

World Medical Journal



Official Journal of The World Medical Association, Inc.

Nr. 1, March 2016

vol. 62

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Publisher

The Latvian Medical Association, "Latvijas Ārstu biedriba",
Skolas street 3, Riga, Latvia.

ISSN: 2256-0580



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

Health Databases and Biobanks — Ethical Dilemmas

The electronic environment of medical service and research has increased immensely the possibilities of connecting information but at the same time it poses various new ethical aspects to physicians. The electronic medical record is one of these welcomed novelties as it helps physicians and other health care workers in their daily practice. It is a practical solution that makes it possible to have all information on a given individual easily accessible. The main ethical issues are security of data and who is having access but apart from that there are few difficult dilemmas. On the other hand, information for secondary use creates multiple ethical issues. The WMA has for a long time been aware of these possible problems, but a specific initiative in Iceland in the last years of the 20th century spurred a lively dialogue, not only inside the country but internationally as well. It was an eye opener on how data can be used on a higher level as all information from medical records was supposed to be linked to a genealogical database of a whole population as well as to a third database on genetic information. The main “selling point” was to create new knowledge, but the intention was also to sell information to various buyers such as insurance companies. The issue was brought to the WMA who subsequently made a policy statement on the secondary use of medical data, adopted in 2002. This policy was up for revision in 2012 and a prolonged process started, most likely coming to an end this year.

The revision policy has in many aspects been unique for the WMA only to be compared to the policy making for the Document of Helsinki (DoH). This is not a coincidence as the policy on Health Data and Biobanks is to some extent an extension of the DoH with the addition that is not only directed to research on humans but for other secondary use as well. One of the main dilemmas has been the rights of individuals on the one hand and the interest of the holders of data on the other hand. To guard the rights of patients and healthy individuals in their dealings with the health system has been one of the cornerstones of the work of the WMA, evident by many of its policies such as the DoH and the Declaration of Lisbon on the rights of patients. In the case of the use of health data and human biological material, consent is one of main ethical issues. Individuals should have the right to decide on the use of data of themselves. On the other hand, when planning for the use of data from millions of individuals, it is not practical to ask each

and everyone to consent. This has been solved in many ways. One is simply to use data without consent of any kind but that is unacceptable. Another solution is the so-called open consent when an individual accepts that his/her data can be used for any purpose at a later time. This is also unacceptable, at least to the WMA. Other terms have been coined such as broad consent or even mega consent, meaning that the individual is to some extent informed of later use. In the current draft of the revised policy this is solved in a rather complex way but that is unavoidable. Just to mention some of the requirements for consent, individuals should be well informed of the purpose of keeping the data or material, the rules of access to data, the governance arrangements, commercial use, if applicable, and benefit sharing. Many other ethical aspects are addressed as well in the draft that now has been sent formally to the Secretariat of the WMA for processing.

This has been the work of many. Foremost, the representatives of nine National Member Associations of the WMA forming a work group that has had this topic in its hands for the last four years. In two mini-conferences in Copenhagen and Seoul, external experts have been invited to explain various aspects of the use of data and material and they have participated in a dialogue with the work-group members. The participation in an open consultation was overwhelming as around 90 different partners commented and brought forward various ideas.

As a chair of the workgroup I would like to extend special thanks to all of the work group members, to the Danish and Korean Medical Associations for hosting the meetings with external experts and to the German Medical Association for hosting a smaller work group meeting. Thanks are also due to our special experts at many of our meetings, professors Urban Wiesing from Tübingen in Germany and Dominique Sprumont from Neuchatel in Switzerland.

Last but not least, the help of the Secretariat has been absolutely instrumental in making the whole process possible.

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Ageing and Ageism

Based on a plenary presentation at the 3rd International Congress of Person Centered Medicine in London, October 2015



Jon Snaedal

Life expectancy and longevity

Life expectancy is a statistical measure of how long a person may live, based on the year of his/her birth. The term is, however, more frequently used for whole populations and is one of the terms used to estimate the overall health of a population. The term equals average number of years a person born today is expected to live, if mortality rate for each age remains the same in the future. Life expectancy of human populations has been increasing for at least a century and there is no plateau in sight. Inequality in life expectancy is, however, immense and seems not to be diminishing, neither between countries nor inside countries. This is in some cases the result of population unrest and armed conflicts that have been shaping the life of entire populations such as in Syria, Yemen and Sudan just to mention the few most recent and apparent cases. The inequality between countries becomes apparent when looking at the UN population prospects

showing life expectancy of lower than 45 years in some sub-Saharan Africa but more than 85 years in Japanese women. This follows very closely the economic state of respective countries (Figure 1).

When looking at the numbers and how they have been changing, it is amazing to see that the average lifespan in high-income countries has increased by almost three months every year since 1840. For the first many decades, this increase was due to decreasing mortality among the new-born and young children but during the last decades, the life expectancy of the >65 years of age has increased the most.

The causes of increased longevity are manifold but public health initiatives have had more impact than direct medical intervention but there is an overlap between these two types of measures such in the case of general vaccination. Of medical intervention, vaccination of children is the single most effective intervention leading to lower infant mortality and by that, increased longevity. Taking this fact into account, it is really sad to witness some misguided ideas of possible side effects of vaccination that have led to lower proportion of individuals being vaccinated and in turn increased susceptibility of children and vulnerable populations to communicable diseases. This has been much debated and is tackled in many ways. One is to inform and educate, exemplified by the American Academy of Pediatrics [1], another to dictate by laws. The WMA addressed this in a policy document of 2012 "WMA Statement on Prioritization of Immunization" [2]. Another very successful medical intervention, accounting for a very low maternal and infant mortality in high-income countries, is prophylactic health care in pregnancy and for infants

in the first year of life. It is a sad reminder of inequality of the world that even simple interventions, with very well documented results, are not provided for in many low-income countries. We know better and we can do better.

Yet another medical intervention leading to increased longevity of individuals and increased life expectancy is antibiotic treatment for communicable diseases. This has benefited adults as well as children and has led to very low mortality of infections that before were deleterious.

More complicated interventions such as treatment of cardiovascular diseases or cancer have had some effect, not least to increase longevity of middle aged and older individuals. As a consequence of all this, more and more are living to older age and as fertility rate has been decreasing, the proportion of older people has been increasing drastically during the last few decades leading to ageing populations, a development with no definite end in sight [3].

As mentioned before, inequality is evident and seems not to be generally decreasing. This leads to differences in life expectancy related to different social classes and education. This has been addressed in the Marmot review [4] and in the WMA policy document "WMA Declaration of Oslo on Social Determinants of Health in 2012" [5]. Some examples from the first Marmot review: In England, premature death caused by health inequalities amounts totally to between 1.3 and 2.5 million extra years of life. Another example: if those without a university degree would live as long as those with degree, more than 200.000 premature deaths would be prevented each year.

Life extension

Some attention has been put on the possible biological increase in life expectancy.

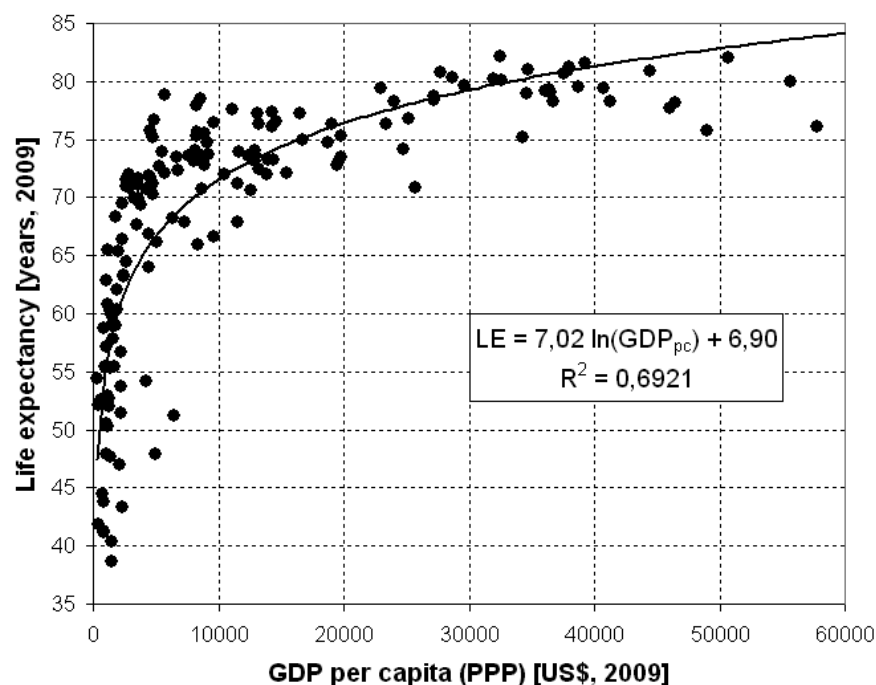


Figure 1. Life expectancy and economic state

Even though life expectancy has been increasing generally and the number of centenarians has been rising, there is yet no direct evidence of increased absolute maximum life span of humans that seems to be around 120 years. The attention has been focused on the genetics of ageing and many have been dreaming of some kind of manipulation of longevity genes in order to increase life expectancy. The term “Life extension science” has been created, addressing possible intervention with the aim to extend both maximal and average life span. The ideas are many: to use molecular repair, stem cell therapy or by use of simple anti-ageing products. Specific organizations have been established to further research in this field [6]. This has been widely criticized in the medical and lay press [7] and very few established scientists have been active in this field. It came therefore as a surprise when the FDA in the US decided to allow for a trial for age prolonging by an old medication for diabetes, metformin.

This trial is both based on evidence from animal research [8] and compelling evidence from epidemiological studies on humans with type 2 diabetes [9]. This study used observational data from the UK Clinical Practice Research Datalink (CPRD) with information from almost 80 thousand subjects treated with metformin, 12 000 treated with sulphonylurea drugs, and 90 000 matched subjects without diabetes with a total, censored follow-up period of more than 500 000 years. Patients with type 2 diabetes treated with metformin monotherapy had longer survival than did matched, non-diabetic controls. However, those treated with sulphonylurea drugs had markedly reduced survival compared with the other groups. The planned metformin trial, which is called Targeting Aging with Metformin, or TAME, is scheduled to start in 2016 and participants are currently being recruited. It is of course interesting to see if individuals can live a healthier life by simple intervention but to prolong life be-

yond maximal life span creates many ethical dilemmas.

Social aspects of ageing

With ageing comes less ability to work and to earn for living. This has, of course, been known for centuries but it was not legally addressed until the Prussian authorities adopted “The Old Age Pension Program” in 1889 designed to provide a pension annuity for workers who reached age 70. This is the first legislation containing social action to secure income for the oldest in society. At that time, the average life span was less than 60 years and thus the proportion of those older than 70 was low. In most middle income and high-income societies, schemes of old age pension have now been in place for decades but the age limit for pension has been lowered to 60–65 years in most countries in spite of increased longevity of populations. The scenario is, however, changing rapidly and the financial burden has now increased to the level that this is not longer sustainable. One country after another is now taken actions to try to lessen the financial burden and the most influential act is to increase the pension age. For example in the UK, the state pension age for men has been 65 years and for women 60 years. According to the Pension Acts of 2011 and 2014 [10], there will be a stepwise increase, steeper for women, up to 67 years in the coming years.

But when do we get *old*? For practical purposes, ageing is often divided into “younger old” (65–80 years) and “older old” (>80 years) but this distinction is not universal and biological age is not equal to chronologic age. Generally, individual normal variation increases with age and to that is added the effect of intrinsic and extrinsic factors. Therefore, the difference in “age appearance” increases with age. In line with increased longevity, more aged individuals than ever enjoy healthy life without diseases and disabilities and to some extent, the goal of “compression of morbidity” is being

met as described in a landmark article in 1980 [11]. By that is meant that the time spent with ill health, functional disability and frailty before death is being shortened.

In every discussion on the effect of ageing of societies, old people are considered a financial burden and when looking at the increasing proportion of older individuals towards people in working age it is evident that there is an ever increasing burden in society. The International Labour Organization has discussed this frequently and has provided some advice [12]. However, older individuals need not to be a financial burden in society. Actually, in Iceland, it has been calculated that in a decade or two from now, those older than 65 years will be a financial asset instead of burden for the society. The reasons are mainly twofold. One is the high level of employment in the ages 65-75 years. Another reason is that pension funds outside the state pension system have been created and form now a good deal of the income of older individuals. Currently, the pension funds are little less than 150% of GDP of the country, the second highest level in the world. On top of this comes that older individuals are becoming healthier.

The increased proportion of the aged in society has many consequences other than financial. The constant focus on the burden of the aged creates a negative view of the individuals and groups and is to some extent the cause of what we call *Ageism*.

Ageism

The term "ageism" was coined in 1969 by Robert N. Butler [13]. The term is used for prejudice or discrimination and involves holding negative stereotypes of individuals and groups based on age. Ageism has mainly been used for individuals in old age but can also be used for other ages, for example, teenagers that feel they are not respected because of their immaturity. Ageism towards the elderly involves often

how younger people expect older people to behave but the concept is broader and exists in all aspects of society. Ageism can be categorized such as:

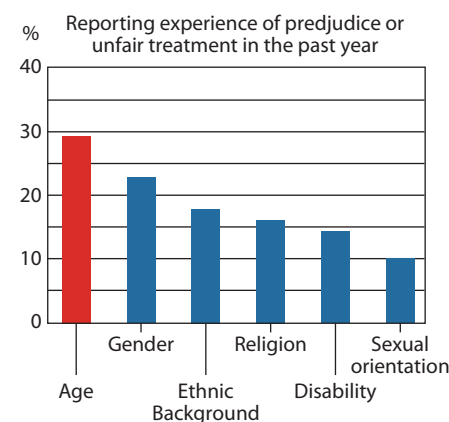
Succession: younger people assume that older people have "had their turn" and should make way for younger generations.

Consumption: there are limited resources in society and younger people feel they should be spent on them (education, etc.) rather than on the older generation.

Identity: older people should "act their age" rather than "steal" from younger people such as in clothing and manner.

Ageism leads to discrimination and in a study by University of Kent [14], age was the single most prevalent basis for discrimination, more than those based on gender, religion or sexual orientation even though the latter ones have created more headlines (Fig 2). Ageism can also be categorized in terms of intention or if it is directed at persons or is institutionalized. Ageism can also be evident or hidden. Intentional ageism is when attitudes and language is used with purpose, taking advantage of older people vulnerability. This includes missions, rules and practices that discriminate against individuals or groups based on their age. An upper age limit for polls is one such example indicating that the views of older individuals are not interesting or important. Another example is how individuals are chosen for interviews in official media. Unintentional ageism is possibly more prevalent. These are descriptions and practices that include bias due to age by those unaware of the bias. The use of language is throwing a light on this. In a survey carried out in students participating in senior mentoring program, 12% of tweets they used contained remarks that were considered discriminating [15]. Sometimes this is done by the best of intentions, to avoid putting responsibility on individuals based on their age without

recognizing that the same individuals welcome this responsibility.



Source: Ago Concom/University of Kent

Figure 2. Discrimination based on age, gender etc.

Ageism is evident in working life such as in legislation, in advertising, in attitudes in the workplace and when cut downs are performed. Ageism is prevalent in the health care and often unintentionally. Upper age limits based on chronological ageing has been prevalent but increasingly, considerations based on biological ageing are used. Older individuals referred to emergency units are sometimes termed "social referrals" when an obvious medical reason is not found. The reason in these cases is most often multi-morbidity in an individual that has experienced a deterioration, small to outsiders but immense in his or her own experience. Another term used for older individuals in hospital wards is "bed blockers", a hugely degrading term.

But how is ageism felt by older individuals? From data derived from the fifth wave of the English Longitudinal Study of Ageing (ELSA) it seems evident that a third of the respondents experienced age discrimination and this increased with the age of the respondents. Discrimination was associated with older age, higher education, lower levels of household wealth and being retired [16].

Initiated by the Brazilian Medical Association, the WMA is currently developing a policy document on ageing that is now being considered by the National Member Associations. In this comprehensive draft to a statement, an advice is given to appropriately train all health care professionals, especially physicians, to deal with the health problems of older people, which imply not only training geriatricians but also mainstreaming aspects of ageing into the medical curriculum. This draft to a policy will be discussed and debated at the next Council meeting in Buenos Aires.

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‘Show Doctors’ and Korean Medical Association’s Efforts for Self-Regulation



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TV Appearances by Physicians and ‘Show Doctors’

KMA strongly recommends that physicians contribute to public health by delivering correct health information to the public as professionals through broadcasting media. However, recently many medical information programs have grown beyond a platform for simply providing medical information and have increasingly become entertainment programs, leading to issues of being too sensational and including distorted and exaggerated content.

Of course, most of the physicians who appear on these shows are respected experts in their relevant fields and conduct them-

selves properly on TV in line with their professional honor and integrity by providing the public with evidence-based health information in an easy-to-understand manner. However, some physicians have either abused TV appearances as a means of commercial marketing or have provided unclear information to viewers which directly harms not only the public but also other physicians who conduct themselves properly on TV. As a result, KMA came to establish guidelines regarding TV appearances by physicians.

What are ‘Show Doctors’?

According to KMA’s definition, a show doctor is a physician who appears on broadcasting media as a physician and either promotes procedures not medically recognized or frequently carries out indirect, exaggerated or false advertisement including

endorsement of specific health foods or supplements.

Birth of Show Doctors and Show Doctor Cases Nos. 1 and 2

Late last year, a famous Korean singer in his late 40s suddenly passed away after receiving surgery. The singer had already received gastric banding surgery and underwent another round of surgery from the same surgeon after complaining of abdominal pain, but died during post-operative period. As a part of legal proceedings aimed at determining whether medical negligence was involved, it was discovered that the surgeon in question had appeared on a health and medical information program regularly, which led to some media to speculate whether the surgeon may have been negligent of patient care because of his frequent media appearances.

Also, late last year, a physician appeared on a health information program related with hair loss and said that *Houttuynia cordata Thunb*, a herb, was effective in treating hair loss, and also sold products containing the same herb through on-line shopping sites. This led to a sudden increase in prices of the herb, and a patient who had received hair transplant surgery strongly protested to his doctor after watching this program. The doctor described above has been designated as the first show doctor by KMA and is currently pending a decision by the KMA's Central Ethics Committee. The second show doctor case involves another doctor who appeared on a TV health program and said that after taking lactic acid bacteria per oral infertility patients became pregnant, people who used to wear glasses no longer had to and patients on medication for chronic diseases such as diabetes and rheumatoid arthritis stopped medication. At the same time, the physician appeared on home-shopping channels and sold lactic

acid bacteria products, which triggered serious social controversy.

Reasons for Show Doctors

1. Excessive competition over ratings due to increase in medical information programs.
2. TV channels need cast members and physicians want to appear on TV.
3. Black market regarding payment for appearances by TV companies.

Types of Show Doctors

1. Physicians who appear on TV to promote products or to market his/her hospital.
2. Physicians who want to become celebrities or TV personalities.
3. Physicians who participate in health food businesses.
4. Physicians who place ungrounded trust on efficacy of foods or health supplements.
5. Physicians who place strong belief in alternative medicine rather than modern medicine.

KMA's Adoption of Guideline on Show Doctors

KMA referenced various sources including the regulations of the Korea Communications Standards Commission, related provisions of the Broadcasting Act, regulations on review of programs that introduce or sell products, regulations of the KMA's Central Ethics Committee, Article 56 of the Medical Services Act on prohibition of medical advertisement and Article 23 of the Enforcement Decree of the Medical Services Act on standards for prohibition of medical advertisement in order to create the basic framework for the guideline, which was then finalized by having the Show Doctor Taskforce revise and supplement the framework according to ethics regulations. The Medical Services Director, Public Relation Director, Legal Affairs Director

of KMA and the Director of the Medical Policy Research Institute participated in the Show Doctor Taskforce to share expert knowledge on experiences of reviewing medical advertisement and ethics regulations of other countries. KMA's Guideline on Broadcasting Appearances by Physicians version 1.0 was distributed on March 26, 2015 after receiving feedback from medical journalists and the Korean Society of Medical Ethics.

Used as Guideline for Physician TV Appearances

KMA distributed the guideline to its physician members and broadcasting related personnel and asked for their active participation. The Korean Association of Producers, the Korean Communications Standards Commission, the Ministry of Health and Welfare and various health and medical organizations responded positively and MOUs were signed to promote the production of proper health information programs in the future. Also the broadcasting review standard was recently amended and supplemented according to the KMA guideline, and even the press extensively covered the guideline which has increased public support for KMA for its efforts to self-regulate.

Ethics Guideline and Controversy over Adoption as Legal Obligation

The Ministry of Health and Welfare newly added regulations on administrative penalties against show doctors to the Enforcement Decree of the Medical Services Act for "actions that harm the dignity of medical professionals" (up to 1 year of license suspension).

Regarding this, KMA's position is that any guideline on broadcasting appearances by

physicians should be approached as a recommendation and ethical norm, and KMA is against the adoption of any compulsory legal measure against physicians. However, the issue of show doctors is not limited to just physicians and involves all health-related professionals such as traditional medicine doctors, dentists, pharmacists, nurses and nutritionists. In particular, Korea has a two-tracked medical system that recognizes traditional medicine doctors who practice empirical alternative medicine as a separate professional group, apart from physicians who practice modern medicine. As a result, there is greater concern of medical professionals appearing on TV and transmitting wrong medical information to the public without any or proper evidence. Accordingly, the medical authority has insisted that penalties against show doctors should maintain equity among different medical professions, and adopted the amended enforcement decree which is expected to be

applied to all medical and health professionals.

Future KMA Plans against Show Doctors

KMA created the Show Doctor Review Committee on May 20, 2015 to restart its activities regarding sanctions against show doctors. The Review Committee expressed its commitment to consider the issue of show doctors from a more fair and professional perspective by appointing KMA officers who had been members of the Show Doctor Taskforce as well as journalists and ethics experts as members. Also, the Review Committee is planning to strengthen its exchange with the Korean Communications Standards Commission and broadcasting producers to prevent TV programs from violating the guideline and to prepare follow-up measures regarding any future

violations. The Committee also plans to expand the guideline to cover appearances by physicians in all forms of mass media. KMA is greatly encouraged by the fact that the Guideline on Broadcasting Appearances by Physicians proposed by KMA was adopted as a WMA resolution at the WMA General Assembly held in Russia in October 2015 and promises to continue its efforts to provide correct health information to the public.

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Medical School Numbers and Career Choices: Current Problems in Medical Education



David Gordon



Line Engelbrecht Jensen

It is generally agreed that there has been progress in recent years in many of the aspects of medical education, but a particular problem is that we do not have good information on the numbers of new medical schools, and their quality. How do we decide how many medical schools are needed? How do we decide which standards these schools as well as long-established schools should use, and how do we assess their performance in meeting those standards? We also need a better understanding of the processes that decide entry of newly qualified doctors into specialist training. How are their choices influenced and managed, and how do they meet the needs of the health care system?

The development of new medical schools is an uncertain process [1,2]. Very broadly, in first-world countries, the approximate figure of new medical students required was that, for each million of the population, there should be 100 new medical students each year [3]. This figure is probably now

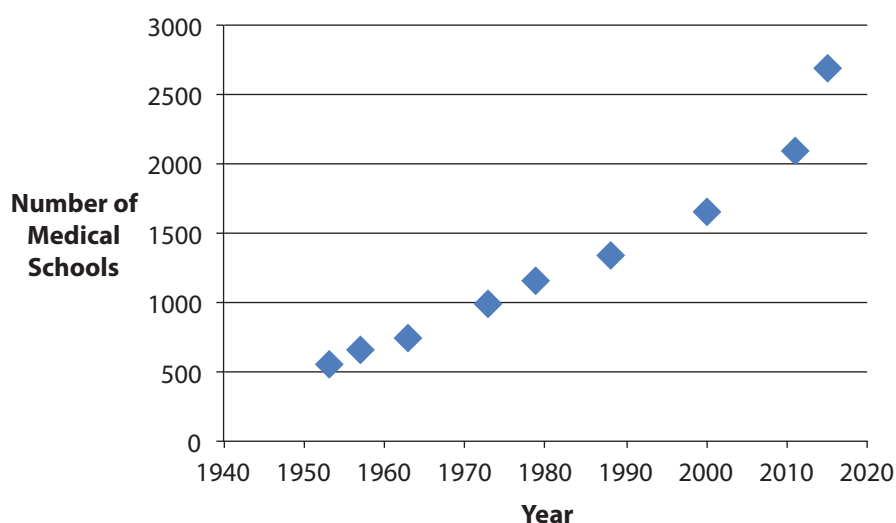


Figure 1.

significantly higher for a number of reasons – the increased feminisation of the medical workforce [4] and the increasing complexity [1] of medical practice being important factors. However, in many countries, a new medical school may be agreed for reasons that are political [5] or commercial rather than rational, for example “for profit” medical schools[6].

An interesting example of a planned process for the development of new medical schools comes from the early history of the USSR. Leaving aside the long-established medical schools of Russia and Ukraine (and also the special case of the three Baltic states), in each republic of the former USSR, the first ever medical school was always set up within 10 years of the republic joining the USSR. This is a remarkable example of planning of the health medical workforce to meet the needs of the population in nations that had been neglected by the Czarist Russian empire, and contrasts with the many failures of planned Soviet economies in other walks of life [7].

Since 2013, the World Federation for Medical Education (WFME) [8] and the Foundation for the Advancement of International Medical Education and Re-

search (FAIMER)[9] have jointly managed the World Directory of Medical Schools, WDMS[10], the only authoritative list of all the medical schools in the world. In 2015, WDMS lists over 2700 medical schools, but there is a supplementary list of about 600 additional schools that are believed to exist. This supplementary list was created using information obtained from a number of sources. However, verification that these additional schools actually exist, and meet the criteria for inclusion in WDMS, is difficult to obtain, because reliable official sources are slow, and sometimes unwilling, to provide information.

The number of medical schools in the world is growing rapidly and much of this growth is without good reason – national governments failing to take, or ignoring, expert advice, or subject to corrupt practices; or commercial organisations establishing unnecessary schools solely for profit. However, many new medical schools are undoubtedly founded for worthy reasons: the health care system that will benefit from the new school needs more doctors.

Yet, even if there is a good reason for a new school or schools, exact decisions are not always made on the best evidence. Predict-

ing the future is logically not easy, but many countries do work actively with workforce planning [1,11]. These predictions are obviously not the exact truth but may be the best evidence available. However, these efforts to predict future demand as well as understand fluctuations of supply of doctors have been seen to be ignored when decisions on changes in medical student numbers and opening of new schools are taken. This tends to happen when current political “gut feelings”, often related to election years, take priority over best evidence with politicians acting primarily in response to current political, demographic and economic pressures [5].

These decisions naturally carry implications far into the future. Another flaw is the failure to consider the careers and career choices of doctors after obtaining their primary medical qualification. A potentially large increase in number of medical students needs to be matched by additional numbers of postgraduate training positions and unwanted, rushed, educational reforms can be the result when the lack of postgraduate capacity is realised too late, as seen in the UK [12]. This led to disruption of many careers and loss of doctors overseas from the UK. Another risk is to educate doctors with little prospect apart from unemployment, a personal problem for the unemployed doctor, a potential financial problem for society and a stimulus for further rushed reforms [11].

Regarding the quality of new as well as already existing medical schools, the standards for medical education have been a concern of WFME for many years [13]. Although WFME standards for basic medical education have been extensively adopted world-wide, with appropriate adjustment to meet the local context of medical education, the process of systematically assessing whether or not a medical school is actually meeting the standards has been patchy. This process – the accreditation of educational programmes, the certification of the suitability of medical education programmes, and of the competence of medical schools

in the delivery of medical education – is of the highest importance.

After WFME had completed its programme of developing standards for medical education, including standards for basic medical education, for postgraduate medical education, and for continuing professional development of medical doctors, it turned to consideration of the use of these standards in accreditation. The outcome was a joint World Health Organization–WFME statement on the promotion of accreditation, and a WHO–WFME policy paper on the processes of accreditation [14]. That policy paper remains the definitive statement of how the accreditation of medical education programmes should be carried out.

Accreditation has a cost in money and staff time, but it is a cost that must be accepted. To run the teaching programmes of a medical school without assessing how well they are performing their function is as illogical as flying an aeroplane without making sure the aircraft is mechanically sound, regularly serviced, and supplied with fuel. The evidence for the efficacy of accreditation is limited [15] but is often seen most clearly when accreditation is introduced for the first time to a long-established education system [16].

The implicit value of accreditation was acknowledged by the Educational Commission for Foreign Medical Graduates (ECFMG) of the USA when it announced the policy that, with effect from 2023, overseas medical graduates wishing to work in the USA will only be accepted for assessment if they have graduated from a school that meets North American or WFME standards for accreditation [17]. This requires that we must be certain that accrediting agencies are meeting accepted international standards, to verify that the assessment of medical schools within the remit of each accrediting agency are working to the right standard. The outcome is the WFME Recognition of Accreditation Programme, in which official accrediting

agencies are evaluated in their performance in a transparent and rigorous process to ensure that accreditation of medical schools is always at an internationally accepted and high standard, meeting the agreed WHO–WFME policy [14].

The new ECFMG policy has undoubtedly been a powerful stimulus to the accreditation of medical education, world-wide. However, international recognition of accreditation of medical schools is much more important than simply a permit to apply to work in another country. It is important that it verifies the standard of education for all medical graduates, to the future benefit of society and the patients of these doctors of the future.

We therefore call for a coherent system: student numbers and (where necessary) new medical schools determined by rational and evidence-based data; postgraduate service and training posts aligned to the needs of the health care system and to the number of emerging graduates; medical schools delivering programmes of education to contextually relevant standards; the performance of medical schools being evaluated and enhanced by accreditation; and accrediting agencies being evaluated to ensure that they are also at the required standard. If all elements of this system work together, and with the best motives, then the problems of medical education will be many fewer.

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Medical Education in the Postmodern Era



Leonid A. Eidelman

One generation passeth away, and another generation cometh; and the earth abideth for ever. (Ecclesiastes 1:4)

How do you know something is fine art in the postmodern era? Because the museum curator said it is.

In the postmodern era, characterized by a democratization of opinion and influence, anyone can be an art critic, anyone can be a politic pundit and anyone can be a medical expert. In today's "flat world," truth is supposed to be relative. Information is now crowd-sourced and diversified. Medical opinions that were once taken at face value from one's own doctor are now parsed through the internet, dissected in online forums with other laypersons. The question is not whether this evolution is good or bad; the question is how traditional systems and structures – such as medical education – will evolve to remain relevant and at their best.

We are now more than half a century into the postmodern era, which introduced multiculturalism and relativism into a world of

certainty and hierarchy. In 1966 the artist Carl Andre debuted with *Equivalent VIII*, known colloquially as the Bricks. Andre's piece comprised 120 bricks that were "placed in meticulous rectilinear relationship within the gallery space" [1] making a new use of the environment as part of an art display. Stacked firebricks became art when a museum bought and displayed them. Not long after, a non-orchestral performance with a sound mixer and no plot became an opera when its director called it an opera. In 1967 Jacques Derrida's *Of Grammatology* was published, creating the concept of deconstructive criticism and effectively reinventing literary theory.

Postmodernism differs from modernity in its questioning of reason, rejection of great narratives and emphasis on subcultures. Rather than searching for one ultimate truth that could explain all of history, postmodernism focuses on contingency, context and diversity. The postmodern world is characterized by the coexistence of various narratives in one global village.

Amid these changes in philosophy, cultures and values contracted and expanded, and medicine, once an absolute, began its transformation. Modernism had venerated doctors as educated authority figures, experts on medicine whose knowledge could be taken for granted; postmodernism emerged and questioned reason, rejected overarching narratives and respected alternative backgrounds and approaches.

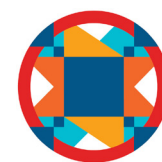
Fifty years later, medical schools and residency programs are made up of the second postmodern generation, millennials [2]. This generation approaches medical school with a wholly new set of expectations, needs and learning styles. When millennials enter medical school, they are older than medical students have traditionally been, and their backgrounds more varied. They have needs

that will not be met within a traditional program. Millennial students have expectations of a less formal relationship with their professors; they crave mentors and interaction, rather than lectures and authority. They prefer team learning as much as team working. They place much less emphasis on professional formalities and much more on their individual impacts and purposes within medicine. They are accustomed to digital formats and interactive learning, and resistant to the traditional podium-audience model [3].

The medical world is very different from the one in which the more traditional teaching format was developed, and the distinction between modern and postmodern theory has been amplified by the digital age. Medical students and residents, like everyone in the developed world, live a reality of entirely new forms of communication. They have been habituated to visual learning and prompt gratification, accustomed to having answers always at their fingertips. There is an information explosion: no longer do we live in a world in which information is centralized. "Truth" and "expertise" are more democratic than ever before, and with the perseverance of postmodern theory, there is an ongoing focus on the diversity of ideas and a rejection of absolute truth.

Millennial learning practices are the newest iteration of the postmodern movement. When burnout and job dissatisfaction among physicians are at record highs, the probable conclusion is that the old system does not suit contemporary needs. The only option now is to make adjustments and sync up postmodern needs and desires with a postmodern learning environment.

Millennials begin their training with the same excitement and same good intentions as medical students always have, but they suffer burnout increasingly early in their careers: 45% of physicians have symptoms of burnout, and 46% of interns experience symptoms of depression in their first year [4]. According to Richard Schwartzstein, "We have [medical



students] memorize long lists of facts, delay their involvement with patients, and expose them to frustrated and overwhelmed faculty members who are under increasing pressure to generate greater clinical revenue. And students' empathy diminishes [5]."

It is imperative, therefore, that the medical establishment makes adjustments to insure that medical students are taught in the environments in which they will learn most effectively and be content in their chosen profession. Physician dissatisfaction is strongly associated with medical errors, prescribing habits, patient compliance, patient dissatisfaction and medical malpractice suits. Learning styles are just one component of keeping students and residents on track. To preempt burnout, the medical community

must encourage "happiness" among medical students and young doctors. Young doctors should be given the skills, time and space to create healthy lifestyles. Medical programs should use their platforms to emphasize a work-life balance, and remind students that they will be better doctors – and more fulfilled individuals – if they regularly remember to take care of themselves as well as their patients.

Today, medical students are well-educated, technology-oriented and empathetic. They have expectations that should be considered and valued, and the postmodern era calls for recognition of the evolution of learning. The medical establishment can, by adjusting to the new styles of the millennial generation, create better working conditions and better

patient care, delay burnout, enhance resilience and ultimately lead to professional fulfillment.

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Social Determinants of Health

Report from Satellite Meeting Commonwealth People's Forum



Sascha Reiff

The Medical Association of Malta (MAM) organised a satellite meeting for the Commonwealth People's Forum during the Commonwealth Heads of Government Meeting (CHOGM) held in Malta in November 2015.



Gordon Caruana

Mr. Gordon Caruana Dingli, President of MAM, introduced the topic of social determinants of health and argued that these are not only significant in less developed countries since social gradients exist even in af-

fluent societies. His main message was that measures to reduce inequities require commitment at all levels: political, social, and individual healthcare professionals.

The conference was opened by the Hon. Parliamentary Secretary Mr. Chris Fearne who described social determinants of health as being the area where politics and health interact. He believes that politicians should work together in a whole-of-government approach and take policy decisions that would improve these social factors, to ultimately lead to an improvement in public health.



Chris Fearne

Dr. Solaiman Juman, President of the Commonwealth Medical Association



Solaiman Juman

tion described social determinants of health as being the root causes of the causes of ill health and argued for investment in areas other than healthcare, to indirectly improve public health. His main message was that countries should aim to improve empowerment and health literacy of their population, mainly through education.

Dr. Natasha Azzopardi Muscat, President Elect of the European Public Health Association presented statistics which clearly show that Malta is not immune to social gradients.



Natasha Azzopardi

Differences in educational level, gender, ethnicity, household income and even living in certain regions are associated with differences in rates of mortality, health, level of physical activity, BMI, and presence of certain diseases. She also argued the case that general socioeconomic, cultural and environmental conditions influence outcomes in health as much as, if not more than, individual lifestyle factors. The former is causing social gradients to increase, especially post-financial crisis, and is due to the non-implementation of preventive interventions. Countering this trend requires the will and the means to make change happen. Further research, implementing effective policies and sharing of best practice across the EU and Commonwealth are key to reducing health inequalities.

Mr. Duncan Selbie, CEO of Public Health England followed up on Dr. Azzopardi Muscat's recommendations by listing the most important contributions to reducing inequity in health:



Duncan Selbie

employment and housing. These would provide a positive feedback by decreasing risks to health, and increasing income, access to healthcare, education and ultimately better health.

Sir Michael Marmot, who chaired the WHO Commission on Social Determinants of Health and is now President of the World Medical Association, presented evidence that showed how interventions in early childhood can help children in the lowest quintile of development to catch up with their peers who are in the highest quintile of development if placed within a better socioeconomic environment. Similarly, countries which have high levels of social mobility have less income inequalities. Inequities in the current generation are damaging the chances of future generations, further perpetuating the problems. He argued for giving children the best start in life possible, creating fair employment and good work, ensuring a healthy standard of living and growing old healthily. Inequalities are inevitable but it is up to us to change the magnitude of inequalities. Do something, do more, do better!



Sir Michael Marmot

Ms. Mary Ann Sant Fournier, President of the Malta Chamber of Pharmacists introduced Mr. Raymond Anderson, President of the Commonwealth Pharmaceutical Association who reiterated the message



Raymond Anderson

that we should follow the social model of care which is based on the understanding that in order for health gains to occur, social, economic and environmental determinants

must be addressed. He believes resources should be channelled towards building social capital – interventions which increase community awareness, connections and relations. He presented a programme (Building the Community- Pharmacy Partnership) which takes advantage of the close contact that community pharmacists have with their communities, to create a partnership between them, encourage community activity and empower people. This could lead to a reduction in health inequalities.

Finally, the Rt Hon. the Lord Kakkar concluded that the true underlying factors for improving health are not the technology and procedures that are available in specialist institutions, but the general socioeconomic, cultural and environmental conditions within our society. We need to turn our attention to these determinants of health and work towards equity in our societies. This requires action at all levels.



Lord Kakkar

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Solving the Climate Crisis will Make us Healthier and More Prosperous



Kevin de León

Scientists and medical professionals have warned for decades that climate change will create unprecedented challenges to public health, especially among impoverished communities. According to [recent research](#) published in the scientific journal, *Lancet*, climate change “threatens to undermine the last half century of gains in development and global health.” We are already observing some of those consequences. Parts of Asia and Latin America that were previously immune are experiencing [unprecedented levels of insect-borne disease](#) such as malaria and dengue fever, while drought and famine have wreaked havoc on a massive scale across the Middle East and Africa, in some cases prompting or exacerbating violent conflict. There is no question, addressing climate change is an issue of human rights and civil rights – of life and death.

Fortunately, it is not too late to slow or prevent altogether many of the worst impacts of a warming planet. Based on what the science is telling us, it is no overstatement to say that

tackling climate change could be the greatest global health opportunity of this century. The Paris agreement establishes ambitious goals that, if met, would go a long way to avert a global health catastrophe. But it is up to each and every nation, and to the subnational governments at every level, to see to it that we meet those goals. Ultimately, this fight will be won or lost nation by nation, state by state, city by city.

Now the truly difficult work begins. We need to ensure that our transition to a clean energy economy protects our most vulnerable and disproportionately impacted communities, both globally and locally, including the poor, sick, and elderly, who bear the disproportionate impacts of air pollution, extreme weather, and other impacts associated with climate change.

In the United States, pollution from freeways, power plants, refineries, ports and other sources disproportionately harm the poor and people of color. A recent study by the national NAACP found that 40% of the 6 million Americans living in close proximity to coal-fired power plants are people of color.

As President Obama has noted, “Today, an African-American child is more than twice as likely to be hospitalized from asthma; a Latino child is 40 percent more likely to die from asthma.” So, the President continued, “if you care about low-income, minority communities, start protecting the air that they breathe.” (Remarks by the President, August 3, 2015).

My home state of California is no stranger to the costs of air pollution and extreme weather patterns. According to the American Lung Association, [California is home to the five most polluted cities in the na-](#)

[tion](#) for ozone and particulate matter, which come primarily from vehicle tailpipe emissions. 8 in 10 Californians currently live in areas with unhealthy air. Twice as many Californians die early deaths from the health impacts of vehicular pollution than from motor vehicle accidents every year. To make matters worse, we have endured nearly five consecutive years of record drought, along with devastating wildfires, both of which have harmed our economy and the health of our communities.

Making clean energy and low-carbon transportation options available to all, regardless of socioeconomic background, is critical not only because it is the right thing to do, but because it accelerates our transition to a more sustainable economy.

When electric vehicles, solar panels, and other clean energy technologies are available only to the wealthy and privileged, we are not achieving the reductions in emissions and improvements in air quality that we need to achieve to make a difference for the climate or for the health of our communities.

The voice of health professionals is vitally important in this debate. From the perspective of legislators trying to advance equitable solutions to this monumental challenge, we need you to be engaged in the policy trenches. We need you to educate your communities, colleagues, and policymakers at every level of government about why climate change is the health equity issue of this century: what’s at stake, and the health co-benefits of strong climate action.

I urge you: use your voice to support climate policy solutions that bring health and equity co-benefits to the communities that need them most.

*Senator Kevin de León (D-Los Angeles),
President pro Tempore of the
California State Senate*

Punching to Fortune or to the Grave? Scrutiny on Boxing



Bernard Mutsago



Selaelo Mametja



Mzukisi Grootboom

Introduction

Studies prove that boxing is a dangerous sport associated with devastating injuries and chronic neurological damage to its participants. Despite this, boxing still has a huge following worldwide and concerned health bodies have expressed serious concern about the dangers associated with the sport.

Deep in the Eastern Cape (EC) province of South Africa, in a local township called Mdantsane – the second largest township in South Africa – thousands of youngsters are raised up in a boxing climate of almost religious proportions. In that township, ramshackle and overcrowded gymnasiums and boxing clubs flourish, to which scores of youths daily flock for training sessions under the tutelage of home-grown trainers. Doubtless, many of the youngsters are lured by the prospect of fame and fortune, some by genuine love of the ‘sport’. A handful of schools in the area offer boxing as an extra-curricular activity.

Located in the same province as the home of the illustrious, once amateur boxer and former president of South Africa, Nelson Mandela, Mdantsane has earned itself the name “the Boxing Mecca of South Africa”. It is where boxing world champions

like Nkosana ‘Happyboy’ Mgxaji, Welcome Ncita and Vuyani Bungu hail from. It is also where the shock of a native hero’s death hits the most, such as when the boxer Mzwanele Kompolo died in 2015 following a fatal blow to the head during a match.

About 1500 kilometres from Mdantsane, in the north-lying South African province of Limpopo, a rural Venda village has also earned its title of “the Mecca of bare-knuckle fighting”. The indigenous tradition of *Musangwe* – characterised by extreme, unsupervised, open field fist fighting – is a common Venda cultural event believed to have been handed down to the generations by ancestors since as early as the 18th century. At a traditional *Musangwe* boxing tournament, only male villagers qualify as spectators and participants. High profile traditional leaders, tribesman and organisers fiercely defend the practice, which they claim helps young men build their courage and prepare them for life’s challenges.

To the participants, the treacherous punches, dangerous knockouts, loss of teeth, and other unseen bodily harms are a fair price for the personal and tribal glory that accompanies the conquest. Unlike Mdantsane though, *Musangwe* fighters are not in the game for money, and there has never been a world champion from that area.

Such is the character of boxing in certain places in South Africa. There could be similar – or worse – versions of this sort of informal brutal activity in other countries in Africa or across the globe. Unsupervised or underground boxing competitions put at risk the lives and health of many athletes, especially naive youngsters who are enticed by money. On the whole, South Africa has a relatively well established formal boxing regime which has significant spectatorship, over 500 licensed boxers, and 9 international title holders in 2012 [1]. Further, the existence of the South African Boxing Act 2001 as well as formal boxing authorities, such as Boxing South Africa and the South African National Amateur Boxing Organisation, facilitate the control and regulation of the sport, although lacking emphasis on health and safety of boxers.



Figure 1. Mdantsane township, South Africa

Arguments against boxing

Boxing is a collision sport. While participating in any sporting activity entails the risk of catastrophic or fatal injury, boxing is unique in its intent on inflicting deliberate physical harm on the opponent; this is the hallmark of boxing criticism. As knocking the opponent down is a principal motiva-

tion in boxing, the head region is specifically targeted, producing an alarming incidence of chronic brain injury [2]. Calling for the abolishment of boxing, the then Secretary General of the World Medical Association in 2000, Dr. Delon Human, described boxing in strong terms: *"It [boxing] cannot fairly be described as a sport; it is simply a barbaric practice"* (emphasis mine) [3].

Examination of the available literature shows that repeated trauma to the head results in minor to serious head injuries and associated neurological complications leading to long term neurodegenerative diseases such as Parkinson's and Alzheimer's diseases. For example, study findings published in the British Journal of Sports Medicine [4] show that the most commonly injured body region was the head/neck/face (89.8%), followed by the upper extremities (7.4%). Specifically, injuries to the eye region (45.8%) and concussion (15.9%) were the most common. Another study found that 51% of injuries were to the facial area, 17% to the hands, 14% to the eyes, and 5% to the nose [5].

Sustained blows to the head lead to acute and sub-acute neurological consequences that include cerebral concussions ("knock outs"), headaches, tinnitus, forgetfulness, impaired hearing, dizziness, nausea, impaired gait, cognitive deficits and acute neuronal and astroglial cell lesions associated with Alzheimer's disease. The most threatening of long term consequences of head blows/injuries is chronic traumatic encephalopathy (CTE) also known as chronic traumatic brain injury (CTBI), dementia pugilistica and 'punch drunk'[6]. Other consequences include tremors, dysarthria, Parkinson's disease, ataxia spasticity, dementia, memory disorders, depression, addiction and irritability [2, 5, 7].

Not only do boxing injuries affect the head but many other areas of the body, such as the upper and lower extremities as well as the thorax and back [8].

Boxing risks for children and adolescents have particularly attracted great attention. Many young boys and girls around the world take part in the dangerous sport of boxing despite the attendant risks. For example, an excess of 18 000 youngsters below 19 years of age were registered with USA Boxing in 2008 [9]. Although amateur boxing is considered safer than professional boxing, injuries still occur [10]. Medical organisations such as the American Academy of Paediatrics, the Australian Medical Association and the Canadian Paediatric Society oppose boxing as a sport for children and adolescents [9].

Not only do injuries occur during competition but also during training. A prospective cohort study published in 2006 found 57% of injuries occurring during competition, versus 43% occurring in training. Intensity of the physical combat was found to be a stronger risk factor than exposure time. The study also found that although training took 99% of the time, only 43% of injuries occurred during training and 92% of the injuries sustained by the cohort during competition were to the head [10].

Other arguments in condemnation of boxing border on the moral, ethical and legal grounds. These include observed association with aggression and criminality [5] as well as the discreditable demonstration of interpersonal violence through the media. The later sparks calls for censorship by authorities such as the Australian Medical Association which recommends that media coverage of boxing should be subject to control codes similar to those which apply to television screening of violence [11]. It is argued that the courage and discipline purported to be provided by boxing can be obtained from other safer sports.

Boxing fatalities

While surveillance data is generally poor, boxing fatalities are reported in various

sources, including the media. The cause of sudden death in the ring is either cardiac or neurological [12], with subdural haematoma being the leading cause of death in sports-related traumatic brain injury [2]. Annually, about 10 boxers die due to a knockout in most cases [13]. There were 339 mortalities between 1950 and 2007 (mean age, 24 ± 3.8 years); 64% were associated with knockouts and 15% with technical knockouts [14].

There has been a string of boxer fatalities in South Africa, including the deaths of Phindile Mwalase and Mswanele Kompolo who both died directly as a result of a blow to the head in 2014 and 2015 respectively. Unfortunately most local boxers are not well funded and end up seeking healthcare in public health facilities. Globally, some deaths have not been mere statistics but incendiary events that changed the history of boxing. In 1994 the British Medical Association made calls for the ban of boxing following the death of a 23 years old professional boxer, hours after a boxing fight. A blood clot was removed from his brain. In March 2015, the Australian Medical Association also called for a ban following the death of a 23 years old professional boxer

The fortune factor

Boxing was never initially intended for physical fitness, but for the amusement of ancient nobles and crowds, against the will of participants who were often slaves. Today, boxers have autonomy and they partake in boxing for a variety of reasons. A certain national boxing authority identifies fitness merely as an 'additional benefit' of boxing [1]. It is highly unlikely that many modern fighters climb into the ring just to entertain spectators.

There is something else phenomenal lurking behind the craze of boxing. Although few of them reach the level of better-paying professional boxing, *"for young men, in this*

place [Eastern Cape Province, South Africa], boxing is the only way out of poverty" (emphasis mine) [15]. This telling expression reveals the power of the lucrativeness of this 'sweet science' to many aspiring boxers in deprived circumstances in various parts of the world. Not surprisingly, needy parents of such ambitious youngsters seem to accept and encourage the pursuit of a boxing career as a straight route out of poverty.

Under the fortune proposition, it becomes easy to explain boxers' tendency to hide their unfitness or previous injuries. Noh et al. found that "of the athletes who returned to training following injury, only 19.33% of them had completed their full treatment. Most returned to training early due to **greed**" [16]. Some sources also note that the pressure to participate while injured or not having fully recovered may come from coaches and managers [17].

One wonders how many youngsters go into the boxing sport without fully understanding the risks. Ironically, many boxers, most probably in the African milieu, die bankrupt. In the article *Whores, Slaves and Stallions: Languages of Exploitation and Accommodation among Boxers* [18], Wacquant eloquently elucidates the 'corporeal exploitation' and manipulation of boxers by "flesh peddlers", i.e. the promoters and matchmakers who further their financial interest at the expense of boxers' safety and dignity. Against the constant plea by boxers and boxing structures for more boxing sponsorship, the British Medical Association, one of the most ardent opponents of boxing, criticises increased funding for boxing [19].

Boxing legality in various countries and the banning-unbanning 'seesaw'

While boxing participation and spectatorship continues to be huge and permitted

Table 1. Medical Organisations' Position Statements on Boxing Ban

Organization Position	Organization Position
American Medical Association (2007)	Recommends that until boxing is banned , head blows should be prohibited
American Academy of Paediatrics (1997)	Opposes boxing as a sport for any child, adolescent, or young adult
Australian Medical Association (2007)	Opposes all forms of boxing; recommends the prohibition of all forms of boxing for people younger than 18 years
British Medical Association (2007)	Opposes amateur and professional boxing; calls for complete ban on boxing; recommends banning boxing for those younger than 16 years
Canadian Medical Association (2002)	Recommends that all boxing be banned in Canada
World Medical Association (2005)	Recommends that boxing be banned

in many countries, in other countries it is either outright untolerated — as in Iceland, Iran and North Korea — or has been on a legal pendulum. For example, Albania banned boxing in 1960 only to unban it in 1991. In Sweden, boxing was forbidden from 1970 until 2007, when the country amended boxing conditions. Recently, two more countries, Cuba and Norway, joined the unbanning bandwagon in 2013 and 2014 respectively. The ongoing wave of unbanning in countries appears to be based on considerations not quite allied to boxers' safety.

Clearly, boxing has failed to garner attractiveness among medical bodies, a number of whom possesses official positions condemning boxing or some forms of it on the basis of scientific evidence. The World Medical Association (WMA), a representative body for 112 national medical associations and about 10 million physicians, issued a statement recommending the ultimate banning of boxing [20]. Among the medical associations supporting banning of boxing are the Australian, American, British, Canadian, Irish, Danish, Finnish, Portuguese, German and Belgian medical associations [21, 4]. Other medical bodies, such as the South African Medical Association, currently do not have official positions on boxing.

Role of the ringside physician

To the medical fraternity, the boxer's health and safety is the first concern. Many medical professionals serve as sports physicians rendering medical services in various capacities at sporting events. In the 2012 London Olympic Games, 5000 medical volunteers were involved. Such roles require physicians to possess appropriate skills, educate boxers or parents about the risks of boxing, be cognisant of possible litigation [22], and exercise personal choice on whether or not to provide care in boxing events [17]. The ringside physician, as part of an integral multidisciplinary boxing team, plays a part at each stage of the boxer's career, such as issuing of boxing licences; pre- and post- contest examinations; involvement in training; attending to boxers during competition; and performing annual medical evaluations [23].

The relationship between the boxing referee and the ringside physician is a contentious subject that is discussed elsewhere [12]. By virtue of their training, ringside physicians are uniquely positioned to assess boxers' health risks and to avert catastrophic injuries and deaths in the ring. Calls have been made (for example, by the World Medical Association and the Australian Medical Association, among others) for ringside

physicians to be given the power to terminate a bout [20, 11].

Boxing safety standards

Interventions to enhance boxing safety differ from country to country. Although a series of vital amendments to boxing rules, standards and equipment that were gradually implemented since the 20th century have *minimised* the risks in boxing, neurological and non-neurological injuries have continued with this sport [24]. This demonstrates that the intervention measures may not be adequate. As with any other sports, boxing injury risk cannot be totally eliminated, but lessened. Risk to the head remains. Even in amateur boxing, where a knockout is less common, there is still a risk of concussion from blows to the head [22]. Although in most countries, including South Africa, boxing is regulated, the health and safety of boxers is not adequately emphasized. In a number of countries, the governments or boxers carry the costs of health care and insurance companies do not usually provide cover for health care or disability amongst boxers. The boxers are at risk of catastrophic health expenditure. Boxers often rely on governments for social security grants in case of disability. The current WMA statement, inter alia, is propounding an injury preventive approach that includes: strict medical evaluation of boxers, education, improvement and use of safety equipment, and the active role of ringside physicians.

Conclusion

Whilst banning boxing will be an ideal prevention strategy, in the absence of banning, international boxing bodies, governments and local boxing bodies must develop evidence-based injury prevention measures amongst boxers. The medical surveillance should be implemented starting at the beginning of boxer's careers and to the grave. This will provide information on long term

sequelae of boxing and risk reduction strategies. The boxers must have access to quality health care services and be protected against financial catastrophe. Doctors looking after boxers must promote evidence-based prevention, treatment and rehabilitation of boxers.

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Carte Blanche on Smoking



Roland Lemye

Media regularly mention the measures to reduce the number of smokers and tobacco consumption in general. Such measures are sporadically but begrudgingly taken. Nevertheless, tobacco consumption is a real pledge for health and deserves to mobilize all efforts.

Adult smokers have to leave public places to satisfy their bad habit but people still have to go through the smoky cloud. Smokers jeopardize not only their own health but first and foremost other people's health.

Still the main victims are children, particularly in the private sphere. They have not chosen it, but they are prejudiced twice. First of all because of the passive smoking whose harmfulness is well known. It seems it is even worse than active smoking in open spaces. Secondly, they are under the influence of adults' example (parents in particular) who give them a positive image of smoking. We all know that most children whose parents smoke also become smokers.

It is of paramount importance to protect children. Small infants run more risk of suffering from respiratory infections when submitted to a smoky environment. In such cases, infections are more severe.

Teenagers under the influence of their parents and adults in general are tempted to smoke and start at a very young age. Therefore, they are one of the favorite target groups for tobacco companies. Since these are killing their customers, they have to replace them on a more regular basis. Tobacco is impregnated and treated to make cigarettes more enjoyable but above all to speed up the addiction process. They develop commercial and advertising strategies in order to interest as many people as possible – the younger, the better.

Keeping our children away from this pledge should be a priority. Smoking kills more than terrorism.

With this in mind, children should live in a tobacco-free environment from a very early age: without smoke and without any related waste product. They also should evolve without any advertising message which could give a positive image of smoking.

It is up to the legislator to take measures concerning those advertising messages.

As far as the non-smoking environment is concerned, many initiatives have already been taken but the legislators, wherever they come from, are afraid of interfering in the private sphere. This is wrong. One person's freedom ends where another's begins and it is the same about private life, in particular when it concerns children.

The first step should consist of introducing in children's rights the right to live in a non-smoking environment. This way, this right

will naturally extend to the private sphere. Every house, common area or kid's bedroom (at least the one where he/she sleeps) must be smokeless. The same applies to cars in which children are transported.

Is this an invasion of privacy? Is this objective impossible to achieve?

I do believe it is possible. Most countries legislated to make corporal punishments illegal. This prohibition applies to both the family framework and the family home. Even if we know that the aim has not been totally achieved, it has had an unprecedented influence on society.

In Belgium, plenty of social workers are visiting families to check on feeding and care babies or infants receive. Their work is mostly educational but can also include more coercive guidance. Social workers have means of action in case mistreatments, for example, are observed. Smoking in a child's environment is a kind of mistreatment. We must consider it as an abuse. We must do something!

Maybe legislators will take measures. If so, they will act reluctantly, as usual. They should feel the moral pressure of the whole society on their shoulders.

May everyone feel responsible for this issue!

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European Countries Moving Towards Digital Prescription



Le Vallikivi

Introduction

Digital prescription or ePrescription is understood as the process of electronic transfer of a prescription by a healthcare provider in a primary care or community health centre setting to a pharmacy for retrieval of the drug by the patient [1, p. 36]. In 2010 only a few European countries used e-prescription system in full – electronic prescribing was possible in 15 countries, electronic transfer to the pharmacy – in 9 countries, and dispensation data were recorded in 7 countries [1, p. 7].

In Estonia, e-prescription was launched on 1 January, 2010 as a complete nation-wide system. According to the data of the Estonian Health Insurance Fund (EHIF) in 2014, 98.5% of all prescriptions in Estonia were issued in the format of e-prescription. The authors' aim was to study the current e-prescription related experiences of family physicians in other European countries in 2014.

Methods

The survey was done and reflects the data of 2014. To gather the relevant data a questionnaire consisting of 14 multiple-choice questions with a space for free text commentary was sent to representatives of pan-European quality and safety promoting organization (EQuIP) member countries and to experts in non-EQuIP countries Latvia and Lithuania. In 2014 representatives of 23 European countries belonged to EQuIP. Altogether we received answers from representatives of 25 countries and the current analysis is based on these answers except for Greece where major inconsistency was found between the answers from the expert and international reports, according to which the answers were corrected [2]. Representatives of Croatia, United Kingdom, Belgium, Denmark,

Germany, Norway, Slovenia, Spain, Turkey, Austria, Czech Republic, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, the Netherlands, Portugal, Poland, Sweden, and Switzerland completed the questionnaire. All respondents were experts whose jobs were related to the field of family medicine – practicing GPs, those involved in training of GPs, scientists or healthcare managers of family medicine.

Results

Out of the 25 participating countries, a nation-wide e-prescription system existed in nine countries: Estonia, Finland, Sweden, the Netherlands, Denmark, Turkey, United Kingdom, Croatia, and Greece. Regionally functioning e-prescription system was in Spain and Italy, and it was organized between some partners – insurance providers, healthcare providers, and pharmacies – in three countries: Belgium (ongoing pilot project), the Czech Republic and Norway. Digi-

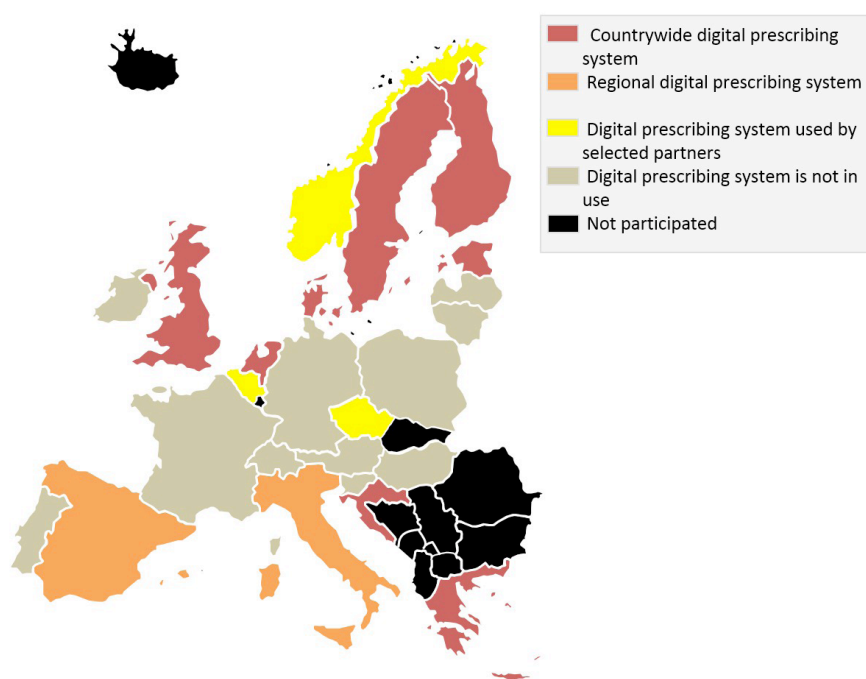


Figure 1. Existence of digital prescription system in the responding countries (01.07.2014)

Table 1. Discussions on nation-wide digital prescription system as future perspective.

Yes, digital prescription system will be implemented in the near future	Yes, but different parties have different opinions	No discussion
Belgium Portugal Latvia Hungary Slovenia Spain	Austria Czech Republic France Germany Norway Poland	Ireland Switzerland

Table 2. Existence of central prescription database in responding European countries.

Nation-wide central database	Regional database	Database between certain partners	Health care provide database	No database
Belgium Croatia Denmark Estonia Finland Hungary Portugal Slovenia Greece Sweden Turkey	Spain Italy	Czech Republic Latvia France Norway	Switzerland Netherlands Germany Austria Poland Ireland United Kingdom	Lithuania

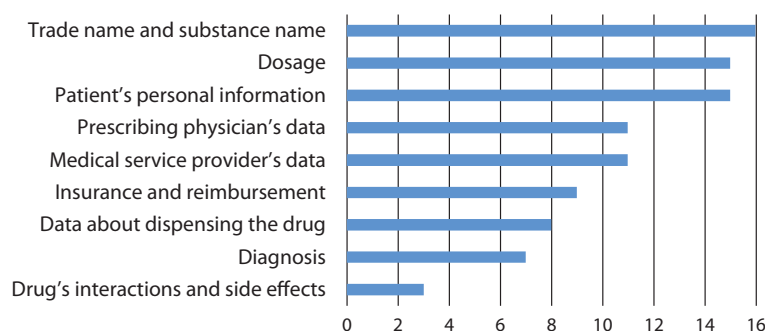


Figure 2. Information in central database, number of countries

tal prescription did not exist in eleven countries: Austria, France, Germany, Hungary, Ireland, Latvia, Lithuania, Poland, Portugal, Slovenia, and Switzerland. In the countries where digital prescribing was available (Figure 1), around 90–100% of the prescriptions were issued using the digital system.

There was no digital prescription system or it existed only between selected partners in 14 countries altogether. In most of these countries there were ongoing discussions

about digital prescription or such a system was about to be launched in the near future. According to the opinion of the representatives of Ireland and Switzerland there had been no discussions about implementing a nation-wide digital prescription system in these countries, however, according to the Swiss e-health strategy report [3] such discussions have been held.

In European countries, the systems for handling prescriptions had diverse structures

for collecting various data at various levels. A nation-wide prescription database existed in eleven of the responding countries; in two countries, the database existed at the regional level and in four countries, there was a database between certain partners. A healthcare provider based database existed in two countries. No database existed in Lithuania (Table 2).

Seventeen countries used the database to manage various medication-related data (Figure 2). The database usually contained information about the active substance, trade name of the medicament, prescribed dosage, patient and doctor writing out the prescription. In several countries, the database also included information about the purchase made according to the prescription (Figure 2).

In all countries, the doctor could obtain information about the treatment the patient was receiving as reported orally by the patient or in written form from the doctor. Medication data were available to the doctor in the form of electronic interaction in eight countries; in three countries, this information was available in the regional database and in four countries only within the respective healthcare institution. Experts from several countries (Norway, Belgium, United Kingdom) indicated that family doctors and other specialists differed in their possibilities to access the prescription data, e.g. the systems allowed to follow the prescriptions issued by GPs but not by other specialists.

In many countries, various data sets to assist in prescribing were available (Figure 3). Supported by linking different e-solutions the system provided pre-filled information of the prescribing doctor, healthcare provider and patient, thereby diminishing both manual input and error, influencing significantly both quality and safety. No e-prescribing system gave a possibility to assess the use of over-the-counter medication yet.

The exact definition of clinical decision support system was not given before asking the

experts about its existence and functionality. The answers indicated that no decision support existed in 11 countries out of 25, in the rest of the countries there was some level of clinical decision support. There was no country with 100% decision-making support system coverage for all the doctors. The extent of the decision support application was different between countries. For example, in Finland around 40% of GPs and 50% of hospital based doctors used the EbMed decision support system, while in Belgium there were certain support modules in only one or two parts of the medical software out of 17.

The nature and content of decision support depended on the software used by the particular GP. In some countries, for example Germany, optional software supplements for decision support were available at an extra cost. The most extensive functionalities of the decision support system have been developed in Finland.

The most often encountered ways of decision support dealt with pharmacological data of the medication, drug interactions, adverse reactions, warning about patient's allergies, concurrent diagnosis, gender and age-based warnings and helped with correct dosage in accordance with the treatment guidelines (Figure 4).

Renewals and prescribing out of office

In eight countries the only way to renew a prescription was by visiting the doctor. In the remaining 17 countries, there were various alternatives: a phone contact with the doctor, visit to the nurse, phone contact with the nurse, and electronic prescription request or prescription renewal by the pharmacist. In some countries it was possible to request medication electronically either by sending an e-mail to the practice or using its homepage.

In 11 countries out of 25 only paper prescription could be issued outside of the doc-

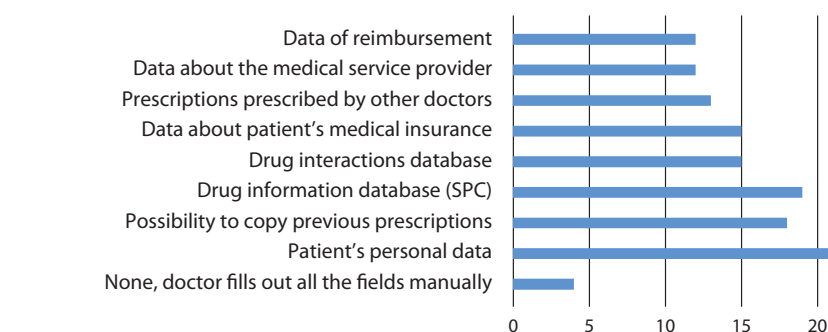


Figure 3. E-health solutions to help the prescribing doctor, number of countries

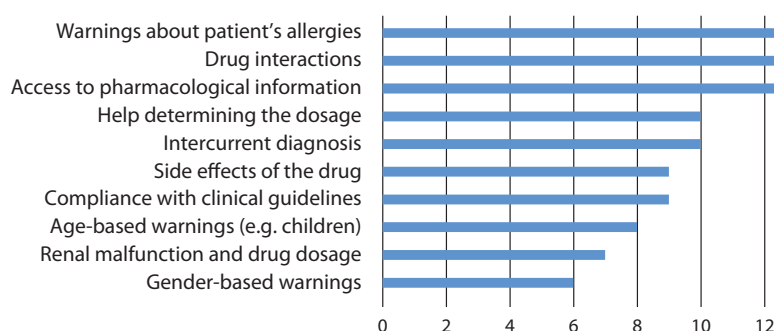


Figure 4. Functions of clinical support systems, number of countries

tor's office. In Denmark, Sweden, the Netherlands, and with some software versions in Turkey there was a smartphone/tablet solution for browser based remote desktop. In Denmark, the Netherlands, Finland, UK, and Ireland it was possible to order a prescription from the pharmacy by phone. In Portugal, Greece, Finland, UK and Denmark it was possible to prescribe over the internet. In Switzerland, France and Denmark it was possible to send a prescription to the pharmacy by fax.

Feedback about prescribing

Doctors received systematic feedback on prescriptions in 16 countries. Surprisingly there was no feedback system in well digitalized Finland and Norway. Doctors did not receive systematic feedback on the medications they had prescribed also in It-

aly, Ireland, Latvia, Switzerland, Germany, Poland and Slovenia. The most common kind of feedback dealt with the prescription's compliance with clinical guidelines (15 countries), and also with cost control by encouraging prescription of generic medications (10 countries). Usually the institutions giving feedback were insurance companies or healthcare regulating institutions.

Benefits and harms of digital prescribing

According to the respondents' responses, the benefits of the digital prescription system from the doctors' points of view were the following: complete overview of the patient's medication, indirect information about the treatment compliance with the dispensation data. Issuing the prescription was easier, faster, and safer for the patient



Katrin Martinson

(decision support assisted, for example, in dosing, selecting the most suitable medication, and selecting applicable discount).

The experts presumed that from patient's point of view receiving the prescribed medication got faster, easier and safer, the prescription could be requested over the internet or by phone; the patient could not lose the prescription.

As concerns pharmacists, the main benefit was that prescriptions were 100% readable, and handling was fast and safe – there were fewer errors due to misreading or typing. Pharmacists needed less time to enter the prescription; in addition, a pharmacist was better informed when advising the patient if there was access to the information about all the medications prescribed.

The experts saw simplicity and safety of the system as its most important benefit for society: a patient, healthcare provider and pharmacist could save time. There was a good overview of both: the prescribing

practice and dispensation giving a possibility to analyze the treatment quality and treatment costs, there was timely and accurate overview available for different partners in the system.

According to the respondents' responses, the transit to digital prescription has not been flawless and has caused problems unknown during the paper-prescription era. Episodic disturbances in the internet, prescription centre's or GP's software were causing occasional disruptions in the functioning of the system.

From the doctors' point of view, there was occasionally insufficient systematic control over repeat prescriptions and the patient might get the medication for a long time without meeting the doctor even if it was needed. There is apprehension that the doctor-patient relationship was transforming to be even more computer-centred.

From the patient's point of view the concern was most often related to a patient losing contact with the doctor. It was sometimes dif-

ficult for a patient to understand the prescriptions, and there was a need to turn to a pharmacy or the GP office to check the details.

The experts presumed that for pharmacists the digital prescription system required more IT knowledge and IT equipment in the pharmacy.

As concerns society the experts saw as potential problematic areas the security of sensitive personal data as well as weakening of the relationship between the doctor and the patient.

Summary

The purpose of this study was to get an overview how widely the digital prescribing is used in European countries, how the systems work and whether they are connected to nation-wide or regional databases, and whether there are supporting mechanisms for safe prescribing.

From the quality and safety aspect, digital prescription provides an excellent opportunity to prevent treatment errors and support the compliance of clinical practices with the current treatment guidelines through the decision support system. The central database provides an opportunity to analyze prescribing on the whole and at the level of single practitioner's practice. Adequate feedback mechanisms enable to introduce changes into the prescribing practice.

The dream of pan-European digital prescriptions may remain a dream for a long period of time. There are large differences in the digital prescription systems in European countries. Still, the benefits of the system outweigh the difficulties. The experience of developing and implementing the digital prescribing system in different countries provides all partners with valuable information on developing novel combined IT-services for healthcare and a possibility to avoid mistakes made in other countries.

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The authors are thankful to all EQuIP Assembly members and Dr. Dana Mishina,

Dr. Evelin Hanikat, Dr. Siiri Johanson, Professor Vytautas Kasulievicius, Professor Christos Lionis for their contribution.

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“This Year Our Office Will Go Green”: Announcing a New Free Service for WMA Member Countries

“This year our office will go green.” Have you said or thought this? Has this been a goal for your office, clinic or outpatient facility that you have not accomplished? The World Medical Association now offers to its members a new free service, My Green Doctor, which can make this possible.

My Green Doctor is located on the web at www.mygreendocor.org. This practice management tool has demonstrated that it can save offices money as they learn environmental sustainability. One large group in the United States began saving money in the first month of using this system and continues to save more than \$2000 US per doctor annually.

My Green Doctor is a complete, simple-to-follow program that is used by those who work in the office. They learn how to create and manage an office Green Team, and how to make changes in the office that make the office healthier and more efficient. The office also learns ways to teach these ideas to the patients. This is another way in which your practice improves community health outcomes. My Green Doctor will make your colleagues and you truly proud.

Why Go “Green”?

First of all, what do we mean by “green” and why should this be a goal for your office? “Green” means to become an office that has reached established benchmarks in managing its environmental impact. With My Green Doctor, each office decides which topics are important to and relevant to its situation. An office might consider how energy, water, paper products, chemicals or other resources are used. It might consider how office staff members and patients travel to and from the office since our transportation decisions have an environmental impact. It might mean changing the foods we choose to have in the office. My Green Doctor offers more than 140 Action Steps and Education Steps to pick from.

Becoming a green doctor office is not difficult; your Green Teams simply meet over lunch to make changes according to the plans provided by My Green Doctor. In this manner, the office can look forwards to making gradual improvements that over six to twelve months provide significant satisfaction.



Todd L. Sack

The benefits are real and nearly immediate. Your office is likely to save electricity and water, which is real money. For example, a five-office practice in Pensacola, Florida is saving more than \$14,000 US each year on its electric bill. In addition, the people who join your office “Green Team” will enjoy it because each person is contributing to making their workplace safer, cleaner and healthier. This builds office morale and a team approach to problem-solving.

Your patients will see the improvements: recycling bins in your waiting room, brochures or posters for them to read, a “Green Doctor Recognition” certificate from the

World Medical Journal



World Medical Association on your wall, and likely other measures that will tell them that yours' is a modern, progressive office with a broad interest in their health. My Green Doctor is designed for doctor offices, is peer-written, peer-reviewed, non-partisan, based on solid science, and is written to be understood by anyone working in a medical office.

Text box idea: "*www.mygreendoc.org is a free, non-profit site that is based on solid science and is managed by physicians. It is easy to use and confidential, plus no ads, pop-ups, banners, or passwords.*"

Getting Started

Start by talking with your practice's managing physicians, owners or Board of Directors. They should agree to adopt environmental sustainability as a core value for your company and to choose My Green Doctor to guide the process. My Green Doctor provides a sample company environmental sustainability policy and a ten-minute Power Point talk to introduce these ideas. If you are a large practice, your company will want to appoint an Environmental Sustainability Committee that will meet monthly to coordinate your progress.

Each office will learn how to initiate and manage an office Green Team. The Team consists of members of the office staff who are willing to meet monthly over lunch. The best teams draw volunteers from many sectors of the office—nurses, front office staff, cleaning personnel, managers, physicians, etc. At these meetings, the Team members will consider Action Steps to adopt for the office. At subsequent meetings, the Team will review the progress made as well as the setbacks, and will consider other Action Steps to pursue. Along the way, the Team decides how to share this information with other staff members, with their families and the patients. These are the Education Steps.

A key early step is to find someone to be the Green Team Leader. This might be a physician, an office manager, or anyone who wants to help out. The leader will schedule the Team meetings, send reminders to members, and manage the meetings to be sure that each Action Step has a Champion who takes responsibility for reporting back at the next Team meeting. The position of Team leader can rotate every few months. The Team will report its progress quarterly to your Environmental Sustainability Committee or to the Board of Directors.

Six Tips for Green Team Success:

1. Declare environmental sustainability to be a core value.
2. Adopt an environmental sustainability policy for your practice.*
3. Require Green Teams to meet monthly in every office.
4. Make small, steady steps with one new Action Step each month.
5. Teach: use email, brochures, green tips, posters, & meetings.*
6. Reward your Team with thanks, praise, and more.

* available at www.mygreendoc.org/resources

A Green Team's First Meeting

Your Green Team will not need experts, outside consultants, or prior knowledge of environmental management. Ask office members to join you for your first meeting over lunch and to register at www.mygreendoc.org (no passwords are needed). They can bring their laptops or you might photocopy the one-page "Quick Start, Now!" guide and the "Quick Start, Now!" Action Steps from one of the Workbooks.

At the first meeting, the Green Team will choose one or two Action Steps from any of the seven Workbooks. It is easiest to pick from "Energy Efficiency", "Solid Waste & Recycling", or "Drug Disposal & Chemicals". Each of these workbooks has an "Introduction" section, a "Background In-

formation" section, and an "Action Steps" section.

A good place to start is the "Energy Efficiency" Workbook. You might adopt the policy to turn machines off at night or to adjust the thermostats to save money. For each Action Step, discuss how it will be implemented, how you will share your plans with the entire office, pick a champion from the Team to oversee the Step, and set a date for completion. Someone should record your decisions on the Green Team Notes form provided by My Green Doctor, and be sure to set the date for the next meeting.

Your Next Meetings

Plan for your Green Team to meet monthly. At each meeting, review the progress and setbacks experienced with the Action Steps that you have adopted. Look at other Workbooks, starting with those that have the easy "Quick Start, Now!" steps. Read together the "Introduction" and "Background Information" sections because these sections provide the knowledge base that will engage and empower each member of your Team.

After a few months, consider some of the more ambitious but interesting options for your office. For example, you might build a comprehensive energy plan to save big money, or reconfigure people's work schedules to minimize their transportation environmental impacts, or eliminate Styrofoam, bottled water or hazardous cleaning chemicals. You could agree to use the "Healthy Foods" guidelines for food gifts that are brought to your office by salespeople. You could sponsor a community garden or start one yourselves. You could install a solar hot water heater or simply turn off your hot water heater forever as a few offices have done. You can purchase renewable energy credits (REC's) to offset the carbon dioxide pollution from your office's energy use.

World Medical Journal



Education Steps: Your Biggest Impact

Whatever your office does, you will want to talk about it, perhaps even to brag a bit. www.mygreendoctor.org offers dozens of Education Steps. These can be a powerful part of each Green Team meeting. An Education Step could be a short text message or memo to co-workers, a brief report at each staff meeting, or an item in each office newsletter. For patients, they can be a poster in the waiting room or a sticker on light switches such as "Please Turn Me Off". The website offers many free, downloadable brochures that you can print and place in your waiting rooms for your patients to take home (click the Resources tab). Your Green Team will only be truly effective if you educate those around you.

Green Team members take ideas home to their families and neighbors. These include ideas about energy efficiency, wise water and chemicals uses, healthy food choices, and healthy transportation decisions. Peo-

ple look to health providers and doctors as role models; when we recycle, keep organic gardens, bicycle to work or drive energy-efficient cars, our patients and neighbors pay attention. The exchange of information is a two-way street with Green Team members often bringing green ideas to the office that they learn from their children.

Text box idea: "A Green Team's greatest impact comes from teaching others."

Green Doctor Office Recognition

Monthly meetings can earn your office the Green Doctor Office Recognition certificate within six months. The office must meet the standards established and maintained by My Green Doctor physicians. These include completing five Green Team Meetings, implementing five Action Steps, and completing five Education Steps. The "Nuts & Bolts" tab of www.mygreendoctor.org describes how to record your Green Team Notes and how to submit your documentation.

Going Green, For Good

Businesses large and small have been "going green" for decades. Their motivations are as diverse as their business plans and profit margins. Like doctor offices, most start because they want to save money and most accomplish that. But many businesses report that the non-monetary advantages are the most rewarding and are gained when businesses not only "go green" but also stay green "for good". These offices have used the greening process to foster a culture of teamwork, resources conservation and mutual respect. The World Medical Association is proud to offer My Green Doctor to its members without a fee and urges you to register your office today.

*Todd L Sack,
MD, Florida physician in private
practice for more than twenty years;
editor My Green Doctor for the WMA.*

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On the International Public Coordination Health Committee

The International Public Coordination Health Committee was established on May 15, 2015, in Almaty, Kazakhstan, at the initiative of the National Medical Association of the Republic of Kazakhstan and the non-commercial partnership the National Medical Chamber of the Russian Federation. The purpose of the Committee is to create a dialogue platform for the medical community from different countries and various medical organizations and associations whose activities are aimed at improving the quality indicators of health and preservation of human life.



Aizhan Sadykova

The Headquarters of the International Coordination Public Health Committee is at the office of the National Medical Association in Almaty, 117/1 Kazybek bi str.

On October 13, 2015, in Moscow the first meeting of the International Public Coordination Health Committee was held which took place at the Research Institute of Emergency Children's Surgery and Traumatology. The meeting was attended by representatives of Belarus, Bulgaria, Greece, Kazakhstan, Latvia, the Pridnestrovian Moldavian Republic, Russia and Finland.

The meeting adopted Regulations on the International Public Coordination Health Committee and regulations on the following structural units: Eurasian Council on Bioethics, Eurasian Council on Mediation in Healthcare, International Committee on Informatization of Health and International Committee on Independent Expertise of Treatment Quality. The Heads of the units were nominated and approved.

The Committee welcomes further cooperation through Memorandum of International Cooperation and Mutual Understanding in Health Sector which now is open for signing to all organizations.



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Australian Medical Association (AMA)

Office Bearers:

President: Professor Brian Owler, a Neurosurgeon based in Sydney, Australia
Vice President: Dr. Stephen Parnis, an Emergency Physician based in Melbourne, Australia



Brian Owler

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

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

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

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

The AMA publishes two magazines that are distributed to all members and which contribute to national information and debate on medical research and health policy.

The prestigious *Medical Journal of Australia*, which celebrated its centenary in 2014, publishes peer reviewed medical research papers and provides a forum for debate on pressing clinical issues.

In addition, the AMA publishes a fortnightly national news magazine, *Australian Medicine*, which keeps members informed about national and international developments affecting health policy, as well as updates on the Association's policy and advocacy work.

The AMA has a strong presence in national health policy debates. It is one of the nation's most active lobby groups, and maintains a strong network of contacts among Government Ministers, Federal politicians and political parties.

It frequently presents submissions to, and appears before, parliamentary inquiries into health issues, and is also represented on many government committees, advisory bodies and instrumentalities, ensuring that the voice of the profession is heard well before decisions are made.

The AMA keeps politicians informed about the views of the profession in order to help achieve better health outcomes for all Australians.

The AMA frequently runs campaigns to influence government decisions and policies.

All policies and advocacy by the AMA is conducted in the interests of patients and the medical profession.

AMA House, 42 Macquarie Street, Barton, ACT, Australia, 2600

Secretary General Anne Trimmer

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E-mail: atrimmer@ama.com.au

Website: www.ama.com.au

Austrian Medical Chamber (ÖÄK – Österreichische Ärztekammer)

Office Bearers:

President: Dr. Artur Wechselberger

Vice Presidents: Dr. Karl Forstner,
Dr. Harald Mayer

International Affairs: Dr. Johannes
Steinhart, Dr. Reiner Brettenthaler

Directors: Dr. Lukas Stärker, Dr. Johannes
Zahl



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

Activities and Services: Legal responsibilities of the Austrian Medical Chamber include, besides others, admission to and administration of the medical register, as well as recognizing foreign medical qualifications. Furthermore, the Austrian Medical Chamber is the competent authority for issuing medical diplomas and for conducting specialist and GP qualifying exams. The elaboration of concepts, expert opinions and proposals regarding the Austrian health care system, including the right to comment on draft bills or enacting guidelines on medical fees, on the medical code of conduct etc., as well as concluding contracts with social insurance institutions and collective agreements, and executing disciplinary legislation and arbitration also belong to the responsibilities of the Austrian Medical Chamber. Moreover, the Chamber is involved in the elaboration of specialist and GP training programs, and it also has its own institution offering CME/CPD for Austrian medical doctors. The Chamber provides counselling for its members in issues relating to professional law and in international matters. Information for members is provided on the website and in the journal of the Austrian Medical Chamber (*Österreichische Ärztezeitung*).

International collaboration: Besides its WMA membership, the Austrian Medical Chamber is also a member of AEMH, CEOM, CPME, EANA, EFMA/WHO, EJD, FEMS, UEMO, UEMS and ZEVA. The Austrian Medical Chamber actively participates in the work of these organisations and regularly attends meetings.

Vision: The Austrian Medical Chamber aims at achieving a positive framework for medical practice in Austria. This includes in particular the improvement of the specific working conditions for doctors. Thereby, the work of the Austrian Medical Chamber constitutes a major contribution to the wellbeing of the patients and the Austrian healthcare system in general.

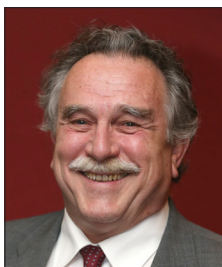
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Association Belge des Syndicats Médicaux

Office Bearers:

President: Dr. J. de Toeuf
Vice-President: Drs. M. Moens –
L. De Clercq – R. Lemye – M. Vermeulen
Secretary General: Drs. M. Masson –
Y. Louis
Treasurer: Dr. L. Herry
Head of International Affairs:
Dr. B. Maillat



J. de Toeuf

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

Quite rapidly, physicians from all over the country get organized and created doctor's associations on the ground. Those associations federated and developed necessary means to deal with conflicting situations. This association that is presently called ABSyM/BVAS was the successor of the former Belgian Medical Federation (Fédération médicale belge - FMB) which was unable to organize a

resistance movement. The conflict raised the year after, in 1964, with a medical strike that lasted nearly one month and had been very well planned. The medical corps, organized as an emergency doctor service, then proposed nothing more than depersonalized care, according to the modalities and procedures the government wanted to establish. As the conflict got worse and since the government had decided to requisition physicians, the ABSyM/BVAS launched a "luggage" operation. Most of the physicians went abroad to escape the potential requisitions. This operation brought the government to give in on this issue. The conflict led to some agreements that foresaw an annual collaboration system between the ministry of public health and social affairs, mutual companies and physicians which allowed the coexistence of a medical private practice and a social financing. This annual or biennial agreements' system is still ongoing although it has been dealing with many problems and had to tackle the evolution of the medical profession in which it is often difficult to fully preserve the Hippocratic principles. Let's think about the control over expenditure, the necessity of teamwork but also the exchange of data which is the inevitable consequence to reach the necessary balance.

The ABSyM/BVAS did not only focus on union defense. It has been firmly committed in the defense of patients' interests and dialogue with them, who have also formed associations. The ABSyM/BVAS has been committed in the quality of care thanks to an incentive system rather than restraints and sanctions. Furthermore, the ABSyM/BVAS gives priority to security and patients' rights and also organizes direct dialogue with other health care professionals (pharmacists, dentists, nurses, physiotherapists...). It also takes care of the working conditions of physicians and their health. Its sphere of activity is as extended as the one of associations but in the meantime, it also preserves means of action when the negotiation shows no signs of good results. The Belgian "defederalization" which is currently ongoing gives the ABSyM/BVAS new concerns, especially since it remains one of the few unitary organizations in the country. Nevertheless, the strongly professionalized ABSyM/BVAS is looking to the future with confidence.

Member of CPME, UEMO, ARMH, EANA, EFMA and WMA. The ABSyM/BVAS is active in many organs of the INAMI/RIZIV (Belgian Federal Institute for Health Insurance), such as the General Council, the Insurance Committee, the Assessment Committee of Medical Practices with regard to Medicines, the Drug Reimbursement Commission, etc. and is also represented into work-groups of the Public Health Ministry.

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Website: www.absym-bvas.be

Brazilian Medical Association (AMB)

Office Bearers (2014–2017):

President: Florentino de Araujo Cardoso
1st Vice-President: Eleuses Vieira de Paiva
2nd Vice-President: Lincon Lopes Ferreira
Secretary General: Antônio Jorge Salomão
1st Secretary: Aldemir Humberto Soares
1st Treasurer: José Luiz Bonamigo Filho
2nd Treasurer: Miguel Roberto Jorge
Director of International Affairs: Nívio Lemos Moreira Junior



*Florentino de
Araujo Cardoso*

Membership: Any medical doctor from any State in the country can join the Brazilian Medical Association as a regular member if he/she is a regular member of his/hers State Medical Association which are Affiliated to the AMB. Medical Students can join as associate member and has its representation through the Young Doctor Committee.

Services provided: The main services provided by the AMB to their members are: Board Certification along with the respective Specialty Society, the Brazilian Hierarchical Classification of Medical Procedures which defines the minimum cost of medical procedures should be, news and scientific publications, representation of their interests in national and international forums.

Activities:

- for Members: a Continuing Medical Education Program, the Evidence Based Medical Guidelines Project, cultural activities, Medical Meetings, Members Benefits Club and Leadership Program.
- for the Public: Salve Saúde (Cheers Health) - Campaign to promote healthy habits and the prevention of Non Communicable Chronic Diseases. Caixa Preta da Saude (Health Black Box) - Campaign to encourage the population to denounce precarious conditions of health services. Patient Safety Commission . Electronic Prescription.

With the Government: a Law Proposal to increase yearly funding for health to a minimum of 10% of the GDP, lobby at the Ministry of Education for quality control when approving new and inspecting existent medical schools and Medical Residents Training Program , lobby at the Ministry of Health for adoption of a medical career in the public services, and improve the quality of Public Health Care.

With the Media: press releases related to health issues of public interest, promotion of debates related to health policies, educa-

tion on health related issues, Social Media and Digital Communication.

With Strategic Partners: special programs with pharmaceutical and health insurance companies, and financial institutions aiming to promote health information to the public as well as to provide free access to scientific publications to Brazilian physicians. Exchange of information and activities with others National Medical Associations and International Health Organizations.

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French Medical Council

Office Bearers:

President: Dr. *Patrick Bouet*
Secretary General: Dr. Walter Vorhauer
President of the International Relations
Delegations: Dr. Xavier Deau, Immediate
Past-President of the WMA.



Patrick Bouet

The French Medical Council in a nutshell

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

- The French Medical Council is a private body charged with a public service obligation whose existence is established in the French Code of Public Health.
- In France, doctors must be registered to be allowed to provide items of medical service. According to the French Law, the French Medical Council is the one managing the whole process of registration of doctors (including the establishment and maintenance of the official register of doctors), monitoring their conditions of practice as well as taking care of the recognition of their professional qualifications.
- The French Medical Council consists of one Departmental Council per French Department (95 in total), one Regional Council per French Region (22 in total). The French National Council is made up of 54 members (from each Region), elected by the

Departmental Councils, a member appointed by the Academy of Medicine, and a Councilor of State appointed by the Minister of Justice.

- Members of the National Council meet in four different sections: Ethics and good medical practice, Professional practice, Medical training and competence and Public health and medical demography.
- The Council writes and updates the French Code of Medical Ethics, which is an integral part of the French National Code of Public Health.
- The French Medical Council also acts as a disciplinary body for doctors
- The Council has set up 2 Delegations: one for internal affairs (to support and oversee the Departmental and Regional Councils) and one for European and International Affairs (DAEI) (to work with other European and international bodies).

European and International Commitments

- Since 2012, the French Medical Council is an official member of the World Medical Association
- The French Medical Council runs the General Secretariat of:
 - The European Council of Medical Orders (CEOM) which brings together Medical Councils and regulatory bodies from 16 European countries. It aims at promoting the practice at European level of high quality medicine respectful of patients' needs
 - The Conference of Medical Councils from French-speaking countries (CFOM) which is a collegial forum for discussion among medical regulatory bodies from French-speaking countries.

Brussels representative office

The French Medical Council opened in 2008 a representative office to the European Institutions in Brussels in order to closely monitor European legislation on health.

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Bundesärztekammer/ German Medical Association (GMA)

Office Bearers and Representatives:

President: Prof. Dr. Frank Ulrich

Montgomery

Vice-President: Dr. Martina Wenker,

Vice-President: Dr. Max Kaplan,

Honorary President: Prof. Dr. Karsten Vilmar,

Secretary General: Tobias Nowoczyn,

Head of Department for International

Affairs: Dr. Ramin Parsa-Parsi, MD MPH, *Frank Ulrich*

Policy Advisor: Domen Podnar,

Department for International Affairs *Montgomery*



The German Medical Association (*Bundesärztekammer*) is the joint association of the State Chambers of Physicians (*Landesärztekammer*) in Germany. It represents the interests of all 481,174 physicians in Germany (as of 31/12/2014) in matters relating to professional policy and plays an active role in opinion-forming processes with regard to health and social policy and in legislative procedures. In addition to in-house committees focused on specific topics relevant to the medical profession, separate bodies such as the Scientific Advisory Board and the Drug Commission are housed within the GMA, but have their own statutes and rules of procedure. Their members are elected by the Executive Board of the German Medical Association or the German Medical Assembly – the annual parliament of the German medical profession.

The GMA is also home to the Office for Transplantation Medicine (*Geschäftsstelle Transplantationsmedizin*), which advises on and monitors compliance with transplantation regulations.

Activities

The activities of the German Medical Association include:

- Developing and maintaining the
 - (Model) Professional Code (*(Muster-)Berufsordnung*), used by the State Chambers of Physicians as a basis for their own legally binding Professional Codes, which outline the ethical and professional obligations of physicians among themselves and vis-à-vis patients.
 - (Model) Specialty Training Regulations (*(Muster-)Weiterbildungsordnung*), used by the State Chambers of Physicians as a basis for their own legally binding Specialty Training Regulations, which define the content, duration and objectives of specialty training and specialist designations.



- (Model) Regulations on Continuing Medical Education ((Muster-)Fortbildungsordnung), used by the State Chambers of Physicians as a basis for their own legally binding Regulations on Continuing Medical Education.
- Ensuring quality medical care by coordinating exchange among the 17 State Chambers of Physicians.
- Cultivating a sense of unity among all physicians practising in Germany by advising and informing them of all important processes and activities relevant to their profession.
- Achieving the most uniform possible regulation of professional duties and principles for medical practise in all fields.
- Safeguarding the professional interests of physicians in matters beyond state jurisdiction through exchanges with the Federal Government, the *Bundestag* and the *Bundesrat* (the two houses of parliament) and political parties.
- Communicating the position of the medical profession on matters relating to health policy and medicine.
- Promoting continuing medical education.
- Promoting quality assurance.
- Establishing and maintaining good relations with the global medical community.

Membership

Membership in one of the 17 State Chambers of Physicians is compulsory for all physicians practising medicine in Germany. Individual physicians are therefore indirectly members of the German Medical Association.

International commitment

The GMA represents the interests of the German medical profession on the international stage through its membership in numerous international organisations and bilateral relations with medical organisations abroad.

In its work with the World Medical Association (WMA), the Standing Committee of European Physicians (CPME), the European Forum of Medical Associations (EFMA), the European Conference of Medical Chambers (CEOM), the European Network of Medical Competent Authorities (ENMCA) and the annual ZEVA Symposium of the Central and Eastern European Chambers of Physicians, the GMA contributes to the dialogue on important social and ethical issues that impact the global medical community.

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Indian Medical Association (IMA)

Office Bearers:

President: Dr. S S Agarwal

National Hon Secretary General:

Dr. K K Aggarwal



S S Agarwal

Indian Medical Association (IMA) is the only representative, national voluntary organization of Doctors of Modern Scientific System of Medicine in India, which looks after the interest of doctors and the well-being of the community at large with the following objectives:

1. To promote and advance medical and allied sciences in all their different branches and to promote the improvement of public health and medical education in India.
2. To maintain the honour and dignity and to uphold the interest of the medical profession and to promote co-operation amongst the members thereof;
3. To work for the abolition of compartmentalism in medical education, medical services and registration in the country and thus to achieve equality among all members of the profession.

The founding fathers way back in 1928, felt the need of a national organization of the Medical Profession. Before that, some members of the profession – a selected few – were members of the British Medical Association, which had opened branches in India to cater to the local needs. These stalwarts, ultimately succeeded in formation of Indian Medical Association and reached an agreement with the British Medical Association that they will have no branch in India and got mutually affiliated which relationship continues till today.

Indian Medical Association, in the year 1946, helped in the organization of the World Medical Association and thus became one of its founder members. As an organization, it has been and continues to play an important role in its deliberations.

Dr. R.V.Sathe, the then President, IMA held the chair of the President of WMA when the WMA met in New Delhi in 1962. It's a matter of pride that another illustrious Past President of IMA Dr. A.K.N. Sinha also held the office of the WMA and now another eminent Past President Dr. Ketan Desai will take over this post in 2016.

The IMA has been playing an important role in the deliberations of the World Medical Association at New Delhi since its inception. IMA, withdrew from World Medical Association in 1985, since the organization refused to expel South Africa despite its dismal record

of racial discrimination. IMA later in February, 1993 decided again to become its member. 45th General Assembly of the World Medical Association at its meeting held on October 2-5, 1993 approved IMA's membership of the WMA.

Today, IMA is a pan-India voluntary organization of practitioners of modern system of medicine. It has a membership of over 2,56,000 doctors spread over 30 state branches & 1700 local branches in almost all the districts of India. IMA is reaching to approximately 33 crores (330 million) of people every month and ensuring affordable & quality treatment.

The vast human resources and infrastructure at the command of IMA is a national health asset. IMA members have been involved in various programmes which are aimed mainly for the benefit of the community organized by various national and international agencies.

IMA has complemented many Government Programmes like Revised National Tuberculosis Control Programme (RNTCP), Anaemia-Free India, Leprosy Eradication Programme, Child Survival & Reduction of Infant Mortalities and has provided all assistance and expertise, whenever required, to ensure making healthcare accessible, affordable, qualitative and available timely for all.

IMA branches run Blood Banks, Bio-medical waste disposal units, Palliative care units for cancer and Reproductive & Child Health (RCH) centres besides imparting training to its members in meeting various health challenges. IMA also articulates its views on policy matters and legislations pertaining to health.

National Headquarters

The National Headquarter of the IMA is situated at New Delhi. It publishes a monthly Journal "Journal of Indian Medical Association" as an academic feast to all its members.

The leadership of all IMA consists of Office-bearers Headquarters, of State & Local Branches, Working Committee and Central Council Members.

IMA has three Academic Wings

- IMA College of General Practitioners
- IMA Academy of Medical Specialties
- IMA AKN Sinha Institute of Continuing Medical & Health Education and Research

IMA has the following wings & Schemes running for the benefit of its members:

- IMA National Social Security Scheme
- IMA National Professional Protection Scheme
- IMA Hospitals Board of India
- IMA National Health Scheme
- IMA National Pension Scheme

IMA leadership communicates to each and every member through virtual Team IMA Group & through eIMA News & SMSes on a daily basis. We also communicate to the public through IMA PR and communication department on a daily basis.

IMA also organizes Press Conferences in every State on regular basis and conducts similar Press Conference simultaneously in 100 Branches at the time.

IMA has trained 100% operational PCR staff of Delhi Police on CPR-10 in a record time. The same is now being replicated at a national level.

IMA projects include awareness regarding Child Sexual Abuse, Standards of TB Care, Violence against medical establishments, sealing of charges during national calamity & availability of emergent medical care to everybody in time.

IMA's Swachh Bharat Swastha Bharat Initiative (Clean India Healthy India Initiative) spreads awareness about safe water, food hygiene and control of vector borne diseases.

Under Aao Gaon Chalen (Let's Go to Villages), IMA has adopted more than 100 villages and provides them free treatment on a regular basis. Over 10,000 free surgeries have already been done through this Project.

IMA is represented on various Government and Semi-Government bodies of the Central and State Governments and on other national institutions and thus contributes its view at these forums and renders active cooperation within its policy framework. As a voluntary body, the Association has been drawing the attention of the Government and others concerned, to the specific areas in the field of health care in which the voluntary agencies could play a leading role particularly in the implementation of national health programs for achieving the goal of "Health for All". It has been organizing International and National Conferences, Seminars and Conventions on subjects of topical interest from time to time.

The official representatives of the Association have also been participating in International Conferences abroad and in the General Assembly and Council Meetings of the World Medical Association, the Commonwealth Medical Association & WONCA etc.

As a part of our commitment to public health, Indian Medical Association has undertaken a large number of projects related to the health of the general masses and the social practices of the Indian community. To name a few others, IMA has successfully undertaken projects related to Polio, Tuberculosis, Anaemia Free India, HIV/AIDS, Hepatitis, Prostrate Diseases, Avian and Swine Flu and many other. We have collaborated with many International agencies and organizations like UNICEF, UNFPA, PLAN International and Clinton Foundation etc. and Govt. departments in our other projects related to Child Trafficking, Sex Selection, Baby Friendly Hospitals Initiative where breastfeeding is promoted, Infant mortality, Adolescent Health and Pharmacovigilance etc.



It is desirable for various National Medical Associations to exchange study programmes, e-connect through video conferences and conduct medical educational programmes and faculty exchange with Indian Medical Association.

IMA can also provide consultancy services from Indian doctors to patients from other countries.

IMA helps in providing regular medical updates and updating medical journals of various NMAs. We can even issue joint advisories from time to time during any infection outbreaks.

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Kuwait Medical Association

Office Bearers (2014–2016):

President: Dr. Mohammad AlMutairi

Vice President: Dr. AbdulMehsen AlKandari

General Secretary: Dr. Mohammad Faisal Al-Qenai

Treasurer: Dr. Mohammad Abdullah AlObaidan

Executive Board Member: Dr. Laila Saud AlEneizi

Executive Board Member: Dr. Aseel O A AlSabbrei

Executive Board Member: Dr. Nawaf F S Dehrab



Mohammad AlMutairi

Membership: All physicians in Kuwait from different specialties including newly graduates are members of Kuwait Medical Association (KMA).

Services provided:

1. Issuance of Kuwaiti Medical Journal since 1967
2. Establishment of Health Studies Centers such as Late Mohamed Abdul Mohsen Al-Kharafi Center for Medical Information
3. Training sessions for medical practice related-skills (e.g. writing medical articles)
4. Establishment and strengthening the collective solidarity fund for the members of the medical professions associations

5. Regulation of seasonal Association Group tours inside Kuwait and abroad regularly
6. Association provides its professional consults for the National Assembly, the Amiri Diwan and the Council of Ministers upon their request
7. Playing a role in fortifying the health development in the community advocacy and awareness campaigns in relation to diabetes, heart disease, AIDS and others

Vision:

1. Improving health and healthcare services in Kuwait
2. Encouraging cooperation, support and exchange of experiences between the Arab physicians
3. Cooperating with similar foreign professional bodies, international and regional organizations to serve the objectives of the association.

International collaboration

Kuwait Medical Association is currently collaborating with several international organizations including:

1. Doctors Without Borders (MSF)
2. Healthcare Without Harm
3. World Medical Association
4. Arab Medical Union

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State of Kuwait

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Website: www.kma.org.kw

New Zealand Medical Association

Office Bearers (2013–2015):

President: Branko Sijnja

Chair: Stephen Child

Deputy Chair: Kate Baddock

General Practitioners Council Chair: Kate Baddock

Specialists Council Chair: Harvey White

Doctors-in-Training Council Chair: Marise Stuart



Branko Sijnja

Membership: The New Zealand Medical Association (NZMA) is the country's foremost pan-professional medical organisation in New Zealand representing the collective interests of all doctors. The

World Medical Journal



NZMA's members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students.

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

The key roles of the NZMA are:

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

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

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

Activities (some examples)

- With Members:
 - Revision of the profession's Code of Ethics, which lays down principles of ethical behaviour, applicable to all doctors. It also includes recommendations for ethical practice.
 - Representing member practices in employment negotiations with the nurses' union.
 - Providing advisory services for both employer and employee doctors on professional and business matters
- With the Public: *Reducing alcohol-related harm: a policy briefing* – this publication recommended a suite of measures to be considered as part of an approach to tackling the harm caused by alcohol abuse. This was a major piece of work for the NZMA, with several months' research into the latest evidence of the harms associated with alcohol and on the successful ways in which these can be addressed.
- With local and central Government: Advocacy on: Physician assisted dying; National Health Strategy; Pharmacy Action Plan; local alcohol policies; New Zealand's climate change target; free trade agreements; health literacy; support for plain packaging for tobacco products; eliminating illicit trade in tobacco products; a new national drug policy; non-medical prescribing; health equity and social determinants; health structure and funding, with particular reference to primary care.

- With the Media: Responsiveness to media and release of media releases related to health issues of public interest (obesity etc); promotion of debates related to health policies (Trans Pacific Partnership Agreement; tobacco packaging; refugee support; alcohol policies etc).
- With Strategic Partners: Submissions to the Medical Council of New Zealand on good prescribing, better data, registration of foreign-trained doctors. Advocacy to the national funding agency for pharmaceuticals (PHARMAC) on proposals for procurement of medical devices for hospitals; prescribing by different occupational groups; and various individual drug funding proposals; advocacy to the Pharmaceutical Society on the draft National Pharmacist Services Framework; workforce planning and sustainability (with Health Workforce New Zealand and other agencies).

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Nigerian Medical Association (NMA)

Office Bearers (2014–2016):

President: Dr. Kayode Obembe

1st Vice President: Dr. Titus Ibekwe

2nd Vice President: Dr. Barthly Okorochukwu

Secretary General: Dr. Adewunmi Alayaki

Deputy Secretary General: Dr. Chuks Ossai- Abaninwa

National Treasurer: Dr. Abdulrahman Abubakar

Editor NMJ: Dr. Francis Uba



Kayode Obembe

Membership: All medical and dental practitioners in Nigeria are members of the Nigerian Medical Association on induction as a medical practitioner and fulfilling the necessary provisions as stipulated by the Medical and Dental Council of Nigeria. Membership cuts across members in Nigeria and those in the Diaspora.

Aims and Objectives:

1. To ensure that Medical and Dental Practitioners in the country uphold the physicians oath
2. To promote the advancement of health and allied sciences



3. To assist the government and people of the federal Republic of Nigeria in the provision of smooth, efficient and effective health-care delivery system in the country.
4. To promote the welfare and interaction of all medical and dental practitioners in the country
5. To cooperate with organizations anywhere in the world which have similar aims and objectives

To consider and Express views on all proposed legislations and national issues especially those affecting healthcare delivery system and medical and dental education in Nigeria.

Vision: A formidable professional body committed to fostering effective and efficient health care delivery, high ethical standards and the interest of its members.

Core Values:

- High ethical standards of practice
- welfare of members
- compassionate service
- integrity

Mission: To build a sustainable professional Association of Medical and Dental professionals that will advance the delivery of qualitative health care services through continuing Professional development, advocacy and policy development, knowledge management and public education, in collaboration with other relevant stakeholders.

International collaboration: The NMA is in collaboration with several International organisations, among these includes: World Medical Association, African Medical Association, Collaboration is ongoing with several national medical associations, United Nations organisations, USAID, DFID etc.

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Norwegian Medical Association

Office Bearers:

President: Dr. Marit Hermansen

Vice-president: Dr. Jon Helle

Secretary General: Dr. Geir Riise

The Medical Ethics Committee:

chairperson: Dr. Svein Aarseth



Marit Hermansen

Organisation and membership: The Norwegian Medical Association (NMA), was founded in 1886 as the professional association and trade union for Norwegian physicians. Membership is voluntary, and approximately 96 % of the Norwegian physicians are members. The main aims of the NMA are to protect and develop the professional, social and financial interests of its members, to promote their interests in matters concerning medical education, professional development and scientific activities, and to advance the quality of the Norwegian health care system.

Main bodies of the Norwegian Medical Association: The Annual Representative Meeting (ARM) is the chief decision-making body and elects the Central Board of 9 members, including the president and vice-president. The election period for the board is two years. ARM also elects the Medical Ethics Committee. The NMA consists of 19 local branches (one in each county), 7 occupational branches, 45 speciality branches, one for retired doctors and one student organisation.

The seven occupational branches organise members that share occupational interests: junior doctors, consultants, general practitioners, researchers, occupational health doctors, private practicing specialists and public health doctors. The occupational branches have their main interests in salaries and working conditions, while the speciality branches are engaged in scientific and professional activities like education, quality improvement etc.

The secretariat: The secretariat has six departments: Dep. of Professional Affairs, Dep. of Communication and Politics, Dep. of Finance and Administration, Dep. of Law and Working Life, Institute for Studies of Medical Profession and The Norwegian Medical Journal. The number of full-time staff members is 140.

The role of The Norwegian Medical Association

The Norwegian Medical Association is the only medical association for doctors in Norway. The NMA has two main responsibilities:

1. Negotiating salaries and working conditions for the members
2. Taking care of the members professional and scientific interests

World Medical Journal



In addition the NMA is responsible for much of the post-graduate specialist education.

Areas of priority

The Norwegian Medical Association will for the next two years (2015–17) particularly work for:

- Confident physicians – safe patients
- Improve governance, organization and leadership of the specialist health care sector
- Improve the leadership of the medical profession in the primary health care sector
- Secure quality and capacity in the specialist education

Some data about Norway

Norway has a population of 5 160 000 and is situated in the northern part of Europe and has borders to Sweden, Finland and Russia.

Healthcare and services are financed by taxation and are designed to be equally accessible to all residents, independent of social status. With its 220 000 employees, the health sector is one of the largest sectors in Norwegian society.

The healthcare system is under the jurisdiction of the Ministry of Health and Care services, which is responsible for planning and monitoring national health policy. Responsibility for provision of services is decentralized to the municipal and regional level. The municipalities are in charge of providing primary healthcare services, while the four Health regions provide the specialized medical services, mainly hospital care.

General practice is organised through a list patient system. The list-patient system is a national system organised and run through agreements between the NMA and the health authorities where the general practitioners are mainly self-employed.

There are some specialist practices working under agreements with the Health regions.

Norway only has a few numbers of authorized private hospitals and health services in addition to the public facilities.

The number of doctors, including students and retired doctors, are about 32 262. In relation to inhabitants we have among the highest number of doctors in Europe, in 2014 the ratio was one doctor per 218 inhabitants.

The Journal of The Norwegian Medical Association is issued every second week (22–24 per year).

Post-graduate medical education: There are 45 recognised medical specialities in Norway of which eight are sub-specialities under internal medicine and five are sub-specialities under general surgery. The majority of the specialities relate to health services in institutions (hospitals). Specialities in primary health care are general medicine, community medicine and occupational medicine.

Health politics: The NMA is involved in many of the activities run by the health authorities through meetings, working groups and political work. The NMA also appoints members to participate in different task groups, and meetings with the political parties in the Parliament.

International collaboration: The Norwegian Medical Association meets twice a year with the other Nordic medical associations to discuss areas of common interest. We cooperate with the Chinese Psychiatric Association on human rights and ethics in psychiatry and Human Rights Foundation of Turkey on torture and rehabilitation of torture survivors. We also have a project in Malawi, to support the Society of Medical Doctors of Malawi establishing a well-functioning secretariat.

The Norwegian Medical Association

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Panhellenic Medical Association (PhMA)

Office Bearers:

President: Dr. Michail Vlastarakos,

1st Vice-President: Dr. Constantinos Giannakopoulos

2nd Vice-President: Dr. Constantinos Koutsopoulos

Secretary General: Dr. Dimitris Varnavas

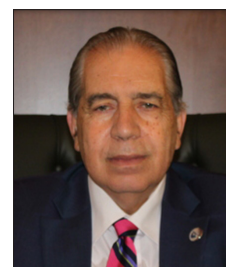
Treasurer: Dr. Vladimiro Panagiotidis

Members of the Board: Drs Anastasios

Vasiadis, Athanasios Exadactylos, Pavlos

Kapsambelis, Anna Mastorakou, Christos Papazoglou, Grigorios

Rokadakis, Ioannis Chronopoulos, Michalis Psaltakos, Panagiotis Psycharis.



Marit Hermansen

The Panhellenic Medical Association, the national Medical Association of Greece, is an independent public legal entity, established by the Legislative Decree of 1923 (OJ 309 A/1923), having its registered offices in Athens. It is the central coordinative body and the supervisory organisation of all Greek physicians and country's local Medical Associations.

World Medical Journal



Within the Panhellenic Medical Association, the Supreme Disciplinary Board is constituted, with 6 regular members and 4 surrogate members, elected by the General Assembly, as well. The Disciplinary Board is empowered to hear doctors' appeals of the decisions of the local medical associations' disciplinary board.

President of the Supreme Disciplinary Board of PhMA: Dr. Matina Pagoni

Vice-President: Dr. Stavros Fotopoulos

Members: Members of the PhMA are the 60 local medical associations of the country. Doctors' registration within the local medical association of the region where they practice medicine is mandatory. The Panhellenic Medical Association's bodies are the *General Assembly*, which is consisted of elected delegates from the local medical associations and the *Board*, consisted of 15 members elected by the General Assembly.

Aims and objectives: The Panhellenic Medical Association is an institutional consultant of the State on health issues, and it covers competences of medical trade unions. It participates in the negotiations on issues such as, the remuneration of physicians' salaries, working conditions of doctors, medical fees for self-employed physicians, pension issues, etc., and is represented at competent governmental expert committees. At the same time, it is in regular dialogue with other national bodies in the health field, making every effort to resolve problems that arise.

Since April 2016, the PhMA has been legislated to grant medical specialty titles and medical practice licenses, which are issued by the local Regions, so far.

The PhMA, having signed a Cooperation Agreement with the UEMS-EACCME, accredits scientific educational events related to lifelong learning of physicians and continuing professional development.

Recently, the Institute of Scientific Research of the PhMA is established, dealing with issues of Healthcare, pharmaceutical policy, medical tourism, international affairs, etc.

International membership: The PhMA represents Greek physicians, as a member, to: Standing Committee of European Doctors (C.P.M.E.), European Union of Medical Specialists (U.E.M.S.), European Association of Senior Hospital Physicians (A.E.M.H), Conseil Européen des Ordres de Médecins (CEOM) and since October 2015, the PhMA is the 112 member of the WMA.

Panhellenic Medical Association

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Polish Supreme Chamber of Physicians and Dentists

(Naczelna Izba Lekarska)

Office Bearers (2014–2018):

President: Maciej Hamankiewicz

Vice-Presidents: Romuald Krajewski,
Zyta Kaźmierczak-Zagórska, Agnieszka
Ruchała-Tyszler (dental practitioner)

Secretary: Marek Jodłowski

Deputy Secretary: Anna Lella (dental practitioner)

Treasurer: Wojciech Marquardt



Maciej Hamankiewicz

The Polish (Supreme) Chamber of Physicians and Dentists (Naczelna Izba Lekarska) and the regional chambers of physicians and dentists (okręgowe izby lekarskie) are the organizational bodies of the professional self-government of physicians and dental practitioners in Poland who are associated in the chambers with equal status. The professional self-government of physicians and dental practitioners in Poland was founded in 1922, dissolved in 1952 and reestablished in 1989. There are 23 regional chambers and a separate chamber of military physicians and dentists that has legal status of the regional chamber although it is active in the entire country. Every physician and every dental practitioner who holds the right to practice the profession in Poland is a member of one of the regional chambers by virtue of the law. Currently the joint self-government associates 178 000 physicians and dentists in Poland, including approximately 125 000 practicing physicians. The highest authority of the Supreme Chamber of Physicians and Dentists is the General Medical Assembly whereas the regional medical assemblies are the highest authorities of the regional chambers. In the period between assemblies – the Supreme Medical Council and regional medical councils respectively. The Supreme Medical Council represents the medical and dental professions at the state level, and regional councils at regional levels.

Scope of activity

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

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



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

The chambers of physicians and dentists:

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

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Portuguese Medical Association

Office Bearers:

Presidente: Prof. José Manuel Silva

Treasurer: Prof. Alberto Caldas Afonso

Secretariat: Dra. Rita Martinho

The organisation of medical practice in Portugal started with the creation of the Portuguese Medical Association in 1898.

On 24 November 1938, by Decree-law no 29171 the Medical Association was created covering mainly those physicians that practice independently.



José Manuel Silva

Facts like the need to separate disciplinary action from administrative or directive action and the need to imply juridical expression to a set of important principles of deontological nature as well as social evolution led to the revocation of the statute approved by the aforementioned decree and its replacement by a statute approved by the Decree-law no 40651, of 21st of June 1956.

This Statute, integrated in the political rule in force, even if fully respecting the defence of deontology and technique by the medical associative body to which it also granted disciplinary action had nevertheless been approved by doctors but resulted solely from governmental decision, in the use of powers that the Constitution 1933 allowed.

The evolution of Portuguese society and the changes that occurred in the course of time towards a bigger intervention of state services in rendering medical care to the population as a means of guarantee the right to health, in an organised way, and of which the creation of Socio-Medical Services of the Welfare fund are an example, gave a progressive importance to dependant medical practice and proved that the existing regulation is incapable and outdated.

The events that took place after 25th of April 1974 (Carnation Revolution) and the social changes occurred pointed out the need to adjust the Statute of the Portuguese Medical Association to the new social philosophy and conditionality.

As a result of the work developed, a new statute project was drafted and the whole process ended in consulting doctors and democratic voting leading to its approval by an overwhelming percentage of votes in favour. This statute, besides covering all the doctors in practice of their profession, reveals a remarkably decentralised feature and full respect for democratic liberties.

The renovated Medical Association being urged to practice its activity fully independently from the government, political groups or other organisations, the statute recognises and supports that the defence of genuine interest of doctors may reflect in the first place a humanised practice that respects the right to health of all citizens and devotes the principle of creation of a National Health Service in which the doctor will necessarily play a predominant and fundamental role.

It is the government's domain, in the use of its legislative powers to approve the Statute of the Portuguese Medical Association, given the important public goal that it pursues, the need to imply a compulsory feature to the enrolment in the Association, the attribution of deontological function and disciplinary power. In any case the revocation of the previous statute approved by Decree-Law would always have to be done through the legislative form.

Membership: All the doctors to practice the profession must be registered (mandatory) in the Portuguese Medical Association and have a individual license. The practice of medicine depends on the enrolment in the Portuguese Medical Association.

The Portuguese Medical Association accepts enrolment solely of Portuguese or foreign graduates in medicine by a Portuguese or foreign university, as long as in this last case there is an official equivalence of the course duly recognised by the Medical Association.

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

Competence of the Portuguese Medical Association

1. Recognition of responsibility of physicians emerging from infractions of Medical Ethics is a disciplinary responsibility that is exclusive to the Medical Association.
2. When violations of medical ethics are found relating to physicians working in state bodies, cooperatives or private companies, these organizations shall limit themselves to notifying the Medical Association of the supposed infractions.
3. If the nature of ethical and technical infractions also includes supposition of a disciplinary infraction included in the legal remit of these entities, respective responsibilities shall be separately exercised.

Principles and goals

1. The Medical Association recognises that the protection of doctors' legitimate interests imply the practice of a humanised medicine that respects every citizen's right to health.
2. The Medical Association practices its activity with full autonomy from the state, political, religious groups or other organisations.
3. The democratic system rules the structure and the internal life of the Medical Association and its control is a duty and a right of all its associates namely in what concerns the election and destitution of all its leaders and the free discussion of all the issues of associative life.
4. The freedom of opinion and the free democratic game foreseen in the previous number and guaranteed in the present Statute do not justify the constitution of any autonomous organisms within the Medical Association that may distort or influence the normal rules of democracy and may lead to disagreement among its members.
5. The Medical Association may adhere to any unions or federations of medical associations and shall collaborate with other health technicians through the competent professional organisations in the interest of health protection and promotion.
6. The Medical Association's main goals are:
 - To protect medical ethics, deontology and professional qualifications in order to assure and make respect the user's rights to a qualified medicine;
 - To encourage and protect the interests of medical profession at all levels, particularly in what concerns socio-professional promotion, social security and work relations; (1)
 - To promote the development of medical culture and contribute to the establishment and constant improvement of a National Health Service collaborating in the national health politics in every aspect namely in the medical education and careers;
 - To give opinion on all matters related to teaching, the practice of medicine and with the organisation of services that deal with

health whenever it may be convenient to do so, close to the competent official entities or when the latter may request;

- To watch for the correct observance of legal formalities of the present Statute and respective regulations namely in what concerns the title and the medical profession promoting judicial action against those who use or practice it, illegally;
- To issue professional licence and promote doctor's professional qualification by the concession of titles of differentiation and for the active participation in post-graduate education.

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Royal Dutch Medical Association (KNMG)

Office Bearers (2012–2016):

President: Prof. Dr. R.J. (Rutger Jan) van der Gaag



R. J. van der Gaag

The Royal Dutch Medical Association (KNMG) is the professional organization for physicians of The Netherlands. It was established in 1849. Since January 1st 1999 the KNMG has become a federation of medical practitioners' professional associations.

Our main objectives are to improve the quality of medical care and healthcare in general, and to improve public health. This is achieved by proactively responding to developments in health care and society, by developing guidelines and policies, by lobbying, and by providing services to our members. Another important task of the KNMG is the regulation of vocational training and registration of specialists.

The federation consists of the Association of Public Health Physicians (KAMG), the National Association of salaried Doctors (LAD), the National Association of General Practitioners (LHV), the Dutch Association for occupational Health (NVAB), the Association for elderly care physicians (Verenso), the Dutch Association of Insurance Medicine (NVVG), the Dutch Federation of Medical Specialists (Federatie van medisch specialisten) and the Association of Medical Students (De Geneeskundestudent).

We work in close collaboration with other stakeholders, e.g. government, politics, health care insurance companies, patient organizations, and other organizations in healthcare. The goal is to promote the medical and associated sciences, and achieve high quality



healthcare. Our policies cover the full range from public health issues, medical ethics, science, health law to medical education.

Another important task of the KNMG is the legal system concerning the postgraduate training and registration of specialists. Legislative boards issue rules on specialist training, recognition of trainers, hospitals etc., specialist registration and the recertification of specialists. The registration committees carry out legislation regarding the tasks mentioned above in the interest of the public.

KNMG activities

1. A campaign on medical professionalism. In 2009 a national campaign will be launched, aimed at all physicians. The main goal is to support doctors in their professional conduct: good quality, earning trust of their patients and accountability.

2. Promoting. Promoting quality of healthcare, safety and transparency of medical practice and professional integrity, through the establishment of guidelines and advice and influencing government and politics.

Activities are:

- Development of a quality framework: the quality and patient safety requirements any doctor in The Netherlands should meet;
- Contribute to educational modernisation of the training of medical specialists and the curriculum in accordance with the CanMEDs model;
- Contribute to the modernisation of the Individual Health Care Professionals Act (Wet BIG). This Act concerns the quality of care guaranteed by legally protected professional titles and provides a register of health care professionals (the BIG-register). The BIG-register registers pharmacists, physicians, physiotherapists, health care psychologists, psychotherapists, dentists, midwives and nurses. Only those listed in this register may carry the legally protected titles belonging to these professions;
- Monitoring Health Insurance Act: under the new Health Insurance Act, all residents of the Netherlands are obliged to have a health insurance. The system is a private health insurance with social conditions. The system is operated by private health insurance companies; the insurers are obliged to accept every resident in their area of activity. A system of risk equalization enables the acceptance obligation and prevents direct or indirect risk selection.
- Contribute to strengthening patients' rights. Especially in the fields of quality, safety and legal complaints.
- Activities related to "end of life" care: implementing the palliative sedation guideline and research on decisions of physicians concerning the final stage of life. See: KNMG position paper: the role of the physician in the voluntary termination of life

3. Studies. The KNMG studies trends and influences policies and legislation in relevant areas where professional values and responsibilities are of major significance. *e.g.:*

- Monitoring, and if possible, influencing developments on health insurances and the Exceptional Medical Expenses Act (AWBZ) which is a national insurance act for long-term care. This is intended to provide the insured with chronic and continuous care. This involves considerable financial consequences, such as care for disabled people with congenital, physical or mental disorders;
- Commenting on reports from government advisory boards

4. International activities. The KNMG is an active member of the Comité Permanent des Médecins Européens (CPME) and the World Medical Association (WMA). The CPME is involved in influencing policy at European level and is of great importance, because the practice of European doctors is increasingly influenced by the European dimension.

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Romanian College of Physicians

Office Bearers:

President: Dr. Gheorghe Borcean

Vice President: Dr. Constantin Carstea

Vice President: Prof. dr. Mircea Cinteza

Vice President: Dr. Calin Bumbulut

Secretary General: Dr. Viorel Radulescu



Gheorghe Borcean

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

Any doctor who wants to practice medicine in Romania, according to the law, may become member of the Romanian College of Physicians.

The Romanian College of Physicians has 9,000 members. They can:

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

Activities:

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

World Medical Journal



Singapore
Medical
Association

The Romanian College of Physicians is an active member of the following international organisations: WMA, UEMS, CPME, AEMH, UEMO, CEOM.

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Singapore Medical Association

Office Bearers:

President: Dr. Wong Tien Hua

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2nd Vice President: Dr. Toh Choon Lai

Honorary Secretary: Dr. Daniel Lee Hsien Chieh

Honorary Assistant Secretary: Dr. Lim Kheng Choon

Honorary Treasurer: Dr. Tammy Chan Teng Mui

Honorary Assistant Treasurer: Dr. Benny Loo Kai Guo

Members: Dr. Anantham Devanand, Dr. Chong Yeh Woei, Dr. Lee Pheng Soon, Dr. Lee Yik Voon, Dr. Ng Chee Kwan, Dr. Noorul Fatha As'art, A/Prof Nigel Tan Choon Kiat, A/Prof Tan Sze Wee, Dr. Tan Tze Lee, Dr. Tan Yia Swam, Dr. Toh Han Chong, Dr. Wong Chiang Yin, Dr. Bertha Woon



Wong Tien Hua

As the national medical association, SMA is committed to engaging in dialogue with various stakeholders on issues related to patient care and medical practice, by highlighting concerns received via feedback from members, and proposing alternative policies, where applicable. At SMA, we adopt a wide spectrum of approaches, ranging from quiet diplomacy to public position statements, to help advocate the rights of patients and doctors.

In 2015, SMA took official positions on important issues related to both doctors and patients, sparking active discourse and creating awareness of issues pertinent to our current medical landscape. These areas of concern include cost of medical indemnity and medical litigation reforms, ethical code and guidelines changes and assimilation of foreign-trained doctors into our healthcare landscape. Aided by SMA publications' growing influence on the local healthcare landscape, we aim to continue bringing greater awareness to issues that impact both doctors and patients for the betterment of local healthcare.

Our members are at the heart of what we do. We remain focused on engaging the profession and delivering services that our members value. These include providing resources and opportunities to aid our members in their development as a medical professional and a leader in their respective fields.

The SMA Centre for Medical Ethics and Professionalism (CMEP) was officially launched in June 2000 to promote the art and science of medical ethics and medical care for the betterment of patient care and public health. SMA CMEP aims to provide leadership in the areas of academic training, discussion, resource development and research, so as to support a high standard of medical professionalism. In 2013, the SMA set up a separate Charity for its charitable work of mainly supporting needy medical students with bursaries and promoting volunteerism amongst the profession. The Charity is supported through donations from the SMA, its members, and its well-wishers.

A commitment to lifelong learning is part of the professionalism that comes with being a medical doctor. SMJ has remained an open-access journal, as we recognise that broad access to research results is an essential component of lifelong learning. We provide access to information-rich literature in the form of scientific research papers, self-learning CME articles, as well as insightful discussions on practice guidelines, medicolegal issues and others. Through waiver of our article submission fee, we also encourage SMA members to share their knowledge and research results with the medical community.

Key Statistics

- 20 councils members
- 7361 members
- 74 courses conducted for more than 2900 participants with S\$64,000 course subsidies disbursed
- 30 membership events for >2400 participants

International collaboration

- WMA: SMA is a Constituent member of the WMA.
- CMAAO
 - Dr. Chong Yeh Woei Vice-chair of council
 - Dr. Bertha Woon Councilor
- MASEAN: SMA serves as the secretariat for MASEAN.
 - Dr. Wong Tien Hua Chairperson (since 2014)
 - Dr. Lee Yik Voon Secretary General (since 2009)
 - Dr. Daniel Lee Assistant Secretary General (since 2014)
 - Dr. Tammy Chan Chairperson, Finance Committee (since 2011)

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Spanish General Medical Council (OMC)

Office Bearers:

President: Dr. Juan José Rodríguez-Sendin

Secretary General: Dr. Juan-Manuel Garrote



Juan José Rodríguez-Sendin

The Organización Médica Colegial of Spain (OMC) or General Medical Council is the institution formed by the 52 medical colleges of Spain and is in charge of the arrangement, regulation, control and defence of the medical profession according to the Spanish rules and regulations. Although the medical colleges have been regulated by Law since 1898, the General Council of Medical Colleges of Spain was formed in 1921. This is the body which groups and coordinates the provincial and autonomous Medical Colleges, as public law corporations, that are an authority within the profession.

The General Medical Council activities are focused on very diverse areas, always related to the medical profession. Besides the habitual activities of record and professional control as well as qualifications, the General Medical Council promotes continuous medical training activities for which it has a specific Foundation. It also has a Central Medical Ethics Commission which not only studies the cases that it receives from the Medical Colleges, but it also carries out studies and documents about the position of the medical profession in fundamental ethical questions that concern it. Thus in the last months, it has updated its positions on medical care at the end of life and on the regulation of conscience clause for health care professionals who don't want to perform abortions.

The General Medical Council has a digital journal "Médicos y Pacientes" <http://www.medicosypacientes.com> and OMC magazine <http://www.cgcom.es/revista/archivo> and other newsletter from International Department, and from Fundación para la Protección Social (Foundation for Social Protection) and Fundación de los Colegios Médicos para la Cooperación Internacional (Foundation for International Cooperation) which maintains updated information about questions of medical health care and social interest, but also of information and interest for the patients. Also the General Medical Council has approved the creation of a Social Council to foster and to promote meetings and collaboration with patients who are the *raison d'être* of medicine.

In the last years the General Medical Council has tightened its bonds of collaboration and action with the most representative medical entities of Spain: the medical trade unions, the Conference

of Deans of Medical Universities, the State Council of Medical Students, the Federation of Spanish Medical Scientific Associations and the National Commission of Specialities in Health Sciences, integrating with them all what is known as the Forum of the Medical Profession.

In addition, the General Medical Council is developing a wide activity in defence of medical association and contributing its point of view to the legal regulations. Our association understands that the association formula is the one that best guarantees the social protection of the patient's interests, the fulfilment of Ethics, the control and regulation of the profession, which has been commended the protection of an important asset: health. We belong to the Ethics Committee. Also it undertakes intense actions to assure that the authority to prescribe drugs is reserved to health care professionals because the competence to prescribe is inseparably linked with the diagnosis for reasons of efficiency, quality and safety in health care.

Efforts are also being made in social and health matters of general interest, promoting numerous training and informative actions aimed at health care professionals and the population at large, among which can be highlighted information about Influenza A (H1N1), the Effects of the Climate Change on Health, the Prescription and the Rational Use of Drugs.

Certifying the competence of the doctor and the licensing based on the achievement of professional, accredited psychophysical and updating of professional competence criteria is another challenge that has raised the Spanish medical Council from 2010, strengthening corporate commitment patient and society and transparency for physicians and society.

The Spanish medical Council has a very extensive international collaboration. It plays an active role in the World Medical Association, European medical organizations like the CEOM (European Council of Medical Orders) and organizations of medical specialists (UEMS), general practitioners (UEMO), hospital health care professionals (AEHM), doctors in training (EJD). Recently the OMC became full member at the Confederación Médica de Latinoamérica y el Caribe (CONFEMEL). The cooperation with the countries of Latin America organized through the FIEM (Latin-American Forum of Medical Entities) is of special interest, without forgetting the social and solidarity action for which the OMC has formed a Solidarity Foundation with the purpose of promoting and channelling help and cooperation for medical – health care in countries with precarious health care and vulnerable and needy populations.

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Obituary

Dr. Eitaka Tsuboi, 1929–2016

Dr. Eitaka Tsuboi passed away at the age of 86 due to respiratory failure on February 9, 2016.

He was born in 1929 in Koriyama City, Fukushima Prefecture, Japan. He majored in radiology at the Japan Medical University and graduated in 1952. He continued to study radiology at the National Cancer Center from 1962. In 1977, he became the chairman of the board of directors of Tsuboi Hospital and contributed to the enhancement of community health. His area of specialization was respiratory cancer. He served as the President of the Japan Medical Association (JMA) from 1996 to 2004. During his term, he worked with the belief that JMA's activities should be expanded globally and the JMA should be open minded in considering the ideal way of the professional development of physicians and in developing visions for national healthcare. He was also involved in World Medical Association's (WMA) activities; he was inaugurated as the WMA President at the WMA Edinburgh General Assembly in 2000. He invited the WMA executives and held two international conferences in Tokyo in 2001 on the themes of "Highly advanced medical care and medical ethics" and "Patient safety." The WMA declarations prepared from these events are still a part of the WMA policy documents. He was also active in other international activities during this period. He also supported the Takemi Program in International Health at the Harvard School of Public Health. In 2000, King Birendra of Nepal

honored Dr. Tsuboi the highest award for foreigners for over a 10-year-long contribution to school health and community medicine projects in Nepal. Early in his career, he became involved in the establishment of the National Cancer Center in Bangkok, Thailand. Based on his experience, he regarded the bonding



of physicians across the borders as the key element in Asia. He constantly underlined the importance of an affiliated regional organization of the WMA, namely the Confederation of Medical Associations in Asia and Oceania (CMAAO). During his eight years of tenure as the JMA president, his drive was supported by his ability to take actions and by belief in the foundation.

We would like to express our sincere gratitude to all WMA colleagues who helped Dr. Tsuboi during his tenure at the WMA.

Japan Medical Association (JMA)