,
Dear Friends,

I am particularly honoured and pleased to welcome here in Moscow the 116 members of our world medical association or their representatives.
As it happens we are holding here in Moscow not only our 2015 General Assembly but also the 201st WMA Council Session and the Annual meeting of junior doctors.
I wish to thank the Russian Medical Society for their friendly welcome and efficient organisation.
Thanks are also due to the Russian Government and the Moscow City Council for their support.
As I open this General Assembly, I believe it is appropriate to recall the goals of the World Medical Association.
Our aim is to serve mankind by striving to achieve the highest international standards in terms of medical education, medical science, medical art, medical ethics and medical care for all the peoples of the world.
The world is currently undergoing major upheavals. More than ever the medical profession and our associations must be present and play an active role on the global scene.

Climate change.
A very last chance of reaching a consensus on global warming will come up at the COP21 meeting in December in Paris. Physicians are called upon to deal with the consequences of climate change on human health worldwide.

Geopolitical upheavals
Migrant populations requiring immediate health care, irrespective of their language, culture, religion or skin colour.

Upheavals due to armed conflicts
Here again doctors should guarantee high standards of medical care in safe conditions, for both patients and medical staff, consistent with the ethical standards of our World Medical Association and our Health Care in Danger programme.

Scientific upheavals
With a very rapid evolution of medical science and new technologies requiring an urgent updating of medical training.
Throughout our discussions at this General Assembly, we must therefore insist on the absolute necessity of enforcing strong ethical values, particularly as regards the autonomy of physicians.
Medical autonomy is without doubt an overarching ethical value inasmuch as it guarantees patient trust, professional confidentiality and the protection of personal data.
It also means a respect for human beings, for their enlightened consent or acceptance, their vulnerability and their rights as human beings.
I am, we are all, concerned by these upheavals which result in social and political situations that impact negatively on human health, mainly on the poorest.
The WMA, our National Associations, each and every one of us individually, all must work together, in a spirit of brotherhood, equity and solidarity, with full respect for the basic values of medical ethics.
We should avoid all forms of fundamentalism, be it social, political, professional or religious, whilst preserving our own personal professional freedom – such are the stakes if we are to safeguard the physician's autonomy.
Medical autonomy impacts directly on all our patients as well as on our ability to care for foreign or migrant patients.
A flood of migrants is fleeing violence and the fundamentalism of certain ideologies, bringing us back to the historical and ethical origins of our World Medical Association.
Let us accept these people and give them the medical care they require.
For such is our simple duty, our contribution to the survival of peace in the world.
Amidst these upheavals the physician is at the forefront of the quest for peace and equity, for he is expected to provide an immediate medico-social response to the social determinants of health.
Let us help our medical associations, our physicians to provide quality medical care for all human beings. In full independence, full confidence, whilst such are the values I strove to promote through my one-year mandate as your President.
Before I conclude, I would like to express my personal gratitude to WMA Council members, Chaired by Dr. Mukesh Haikerwal and subsequently by Dr. Ardis Hoven as well as the secretariat as a whole under Dr. Kloiber's leadership. My thanks also go to our Past President Margaret Mungherera for her brave involvement in the African project. I also extend my best wishes to Sir Michael, who will take over the Presidency with his well-known dynamism, enthusiasm, and joie de vivre.
My warmest thanks also go to our devoted office staff, Sunny, Clarisse, Anne-Marie, Julia, Roderic and Lamine.
Thank you all for the high standard of your contributions. Let us continue to bear witness to and actively enforce the ethical values of the World Medical Association.
In view of the serious problems we face, we should continue to provide leadership for all our medical associations.
It is our duty to combat violence relentlessly by providing quality medical care for all.
Let us be proud of being physicians.
Let us be proud of our World Medical Association.
Let us be proud of serving peace for the welfare of mankind.

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Inaugural Address as WMA President

Sir Michael Marmot, WMA General Assembly, Moscow 16 September 2015

Honoured Guests, Colleagues,
In May 2011 Mary hanged herself. She was found in the yard of her grandparents' house on a First Nations Reserve in the province of British Columbia in Canada. She was fourteen. She was a First Nations, aboriginal, Canadian.
Her story has particulars. All suicides do. She had been physically and emotionally abused at home and in her community, and possibly sexually abused. Her mother was mentally unstable and heard voices telling her to 'snap' her child's head. Officials attributed the suicide to a dysfunctional child welfare system, and to the fact that no one took her complaints of abuse seriously or acted on them.
There is another way to look at Mary's sadly foreshortened life, and that is to realise that though her personal tragedy was unique, there are many young aboriginal Canadians who experience similar tragedies. In fact, the aboriginal youth suicide rate in British Columbia is five times the average for all young Canadians. One cannot understand fully why Mary saw no way out without also asking why so many other young aboriginal people in British Columbia reached the same desperate point.
The starting point is poverty, bone-grinding poverty, low educational levels and high unemployment. But there were about 200 bands of aborigines in British Columbia, more or less all in poverty. Yet 90% of the adolescent suicides occurred in 12% of the bands. Why some and not others? The difference was empowerment of communities. Empowered communities participated in land claims; self-government, had control over educational, police and fire, and health services; and establishment of 'cultural' facilities. The results were clear: the greater the cultural continuity and community control over their destiny, the lower was the youth suicide rate. Poverty is bad, but poverty is not destiny. Empowerment of communities can save lives. I draw similar lessons from studying the health of New Zealand Maoris, Indigenous Australians, Native Americans or indeed that of excluded groups elsewhere in the world.
In January 2010, Haiti's earthquake wreaked havoc and 200,000 people died. Less than two months later a quake 500 times stronger hit Chile and the death toll was in the hundreds. Haiti was underprepared in every way imaginable. Chile was well prepared, with strict building codes, well-organised emergency responses and a long history of dealing with earthquakes. True, the epicentre of the Haitian earthquake was closer to population centres than that of the Chilean quake, but that was only part of the explanation for the different scale of devastation. What turns a natural phenomenon into a disaster is the nature of society. The number of people who died had more to do with Haiti's lack of societal readiness and response than with the strength of the quake.
In 2011 the London borough of Tottenham broke out in urban riots. The precipitant was the killing of a black man by police. But, unacceptable as that is, it was not the underlying cause. Inequality was the culprit. I had been citing an area of Tottenham as having the worst male life expectancy in London – 18 years fewer than in the best-off area. All in one of the world's premier global cities. London now has more high-end properties, a price tag more than $5million, than Manhattan, Hong Kong, Singapore or Sydney. It is not surprising that the riots broke out in the area with the worst health. Ill-health does not cause riots. Nor do riots cause ill-health – at least not directly. Relative deprivation causes both urban unrest and ill–health. Ninety per cent of young people arrested in the riots were not in employment, education or training.
Similarly, in Baltimore in the US. When a black man was killed in police custody riots broke out. Not uniformly across the city, but in the area with condemned houses, low levels of education and income and a twenty year disadvantage in life expectancy compared to the area with leafy opulence.
Inequality strains the binds of a cohesive society. In Baltimore, those binds snapped. The immediate effect is civil unrest. The longer term effecs is health inequity.
These examples illustrate that the way we organise our affairs, at the community level or, indeed at the whole societal level, are matters of life and death. As doctors we cannot stand idly by while our patients suffer from the way our societies are organised. Inequality of social and economic conditions is at the heart of it.
There are three aspects of Mary's tragedy worth emphasising. The first is the vital issue of violence to girls and to women. It can be fatal, both because it drives women to suicide and because they may be killed by their partners. Second, I emphasised empowerment of communities. But empowerment of individuals is also of vital importance. A key route to female empowerment, globally, is education. Evidence shows clearly: the greater the education of women the less the likelihood of being subject to domestic violence. Third is the importance of mental illness. Mental ill-

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ness and substance use disorders constitute the number one cause of years spent with disability, globally. We cannot be concerned with health, globally and in our countries, and not be concerned with mental illness and substance use.

More generally we need to recognise the importance of the mind to health equity. The mind is the major gateway through which social determinants exert their effect on health. Recognizing the importance of the mind takes us back to early child development and what I have called: equity from the start.

In Aldous Huxley's dystopia, *Brave New World*, there were five castes. The Alphas and Betas were allowed to develop normally. The Gammas, Deltas, and Epsilons were treated with chemicals to arrest their development intellectually and physically, progressively more affected from Gamma to Epsilon. The result: a neatly stratified society with intellectual function, and physical development, correlated with caste.

That was satire, wasn't it? We would never, surely, tolerate a state of affairs that stratified people, then made it harder for the lower orders, but helped the higher orders, to reach their full potential. Were we to find a chemical in the water, or in food, that was damaging children's growth and their brains worldwide, and thus their intellectual development and control of emotions, we would clamour for immediate action. Remove the chemical and allow all our children to flourish, not only the Alphas and Betas. Stop the injustice now4 Yet, unwittingly perhaps, we do tolerate such an unjust state of affairs with seemingly little clamour for change. The pollutant is called social disadvantage and it has profound effects on developing brains and limits children's intellectual and social development. Note, the pollutant is not only poverty, but also social disadvantage. There is a clear social gradient in intellectual, socia, and emotional development – the higher the social position of families the more do children flourish and the better they score on all development measures. This stratification in early child development, from Alpha to Epsilon, arises from inequality in social circumstances.

This social gradient in children's possibility to fulfil their potential, in its turn, has a profound effect on children's subsequent life chances. We see a social gradient in school performance and adolescent health; a gradient in the likelihood of being a 20 year old not in employment, education, or training; a gradient in stressful working conditions that damage mental and physical health; a gradient in the quality of communities where people live and work; in social conditions that affect older people; and, central to my concern, a social gradient in adult health. A causal thread runs through these stages of the life course from early childhood, through adulthood to older age and to inequalities in health. The best time to start addressing inequalities in health is with equity from the start. But intervention at any stage of the life course can make a difference. Relieving adult poverty, paying a living wage, reduction in fuel poverty, improving working conditions, improving neighbourhoods, and taking steps to reduce social isolation in older people can save lives.

The health gradient to which these life course influences give rise is dramatic. There is a cottage industry, taking subway rides in various cities and showing how life expectancy drops a year for each stop. I have referred to twenty year gaps in Baltimore and London; but the health differences between rich and poor, dramatic as they are, are only part of the problem. Commonly, people say to me: I am neither rich nor poor; what does any of this have to do with me? The evidence shows that there is a social gradient in health that runs from top to bottom of society. People in the middle have worse health than those above them in the social hierarchy, but better than those below. We calculated for England that if everyone enjoyed the same life expectancy as the top 10%, based on education, there would be 202,000 fewer deaths each year; over 500 a day.

One problem, then, is poverty. Another is inequality. Both damage health and lead to an unjust distribution of health. I have spent my research life showing that the key determinants of health lie outside the health care system in the conditions in which people are born, grow, live, work and age; and inequities in power, money and resources that give rise to these inequities in conditions of daily life. Since the establishment of the WHO Commission on Social Determinants of Health in 2005, I have been using research knowledge to argue for policies on social determinants of health.

Yet here I am, humbled by assuming office as President of the World Medical Association. Is there not a contradiction? The World Medical Association, WMA, upholds the highest ethical standards of the practice of medicine. It speaks out fearlessly when the right of doctors to pursue their noble calling is threatened. As President, I want the WMA to use the same moral clarity to be active against the causes of ill-health and what I call the causes of the causes – the social determinants of health.

The opening sentence of my recent book, *The Health Gap: The Challenge of an Unequal World,* was: why treat people and send them back to the conditions that made them sick? No one is as concerned about health and disease as we in the medical and other health professions. It has been and will be my mission to encourage our concerns with the conditions that make people sick.

I am hugely encouraged already. My friends in the Canadian Medical Association conducted Town Hall meetings across Canada to engage the public in discussion on how the conditions of their lives related to their health. The Canadian Medical Association then took the initiative to suggest a meeting at BMA House in London. Twenty countries and 200 people asked to come, including our now-Chair of Council, Ardis Hoven, and then-president, Xavier Deau, and participated with enthusiasm. I apologise in advance: I already have more invitations from medical colleagues, enthusiastic for the health equity agenda, than I could possibly meet. We need a global social movement.

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I have been arguing that we have the knowledge of what to do to act on social determinants and health equity; we have the means. We need to ensure that we have the will.

Do we really have the means? Consider. What do the following have in common?

- 48 million people of Tanzania
- 7 million people of Paraguay
- 2 million people of Latvia
- top 25 US hedge fund managers

In 2013 each of these four groups had a total income of between $21 and 28 billion. Imagine with me something totally fanciful: that the 25 hedge fund managers gave up their income for one year. It would double the income of Tanzania. The hedge fund managers wouldn't feel it, because they will earn an average of $1billion each the next year. I am not suggesting for a moment that we simply pass the cash to individual Tanzanians. But think of the clean water that could be piped, the schools that could be built, the nurses trained and employed.

There is a great deal of money sloshing about. Great inequality between countries stops the money being spent in ways that would benefit the poor and the needy.

Suppose, though, that there was reluctance to see ourselves as part of a global community. We would still have to address staggering levels of inequality of income and wealth within countries. Here is an even more fanciful thought. Suppose that the hedge fund managers of New York paid a third of their $24 billion income in tax – unlikely I know – that money could fund 80,000 New York schoolteachers. 80,000.

What has this to do with doctors? At the meeting of National Medical Associations that we held in London we heard inspiring examples of how doctors are already working with communities to deal with the social causes of ill-health. In India I was taken by medical colleagues to a tribal area in Gujarat where the doctors are not only treating people who, hitherto, had no access to health care, but are working with others in community development and education to improve the conditions of daily life for marginalised people. In Brazil, the social gradient in stunting of young children is becoming progressively flatter. In Bangladesh and Peru inequalities in child mortality are decreasing. I am excited by the interest generated in social determinants of health globally in every region of the world: South Africa, Zambia, Morocco, Colombia, Cuba, Costa Rica, Panama, Surinam, Taiwan, Sweden, Norway, Finland, Iceland and … I could go on.

Colleagues, we can make a difference to the causes of the causes of health equity, as part of the practice of medicine. There is another way we can make a difference, too. I do not go for long without quoting the great German pathologist, Rudolf Virchow, who said that "physicians are the natural attorneys of the poor". We can, we do, we should speak up about inequity in social conditions that damage the health of the populations that we serve.

It means to, that we should recognise and be vocal about any societal trends that are likely to affect health equity: climate change, trade, financial crises.

I hold a Bernard Lown visiting professorship at Harvard. Bernard Lown, great cardiologist and co-founder of International Physicians for the Prevention of Nuclear War, said: never whisper in the presence of wrong. Already WMA speaks up in a loud voice about the highest ethical standards of our profession. We should not whisper at the gross inequities in the world that give rise to health inequities.

In fact, so close is the link between social conditions and health that, I argue, health equity is a good measure of social progress; much better than income growth. Senator Robert Kennedy in a famous speech criticised Gross National Product as a measure of social progress. He said:

the gross national product does not allow for the health of our children, the quality of their education or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages, the intelligence of our public debate or the integrity of our public officials. It measures neither our wit nor our courage, neither our wisdom nor our learning, neither our compassion nor our devotion to our country, it measures everything in short, except that which makes life worthwhile.

Health and health equity are not only worthwhile in themselves but they reflect much else that makes life worthwhile: the freedom to lead lives we have reason to value.

As doctors, at our best, we flourish in the cause of social justice. There is a great deal of injustice in the world. Can we really be optimistic? Let me quote from Nobel Prize winning poet Seamus Heaney:

History says, don't hope
On this side of the grave.
But then, once in a lifetime
The longed-for tidal wave
Of justice can rise up,
And hope and history rhyme.

So hope for a great sea-change
On the far side of revenge.
Believe that further shore
Is reachable from here.
Believe in miracle
And cures and healing wells.

I have had much reason to praise our medical students at the IFMS, and our junior doctors. In the spirit of Heaney I say to our younger colleagues: believe in miracle and cures and healing wells not just for our patients but for society, too. If this sounds idealistic I remember the words of Halfdan Mahler, former Director-General of WHO, who said when we published the report of the Commission on Social Determinants of Health: remember, idealists are the realists in human progress. I have another poet who has been my companion. When we launched the Commission on Social Determinants of Health in Santiago, Chile, I quoted Pablo Neruda. I did again at each report we have published and I do so again now. I invite you to:

Rise up with me…
Against the organisation of misery.

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WMA 2015 General Assembly Report

Moscow, Russian Federation, October 14–17

Wednesday, October 14

At the invitation of the Russian Medical Society, delegates from 58 National Medical Associations met at the World Trade Center in Moscow, Russia, October 14–17, for the WMA's 2015 General Assembly.

Council

Dr. Ardis Hoven, Chair of the WMA, opened the 201st Council session.

The Secretary General, Dr. Otmar Kloiber, welcomed delegates from the Russian Medical Society and a new member of the Council, Dr. Steve Hambleton (Australian Medical Association). There were no formal apologies of absence.

Secretary General's report

Dr. Kloiber referred to the written Council report that set out the secretariat's work over the past six months.

He highlighted three items. First was the close co-operation with the World Health Organisation on the prevention and control of non communicable diseases. A workgroup was being set up on the strengthening of health care systems and the WMA needed help from NMAs to ensure that physicians were included on the workgroup.

The second was the WMA influenza campaign and the need for the WMA to learn from the activities and campaigns of NMAs. He reminded delegates that the two targets of the campaign were to get a higher penetration of immunisation in the general population and more importantly to get health professionals and especially physicians immunised. The immunisation rate of health professionals in many countries was simply not high enough and they all owed it to their patients and their families to be vaccinated.

The third item was the United Nations new sustainable development goals, a series of objectives to improve the lives of people through economic, social and environmental dimensions and the eradication of poverty in all forms. The goals were adopted in September to cover the period from 2016 to 2030 and they replaced the Millennium Development Goals which had been aimed mainly at developing countries with varied success. The new goals were more ambitious and holistic and were aimed to apply to all countries. There were 17 goals and 169 targets and all were extremely ambitious. It was important for the WMA to reflect these goals and to co-operate.

Emergency Resolutions

The Council then heard arguments for three items to be considered as matters of urgency.

Attacks in Turkey

The Turkish Medical Association proposed a resolution calling for an end to recent attacks on healthcare personnel, patients, and health care facilities in Turkey. Delegates heard that a physician, a nurse and an ambulance driver had been killed within the last two months and there had been attacks against health care facilities and ambulances. There were curfews and the wounded were not able to access health care facilities. Preventable deaths were occurring as a result. The emergency resolution called for all parties involved to respect the professional autonomy and impartiality of healthcare staff, and to comply fully with international human rights law and other relevant international regulations.

The Council agreed that this matter should be accepted as an emergency resolution.

Global Refugee Crisis

The British Medical Association said it was very difficult to overestimate the degree of urgency of this matter. They had seen over the past year the numbers of refugees increasing significantly. Recently this had worsened and every country was close to breaking point. Politicians appeared not to know how to handle the matter. The essential issue was one of humanity and looking after the interests of people who were suffering. At the end of day this became a health problem if they did not treat people with humanity.

The Council agreed that this matter should be accepted as an emergency resolution.

Afghan Hospital Bombing

The Spanish Medical Association introduced a resolution about the recent bombing of a hospital in Kunduz, Afghanistan. It argued that the WMA should condemn this bombing which went against the Declaration of Human Rights. The resolution demanded an immediate investigation by an independent organisation and investigation into those who had committed this act.

Dr. Kloiber reminded the meeting that when the bombing occurred the WMA had issued a press release joining in the condemnation and Dr. Xavier Deau, the President, had said: 'This latest tragedy strengthens our determination to ensure the safety of hospitals, health care facilities, patients and healthcare personnel during armed conflicts. It underlines the importance of our work with the International Committee of the Red Cross to urge all governments to do more to ensure the safety of health care in situations of violence. Tragedies such as this shame us all.

The Council agreed that the proposed resolution should be accepted as an emergency resolution.

Chair's Report

Dr. Ardis Hoven gave a brief oral report, saying that the WMA had continued to achieve significant global recognition for the value it brought to world medicine and to physicians and their patients throughout the world. It was a highly recognised global leader in health, particularly through the work with the Declaration of Helsinki.

Socio-medical affairs committee

Dr. Miguel Roberto Jorge (Brazilian Medical Association) took the chair.

Dr. Kloiber brought the committee up to date with three items.

There had been some movement on tobacco control with a focus on the effect of tobacco on children, especially banning smoking in cars. This was being recognised more and more by lawmakers. He urged national medical associations to approach their governments to work on legislation to better protect children.

On alcohol, more and more governments were considering minimum pricing and again it would be good if as many NMAs as possible could discuss this with their lawmakers.

Finally, the WHO was developing a new Global Strategy on Human Resources for Healt, which represented a strategic vision towards universal health coverage within the framework of the UN sustainable development goals. More effort was needed to involve physicians in the development of health policies and he again urged NMAs to stress this when meeting their governments.

Health and Environment

Dr. Dongchun Shin (Korea), Chair of the Environmental Caucus, reported on the activities of the caucus that had met the day before. The meeting focused on the forthcoming United Nations Climate Change Conference in Paris in December 2015. There was a fruitful exchange of information on the activities planned by participants within the framework of the event. They had been trying to put health at the centre of the negotiations. It was also an opportunity to present and discuss WMA activities planned in connection with the Paris conference.

Health Care in Danger

Prof. Vivienne Nathanson (British Medical Association), chair of the Workgroup on Health Care in Danger, reported on the activities of the group, which had met the day before. Dr. Bruce Eshaya-Chauvin, coordinator of the International Committee of the Red Cross Health Care in Danger Project (HCiD), had updated the group on the activities taken over the past six months and had emphasized that the ICRC was now trying to promote a move from a community of concern on HCiD issues to a community of action. From this perspective, the workgroup encouraged constituent members to take up the initiative and would invite them to report on their activities in this area.

Ageing

Dr. Nivio Moreira (Brazilian Medical Association) reported on the activities of the workgroup that had been set up with the mandate to produce a proposed policy on ageing. The members had worked on a preliminary draft via email with the support of an expert, Dr. Alexandre Kalache, and was now suggesting that the draft should be circulated to national medical associations.

The committee agreed with this proposal.

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

The Spanish Medical Association reported that the workgroup had met the previous day and discussed a preliminary draft which it suggested should be finalized and submitted to the Council for consideration in Buenos Aires next April.

This was agreed by the committee.

Physicians' Well-being

The committee considered the proposed Statement on Physicians' Well-being which was introduced by Dr. Robert Wah (American Medical Association), Chair of the Workgroup. The committee considered several proposed amendments. One was a suggestion that because physicians suffering ill health often tried to treat themselves they should get the right diagnosis from the most experienced physician in their department of practice. However, this suggestion was voted down.

Another amendment was to change the wording of the document to refer to 'education' rather than 'training'. It was argued that physicians were under considerable risk of losing their professional autonomy and clinical independence. This was mainly done with words and the medical profession was in danger of being seen as a technical service. It was important therefore to talk about 'educating' physicians rather than 'training' physicians. It was agreed to review this point before the Council meeting on Friday.

The committee agreed that the document should be sent to the Council and then forwarded to the Assembly for adoption.

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Smallpox Destructions

The committee considered a proposed Statement on the Destruction of Smallpox Virus Stockpiles from the Junior Doctors Network. It was proposed that the document be considered by a small workgroup. But the document failed to win support and it was decided that the document should not be approved.

Transgender

The Committee considered a proposed Statement on Transgender People introduced by the German Medical Association. The committee was told that the document was intended to serve as a guideline for patient-physician relations and to foster better training to enable physicians to increase their knowledge and sensitivity toward transgender people. It acknowledged the inequities faced by the transgender community and the crucial role played by physicians in advising and consulting with transgender people and their families about desired treatments. Although the proposers of the document were aware of the cultural sensitivities in some parts of the world with regard to this issue, it was important for the WMA to stress that cultural, political or religious considerations must not take precedence over the rights, health and well-being of transgender people, or any patient for that matter. The German Medical Association argued that although the paper provided context by briefly addressing some of the broader social issues faced by transgender people, the overall scope of the paper, and especially the recommendations, was focused on the role of the physician and the healthcare system at large in providing equitable treatment to transgender people. It was important for the medical community to highlight the potential health effects of negative social attitudes, stigmatisation and discrimination towards the transgender community.

During the debate that followed it was explained that the issue of intersexuality should not be incorporated into this document but should be the subject of a separate paper, which the Royal Dutch Medical Association had volunteered to prepare.

The committee agreed to the document being sent to the Council for forwarding to the General Assembly for approval and adoption.

Vitamin D Insufficiency

The committee considered the proposed Statement on Vitamin D Insufficiency. This urged national medical associations to support continued research into vitamin D deficiency which affected about a third of the population.

The committee agreed that the Statement be sent to the Council for approval and then forwarded to the General Assembly for adoption.

Mass Media Appearances

The committee considered proposed guidelines on Mass Media Appearances by Physicians, introduced by the Korean Medical Association. It was explained that the document arose from serious concern over the increase of physicians' appearing on the mass media to recommend unproven treatments or products. The guidelines were aimed at preventing physicians from being involved in commercial activities that might compromise professional ethics. They would also contribute to patient safety by ensuring physicians provided accurate, timely, and objective information.

During a debate, it was decided to amend the document to include the phrase that physicians should not introduce false fr exaggerated statements regarding their qualifications.

Discussion also took place on the document's statement that 'When appearing in media, physicians shall provide objective and evidence-based information and shall not recommend medical procedures or products that are not medically proven.' It was decided to leave in the words 'evidence-based information' but add the words 'or justified' at the end of the sentence.

The committee agreed to amend the document to say that 'Physicians should not recommend specific products' rather than 'physicians should not recommend specific foods or health supplements'. The committee also debated whether the wording that 'Physicians shall not engage in the promotion, sale or advertising of commercial products' should be changed to 'Physicians should take great care when engaging in the promotion….' But on a close vote it was decided to keep the wording unchanged.

It was also decided to change the title of the document to 'Guidelines on Promotional Mass Media Appearances by Physicians'.

The committee agreed that the proposed guidelines, as amended, be sent to the Council for approval and forwarded to the General Assembly for adoption.

Boxing

ThecCommittee considered a proposed major revision of the WMA Statement on Boxing submitted by the South African Medical Association.

It was agreed that the document be circulated among constituent members for comment.

Tobacco

The committee considered a proposed revision of the WMA Resolution on the Implementation of the WHO Framework Convention on Tobacco Control produced by the Australian Medical Association aimed at encouraging national medical associations to get their governments to implement the Framework and in particular to introduce a ban on smoking in enclosed public places and work places.

It was agreed that the document be circulated among national medical associations for comment.

Female Genital Mutilation

The committee considered a proposed revision of the WMA Resolution on Female Genital Mutilation prepared by the British Medical Association, encouraging national medical associations around the world to become more active in campaigning to end the practice.

It was agreed that the document be circulated among constituent members for comment.

Body Searches of Prisoners

The committee considered a proposed revision of the WMA Statement on Body Searches of Prisoners, also prepared by the British Medical Association.

The committee again agreed that the document be circulated among constituent members for comment.

Workers' Health & Safety

The committee considered a proposed Resolution on Occupational Health & Safety submitted by the Turkish Medical Association, as well as a proposed Declaration on responsibility of employers for workers' health protection and occupational safety submitted by the Russian Medical Society. A proposed Declaration on Protection of Human Reproductive Health which addressed health reproductive issues in relation to challenging working condition, was also considered.

The committee decided to recommend to the Council that a workgroup on Occupational Health be set up with the mandate to look at the three proposed policies with the aim of preparing a single proposal, if appropriate.

Armed Conflicts

The committee then considered three proposed Declarations – two from the Russian Medical Society on Priority of Human Life and Health in Resolution of Territorial Disputes and Armed Conflicts and on Children's Rights to Prioritized Evacuation, Medical & Humanitarian Aid in the Areas of Local Armed Conflict. A third proposed Declaration on Triggering and Carrying out Armed Conflicts as a Measure of Achieving Objectives of State Politics was submitted by the Polish Medical Chamber.

It was agreed that a workgroup be set up with the mandate to look at the three proposals with the aim of preparing a single proposal, if appropriate.

Life Environment

A proposed Declaration on Maintaining Safety of Life Environment for Human Health, submitted by the Russian Medical Society, was briefly considered, but failed to find support.

Physicians' Right to Information

The committee considered a proposed Declaration on Physicians' Right to Information about the World Medical Association and its Policies submitted by the Russian Medical Society. Its aim was to increase awareness about WMA policies among physicians.

The committee agreed that the document be circulated to constituent members for comments.

Professional Autonomy of Physicians

The committee considered a proposed Declaration on Professional Autonomy of Physicians as the Main Condition for Implementation of the Human Right to Health submitted by the Russian Medical Society and it was agreed that it be circulated among constituent members for comments.

Obesity in Children

The committee considered a proposed Statement on Obesity in Children proposed by the Israeli Medical Association. It was explained that the document brought together different aspects to combat childhood obesity, such as education and economic incentives through taxes on unhealthy foods.

It was agreed that the proposed Statement be circulated among constituent members for comments.

Advocacy

Dr. André Bernard (Canadian Medical Association), Chair of the Advocacy Advisory Committee, reported on the activities of the Committee that had met the day before.

The committee had discussed the issue of social media and the use of twitter during WMA meetings.

It had also considered the proposal for an International World Day on Combatting Violence and it was agreed to explore what opportunities might be provided by the World Humanitarian Summit in 2016 to organise an event.

Finally the committee considered how to build on the success of the advocacy session held in Durban in 2014, and agreed to contact the Taiwanese Medical Association to discuss the possibility of holding an advocacy training session during the next General Assembly in Taiwan in 2016.

Attacks against Healthcare workers and facilities in Turkey

The committee considered the proposed urgent Resolution to stop attacks against

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healthcare workers and facilities in Turkey. Following an explanation from the Turkish Medical Association and a brief debate, it was agreed that the proposed Resolution be sent to the Council for forwarding to the General Assembly for approval and adoption.

Global Refugee Crisis

The committee considered the proposed urgent Resolution on the Global Refugee Crisis submitted by the British Medical Association. Delegates were told it was important that the WMA made the point that refugees were people and as people they were suffering. Doctors understood the suffering that had caused them to becoge refugees. The process of being a refugee was worsening this suffering. They needed to be treated with humanity. Yet much of the international debate had been very alienating. This was an opportunity to switch the tenure of the debate.

The committee agreed that the Resolution as amended be sent to the Council and forwarded to the General Assembly for approval and adoption.

Bombing of the hospital run by Médecins Sans Frontières in Kunduz, Afghanistan

The committee considered the proposed urgent resolution on the bombing of the hospital of *Médecins Sans Frontières* in Kunduz, Afghanistan submitted by the Spanish and South African medical associations. The meeting heard of the concern about continued attacks on health care workers and facilities around the world. The recent bombing of the hospital in Kunduz attested to this particular concern. It was important that the WMA Assembly was part of the cry around the world to advocate for the setting up of an independent body to investigate the circumstances of the bombing of this hospital.

It was agreed that the proposed resolution be approved and sent to the Council for forwarding to the General Assembly for approval and adoption.

Medical ethics committee

Dr. Heikki Pälve (Finland Medical Association) took the chair.

The committee meeting opened with Dr. Kloiber reporting on four items:

First,Hhe said that an international discussion was taking place on end of life care, euthanasia and physician assisted suicide and the WMA had to enter the debate. The WMA would organise a session on this topic at the Bioethics, Medical Ethics and Health Law Conference in Naples the following week.

Second, he said the revised Declaration of Helsinki had been discussed at many international conferences and very positively. The University of Harvard had now invited the WMA to speak about post-trial access to care.

Next, the Olympic Committee had invited the WMA to take part in the revision process of the Olympic Medical Code of Ethics and submit comments.

Finally, he said that the WMA was involved in the discussion at the WHO on the regulatory aspects of biosimilars, which dealt with the classification, remuneration systems and bioethics of biosimilars. The European Union had also invited the WMA to speak about the ethical aspects of biosimilars.

Dr. Jeff Blackmer (Canadian Medical Association) reported that the CMA and the Royal Dutch Medical Association were working on a paper to address end of life care and assisted dying. This would be presented in 2016.

Person Centered Medicine

The committee received an oral report from the Chair of the Workgroup on Person Centred Medicine, Dr. Andrew Dearden (British Medical Association). He said the workgroup would develop a new policy to be presented at the Council meeting in Buenos Aires in April 2016. This would be based on comments previously submitted on the draft polics presented to the committee in Tokyo in 201, and the workgroup's background paper.

Health Databases

The committee received an oral report from Dr. Jon Snædal (Iceland Medical Association), Chair of the Workgroup on Health Databases and Biobanks. The WMA had received 90 comments from international experts in response to a public consultation on the workgroup's draft paper this year. This was followed by a series of meetings. The next meeting to discuss the topic would take place during the Bioethics, Medical Ethics and Health Law Conference in Naples. A workgroup expert meeting in Korea was planned for February 2016, along with a satellite session during the World Congress of the International Association of Bioethics in Edinburgh in June 2016. It was hoped to have a draft version ready for discussion at the next Council meeting in Buenos Aires in April 2016.

Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools

The rapporteur, Prof. Vivienne Nathanson, asked the committee to consider the revised version of the WMA Resolution on Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools, which had been sent out for comments to WMA members as part of the annual policy review. During a debate, delegates made

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several detailed amendments to the wording.

The committee agreed that the proposed Resolution, as amended, be sent to the Council with the recommendation that it be forwarded to the General Assembly for adoption.

Declaration of Geneva

The proposed revision of the Declaration of Geneva was introduced by Dr. Ramin Parsa-Parsi (German Medical Association), Chair of the workgroup. He asked the WMA's ethics adviser Prof. Urban Wiesing to report on the issue. Prof. Wiesing reminded the meeting that the Declaration was written and adopted in 1948 as an answer to World War Two and the atrocity of physicians during the Nazi regime. It was intended as a substitute to the Hippocratic Oath and was one of the most important documents of the WMA. The Declaration had undergone minor amendments on several occasions. The decision to consider revising the document was not a response to any controversy. It was simply to investigate whether the document was still up to date. He outlined a number of areas that might be examined.

The workgroup recommended that the committee start a careful revision process and revise the policy only where there were strong arguments for a change.

The committee agreed that the workgroup should proceed with its review process.

Non-discrimination in Professional Membership and Activities of Physicians

The committee considered a proposed minor revision to the Statement on Non-discrimination in Professional Membership and Activities of Physicians.

The committee agreed that the revision of the proposed Statement, as amended, be sent to the Council for forwarding to the General Assembly for adoption.

HCiD Toolkit for Doctors

The committee considered the WMA proposal for a toolkit for doctors working in situations of violence.

The committee agreed that this be approved, and that its publication on the WMA webpage as an educational tool be approved by the Council.

Mental Illness

The committee considered the proposed revision of the WMA Statement on Ethical Issues concerning Patients with Mental Illness. The guidelines were revised to take account of the progress in psychiatric treatment which now allowed for better care of patients with mental illness.

The committee decided that the document, as amended, be approved by the Council with the recommendation that it be forwarded to the General Assembly for adoption.

Statement on Conflict of Interest

The committee considered a proposal for rewording the WMA Statement on Conflict of Interest to align the policy with the Declaration of Helsinki. This was accepted as an editorial amendment.

Protection of human reproductive health

The committee considered a proposed revision of the WMA Declaration on Protection of Human Reproductive Health to further complement the existing WMA policies on reproductive health.

It agreed that the proposed Declaration be referred to the workgroup on occupational health.

The Participation of Physicians in Pre-natal Gender Selection

The committee considered the proposed WMA Resolution on the Participation of Physicians in Pre-natal Gender Selection and it was agreed that the proposed Resolution be circulated to constituent members for comment.

Human Rights

Clarisse Delorme, WMA Advocacy Advisor, reported that the WMA had been invited by the UN Special Rapporteur on Torture to participate in an expert meeting that would inform the drafting of a new thematic report by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, Professor Juan E. Méndez. The report would address gender perspectives on torture and other cruel, inhuman or degrading treatment or punishment.

Finance and Planning Committee

Dr. Dongchun Shin (Korean Medical Association) took the chair

Financial Statement

The Audited Financial Statement for 2014 was agreed by the committee and sent to the Council for forwarding to the General Assembly for approval and adoption.

WMA Budget and Membership Dues Payments

The budget for 2016 was agreed and sent to the Council for forwarding to the General Assembly for approval and adoption.

The committee also received the Dues Categories 2016 and it was agreed to recommend to the Council that this be forwarded

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to the General Assembly for its information.

Strategic Plan

Dr. Shin referred to the fact that the current WMA Strategic Plan was valid until the end of 2015 and should then be renewed. The Secretary General suggested developing the Strategic Plan for the period 2016-2020 in a way which would enable the WMA to be recognized as global medical leaders and to increase its capacity to act, respond and lead. He said the strategic aims had to be supported by stronger business development, allowing the Association to grow without limiting its independence.

The committee agreed that the Secretariat should develop a Strategic Plan for 2016-2020, coordinating with the Business Development Group, and should report back to the Council in Buenos Aires in April 2016.

Business Development

The committee received an oral report and a written report from Dr. Dearden, the Chair of the Business Development Group. Dr. Dearden said the paper was not final but rather was intended to provide direction.

The committee recommended that the report be approved by the Council.

WMA Statutory Meetings

The committee considered arrangements for future WMA meetings. The Confederación Médica de la República Argentina reviewed plans for the 2016 Council Session in Buenos Aires and the Taiwan Medical Association welcomed delegates to attend the 2016 General Assembly in Taipei.

The committee agreed to recommend the Council to approve that the venue for the 209th Council session in April 2018 be Riga, Latvia.

WMA Special Meetings

The committee received an oral report from the Secretary General concerning two meetings. Firs aOne Health Conference held in Madrid in May 2015 was successful. It was planned to hold the next conference in Japan in 2017. Secony, the H20+ Health Summit in 2015, which was planned to be held in Turkey, could not take place due to planning constraints. There was a strong common interest with the Turkish Medical Association (TMA) in the health of refugees and the Secretary General said he would look into the possibility of organizing a meeting on 4this issue together with the TMA. He was also exploring the possibility of a H20+ Health Summit in 2016 in China.

The committee agreed to recommend to the Council that planning for the One Health Conference with the World Association of Veterinarians in spring 2017 in Japan be continued in cooperation with the Japan Medical Association and the Japan Veterinarians Association and that the Council authorizes the Secretariat to continue to organize the H20+ Health Summit in 2016.

Membership

The committee considered an application from the Panhellenic Medical Association and agreed to recommend to the Council that the Association be admitted into WMA membership.

Governance Review

Dr. André Bernard, on behalf of the Canadian Medical Association, proposed that a workgroup be established to review the governance of the WMA. It should have a broad membership representation, including the Associate Membership, to examine possibilities for a governance review.

The committee recommended that the Council approve the proposal..

Thursday, October 15

Associate members

Dr. Joseph Heyman (American Medical Association) took the chair.

The meeting received reports on the Junior Doctors Network from Dr. Elizabeth Wiley, JDN Deputy Chair, and on the Past Presidents and Chairs of Council Network from Dr. Jon Snaedal.

Global Medical Electives

A proposed Statement on Ethical Considerations in Global Medical Electives was presented by Dr. Xaviour Walker on behalf of the JDN and the committee agreed that the Statement be considered by the General Assembly.

Fossil Fuel Development

The meeting considered a proposed Statement on Fossil Fuel Development presented by Dr. Peter Orris. A brief debate took place on the recommendation that NMAs and other health organisations should begin a process of transferring their investments from energy companies whose primary business relied on fossil fuels to those providing renewable energy sources.

The committee agreed that the document as amended should be sent to the General Assembly for consideration.

Scientific session

The theme of the session was 'Medical Education', with speakers from all parts of the globe addressing the meeting.

The morning session opened with a speech from President elect Sir Michael Marmot, who spoke about 'Social determinants of health in undergraduate and postgraduate education'.

He talked about social justice, political empowerment and creating the conditions for people to have control of their lives. He identified six policy recommendations to achieve this – giving every child the best start in life, enabling all children, young people and adults to maximise their capabilities and have control over their lives, creating fair employment and good work for all, ensuring a healthy standard of living for all, creating and developing healthy and sustainable places and communities and strengthening the role and impact of ill health prevention. He illustrated his talk with statistics on life expectancy, under five mortality, global disability and obesity. And he ended with the words 'Health is a Human Right. Do Something. Do more. Do better'.

Professor David Gordon, President of the World Federation for Medical Education, titled his speech 'Trends in Medical Education: sometimes getting better, sometimes getting worse'. He described medical education as sometimes well planned, sometimes chaotic. He said the Federation was not primarily concerned with the detail of education and how it was taught, but more with the quality, management, organisation, support and delivery of medical education. And he spoke about the current growth of medical schools which was often bad and uncontrolled.

Professor Kenji Matsubara, Vice President of the Japanese Medical Association, spoke about the CME system in Japan and said that continuing professional development was not carried out at the behest of others, but was rather pursued of one's own accord to provide patients with safe and high quality health care. Physicians had a responsibility to broaden their knowledge, improve their skills and continuously devote themselves to study throughout their lives in order to practice constantly advancing medicine and health care. Physicians should be motivated to pursue a lifelong education on their own initiative. This was why the Japanese Medical Association provided CME programmes to facilitate effective self-learning and training. Its purpose was to further raise physicians' desire for training and to increase the public's trust by highlighting physicians' efforts to study.

Dr. Robert Wah, Past President of the American Medical Association, spoke about accelerating change in medical education and the medical school of the future with programmes focused on team-based care, population health and chronic disease management. He referred to the importance of technology to enhance learning and the use of big data to understand health outcomes. Dr. Leonid Eidelman, President of the Israel Medical Association, spoke on Medical Education in a Post-Modern Era and compared modernist theory with post-modern theory. He said that each generation of medical students came with different expectations, different learning needs and different styles. Today's Millennials, born after 1982 did better when given specific goals but needed constant stimulation and direction. They wanted constant feedback and were interested in balancing personal and professional lives. He referred to the extent of burnout among physicians and said this was strongly associated with medical errors, prescribing habits and patient compliance.

His conclusion was that the postmodern era called for recognition of generational differences and that adjustments to new styles could lead to better working conditions, better patient care, delayed burn out and professional fulfilment.

Professor Lizo Mazwai, President of the South African Medical Association, gave a talk entitled 'Transformation of Medical Education for the 21st Century'. He referred to the five star doctor as being a care provider, a decision maker, communicator, community leader and manager. He said that the principles of medical education or training would always evolve due to influences of socio economic factors, disease profiles and the expanding role of science and technology. The challenge was to adapt curricula to be relevant both locally, regional and globally. Internationalisation of health and globalisation of resources demanded that medical schools should continue to share knowledge and technology more for better equipped doctors.

Professor Florentino Cardoso, President of the Brazilian Medical Association, spoke about the importance of continuing medical education and the motivations for learning, while Professor Gia Lobhanidze, Chairman of the Georgian Medical Association spoke about medical education in Georgia going back to 1919. He looked at the problems today, following the privatization of medical institutions. As a result there were almost no university clinics, poor mastering of clinical proficiency and a low quality of undergraduate and post graduate education.

Professor Steve Hambleton, Immediate Past President of the Australian Medical Association, spoke about medical education in Australia and the way it was embracing digital transformation. He referred to the country's workforce and said there was a high reliance on international health professionals. There was a growing trend towards specialisation and the medical training pathway was poorly co-ordinated. The Government was now investing in digital health and this would enhance e-learning. Professor Sun Baozhi, from the Research Center for Medical Education and China Medical University, spoke about his country's handling of medical education, the progress made over the past 100 years and the challenges faced by the country over the past three decades. These included skill imbalances and the shortage of nurses and an insufficiency of education resources for students.

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Climate change

During a workshop session on climate change, Dr. Todd Sack, editor of My Green Doctor and a gastroenterologist in Jacksonville, Florida, talked about bringing environmental sustainability to medical offices. He spoke about creating a healthier office and community with employee participation and team building. He described a practice management tool for medical offices and said that My Green Doctor showed offices how to create and manage an office green team. The result was a saving of money and a greener environment.

Friday, October 16

Adjourned council

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

Socio-medical affairs committee

Physicians' Well-Being

Following on the debate in the committee about using the word 'education' rather than 'training', the Council approved amendments to the document.

A proposal was also made to delete a paragraph relating to physician autonomy that read: 'Physician autonomy is one of the strongest predictors of physician satisfaction. Increasing external regulatory pressures such as undue emphasis on cost efficiencies and concerns about consequences of reporting medical errors may unduly influence medical decision-making and diminish a physician's autonomy.' It was argued that it was reasonable for physicians to be cost efficient and to look into adverse events when they occurred. This was part of their professional life. However, the proposal was defeated and the Council approved the document as amended and agreed that it should be forwarded to the General Assembly for adoption.

Mass Media Appearances

The Council approved the proposed Guidelines.

The remainder of the Socio-Medical Affairs Committee report was approved by the Council.

Medical ethics committee

The Medical Ethics Committee report was approved by the Council.

Finance and planning committee

The Finance and Planning Committee report was approved by the Council.

Associate members

The Chair, Dr. Joseph Heyman, said progress had been made in making Associate membership more meaningful, including more conference calls, an educational webinar and a web forum for members. Calling for an increase in membership, he repeated what he had said before that no-one would be Council membes for ever, but they could be Associate members for the rest of their lives.

Junior Doctors Network

Dr. Ahmet Murt, Chair of the JDN, reported that junior members were now attending the World Health Assembly meetings. The network had developed a close working relationship with the World Federation of Medical Education. The juniors had published three newsletters and were considering other publications. They were also organising more regional meetings and activities and following the WHO regional committee meetings.

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Dr. Peteris Apinis, Editor in Chief of the WMJ, said that this was the 61st year of the publication of the World Medical Journal. It was the first year that the Journal has been published digitally, although they continued to print 50 hard copies of the Journal to mail to the WMA office and leading libraries. He said he intended to pursue the idea of making a photo album featuring snapshots of various WMA events. The length of the Journal remained unchanged – 40 pages plus a cover page. The contents had, however, changed with more focus on opinion leaders and interviews.

Assembly ceremonial session

The President, Dr. Xavier Deau, called to order the Ceremonial Session.

The Secretary General, Dr. Otmar Kloiber, welcomed the Honourable Dr. Tatiana Vladimirovna Yakovleva, Deputy Minister of Health of the Russian Federation, Prof. Mikhail Paltsev, Chief Academic Secretary of the Russian Academy of Sciences, Prof. Natalia Narotchnitskaya, Director of the Institute of International Collaboration, Mr. Igor Khalevinskiy, President of the Russian Association of Diplomats, Mr. Andre Mankowskiy, Chairman of the Guardianship Board of the Russian Medical Society, Mr. Timofey Nizhegorodtsev, Head of Department of the Social Sphere of the Anti-Monopoly Service, Mr. Sergey Muravyov, Head of Department of International Collaboration of the Ministry of Health of Russia, The Honorable Sir Tim Barrow, UK Ambassador to the Russian Federation and the Honourable Mr. Kamil Mohamed Ali, Ambassador of the Republic of Djibouti.

He went on to introduce the official delegations from each of the Constituent Members present, as well as the observers from non-member medical associations and international organizations.

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The Honourable Dr. Tatiana Vladimirovna Yakovleva, Deputy Minister of Health of the Russian Federation, officially welcomed delegates to the 66th General Assembly, saying that it was an opportunity for a valuable exchange of views and professional discussion. She went on to stress that universal access to healthcare and improvements in the quality of medical services were the responsibility of the State, society and the medical community, and the importance of cooperation between governmental bodies and the medical community. She stated that the Russian Ministry of Health cooperated closely with medical professional bodies in the development of regulation, the development and approval of clinical recommendations on health issues, CPD, licensing and registration, policy development, health insurance and medical ethics. She described recent developments in Russia leading towards autonomous regulation of the medical profession, the representative organisation being the Russian Medical Chamber.

Prof. Vladimir Dmitrievich Parshin, President of the Russian Medical Society, then addressed the Assembly. He spoke about the importance of physicians being able to travel abroad to meet their colleagues. The medical profession in Russia had long retained the idea from the Soviet era that their activities must be regulated by state administrative bodies, with professional bodies playing a secondary role. However, new attitudes were developing with a growing recognition of the principle of professional freedom and autonomy. This was the cornerstone principle of the WMA and was connected with professional responsibility and the right to health. He said that the Russian Medical Society was the only medical organisation in Russia which had been pursuing the ideals of the WMA for the past 20 years, despite resistance from some powers. He stated that holding the WMA Assembly in Moscow would help to raise awareness of the importance of professional autonomy and expedite this process. He closed by inviting delegates to return to Moscow, emphasising traditional Russian hospitality derived from the many nations which make up the vast federation, and wished them every success at the meeting.

The WMA Chair Dr. Ardis Hoven then paid tribute to the retiring WMA President, Dr. Xavier Deau. She said he had presided with great distinction over the affairs of the Association. He was a highly respected physician exemplifying the highest ethical standards of the profession and he had guided the WMA and the profession over the past year, travelling exhaustively. He was a gentle man in manner, strong in opinion, highly competent and wise in decisions, commanding by his presence and passionate about his patients.

Dr. Deau delivered his valedictory speech (see box) and was given a standing ovation.

Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London, was then installed as the 66th President of the WMA to serve in 2015/16.

He took the oath of office as President and delivered his inaugural speech (box).

Saturday, October 17

General assembly plenary session

The Credentials committee reported that 58 WMA constituent members had been registered and recognised at the meeting and 57 were in good standing. The total number of votes was 136.

General report

Dr. Kloiber introduced the written report that had been tabled, detailing the work of the WMA secretariat and the Council over the past year. He highlighted several items, mentioning the advocacy work that had been carried out in publicising the revised Declaration of Helsinki. A similar approach was now being taken in seeking public input for the new WMA policy project on databases and biobanks. The WMA had received up to 90 well written and thoughtful comments on how stakeholders and interested groups thought it should proceed with this policy. This had led to new insights about the policy.

In addition to the work of developing policy, the secretariat had been involved more and more in human rights issues. It had been very active with the United Nation organisations and with members in addressing both individual issues as well as more general political issues. The spread of activity had been extremely broad and reflected the issues member organisations faced, ranging from strictly medical problems such as vitamin D to theoretical issues such as trade agreements. However, the WMA secretariat at Ferney Voltaire was very small and it had to be highly selective and set priorities. He was disappointed not to be able to help all the requests received.

Committee Reports

The Assembly adopted the following policy documents without debate:

- Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide (see p.148)
- Revised Statement on Non-Discrimination in Professional Membership and Activities of Physicians (see p.149)
- Statement on Ethical Issues concerning Patients with Mental Illness (see p.150)
- Declaration on Alcohol (see p.141)
- Statement on Providing Health Support to Street Children (see p.152)
- Statement on Riot Control Agents (see p.155)
- Statement on Mobile Health (see p.153)
- Revised Statement on Nuclear Weapons (see p.154)
- Statement on Physicians' Well-being (see p.143)

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- Statement on Vitamin D Insufficiency (see p.147)
- Guidelines on Promotional Mass Media Appearances by Physicians (see p.147)
- Declaration of Oslo on Social Determinants of Health (retitled) (see p.151)
- Attacks against Healthcare workers and facilities in Turkey (see p.140)
- Global Refugee Crisis (see p.145)

Statement on Transgender People

Professor Monsignor Pablo Requena (Vatican Medical Association) said he would be abstaining on the vote on this Statement. He explained that the Vatican delegation condemned absolutely any unfair discrimination and would resist any discrimination against transgender people. However, in some parts of this document a number of matters that were not strictly medical were discussed and the Statement proposed some solutions that they did not all share.

The Assembly agreed to adopt the Statement.

Bombing of the hospital run by Médecins Sans Frontières in Kunduz, Afghanistan (see p.141)

The Japanese Medical Association referred to the demand in the emergency Resolution for an immediate enquiry by an independent body into the attack. It asked whether it was possible for a third party to investigate the bombing and suggested that this point be deleted. However, the Spanish Medical Association argued that only an independent investigation would shed light on what had occurred. If there was no independent investigation and no attempt at trying to find a plausible explanation it would be disastrous. It urged that this point be maintained in the resolution. This was supported by speakers from Cote d'Ivoire, South Africa and India. Dr. Ved Prakash Mishra (Indian Medical Association) said the call for an independent investigation must be maintained. On such a human tragedy which had shaken the feet of civility and humanism if they deleted this they would just be bystanders and onlookers to human devastation. If they did not call for an independent investigation they would be losing relevance, consequence and impact.

But Dr. Frank Ulrich Montgomery (German Medical Association) said that the American President had already apologised for the bombing and therefore an independent investigation was not necessary.

On a vote, the proposal to delete the call for an investigation was supported by 55 votes to 45 with three abstentions and the emergency Resolution as amended was supported by 76 votes to 13, with 26 abstentions.

Treasurer's Report

Dr. Masami Ishii, the Treasurer, reported on the Financial Statement for 2014 and the Budget for 2016. He referred to the positive financial developments due to thrifty use of budget means, efficient cost controlling, a risk-free investment policy and the full commitment of the Secretary General. Mr Adi Hällmayer, the financial adviser, provided additional information on the 2014 statement, drawing particular attention to the savings made by the South African Medical Association in their organization of the General Assembly in Durban.

Dr. Ishii reported on the dues increases that would be necessary to maintain the financial stability of the Association, and reminded the delegates that investment was necessary to maintain the important activities of the WMA. He said the budget represented investment in the future of the profession, summarizing the ways in which the WMA was supporting physicians and promoting the highest standards of medical ethics across the world. The money would be used to establish further communications and educational missions.

The Audited Financial Statement for 2014 and the proposed Budget for 2016 were approved and adopted.

Membership

The Assembly agreed to the admission of the Panhellenic Medical Association as a WMA Constituent Member.

Social Determinants of Health

The Secretary General said that in view of the importance of this topic, the Council had suggested that the WMA Statement on the Social Determinants of Health be changed to a Declaration entitled The Declaration of Oslo on the Social Determinants of Health. This was approved by the Assembly.

Associate Members

The Assembly received two proposed policy documents from the Associate Members, the proposed Statement on Ethical Considerations in Global Medical Electives and the proposed Statement on Fossil Fuel Development. It was agreed that these should be sent to the Council for consideration.

World Veterinary Association

Dr. Zoran Katrinka, from the World Veterinary Association, spoke about the WVA, saying that it was a global organisation and a federation of national and regional associations. It had member associations from more than 60 countries with 500,000 individual members. Its mission was 'to ensure and promote animal health and welfare and public health globally, through developing and advancing veterinary medicine, the veterinary profession as well as public and private veterinary services'. The three pillars of veterinary medicine were animal health, public health and animal welfare. When it came to animal health, prevention was better than cure, through monitoring, surveillance, early diagnosis and reporting of animal diseases. Animal welfare was a matter of respecting freedoms and promoting sustainable, high welfare agriculture. Public Health related to the role veterinarians played in food safety. He said veterinarians did much to maintain control of zoonotic diseases. Some 60 per cent of infections and transmissible human diseases were zoonotic in their nature and some 70 per cent of the new emerging transmissible diseases were of a zoonotic nature or had a zoonotic potential. And up to 75 per cent of the potential or actual bioterrorism agents were zoonotic in nature. He also spoke about education and lifelong learning and ways being developed to strengthen the veterinary profession in the light of stress and the number of suicides among veterinarians. He spoke of the common challenges facing physicians and veterinarians and for these reasons it was all the more important for the professions to work in unison, as exemplified by the success of the One Health conference in Madrid this year.

Medical Women's International Association

Professor Kyung Ah Park, President of the Medical Women's International Association and Professor of Anatomy at Yonsei University College of Medicine in Seoul, Korea, then addressed the Assembly. She said the MWIA had around 20,000 members from 46 member countries. She gave the history and structure of the organization. It was founded in 1919 with the aims of offering medical women the opportunity to meet, to promote the general interest of medical women by developing cooperation, friendship and understanding without regard to race, religion or political views, to overcome gender-related differences in health and healthcare between women and men, girls and boys throughout the world, to overcome gender related inequalities in the medical profession and to promote Health for All throughout the world with particular interest in women, health and development.

As the current president, Dr. Park said her theme was the prevention and elimination of domestic and sexual violence and she mentioned the various projects she hsd overseen in this area, as well as cooperation on a Canadian project to distribute birthing kits in order to lower maternal and infant mortality. She had also overseen a survey on violenc, to which 32 countries had responded. Her aim was also to expand membership of the organisation to include more countries, especially in central Asia.

CPME

Dr. Katrín Fjeldsted, President of the CPME (Standing Committee of European Doctors), said her organization represented 34 countries in Europe. They were the voice of the medical profession towards the European Commission where they were stakeholders. They were consulted on matters concerning the medical profession, patients, health in Europe, although matters of health and health services belonged to the member states. She spoke about CPME's work and the joint activities with the WMA and other organisations. She expressed her gratitude to Dr. Deau for the close cooperation he had facilitated over the past year with the WMA, highlighting the WMA policies CPME has endorsed and the areas in which they shared similar policies, such as professional autonomy, the TTIP agreement, alcohol and tobacco, patient safety, healthy aging, and eHealth.

International Trade Agreements

Dr. Andrew Deardon (British Medical Association) opened a debate on current international trade agreements, designed to allow NMAs to report on their activities in this area.

He said the BMA was not anti-trade but it was pro-health. A lot of work had been done by the WMA and a number of countries. The BMA wanted to get an idea of what other countries felt about these agreements. The question was what more they could do. It was not that they should oppose trade, but that they should safeguard health.

Dr. Kloiber reiterated that the WMA had no fundamental opposition against trade and trade agreements. Trade, if it was fair, could help to ease the burden of many countries. However, with some trade agreements there could be detrimental effects on health, such as the attempts of the Mexican Government to reduce the sugar intake by children which had been stalled by some countries in north America. The Mexican Government had to give up and yet Mexico was suffering a real obesity epidemic. The same thing had happened with tobacco legislation. Regulations against tobacco in many countries had been attacked on the basis of trade agreements and were being dealt with in secret courts. They were a real threat to many countries. Trade agreements could have detrimental effects on social conditions and could inhibit domestic legislation on health issues. The WMA's concern was that these agreements were being made in secret.

Leah Wapner (Israel Medical Association) reminded the Assembly that this was not the first time the WMA had taken a stand on an issue of trade and health that was not very popular at the beginning. Its position a few years ago on patenting genes was similar. The WMA had said then it was against patenting and everyone said this opposition was against trade. Since then the US and Australia had come out with a conclusion that genes could not be patented. At the moment the WMA had a very serious issue of public relations and making its standpoint understandable. What it was doing here was a very important first step getting information from the regions. The need now was to turn this into something more practical by developing an advocacy strategy. They could then advocate for this around the world. This would enable NMAs to have an advocacy strategy within their country, to approach their Parliamentarians to say why it was so important to put safeguards for health within these trade agreements.

Dr. Sergio Isaza Villa (Columbia Medical Federation) said it was vital that the WMA made known its stand with regard to high

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cost treatments and the rights of physicians to voice opinions regarding treatment. They should try to control exorbitant costs based on patents. Secondly, on physician autonomy, in Columbia a law had been passed to defend and protect the decisions of physicians regarding treatment decisions. He believed this was directly related to the issue of physician autonomy and world trade agreements.

Dr. Steve Child (New Zealand Medical Association) said that New Zealand had signed four free trade agreements in the last 20 years and many of the things being discussed had been present in these negotiations throughout that time. He said it was important that the WMA approached this issue from a principled point of view rather than on individual issues. In the Trans-Pacific Partnership Agreement (TPPA) signed two weeks ago, tobacco was excluded and public health policy provisions were protected. Countries were allowed to still mandate their own public health policy provisions.nMoreover, biosimilars and biologic patents had remained the same. Referring to the issue of transparency with these negotiations, he said that all countries needed to take the agreements back to their Parliaments for enabling legislation to be passed.

Other speakers reported on the approaches they had made to their governments and called on the WMA to stand firm on this issue. Dr. Juan Rodriguez Sendin from the Spanish Medical Associatio, spoke about the difficulty in getting information about these trade agreements from their Parliamentarians. So many issues were at stake and unless the situation changed radically and they got to know the content of these treaties the WMA should warn public opinion about the danger of these negotiations.

Speakers from Malaysia, Argentina, India and Nigeria added their voices in opposition to these agreements. Many speakers called on the WMA to publicly state their opposition to these agreements. Dr. Elizabeth Wiley, deputy chair of the JDN, spoke about the threats to public health from these negotiations, whether it was to professional regulations, access to medical education or climate change mitigation strategy, access to medicines and tobacco regulation.

At the end of the debate Dr. Hoven said she recognised the many challenges facing the WMA from these trade agreements and she would be asking the advocacy group to put this matter on its agenda.

Open session

WMA Influenza Campaign

Dr. Julia Tainijoki-Seyer, medical advisor with the WMA, gave an overview of the WMA's influenza prevention campaign. In addition to the global mortality, flu caused 3.5 million cases of illness. This presented an economic burden with indirect and direct costs. Up to 60 per cent of health professionals had the virus, but 30 per cent were not aware they had the flu, yet they still saw patients. The aims of the campaign were to inspire health professionals to get immunised, to be a role model for their patients and to focus on vulnerable groups. She stated that the focus of this year's campaign had been children, due to their lack of prior immunity and more frequent exposure to the virus. She presented the materials developed for the website, including the motto "let kids be kids", and encouraged NMAs to use the material, which were free of charg, or to link the webpages on their own websites. She closed by presenting a video of Sophia, an animated ambassador for the WMA and she asked NMAs to share information about their own activities on influenza with her.

Tree of Hippocrates

Dr. Yoshitake Yokokura (Japan Medical Association) described the legend that Hippocrates taught medicine underneath an old plane tree which still stood on the Greek island of Kos. The tree was almost dead. However, tree doctors commissioned by the Greek government and the Japanese Embassy had concluded that the tree could be saved. He said that Hippocrates was the Father of Medicine and it was their duty to save the life of this tree. He urged the WMA to collect donations to regenerate the Tree of Hippocrates.

Turkey

Dr. Ilhan Bayazit (Turkish Medical Association) spoke about attacks on health care personnel and facilities in Turkey. Several health care staff had been killed. He also spoke about the previous week's bombing in Ankara during a peace rally march. Police had used tear gas immediately after the explosion.

Israel

Dr. Leonid Eidelman (Israel Medical Association) reported on the issue of force feeding of hunger strikers in Israel. He said that over the last few years detainees held in Israeli prisons had used hunger strikes as a tool for having their demands met. More than a thousand hunger strikes had taken place in recent years, lasting from several days to weeks and months. In June 2014 around 100 strikers were simultaneously hospitalized. This prompted proposed legislation in the Israeli Parliament allowing for the force feeding of hunger strikers in hospital with court permission and despite active opposition from prisoners. Against this background the Israeli Medical Association had convened a consensus conference with all interested parties and the conference had reached several conclusions relating to physicians' treatment of hunger strikers. These included emphasising that doctors must respect the free will of hunger strikers as people and patients while doing all they could to help the hunger striker to stay alive, that forced medical treatment including force feeding was forbidden, and that physicians must maintain medical confidentiality when treating patients. Following the conference the Israeli Medical Association had prepared guidelines for physicians and had set up a 24-hour emergency hotline to provide advice to physicians.

Dr. Eidelman said that the Israel Medical Association could not support the proposed legislation on this issue which was in contradiction with physicians' ethical obligations as set out in the WMA Declaration of Malta, which said that force feeding was a form of inhuman and degrading treatment.

Cote d'Ivoire

Dr. Kroo Florent Aka (Ordre National Des Medicines De La Côte D'Ivoire) said that the buruli ulcer was one of about 15 tropical diseases which the WHO officially considered as orphan or neglected illnesses due to a lack of a budget to treat them. It affected tropical, sub-Saharan countries, including China and Australia. There were 2,197 cases in 2014, 38per cent of which were in the Ivory Coast. He explained that the disease was caused by a micro bacteria from the same family as TB and leprosy, with fresh water bugs found in lakes and rivers as carriers. It produced blisters on the bodies of adults and children which evolved into extensive necrosis of soft skin tissue and abscesses, with some resulting in the development of skin cancer. Successful treatment was possible if the disease was caught in its early stages, but that access to treatment in many areas was very limited, meaning that by the time many patients get to hospital the effects were irreversible. He asked the WMA to raise this topic at the next WHO Assembly and requested the development of a strategic plan and sufficient funding to fight the disease.

Any other business

Junior Doctors Network

Dr. Ahmet Murt, Chair of the Junior Doctors Network (JDN), reported that the Network had been growing continually and expanding the scope of its work, covering a broad range of issues, not only those directly associated with junior doctors. He commented on the collaboration with medical students and mentioned the recent regional meeting in Macedonia and forthcoming meetings in Istanbul and Malta. He went on to thank the Russian Medical Society for enabling the JDN to hold their meeting in Moscow, which had enjoyed the highest participation ever. He congratulated his Japanese colleagues, who had won the JDN champions award at this meeting.

Bombing of the hospital run by Médecins Sans Frontières in Kunduz, Afghanistan

At the suggestion from the Spanish Medical Association, the debate on the emergency motion on the bombing of the MSF hospital was reopened. Dr. Fernando Rivas urged the Assembly to reconsider its earlier decision to delete the call for an independent investigation. He said MSF were colleagues and allies of the WMA and they had requested an independent investigation into the bombing. Despite having received a message from the US president, MSF continued to request that an international humanitarian fact-finding commission be brought in to conduct an independent investigation. He called for the WMA to take the side of physicians not governments.

Dr. Mzukisi Grootboom (South Africa Medical Association) said he was extremely disappointed at the outcome of the earlier debate to strike out the call for an independent investigation. This was not just an attack on a hospital. It was an attack on the Geneva Convention. The WMA needed to show leadership and support those doctors who were at the hospital taking all the risks to save people's lives. Dr. Rutger Jan Van der Gaag (Royal Dutch Medical Association) supported the call to reconsider, saying that they should not be put off by the fact that the President of the United States had apologized. It was extremely important to go further. Dr. Jeff Blackmer (Canadian Medical Association) said that if the WMA decided not to call for an independent enquiry the Canadian Medical Association would be releasing a strongly worded press statement the following week urging an independent investigation and he encouraged other NMAs to do likewise.

Dr. Frank Ulrich Montgomery (German Medical Association) said that detailed accounts of the bombing had already been published. An investigation committee had also been set up and he asked what an additional inquiry would add. It was not necessary.

However, other speakers from India, Argentina and Nigeria supported the call for an enquiry.

Delegates voted for the emergency resolution to be reconsidered. And they went on to vote by 62 votes to 43 with nine abstentions in favour of the original resolution, including the call for an independent investigation.

Junior Doctors

Dr. Georgiana Luisa Baca (United Kingdom) spoke about government plans in England to remove the regulation of the working hours of junior doctors, introduce a seven day working pattern and not recognise university degrees or part-time work as work experience. She thanked the BMA and Royal Colleges for their strong support of the junior doctors, holding it up as a positive example of collegial support.

The Taiwan Medical Association presented a short video of Taiwan, inviting all delegates to attend the next year's General Assembl, which will be held in Taipei.

The Chair thanked the delegates for their efforts, time, thoughtfulness and commitment to the WMA and the health of their patients and concluded the meeting.

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WMA Resolution to Stop Attacks against Healthcare Workers and Facilities in Turkey

Adopted by the 66th General Assembly, Moscow, Russia, October 2015

Preamble

Several media report that over the last two months of conflict in Turkey, healthcare workers have been killed, wounded or threatened with guns. Some physicians have been taken out of ambulances and beaten. Access to wounded people is prevented by security forces, and ambulances as well as health facilities are regularly targeted. A rather comprehensive study conducted by the Turkish Medical Association confirms these facts.

There are indications that attacks on healthcare workers and the obstructions of service delivery are used as a deliberate political instrument to intimidate people, depriving them of their democratic rights.

Parties in armed conflict have the obligation to protect health care provision to wounded and sick and to prevent attack on or threat to medical activities, healthcare workers and facilities. Physicians and other healthcare workers should not be impeded to perform their duties. Such attacks constitute blatant violation of international human rights law, in particular the inherent right to life that shall be protected by law, and the right to enjoy the highest attainable standard of health [1].

These attacks undermine gravely as well fundamental medical ethics principles, in particular WMA international Code of Medical Ethics and the Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies endorsed by civilian and military health-care organisations [2], stating that: "Health-care personnel, as well as health-care facilities and medical transports, whether military or civilian, must be respected by all. They are protected while performing their duties and the safest possible working environment shall be provided to them" (article 10).

Recommendations

The WMA urges all parties to:

1. Stop attacks on healthcare workers and patients, health care facilities, and ambulances and ensure their safety,
2. Respect the professional autonomy and impartiality of healthcare workers,
3. Comply fully with international human rights law as well as other relevant international regulations that Turkey is a State Party to, and
4. Document and record all violations and duly prosecute their perpetrators.

[1] International Covenant on Economic, Social and Cultural Rights, article 12 – December 1966
[2] Adopted by the ICRC, the WMA, the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the International Pharmaceutical Federation (FIP) – June 2015

WMA Resolution on Global Refugee Crisis

Adopted by the 66th General Assembly, Moscow, Russia, October 2015

The WMA recognises that mass movement of people often follows disasters that flow from armed conflict or natural phenomena as populations seek to escape danger and deprivation. The current mass movement of the populations, to escape the effects of armed conflict including bombing, lack of access to utilities, clean water, and the destruction of homes, schools and hospitals, has been numerically larger than any mass movement of populations in over 70 years.

While the WMA recognises that countries may have concerns about their ability to absorb significant numbers of new migrants, we recognise that people fleeing warfare or natural phenomena are doing so because they are desperate and often face life-threatening conditions. They are afraid for their health, safety and welfare, and that of the family members who accompany them.

Most countries have signed international treaties giving them binding obligations to offer aid and assistance to refugees and asylum seekers. The WMA believes that when there are events, including on-going events, such as conflict which generate refugee crises governments must increase their efforts to provide assistance to those in need.

This should include ensuring safe passage for refugees and appropriate support after they enter countries offering refuge. Recognising that the disaster from which they have fled and the vicissitudes of the journey may have led to health problems it is essential that receiving countries establish systems to provide health care to refugees.

Governments should seek to ensure that refugees and asylum seekers are able to live in dignity within their country of refuge and make all efforts to enable their integration into their new society. The international community should seek to obtain a peaceful solution in Syria under which the population can either stay at home safely or, if they have already left, safely return home.

The WMA recognises that mass population movement causes significant stress on the existing populations of countries as well on those who become refugees. We believe that governments and international agencies including the United Nations must make more concerted efforts to reduce the pressures that lead to such movements, including rapidly providing extensive relief after natural phenomena, and making more efforts to avert or stop armed conflict. Re-establishing security of food, water, housing, sewerage, education and health care, and improving public safety should make a significant impact and reduce the numbers of refugees.

The WMA:

- Recognises that the process of becoming a refugee is damaging to physical and mental health;
- Commends those countries that have welcomed and cared for refugees, especially those currently fleeing Syria;
- Calls on other countries to improve their willingness to receive refugees and asylum seekers;
- Calls on national governments to ensure that refugees and asylum seekers are enabled to live in dignity by providing access to essential services;
- Calls on all governments to work together to seek to end local, regional, and international conflicts, and to protect the health, safety and welfare of populations;
- Calls on all governments to cooperate in providing immediate help to countries facing the effects of natural phenomena, remembering that those already the most socio-economically disadvantaged will face the most challenges;
- Calls upon global media to report on the refugee crisis in a manner that respects the dignity of refugees and displaced persons, and to avoid bigotry and racial or other bias in reporting.

WMA Resolution about the Bombing on the Hospital of MSF in Kunduz

Adopted by the 66th General Assembly, Moscow, Russia, October 2015

After the events of October 3 in Kunduz (Afghanistan), the WMA:

1. Extends its deepest condolences to families, colleagues and friends of doctors, healthcare workers and patients killed in the bombing.
2. Deeply regrets and condemns the bombing of the Hospital of MSF, considering it a violation of human rights.
3. Reaffirms its positional statements on "Healthcare in Danger" and calls on all countries to respect healthcare personnel in conflict situations.
4. Demands an immediate enquiry into the attack by an independent body and the assumption of responsibilities.

WMA Declaration on Alcohol

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

1. The burden of disease and injury associated with alcohol consumption is a critical challenge to global public health and development. The World Medical Association offers this declaration on alcohol as its commitment to reducing excessive alcohol consumption and as a means to support its members to assist them in promulgating harm-reduction policies and other measures.
2. There are significant health, social and economic problems associated with excessive alcohol use. The harmful use of alcohol kills approximately 2.5 million people every year (almost 4% of all deaths worldwide), and is the third leading risk factor for poor health globally, accounting for 5.5% of disability-adjusted life years lost. The WMA Statement on Reducing the Global Impact of Alcohol on Health and Society addresses these problems in more detail.
3. Effective alcohol harm-reduction policies and measures will include legal and regulatory measures that target overall alcohol consumption in the populatio, as well as health and social policy interventions that specifically target high-risk drinkers, vulner-

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able groups and harms to people affected by those who consume alcohol.

4. There are many evidence-based alcohol policies and prevention programmes that are effective in reducing the health, safety and socioeconomic problems attributable to harmful use of alcohol. However, many countries have relatively weak alcohol policies and prevention programmes that are ineffective at protecting health and safet, and preventing harm. International public health advocacy and partnerships are needed to strengthen and support the ability of governments and civil society worldwide to commit to, and deliver on, reducing the harmful use of alcohol. Health professionals have an important role to play in preventing, treating and mitigating alcohol-related harm, using effective preventive and therapeutic interventions.
5. The World Medical Association has a leadership role to encourage and support the development and implementation of evidence-based national alcohol policies by promoting and facilitating partnerships, information exchange and health policy capacity building.

Objectives

In developing policy, the WMA recommends focusing on the following broad objectives:

- **Strengthen health systems** to identify and improve a country's capacity to develop policy and lead actions that target excessive alcohol consumption.
- Promote the development and evaluation in all countries of **national alcohol strategies** which are comprehensive, evidence-based and include measures to address the supply, distribution, sale, advertising and promotion of alcohol.
- Through government health departments, accurately **measure the health burden** associated with alcohol consumption through the collection of sales data, epidemiological dat, and per capita consumption figures.
- Support and promote the **role of health and medical professionals** in early identification, screening and treatment of harmful alcohol use.
- **Dispel myths** and dispute alcohol control strategies that are not evidence-based.
- Reduce the impact of harmful alcohol consumption in **at risk populations**.
- Foster multi-disciplinary **collaboration** and coordinated **intersectoral action**.
- **Raise awareness of alcohol-related harm** through public education and information campaigns.

Priorities

The following priorities are suggested for WMA members, national medical associations and governments in the development of integrated and comprehensive policy and legislative responses.

Regulate affordability, accessibility and availability

Pricing policies

Increase alcohol prices, through volumetric taxation of products based on their alcohol strengt, and other proven pricing mechanism, to reduce alcohol consumption at the population level, particularly in heavy drinkers and high risk groups.

Accessibility and availability

Regulate access to, and availability of, alcohol by limiting the hours and days of sale, the number and location of alcohol outlets and licensed premises, and the imposition of a minimum legal drinking age. Governments should tax and control the production and consumption of alcohol, with licensing that emphasises public health and safety and empowers licensing authorities to control the total availability of alcohol in their jurisdictions.

Public authorities must strengthen the prohibition of selling to minors and must systematically request proof of age before alcohol can be purchased in shops or bars.

Regulation of non-commercial alcohol

The production and consumption of non-commercial forms of alcohol, such as home brewing, illicit distillatio, and illegal diversion alcohol to avoid taxes, should be curtailed.

Reduce harmful alcohol use

Regulation of alcohol marketing

Alcohol marketing should be restricted to prevent the early adoption of drinking by young people and to minimise their alcohol consumption. Regulatory measures range from wholesale bans and restrictions on measures that promote excessive consumptio, to restrictions on the placement and content of alcohol advertising that is attractive to young people. There is no evidence that industry self-regulation and voluntary codes are successful at protecting vulnerable populations from exposure to alcohol marketing and promotion

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Increase public awareness of harmful alcohol consumption through product labelling and public awareness campaigns.

In conjunction with other measures, social marketing campaigns should be implemented to educate the public about harmful alcohol use, to support drink driving policie, and to target the behaviour of specific populations at high risks of harm. Public awareness measures can also include health warning labels on alcohol products, mandated by an independent regulatory body.

The role of health and medical services in prevention

Health, medical and social services professionals should be provided with the training, resources and support necessary to prevent harmful use of alcohol and treat people with alcohol dependence, including routinely providing brief advice to motivate high-risk drinkers to moderate their consumption. Health professionals also play a key role in education, advocacy and research. Specialised treatment and rehabilitation services should be available and affordable for alcohol dependent individuals and their families.

Drink driving measures

Key drink-driving deterrents should be implemente, which include a strictly enforced legal maximum blood alcohol concentration for drivers of no more than 50mg/100ml, supported by social marketing campaigns and the power of authorities to impose immediate sanctions.

Respond to the alcohol industry

Limiting the role of the alcohol industry in alcohol policy development

The commercial priorities of the alcohol industry are in direct conflict with the public health objective of reducing overall alcohol consumption. Internationally, the alcohol industry is frequently included in alcohol policy development by national authorities, but the industry is often active in opposing and weakening effective alcohol policies. Ineffective and non-evidence-based alcohol control strategies promoted by the alcohol industry and the social organisations that the industry sponsors should be countered. The role of the alcohol industry in the reduction of alcohol-related harm should be confined to their roles as producers, distributors and marketers of alcoho, and not include alcohol policy development or health promotion.

WMA Statement on Physicians Well-Being

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Physician well-being refers to the optimization of all factors affecting biological, psychological and social health and preventing or treating acute or chronic diseases experienced by physicians including mental illness, disabilities and injuries resulting from work hazards, occupational stress and burnout.

Physician well-being could have positive impact on patient care, but more research is needed. The profession should therefore encourage and support on-going research on physician's health. Evidence that already exists should be implemented in policy and practice. While physicians tend to have healthy habits, it is essential to enhance their health as a way to improve health for the whole population.

Physicians and medical students at all career stages are exposed to both positive experiences as well as a variety of stressors and work injuries. The medical profession should seek to identify and revise policies and practices that contribute to these stressors and collaborate with NMAs in order to develop policies and practices that have protective effects. Like all human beings, physicians experience illness, and they also have family obligations and other commitments outside their professional lives that should be taken into account.

One reason physicians delay seeking help is their concern about confidentiality and feeling ill at ease in the patient role. They experience feelings of responsibility towards their patients and are sensitive to external expectations on their health. Therefore, physicians must be assured of the same right of confidentiality as any other patient when seeking and undergoing treatment. The health care system may need to provide special arrangements for the care of physician-patients in order to uphold its duty to provide privacy and confidentiality. Prevention, early assistance and intervention should be available separately from any disciplinary process.

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Threats, Barriers and Opportunities for Physician Well-Being

Professional Roles and Expectations

The medical profession often attracts highly driven individuals with a strong sense of duty. Successfully completing the long and intense educational requirements often confers upon physicians a high degree of respect and responsibility in their communities.

With these high levels of respect and responsibility, physicians are subject to high expectations from patients and the public. These expectations can contribute to prioritizing the care of others over care of self and feelings of guilt and selfishness for managing their own well-being.

There is a direct relationship between physicians' and patients' preventive health practices. This relationship should encourage healthcare systems to better support and evaluate the effects on patients of improving physician and medical student health.

Work Environment

Working conditions, including workload and working hours, affect physicians' motivation, job satisfaction, personal life and psychological health during their careers.

Physicians are often perceived as being immune to injury and diseases as they care for their patients, and workplace health and safety programs may be overlooked. Physicians who are employed by small organizations or who are self-employed may be at even a higher risk for occupational diseases and may not have access to health and safety programs provided by large health care establishments.

As a consequence of their professional duties, physicians and physicians in postgraduate education often confront emotionally challenging and traumatic situations including patients' suffering, injury and death. Physicians may also be exposed to physical hazards like radiation, noise, poor ergonomics, and biological hazards like HIV, TB and hepatitis.

Some healthcare systems may exacerbate stress because of the hierarchies and competition inherent in them. Physicians in postgraduate education and medical students can be victims of harassment and discrimination during their medical education. Due to their position within the medical hierarchy, they may feel powerless to confront these behaviours.

Physician autonomy is one of the strongest predictors of physician satisfaction. Increasing external regulatory pressures such as undue emphasis on cost efficiencies and concerns about consequences of reporting medical errors may unduly influence medical decision-making and diminish a physician's autonomy.

Illness

Even though medical professionals recognize that it is preferable to identify and treat illness early, physicians are often adept at hiding their own illnesses and may continue to function without seeking help until they become incapable of carrying out their duties. There are many potential obstacles to an ill physician seeking care including: denial, confidentiality issues, aversion to the patient role, practice coverage, fear of disciplinary action, potential loss of practice privileges, loss of performance based payment and the efficiencies of self-care. Because of these obstacles doctors are often reluctant to refer themselves or their colleagues for treatment.

Illnesses can include mental and behavioural health problems, burnout, communication and interpersonal issues, physical and cognitive problems and substance use disorders. These illnesses and problems can overlap and can occur throughout the professional life cycle from basic medical education to retirement. It is important to acknowledge the continuum of physician well-being, ranging from optimal health, to minor illness, to debilitating illness.

Substance abuse may disrupt a physician's personal life and may also significantly affect his or her ability to care for patients. Easy access to medications may contribute to physicians' risk for abuse of recreational drugs and prescription medications. Assistance prior to impairment in the workplace is protective for physicians, their professional credentials and their patients.

Improved wellness promotion, prevention strategies and earlier intervention can help mitigate the severity of mental and physical illnesses and help reduce incidence of suicide in physicians, physicians in postgraduate education and medical students.

Recommendations

The World Medical Association recommends that National Medical Associations (NMAs) recognize and, where possible, actively address the following:

1. In partnership with medical schools and workplaces, NMAs recognize their obligation to provide education at all levels about physician well-being. NMAs should collaboratively promote research to establish best practices that promote physician health and to determine the impact of physician well-being on patient care.
2. Physician well-being should be supported and provided within and outside the workplace. Support may include but is not limited to referral to medical treatment, counselling, support networks, recognized physician health programs, occupational rehabilitation and primary prevention programs including resiliency training, healthy lifestyles and case management.
3. NMAs should recognize the strong and consistent link between physicians' and patients' personal health practices, providing yet another critically important reason for health systems to promote physician health.
4. Physician health programs can help all physicians to proactively help themselves via prevention strategies and can assist physicians who are ill via assessment, referral to treatment and follow-up. Programs and resources to help promote positive psychological health should be available to all physicians. Early identification, intervention and special arrangements for the care of physician-patients should be available to protect the health of physicians. Fostering a supportive and accepting culture is critical to successful early referral and intervention.
5. Physicians at risk for abuse of alcohol or drugs should have access to appropriate confidential medical treatment and comprehensive professional support. NMAs should promote programs that help physicians re-enter medical practice with appropriate ongoing supervision at the completion of their treatment programs. More research should be conducted to determine best practices in preventing substance abuse among physicians and physicians in postgraduate education.
6. Physicians have the right to working conditions that help limit the risk of burnout and empower them to care for their personal health by balancing their professional medical commitments and their private lives and responsibilities. Optimal working conditions include a safe and reasonable maximum number of consecutive and total working hours, adequate rest between shifts and appropriate number of non-working days. Relevant organizations should constructively address professional autonomy and work-life balance problems and involve physicians in making decisions about their work lives. Working conditions must not put the safety of patients or physicians at risk, and ultimately physicians should be engaged in establishing optimal workplace conditions.
7. Workplaces should promote conditions conducive to healthy lifestyles, including access to healthy food choices, exercise, nutrition counselling and support for smoking cessation.
8. Physicians, physicians in postgraduate education and medical students have the right to work in a harassment and violence-free workplace. This includes freedom from verbal, sexual and physical abuse.
9. Physicians, physicians in postgraduate education and medical students have the right to a collaborative safe workplace. Workplaces should promote interdisciplinary teamwork, and communication between physicians and all other professionals in the workplace should be offered in a spirit of cooperation and respect. Education on communications skills, self-awareness and team-work should be considered.
10. Medical staff should undergo training in recognizing, handling and communicating with potentially violent persons. Health care facilities should safeguard against violence including routine violence risk audits, especially in mental health treatment facilities and emergency departments. Staff members who are victims of violence or who report violence should be supported by management and offered medical, psychological and legal counselling.
11. Medical schools and teaching hospitals should develop and maintain confidential services for physicians in postgraduate education and medical students and to raise awareness of and access to such programs. Workplaces should consider offering medical consultations to physicians in postgraduate education in order to identify any health issues at the outset of medical education.
12. Workplace support for all physicians should be easily accessible and confidential. Physicians evaluating and treating their medical colleagues should not be required to report any aspects of their physician-patients' care in any manner not required for their non-physician patients.

WMA Statement on Transgender People

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

In most cultures, an individual's sex is assigned at birth according to primary physical sex characteristics. Individuals are expected to identify with their assigned sex (gender identity) and behave according to specific cultural norms strongly associated with this

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(gender expression). Gender identity and gender expression make up the concept of "gender" itself.

There are individuals who experience different manifestations of gender that do not conform to those typically associated with their sex assigned at birth. The term "transgender" refers to people who experience gender incongruence, which is defined as a marked mismatch between one's gender and the sex assigned at birth.

While conceding that this is a complex ethical issue, the WMA would like to acknowledge the crucial role played by physicians in advising and consulting with transgender people and their families about desired treatments. The WMA intends this statement to serve as a guideline for patient-physician relations and to foster better training to enable physicians to increase their knowledge and sensitivity toward transgender people and the unique health issues they face.

Along the transgender spectrum, there are people who, despite having a distinct anatomically identifiable sex, seek to change their primary and secondary sex characteristics and gender role completely in order to live as a member of the opposite sex (transsexual). Others choose to identify their gender as falling outside the sex/gender binary of either male or female (genderqueer). The generic term "transgender" represents an attempt to describe these groups without stigmatisation or pathological characterisation. It is also used as a term of positive self-identification. This statement does not explicitly address individuals who solely dress in a style or manner traditionally associated with the opposite sex (e.g. transvestites) or individuals who are born with physical aspects of both sexes, with many variations (intersex). However, there are transvestites and intersex individuals who identify as transgender. Being transvestite or intersex does not exclude an individual from being transgender. Finally, it is important to point out that transgender relates to gender identity, and must be considered independently from an individual's sexual orientation.

Although being transgender does not in itself imply any mental impairment, transgender people may require counseling to help them understand their gender and to address the complex social and relational issues that are affected by it. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5) uses the term "gender dysphoria" to classify people who experience clinically significant distress resulting from gender incongruence.

Evidence suggests that treatment with sex hormones or surgical interventions can be beneficial to people with pronounced and long-lasting gender dysphoria who seek gender transition. However, transgender people are often denied access to appropriate and affordable transgender healthcare (e.g. sex hormones, surgeries, mental healthcare) due to, among other things, the policies of health insurers and national social security benefit schemes, or to a lack of relevant clinical and cultural competence among healthcare providers. Transgender persons may be more likely to forego healthcare due to fear of discrimination.

Transgender people are often professionally and socially disadvantaged, and experience direct and indirect discrimination, as well as physical violence. In addition to being denied equal civil rights, anti-discrimination legislation which protects other minority groups may not extend to transgender people. Experiencing disadvantage and discrimination may have a negative impact upon physical and mental health.

Recommendations

1. The WMA emphasises that everyone has the right to determine one's own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual's right to self-identification with regards to gender.
2. The WMA asserts that gender incongruence is not in itself a mental disorder; however, it can lead to discomfort or distress, which is referred to as gender dysphoria (DSM-5).
3. The WMA affirms that, in general, any health-related procedure or treatment related to an individual's transgender status, e.g. surgical interventions, hormone therapy or psychotherapy, requires the freely given informed and explicit consent of the patient.
4. The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria.
5. The WMA explicitly rejects any form of coercive treatment or forced behaviour modification. Transgender healthcare aims to enable transgender people to have the best possible quality of life. National Medical Associations should take action to identify and combat barriers to care.
6. The WMA calls for the provision of appropriate expert training for physicians at all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender healthcare.
7. The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights. As role models, individual physicians should use their medical knowledge to combat prejudice in this respect.
8. The WMA reaffirms its position that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation (WMA Statement on Forced and Coerced Sterilisation). This also includes sterilisation as a condition for rectifying the recorded sex on official documents following gender reassignment.
9. The WMA recommends that national governments maintain continued interest in the healthcare rights of transgender people by conducting health services research at the national level and using these results in the development of health and medical policies. The objective should be a responsive healthcare system that works with each transgender person to identify the best treatment options for that individual.

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WMA Statement on Vitamin D Insufficiency

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Vitamin D has major role in calcium and bone metabolism. Normal values are 75-100 nmol/L (30-40 ng/ml). Vitamin D deficiency is defined if serum hydroxyvitamin D levels are less than 50 nmol/L (20 ng/ml), insufficiency as 50-75 nmol/L (20-30 ng/ml).

Studies demonstrate that vitamin D is essential also for overall health and well-being. In the body vitamin D is produced during exposure to sunlight and in lesser degree by food intake.

Vitamin D exists in two forms: vitamin D_3 (cholecalciferol in humans and other mammals) and vitamin D_2 (ergocalciferol in plants), but both are similarly metabolized. Vitamin D_3 is more active than vitamin D_2.

The serum concentration of the hepatic metabolite of vitamin D_3, the 25-hydroxyvitamin D, is considered as the best biomarker of vitamin D status.

Vitamin D deficiency is an important health issue globally. About one third of the population is estimated to have lower serum concentration of vitamin D.

Many studies have shown that vitamin D deficiency is linked to impaired growth and development. Because vitamin D receptors are broadly distributed in tissues, vitamin D deficiency is associated with musculoskeletal disorders (osteoporosis), falls, fractures, autoimmune disorders, chronic inflammatory diseases, type 2 diabetes mellitus, and cardiovascular, neurologic and psychiatric disorders. High risk groups are young children, the elderly and pregnant women. Primary factors, contributing to vitamin D deficiency, include reduced sunshine exposure, poor quality diet, availability of fortified foods and supplement use.

Recommendations

Because of widespread occurrence of vitamin D deficiency/insufficiency it is desirable to focus attention on adequate preventive actions in populations at risk. Determining vitamin D levels requires only a blood test, and oral supplementation is a simple treatment method. Sun exposure is not generally recommended because it can increase the risk of skin cancer.

The World Medical Association recommends that national medical associations:

1. Support continued research in vitamin D and its metabolites.
2. Educate physicians about the evolving science of vitamin D and its impact on health (documents, brochures, posters).
3. Encourage physicians to consider measuring the serum concentrations of 25-hydroxyvitamin D in the patients at risk of vitamin D deficiency.
4. Monitor development of dietary recommendations for vitamin D.

WMA Guidelines on Promotional Mass Media Appearances by Physicians

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Mass media can effectively play diverse roles in medical communication. Physicians, as professionals and experts, can contribute to improved public health by providing the public with accurate health

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related information. Mass media provides a channel through which physicians may contribute to society by leveraging mass media appearances in positive ways.

However, the increase in instances of physicians' frequent appearances on mass media to recommend unproven treatments or products and to use such appearances for marketing purposes is posing a serious concern. The public may readily accept groundless recommendations by physicians and may develop unrealistic expectations. The subsequent confusion and disappointment can damage the patient-physician-relationship.

This issue is more serious in some countries where there are different systems of medicine, including alternative medicine.

Recommendations

The WMA recommends the following guidelines regarding mass media appearances by physicians to prevent them from being involved in commercial activities that may compromise professional ethics and to contribute to patient safety by ensuring physicians providing accurate, timely, and objective information.

Accurate and Objective Delivery of Scientifically Proven Medical Information

When appearing in media, physicians shall provide objective and evidence-based information and shall not recommend medical procedures or products that are not medically proven or justified.

A physician shall not use expressions that may promote unrealistic patient expectations or mislead viewers about the function and effect of medical procedures, drugs or other products.

Physicians shall include important information including possible adverse effects and risks when explaining medical procedures, drugs, or other products.

Not Abusing Mass Media as a Means of Advertisement

Physicians should not recommend specific products by either specifically introducing or intentionally highlighting the name or trademark of a product.

Physicians shall practice prudence regarding personal appearances on home shopping program.. The physician should have no financial stake in the products being sold.

Physicians shall not be a part of mass media advertisement on any produc, which is harmful to huma, and/or environment.

Maintaining Professional Integrity

Physicians shall not require or receive economic benefits for mass media appearances other than a customary appearance fee.

Physicians shall not provide economic benefits to broadcasting personnel in order to secure mass media appearances.

Physicians shall not engage in the promotion, sale or advertising of commercial products and shall not introduce false or exaggerated statements regarding their qualifications such as academic background, professional experience, medical specialty and licensure as a specialist, for the benefit of the economic interests of any commercial entity.

WMA Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide

Adopted by the 51st World Medical Assembly, Tel Aviv, Israel, October 1999
and revised by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Medical School curricula are designed to prepare medical students to enter the profession of medicine. Increasingly, in addition to core biomedical and clinical knowledge, they teach skills including critical appraisal and reflective practice. These additional skills help to enable future doctors to understand and assess the importance of published research evidence, and how to evaluate their own practice against norms and standards set nationally and internationally.

In much the same way that anatomy, physiology and biochemistry are a solid base for understanding the human body, how it works, how it can fail or otherwise go wrong, and how different mechanisms can be used to repair damaged structure and functions, there is a clear need for physicians in training to understand the social, cultural and environmental contexts within which they will practice. This includes a solid understanding of the social determinants of health.

Medical ethics includes the social contract made between the health care professions and the societies they serve, based upon established principles, on the limits that apply to medical practice. It also establishes a system or set of principles through which new treatments or other clinical interventions will be sieved before decisions are made on whether elements are acceptable within medical practice. There is a complex intermingling of medical ethics and the duties of physicians to patients, and the rights patients enjoy as citizens.

At the same time physicians face challenges and opportunities in relation to the human rights of their patients and of populations, for example, occasions for imposing treatments without consent, and will also often be the first to observe and to itemize the infringement of these rights by others, including the state. This places very specific responsibilities upon the observing physician.

Physicians have a duty to use their knowledge to improve the well-being and health of patients and the population. This will mean considering social and societal change, including legislation and regulation, and can only be done well if doctors can take a holistic view within clinical and ethical parameters.

Physicians should press government to ensure legislation supports principled medical practice.

Given the core nature of health care ethics in establishing medical practice in a manner that is acceptable to society and that does not violate civil, political and other human rights, it is essential that all physicians are trained to perform an ethics evaluation of every clinical scenario they may encounter, while simultaneously understanding their role in protecting the rights of individuals.

Physicians' ability to act and communicate in a way that respects the values of the individual patient is a prerequisite for successful treatment. Physicians must also be able to work effectively in teams with other health c are professionals including other physicians.

Failures of individual physicians to recognize the ethical obligations they owe patients and communities can damage the reputation of doctors both locally and globally. Therefore it is essential that all doctors are taught to understand and respect medical ethics and human rights from the beginning of their medical school careers.

In many countries ethics and human rights are an integral part of the medical curriculum, but this is not universal. Too often teaching is undertaken by volunteers, and can fail if those volunteers are unable or unavailable to teach, or if that teaching is unduly idiosyncratic or inadequately based upon clinical scenarios.

The teaching of medical ethics should become an obligatory and examined part of the medical curriculum within every medical school.

Recommendations

1. The WMA urges that medical ethics and human rights be taught at every medical school as obligatory and examined parts of the curriculum, and should continue at all stages of post graduate medical education and continuing professional development.
2. The WMA believes that medical schools should seek to ensure that they have sufficient faculty skilled at teaching ethical enquiry and human rights to make these courses sustainable.
3. The WMA commends the inclusion of medical ethics and human rights within post graduate and continuing medical education.

WMA Statement on Non-Discrimination in Professional Membership and Activities of Physicians

Adopted by the 37th World Medical Assembly, Brussels, Belgium, October 1985
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and revised by the 66th WMA General Assembly, Moscow, Russia, October 2015

The World Medical Association is in favour of equality of opportunity in medical association activities, medical education and training, employment, and all other medical professional endeavours regardless of any factors of discrimination.

The World Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in National Medical Associations to any duly registered physician because of any factors of discrimination.

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The World Medical Association calls upon the medical profession and all individual members of National Medical Associations to exert every effort to prevent any instance in which such equal rights, privileges or responsibilities are denied.

WMA Statement on Ethical Issues Concerning Patients with Mental Illness

Adopted by the 47th WMA General Assembly, Bali, Indonesia, September 1995
and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Historically, many societies have regarded patients with mental illness as a threat to those around them rather than as people in need of support and care. In the absence of effective treatment, to prevent self-destructive behaviour or harm to others, many persons with mental illness were confined to asylums for all or part of their lives.

Today, progress in psychiatric treatment allows for better care of patients with mental illness. Efficacious drugs and psychosocial interventions offer outcomes ranging from complete recovery to remission for varying lengths of time.

The adoption in 2006 of the United Nations Convention on the Rights of Persons with Disabilities constituted a major step towards viewing them as full members of society with the same rights as everyone else. It is the first comprehensive human rights treaty of the 21st century. It aims to promote, protect and reinforce the human rights and dignity of all persons with disabilities, including those with mental impairments.

Persons with major mental illnesses and those with learning disability have the same right to preventive services and interventions to promote health as others members of the community, for which they often have greater need because they are more likely to live unhealthy lifestyles.

Patients with psychiatric morbidity may also experience non- psychiatric illness. Persons with mental illness have the same right to health care as any other patient. Psychiatrists and health care professionals who provide mental health services should refer patients to other appropriate professionals when patients need medical care. Health care professionals should never decline to provide needed medical care solely because the patient has a mental illness.

Physicians have the same obligations to all patients, including patients with mental illness. Psychiatrists or other physicians who treat patients with mental illness must adhere to the same ethical standards as any physician.

The physician's primary obligation is to the patient and not to serve as agents of society, except in circumstances when a patient presents clear danger to himself/ herself or others due to mental illness.

Physicians' Ethical Responsibilities

The stigma and discrimination associated with psychiatry and the mentally ill should be eliminated. Stigma and discrimination may discourage people in need from seeking medical care, thereby aggravating their situation and placing them at risk of emotional or physical harm.

Physicians have a responsibility to respect the autonomy of all patients. When patients who are being treated for mental illness have decision-making capacity, they have the same right to make decisions about their care as any other patient. Because decision-making capacity is specific to the decision to be made and can vary over time, including as a result of treatment, physicians must continually evaluate the patient's capacity. When a patient lacks decision-making capacity, physicians should seek consent from an appropriate surrogate in accordance with applicable law.

The therapeutic relationship between physician and patient is founded on mutual trust, and physicians have a responsibility to seek patients' informed consent to treatment, including patients who are being treated for mental illness. Physicians should inform all patients of the nature of the psychiatric or other medical condition, and the expected benefits, outcomes and risks of treatment alternatives.

Physicians should always base treatment recommendations on their best professional judgment and treat all patients with solicitude and respect, regardless of the setting of care. Physicians who practice in mental health facilities, military or correctional institutions may have concurrent responsibilities to society that create conflicts with the physician's primary obligation to the patient. In such situations, physicians should disclose the conflict of interest to minimize possible feelings of betrayal on the patient's part.

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Involuntary treatment or hospitalization of persons with mental illness is ethically controversial. While laws regarding involuntary hospitalization and treatment vary worldwide, it is generally acknowledged that this treatment decision without the patient's informed consent or against the patient's will is ethically justifiable only when: (a) a severe mental disorder prevents the individual from making autonomous treatment decisions; and/or (b) there is significant likelihood that the patient may harm him/her self or others. Involuntary treatment or hospitalization should be exceptional and physicians should utilize it only when there is good evidence that it is medically appropriate and necessary and should ensure that the individual is hospitalized for the shortest duration feasible under the circumstances. Wherever possible and in accordance with local laws, physicians should include an advocate for the rights of that patient in the decision process.

Physicians must protect the confidentiality and privacy of all patients. When legally required to disclose patient information, the physician should disclose only the minimum relevant information necessary and only to an entity legally authorized to request or require the information. When databanks allow access to or transfer of information from one authority to another, confidentiality must be respected and such access or transfer must comply fully with applicable law.

The participation of individuals with psychiatric illness in research needs to be in full accordance with the Recommendations of the Declaration of Helsinki.

Physicians must never use their professional position to violate the dignity or human rights of any individual or group, and should never allow their personal desires, needs, feelings, prejudices or beliefs to interfere with a patient treatment. Physicians must never abuse their authority or take advantage of a patient's vulnerability.

Recommendations

The World Medical Association and National Medical Associations are encouraged to:

1. Publicize this Statement and affirm the ethical foundations for treatment of patients with mental illness.
2. While doing so, call for full respect – at all times – of the dignity and human rights of patients with mental illness.
3. Raise awareness of physicians' responsibilities to support the well-being and rights of patients with mental illness.
4. Promote recognition of the privileged relationship between patient and physician based on trust, professionalism and confidentiality.
5. Advocate for appropriate resources to meet the needs of persons with mental illness.

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WMA Declaration of Oslo on Social Determinants of Health

Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011
and the title (Statement to Declaration) changed by the 66th WMA General Assembly, Moscow, Russia, October 2015

The social determinants of health are: the conditions in which people are born, grow, live, work and age; and the societal influences on these conditions. The social determinants of health are major influences on both quality of life, including good health, and length of disability-free life expectancy. While health care will attempt to pick up the pieces and repair the damage caused by premature ill health, it is these social, cultural, environmental, economic and other factors that are the major causes of rates of illness and, in particular, the magnitude of health inequalities.

Historically, the primary role of doctors and other health care professionals has been to treat the sick – a vital and much cherished role in all societies. To a lesser extent, health care professionals have dealt with individual exposures to the causes of disease – smoking, obesity, and alcohol in chronic disease, for example. These familiar aspects of life style can be thought of as 'proximate' causes of disease.

The work on social determinants goes far beyond this focus on proximate causes and considers the "causes of the causes". For example, smoking, obesity, alcohol, sedentary life style are all causes of illness. A social determinants approach addresses the causes of these causes; and in particular how they contribute to social inequalities in health. It focuses not only on individual behaviours but seeks to address the social and economic circumstances that give rise to premature ill health, throughout the life course: early child development, education, work and living conditions, and the structural causes that give rise to these living and working conditions. In many societies, unhealthy behaviours follow the social gradient: the lower people are in the socioeconomic hierarchy, the more they smoke, the worse their diet, and the less physical activity they engage in. A major, but not the only, cause of the social distribution of these causes is level of education. Other specific examples of addressing the causes of the causes: price and availability which are key drivers of alcohol consumption; taxation, package labelling, bans on advertising, and smoking in public places which have had demonstrable effects on tobacco consumption. The voice of the medical profession has been most important in these examples of tackling the causes of the causes.

There is a growing movement, globally, that seeks to address gross inequalities in health and length of life through action on the so-

cial determinants of health. This movement has involved the World Health Organisation, several national governments, civil society organization, and academics. Solutions are being sought and learning shared. Doctors should be well informed participants in this debate. There is much that can happen within the practice of medicine that can contribute directly and through working with other sectors. The medical profession can be advocates for action on those social conditions that have important effects on health.

The WMA could add significant value to the global efforts to address these social determinants by helping doctors, other health professionals and National Medical Associations understand what the emerging evidence shows and what works, in different circumstances. It could help doctors to lobby more effectively within their countries and across international borders, and ensure that medical knowledge and skills are shared.

The WMA should help to gather data of examples that are working, and help to engage doctors and other health professionals in trying new and innovative solutions. It should work with national associations to educate and inform their members and put pressure on national governments to take the appropriate steps to try to minimise these root causes of premature ill health. In Britain, for example, the national government has issued a public health white paper that has at its heart reduction of health inequalities through action on the social determinants of health; several local areas have drawn up plans of action; there are good examples of general practice that work across sectors improve the quality of people's lives and hence reduce health inequalities. The WMA should gather examples of good practice from its members and promote further work in this area.

WMA Statement on Supporting Health Support to Street Children

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

The WMA recognises that having children living on the streets is unacceptable in society even though this phenomenon is difficult to avoid in many communities around the world.

The WMA intends to raise awareness within civil and medical society about the fundamental role played by medical contact in improving the situation of street children. In this regard, it is important that the initial contact with street children be based on trust. Therefore, together with other healthcare professionals and social workers, medical contact should be viewed as the first step towards resocialising street children by building trust between the physician and the street child. Once achieved, a more global multidisciplinary and multidimensional approach can follow to improve the well-being of street children.

- Childhood and adolescence are the beginnings of a long physical, mental, cultural and social growth process;
- The health of young people shapes the health of tomorrow's population;
- Young people play a part in social cohesion and they are an asset to any country;
- Addressing the social determinants of health is essential to achieving equity in healthcare. The social determinants leading to the appearance and growth of the phenomenon of street children are varied and complex;
- The negative health impact of living on the streets for children, both in terms of the additional health risks to which these children are exposed and their lack of access to healthcare and prevention; street children are, in particular, more vulnerable to acute illnesses and traumatic injuries. In addition, preventive care and continuity of care are non-existent for street children due to frequent relocation;
- The health of street children remains critical and has been exacerbated by the global financial and economic crisis which has contributed to family break-ups, social upheaval and disruptions in healthcare and education;
- Children may be victims of discrimination arising from their gender, ethnic origin, language, religion, political opinion, handicap, social status or population migration;
- Street children are especially vulnerable to abuse, violence, exploitation and manipulation, including trafficking;
- Child homelessness often goes unrecognised at a national and international level since it is difficult to quantify and assess.

Recommendations

1. The WMA strongly condemns any violations of the rights of children living on the streets and any infringements of these rights, in particular discrimination and stigmatisation and their exposure to abuse, violence, exploitation and manipulation, including trafficking.
2. The WMA calls upon governments to address the factors which lead to children living on the streets and to take action to implement all applicable legislation and systems of protection to reduce the health implications for street children. National authorities have an obligation to provide care for all children and, where necessary, to support their return to a living environment appropriate for a child.
3. Reducing health implications includes not only direct treatment of health issues but also protection of Street Children from health risks such as exposure to drugs, HIV infection, smoking and drinking.
4. The WMA calls upon governments, national medical associations and healthcare professionals to acknowledge the scale of this phenomenon and to instigate prevention and awareness campaigns. These children must be able to access the full range of necessary health and social protection.
5. The WMA urges all national medical associations to work with legal counterparts, governments, health care professionals and public authorities to ensure the fundamental rights of children, who are a particularly vulnerable population in need of protection, particularly access to healthcare and education. The right to food and housing should be guaranteed, and any form of discrimination or exploitation should be forbidden.
6. The WMA condemns any improper age-assessment practices that make use of insufficiently reliable clinical or paraclinical investigations. Until they reach adulthood, adolescents must be able to enjoy their status as minors, as recognised by the UN International Convention on the Rights of the Child.
7. The WMA urges physicians to remain vigilant in terms of delivering all the support required to provide suitable and comprehensive care for street children. Physicians should be aware that homelessness is a pervasive problem. They should be knowledgeable about the existence of homelessness in their own communities and are encouraged to establish a relationship of trust between the physician and the street child to become involved in local relief and advocacy programs.
8. The WMA maintains that every effort should be made to provide all children, and particularly those that are homeless, with access to a suitable and balanced psycho-social environment, in which their rights, including the right to health, are respected.

WMA Statement on Mobile Health

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

Mobile health (mHealth) is a form of electronic health (eHealth) for which there is no fixed definition. It has been described as medical and public health practice supported by mobile devices such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other devices intended to be used in connection with mobile devices. It includes voice and short messaging services (SMS), applications (apps), and the use of the global positioning system (GPS).

Sufficient policies and safeguards to regulate and secure the collection, storage, protection and processing of data of mHealth users, especially health data, must be implemented. Users of mHealth services must be informed about how their personal data are collected, stored, protected and processed and their consent must be obtained prior to any disclosure of data to third parties, e.g. researchers, governments or insurance companies.

The monitoring and evaluation of mHealth should be implemented carefully to avoid inequity of access to these technologies. Where appropriate, social or healthcare services should facilitate access to mHealth technologies as part of basic benefit packages, while taking all the required precautions to guarantee data security and privacy. Access to mHealth technologies should not be denied to anyone on the basis of financial status or a lack of technical expertise.

mHealth technologies cover a wide spectrum of functions. They may be used for:

- Health promotional (lifestyle) purposes, such as apps into which users input their calorie intake or motion sensors which track exercise.
- Services which require the medical expertise of physicians such as SMS services providing advice to pregnant women or wearable sensors to monitor chronic conditions such as diabetes. mHealth technologies of this nature frequently meet the definition of a medical device and should be subject to risk-based oversight and regulation with all its implications.

mHealth may also be used to expedite the transfer of information between health professionals, e.g. providing physicians with free, cross network mobile phone access in resource poor settings.

Technological developments and the increasing prevalence and affordability of mobile devices have led to an exponential increase in the number and variety of mHealth services in use in both developed and developing countries. At the same time, this relatively new and rapidly evolving sector remains largely unregulated, a fact which could have potential patient safety implications.

mHealth has the potential to supplement and further develop existing healthcare services by leveraging the increasing prevalence of mobile devices to facilitate access to healthcare, improve patient

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self-management, enable electronic interactions between patients and their physicians and potentially reduce healthcare costs. There are significant regional and demographic variations in the potential use and benefits of mHealth. The use of certain mHealth services may be more appropriate in some settings than others.

mHealth technologies generally involve the measurement or manual input of medical, physiological, lifestyle, activity and environmental data in order to fulfil their primary purpose. The large amount of data generated in this way also offers huge scope for research into effective healthcare delivery and disease prevention. However, this secondary use of personal data also has great potential for misuse and abuse, of which many users of mHealth services are unaware.

The expansion of mHealth services has been largely market driven and many technologies have been developed in an uncoordinated, experimental fashion and without appropriate consideration of data protection and security or patient safety aspects. It is often impossible for users to know whether the information provided via mHealth stems from a reliable medical source. Major challenges faced by the mHealth market are the quality of mHealth technologies and whether their use ultimately helps patients or physicians achieve the intended purpose.

Comprehensive regulation and evaluation of the effectiveness, quality and cost effectiveness of mHealth technologies and services is currently lacking, which has implications for patient safety. These factors are crucial to the integration of mHealth services into regular healthcare provision.

Recommendations

1. The WMA recognises the potential of mHealth to supplement traditional ways of managing health and delivering healthcare. While mHealth may offer advantages to patients otherwise unable to access services from physicians, it is neither universally appropriate nor always an ideal form of diagnosis and treatment option. Where face-to-face treatment is available this is almost always advantageous to the patient.
2. The driving force behind mHealth must be the need to eliminate deficiencies in the provision of care or to improve the quality of care.
3. The WMA urges patients and physicians to be extremely discerning in their use of mHealth and to be mindful of potential risks and implications.
4. A clear distinction must be made between mHealth technologies used for lifestyle purposes and those which require the medical expertise of physicians and meet the definition of medical devices. The latter must be appropriately regulated and users must be able to verify the source of information provided. The information provided must be clear, reliable and non-technical, and therefore comprehensible to lay people.
5. Concerted work must go into improving the interoperability, reliability, functionality and safety of mHealth technologies, e.g. through the development of standards and certification schemes.
6. Comprehensive and independent evaluations must be carried out by competent authorities with appropriate medical expertise on a regular basis in order to assess the functionality, limitations, data integrity, security and privacy of mHealth technologies. This information must be made publicly available.
7. mHealth can only make a positive contribution towards improvements in care if services are based on sound medical rationale. As evidence of clinical usefulness is developed, findings should be published in peer reviewed journals and be reproducible.
8. Suitable reimbursement models must be set up in consultation with national medical associations and healthcare providers to ensure that physicians receive appropriate reimbursement for their involvement in mHealth activities.
9. A clear legal framework must be drawn up to address the issue of identifying potential liability arising from the use of mHealth technologies.
10. Physicians who use mHealth technologies to deliver healthcare services should heed the ethical guidelines set out in the WMA Statement on Guiding Principles for the Use of Telehealth for the Provision of Health Care.
11. It is important to take into account the risks of excessive or inappropriate use of mHealth technologies and the potential psychological impact this can have on patients.

WMA Statement on Nuclear Weapons

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998
and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008
and by the 66th WMA General Assembly, Moscow, Russia, October 2015

The WMA Declarations of Geneva, of Helsinki and of Tokyo make clear the duties and responsibilities of the medical profession to preserve and safeguard the health of the patient and to consecrate itself to the service of humanity. The WMA considers that it has a duty to work for the elimination of nuclear weapons.

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Therefore the WMA:

- Condemns the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons;
- Requests all governments to refrain from the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons and to work in good faith towards the elimination of nuclear weapons;
- Advises all governments that even a limited nuclear war would bring about immense human suffering and substantial death toll together with catastrophic effects on the earth's ecosyste, which could subsequently decrease the worlds food supply and would put a significant portion of the world's population at risk of famine; and
- Requests that all National Medical Associations join the WMA in supporting this Declaration, use available educational resources to educate the general public and urge their respective governments to work towards the elimination of nuclear weapons.
- Requests all National Medical Associations to join the WMA in supporting this Declaration and to urge their respective governments to work to ban and eliminate nuclear weapons.

WMA Statement on Riot Control Agents

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

Preamble

There has been a long-standing concern regarding the use of chemical weapons. Despite this concern, poison gas was used fairly extensively during World War I, leading to a call from the International Committee of the Red Cross (ICRC) in February 1918 for cessation of its use.

This led to the Geneva Protocol of 1925, the Biological and Toxin Weapons Convention of 1972 (BTWC) and the Chemical Weapons Convention of 1993 (CWC).

All but six countries in the world have signed and ratified the CWC; two more have signed but not yet ratified, making it a nearly universally accepted Convention.

The conventions prohibit the development, production and stockpiling of chemical weapons in addition to their usage in warfare and call for measures to decommission or destroy existing stores. However, the CWC allows the use of specific chemicals in domestic law enforcement including riot control situations, which means that governments might hold stockpiles of certain agents. Even so, riot control agents cannot be used in warfare; the exclusion has reached the status of customary law which allows their use only in domestic or national jurisdictions.

Although there is academic and military interest in what is often called non-lethal weapons, the incidence of morbidity and mortality caused by weapons are not criteria used in prohibition. A tiered approach based upon degrees of lethality of specific weapons is contrary to the ethos of both conventions.

In situations of widespread public unrest and political or other uprisings governments unfortunately may choose to deploy riot control agents in a domestic setting. Although this is not in conflict with the principles of the CWC their use may still give rise to specific medical, legal and ethical challenges.

While riot control agents are designed to make remaining within the riot unpleasant and impractical, they are not expected to directly cause any injuries or deaths. As with all other agents, how they are used determines the concentration to which individuals are exposed. The ability to take evasive actions, such as leaving the area, to reduce exposure may also have an impact. It is recognised that individual determinants including general health and age will affect an individual's response to chemical agent.

Release of chemical agents such as tear gas in a small enclosed space exposes individuals to concentrations far higher than those expected in normal deployment in riot situations, causing higher levels of serious morbidity and potentially death.

Misuse of riot control agents, leading to serious harms or deaths of demonstrators, exposing individuals excessively or using them for oppressing non-violent peaceful demonstrations, may lead to a breach of the human rights of the individuals concerned, in particular the right to life (article 3), the right to freedom of expression (article 19) and of peaceful assembly (article 20) of the Universal Declaration of Human Rights.

Governments, who authorize the stockpiling and use of such agents by their police and security forces, are urged to consider that there might be fatal results of their usage. Governments are required to ensure that they are used in a manner which minimise their likelihood of causing serious morbidity and mortality.

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Recommendations

1. The WMA recognises that the inappropriate use of riot control agents risks the lives of those targeted and exposes people around, amounting to a potential breach of human rights standards, in particular the right to life, the right to freedom of expression and of peaceful assembly as stated in the Universal Declaration of Human Rights.
2. In case of use of riot control agents, the WMA urges States to do so in a manner designed to minimise the risk of serious harm to individuals, and to prohibit its use in the presence of vulnerable populations, such as children, older people or pregnant women;
3. The WMA insists that riot control agents should never be used in enclosed spaces where chemical concentrations may reach dangerous levels, and where people cannot move away from areas with high concentrations of the agent;
4. The WMA insists that governments train police and other security forces in the safe and legal use of riot control agents, in order to minimise the risk of harm when they are deployed. This must include the rapid evacuation of any individual who is apparently suffering from a high level of exposure, not aiming people, and not using the agent excessively;
5. The WMA insists that States penalise individuals who misuse riot control agents and who deliberately endanger human life and safety by using the agents. Such misuse leading to serious physical harms or death of individuals should be investigated by independent experts.
6. The WMA calls for unimpeded and protected access of healthcare personnel to allow them to fulfil their duty of attending to the injured as set forth in the "WMA Declaration on the protection of healthcare workers in situations of violence".
7. The WMA recommends that because of the significant difficulties and risks to health and life associated with the use of such riot control agents States should refrain from using them in any circumstances.

Body Cavity Searches

Vivienne Nathanson

The BMA prepared a revised version of an old WMA policy for consideration at the Committee Meetings in Moscow. Earlier consideration had made it clear that revision was necessary; the BMA agreed to undertake the work. Hernan Reyes, lately of the ICRC worked with the author, to ensure that the version submitted was in accordance with international norms.

Why does this matter?

Body cavity searches are a reality of life within detention settings worldwide. At their least harmful they are rarely performed, but done when it is considered that a detainee might have concealed within a body cavity drugs, weapons or other contraband items. These items might pose a risk of immediate harm to the detainee him/herself, to those around the detainee including prison guards, or might post a future threat within the detention environment.

There are a number of simple ethical principles that need to be observed during the search, regardless of who carries it out. Where doctors are asked to become involved, the ethical principles are added to by consideration of the patient-doctor relationship.

Before any search

All body cavity searches are, at least, potentially demeaning, generating psychosocial harm at some level. They can also result in actual physical harm to the detainee, especially if carried out by someone without training, or by someone not using appropriate care and attention.

The fact that there is a potential risk is not a reason to insist that doctors carry out all such searches; but it is an imperative to require that those performing searches are properly trained and carry out their searching in a safe manner.

Why not a doctor performing the search?

In most cases the searches are carried out for non-medical reasons. Although the detainee could suffer harm from some concealed items in most cases the harm would be caused by their later use on the detainee him/herself or on their use by the detainee against others. The search is therefore performed for reasons associated with the good order of the place of detention, for reduction in the presence of weapons, drugs or other contraband and other associated reasons. If doctors perform the search they are becoming simple arms of the institution, rather than the dispassionate medical professional. This risks undermining the separation of the role of the doctor and thus the patient (detainee)-doctor relationship. If the detainee sees the doctor as just another part of the prison system s/he is unlikely to trust the doctor, and ultimately that breakdown in trust raises significant risks to both patient and doctor, and to public health within the prison community.

Wherever a search is carried out it should be in private. This means within a room or facility where the only people present are the detainee, the person performing the search and at most one witness. More witnesses risks the procedure becoming a spectacle, and demeaning the detainee. A witness may be necessary to protect both the detainee and the searcher. From the perspective of the detainee this should be someone who can be trusted to tell the truth – and to therefore prevent an abusive search. From the searchers point of view the witness should be someone who will stand up to bullying within the prison and protect him from accusations of carrying out an abusive search (provided of course that this is the truth).

Gender of the searcher

In an ideal world the gender of the searcher should be the same as that of the detainee. But this does not protect completely from the reality that searches could be carried out in asexually inappropriate manner – in general it is likely to lessen the embarrassment of the detainee that might help to prevent psychosocial harms.

When the detainee requests a doctor as searcher

On occasion the detainee might ask for a doctor to perform the search; doctors can agree with this, and should ensure before they search that the detainee is aware that, on this occasion, the doctor is acting for the place of detention and not as a prisoner advocate. Doctors are faced with a difficult decision when this request is made as doctors are likely to sympathise with the detainee but have to be aware of the risk that this will undermine the trust that is needed between detainee as patient and his/her doctor.

Consent

Doctors should only carry out searches with the consent of the detainee. They should seek to persuade detainees who are reluctant to be searched that consent and compliance is in their best interest if it is clear that the prison authorities will carry out such searches regardless of consent. They should also seek to ensure that those carrying out such searches do so only where there is good reason to perform them, and then to use the most ethically correct and non-traumatic approach possible.

Abusive searches (rectal examinations)

There is emerging evidence that in some detention settings regular, routine ano-rectal examinations are being performed. This is clearly abusive as there is no relationship with specific perceived threats or evidence of concealments. The "tests" are being conducted without regard to the ethical principles and with a clear intent of humiliating the detainees. This is abuse and unacceptable in any jurisdiction. Doctors who are aware of such abuses must report it or they become complicit in a serious abuse of human rights.

The subject of searches is complex – issues around non-compliance by the detainee, immediate risk to others, the management of transgendered persons all raise considerable questions.

Transgender persons

The draft includes a clause about the management of searches in transgender persons. This is included to flag up the fact that this group of detainees need to be treated with special care, in particular as they are likely to be especially sensitive to such searches, including to the gender of the person performing the search. The clause is therefore intended to sensitise both doctors and prison authorities reading the guidance to the specific broader needs of this group of detainees.

The purpose of the revised WMA guidelines is to introduce as a basic concept the separation wherever possible of the doctor from the machinery of the place of detention and the importance of recognizing that this process might be occasionally essential but it is always problematic and can be seriously abusive and harmful. That encourages the WMA member associations and their members to attempt to preserve the dignity and bodily integrity of their patients – the detainees.

As the redrafters of the resolution the British Medical Association will be interested to see whether the current draft covers issues with sufficient clarity and in enough depth to be of use to WMA members.

Prof. Vivienne Nathanson,
Chairman, Nathanson Health Associates Limited;
Consultant to the BMA on WMA matters; Principle adviser on public health to the WMA

E-mail: viv.nathanson@googlemail.com

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The Climate/Health Nexus at COP21 & Beyond

The health risks posed by climate change are well-recognised, and threaten populations of both low- and high-income countries [1, 2, 3, 4]. They range from the direct health impacts of more frequent heatwaves, flooding and extreme weather events such as storms and bushfires to less direct impacts such as spreading vector-borne diseases, worsening food security and malnutrition and population displacement [3, 5]. At the same time, tackling climate change has been called "the greatest global health opportunity of the 21st century" [4] due to the significant health co-benefits of low-carbon solutions.

For instance, there is now growing attention on short-lived climate pollutants (as compared to carbon dioxide, which is long-lived) such as black carbon and methane, which result in air pollution that kills 7 million people annually. Specifically, rising global car use and the use of polluting fuels such as coal for energy are both major contributors to outdoor air pollution, which is responsible for 3.7 million premature deaths worldwide [6], so a transition to renewable energy and active travel (walking and cycling) could save millions of lives each year attributable to reductions in cardiovascular and respiratory mobidity over the short term alone. These twin imperatives to protect and promote health in the face of climate change lie behind a number of recent health sector declarations and initiatives, from the WHO's Call To Action [7] to the 'Doctors for Climate Action' campaign led by the Royal Australasian College of Physicians [8].

Earlier this month, a historic and unprecedented international agreement was adopted at the United Nations (UN) climate change negotiations in Paris (COP21). This agreement established a critical new framework for curbing greenhouse gas emissions and transitioning away from carbon-intensive economies – thus ultimately tackling climate change and protecting public health. The Paris agreement is not perfect, but it is a monumental step toward a coordinated and effective global response and presents a critical moment for physician and health sector leadership and engagement on climate change.

The Paris Agreement: What it is and what it means for health…

The Paris Agreement was adopted on 12 December 2015 and represents one of the most seminal international agreements affecting health to date. Indeed, World Health Organization Director General Dr. Margaret Chan has described the Agreement as "a significant public health treaty, with a huge potential to save lives worldwide" [9]. Described as "a health insurance policy for the planet" [10] by UN Secretary General Ban Ki-Moon, the Agreement is a product of years of negotiations under the UN Framework Convention on Climate Change (UNFCCC).

The UNFCCC was established as part of the Rio Convention (1992) and includes 196 parties which represent 195 countries and the European Union which have agreed to work towards realizing the ultimate objective of the Convention, "stabilization of greenhouse gas concentrations in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system" [11]. Each year, the Conference of Parties (COP) is held to assess progress under the UNFCCC. Recognizing the urgency of action on climate change and using the framework provided by the Ad Hoc Working Group on the Durban Platform for Enhanced Action (ADP), this year's COP21 in Paris was preceded by months of negotiations in anticipation of a fair, ambitious and binding agreement to establish an agreement for a coordinated global response.

Table 1 summarizes key provisions of the Agreement text that are relevant to health. Health is explicitly included in terms of the "right to health" both in the preamble of the Agreement as well as the decision adopted in Paris:

"Acknowledging that climate change is a common concern of humankind, Parties should, when taking action to address climate change, respect, promote and consider their respective obligations on human rights, the right to health, the rights of indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations and the right to development, as well as gender equality, empowerment of women and intergenerational equity."

This language implies that parties, when taking climate action, should consider and promote "the right to health" as well as principles of human rights and equity. Thus, this language at least implicitly recognizes and compels health sector engagement in action on climate change.

National Climate Action: The Foundation of the Paris Agreement

Leading up to the UN Framework Convention on Climate Change (UNFCCC) Climate Conference (COP21), parties submitted national commitments to tackle climate change, called Intended Nationally Determined Commitments (INDCs). These voluntary commitments are designed to support the Paris Agreement and to succeed the Kyoto Protocol in curbing greenhouse gas emissions. The UNFCCC conducted an analysis of INDCs submitted prior to 1st of October 2015 including 119 INDCs, reflecting commitments of 147 parties to the Convention, and representing 86% of global emissions in 2010. It concluded that these submissions were insufficient to meet the two degree Celsius mitigation goal while also noting that many parties' contributions were conditional on anticipated international support [13]. A recent INDC subgroup analysis by the NewClimate Institute identified potential missed co-benefits including approximately 150, 000 preventable premature deaths from ambient air pollution [14].

In the context of engagement of the health sector in national action to address climate change, the World Health Organization (WHO) recently launched the Climate and Health country profile initiative, through which it strives to "provide relevant and reliable country-specific information about the current and future impacts of climate change on human health, the opportunities for health co-benefits from climate mitigation actions, and current policy responses at country level" to inform engagement and advocacy [15]. Currently 15 countries from different regions have created their country profile. Identified indicators of national progress in protecting health from climate change include:

- Identification of a national focal point for climate change in the Ministry of Health;
- Approval of a National Health Adaptation Strategy;
- Inclusion of health implications of mitigation policies in national strategy for climate change;
- Completion of a national assessment of climate change impacts, vulnerability and adaptation for health;

Table 1. Summary of Selected Key Health-related Provisions of the Paris Agreement [12]

Health	Paris Agreement Preamble, COP Decision	• Acknowledges the right to health in context of action to address climate change
	COP Decision (Workstream 2)	• Recognizes "the social, economic and environmental value of voluntary mitigation actions and their co-benefits for adaptation, health and sustainable development."
Human Rights	Paris Agreement Preamble, COP Decision	• Acknowledges human rights in the context of action to address climate change
Equity	Paris Agreement Preamble, Art. 2 & Art. 4	• Recognizes that implementation of the Agreement should "reflect equity and the principle of common but differentiated responsibilities and respective capabilities."
Mitigation	Paris Agreement Art. 2 & Art. 4	• Sets the long term goal to "[h]olding the increase in global average temperature to well below 2°C" and pursuing efforts to "limit the temperature increase to 1.5 °C above pre-industrial levels" • Recognizes mitigation cobenefits
	COP Decision (Workstream 2)	• Recognizes the mitigation co-benefits during the pre-2020 period
Adaptation	Paris Agreement Art. 2	• Includes the ability to adapt to the adverse impacts of climate and foster climate resilience and low greenhouse gas emissions development, in a manner that does not threaten food production as part of the long-term goal of the Agreement
Loss & Damage	Paris Agreement Art. 8	• Includes recognition of the importance of "averting, minimizing and addressing loss and damage associated with the adverse effects of climate change" • Identifies areas of cooperation and facilitation to enhance understanding, action and support which can include: emergency preparedness, non-economic losses, resilience of communities
Financing	COP Decision	• Sets a new collective quantified goal from a floor of USD 100 billion per year by 2025, taking into account the needs and priorities of developing countries
Non-party Stakeholders	COP Decision	• Invites non-party stakeholders to scale up efforts and support actions to reduce emissions and/or to build resilience and decrease vulnerability to the adverse effects of climate change
Transparency	Paris Agreement, Art. 13	• Establishes an enhanced transparency framework for the Agreement implementation
Education	Paris Agreement, Art. 12, COP Decision	• Calls on countries to take measures to "enhance climate change education, training, public awareness, public participation and public access to information"

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- Investment in institutional and technical capacities relevant to climate change and health;
- Implementation of projects/programs to address health adaptation to climate change;
- Implementation of activities to increase climate resilience of health infrastructure;
- Allocation of domestic and international funds to build health resilience to climate change; and
- Assessment of the health co-benefits of climate mitigation policies [16].

These indicators are an important tool to assess national action and progress on climate and health over the next few years.

Health Sector @ COP21

The health sector has been involved in the negotiations leading up to the Paris climate change conference [17] and had a significant presence both within the negotiating space as well as in the surroundings with many health-focused events. Some of the key health sector events during COP21 include:

- The Paris Conference on Climate Change and Healthcare (Organized by Health Care Without Harm with the French Hospital Federation) [18]
- Health professionals in action for Healthy Energy and Climate (Organized by the Health and Environment Alliance – HEAL in collaboration with the Conseil National de l'Ordre des Médecins (CNOM), the World Medical Association (WMA) and the International Federation of Medical Students Associations (IFMSA) [19]
- Sustainable energy for all and the climate-health- development nexus: Lancet Commission on Health and Climate Change (Organized by The Lancet Commission on Health and Climate, the Global Alliance for Clean Cookstoves, Helio International and the United Nations Foundation)
- Evaluating the Health and Climate Benefits of Clean Cooking (Organized by the UN Foundation, the Global Alliance for Clean Cookstoves, the Fondation Maison des sciences de l'Homme)
- Why the Climate Change Agreement is critical to Public Health (World Health Organization)
- Effects of Climate change on the Social and Environmental Determinants of Health in Africa: What can communities do to strengthen their climate resilience? (Organized by the WHO AFRO Regional Office)
- Health Central to Climate Change Action (Organized by the Principality of Monaco and the Health and Environment Alliance (HEAL))
- Healthy Lives on a Healthy Planet: What is Next for Research and Policy? (Organized by The Université Sorbonne Paris Cité (Centre Virchow-Villermé for Public Health Paris-Berlin) together with The University of Geneva, the London School of Hygiene and Tropical Medicine, the University of Heidelberg, the World Health Organization, the Rockefeller Foundation, and The Lancet)
- The Cost of Coal Film Festival (Pacific Environment, Greenpeace East Asia, Healthcare Without Harm, Ecodefense, groundWork, Climate and Health Alliance (CAHA))

There was a wide range of additional side events covering the intersection between climate change and public health which are not listed above.

A recent study of World Federation of Public Health Associations (WFPHA) of national governments' climate and health policies found a majority of respondent countries have not comprehensively identified health risks of climate change, while, more than 40% have not involved the health sector in mitigation planning or invested in climate-health research. These findings suggest a need for more effective health sector integration and engagement in national action to address climate change and protect health [17]. Similarly, a preliminary analysis of INDCs by the World Medical Association shows that nearly two-thirds of parties (121) included health in some form in their initial commitments, however only about half mention health adaptation (90) and very few (28) mention health in relation to mitigation. The analysis found significant variation across regions with African States (88.9%), Asian States (69.1%) and Latin American & Caribbean States (81.8%) demonstrating leadership in integrating health, while Western European & Other States (13.8%) and Eastern European States (13%) less frequently incorporating health in INDCs [18].

Climate and Health Summit 2015: Engaging with Health in a Post-2015 World [19]

The Climate and Health Summit at COP21 brought together health professionals, policy-makers, negotiators, and academics working at the climate and health nexus around the theme of 'Engaging with Health in a Post-2015 World'. Coordinated by the Global Climate and Health Alliance in collaboration with the WHO and a number of partner organizations, the Summit included a diverse array of sessions ranging from health adaptation and community resilience to communicating climate change through health to exploring how the health sector can best engage with other sectors. During the Summit, an unprecedented alliance of doctors, nurses, and other health professionals from every part of the health sector came together to announce declarations representing over 1,700 health organizations, 8,200 hospitals and health facilities, and 13 million health professionals, bringing the global medical consensus on climate change to a new level. The event issued a resounding message that the health sector is now engaged and is committed to continuing to work to protect health from climate change, and to advocate for public policy which puts health at the centre of climate action.

Post-Paris: What's Next?

The Paris Agreement establishes a new multilateral framework for effective and coordinated global climate action across sectors. Drawing on the momentum of COP21, it is critical that parties work to meaningfully integrate health by promoting health sector engagement, incorporating health in adaptation, mitigation, and loss and damage, as well as ensuring adequate financing [20]. This includes, for example, technical assistance to the UNFCCC in order to best integrate health in relevant areas of work as well as assistance offered on the national level for adequate consideration of health in national climate change planning.

Internationally, health professionals can meaningfully engage in:

- Collaboration with non-health professionals to ensure appropriate valuation of health co-benefits of mitigation policies;
- Development and implementation of adaptation initiatives within and beyond the health sector to consequences of climate change;
- Engagement with the Warsaw International Mechanism, the mechanism tasked by the UNFCCC to address loss and damage associated with impacts of climate change, in ensuring adequate valuation of health losses due to climate change.

National medical associations and similar organizations are well-positioned to engage in post-Paris climate action and the Agreement implementation. Relevant avenues for future engagement include:

- Educating members on the climate-health nexus and opportunities for climate action;
- Integrating climate-health education and competencies into medical school curricula, licensure/credentialing and/or continuing medical education requirements;
- Engaging in the development and implementation of national climate plans;
- Participating in climate and health advocacy through organized national climate and health groups, such alliances where one exists, or consider forming an advocacy alliance;
- Engaging media on the numerous health sequelae of climate change, and the health opportunities of acting on the causes of climate change;
- Promoting local and national policies and initiatives to address climate change's adverse health effects;
- Mainstreaming climate change and health into existing horizontal and vertical public health programs, such as universal health coverage [21], maternal and child health, infectious and non-communicable disease prevention and control, etc.
- Undertaking local research to better quantify the health-related risks of climate change and the health co-benefits of mitigation;
- Addressing the carbon footprint of the health sector itself and to build climate

The World Medical Association participated in climate change negotiations as observers. The WMA delegation included Dr. Xavier Deau (WMA Immediate Past President), Dr. Peteris Apinis (Latvian Medical Association), Dr. Peter Orris (University of Illinois – Chicago), Dr. Yassen Tcholakov (Junior Doctors Network), Dr. Elizabeth Wiley (Junior Doctors Network), Dr. Knut Erling Moksnes (Norwegian Medical Association), Dr. Jaroslav Blahos (Czech Medical Association), Dr. Marie Colegrave (French Medical Council), Dr. Bjorn Oscar Fagerberg (Swedish Medical Association), Dr. Lujain Al-Qodmani (Kuwait Medical Association/Junior Doctors Network), Mardelangel Zapata Ponze de Leon (Colegio Medico de Peru/Junior Doctors Network), Dr. Georgiana Luisa Baca (Junior Doctors Network), Dr. Otmar Kloiber (WMA Secretary General), Clarisse Delorme (WMA Advocacy Advisor), Dr. Bayazit Illhan (Turkish Medical Association). (although not all pictured)

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resilience in order to help withstand climate impacts which cannot be avoided; and
- Continuing to advocate for 1.5° C to protect public health and engage with countries' mitigation strategies to ensure this aim is included in national policies.

The Paris Agreement is a significant symbolic and substantive accomplishment with the potential to catalyze a coordinated global response to climate change. It is essential that physicians and organized medicine recognize the relevance of this victory to our patients and public health – and, as members of the health sector, engage in implementation on a local, national and/or global level to ensure the Agreement's success.

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Elizabeth Wiley, MD, JD, MPH,
University of Maryland, Baltimore, USA,

Yassen Tcholakov, MD, MIH, McGill University, Montreal, Canada

Isobel Braithwaite, MPH BSc,
University College London, UK

Claudel P-Desrosiers, University of Montreal, Montreal, Canada

Pablo Vega, MD, MPHc,
Universidad de Chile, Chile

Edgardo Vera, MD, MPHc,
Universidad de Chile, Chile

Lujain Alqodmani, MD, BMSc,
University of Kuwait, Kuwait

Kimberly Williams MD, MSc,
University of Calgary, Canada

Sudhvir Singh, MBChB, BMedSci,
University of Auckland, New Zealand

Luisa Georgiana Baca, MD, MSc
MedEd candidate, UCL, London, UK

Charlotte Holm-Hansen, MD,
University of Copenhagen, Denmark

Renzo Guinto, MD, Health Care Without HarmAsia and Reimagine Global Health, Philippines