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**Cover painting : The picture is of the man
who first was called doctor in Iceland,
Hrafn Sveinbjarnarson (a name which is usual
today as well). He was born in 1166 and died
in 1213. He traveled to Norway, England,
France and Italy where it is believed that he
studied medicine at the University of Salerno.
One of the sagas written in the 12th and 13th
century was dedicated to him and tells stories
of his abilities to heal and cure patients with
various illnesses.**

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Editorial

“Glass Pearls for Diamonds”

It is encouraging to see that gender differences in medicine now get more attention. In this issue Petra Thürmann gives a general overview of gender-specific differences in pharmacotherapy putting a spot on an obvious concern in medicine we have long overlooked. It may not be of any use to blame somebody for this long-lasting negligence, but it is clear that continuing “as-we-have-always-done-it” is no option. Petra Thürmann distinguishes between sex as a biological category and gender as a broader socio-biological concept. Although overlooking the biological differences for ages, there will be more and even more painful revelations when we look deeper into the sociological differences in medical treatment.

WMA Past President Jim Appleyard, reminds us that likewise, our home has not been made when it comes to children. Their weakness is reflected in our apparent inability to properly include them in medical research and development. The balance between safeguarding children and providing the necessary research inclusion is - and most likely will remain - one of the most difficult and mind twisting ethical challenges. Like the research on and for incapacitated patients and persons this question deserves our attention and care, our engagement and, most difficult, our dispassionate conclusions.

But not only when looking at gender and age differences; inequities are a far bigger problem than we are obviously willing to admit. Searching ways to bring them to the attention of the individual physician and his daily practices is the focus of WMA president Yoram Blachar. His Israeli Medical Association and many other groups have looked into ways of not only describing but also improving the chances for patients to get the treatment they need and want, irrespective of their social, ethnic and economic background. His call comes in a time when societies and governments, politicians and economists highlight the problem, while at the same time their proposals and laws turn medicine more and more into an odd mixture of state control and commodity business, including direct or indirect rationing which of course increases the existing inequalities.

In the affluent countries of this world the relation of physician to population is 1/500 or better. In the poorest countries of this world this goes down to 1/50.000. Just by statistical numbers the chance for people in poor countries to see a physician is 100 times lower than in the rich countries. In reality it is even worse: Calling the chance of an ordinary person in Malawi seeing a physician, as “nil”, is a fair statement.

To cope with that situation the World Health Organization has crafted the strategy of task shifting, which means shifting professional tasks to lay persons. To be quite frank the health professions’

organizations don’t like it. There is a good reason why nurses, midwives, physiotherapists, dentists, pharmacists and physicians are trained for years and years, have to be registered, to do continuing professional development, satisfy quality controls, undergo supervision, be subject to recertification etc.

Do we however, or more importantly, does this world have a choice? Without the involvement of lay people in health care there will be no health care for many, if not most people in this world. It is not the question of whether we do it, rather one of how task shifting is implemented.

Task shifting, especially when done to save money, may result in the exodus of even the last health professionals in a respective country or region. Even worse, a badly managed tuberculosis programme or a botched anti-retroviral treatment campaign for HIV can turn out as into a real nightmare and public health catastrophe.

In her contribution Lea Wapner explains the common position of the health professions to the method of task shifting. It takes a proactive yet cautious approach, trying to avoid the danger of task shifting spiralling down the health care systems of poor countries even more.

Interestingly the concept of task shifting is being driven by the rich countries, the Europeans, the Canadians and the US, including the private donor organizations. Their interest in this issue must be under scrutiny as those countries at the same time are the main recipients of the emigrating health professionals from the poor countries. One must not be a cynic to see what appears to be the bottom line: “the rich countries trading in glass pearls for diamonds”.

WMA past president Jón Snædal reports on a first WMA seminar on human resources issues, which are occur in different countries in different appearances as “scope of practice” or “skill-mix” issues or sometimes only as an increased in delegation of tasks. The seminar has been partnered by the Global Health Workforce Alliance (GHWA) a group consisting of donors and partners in global humanitarian help. It is attached to the WHO in Geneva. GHWA is now developing programmes to help poor countries train and retain their workforce when implementing task shifting. The health professions closely co-operate with GHWA in their programme for “Positive Practice Environments” to improve the workplace for all people working in health care. A challenge which, by the way, does not only affect the poor countries – just the opposite As long as the rich countries do not get their human resource issues in order, the poor countries will continue to suffer from an enormous brain drain.

Dr. Otmar Kloiber, WMA Secretary General

The Role of the Physician in Combating Inequalities in Health



Yoram Blachar

For over 150 years, the existence of health inequality has been acknowledged worldwide. However, despite the magnitude of written documentation accumulated over this lengthy period, it is only within the last three decades that countries have been able to provide conclusive evidence of the social and economic consequences of inequality in health and healthcare services. Health inequalities extract a heavy human cost in terms of morbidity and mortality rates, as well as from the moral implications of discrimination, even if unintended, among populations. They also result in economic expenses such as rising costs for preventative healthcare and days lost at work. It is for these reasons that health inequality is and should be a top priority for legislation all over the world.

In 1971, an English family doctor, Julian Tudor Hart, coined the Inverse Care Law. This law states that "the availability of good medical care tends to vary inversely with the need for it in the population served." Dr. Hart came to this conclusion after working in the coal mining region of Wales. The significance of his declaration lies in his statement that the quality of services provided by the health system, and all its com-

ponents, is not in line with the true health needs of the various population groups, especially those on the fringes of society.

In Israel, as in many countries, health disparities and inequalities span the ethnic, socio-economic, geographic and other determinants. Some of these are readily apparent. For example, Arab men and women have higher mortality rates as compared to their Jewish counterparts, even when the rates are standardized according to age. Despite a large decrease in infant mortality rates since the founding of the state, the rate for Arab populations remains twice that of Jewish populations. Jewish immigrants from Ethiopia are at a disadvantage in terms of understanding physician instructions, receiving quality healthcare and having their disease and treatment properly surveyed. Citizens located in peripheral regions have less accessibility to a number of specialty services as compared to those living in the central areas of the country. Other factors are more insidious, such as the findings that low levels of education results in higher smoking levels among Jewish and Arab populations. Social factors such as unemployment or social exclusion also impact on health and the provision of services.

Health inequalities manifest themselves not only as differences in morbidity and mortality rates, but also as differences in health risks, accessibility to and usage of services, provision of quality healthcare, and treatment outcomes. The main causes for these inequalities are socio-economic differentials, determined by varying levels of salary, acquired knowledge, occupation and occupational hazards, housing, exposure to pollution, infectious diseases, and regional violence. Many of these elements are a direct result of national governmental policies, but the healthcare system itself also has a great influence on the creation of health inequalities, particularly in the areas of sup-

plying and financing healthcare services. It is crucial that physicians continue to impact government so that they devise public policy that will minimize the inequalities in our healthcare system. The reasons for health inequality are complex and include the national level (governmental policy concerning social inequality in general and health inequality in particular); the health system (the Health Ministry, healthcare organizations, and hospitals); medical professionals; and the population itself.

In the United Kingdom, national programs aimed at coping with inequalities in health and bridging gaps began with The Black Report, published in 1980. In 2003 a practical document, *Tackling Health Inequalities: a Programme for Action*, was published. In Sweden, also in 2003, *The National Objectives for Public Health in Sweden* was published and referred extensively to differences in Health. In Holland a plan to reduce socioeconomic inequalities in health was implemented in 2001. In the USA, the results of the *Unequal Treatment* study appeared in 2002. In the study, conducted by USA health institutes, significant differences were found in medical treatment results between population groups, according to race and ethnic background. The Israeli government has contributed to efforts to minimize health inequalities when in 1995 it passed the National Health Insurance Law. The intention of this law was to guarantee that all Israeli citizens are entitled to basic health care coverage.

As healthcare professionals we must be aware of these inequalities and not only take responsibility for any contributions we might inadvertently make to the problem, but also advocate on behalf of our patients. We must provide uniform quality treatment, while remaining culturally sensitive to our patients' specific needs. We must educate those entering the profession about this large-scale problem and train them in specific ways to reduce the range and extent of health inequalities.

However, actions alone will not lead to significantly minimizing health inequality. Therefore, comprehensive policy must be formulated, which will lead to coordinated activities between the health system and parallel systems, including the following:

Decision-maker awareness should be increased concerning the grave significance (health, economic and social) for all of the existing situation.

Medical professional awareness should be increased concerning the serious implications of health inequality.

We all need to act in order to:

- Prevent the medical outcome of social, economic and cultural inequality.

- Identify and tackle existing health inequality in order to minimize it.

A multi-annual program must be determined to meet the defined needs of population groups. The difference in infrastructure and services between the peripheral and central regions must be rectified urgently in a planned affirmative action process.

Doctors stand in the forefront of providing medical services to the population. The inability to finance the required treatment constitutes a digression from the basic principles of any national medical insurance law.

Healthcare services must be adapted linguistically and culturally to the target population, whether in the format of information provided to the individual and population

groups, in the use of signs in different languages or professional translation rather than untrained family members, and in sensitivity to the cultural nuances important to different ethnic groups.

Medical professionals should be provided with knowledge and skills aimed at training them to work with multicultural populations. This training must constitute an integral part of professional studies on all levels (including medical specialization), especially for those who are already working in the system.

Our work is not done until everyone will be able to benefit from quality healthcare services, regardless of socio-economic status, ethnic origin, or locale.

Dr. Yoram Blachar, WMA President

Human Resources for Health and the Future of Health Care

WMA Seminar in Reykjavik (March, 8th-9th 2009)

During the last years, three issues have been discussed inside the WMA in different workgroups, Medical Workforce, Task Shifting and Prescribing. The General Assembly (GA) in Seoul decided to continue to work on these issues in a seminar with input from other stakeholders. Furthermore it was decided by the GA to accept the invitation of the Icelandic Medical Association to organize the seminar in Reykjavik, Iceland in March 2009. The Secretary of the WMA and the office of the IcMA took on the task to organize the seminar.

The idea of this seminar was very well accepted by the member associations of the WMA (the NMA's) as well as by our partners in the Health Service. The three international associations of health professionals invited to speak accepted and sent high level persons to the seminar. These associations were the International Council of Nurses

(ICN), the International Pharmaceutical Federation (FIP) and the World Confederation for Physical Therapy (WCPT). Other stakeholders were the WHO and the

GHWA and the last one agreed to finance not only their own representative to attend but also three representatives from Africa.

The attendance was very good as over 50 representatives from all continents participated. The seminar was held in a new hotel and conference facilities at the Grand Hotel in Reykjavik. The Health Minister of Iceland addressed the meeting at the beginning and the first day was dedicated to input from outside presentations as well as reports from many different NMA's





describing their own experience in task shifting and professional collaboration. The second day was used primarily for the workgroups which used ideas from the first day for their own work. This was facilitated by the rapporteur of the meeting prof. Vivianne Nathanson from the BMA.



As one of the promoters for this seminar I am very pleased with the outcome for many reasons. To work in a seminar like this helps the members of the WMA to come to conclusions in important issues. The WMA relies entirely on the NMA's for making decisions on different issues. The discussions are most often taking place in the standing committees during council meetings or at the GA where the time frame is tight. The outcome then relies mostly on the work of those NMA's which are best prepared for the issue and others might not be able to contribute so much. Workgroups created by the WMA usually do not meet but rely mostly on the chair of the workgroup to prepare a draft of a document to be discussed electronically and then at the next meeting. The electronic method is theoretically valuable and gives all in the workgroup

the same possibility to participate but in reality this is not always so. By discussions on specific issues in a seminar, the NMA's present will then be better prepared for the final decisions made at the following meeting. It is also a pleasure for me to be able to organize such a seminar in my own country

and give the participants an opportunity to come to a country that has up to now not hosted a WMA meeting. Lastly, in my work inside the WMA I have promoted dialog with those we have common interests with or are important recipients of our ideas and we are many that share this viewpoint. By that I mean on one hand other health professionals and on the other the WHO and organisations linked to the WHO like the GHWA. It was a pleasure to witness a successful WMA work on very important issues. There will be continuous dialog at the Council meeting in May in Tel Aviv and the final outcome will hopefully be reached at the GA in New Dehli next October.

*Dr. Jón Snædal, Immediate Past-President
WMA, Icelandic Medical Association*



Upon the Completion of the WMA General Assembly Seoul



Tai Joon Moon

The WMA General Assembly Seoul, hosted by the Korea Medical Association (KMA), took place over four days, beginning October 15, 2008. Korea was overwhelmed with pride and honour to welcome the WMA General Assembly, which was the highlight event of the year for Korea as it celebrates its 120th anniversary of modern medicine and the centennial of KMA. Modern medicine was first introduced to Korea through medical missionaries from countries such as Canada and the U.S. Since then Korean medicine has continued its growth and advancement, including during times of war and rapid economic development. Exchange with the international community has played a vital role in Korea's medical progress.

The General Assembly discussed an agenda filled with a broad range of key topics. Of particular note, a revision of the WMA Declaration of Helsinki was adopted, as was a new policy, the WMA Declaration of Seoul on Professional Autonomy and Clinical Independence. The GA also decided to devote its next Scientific Session on Health and the Environment.

The Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects, the focal point of keen attention, was amended after several years of intensive review to better address recent social and medical developments. Difference of opinion did remain on the use of placebos, but, fortunately the Assembly managed to reach a last minute agreement.

The Declaration on Professional Autonomy and Clinical Independence was proposed amidst a huge amount of attention and anticipation from the 90,000 Korean physicians. On behalf of my Korean colleagues, I express deep gratitude for the unanimous adoption of the Declaration and the honor of having it named the Declaration of Seoul. The document includes statements highly relevant to Korea's current reality. Korea began offering universal health insurance in 1989. As a result, Koreans have come to receive medical care without having to worry about excessive financial burdens, including medicare benefits to the underprivileged 10% of the population. However, the payment system has created complicated relationships among the government, physicians and insurers. In particular, the physician-patient relationship has suffered from confusion on a number of fronts. Significant sacrifice by physicians was required before the system stabilized and it was our dedication to patient care that enabled the system to succeed. However, excessive interference and regulation by the government has created severe friction between the government and KMA. Some Korean patients, accustomed to traditional medicine, demanded non-scientific treatments. For instance, Korean physicians had to overcome the beliefs of some patients who strongly believed that visits to the doctor could not be complete without a shot. The Seoul Declaration will provide practical support to Korean physicians who face such issues daily and will serve as an important guideline in the future.

I imagine other nations with medical insurance are experiencing similar issues. There often is a fundamental misunderstanding as to who exactly is the medical provider. As physicians, we constantly need to be vigilant against government or insurer attempts to take on the role of a provider and interfere in the physician-patient relationship.

In addition to the main business of the General Assembly, the Scientific Session on Health and Human Rights attracted great attention from not only physicians but also the media. Deputy High Commissioner of the UN High Commission for Human Rights, Kyung-Hwa Kang, was sent by the UN Secretary General to speak about global human right issues related with health. Other renowned speakers addressed topics ranging from poverty, human rights abuses by political suppression, torture, human rights abuses of prison inmates, the environment and human rights and medical education on human rights. During my talk, I introduced Dr. Oliver Avison, a missionary doctor who had come to Korea in the late 19th century and single-handedly corrected serious social discrimination prevalent at the time in Korea. Through the true story of Dr. Avison, I wanted to emphasize the responsibility we share for human rights and to demonstrate that we can muster enough power and influence to make a difference if only we have the will.

I earnestly urge the WMA to continue to expand our horizons and presence in areas of traditional interest, such as ethics and physician-patient rights, as well as other critical issues, such as human rights and the environment. Even though physicians alone may not be able to solve all the human rights problems around us, the 2008 Scientific Session was meaningful in itself for inspiring everyone to speak up and demand change.

The Seoul General Assembly also adopted an emergency resolution that reflects our concern as physicians regarding the current global economic crisis. The resolution, which passed unanimously, calls upon all governments to maintain a high standard

of medical care and not to curb investments necessary for patient care despite economic challenges. I applaud the WMA for addressing this crisis with a very timely response.

A special seminar on smoking cessation provided a series of presentations from top speakers and succeeded in attracting audiences beyond expectations. I hope that the special seminar has motivated a more aggressive response on the part of the WMA, national associations and individual physicians to curtail the detrimental health and financial impact of smoking. I promise an augmented effort by KMA on this front in the future.

The Seoul General Assembly was attended by the President, the Prime Minister and the Minister for Health, Welfare and Family Affairs of the Republic of Korea, all of whom paid high tribute to physicians' contribution to extended human life and expressed their gratitude for physicians' efforts. This should be accepted as their deep homage to not just KMA but all physicians around the world – the 8 million colleagues under the WMA umbrella.

The wide variety of topics on the General Assembly agenda contributed greatly to enriching the outcomes of the meeting. The sophisticated manner of proceeding and the high level of participation both left indelible

impressions on Korean members. I express my deepest gratitude to the WMA leadership – Dr. Snaedal, Dr. Blachar, Dr. Arumugam, Dr. Hill and Dr. Kloiber – as well as the leaders of each country, without whose contributions the KMA would not have been able to complete this grand mission with such positive results. KMA now closes its first centennial and prepares for its next. We pledge to continue our endeavor to become better physicians and more ethical physicians serving our patients. I am grateful to share this noble journey with everyone in the WMA family.

*Tai Joon Moon, MD, PhD, President
Emeritus, KMA Chair, KMA
Organizing Committee for WMA
General Assembly Seoul 2008*

Words from Reykjavik on Task Shifting as a Response to the Global Shortage in Health Care Providers



Leah Wapner

The WMA was faced with a daunting task at its recent meeting in Reykjavik when discussing the topic of task shifting. As the WMA represents over 80 national medical associations, it is inevitable that diverse and sometimes opposing views on the implementation of task shifting will arise. For example, the British Medical Association encourages the use of multi-disciplinary teams while the Spanish Medical Association is strongly opposed to the implemen-

tation of task shifting in any form. Both these associations' views must be taken into account, along with over 80 others, for the WMA to adopt a resolution of any scope on the topic.

The first global conference on task shifting was held in Addis Ababa, Ethiopia in January 2008. Attendance included representatives of governments, agencies, professional associations (such as the WMA), education, training and research institutions. The conference ended with a declaration acknowledging the existing shortage of healthcare workers and calling for action to be taken by the various parties involved. The Addis Ababa Declaration perceived action as necessary in order to address the human resource constraints obstructing the implementation of UN Millennium Development Goals which include: the reduction of child mortality, improvement of maternal health and the achievement of universal access to HIV and AIDS services by 2010. In response to the Addis Ababa Declaration, the World Health Professional Alliance adopted twelve points on task shifting that were endorsed by the WMA in May 2008.

1) Skill mix decisions should be country-specific and take account of local service delivery needs, quality and effectiveness factors, efficiency, the current configuration of health services and available resources, as well as production and training capacity, and include the health professions in decision-making.

Country-specific guidelines are necessary for many reasons. The extent of a shortage in health professionals differs between different locales and perspectives for dealing with shortages also differ. Different countries are faced with different health threats, with some threats being easier to deal through the use of task-shifted positions than others. Additionally, each country has its own history of the evolution of different health care disciplines. The creation of country-specific solutions allow for the maintenance of the highest level of care.

2) Roles and job descriptions should be described on the basis of the competencies required for service delivery and constitute part of a coherent, competency-based career framework that encourages progression through life-long learning and recognition of existing and changing competence.

Competency is very difficult to define. Even if a definition of competency can be agreed upon and sufficient data is available, comparing competencies is still a challeng-



ing feat. However, competency must be achieved, as it is insufficient to simply staff health care positions if workers are not able to provide quality care. Once task shifting has been implemented, the level of health-care will deteriorate if healthcare personnel are not exposed to new advances.

3) *There needs to be sufficient health professionals to provide the required selection, training, direction, supervision, and continuing education of auxiliary workers.*

While the implementation of task shifting increases the amount of health workers available to implement more simple tasks, task shifting cannot blur the boundaries of each health discipline. Keeping health disciplines well-defined will assure that the education, progression and definition of new areas for expansion of the profession are in the hands of the correct individuals. It is the task of physicians to determine the requirements for task shifted positions as they are currently the ones performing these tasks.

4) *Regulations for assistive personnel and task-shifting need to be set with the professions involved. It should be clearly stated who is responsible for supportive supervision to assistive personnel. In any case the curriculum development, the teaching, supervision and assessment should always involve the health professionals from whom the task is being shifted.*

The creation and implementation of a proper legal and social framework is necessary to uphold such regulations.

5) *There must be adequate planning and monitoring to avoid the danger of generating a fragmented and disjointed system that fails to meet the total health needs of the patient, offers a series of disconnected and parallel services that are both inefficient and confusing, and may lead to de-motivation and high attrition rates.*

6) *Assistive personnel need compensation and benefits that equal a living wage, a safe workplace and adequate supplies to ensure their own safety and that of patients. At the same time*

they should be expected to work within the code of conduct of their employer.

7) *Deploying assistive personnel will increase demand on health professionals in at least three ways:*

- *increased responsibilities as trainers and supervisors, taking scarce time away from other tasks;*
- *higher numbers will be needed to take care of the new patients generated by successful task-shifting;*
- *health professionals will be faced with patients who have more complex health needs (the simpler cases will be covered by task-shifting) and thus require more sophisticated analytical, diagnostic, and treatment skills.*

The use of assistive personnel should not be implemented as a cost-saving measure. New staff requires adequate compensation.

8) *There needs to be credible analysis of the economic benefit of task shifting to ensure equal or better benefit, i.e. health outcomes, cost effectiveness, productivity, etc. Ongoing evaluation, particularly in skill-mix changes and the introduction of new cadres and or new models of care, should systematically consider the impact on patient and health outcomes as well as on efficiency and effectiveness.*

Credible analysis is difficult to execute. Independent analysis is even more difficult as there are so many different vested interests at play in the implementation of task shifting. Analysis must take place over an extended amount of time as the results of task shifting can rarely be sufficiently observed immediately.

9) *When task shifting occurs in response to specific health issues such as HIV, regular assessment and monitoring should be conducted on the entire health system of the country concerned. In particular, quality assessment linked to overall health outcomes of the population is essential to ensure that programs are improving the health of patients across the health care system.*

Maintaining focus on the patient is of utmost importance when instituting task shifting. Measurable quality indicators must

be developed to assess an improvement or deterioration in the level of health. Assessment must be done for both intermediate and long-term evaluation.

10) *Assistive workers should not be employed at the expense of unemployed and underemployed health professionals. Task-shifting should be complemented by fair and appropriate remuneration of health professionals and improvement of their working conditions.*

The “turf war” issue cannot be ignored. This issue must be taken into account both for the profession giving up its practices and for the profession acquiring additional tasks. Self-interests of the many different players involved in task shifting must be acknowledged. For example, the World Bank and national governments have interests in saving funds. Nurses are interested in acquiring more responsibilities. Physicians are interested in transferring responsibilities. With all these battling interests, it is important to relay its concern that preserving one's profession is legitimate.

11) *Where task shifting is meant as a long-term strategy it needs to be sustainable. If meant as short term, there needs to be a clear exit strategy.*

12) *Assistive workers need to be integrated into health care delivery systems and treated as part of the team.*

Regardless of existing shortages, the end result and the most important outcome of task shifting must be the creation of teamwork.

In conclusion, task shifting remains a topic which challenges the global medical community. The Seminar at Reykjavik aided in clarifying some of the most pertinent issues, but the World Medical Association is still faced with the great challenge of creating a policy which is acceptable to all, or at least most, its members.

*Leah Wapner, Secretary General,
Israel Medical Association*

Task Shifting on Health Care



Nachiappan Arumugam

There are many requirements for the provision of effective and responsive health systems and we all recognise that a critical ingredient is a sufficient and appropriately trained workforce. Currently there is a growing challenge to maintain the needed numbers, quality, mix and distribution of personnel to meet the healthcare needs of the population. The health workforce includes physicians, nurses, public health workers, policy makers, administrators, educators, clerical staff, scientists, pharmacists and health managers amongst others. The myriad of different healthcare groups with overlapping skills and responsibilities and maldistribution has brought about friction and disagreements. Various attempts at developing systems to achieve an amicable working relationship between the different cadres of workers in the healthcare system have met with various levels of success.

The conference today on Human resources for Health and the future of health care in the world is focusing on some issues pertaining to task shifting. We have already heard about the working arrangements in many countries between healthcare workers, complementing one another in many areas while locked in disagreement in other areas. In this presentation I am going to outline the development of human resources over

the years in Malaysia and how an external organisation like ASEAN (Association of South East Asian Nations) and regional and international treaties have and might affect medical human resources in the future.

Task shifting is not a new concept in Malaysia; it existed fifty years ago, when Malaysia obtained its independence. At independence, there were only forty-two primary health care facilities in the country, and medical care to the majority of the population was confined mostly to traditional remedies. The healthcare facilities that were present at that time had only a limited number of doctors and a considerable amount of the work was delegated to hospital assistants and midwives. Since then the health care in Malaysia has notably undergone radical change through systematic planning and building of healthcare facilities. The Primary health care facilities have grown to more than three thousand, comprising of health, community and mobile clinics. A range of comprehensive public health services nationwide is provided, through wide varieties of clinics and hospitals.

The healthcare system in Malaysia currently comprises of both a public and a private sector. The government, committed to the principles of universal access to health care, provides both primary health and tertiary health care to all, for free or at a minimum cost. The service provided by the government is complemented, by a private healthcare sector, which offers a more personalised and luxury care. Over the last few years with growing affluence, the demand for private health care has been escalating and the number of new private healthcare facilities has increased rapidly.

Man power planning and training has been one of the cornerstones of the growth of the Malaysian health care system. Health manpower planning has been and is a challenge in Malaysia as it is in many parts of the world. Initially there were only a few

training centres in the country and the manpower needs were supplemented by overseas trained staff, but steadily the number of local institutions training workers has increased and the country is nearly attaining self sufficiency. Strategic manpower planning and training was instituted many years ago to fine tune training to the demands of the country, but the goal to achieving sufficiency in healthcare manpower has been elusive. The growing number of new medical facilities, increasing scope of medical practice and changing world environment has constantly distorted and outstripped the number of trained personnel.

There has always been some movement of doctors and other healthcare workers especially nurses to and from other countries without grossly disturbing the total manpower equilibrium. In recent times many external factors have upset this delicate balance. Globalisation has made it easier for healthcare workers to work in other countries either on a temporary or permanent basis. It is established that International migration has risen sharply in the recent decade and has been described as "one of the defining issues of the 21st century". Globalisation with rapid universal commercialisation, the availability of unrestricted information and relatively easy travel has fuelled this evolution. This movement of large numbers of healthcare personnel from country to country including Malaysia has caused uncertainty in the training, employment and retention of healthcare professionals. In this uncertain healthcare workers market as many Malaysians go overseas to work the country has had to recruit workers from other countries to run the services here.

The Association of Southeast Asian Nations (ASEAN) is a geo-political and economic organization of 10 countries located in Southeast Asia which was formed on 8 August 1967 by Indonesia, Malaysia, Philippines, Singapore, and Thailand. Since then, membership has expanded to include Brunei, Myanmar, Cambodia, Laos and Vietnam. These countries have different political systems – democracies of dif-

fering standards, communist regimes and monarchies. These countries are at different levels of economic development and their healthcare standards and availability to the citizens are grossly different. In spite of all these differences this grouping is committed to its aims - the acceleration of economic growth, social progress and cultural development among its members, and has drawn up many treaties to help move the agenda forward.

The regional grouping has made the most progress in economic integration, aiming to create an ASEAN Economic Community (AEC) by 2015. The AEC would have a combined population of over 560 million and total trade exceeding US\$ 1400 billion. The foundation of the AEC is the ASEAN Free Trade Zone (AFTA), a common external preferential tariff scheme to promote the free flow of goods within ASEAN. The AFTA is an agreement by the member nations of ASEAN concerning local manufacturing in all ASEAN countries. The AFTA agreement was signed on 28 January 1992. An ASEAN Framework Agreement on Trade in Services was adopted at the ASEAN Summit in Bangkok in December 1995. Under AFAS, ASEAN Member States enter into successive rounds of negotiations to liberalise trade in services with the aim of submitting increasingly higher levels of commitments. AFAS is aimed at substantially eliminating restrictions to trade in trade in services among ASEAN countries in order to improve the efficiency and competitiveness of ASEAN services suppliers.

AFAS provides the broad guidelines for ASEAN Member Countries to progressively improve market access and ensure equal national treatment for services suppliers among ASEAN countries. All AFAS rules are consistent with international rules for trade in services as provided by the General Agreement on Trade in Services (GATS) of the World Trade Organisation (WTO). In fact, liberalisation of services trade under AFAS shall be directed towards achieving commitments beyond Member Countries' commitments under GATS, or known as the GATS-Plus principle.

Mutual Recognition Arrangements (MRAs) are the more recent development in ASEAN co-operation on trade in services. MRAs enable the qualifications of professional services suppliers to be mutually recognised by signatory member countries, hence facilitating easier movement of professional services providers in ASEAN region. ASEAN Member Countries continue to work on further expanding the negotiations to cover all sectors and all modes of supply. The ASEAN Economic Community Blueprint adopted by the ASEAN Leaders at the 13th ASEAN Summit on 20 November 2007 in Singapore sets out concrete steps to be taken to achieve a free flow of services by 2015 with flexibility. MRA on Nursing Services signed on 8 December 2006 in Cebu, the Philippines. MRA on Medical Practitioners, MRA on Dental Practitioners, and MRA Framework on Accountancy Services all signed on 26 February 2009 in Cha-am, Thailand.

Task shifting refers to shifting of tasks from one cadre of healthcare worker to a lower-level cadre or shifting tasks to a new cadre. Though there has not been any recent policy on task shifting, there is a historical legacy allowing less specialised health workers to provide some of the healthcare services. The provision of healthcare in the remote areas, especially in the eastern part of the country, has always been laden with difficult. Generally para-medical staffs that have been credentialed and registered have played a crucial role in providing healthcare in these regions with some amount of supervision. The involvement of the communities, through volunteer health workers, has also helped to extend health services to the remote areas and disseminate public health matters. The policy of the government is to train sufficient medical personnel to fulfil the manpower needs and this is reflected on the increase from one medical school fifty years ago to twenty medical schools today and the establishment of many other training facilities.

While we are debating the role of different healthcare worker and their responsibilities lets us also not overlooks how all the new treaties, groupings, technology and globalisation will affect the healthcare worker and the delivery of healthcare.

*Dr. Nachiappan Arumugam,
Immediate Past-President WMA,
Malaysian Medical Association*

CPME Board meeting 14th March 2009 outcomes

CPME Subcommittees, Board and General Assembly met on 13th and 14th March 2009 in Prague.

The following policy documents were adopted:

CPME reaction to the Green Paper on the European Workforce for Health

Although the Green Paper addresses most of the CPME's concerns, CPME would like to highlight some of the issues and put them higher on the priority list. These issues

are: the scope of the workforce for health, ageing of the population, sustainability of health systems, demography and the promotion of a sustainable health workforce, Public Health capacity, training and managing mobility, global migration of health workers, impact of new technology, and the role of health professional entrepreneurs.

In addition to the considerations regarding these issues, CPME wants to steer clear

from any healthcare-system discussion and particularly on their respective advantages or disadvantages. In the case of entrepreneurial stimulation the above mentioned arguments show that a strict equality between public and private sectors would be needed in order to achieve the proposed actions.

In its response, CPME identifies several clear positions that it will submit to the European Commission for consideration.

CPME reaction to the Communication from the European Commission on telemedicine

Telemedicine can make physical distance between patients and physicians a less important factor. Telemedicine can therefore provide better access to health care to people in remote areas, improve the quality of life of chronically ill patients and reduce hospital stays. Subsequently, this will not only be to the advantage of patients, but also advantageous for relatives and the health care sector in general.

Although telemedicine could also enhance inequity in health care. CPME therefore calls on health authorities and governments to ensure that new technology must be available to all, irrespective of their social or economic background. Furthermore, it is also the task of governments to find ways to contain the rising costs of providing health care and to find affordable ways to provide a reasonable level of care.

The development of telemedicine will most likely continue to be technological and market driven. Health care for the ageing population and self-management of chronic diseases will in the near future become a huge market for health care delivery. CPME therefore stresses that physicians must have a central role in the development of telemedicine and that the development should not be driven mainly by industry. Physician input is needed to ensure that telemedicine is developed in the best interest of the patient, as well as to the benefit of the medical profession.

Legal Control of Tobacco Products

The toll of disease and death caused by the use of tobacco products as recommended by their manufacturers is immeasurably greater than that attributed to the abuse of any drug which is universally classified as "dangerous" and subject to criminal sanctions. Therefore, The CPME calls for the tobacco manufacturing industry to be given ten years' notice of the Committee's intention to press for tobacco products to be classified as dangerous drugs and controlled accordingly. The CPME however strongly believes that smokers and users of other manufactured tobacco products should not be incriminated.

Achieving Healthcare information for all by 2015

The CPME recognises that the availability of relevant, reliable health information contributes to prevent death and suffering and to increase the efficiency of health systems.

The CPME supports efforts to improve the availability of healthcare information for professionally isolated healthcare providers in Europe.

Therefore, the CPME supports HIFA2015¹ and calls upon other European medical and health professional organisations and scientific societies to do the same and to actively contribute to the international dialogue.

End Water Poverty

In order to address the global crisis in water and sanitation, CPME joins the *End Water Poverty* campaign² and urges individual member associations to do the same. CPME calls on Governments to establish a Global

¹ *HIFA2015* is an international campaign and knowledge network with more than 2000 members from 135 countries worldwide. <http://www.hifa2015.org>

² *End Water Poverty* is an international campaign, driven by a growing coalition of organisations, calling for immediate action and for water resources to be protected and shared equitably. <http://www.end-waterpoverty.org>

Framework for Action to ensure sanitation and water for all; and to fulfil the commitment made in the EU Agenda for Action on the Millennium Development Goals.

Mental Health in workplace settings

The CPME recognizes the importance of mental health in workplace settings and strongly believes that having healthy working environments with the right preventive measures in place will contribute to a drop in work related mental health problems, a drop in absenteeism due to mental health disorders, a drop in accident related to work rates, an increase in self-confidence and employee morale in work populations and employees who are healthy and fit.

The CPME endorses the WMA Declaration of Helsinki

The CPME endorsed the WMA Declaration of Helsinki on Ethical principles for medical research involving human subjects, as adopted by the WMA General Assembly in Seoul, Korea in October 2008.

At its General Assembly meeting in Prague on 14 March 2009, the CPME elected the President and Executive Committee for the period 01/01/2010 to 31/12/2011:

- President: **Dr Radziwill**, Poland
- Vice Presidents:
 - Dr Montgomery**, Germany
 - Dr Kubek**, Czech Republic
 - Dr Lemye**, Belgium
 - Dr Pruckner**, Austria
- Treasurer: **Dr Fjeldsted**, Iceland

All CPME Policy documents are available at: <http://www.cpme.eu/policy.php>

For more information about CPME, consult our website: <http://www.cpme.eu>

European Physicians Congratulate the Parliament for Adopting the Cercas Report

CPME representing 2 million physicians, is delighted that the Members of the European Parliament have adopted the Cercas Report on the amendment of Directive 2003/88/EC concerning certain aspects of the organisation of working time.

The European Working Time Directive is the cornerstone of labour protection in the EU. Since there is a very strong link between doctors' and patients' health, CPME welcomes Parliament's vote. Any amendment to this Directive that would imply a deterioration of the social conditions and discrimination of the medical profession should be rejected.

We therefore congratulate the European Parliament for sharing their position with 2 million physicians and advocating that:

- There should be a maximum average working week of 48 hours
- All time spent at the premises of the employer should be counted as working time, as it is already recognised by the European Court of Justice.

CPME celebrates this victory and will continue the European movement to improve doctors' working conditions. We encourage the Parliament to keep a firm stance on these basic principles towards the Council during the conciliation phase.

All documents mentioned are also available directly on CPME website www.cpme.eu

What is the Added Value of EU Health Policies for National Health Systems?

On 23 April 2009, the European Parliament ENVI Working Group on Health held a debate on "What is the Added Value of EU health policies for National Health Systems?" During the discussions, there was a special emphasis on the financial crisis and its implications on the Health Gap between "Old" and "New" Member States.

"EU Added-Value in health policies during the financial crisis"

Speech by Commissioner Androulla Vassiliou

"First I would like to congratulate the CPME for having organised this get together and I hope it will be the start of a long running initiative.

It is important at EU level to have structured and competent groups in order to support health related initiatives and to counterbalance other pressure groups having category interests opposing our health objectives.

We need a strong representation of patients and consumers but it is also important to have by our side the health care providers groups and first amongst them, the physicians.

At political level the many physicians in the European Parliament can be instrumental in shaping EU health policies. Who else but the physicians can advocate for and lead health actions?

This is even more important at EU level considering the efforts that are sometimes required to demonstrate the added value of health initiatives at EU level.

Indeed the fact that the Member States retain their competences in organising, providing and funding the provisions of health care for their citizens should never be a reason for us to disregard the added value we can bring to their policies due to other EU specific fields of competences but also due to the huge potential of cooperation which exists in Europe.

Health is always difficult to promote when it interferes with economic interests and private behaviours. Health initiatives could be seen either to be going against short term economic gains, or interfering too much with peoples' lives.

For all these reasons it is important to be able to build strong cases for justifying those health actions where general interest should prevail.

Living in a media driven society where the loudest voice seems often to be the right one, and where unfortunately there still a lack of active and vocal pro-health lobbies, it has become indispensable to advocate, justify and actively promote any public health initiative.

In the recent past we observed how other interest groups are organised.

A good example was seen during the recent discussions on the nutrition profiles initiative which should implement the legislation on nutritional and health claims, where it was very clear that the "agri and food lobby" promoted their ideas loudly, some of them being good I admit, but most of them being only in defence of their own sectoral interests.

The voices of consumers, patients and physicians have not been heard loud enough in such a context to counterbalance their arguments.



More generally in terms of securing public health objectives, forums like this one today can help to effectively contribute to creating a "health" minded network to help achieve our policy objective of promoting public health strategies more strongly.

And the promotion of public health strategies will become even more important in a time of economic crisis.

A key challenge facing Europe and the world at this moment is to prevent the economic crisis spiralling into a health crisis.

We know from past experience that in times of crisis health outcomes are greatly affected by changes in the resources available for health systems.

Many of the human consequences of recession are becoming apparent – consequences such as higher unemployment; reductions in income; and widespread stress and insecurity. Economic crisis could also lead to a food crisis in terms of nutrition and quality standards.

Many other repercussions may only become noticeable some years from now – such as lower productivity and lower labour participation due to poor health.

Hence it is vital that we reflect all together upon these challenges and focus our thoughts on what needs to be done to mitigate or prevent a worsening of our public health status.

Indeed one of the political consequences of the current crisis is that it should strengthen the case for targeted EU actions on health policy.

I could also take another example where health systems in EU will be at stake: the demographic shift in Europe's population. The consequences of our ageing population, will, if nothing is done, have a significant impact on the financing of European welfare systems, including healthcare.

One way to relax somehow the pressure on these systems would be to develop new technologies at EU level, to increase economies of scales and to spread and make available robust health technology assessments in order to spend the available budget in the most efficient ways.

In this and in other areas, we need to recognise that action at EU level can play an important role to ensure positive synergies among the Member States through cooperation and coordination.

If we consider the existing gaps and divergences between our Member States I believe that the EU can also assist those states which aim at modernising their healthcare and public health schemes, in particular by helping national health systems to find alternative and modern ways of ensuring cost effectiveness and optimal use of resources.

Another relevant area is that of rare diseases. Not all Member States have the resources or expertise to provide effective treatment for every rare disease.

This is one the reason why the Commission is promoting the creation of European Reference Networks on particular conditions. This aspect is duly taken into account in the proposal for a directive on patients rights in cross border health care.

These networks should give patients better opportunities to gain access to diagnosis and treatment and will avoid duplication of efforts by Member State.

The good health of citizens demands long-term investment. And investment in good health does not only mean healthcare and treatment, but also health promotion and prevention.

In time, this investment will pay off – in quality of life, in lower healthcare bills and in a more productive workforce.

Working with health stakeholders is a key part of our health strategy. And it is obvi-

ous to me that to respond effectively to the challenges of the present financial crisis we need their contribution.

I therefore want to engage with networks of health professionals such as the Standing Committee of European Doctors (CPME), to raise awareness about health issues and help move these issues further up the political agenda.

As a body representing all medical doctors in the EU, the CPME is in a unique position to offer broad expertise in matters related to medicine and the medical profession, on which the Commission can build.

I encourage you to be more present, more vocal in helping me to implement those policies which our citizens need to benefit from better health conditions. In your actions coordination with those of your colleagues sitting in the European Parliament will be essential.

This year is an important year for the European Union – a year to reflect on priorities to be determined at European level, but also a year when politicians will be absorbed in trying to tackle the effects of a deep economic crisis.

Discussions on the future Community budget post-2013 will start later this year and continue into next year. Much will depend on the new Commission and the new Parliament to define the ambition and resources for future European health policy.

The Commission is making every effort to help find solutions to the problems we face – to pool resources; to bring people and institutions together; and to achieve economies of scale.

I sincerely hope that you will be part of this effort and help us to strengthen EU health policy.

You have a central role to play: play it!"

“Economic Crises on Health Care in Eastern Europe”

Speech by Editor-in Chief of WMJ Pēteris Apinis

“I am happy to have the opportunity to speak about the consequences of the current economic crises on health care in Eastern Europe.

The economic crisis in Eastern Europe is part of the global financial meltdown that can be traced to the real estate crisis in the United States and the crash of several financial pyramids. The result was a break-down in the financial systems of many countries, including Latvia. In Latvia this crisis was intensified by the state's takeover of the country's largest private bank at the end of 2008. In this takeover, the state invested in the bank an expenditure that corresponds to one and a half times the annual budget for health care in Latvia.

These expenses led to a sizable decrease in the health care budget of Latvia. The cut in health care occurred despite recommendations made by the World Health Organization to avoid compromising health care during the economical crisis. These recommendations were documented in statements: the "Impact of the global financial and economic crisis on health" by the Director-General of World Health Organization, Dr. Margaret Chan, in 2008 and "Resolu-

tion on the Economic Crisis: Implications for Health", adopted by the World Medical Association General Assembly in 2008.

Since its independence until recently, the deficit of the Latvian budget never exceeded 3%. The current forecast is that the nation's budget deficit could reach a staggering 7 to 10 %. As a result of this deficit, the country started to cut expenses – it chopped 9% from the health care budget in December 2008, and another 6% in February, 2009. We are now faced with the prospect of decreasing the health care budget by an additional 20% to 40%.

I would like to bring to your attention what happened in a small African country, that was noted in the world press. Cote d'Ivoire has one doctor for 6000 inhabitants and one nurse for more than 2000 inhabitants. At the same time there are 800 unemployed doctors in the country. This situation was caused by directives from the World Bank and the International Monetary Fund to decrease the number of state employees. The number of doctors was lessened, but not the number of army officers and civil servants. It is too early to compare the situation in Cote d'Ivoire to the predicaments of Latvia,

Lithuania, Hungary and Romania, the economic crisis we are facing raises the spectre of patients receiving greatly reduced or no health care services at all.

How did we arrive in this predicament? I will take Latvia as an example and then expand the discussion.

In the late 1980's health care in Soviet Latvia was regard-



The current co-chairmen of the Health Working Group Prof. Georgs Andrejevs, MEP Prof. Victorio Prodi, MEP

ed as the best in the USSR (which might not be saying much): maternal and infant mortality rates were comparable to those in Western Europe, primary and secondary health care was good, and other indicators were also close to Western Europe.

With the dissolution of the Soviet Union, the communist economic system was replaced by a free market economy. The newly independent and semi-independent states were confronted with economic breakdown, high unemployment and social inequality. Health-wise this manifested itself as depression, alcoholism, high use of tobacco, poor nutrition, family instability, stress-related disorders, increased mortality from cardiovascular diseases, high rates of suicide, accidents in general and a sharp decline in the provision of health care. There even was a term created “transition time losses.” In Byelorussia, Lithuania, Latvia and Estonia the life expectancy of men dropped by three to 3 1/2 years decrease for men and that of women decreased by 1 1/2 to two years.

In Latvia, as well as other Eastern European countries, countless changes and reforms



Commissioner Androulla Vassiliou

*Dr. Pēteris Apinis, Editor-in-Chief of the World Medical Journal
Dr. Michael Wilks, President Standing Committee of European Doctors (CPME)*

were undertaken. The road was not entirely smooth, however. In medical care, multiple new medical establishments developed. These small institutions competed with each other, following the dictum of “medicine as a source of profit”. A typical scene was this: in a small town – on one side of the street was a hospital with a new computerized tomography unit; on other side of the street was an out-patient clinic that also needed computerized tomography to keep up. One of these devices had been bought by loan, another – by leasing, so both of them were acquired under long-term financial commitments.

This situation was not unique to health care: Banks and commerce sectors advertised credits on goods and consumer credit expanded very quickly in the new national economic system. In medicine, suppliers were ready give credit to hospitals and other health institutions, asking for long-term paybacks. But at the same time, there was a decrease in the production industry. Factories were taken down and housing built. There was a dramatic price increase in real estate and a quickly expanding “bubble” that finally broke.

In several Eastern European countries, short-term credits exceed more than 80% of the budget of the hospitals. Many municipalities became insolvent this year because they took big credits to purchase devices for their local hospitals. It has been mentioned in the press that many of the acquired devices bought by Eastern European countries were overpriced and not adequately equipped. This raises the concern of whether corruption played a role in these purchases.

Let us talk about reimbursed medication. The difference between reimbursed medication expenditure in Eastern Europe and Western Europe is ten fold. Latvia is budgeted to spend 42 Euros per capita for reimbursed medication (last year it was 48 Euros). In comparison, in the European Union the expenditure for medication reimbursement is 350 Euros per capita. In Latvia the TOTAL expenditure of the state health

care system is only 336 Euros per capita. Patient payment for certain services is increased to 75%.

We are now threatened with another 20% cut in the health budget of Latvia in the second half of 2009. This would bring down the Latvian per capita health expenditure to a mere 269 Euros on average. It is not surprising that, according to the Consumer Health Index

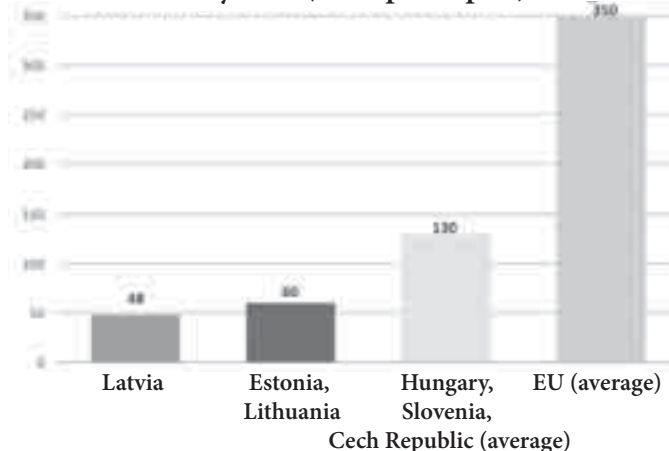
prepared by Swedish expert Arne Bjornberg and Czech Professor Marek Ulrich, Latvia occupies the last position – number 31.

We may still be ahead of Byelorussia, Ukraine and Moldova, but to be with them cannot be the aim for Latvia, a member state of European Union. In the European Union public health is measured in terms of primary health care specialist accessibility, the number of neglected cases of cancer, the incidence of heart attacks in different age groups, infant mortality rates, accessibility of mammography, lost life years, etc. All these indicators are impaired by the huge financial difficulties, as well as bureaucratic obstacles.

I don't want to bother you with statistical data about the concerns of Latvia, the Baltic States or Eastern Europe. All the statistical indicators for the health status of the population are on a strong decline in East European countries, especially when compared with the health status of people living in Western European countries.

I would like to say a few words about the migration of health professionals. Approximately 10% of our graduates go to work in Western European clinics during the first year after receiving their medical diplomas. Another 10% disappear from Latvian pa-

Expenditure for pharmaceuticals for ambulatory care (EUR per capita) – 2008



tient care step by step as they continue to learn, move on to science, to pharmacological firms or research or even worse, into the business world unrelated to health care.

A major problem for Latvia is the recruitment of doctors and nurses to other West European countries. In Latvia, at least two companies constantly work to recruit medical staff to go to French and English speaking countries as well as to Scandinavia. Every doctor or nurse who leaves Latvia is really great loss to the country. Western Europe takes away our intellectual potential by offering higher salaries.

In 2006 the European Commission issued a document: “Health in Europe: strategic approach.” This marked the starting point for a new health care strategy. In October 2007 the Commission accepted the White Paper “Together for Health: A Strategic Approach for the EU 2008-2013”.

The European Union has decided to give more political strength to health care. The EU signified that Europe had to recognize citizens' health as a political, and not only socio-economic, priority. To ensure the well-being of European citizens, the importance of collaboration of European Union member states in the health care field was delineated as a very important aspect. The

European Union determined that the health of European citizens is a common problem and should be solved in collaboration and not independently.

The Lisbon Strategy sets health as a main priority in one's life, so member states should support health prevention and health care with effective policies. Even more, there it is clearly stated that each member state is responsible for the health status of its citizens. But, as a final consequence this must also mean that Europe is responsible for health status of each European citizen. This Lisbon document also defines the fundamental principles for further development of health care prevention in Europe. The second principle is that the health of each citizen is the main treasure of each member state and the whole Union.

The European Union should support actively – and I mean politically as well as financially – the health care systems in the new member states.

We need to stop cutting the health care systems by 30 % now!

For sick people this support will mean rescue for a cancer patient whose treatment will otherwise no longer be financed; it will mean a rescue for a pneumonia patient who

cannot pay for the antibiotics “out of pocket”. And for healthy people it will mean a boost for the economy. Investing in health gives a far higher return than all the money European governments are currently pumping into questionable banks.

How can the European Union help its new member states, which are struggling? Here are some concrete suggestions:

- We have very little resources to pay for outpatient medicines. Thus, many minor ailments go untreated and become worse, resulting in hospitalization. The European Union could help with medicine compensation for next 2 years by investing 4 billion Euros per year in Eastern Europe (it is 120 million for Latvia).
- Where rural hospitals cannot be maintained, small rural hospitals can be closed or the number of hospital beds decreased. However, this creates social tension, loss of jobs and is not an inexpensive proposition. The European Union can provide the financial means to be able to deal with these situations.
- The European Union could help to provide sufficient transportation for emergency and non-emergency patients, especially if health care facilities become inaccessible when local facilities close.
- Medical professionals in Eastern Europe are interested in treating patients from

Germany, the United Kingdom and other European countries. High quality care can be offered inexpensively in the new member states of the European Union if health care facilities are expensive or strained in your home country. It would be good to erase national boundaries for health care in the European Union.

In conclusion, I appeal to You, the honourable Commissioners and you –honourable members of the European Parliament, to direct your attention to problems of health care in East Europe and to support the development of appropriate policy and the necessary financial means. Maintaining health of the people is not a cost, but rather a solid investment. In these times this may be the only investment that for sure will pay off. Don't miss this opportunity.

Without your attention and efforts the health care situation in East Europe, especially in the rural areas, will further deteriorate and put the lives and the health of many people in those regions at risk.

Thank you for giving me the opportunity to report how the current economic crisis in Eastern Europe has affected health care in your new member states. I hope this will encourage you to act.”

The 2nd Annual Hospice and Palliative Care Conference

The 2nd annual Hospice and Palliative Care in Developing Countries conference is being held in Fresno, California, USA. UCSF Fresno auditorium, Friday, September 18 & Saturday, September 19, 2009. Representatives from South America, Africa, S.E. Asia, and North America will be presenting. We are reaching out to medical professionals that may wish to attend, and to those that may be interested in exhibiting sponsorship opportunities.

Our objectives are to:

- Understand how different cultures view death and dying;
- Recognize volunteer, educational, and partnership opportunities in developing countries;
- Identify factors influencing healthcare access rural vs. urban;
- Learn the complexity and magnitude of treating HIV/AIDS in children and adults suffering from TB, Dysentery, Cancer, Malaria, and malnutrition;

- Understand WHO pain management protocols and compounding end of life medications
- Understand ELNEC International's influence in developing countries.

Further information, including flyers which could be distributed, can be obtained by contacting Nancy Hinds at nancy@hindshospice.org or Jill Huff

*Jill Huff, Community Development Coordinator, Hinds Hospice
www.hindshospice.org*

Clinical Research on Children

An ethical imperative



James Appleyard

Around 10 million children worldwide under the age of 5 die every year according to recent statistics from the World Health Organisation. Many of these deaths are from treatable conditions, the most common of which is pneumonia. Others include diarrhoea, malnutrition, malaria, and HIV AIDS. Few countries are on track to achieve WHO Millennium Developmental Goal (MDG) No 4, which aims to reduce by two-thirds, between 1990 and 2015, the mortality of children under 5 years [1].

Even though effective interventions exist, these may entail the use of essential medicines, which are not available in dosage forms for children, particularly in low and middle income countries. Lack of the availability of these essential interventions has been identified as a major reason for countries not making adequate progress towards their MDGs.

It is essential to increase awareness of the problem, implement known effective interventions and understand how to be more effective in achieving progress through audit and research.

Furthermore Physicians in all countries are taking significant risks when they treat children with medications that may have not been adequately tested for their efficacy and safety during childhood [2]. Such treatment decisions have to be taken in everyday clinical practice. They tend to be based on trial and error from the physicians' personal experience, advice from colleagues, anecdotal reports from the literature and extrapolations from adult studies. In addition, medication errors are a constant hazard in paediatric clinical practice. Continuous changes of the dosage regime that are necessary during a child's growth and development make the calculation of the correct dose for each child difficult. The frequent use of off-label medicines with extemporaneous formulations or physician or nurse-made manipulations provide optimal conditions for these medication errors [1].

Ingredients or excipients for improving solubility, sterility and the taste of children's medicines may also cause toxicity (e.g. benzyl alcohol and diethylene glycol). Severe adverse drug reactions in children are not always fully reported. Some of the most dramatic examples of these are the apnoea caused by too large a dose of phenobarbitone, pethidine and prostaglandin, convulsions following the administration of theophylline and hepatic failure associated with high doses of paracetamol (acetaminophen).

Recognising these significant risks in the care of their patients, practicing pediatricians, particularly in the USA, pressed for changes in the regulation of medicines for children. In 1996, the American Academy of Pediatrics (AAP) [3] reported that only a small fraction of all drugs and biological products marketed in the U.S. at that time had had clinical trials performed in paediatric patients. A majority of marketed drugs are not labeled for use in paediatric patients. The AAP also pointed out that many drugs

used in the treatment of both common childhood illnesses and more serious conditions carried little information in the labels about use in paediatric patients.

In order to address these inadequacies, the Food and Drug Administration (FDA) published (<http://www.fda.gov/>) regulations that ensure that manufacturers specifically examine the drugs' effects on children if the medications are to have clinically significant use in children. Paediatric research has since been encouraged by the paediatric exclusivity provision of the ensuing Food and Drug Administration Modernisation Act of 1997. This extended patent protection to give pharmaceutical companies an additional six months of marketing exclusivity if they do studies in children requested by the FDA. The FDA's "pediatric rule" required paediatric studies under certain circumstances [4].

In January 1997 the National Institute of Health in the United States, a major funder of clinical research worldwide, developed the policy that children (defined as individuals under the age of 21) must be included in all human subjects research, conducted or supported by the NIH, unless there are scientific and ethical reasons not to include them.

In the European Union, the Council resolved in 2000 to set their objectives for regulation on medicinal products for pediatric use, which aimed to stimulate research into and to increase the availability of medicines for children [5]. Draft regulations were consulted upon in 2004, which proposed the establishment of a European Paediatric Board with the European Medicines Evaluation Agency, that all new medicines should have a paediatric investigation plan with a six month extension in patent term, and a new system of granting paediatric use marketing authorizations (PUMAs) for existing products. These regulations took effect in 2006 and have already had a positive effect on promoting research in Europe (http://ec.europa.eu/enterprise/pharmaceuticals/paediatrics/medchild_en.htm).

The WHO publication *Child Health Research – a foundation for improving Child Health* [6] asserts that “Child health research must address the leading causes and determinants of morbidity and mortality at different stages of a child’s development and identify and implement interventions that address these causes.” Six main areas for research are identified:

- **Descriptive epidemiology and burden of disease:** To describe the scale of the problem and identify the causes of child illness and death in different communities;
- **Aetiology and mechanisms of disease:** To understand the determinants of childhood disease;
- **Development of interventions:** To design the most appropriate strategies to improve child health
- **Impact and evaluation of intervention:** To measure the effect of the implemented strategies including new medications and raise new research questions;
- **Health systems:** To increase the effectiveness of child health interventions and services;
- **Health policy:** To analyse retrospectively and monitor prospectively the scaling up of child health and nutrition interventions.

There are currently several layers of “protections” for child subjects in clinical research.

- The regulatory oversight available in each country.
- Specific guidance, e.g., I.C.H. Good Clinical Practice – in the absence of compliance with such guidance, most ethical pharmaceutical companies will not conduct a clinical trial [6, 7, 9].
- Professional ethical codes of practice such as the Declaration of Helsinki [8] provide the *external* governance of medical researchers, who individually need to *internalise* the principles to form their professional conscience – an essential *internal* governance.
- Establishment of local research ethics committees and institutional review boards in the USA which provide essen-

tial ethical scrutiny by their professional and lay membership.

No clinical research project should proceed without the informed consent of parents and consent/assent of the child.

In my view it has now become an ethical imperative, in the words of the Ethics Committee of the Conference of European Specialists in Paediatrics [5] that “**Children should share in the benefits from scientific research relevant to their individual age-related health needs.**”

Although FDA, the European Commission and WHO have brought a new emphasis on research on drug development for children, there remains a reluctance to include children in this research and especially in clinical trials. There are several reasons for this:

- Because of a child’s increased vulnerability, there is an understandable parental reluctance to add any risk to their children’s welfare;
- Children have different physiological, psychological and pathogenic features occurring at the different ages and stages of their growth and development from the premature newborn infant through adolescence;
- Risks to child subjects are increased both in the short and long term;
- Because of the complexity, high cost and relatively low financial return, pharmaceutical companies reluctance to invest in this field;
- And importantly, outside North America, Europe and Japan there is a lack of universal ethical and regulatory guidance for researchers and sponsors upon which parental trust depends.

Every child and young person under eighteen has rights and responsibilities that are protected by the United Nations Convention on the Rights of the Child (UNCRC). The Convention was adopted by the United Nations General Assembly in 1989 and has been ratified by 191 out of 193 countries, territories and states, making it a truly global bill of rights (see note.) UNICEF uses

the UNCRC as a framework for its work for all the world’s children.

But there is a lack of universal **ethical** guidance. The WMA’s current initiative seeks to redress this. Families with children need to understand the need for clinical research, have confidence in the research process (the research protocols), and trust those who conduct research on their children – experienced paediatric researchers and their teams

Codes of professional ethics have been developed. Following the original Declaration of Helsinki in 1964, which did not include any reference to the specific needs of children, the Belmont Report in the United States highlighted three ethical principles – respect for persons (autonomy), beneficence and justice. Recent publicity about adverse events in clinical trials has heightened public anxiety and revealed the serious failures related to issues of non malfeasance, honesty and transparency.

These are underpinned in my view by seven core ethical principles [9], namely

- Autonomy
- Beneficence
- Non malfeasance
- Fidelity
- Truthfulness
- Confidentiality
- Justice

These principles need to support the statements in medical professional ethical codes and codes of practice. They should be internalized to form the medical conscience of the physician and physician researcher upon which the trust by children and their families can be built.

The recently revised WMA Declaration of Helsinki (2008) encompasses these principles. The Declaration is the only **universal** guide to medical ethical practice in all the nations of the world. Child subjects, however, need special protections beyond those important general principles that apply to all research subjects [8]. In the revised

Declaration, children are included under the safeguards required for “incompetents” as is illustrated by the relevant paragraphs: 11, 12, 27 and 28.

Paragraph 11: *For a potential research subject who is incompetent, the physician must seek informed consent from the legally authorized representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the population represented by the potential subject, the research cannot instead be performed with competent persons, and the research entails only minimal risk and minimal burden.*

Paragraph 12: *When a potential research subject who is deemed incompetent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorized representative. The potential subject's dissent should be respected.*

Paragraph 27: *For a potential research subject who is incompetent, the physician must seek informed consent from the legally authorized representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the population represented by the potential subject, the research cannot instead be performed with competent persons, and the research entails only minimal risk and minimal burden.*

Paragraph 28. *When a potential research subject who is deemed incompetent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorized representative. The potential subject's dissent should be respected.*

The general wording of the Declaration of Helsinki [8] does not reflect the integrity and relative autonomy of an “incompetent” person such as a child. Children differ from adults biologically, with their increased vulnerability, age specific needs with gradual maturation, and growth and development potential.

Then there is the key issue of risk. The Declaration of Helsinki insists that the risk to any subject who lacks competence is only “minimal.” Yet in practice there is of necessity a hierarchy of risk for children that needs to be assessed in relation to the seriousness and severity of any clinical condition. Children and their families must be confident that the necessary safeguards related to the risk taken by their child are in place. This underpins the trust in their physician researcher.

The WMA Declaration of Ottawa on the Right of a Child to Healthcare (1998) includes a short protective sentence on Research under the General Principle 4: “to protect every child from unnecessary diagnostic procedures, treatment and research.”

In order to both promote yet protect children in medical research, a proposed Statement on “Ethical Principles for Medical Research on Child Subjects” was referred by the Associate Members to the WMA Council at the General Assembly in Copenhagen in 2007. The Council decided to set up a working group to revise the Declaration of Ottawa and include a section on Research in Children within it. This significant revision is now out for consultation.

There needs to be clear statements on the **ethical principles** that flow from the fact that children involved in research need special protection. Each statement that follows is both self standing and inter related to the others.

Scientific necessity

- There must be a scientific necessity for any research to be undertaken on children, i.e., children should not be enrolled in a clinical investigation unless absolutely necessary to answer an important scientific question about the health and welfare of children.
- Biomedical studies involving children as research subjects should be focused on the knowledge of epidemiology, pathogenesis, diagnosis and treatment of diseases or conditions of childhood.

- A child should not be involved in research that can be carried out on laboratory models, animal subjects or adult persons.
- Physicians must respect the personhood and relative autonomy of a child.

Consent

- The issues of consent, assent and dissent are of key concern in the pediatric age group which are not specifically covered by the Declaration of Helsinki.
- Children are minors who have not reached the legal age for self responsible consent.
- Informed *consent* means the permission of the child's parents or legal representative for the participation of their child in a research study, following sufficient information to enable them to make an informed judgment.
- Informed *assent* means the agreement of the child to participate in the research, following information being provided in a form understandable to his/her age
- Where possible, the consent of both parents should be sought prior to enrolling a child in a biomedical research project.
- There must be no forced or undue influence, financial or otherwise on the child's decision to participate in the research or on the parent's/legal representative's permission.
- The refusal to participate in the research - dissent - by a child, if capable, must be respected.

Risk

- Risk is defined as potential harm (real or theoretical) or potential consequence of an action. It may be physical, psychological, or social, and may be immediate or delayed. It may vary according to age groups. Risk should be assessed in terms of probability, magnitude and duration.
- There is thus a need to balance the potential direct or indirect benefits to children with the degree of risk involved in the research.
- Physicians should avoid unnecessary risks, discomfort, stress or potential harm leading to physical, psychological, social, spiritual impairment

- *Minimal* risk involves routine procedures, questionnaires, observation and measurements
- A minor increase over minimal risk may be undertaken when:
 - the research is concerned with diagnoses and treatment and the direct and indirect benefits to the child subject outweigh the known or anticipated risks involved;
 - where the research is likely to yield justifiable generalisable knowledge of vital importance about the child's disorder or condition, which is of vital importance for the understanding or amelioration of the disorder or condition;
 - the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
 - the research provides the only opportunity to identify, prevent or alleviate a rare disease confined to childhood.

Study Protocols

- Study protocols and study designs must be child specific and include the scientific justification for the research.
- The performance of a study must be guaranteed to be conducted by experts competent in childhood diseases and disorders, empathetic and truly conversant with children, parents and the legal requirements where the interests of the child are paramount.

Confidentiality

- All personal and health related information collected and stored about the child subject and the family must remain confidential.

Research Ethics Committees

- The interests of the child subject should always be represented on independent research ethics committees by members who are knowledgeable in pediatric, clinical, psychosocial and ethical issues.

These statements should act within the Declaration of Ottawa as reference ethical standards for all physicians and physician researchers throughout the world, against which they will be judged by their peers. Each national medical association can derive from them local culturally sensitive guidelines. With the trust that is earned when medical researchers act in an ethical and transparent manner to prevent the ethical abuses of the past [12] and to plan for the future [13,14], it is hoped that more parents will recognize the benefits that research on their children can bring to them and all children worldwide.

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Note

The 1989 United Nations Convention on the Rights of the Child (CRC) is a comprehensive human rights treaty which enshrines specific children's rights in international law. These rights define universal principles and standards for the status and treatment of children worldwide.

Human rights are founded on respect for the dignity and worth of each individual, regardless of race, gender, language, religion, opinions, wealth or ability and therefore apply to every human being everywhere.

The Convention on the Rights of the Child is presently the most widely ratified international human rights treaty – all UN member states except for the United States and Somalia have ratified the convention.

In addition, the CRC is the only international human rights treaty which includes civil, political, economic, social and cultural rights, and sets out in detail what every child needs to have for a safe, happy and fulfilled childhood. It is the most complete statement of children's rights ever produced and has 41 substantive articles.

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Gender-specific Differences in Pharmacotherapy



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Background – gender-specific differences in physiology, aging population and social aspects

The terms sex and gender are frequently used and also frequently misunderstood in medical science. Whereas sex relates to the biological concept, gender includes social background, culture and history [1]. However, it is not always possible to make a clear distinction between these aspects of life, since social behaviour may have an influence on biological aspects. For example, smoking results in enzyme induction and thereby explains differences in drug metabolism. In this articles, the terms sex and gender will be used as appropriately as possible, keeping in mind the aforementioned considerations.

It is a widely acknowledged fact that gender differences do exist in relation to the frequency, perception and peculiarities of symptoms and diseases, with myocardial infarction being one of the most prominent and typical examples [2]. Due to differences in the physiology between sexes, differences in drug absorption, distribution

and metabolism can be assumed and will be addressed in this article. More over, physiological sex differences on the level of receptors and enzymes result in variances in drug effects, efficacy and safety profile.

The following example highlights the interplay between pharmacology, epidemiology and society: in the German Network of Regional Pharmacovigilance Centers, adverse drug reactions (ADRs) resulting in hospitalisation are documented [3]. Women are at least twice as likely as men to suffer from severe dehydration and electrolyte disturbances [4]. One explanation is the higher prescribing frequency of these drugs to women, as well as the fact that there are more aged women than men. In addition, animal experiments show a higher sensitivity of female rats to thiazide and loop diuretics when compared to male animals [5,6]. These observations stimulated further research revealing pronounced sex differences in the pharmacokinetics, for example, of torasemide, explaining stronger treatment effects [7]. As a conclusion, the epidemiological observation can only be explained by a combination of sex and gender aspects.

Sex-specific differences in pharmacokinetics

Due to sex differences in body weight, distribution of water, muscle and fat, differences in the pharmacokinetics of drugs can be expected. The most relevant differences are, at present, known for drug metabolism, especially via the cytochrome P450 enzymes, which are responsible for major metabolic pathways. The most frequently involved enzyme is CYP3A4, which is expressed to a higher percentage in female than male livers [8]. Substrates of this enzyme such as methylprednisolone, midazolam, nifedipine und verapamil are therefore eliminated somewhat faster in women when compared to men [9]. The betablocker metoprolol is

mainly metabolised via CYP2D6. Following a 100 mg dose, women exhibit 40 % higher plasma levels than men and an approximately two-fold higher area under the concentration/time curve (AUC) [10]. This results in more pronounced effects on blood pressure and heart rate. Women suffer more frequently than men from serious ADRs following betablockers metabolised via CYP2D6 (metoprolol, propranolol, carvedilol, nebivolol). For those betablockers that are independent of that enzyme no sex differences occurred [11]. Since betablockers in daily practice are carefully titrated, these differences go in most cases unnoticed and become obvious only after gender-sensitive statistical evaluation of databases.

The enzyme CYP1A2 metabolising, for example, theophylline and caffeine, exhibits a slightly lower activity in women than in men, resulting in approximately 35 % higher plasma levels of clozapine in comparison to men. Likewise, plasma levels of the antidepressants fluvoxamine and sertraline are 70 – 100 % and 50 – 70 % higher in female than in male patients, respectively [12].

Sex-specific differences occur within other metabolic pathways as well [13]. A remarkable finding in cancer chemotherapy may be used for illustration: 5-fluorouracil is metabolised more slowly in women than in men [14], resulting in approx. 25 % higher plasma levels associated with a significantly higher toxicity during chemotherapy in patients with colorectal cancer [15].

Sex, gender and differences in effects of drug therapy

As already shown in the introductory example, pharmacodynamics play a major – although not well-studied – role in sex-differences of drug therapy. In patient-controlled analgesia, men required 40 % higher morphine doses than women to control pain following major abdominal surgery [16]. In general, women show a greater response than men to kappa-opioids, e.g. pentazocine, and they more frequently experience

opioid-associated side effects such as vomiting and respiratory depression [17].

With regard to psychotropic drugs, one should keep in mind that depression is more frequently diagnosed in women and symptoms are different between genders [18]. Besides the already-described differences in pharmacokinetics of psychotropic drugs, pre-menopausal women especially tend to respond better to selective serotonin-reuptake-inhibitors (SSRI) than to tricyclic antidepressants or norepinephrine-reuptake-inhibitors [19]. Interestingly, response of post-menopausal women seems to be comparable to men [20].

The most extensively studied medical specialty with respect to sex and gender is the cardiovascular field. Acetylsalicylic acid (ASS) given for primary prevention of myocardial infarction does not reduce these events in women when compared to men, but lowers the risk for stroke significantly – by 17 %; only women above the age of 65 years benefit from primary prevention with ASS [21]. However, in secondary prevention both sexes show comparable efficacy with respect to cardiovascular morbidity and mortality [22].

The therapeutic benefit of cardiac glycosides seems to be rather limited in women, as shown by a retrospective analysis of the DIG trial [23]. However, cardiac glycosides are still widely prescribed and an analysis of German ADR-data showed that more than two-thirds of all serious ADRs related to these drugs occur in women. In about 90 % of these ADRs the low body weight and the slow elimination rate of frail elderly women has apparently not been considered [24].

Even in oncology sex and gender-differences may appear. In a retrospective analysis of 227 patients (80 females) with non-small-cell lung cancer receiving chemotherapy with carboplatin and paclitaxel, remarkable differences appeared for tumor type, treatment response and overall survival. Beneath numerable considerations one aspect seems noteworthy: 83 % of male patients

were smokers and only 24 % of the female patients. As shown by molecular pathology, adenocarcinoma of smokers exhibit a certain RAS-mutation, whereas tumors of non-smokers are more likely to develop mutations in the epidermal growth-factor (EGFR) signalling pathway. This may result in malignancies with different progress characteristics and differences in the response to drugs such as gefitinib, which inhibits the EGFR-tyrosine kinase [25].

Women experience more side effects than men

The higher reported rate of side effects in women may be a result of the higher likelihood to talk with their doctors and the higher drug consumption of females. However, the observed frequency of ADRs per 10.000 patient-months is higher in females compared to males across all age groups, irrespective of drug consumption [26]. It remains unclear why women report more ACE-inhibitor-associated cough than men [27] or more frequently develop cutaneous reactions to nevirapine [28]. It has been demonstrated in animal experiments [29] and epidemiological studies that females have a higher risk for QT-prolongation when compared to males, irrespective of drug class and indication [30, 31]. Even differences detected in women during the menstrual cycle could be demonstrated [32]. It should be noted in this context, that QT-prolongation is an ADR that resulted in market withdrawal or restriction of use for numerous drugs such as astemizole, terfenadine, grepafloxacin, cisapride and budipine.

Treatment with neuroleptics may lead to hyperprolactaemia and other metabolic disturbances, which occur more frequently in female than in male patients and increase the risk for osteoporosis particularly in females [33]. Since osteoporosis in general is a problem more strongly related to the female sex, potential pro-osteoporotic side effects warrant closer surveillance in women. In a randomised, controlled trial comparing metformin, glyburide and rosiglitazone over 4 years, the number of fractures under

rosiglitazone was twice as high as in the other treatment groups (5.1 %, 3.5 % and 9.3 %, respectively) in female study participants – in male patients no differences were seen in this regard [34]. Rosiglitazone given over 14 weeks to post-menopausal women reduced bone density measured at the proximal femur by 1.9 % in comparison to placebo with 0.2 % ($p = 0,003$) [35].

Opportunities for research – actions required

There are numerous indicators suggestive of sex- and gender-specific differences in pharmacotherapy. Particularly the accumulation of side effects in women should generate research questions considering sex and gender effects. Even today, women appear to be underrepresented in clinical trials investigating efficacy and safety of new drugs and results are not presented in a sex-sensitive manner [36,37]. Trials submitted to the US Food and Drug Administration between 1995 and 1999 were analysed with respect to sex-distribution: approximately 25% of trial participants were female and during phase II and III women were apparently equally represented [38]. However, this relates only to those trials, where the sex of participants was recorded: in a considerable number of studies this was not the case, despite effectual guidelines. A recent evaluation of the European Agency EMEA revealed that in some indications women were not enrolled in clinical trials according to the expected female prevalence for a given condition investigated [39].

In conclusion, pharmacokinetic differences between sexes tend to be small, but may result in higher rates of side effects in women. The simple approach of considering body weight and renal function (especially in frail elderly women) before each prescription could contribute markedly to safety of drug therapy in males and females as well. Complex sex and gender differences in pathophysiology and pharmacodynamics remain obscure for many symptoms and conditions and findings are often obtained by chance and lead to surprise.

Concerning clinical research, some awareness of the relevance of sex and gender has been achieved, however stringent follow-up and transfer of existing data into medical practice is still in its infancy.

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Development of Bioethics in Ukraine

The development of Bioethics in Ukraine is an example for other countries. First, local Bioethical Committees in Ukraine were created in 1992 in two organizations: the Institute for Occupational Health of Academy of Medical Science of Ukraine in the scope of Ukrainian/American Chernobyl Ocular Study (UACOS) and in the Institute of Obstetrics and Gynecology of Academy of Medical Science of Ukraine in the scope of the joint Ukrainian-USA Project "Mother and Child".

These two inter-governmental projects have been performed jointly with Columbia University and the University of Illinois in the United States. For these projects, informed consent forms for medical examinations of subjects, the Declaration of rights of patients and, separately, of investigators, and other related documents [1, 2] have been developed and adopted in both the Ukraine and the USA. The Statutes of the committees dealing with medical aspects of these projects were adopted by the Government of Ukraine and the USA. Historically, resolution of dissimilar or even conflicting bioethical restrictions between participating countries has been achieved on an ad hoc basis.

The next step was taken in 1995. The model of the Declaration of patients' human rights support was adopted in Ukraine. Standard documents have been developed for reviewing medical ethical aspects of scientific projects with human participation. These documents were tested in twelve regions of Ukraine before implementation into medical practice.

Ten year ago, owing to the initiative of the Presidium of National Academy of Sciences of Ukraine (NAS), and to Boris Paton, President of the National Academy of Sciences, systematic and successive activity in the field of bioethics began at the national level. The Committee on Bioethics, established as a branch of the Presidium of NAS

of Ukraine, takes an advisory, organizing and coordinating role, aiming to reach the level of the international community in this respect.

The Committee on Bioethics deals with all aspects of ethics in science and practical aspects of medical ethics and international activity. At the First National Congress on Bioethics in September 2001, with international participation, a set of standardized documents was adopted. This accomplishment provided great support for next steps of development [3].

This was extremely important for further development of the collaboration of Ukrainian scientists with foreign partners. Within that period such international organizations as UNESCO, WHO, and the Council of Europe placed bioethics among priority subjects. Ukraine was determined to join the world in this important subject. Also, in our country, bioethics was preceded by a thousand years of experience in medical ethics and doctor's deontology, based on established universal ethics and morals.

Under this commission, more than 250 bioethical committees and associations now work in all parts of Ukraine. All this was done with the enthusiastic participation of people who understand the requirements of a new moral approach to the relationship between patients and doctors. The members of this commission are prominent scientists, public decision-makers and other individuals, such as Academician Elena Lukyanova, Vice-Director of the Institute of Obstetric and Gynecology Academy of Medical Sciences of Ukraine (AMS), Professor Nikolay Kiselyov, Director of the Institute of Philosophy of NAS, Vice-President of AMS, Professor Yuriy Zozulya, Director of the Institute of Neurosurgery of AMS, Leader of the Parliament administration, Vadim Demchenko, Main Editor of the newspaper "Mirror of Week" Vladimir Mostovoy

and a number of other participants totaling twenty-one people.

This Commission is a top-level organization in the country. The head of this Commission is Professor Kundiiev, member of NAS and AMS, Vice-President of AMS of Ukraine. The Commission organizes its meetings one or two times each month. The main task for these meetings is to develop answers to highly important issues for Ukrainian society, e.g., attitudes toward cloning or discussions on the discrepancy in the ethical review of the investigation protocol for executors of large multicentral medical scientific projects with human subjects involved. The Commission, as an advisory board, develops recommendations for executors, members of the parliament or for other governmental organizations, such as the Ministry of Health of Ukraine and others. Once or twice a month members of this Commission have articles published in newspapers or are interviewed on television.

During voting, under the Statute of this Commission, members of this organization must reach consensus on important solutions concerning human rights.

On the other side, intensive efforts in bioethics have brought to light information obstacles in common approaches to main principles of bioethical reviews, driven by ever-accelerating biotechnological innovation wherein developments are ultimately dependent on constantly increasing needs for human and animal subjects for clinical trials. These facts and the current unprecedented movement toward globalization of all aspects of life, including scientific health-related research, serve only to increase the sense of urgency for all countries to accept and apply internationally agreed, at least minimum, bioethical principles for policy standards. They should be incorporated as critical components of Good Laboratory Practice and Good Clinical Practice, related to studies standards, respectively.

In view of such questions and under the governing body of the National Bioethics Com-

mittee, medical ethics problems are solved in the Independent Ethics Committees of Academy of Medical Sciences of Ukraine in Ministry of Health of Ukraine and under the Ukrainian Medical Association.

The UACOS experience, which was programmatically organized around protocols existing in many western countries, can serve as a model for the design and implementation of the administrative infrastructure necessary to apply bioethical standards, being fully consistent with modern society in the twenty-first century.

Over the past 10 years there have been numerous successes. The most significant result is that bioethics took its proper place in the activity of the majority of high-profile medical and biological institutions; bioethics is taught at biological faculties and in higher medical educational institutions and even at high schools and universities. At the same time, there are many complicated issues that remain to be solved.

In recent times, as a result of scientific and technological progress, rapid development in life sciences, and the deciphering of the human gene, we face more and more acute problems and contradictions that require moral judgments to resolve. What is possible for science and technology and what is morally purposeful and acceptable? Our ethical views and principles should be based on an understanding of these differences. We wrestle with questions of strategies for mass prevention of morbidity, via vaccination in particular, to which the attitude in recent times is ambivalent. New issues arise related to assistive technologies, the scales of which ever increase each year. Now, in Ukraine, about 4,500 children have been born as a result of such technologies. We must remember that the first of these was a girl, Katya, born in 1991 in Kharkiv. Within this period of demographic crisis, more attention should be paid to these technologies and to the problem of transplantation of organs and tissues. In Ukraine, these issues are regulated by the legislation; though it is not yet perfect. There are similar regulations

in other countries as well. Despite such regulations, there are often media reports about abuse in these spheres, particularly with respect to the sale of organs and tissue. Compromising ethics for financial gain in this regard is a serious problem, indicating clearly that regulation alone will not solve all problems. Efforts to educate the public and inform social opinion through innovative approaches must be prioritized.

Use of genetically modified organisms and food products, as well as genetic tests, create great concern in society. Discussions around the problem of cloning a human and his/her organs remain complex and difficult. Great attention is now being paid to issues related to stem cells.

What is the driver of moral assessment in terms of implementation of new technologies as they relate to human life? It is, first of all, respect for human dignity and protection of human rights, raising the respect for human life to its highest value. Unfortunately, this key question of bioethics, and ethics in general in society, remains a secondary one, resulting in a great number of social and socio-political contradictions.

Pharisaism is a becoming more and more prevalent – temples are being built while moral principles are in ruins. There is sometimes an impression that people lose the ability to honestly analyze their reality.

It is necessary to realize that changes have taken place that affect our understanding of life – indeed, the role of life itself on the earth – and these changes require proper action at the national, regional and international levels. One such event was the adoption by UNESCO in October 2005 of the Universal Declaration on Bioethics and Human Rights. The Declaration highlights that moral responsibility and analysis of ethical problems should be an integral part of the scientific and technological progress and that bioethics should play a leading role in decision-making when progress and new developments raise difficult issues.

Of course, we should agree with this. Strictly speaking, the key is the need to eliminate the gap between two branches of knowledge – natural and humanitarian. The bridge between the two should join scientific and technological achievements and moral and ethical principles. Van R. Potter, the founder of bioethics, called it a bridge to the future.

In Europe, and in the world in general, priority significance was given to bioethics after the adoption of the Universal Declaration of UNESCO in 2005. The Ukraine has made a significant effort, in the aftermath of this Declaration, to take two steps forward in this respect.

The work of the National Board is executed and will be performed by the Committee on Bioethics of the National Academy of Sciences of Ukraine. Boris Paton, President of Academy, who supports this work, will promote this activity in the future. We are confident of this commitment.

In the ever-increasing search for new technologies, moral principles are often neglected. We often forget the purpose for which we pursue advancement. Human rights and human dignity become detached from technological progress. Again, we can take stem cells as an example. There is no doubt that the pluripotential of stem cells gives us great hope for breakthroughs in medicine; we see on the horizon new methods of treatment of many diseases for which medicine today is essentially powerless. There is a need for consensus on many issues related to embryonic tissues and cells of an adult person. We have no firm answers to the question about the role of somatic mutations, about the action of viruses, or why there are so few stem cells in the healthy man, whereas the need in them is very high. In order to respond to these and many other questions, fundamental research is being conducted, namely within a new Institute of Regenerative and Genetic Medicine, formed within the system of the Academy of Medical Sciences of Ukraine.

Meanwhile, very often commercial interests prevail. Currently, stem cells are widely used in many clinics, including in countries where their use is forbidden by legislation.

The principle laid down in the Universal Declaration on the Human Genome and Human Rights and the International Declaration on Human Genetic Data, adopted by UNESCO, provides for maximum direct and indirect benefits for patients and those participating in research in the use of achievements and scientific knowledge. It also stresses the need to ensure that, in medical practice, the use of new technologies cause no harm. It is necessary to do one's best to avoid any risks. This principle is often violated in respect of not only novel technologies, but in such spheres as clinical trials of pharmacological preparations. The number of clinical trials themselves is notable. Over the last ten years there have been 2,200 such trials in Ukraine, far more than in any other European countries. The question is – why? To begin, such trials are less expensive to conduct in our country. Second, regulations related to trials of new drugs are not as strict as in Western countries.

The low cost of clinical trials in Ukraine is due to not only poor salaries of physicians and scientists but also to very low expenses related to health and life insurance in the case of negative effects from testing new medicines. In the USA, for instance, insurance for such cases amounts to 1.5 million dollars, in Ukraine, 7.5 thousands Hryvna (Ukrainian Currency), i.e. one thousand times less. In EU countries, clinical trials are not profitable for pharmaceutical companies for the same reasons. Under such circumstances Ukraine and the health of its population can be considered at-risk. We must not forget about the tragedy caused by thalidamid exposure.

The number of establishments responsible for clinical trials is constantly increasing; presently, there are nearly 400 of them. It is clear that requirements of Bioethical Committees should be ever stricter; the level of knowledge of members of these commit-

tees should be higher to avoid mistakes and violations. Revised requirements for accreditation and attestation of, at the very least, heads of committees of different levels should be developed as soon as possible.

The pharmacological market, with its relations, is developing rapidly in Ukraine. When medical and social direction do not prevail to regulate this market, it turns into naked business, where extravagant incomes are achieved at the expense of human suffering.

Let us take at least one example. It is logical to suppose that, as cardiovascular disease is the highest cause of morbidity, priority should be given to it in terms of development of treatment and disease prevention. However, aggressive advertising interferes in this process, pushing other priorities on patients. That is why the advertising of pharmacological preparations in most cases is forbidden. The same should be done in Ukraine.

Currently, great hopes for mankind rest on the development of nanotechnologies. Not only scientists, but politicians as well, speak about this now. Much can be done with their use in medicine, beginning with development of new drugs and diagnostics facilities, removal of pollutants, new methods of treatment and prevention. However, world social opinion is divided between hopes for the benefits, and fear of the potential harmful effect on the environment, their use for the development new-generation weaponry, and so on.

With this in view, UNESCO was compelled to gather experts to examine the vexing ethical and political questions related to the application of nanotechnologies in general and in medicine in particular. The discussions resulted in the article "Nanotechnologies, Ethics and Policy". We plan to establish a chair of "Nanotechnologies and Ethics" in Kyiv as an international Board.

We should emphasize one more peculiarity of the III National Congress on Bioethics.

Much attention was paid to the position of ethics in science. Very interesting reports on these problems were given at plenary and sectional meetings. In particular, report by Popovich, Naumovets and other members of the Academy of Sciences were delivered. We would like to underline that these questions were focused directly on the Conference of European Federation of the Academy of Sciences, which finished its work in 2008 in Lisbon. The focus was the need to be guided by the "Code of Ethics of a Scientist", highlighting the need for moral responsibility for falsification of data and plagiarism, as well as for the significance and reliability of the presented information. It also focused on the need for research to be well conceived and independent, for reasonable use of resources in order to avoid unnecessary expenses, and to address improper behavior of partners in international projects.

Unfortunately, the number of cases of infringement of ethical principles in scientific research in medicine has not decreased. It is therefore timely that the National Academy of Sciences takes the role of an active leader and guide of ethical principles in all branches of scientific and practical activity in Ukraine.

We can conclude that the development of bioethics and the adoption of general ethics principles in medical society will move us towards better protection of human rights and human dignity in Ukraine.

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The British Medical Association – a world of service for doctors



Vivienne Nathanson

The British Medical Association celebrated its 175th birthday two years ago. During our long existence we have developed many facets, many sides to the personality that faces our members, and the stakeholders with whom we engage.

Established first as a voluntary professional association we are also a major medical publisher and a trade union. The three major strands of activity fit together in a complex mesh with interactions in unexpected areas. For doctors in the UK we offer services which support them in their workplaces and in their training from the day they arrive at medical school until well after retirement. And in our professional association role we help doctors make a difference to the health and wellbeing of the wider public, not only the individual patients so many are treating every day.

One of the BMAs earliest reports was an investigation into Quackery. In the 1830s a large percentage of those practising as doctors in the UK had no qualification. The report led to the establishment of the General Medical Council and the registration of medical practitioners – including recognition of specific qualifications. We remain involved in similar areas today, working to

help groups of other health professions, to establish themselves as registered practitioners, especially a few of the complementary and alternative therapies. The motive is exactly the same – only through restricting practice to those on a register can you assure patients and potential patients that their therapist has gone through a course of training and should be practising to an agreed high standard.

Our trade union work absorbs most of the BMAs resources; rightly so as this is work that enables our members to practice as doctors in settings that will enable them to deliver high quality care to their patients, and to be appropriately rewarded for this work. There is, it seems, always at least one of the major branches of practice which has a national standard contract up for negotiation with the government and with the employers organisations. In the current global economic crisis such negotiations are complex and difficult, but we rightly have a reputation for tough negotiation. The other side of the union work is local representation – sadly doctors like all other workers can run into trouble with their employers and our role is to represent them. As an adjunct to this we have a 24 hour telephone help line with counsellors to help members in distress and which is frequently accessed by those facing a hostile work environment.

Our publishing continues with the BMJ Publishing Group – a wholly owned subsidiary. Its best known brand is the British Medical Journal, published weekly in English and weekly or monthly in other language editions. It also publishes more than 24 other journals, many in partnership with special interest groups. The editor of the BMJ has complete editorial independence; sometimes uncomfortable for the BMA, but essential if it is to remain a high status, independent peer reviewed journal.

A major area of expansion for the BMJ over the last decade has been the production of learning and knowledge tools for doctors. BMJ Learning on-line has more than 450 modules for continuing professional development. Most are designed for doctors, but the expertise has been recognised by other groups of health workers and the BMJ has been commissioned to produce modules for nurses and paramedics.

Some work appears to fall between the trade union and the professional association – including work on task shifting, human resources for health and medical migration. The BMA does not get precious about this; work is done by those with the right skill set and much of it crosses internal boundaries. Key to everything is networking. The group, working to make sure that the views of doctors is an essential part of planning for the NHS-wide information technology developments in the UK, works with doctors from all branches of practice and with experts from fields such as ethics to ensure that both clinical practicalities and ethical principles are upheld.

But to the public the face they see most often is the professional side of the BMA. From the directorate of Professional Activities we produce materials designed to help doctors be the very best they can be in their medical careers, and we also work to keep the environment in which they work conducive to clinical excellence.

A set of activities that straddles this apparent divide is the lobbying work we carry out on the health of the public. We know – because they tell us – that our members care deeply about the major health problems that we see across our population. Most are working with individuals to deal with those problems, but they want to have a bigger impact. The effects of using tobacco is a clear example. Individual doctors see patients with heart disease, with cancers, with end-stage respiratory failure as a result of their cigarette smoking. They want to help the individuals but also to turn back the tide, to have a real impact in preventing these illnesses. Only a small number work in research, epidemiology or public health, and the

BMA works with and for the greater number in trying to reduce this disease burden.

For several decades we have not only lobbied government for better tobacco control measures, but also commissioned research and published on a wide variety of aspects. Many of our publications are meta-analyses of clinical papers, leading to conclusions and policy directions. One example was a report on the evidence of the harmful effects of second hand or passive smoking, published in time to influence the four governments in the UK in their deliberations of whether the four countries should go smoke free in public places. This work was not a one-off. It followed several decades of reports on related issues which are part of a network of contributions that have significantly reduced the number of smokers in the UK. Sadly, there is a great deal more to do; too many children and young adults are still starting to smoke and many will find quitting difficult or impossible. We will not stop this work until no-one in the UK ever starts smoking and all existing smokers have successfully quit.

There is a nice interaction here with the BMJ. It was here that Richard Doll and Austin Bradford Hill published their seminal work on the effects of smoking on the lives of doctors. By showing over 50 years ago that doctors who smoked died younger than doctors who did not, Doll and Bradford Hill had a salutary effect on smoking rates amongst doctors. UK doctors' smoking rates are about 2.5% against a population rate of near 25%. Doctors were significantly affected not just by knowing that smoking kills but specifically that smoking kills doctors. Perhaps this is a lesson we have been slow to learn in directing and designing anti-smoking messages for population sub groups. When we make the message relevant it is more likely to aid behaviour change than when it is general.

Today the BMA is working with others to try to persuade the Westminster parliament to legislate for a ban on point of sale advertising of cigarettes and an end to cigarette vending machines. Here another UK development

comes into play. We now have four legislatures and we saw with smoke-free public places that administrations in Scotland, Wales and Northern Ireland were keen willing and able to pass banning laws. That helped get Westminster to do the same for England. It may well be that enthusiasm for more legislation is stronger in these other countries and those of us in England will then use that to help us persuade Westminster to follow suit. For the WMA this may be an important lesson as well. Are we good at asking countries where desirable legislation has been passed how it happened? Do we exchange information regularly? And if not, why do we not do this?

There are other major public health challenges today that are mimicking tobacco in their complexity and in the impact they are having on shortening lives and stretching health care budgets. The two biggest of such challenges are alcohol and obesity. The BMA is facing these as it faced tobacco; we are working with large numbers of other interested parties, we are engaging doctors throughout the UK, we are looking for policies that work and we are trying to make sure that the lessons of what worked and what did not work with tobacco are learned. In both cases we need policies that involve many government departments. Alcohol abuse is not just a health problem. It clearly causes problems for law and order and is encouraged by tax and pricing policies (to simplify a complex matrix) and by smuggling. So we have to work with a series of government departments and encourage them to think in a joined up manner. We also have to encourage all politicians to look at the long term. Major advances from changes in diet and exercise will take many years to produce significant changes in health expenditure. Political short-termism must not stop expenditure for longer term benefits.

Climate change is another public health challenge, but one on which action in one country alone will have relatively little impact. There are still some who do not believe the science. The science is, of course complex, and different elements have different levels of "proof". Our policy is to say that the science is what it is, but that we are see-

ing the planet warm and there are clear consequences that follow from that. We add to this that carbon emissions are a significant element and that doctors have two roles to play in reducing these – the first as influential citizens and societal leaders in demonstrating that they will make changes to their lifestyles, and the second is to try to reduce the carbon impact of health care systems. In my professional lifetime I can make a case that medicine has been revolutionised by plastics and disposables. That comes at a carbon cost. In addition health care buildings are designed for a variety of efficiency factors, and we must add carbon emission efficiency to that matrix. The BMA published advice last year on these areas and we are already updating that web resource.

There are many ethics departments in universities around the UK, as with the rest of the world, producing ethics materials and publication of enormous intellectual rigour. Why does the BMA still publish advice in the face of this glut of competitors? Simply, because we know doctors, we know their work-place, we know the clinical situations in which they have to make ethical judgements. As one academic philosopher said: "The BMA advice has to be, and is, practical and relevant to the doctor in the clinical situation. The fact that it is also academically excellent is a great bonus." Common problems include questions about data protection, confidentiality and information governance as well as specific matters such as withdrawing and withholding treatment, and non-treatment decisions. And again the BMA gets into lobbying mode.

In January 2009 the government published the Coroners and Justice Bill. Our parliamentary office noticed that clause 152 would allow government ministers to share information from databases between government departments to enable public policy, after balancing the effects against individual rights. There were no limits to this provision, and it explicitly stated that this could include setting aside other laws or regulations that stopped such data sharing. For doctors this was a potential catastrophe; no doctor would be able

to assure a patient that information in their personal health record would be immune to such sharing as no-one could know what ministers might find desirable in the future. We worked with the media, with other professional bodies including those representing lawyers and the public, to raise concerns as well as going both to parliamentarians and to ministers. No one was able to tell us of a problem to which this was the solution. The intense lobbying got a result – the clause was removed from the bill. Although the government has committed to return to the issue in other legislation it will be, they assure us, in a modified form. We continue to press for the complete exclusion of personal, identifiable health information from any such legislation. So far we have achieved a victory – one that will help to maintain that trust between doctor and patient over information given to us by patients for the purposes of their care. But

we will continue to watch and to press for discussion before a new clause is drafted so that patients are protected and doctors do not find themselves in a no-win situation.

Sometimes work on legislation is far less public. We work with those drafting and amending legislation to make sure it works in the interests of patient care not against it. These teams of people working on legislation are grateful for our expertise in understanding the impact of the words they write on clinical practice and on our ability to find viable alternatives that achieve worthwhile goals without damaging trust or other elements of patients care. In some cases we presage that work by calling together interested experts from around the health care world to make sure we have a common “bottom line” on what is acceptable or not in the draft legislation.

The ethics team produce books on ethics and law, and on human rights as well as guidance notes and on-line “booklets” for members. They are also working with the BMJ – another nice collaboration – to produce ethics e-learning modules. And of course their web pages and advice enjoy thousands of hits by members refreshing their personal ethics expertise.

Every day at the BMA is different. But there are common threads. Our “raison d’être” is to help doctors. We do that by negotiating advantageous contracts and by ensuring that the conditions in which they work also work for optimal medical practice. And we try to help them by providing education and learning support materials. As one of our leaflets says – “the BMA – a World of Service”.

Dr. Vivienne Nathanson, Director of Professional Activities, British Medical Association

Chinese Medical Association (CMA)



Liu Zhi

The Chinese Medical Association (CMA) is a non-profit registered academic and commonweal corporate body voluntarily formed by Chinese medical science and technology professionals, and an important social force in the development of medical science and technology in China.

The CMA, established in 1915, now has 84 specialty societies under its umbrella, cover-

ing all medical fields. The CMA has a membership of about 460,000, and publishes 119 medical journals, one medical information newsletter and one popular magazine. The CMA is closely related to the local medical associations in the provinces, municipalities and autonomous regions. The CMA Head Office is in Beijing.

The CMA mission includes uniting medical professionals, upholding medical ethics, and advocating social integrity. It operates with democratic principles, supports freedom of scholarship, and seeks to raise technical skills of the medical professionals. It promotes the prosperity and development of medical science and technology, and the popularization of medical science and technology knowledge. It promotes the growth of medical science and technology work forces and the integration of medical science and technology with China’s economic development. All these are for the purpose of providing services for its members and for medical professionals, for the health of the Chinese people, and for socialist modernisation in China.

The scope of the work of the CMA includes: organising academic exchange programs on medical science and technology, publishing medical journals and electronic audio-visual products, promoting international academic exchange programs and co-operation, carrying out continuing medical education projects, organizing technical appraisal of medical projects, selecting and presenting awards for excellence in medical and technological research and publications, finding, recommending and training outstanding medical talents, organising technical assessment of medical incidents, undertaking projects entrusted by the government, promoting transformation and practical application of medical research results, and relaying suggestions and requests from the medical professionals to the government and serving as an important linkage between medical circles and the government.

The President of the CMA is prof. Zhong Nanshan (Academician of the Chinese Academy of Engineering, and Director of the Guangzhou Institute of Respiratory Diseases). Full time Vice President and Secretary General of the CMA is prof. Wu Mingjiang.

Liu Zhi, Director, Department of International Relations, Chinese Medical Association

The American Medical Association and the WMA

Global Partners for Physicians

Since 1847, the American Medical Association (AMA) has fought for high quality health care for all Americans, and to improve public health at home and abroad. The AMA mission statement, which has remained unchanged for more than a century, provides our compass: "To promote the art and science of medicine and the betterment of public health." As the largest association of America's physicians, the AMA represents certain core values, including leadership, excellence, integrity and ethical behavior. Through these benchmarks, the AMA stands as an essential part of the professional life of every physician. The AMA shares these goals and values with the World Medical Association.

AMA Advocacy Agenda

While the AMA plays a role on the international health care stage, physicians face pressing concerns here in the United States. Over the decades, the U.S. health care system has developed weaknesses that leave too many patients without regular access to quality care. That is why the AMA is promoting comprehensive health care reform. The global economic slump that has also created economic uncertainty in the U.S. is contributing to the sense of urgency that the nation's health care system needs fundamental changes in order to control costs, improve quality, expand coverage and enhance value. The AMA is playing an important role in shaping the debate. As the largest body of America's physicians, and guardian of their patients, the AMA is willing to listen to all sides of the arguments, consider the nuances of each, and work toward the best possible solutions.

Reforming America's health care system

In the U.S., 2008 was a national election year. The AMA seized the opportunity to

unveil the Voice for the Uninsured campaign, which educated candidates, voters and the media about the ongoing problem of people who lack health care coverage in the U.S. Through advertising, appearances at public events and through the news media, the AMA transmitted its plan for universal health insurance coverage to government officials, elected leaders and patients. The AMA held meetings and follow-up conversations with the major presidential campaigns to educate them about the AMA's Proposal for Expanding Coverage and Choice.

The AMA launched the Voice for the Uninsured Campaign website to showcase the AMA proposal and give the 46 million Americans without health insurance a voice to tell their story. The success of this initiative amplified the AMA's voice as a champion for health system reform. It was another reason why America's physicians will have a role in the 2009 efforts to expand health insurance and in other health care initiatives. To achieve these goals, the AMA is working with many diverse organizations representing patients, hospitals, insurers and employers to identify common ground on approaches to comprehensive health system reform. This effort shares a common message: in order to fix the ailing economy, the U.S. needs reforms that address the related problems of health care costs and the uninsured. The issues the country's health care system faces have been decades in the making, but the need for solutions is immediate.

The Uninsured

At the center of the AMA's vision is the belief that every American, regardless of means, should have access to health insurance. Every patient should maintain the freedom to choose his or her own physi-

cians and health plans, and maintain control over his or her own care. That includes the 46 million Americans who do not have health insurance. They live sicker and die younger. Four out of five uninsured persons are in a family where at least one person is employed. This is not just a statistic, it is a serious public health problem and a poor use of national resources.

America's current health insurance problems began during World War II. At that time, President Franklin Roosevelt imposed wage and price controls to counter wartime inflation. Since employers couldn't raise wages, other means were sought to reward American workers. One way was for employers to start paying for employees' health insurance costs. From there, employer-based health insurance became the dominant means of coverage in the United States.

The AMA "Plan for Reform", which rests on three pillars, calls for an end to linking health insurance to employment, which is no longer practical in the modern economy.

- 1) Provide tax credits for the purchase of health insurance. This would enable patients to buy their own health insurance plan they could take with them from job to job.
- 2) Promote individual ownership of plans. Patients could choose their own doctor, their own hospital and the coverage they want in their price range.
- 3) Reform the insurance market through more competition and less insurer interference and bureaucratic meddling.

Some of these solutions have been incorporated into government proposals for health care reform. But much work remains to be done.

Medicare Payment

The AMA is also active in efforts to reform Medicare, the government-run health care plan for Americans over the age of 65 and with severe disabilities. A seemingly annual problem faced by physicians who treat Medicare patients is that the reimburse-

ment for medical care is threatened with cuts. The formula that determines Medicare payments is based on the US gross national product, and not on the actual cost of providing that care.

In 2008, physicians faced a 10.6 percent cut in Medicare payments. A cut this steep would cause senior citizens to lose access to care by driving physicians away from the Medicare program. Physicians and patients across the country worked together to override a presidential veto of the legislation – a remarkable event that rarely happens in our country. Physicians and seniors won this battle because they contacted Congress by the tens of thousands and because the AMA ran powerful advertisements on TV and in local newspapers encouraging lawmakers to protect access to care for the elderly.

However, this victory is only temporary. The flawed system for reimbursing physicians for treating Medicare patients will result in payment cuts to physicians of 21 percent in 2010. Unless the formula is changed, cuts will total 40 percent by 2015. However, physician practice costs will increase by least 20 percent over this same time period. That is why the AMA is working with Congress and the President to build a system that improves quality and better protects access to care for seniors.

Cost of Care

The AMA is also developing strategies to restrain rising costs while maintaining quality of care. Medical science and technology have moved forward at a lightning pace. The AMA wants to find new ways to enable doctors to use promising new technology while developing new methods to measure and improve the quality of care.

Physician Autonomy

The AMA believes that America's patients will be best served when our country eliminates the disproportionate influence of insurers and government on medical decisions. These important decisions must be placed

back in the hands of the patient and the physician. The AMA has also been active on behalf of physicians when the issues turn to the *business* of medicine. One such area is in obtaining antitrust relief. The AMA seeks to make it possible for physicians to negotiate as a group, instead of as individuals, to counter the powerful advantage held by insurance companies.

Medical Workforce

Considering the conflicts with the health insurance industry, the problem of medical liability lawsuits and erratic Medicare reimbursement, America could face a shortage of physicians in some fields by the year 2020. The AMA seeks to increase medical school class size, allow for additional residency slots to train physicians, and improve the distribution of physicians to underserved and undersupplied specialties, especially in the primary care field.

Quality of Care

The AMA is not only concerned with the quantity of physicians serving American patients, but also with the quality of care. The AMA's efforts in clinical quality improvement begin with performance measure development – measures designed by physicians for physicians.

The AMA houses a group called "The Physician Consortium for Performance Improve-



ment". The Consortium works with national quality groups and government agencies to develop "quality measures" that doctors can rely upon. To date, the Physician Consortium for Performance Improvement has developed more than 250 individual measures covering 42 clinical topics. They were developed by the Consortium in collaboration with specialty societies, and often with the National Committee for Quality Assurance. For ease of use, each measurement set can be implemented in practices using different data sources and can be integrated with both paper and electronic medical records.

In other words, rather than the government telling doctors what is best, the AMA is helping the government understand what is best, as determined by scientific research.

Other Issues

The AMA is also encouraging more attention to issues across the health care spectrum, such as:

- Directing more resources and effort toward disease prevention;
- Helping Americans lead more healthful lifestyles;
- Eliminating gaps in care, particularly for racial and ethnic minorities, the elderly, and low-income families;
- Preparing adequately for large-scale health care emergencies.

Despite its problems, the U.S. health care system does have real strengths. One is choice: patients can choose the kind of insurance they want, their physicians and their hospitals. The U.S. system also has a tremendous ability to innovate and generally has convenient access to treatment and procedures without long waits. The American system of medical education is highly respected. Promising students from all over the world hope to train in U.S. medical schools, which teach the advanced techniques, treatments and procedures that make the science of American medicine among the best in the world.

In the United States, the financial crisis has affected everyone's life. But America's physicians will not be deterred from their responsibilities to patients and their communities. The AMA will continue to help doctors help patients, champion the art and science of medicine, advocate for the interests of member physicians and provide them with the tools and resources they need to succeed, through good times and bad.

The AMA's Role in WMA

The AMA's active participation in the WMA has provided the opportunity to work with our colleagues to pursue solutions to global health problems. This sort of interaction is irreplaceable as the world becomes smaller and the global village larger. Microbes do not respect borders, as international outbreaks of SARS, malaria and the West Nile virus attest.

The international public health agenda is so vast that no single sector or organization can succeed alone. Bridges need to be continually built and ties renewed. Through the AMA's membership and involvement in the WMA, the AMA:

- Strengthens its own policy development;
- Identifies emerging issues and finds solutions to common problems;
- Fulfills a professional obligation to share knowledge;
- Identifies new ways to educate and assist physicians worldwide.

The AMA believes it is important that the WMA succeed and thrive in its mission to find common ground among the world's physicians. That is why the AMA works to help shape the structure and governance procedures of the WMA. The AMA has helped establish bylaws and operating policies, promoted the per capita membership system in the Assembly and Council, and drafted new bylaws that required each national medical association to certify the character, integrity, and competence of their members who run for WMA offices.

The AMA has made significant contributions to WMA policy on professional liability, medical education, ethical research on humans, bioterrorism, alcohol and health, tobacco use, and obesity. Most recently, the AMA has worked toward revisions to the Declaration of Helsinki, called for reductions in mercury use and dietary sodium intake, and urged more cooperation between human and veterinary medicine.

These changing times bring new challenges. Meeting them will require the unified efforts of physicians and patients not just in the United States, but around the world. That is why the AMA values its involvement with the World Medical Association so highly, and encourages all physicians in every country to do the same.

AMA, Communications Department

The French Medical Association (L'Association Médicale Française)

I. The French Medical Association (AMF) was established on 22 December 1992.

The association's purpose are: research, activities, studies or common actions according to European, international or worldwide guidelines concerning health in the teaching of medicine, medical science, medical

practice, medical ethics and medical care insofar as the doctors represented in AMF can achieve it.

II. The Association is composed of:

Founding members:

- The National Order of Physicians (CNOM)

- The Confederation of French Medical Unions (CSMF)
- The Federation of the Doctors in France (FMF)
- The French Mutual Insurance of Health Corps (MACSF)
- The Medical Insurance and Professional Defence Society (*Le Sou Médical*)

Members:

- The "Pasteur Mutualité" group (AGMF)
- The Former Interns Association (AIHPP)



Paris: working party of AMF with the Medical Association Canadian (CMA) and its President the Dr. Ouellet



Paris: working party of AMF with the Medical Associations of Mali, from the Senegal, from Cote d'Ivoire and their Presidents



III. AMF's Operative fields:

Within the AMF and within international medical organisations, the AMF seeks to achieve the best possible standards: in ethics, training, healthcare quality, professional practices, public health, and human rights associated with individual and collective health. The AMF helps practitioners, protects patients, provides accurate information and represents health professionals.

IV. Current policy: extension of the AMF

By communicating to medical professionals the French medical practices embodied by the AMF.

By accessing and participating actively within the International Medical representative bodies:

- Currently : World Medical Association (AMM / WMA) created on 18 September 1947 in Paris (initiated especially by Pr. E. MARQUIS).
- In the future: the European Forum of Medical Associations (EFMA), etc ...

V. AMF participating in ongoing activities:

- The International Code of Medical Ethics
- Patient's rights, the children's rights
- Task delegating
- Medical liability, professional autonomy
- Health and environment, health alerts
- Medical participation in capital punishment cases, etc ...

VI. AMF work in progress

AMF assists the Medical Associations of French-speaking countries and developing countries to participate, alongside and after their approval, in activities in international medical bodies.

- The AMF contributes, through its cross-representation, to providing medical terms in French and French-speaking social-professional topics both in Europe and internationally.
- The AMF wishes to contribute to a "medical diplomacy by and for the doctors" in order to save the profession's autonomy, notably through meetings, team work, seminars: Tuberculosis, HIV / AIDS, parasitic, environmental, Helsinki Declaration, counterfeiting, insurance, compensation, autonomy and professional responsibility, and assistance to colleagues in difficulty.

VII. AMF Projects:

Present and defend in France the fundamental principles of medical practice: ethics, responsibility, solidarity, liberal spirit, justice, public health management, risk compensation, training, skills and best practices.

Develop a collaborating spirit with other independent Medical Associations in order to compare, propose, take up and confirm activities after debate and consensus.

Maintain the profession's international autonomy within representative bodies and spread proven knowledge.

Recall and develop the French medical presence in the AMM (WMA) since its inception in 1947.

VIII. Through its international contacts, the AMF promotes information sharing among practitioners

particularly regarding their demands on health systems, contracts, professional insurance and medical risk insurance and the various unions and scientific activities in France and abroad.

IX. By cross-representation based on the AMF one can learn about the policies of continuing medical education, prevention of medical accidents, updating of knowledge and assistance to colleagues.

X. The AMF is able to assume future partnerships within the framework of actions falling within the scope defined by its statutes.

The AMF is helped by its members to be informed of developments in the health system and contributes to the achievement of national economic policy and research.

For more information, join us on the site <http://www.assmed.fr>

*Dr. Louis-Jean Calloc'h, Secretary General,
The French Medical Association*

Liberal practice in Belgium

The Belgian Association of Medical Trade Unions (ABSyM) was created in 1963 to fight the law that would fix the conditions of medical practice. After long and unsuccessful negotiations, the medical body went on strike. It was the first medical strike in the world.

The government eventually agreed to change the law and a system of agreement between doctors and mutual insurance companies was set up. This system has allowed the co-existence of a social financing and a liberal practice ever since.

Every year in the beginning and every other year now, the medical trade unions and the mutual companies negotiate an agreement about fees and practice conditions.

From 1993, the agreement must be done inside a fixed budget.

Individual doctors may decline the agreement and ask for free fees. They have a month at their disposal to do so. The agreement is only enforced if 60 % of doctors (at least 50 % of specialists and 50 % of GPs) don't decline this agreement. If they accept the agreement, they are entitled to receive an amount (currently 3000 €) for their retirement pension. As self-employed, doctors are only entitled to a very low legal pension (about 800 € a month).

Up to now, between 80 and 90 % of doctors accept the agreement every time. Only twice in 45 years have medical trade unions rejected any agreement. On these occasions, the minister proposed an agreement to individual doctors, but their agreement was refused by more than 50 % of specialists and 50 % of GPs in the whole country. This agreement was not able to be enforced.

What is characteristic of Belgian practice is a large freedom for the doctor, but also for the patient.

Doctors are free to accept the agreement or not, but if they accept it they are still free to do it only for a part of their working time. In that case, they must notify the periods of time when they respect the fees of the agreement and the periods when they do not.

If they don't mention it, they are considered as committed for their whole activity, but they are still free to set fees if the patient has any special requirements (for instance an individual room in hospital). On the other hand, fees resulting from the agreement are not very high (about 22 € for a consultation).

Patients also have freedom of choice. They may choose their doctor. They may consult a specialist without being referred by a GP. They may go directly to the hospital if they need. They may call an ambulance. They may choose their hospital. They may change doctors without any administrative or financial sanction. They may have a second opinion without difficulty.

There is no waiting list and the average time devoted by doctors to their patient in a face to face meeting is about twenty minutes.

If access to health care is easy, it is not free of charge. Patients have to pay a contribution. This contribution varies with the patient's income. About 20 % of the population enjoy a preferential reimbursement.

Patients with chronic illness or families with high expenses in health care have care free of charge when they have reached a certain level of expenses every year.

ABSyM is in favour of this patient contribution instead of rationing.

As one can see, the ABSyM aims to defend Hippocratic principles:

- freedom of choice for the patient

- doctor's independence
- medical secrecy
- but also to defend access to health care for everybody and to promote quality of care and risk management.

With regard to quality, ABSyM negotiated a free system in 1993. This system has been implemented since 1994.

Doctors who follow CME attend a local Peer Review and those who commit themselves to comply with quality norms are accredited.

Accreditation is not only a label of quality. It also entitles the accredited doctor to higher fees and such doctors receive a yearly lump sum (600 €) to insure an independent CME.

Accreditation is free, but more than 85 % of doctors are accredited.

Unfortunately, not everything is perfect.

Because of chronic overspending, measures of cost containment have been taken and doctors are more and more under pressure.

The medical control service has been given large prerogatives to investigate medical activities, with penalties for doctors who have not complied with the rules.

The medical advisers of mutual insurance companies may limit access to expensive drugs, and there are more and more restrictions for access to new drugs and new technologies.

The administrative load is taking more and more doctors time at the expense of the time devoted to patients.

While the budget is now balanced, patients and doctors may pay the price with the freedom that they had enjoyed up to now.

Roland LEMYE, President, ABSyM

The Romanian College of Physicians



Vasile Astarastoe

The Romanian College of Physicians was founded in 1995. At the end of last year, a new board has been elected. Prof. Dr. Vasile Astarastoe is the new president, replacing Prof. Dr. Mircea Cinteza, who has led the organization for a decade. The Romanian College of Physicians is also led by three vice-presidents: Prof. Dr. Vlad Tica, Dr. Gheorghe Borcean and Dr. Constantin Carstea.

The Romanian College of Physicians is organized and functions within the provisions of the Act no. 95/2006, as the physicians' national professional organization, being an institution of public interest, non-governmental, non-political and without patrimonial purpose.

The Romanian College of Physicians is a juridical entity and has institutional autonomy in its relation with any public authority, exerting its attributes without any possibility of interference.

The Romanian College of Physicians has as its main objective the control and surveillance of the practice of medical profession, the application of laws and rules that organize and establish the practice of the profession, the representation of the physician's interests and the observance of the prestige of the medical profession within society.

One of the main concerns of the organization is physicians' emigration. Romania has only half of the necessary number of physi-

cians. There are counties which do not have at least one cardiologist or one endocrinologist. In Botosani county, there is no cardiologist. A number of 98 towns or villages do not have a family doctor. In these circumstances, Romania's joining the European Union has allowed very many physicians to leave and work in a country belonging to the EU. Last year, approximately 4% of the total number of physicians have left Romania, according to a recent study made by the Romanian College of Physicians. Almost 500 physicians have left the capital, Bucharest. Within the last two years, 10 % of the medical staff has worked in a EU country.

France, Germany and Great Britain are the favourite destination countries for Romanian physicians. The most required specialties in these countries are: family medicine, anaesthesiology and psychiatry. "We are facing a crisis as to the number of the medical staff, a crisis that nobody wants to admit", says Prof. Dr. Vasile Astarastoe, president of the Romanian College of Physicians. Another goal of the Romanian College of Physicians are the Guidelines of Medical Practice. "The guidelines of medical practice will be made up according to the priorities related to the state of health in Romania. The Romanian College of Physicians will coordinate both the making up of the medical guidelines and will also monitor their implementation", said Prof. Dr. Vasile Astarastoe, the President of the Romanian College of Physicians.

"It is demonstrated that the guidelines of clinical practice are effective means of changing the process of medical assistance and improving the results in the sanitary field. Being one of the instruments which help health professionals and organizations to improve the quality of the patients' treatment, the guidelines offer the persons who use them the possibility to improve the way in which decisions are taken, improving team work, sharing their knowledge based on experience and reducing the changes in practice. At the

same time, the guidelines permanently bring to date the knowledge of health professionals and make them give up the methods used until that moment in order to follow the best recommended practice", declared Prof. Dr. Vlad Tica, Vice-president of the Romanian College of Physicians. Last year, in Romania there have been endorsed the Guidelines of Obstetrics and Gynaecology. 11 guidelines are elaborated and other 15 are still to be elaborated. "A priority of the Romanian College of Physicians is the making up of a Guide of Guidelines which should offer the common methodology in elaborating all guidelines. We have suggested this guide to the European Union of Specialist Doctors (UEMS), the Romanian College of Physicians being the only representative body from Romania that has been accepted within this imposing institution. In the European countries, the average time for elaborating a guide is 18 months" added Prof. Dr. Vlad Tica.

Last year, the Romanian College of Physicians has become a full member of the UEMS. In this position, the representative of the Romanian College of Physicians, Prof. Dr. Vlad Tica made two important suggestions. The first refers to the possibility to award international credits for national activities, which are ranked as high quality. Now, EACCME (the European institution for awarding the credits of continuous medical education) has as its goal rising the physicians' level of knowledge, free movement, equal accreditation. We have suggested that, if a national CME activity is ranked as good, CME credits could be also recognized in Europe. This way, we can increase physicians' access as 80% of the scientific activities are national. The second suggestion we have sent to UEMS is related to the Guidelines of Medical Practice. UEMS does not have a textbook connected to the elaboration of guidelines. For this reason we have thought to make up a Guide of Guidelines, which should receive UEMS approval. We must make up a guide of good quality, otherwise it will not be approved", said Prof. Dr. Vlad Tica.

Vasile Astarastoe, President of the Romanian College of Physicians

The Icelandic Medical Association

The Icelandic Medical Association (IcMA) was founded in 1918, thus it was 90 years old last year. Iceland is a volcanic island in the mid north Atlantic ocean, its size is 103 000 square kilometres which is almost the size of England, but the island is very thinly populated as the population is only 320 000.

The IcMA has available several small cottages in Iceland that members can rent. This is popular for hiking during the summer.

When the IcMA was founded in 1918, Iceland was still a part of the Danish kingdom. The Republic of Iceland was established in 1944. Approximately 80 % of the population lives in south west region of Iceland, in and around the capital Reykjavik. The University of Iceland in Reykjavik was established in 1911 by fusion of pre-existing schools that gave training in medicine, law and theology. There is one University hospital in Reykjavik and three regional smaller ones in rural Iceland. Some smaller hospitals are also in suburban Reykjavik and surrounding area with specific tasks in co-operation with the University Hospital. Most Icelandic doctors have graduated from the Medical Faculty of the University of Iceland, but have received their specialist training overseas. Currently there are 1800 members of the IcMA and approximately 1200 are active at home. There is currently no shortage of doctors, and neither is there any unemployment amongst the profession. Icelandic doctors commonly live and work in the Scandinavian countries, USA, UK, Netherlands and several other countries, mostly in Europe.

The IcMA consists of nine different regional societies. It is a small association even if over 90 percent of active doctors in Iceland are members, and its function is not stipulated in any law. It is not obligatory to be a member of the association if you work in Iceland as a doctor, but if you receive a

salary by a contract the IcMA negotiates with the government you have to pay dues to the association which is the same amount as the membership fee. The IcMA is both a trade union and professional society. The main purpose of the society according to its statutes is:

- To enhance the wellbeing and honour of the Icelandic medical profession, to enlarge their acquaintance and awareness of society matters.
- To safeguard the independence of doctors and watch over their interests.
- To enrich the further education of doctors and interest them in professional matters.
- To enhance doctors' co-operation in all matters that lead to progress in health affairs
- To participate internationally to further the common interests of doctors.
- To work towards better health of the public and be opinion makers in health affairs.

Working towards these goals the office has a total staff of 3.5 people, one is a doctor who is President of the IcMA and a CEO is a lawyer. The board of the IcMA has 9 members and have a role in co-operating with the authorities, both inside the ministries and in parliament. The opinion of the IcMA is often taken into consideration, during the law-making process. Most of health care is run by the public sector, even if private enterprise is permitted. The private part of the health sector is to a great extent subject to contracts with the National Health Insurance, since we do not have any private health insurance in Iceland.



New Honorary Members of the Icelandic Medical Association

The General assembly of Icelandic Medical Association in September 2008, elected two Honorary Members nominated by the board. Dr. Jon Snædal and Dr. Stefan B. Matthiasson. Dr. Snædal, has through many years worked in medical ethics both at home and Internationally. Dr. Snædal is since 2004 president of the IcMA's ethical committee. He is past President of World Medical Association. Dr. Stefan B. Matthiasson has for many years worked for IcMA in the field of Continuous Medical Education. He was President of CME Committee for The Reykjavik and Icelandic Medical Associations 1987-2001. Here seen with the President of IcMA Dr. Birna Jonsdottir, from right Dr. Snædal, Dr. Jonsdottir and Dr. Matthiasson.

The IcMA takes very seriously its social responsibilities. Ethical issues, professionalism and matters of good conduct are written into the statutes of the IcMA and its Ethical Code and we urge our members to work and live by them. Continuous medical education and personal development at home is prioritised in the IcMA's work as is international participation. IcMA is a founding society both in the European and global context. We currently have focused upon Nordic co-operation, when working both in the Permanent Committee of European Medicine (CPME) and the World Medical Association (WMA), since there we feel most similarities.

Dr. Jón Snædal, Immediate Past-President WMA, Icelandic Medical Association.

From Slave Revolt to Chamber Presidency

Marburger Bund in turbulent times



Armin Ehl

“This is not a doctors’ strike, this is a slave revolt!” This is what was written on many of the hand-painted banners during the great doctors’ strikes in the years 2005 and 2006. Although, at the beginning of the strike campaign, this slogan seemed somewhat exaggerated to many German citizens, everyone in our country knew what it was all about after fifteen weeks of the doctors’ strike. There is a great discrepancy between the often used image of the “demigods in white” and the workaday reality in German hospitals. Reducing this discrepancy has been the job of the Marburger Bund since its foundation in 1947.

Of course, there have been many developments in the German health care system during the more than 60 years since its foundation. The professional situation of doctors has changed significantly through legislation and the increasing economisation of the health care system. Nevertheless the motives which led to the foundation of the Marburger Bund remain relevant: humane working conditions, performance-related remuneration, state-of-the-art medi-

cal qualification as well as quality-focused post graduate training for doctors.

Doctors in Germany are unionised either voluntarily or as mandatory members in various organisations. In Germany there are, in total, about 312,000 physicians in gainful employment. All of them are mandatory members of one of the 17 State Chambers of Physicians in Germany, one for each federal state (only North-Rhine Westphalia has two Chambers of Physicians). These State Chambers have joined forces to form the German Medical Association, which is the head organisation of the so-called doctors’ self-administration. The responsibilities of the Chambers include, amongst others, the representation of vocational interests of all physicians and the promotion of a standardised code of professional duties and guidelines for medical activities in all fields as well as for further vocational training.

Among the physicians in gainful employment, about 140,000 are self-employed in private practice, as general practitioners or as medical specialists. The doctors in private practice have joined to form the *Kassenärztlichen Vereinigungen* (Regional Associations of Statutory Health Insurance physicians). These KVs are somewhat like “co-operatives” that conclude framework agreements – particularly with the over 200 statutory health funds in Germany – regulating the payment of doctors in private practice for services rendered to those citizens covered by a public health insurance plan. (In Germany about 90% of the population are members of a statutory health fund, the remaining 10% are covered by private insurance). At the moment there is great cause for dissatisfaction in Germany among doctors in private practice because the overall payment is too low and the repartition of these poor means among the

different branches and regions in Germany is very controversial.

In addition to self-employed physicians, approximately 148,000 physicians are employed, mostly by the approximately 2100 German hospitals. These physicians are represented by Marburger Bund. The interests of employed physicians are manifold and are reflected in the work of Marburger Bund. First of all, Marburger Bund is the organ representing medical interests vis-à-vis politics on a regional, respectively national, as well as on a European level. Last year, for example, the reform of hospital funding was an important issue in Germany. Together with hospital operators, the German Medical Association (BÄK) and the trade unions for the care sector Marburger Bund constituted an active coalition that culminated in a demonstration of more than 130,000 employees of German hospitals at the Brandenburg Gate in Berlin. Regular talks with the Federal Ministry of Health and Social Security – and even talks with Federal Chancellor Merkel – showed the importance of Marburger Bund.

On a European level we are greatly concerned at the moment about the proposed amendment of the EU Working Time Directive. For many years Marburger Bund has fought for on-call services to be counted as labour time and for weekly working hours to be limited for physicians. The European Court of Justice confirmed in two important rulings [SIMAP 2000, Dr. Jäger (Marburger Bund member) 2003] that on-call services are to be counted as full labour time, thereby strengthening explicitly the labour protection of physicians, as well as declaring illegal mammoth services of 30 hours at a stretch or a weekly working time of over 70 hours. And now the clock is to be turned back due of economic reasons. Marburger Bund is in close contact with the European Parliament and provides arguments for the maintenance of the protective function of the Working Time Directive and against the continued exploitation of physicians.

This leads us to the second pillar of work of the Marburger Bund, which has become increasingly important during the past years, namely, Marburger Bund as the doctors' trade union. Until 2005 there was a collective labour agreement in force for all public servants, and this also applied to employed physicians. It was, however, too undifferentiated. The working conditions of physicians in hospitals are in no way comparable to those of lawyers in public service or of teachers in schools. There is another considerable difference to the other professional categories: physicians are scarce and many positions in hospitals remain vacant for a long time. After all, German physicians, unlike teachers and lawyers, are very much in demand abroad, where they find, more often than not, better working conditions and higher remuneration. All this prompted Marburger Bund to demand a specific labour agreement for physicians in 2005.

When the employers refused to split physicians off from the overall labour agreement that applied to all public servants, it led to the above-mentioned doctors' strike. University hospitals were on strike for 15 weeks with another seven weeks at the approximately 700 municipal hospitals. In particular, the long weekly working hours (keyword: slave revolt) played an important role in the public debate and brought the public to our side. As a result Marburger Bund obtained its own wage agreements and considerably better working conditions in the hospitals. The pictures of the strike went around the world and encouraged

many medical organisations abroad to take a similar approach in their countries. Thus, the emancipation of German hospital physicians and of Marburger Bund became the role model for many others. Frank Ulrich Montgomery, our chairman at that time, Rudolf Henke, our current chairman and the signing author, were engaged in many debates about this in other countries and at the annual meetings of the World Medical Association, the Standing Committee of European Doctors (CPME) and the European Forum of Medical Associations and WHO (EFMA).

The strikes also brought about unprecedented solidarity among physicians. Many physicians, apolitical up until that time, came to join the Marburger Bund, making us a very strong organisation. There are currently 108,000 members, creating one of the biggest medical associations, with free membership in Europe.

To round off the representation of interests for employed physicians, there is the work within the medical chambers. For years we have been playing an important part in decision making within the relevant bodies of the medical self-administration, with respect to the training of physicians, the code of medical ethics, as well as post graduate medical training. Marburger Bund is represented in this process by excellent personalities such as Prof. Karsten Vilmar, honorary president of the German Medical Association and honorary chairman of Marburger Bund, or Prof. Jörg-Dietrich Hoppe, president of the

German Medical Association and honorary chairman of Marburger Bund, as well as by many other members of Marburger Bund in prominent positions.

Finally we have concluded a frame contract with a bank and several insurance companies so that our members may be assisted in nearly all aspects of life by their union. Thus, becoming a member of Marburger Bund is really worth it. We stand for the interests of employed physicians and therefore – as we see it – also for the interests of patients. The stronger the union, the better the representation of interests of employed physicians. We do not get anything for free, we have to fight for everything as the recent past has shown. Repartition of the spare funds will become increasingly difficult in our society, a problem which can only be solved by a well organised medical profession.

The representation of physicians is getting more and more international. We are extremely interested in finding similar medical unions in as many European countries as possible and throughout the world, in order to reach agreements with them and to pool our resources, if required. Therewith, we want to ensure that in all the countries physicians are not treated anymore as "slaves" but adequately, as befits their position as high-level service providers in the society.

*Armin Ehl, Secretary General,
Marburger Bund, Berlin*

Mali National Board of Physicians

(Ordre National des Medecins du Mali)

Mali is located in the heart of West Africa surrounded by eight neighbouring countries and with no land access to the sea. It is a vast country spread over 1 242 238 square km and inhabited by 13 518 000 people. The population is mainly rural engaged into agriculture, cattle breeding and fishing activities. The main agricultural products are

cotton, millet and rice. The economic features of the country are changing with the fast growing gold mining industry. The capital city is Bamako where more than 3 million Malians live and contribute to improve national wealth. Across centuries, several famous empires have emerged and waned

in Mali, making this country a unique place for cultural tourism.

Divided into eight administrative regions, Mali became independent from France on 22nd September 1960. French has remained the official language.

Only later, in 1985 the law N° 185/AN-RM was promulgated which authorised private practice for health related professions. Sub-



Alhousseini AG Mohamed

sequently the law N° 86-35/AN-RM instituted the National Board of Physicians.

The National Board of Physicians is composed of one National Council, several Central and Regional Councils.

The mission of the Board of the National Council is to:

- Ensure that principles of morality, probity, and dedication essential for practicing the profession are respected throughout the whole country with help from the Central and regional Councils;
- Ensure the defence of the honour and independence of the profession;

- Ensure that all members adhere to professional duty and that Deontological ethics code rules are followed.

Main tasks of the Board of the National Council are:

- To address any issue in relation with the Board;
- To pronounce disciplinary sanctions;
- To help resolve conflicts between physicians on one side and between physician and clients;
- To manage the property of the Board including the financial resources from members regular contributions and from others sources allowed by law with the aim to cover Board financial responsibilities with regard to the rights of the members and their families;
- To create and liven up the Board newsletter;
- To evaluate suggestions and make proposals to improve the quality of medical activity.

The Board of the National Council is composed of:

- Ten members elected at the General Assembly of the physician members of the Board;
- Two additional members practicing medicine and residing in Bamako.

The Board of the National Council is assisted by three experts representing various administrations. These experts can advise

but cannot vote. They represent the following structures:

- Ministry of Health
- Ministry of Justice
- Faculty of Medicine, at the University of Bamako.

As of today the Board has registered 2,300 medical doctors across Mali. By law, a physician cannot practice medicine in Mali if not registered with the Board of the National Council.

The Board of the National Council has established working relationships with different institutions across Africa. Among those are the West African Organization for Health (OOAS) of the ECOWAS (Economic Community of West African States), the Economic and Monetary Union of West Africa (UEMOA). The UEMOA has established recently a network of Chairs of National Boards of Physicians from West African member countries of the UEMOA. The aim is to ease the free movement of physicians and to strengthen their right to set up in any country in the UEMOA area.

The Mali National Board of Physicians is member of the World Medical Association since the General Assembly held in Seoul, South Korea, in October 2008.

Alhousseini AG Mohamed, President of Mali National Board of Physicians

Movement for Health: the Role of the World Confederation for Physical Therapy (WCPT)

The World Confederation for Physical Therapy (WCPT) was founded in 1951 in Copenhagen, Denmark, with 11 founding member organisations. Today, representing 101 member organisations and more than 300 000 physical therapists worldwide, WCPT provides the sole international voice for the physical therapy profession (called

physiotherapy in some countries). WCPT's mission is to improve the quality of global health by representing physical therapy and physical therapists internationally, collaborating with national and international organisations, supporting communication and information exchange among regions and member organisations of WCPT and

by encouraging high standards of physical therapy research, education and practice.

Historically, two world wars resulted in unprecedented numbers of casualties on all sides. Physical therapy played an important part in the huge advances made in the management of traumatic injuries. The contribution of physical therapy to restore body functioning was clear and the concept of rehabilitation was extended to include therapeutic activities supporting participation in life areas such as work and leisure.



Catherine Sykes

The first decade of its existence was a time for the Confederation to create a global profile, particularly among official bodies. WCPT made contact with the United Nations (UN) and its agencies and entered into official relations with WHO in 1956.

The Physical Therapy Profession

Today, physical therapists provide evidence based services for individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. Physical therapy is concerned with identifying and maximising quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social well being. Physical therapy involves the interaction between physical therapist, patients/clients, other health professionals, families, care giver, and communities in a process where movement potential is assessed and goals are agreed upon, using knowledge and skills unique to physical therapists. Physical therapists are active members of multiprofessional teams. How the skills of qualified professionals, including physical therapists, are used to best effect across the full pathway of care and across settings is vital to clinically and cost effective health service delivery. Taking a patient-centred, flexible, collaborative and open approach, acknowl-



Tracy Bury

edging the competencies of each professional group, is essential to this.

Membership and Governance

WCPT members are national professional associations representing physical therapists. They are organised in five regions: Africa, Asia Western Pacific, Europe, North America Caribbean and South America, which assist the development of the profession in their geographic area. WCPT's seven subgroups are organised to promote the advancement of physical therapy, and the exchange of scientific knowledge in specific fields of interest.

WCPT holds a general meeting every four years. The meeting approves changes to articles of association, elects the president, vice-president and members of the executive committee, approves policies and debates motions. The executive committee agrees the priorities for the four year period.

WCPT Activities

A range of position papers and policies on various aspects of the profession provide information for WCPT's member organisations, individual physical therapists, governments, international non-governmental organisations, the media and the public. Examples of policies include a description of the profession, entry-level curriculum



Brenda Myers

guidelines, standards of practice and disaster management and preparedness.

Many policy areas are further supported by project work. For example, following the earthquake which struck in May 2008 in Sichuan, China, in co-ordination with Handicap International, WCPT issued a call for physical therapists to assist in the post-disaster rehabilitation. In addition, while China is not a member organisation of WCPT, representatives have visited to advise on the development of education programmes and the profession.

A common set of data items to describe the member organisations of WCPT, the regulation of the profession, the education of physical therapists and elements of practice in the countries represented is currently under development. The aim of the collection is to provide information for representation of the profession by WCPT on the global stage, but also for use by regions and member organisations for regional and national strategic policy setting.

A key element of effective practice is good information on the way people function and communication of information across service settings and between professionals. In this regard WCPT supports the use of the International Classification of Functioning, Disability and Health (ICF). An active programme of education, resource sharing

and participation in collaborative work with WHO has resulted in a range of ICF applications by physical therapists as evidenced in the research literature.

WCPT's programme of work on evidence based practice (EBP) includes providing an on-line resource facilitating access to a wealth of materials that will support physical therapists in providing effective practice. This includes access to on-line journals and databases, clinical guidelines and methodological support.

Communication

Congress: Every four years WCPT hosts a scientific congress showcasing advancements in physical therapy research, practice and education.

Website: The WCPT website is the main means by which WCPT can communicate with members, providing the profession worldwide with a valuable range of material, such as policy statements, briefing papers and access to on-line resources as well as the opportunity to exchange information and share expertise.

WCPT News: WCPT News keeps the membership informed about professional developments and global programmes and policies affecting physical therapists.

World Physical Therapy Day: World Physical Therapy Day falls on 8th September every year, and is an opportunity for physical therapists from all over the world to raise awareness about the crucial contribution the profession makes to keeping people well, mobile and independent. WCPT supports this with a 'toolkit' made up of online, inexpensively produced materials for membership organisations to use.

Representation

WCPT officers represent the profession at the WHO, the UN and other global fora. In 2008, in collaboration with the World Health Professions' Alliance, the Confederation was involved in the organisation of the first-ever inter-professional and international conference on regulation of health professionals in Geneva, Switzerland.

As part of its work to identify and implement solutions to the health workforce crisis, WCPT has joined with the world's leading health and hospital professional associations to deliver a Positive Practice Environments campaign. Supported by funding from the Global Health Workforce Alliance the campaign produced the first-ever joint guidelines on incentives for the retention and recruitment of health professionals.

Global Health

Physical therapists are exercise specialists. There is abundant evidence for the benefits of exercise and the contribution of physical therapy in relation to cardiovascular disease, diabetes, arthritis, mental illness and recovery from trauma. In addition, physical therapists implement strategies to prevent and manage the consequences of physical inactivity associated with ageing and a wide range of chronic diseases.

Further work is required to look at provision of services in areas of severe shortage. This remains a significant challenge for all professions and a focus for further research and policy development. The way to progress this is through multi professional collaboration that embraces innovation and recognises the evolving scope of practice and competencies of each professional group.

To address many of the issues that affect global health WCPT is working with professional associations, governmental and non-governmental international agencies, underlining the profession's commitment to collaborative practice.

Visit: www.wcpt.org

*Catherine Sykes, Professional Policy Advisor,
Tracy Bury, Professional Policy Advisor,
Brenda Myers, Secretary General*

American College of Surgeons 95th Annual Meeting

The International Relations Committee of the American College of Surgeons requests posters from sister societies around the world for public display at the 95 Annual Clinical Congress, which will take place 11-15 October 2009 in Chicago, Illinois.

We will have space to display approximately ten posters. Therefore, we will mount the first ten suitable posters that we receive. Please note that we would prefer to receive posters from societies, publicizing the activities of the societies, rather than posters from individual members of those societies.

If your society would care to participate in this display, please send a poster to the following address:

Ms Kate Early International Liaison Section American College of Surgeons 633 North St Clair Street Chicago, IL 60611-3211 USA

We would like to receive all posters by Monday, 28 September 2009 in order to convey them to the convention center in a timely manner. Should you have questions, please contact Ms. Early via email, at kearly@facs.org.

Thank you in advance for your interest in this request. I hope to greet many of you in Chicago.

*HugoV. Villar, MD, FACS
Chair, International Relations Committee*

Since 1968, the American College of Surgeons has offered **International Guest Scholarships** to competent young surgeons from countries other than the United States or Canada who have demonstrated strong interests and accomplishments in teaching and research. Applications are now being accepted for International Guest Scholarships for the year 2010. **The deadline for receipt of scholarship applications and all supporting documents is 1 July 2009.**

Each Scholarship offers a stipend of \$8,000 US, participation in the Clinical Congress, and the expectation of visits to several North American clinical and research sites of the Scholar's choice. A mentor will be assigned to assist the Scholar in planning his/her tour.

I seek your cooperation in publicizing the availability of the International Guest Scholarships. The International Relations Committee of the College has requested that the requirements for the International Guest Scholarships be widely distributed in your country. This goal can be effectively accomplished by sharing the information about the program requirements.

This information is available in English from the College's Web site at this location: <http://www.facs.org/memberservices/igs.html>.

Applicants are welcome to read the requirements, and then apply to the program by using the link to the direct, online application form at the bottom of the requirements page. The requirements are also available in Spanish (<http://www.facs.org/memberservices/igsespanol.html>) and in French (<http://www.facs.org/memberservices/igsfrancais.html>). **Please note that all applications must be submitted in English,**

Surgeons interested in applying for these Scholarships must apply directly from the College's Web site. Questions may be directed to Ms. Kate Early, International Liaison Administrator, at the College's airmail address shown on our stationery, via fax at 312-202-5021, or via email at kearly@facs.org,

I would greatly appreciate your cooperation in disseminating this information in order to ensure a large number of excellent prospective scholarship applicants. To date, International Guest Scholarships have been awarded to 220 promising young surgeons worldwide (1968-2009).

*Paul E. Collicott, MD, FACS
Director, Division of Member Services*

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Correction: We apologise to the author of the article "National Helath Service(England) for the mis-spelling of his name at the beginning of the article (WMJ 55(1)). It should have read "Tom Frusher". The contact e-mail address is TFrusher@bma.org.uk

