

WORLD MEDICAL JOURNAL

55

Vol.

No. 3, October 2009

OFFICIAL JOURNAL OF THE
WORLD MEDICAL ASSOCIATION, INC.



World Medical Association Officers, Chairpersons and Officials

Dr. Yoram BLACHAR

WMA President
Israel Medical Assn
2 Twin Towers
35 Jabotinsky Street
P.O. Box 3566
Ramat-Gan 52136
Israel

Dr. Dana HANSON

WMA President-Elect
Fredericton Medical Clinic
1015 Regent Street Suite # 302,
Fredericton, NB, E3B 6H5
Canada

Dr. Jón SNÆDAL

WMA Immediate Past-President
Icelandic Medical Assn
Hlidasmari 8
200 Kopavogur
Iceland

Dr. Edward HILL

WMA Chairperson of Council
American Medical Assn
515 North State Street
Chicago, ILL 60610
USA

Dr. Kazuo IWASA

WMA Vice-Chairman of Council
Japan Medical Assn
2-28-16 Honkomagome
Bunkyo-ku
Tokyo 113-8621
Japan

Dr. Jörg-Dietrich HOPPE

WMA Treasurer
Bundesärztekammer
Herbert-Lewin-Platz 1
10623 Berlin
Germany

**Dr. Eva NILSSON-
BÄGENHOLM**

WMA Chairperson of the Medical
Ethics Committee
Swedish Medical Assn
P.O. Box 5610
11486 Stockholm
Sweden

**Dr. José Luiz GOMES DO
AMARAL**

WMA Chairperson of the Socio-
Medical-Affairs Committee
Associação Médica Brasileira
Rua Sao Carlos do Pinhal 324
Bela Vista, CEP 01333-903
Sao Paulo, SP
Brazil

Dr. Mukesh HAIKERWAL

WMA Chairperson of the Finance
and Planning Committee
58 Victoria Street
Williamstown, VIC 3016
Australia

Dr. Guy DUMONT

WMA Chairperson of the Associate
Members
14 rue des Tiennes
1380 Lasne
Belgium

Dr. Karsten VILMAR

WMA Treasurer Emeritus
Schubertstr. 58
28209 Bremen
Germany

Dr. Otmar KLOIBER

WMA Secretary General
13 chemin du Levant
France 01212 Ferney-Voltaire
France

www.wma.net

Official Journal of The World Medical Association

Editor in Chief

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

Co-Editor

Dr. Alan J. Rowe
Haughley Grange, Stowmarket
Suffolk IP143QT, UK

Co-Editor

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

Assistant Editor Velta Pozņaka

wmj-editor@wma.net

Journal design and

cover design by Jānis Pavlovskis

Layout and Artwork

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

Cover painting : Academic painter Juraj

**Oravec. Cosmic gravity (combined technique,
a visual metaphor for fertilization of a germ
cell of an ovulum with cosmologic dimension)**

Publisher

The World Medical Association, Inc. BP 63
01212 Ferney-Voltaire Cedex, France

Publishing House

Deutscher-Ärzte Verlag GmbH,
Dieselstr. 2, P.O.Box 40 02 65
50832 Köln/Germany
Phone (0 22 34) 70 11-0
Fax (0 22 34) 70 11-2 55

Business Managers J. Führer, D. Weber

50859 Köln, Dieselstr. 2, Germany
IBAN: DE83370100500019250506
BIC: PBNKDEFF
Bank: Deutsche Apotheker- und Ärztebank,
IBAN: DE28300606010101107410
BIC: DAAEDED
50670 Köln, No. 01 011 07410
At present rate-card No. 3 a is valid

The magazine is published quarterly.

Subscriptions will be accepted by
Deutscher Ärzte-Verlag or
the World Medical Association

Subscription fee € 22,80 per annum (inkl. 7%
MwSt.). For members of the World Medical
Association and for Associate members the
subscription fee is settled by the membership
or associate payment. Details of Associate
Membership may be found at the World
Medical Association website www.wma.net

Printed by

Deutscher Ärzte-Verlag
Köln, Germany
ISSN: 0049-8122



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

Editorial

The 182nd WMA Council Meeting

The Israel Medical Association was delighted to host this year's Council meeting at the Hilton Tel Aviv. The meeting went smoothly. The discussions were fruitful and agreement was reached on many of the statements. The scope of topics discussed was broad, including child health, medical neutrality, inequalities in health, stem cells and the use of placebos. However, my greatest delight was being able to host my long-time friends and colleagues from the WMA in my home country.

Before beginning the actual Council session, an optional informative session was offered by the Israel Medical Association. As an Israeli, I am constantly bombarded with questions from my colleagues abroad that reflect the complexity of the region in which I live. The recent conflict in Gaza and continued worry in the Middle East over the threat of a nuclear Iran have only increased the amount of inquiries that I receive. This session provided essential background information on many of the issues frequently covered by foreign news agencies, to those WMA participants who wished to attend. Mr. Neil Lazarus is an expert on the Middle East and speaks to over 25 000 people a year through his seminars. Having him speak with WMA Council visitors was a great opportunity to discuss the reality of the Middle East and I appreciate those who spent their free time in order to hear him.

Participants arrived in Israel from countries near and far. For many, this was their first trip to the country that is holy to three major religions. Participants experienced the meaning of that on Thursday, 14 May when we travelled to Jerusalem. In Jerusalem, we saw the Church of the Holy Sepulchre where Jesus was crucified and buried. We saw the Al-Aqsa Mosque which is the second oldest mosque in Islam and the third in holiness and importance after those in Mecca. We also had a chance to visit the Western Wall which has remained intact since the destruction of the Second Jerusalem Tem-

ple. It was my pleasure to participate in this tour and give WMA guests a taste of Israel. We were led through the Jewish quarter of the Old City of Jerusalem, the Arab market (or, as we call it, *shuk*) and we tasted traditional Middle-Eastern cookies and drank freshly squeezed lemonade with mint leaves. In the *shuk* our senses were overpowered with the strong smells of coffee, tobacco and spices, the vibrant colours of the different fabrics and intricate tapestries, as well as the history of the place. Our tour ended at the historical City of David where actors and musicians painted us a picture of what it meant to live in Jerusalem at the time of the Temple. This was a truly unique experience. We continued at the City of David with dinner and musical entertainment in the olive garden.

Additional social events included a visit to the Eretz Israel Museum. There we saw an ancient olive press, flour mill and other working tools traditionally used in the Middle East in ancient times. We were lucky to have a cool breeze while we enjoyed dinner on a grassy lawn at the museum.

Israel, as a melting pot and home to people of all nationalities and religions was a fitting place to host the WMA, which itself is an amalgam of people from various countries, languages and cultures. Our common language, medicine, unites us and allows us to work together to reach common goals, making the WMA what it is – an outstanding organization.

WMA meetings in general and this year's Council Meeting in Tel Aviv in particular, provided another great opportunity for physicians from around the globe to become acquainted with one another, socialize and discuss common issues and challenges in an informal manner. It was my pleasure and my privilege to host this year's Council Meeting and I invite all the delegates to return to Israel in the near future.

Dr. Yoram Blachar, WMA President

Items from the 182nd WMA Council meeting in Tel Aviv, May 2009

Council was opened by the Secretary General who welcomed the following new members, Dr. Ruth Collins Nakai, Dr. Toram Janbu, Dr. Gebrehiwot, Prof Niewenhuijzen Kruseman, Dr. Leonid Mikhaylov, and Dr. Antonio Tunes.

Following the announcement by the Secretary General of the death of Angel Orozco, long-time Executive Director and friend of the WMA, the Council observed a period of silent tribute. *(a memorial tribute will appear in the next issue of WMJ)*

Dr. Edward Hill was re-elected **Chair of Council**, the following officers were elected, **Vice- chair of Council Dr. Ishii**, **Treasurer Professor Hoppe** and members of Standing Committees and Advisers were then elected.

Council then received the reports of the President and Secretary General

Interim Report of the President

"It is my pleasure to host you in Tel Aviv for this year's Council. It is an honour to serve as President of this auspicious organization that impacts physicians in practically every country in the world. This organization dictates the standards of ethics and care and excels in progressing our profession forward. This has been a very busy year for me as President of the WMA and I am excited to share with you some of my experiences. I am pushing many issues and I would like to now highlight some of them.

Throughout the year I have pushed, and I continue to push now, the agenda of fighting inequalities in health. On this note I am happy to report that at this Council session a draft resolution on Inequalities in Health

will be discussed. I expect this discussion to lead to the creation of a Work Group on the topic and I am sure the WMA will reap the benefits of their work and efforts for many years to come. The Israel Medical Association has also prepared a summary on a survey regarding inequalities in health that was distributed to national medical associations through the WMA. We received responses from 17 associations and plan to use the results as a springboard for the work group.

In parallel, I have been working with some of my contacts around the world to create a project on inequalities in health. This project includes a few different aspects but revolves around obesity and diabetes in children. As a pediatrician I chose to focus on youth and since low socio-economic status contributes to obesity and other health complications such as diabetes, I focused on this as part of the inequalities in health platform. The first dimension of this project is being developed with the help of Professor Itamar Raz. Together we are developing a special internet course for physicians on the subject of diabetes. This course will include lectures by internationally renowned diabetes experts and allow online participation from physicians. This course will provide a global perspective on the issue and will provide tips for physicians in treating diabetes, especially to those from low socio-economic backgrounds. Prof. Raz has been enlisting his peers in the global medical community to be involved in building the course and giving lectures. Prof. Raz has also contacted Novo about funding and a decision is pending. I hope that I will be able to be able to update you on Novo's positive answer in the near future.

The second dimension of this project is being developed in conjunction with the American



College of Endocrinology and American Association of Clinical Endocrinologists. The ACE/AACE Power of Prevention program was initiated by Dr. Don Bergman. Through introductions provided by Dr. Yank Coble, I have discussed with members of the AACE the possibility of expanding Power of Prevention to a global level. With the WMA behind this initiative, healthy lifestyle habits will be taught to people all over the world. The first step in this project is translating material that is already available on the Power of Prevention website and in their magazines. International content will then be added to the website, with some of this content being geared towards specific countries and some content applicable to all countries. The AACE and I are also discussing the possibility of creating a partnership through an entirely new project that will focus solely on obesity and diabetes. Dr. Yank Coble has been an active player in this collaboration and is currently investigating avenues for funding of this project as well.

My agenda as president of the WMA also includes the encouragement of Arab countries who are not yet involved, or members, of the WMA to become involved. In this capacity, I was privileged to attend the March Meeting of the International Federation of Medical Student's Associations in Tunisia this year. I was thoroughly impressed by the young doctors who organized and attended the conference. At the conference, I had the honor of presenting the WMA Medical Ethics Manual to a young and eager audience. Unfortunately, while I was there members of the Tunisian Medical Association were unable to meet with me, but I believe the young generation of leaders that I met will eventually propel their national medical associations to greater collaboration. The young generation is interested in pursuing more global medical collaboration through organizations such as the WMA. I look forward to greater cooperation from these countries in the near future.

More specifically, through some of my contacts in Israel I have made overtures to con-

tacts in Tunisia and Morocco in attempt to greater integrate their medical associations in the WMA. There are many WMA projects that they could benefit from participation in and many other WMA projects that could benefit from their participation. I hope that in the near future I will receive responses and meet with representatives from the medical associations in Tunisia and Morocco and be able to report positively back to the Council.

My presidency has also faced many unique challenges, primarily because of my Israeli citizenship. Efforts against me have intensified in light of the conflict in Gaza this year. I must assure you all, as President of the WMA and as President of the Israel Medical Association since 1995; I have continuously worked towards bettering the health of Palestinians with this last conflict in Gaza being no exception. I have continuously and tirelessly intervened in cases where a Palestinian patient was to be evicted from an Israeli hospital due to lack of funds; intervened, including by way of petitions to the High Court of Justice, in situations where Palestinian patients, physicians or medical students encountered difficulties at Israeli checkpoints; and called for funds to be transferred to the PA in the form of food and medicine so that help could be given where it is truly needed.

During the recent conflict in Gaza I was in constant contact with various government officials in positions to help the Palestinians. I wrote regarding the restriction of medical personnel in passing from the West Bank to their place of work, regarding the humanitarian situation in the Gaza strip and regarding the safety of medical personnel in the Gaza strip. I have done my utmost and I continue to work for the health of the Palestinians. That being said, there is nothing I can do for combatants who target innocents and use innocents as human shields. Hamas, a terrorist organization, abhorrently uses hospitals and schools and even a zoo as shields. I sincerely hope that all conflicts in this region and around the world will not

turn to violence. When this happens, we physicians will be allowed to focus on providing the highest level of care and not have to spend so much of our efforts on patching up wounds inflicted by other people. As it says in Isaiah 2:4, "Nation shall not lift up sword against nation, neither shall they learn war any more."

I look forward to a fruitful Council meeting. I am proud of the work that the WMA does and the many ways it affects the medical community – both globally and the impact of the WMA on individual physicians in different countries. Throughout my years being active in the WMA I have been exposed to the great impact the WMA makes and I am proud to be part of it. It is an honour and a privilege for me to serve as this year's President and I hope that my work will contribute to the WMA".

From the Secretary General's Reports

1. Policy

Multi Drug Resistant Tuberculosis Project
"The second phase of the **Lilly MDR-TB partnership** began in May 2008. The continuation of this project includes the development of a **TB refresher course for physicians**, which will serve as an introductory course for the existing MDR-TB course. The New Jersey Medical School Global TB Institute has finalised the draft version of the word document of the TB refresher course and has send it out to international TB experts for review. After the review process the MDR-TB and TB refresher course will be adjusted in their design and will be made more interactive with case studies, videos and more.

WHO recently updated their MDR-TB guidelines and emphasise now more on infection control and laboratory diagnosis. Based on this and on the International Standards of TB Care we updated our MDR-TB course as well. The MDR-TB course has been already translated into

Spanish, Russian, Chinese and Azeri and French will follow soon. Within the next few months all courses will be available on the new server of the Norwegian Medical Association.

A “train-the-trainer course in MDR-TB” will create champions in the field of TB on a local level. Physicians who are experts in TB receive training in adult learning and accelerated learning principles in order to better teach their colleagues. The first of a series of workshops took place in Pretoria, South Africa in November 2008 and the next one will follow in India this year. In cooperation with the Foundation of Professional Development, 15 physicians from South Africa and five WHO consultants from Namibia, Lesotho, South Africa and Kenya, were trained in a three-day workshop consisting of interactive facilitation skills, group assessment and educational strategies. In case studies, role-plays and interactive methodology they immediately applied the adult learning theory within their group and received feedback from the facilitators and the other participants. The Indian Medical Association is organising a similar workshop just prior to the General Assembly. The Chinese Medical Association announced that it would like to organise within the MDR-TB project a train-the-trainer workshop or a GP training in MDR-TB as well.

The WHO is in the process of developing a „Policy on ethics in the TB setting“, with a goal for its adoption at the World Health Assembly in 2010. The WMA has been invited to address the issues related to health professionals in the policy. Dr. Jeff Blackmer from the Canadian Medical Association kindly offered to draft this part of the policy. The first WHO work group meeting to discuss the policy took place in December 2008 in Toronto. Over the next few months the draft policy will be discussed and revised at several international meetings on Ethics and TB.

Given the already critical shortage of health providers and generally weak health sys-

tems in the regions most affected by XDR-TB and MDR-TB, anxiety about safety in the health care environment runs high and can dissuade health providers from accepting assignments in these settings. A set of “Inter-professional workshops on health care worker safety in the context of drug resistant TB” in low and middle-income countries addressed TB infection protection, with the objective of identifying good practices, implementing joint recommendations for facilities and health workers and establishing a working group with a plan of action to communicate the identified practices and recommendations. WMA, together with our South African member and the ICN, IHF and ICRC, organised the first workshop in Cape Town South Africa in November 2007. a second one took place together with the Brazilian Medical Association in Rio De Janeiro, Brazil in March 2009 and the next one will be in South Africa again, in Durban in June 2009.

Together with the other NGO partners involved in the fight against MDR-TB, the WMA participated in a Briefing on the issue for the diplomatic missions in Geneva on March 19th which was World TB Day. MDR-TB still does not receive enough attention and global advocacy is urgently needed.

On the invitation of the German Association of Research-Based Pharmaceutical Companies, the Secretary General presented the work in the field of MDR-TB to German Members of Parliament in Berlin on March 19th, 2009. The discussion served to stimulate interest in the re-occurrence of tuberculosis and its relevance for countries that still have decline in TB incidence.

Tobacco project

The WMA joined the implementation process of the WHO **Framework Convention on Tobacco Control (FCTC)** <http://www.who.int/tobacco/framework/en/>. The FCTC is an international treaty that condemns tobacco as an addictive substance, im-



poses bans on advertising and promotion of tobacco and reaffirms the right of all people to the highest standard of health. The first international treaty negotiated under the auspices of the WHO, the FCTC entered into force in 2005 and is the most widely embraced treaty in UN history, with 168 signatories and 154 ratifications to date.

WHO FCTC held its **Third Conference of the Parties (COP3)** in Durban from 17-22. November 2008 to discuss and amend single articles of the treaty and receive the report of the working groups which are implemented for some of the articles. WMA is a member of the working groups on article 12 - education, communication, training and public awareness- and article 14 - measures concerning tobacco dependence and cessation. WMA was represented at the COP3 conference by Dr. Julia Seyer. WHO recognised the engagement of WMA in this process and is eager to increase the cooperation with physicians on the international and especially on the national level.

Health Workforce

WMA continues its close involvement in the **Positive Practice Environment Campaign (PPE)**. This global 5-year campaign – spearheaded by WHPA members together with the World Confederation for Physical Therapy and the International Hospital Federation – aims to ensure high-quality healthcare workplaces worldwide. During this reporting period, the PPE partners have been in discussion with the Global Health Workforce Alliance (GHWA) about the continuation of the project and also explored funding opportunities. The appointment last March of a full-time coordinator in charge of running the campaign on behalf of the organization members, will allow the PPE to kick off in three selected countries: Uganda, Morocco and Zambia. Taiwan will also be involved in the PPE as a self-funded country.

At the invitation of the Iceland Medical Association and WMA past president, Dr. Jon

Snaedal, the World Medical Association convened a Seminar on Human Resources for Health and the Future of Health Care on 8-9 March, 2009. This seminar was an effort to bring together stakeholders from a range of health professions to focus on these issues and help WMA define some policy priorities in its approach to the subject. The final report of the event includes ideas to facilitate WMA policy development in this area. WMA Advocacy Working Group will consider these proposals and explore follow-up opportunities.

In early March, WMA was invited to take part in the planning process of the next **Conference on Workplace Violence in the Health Sector**, which is scheduled to take place on 27 - 29 October 2010 in Amsterdam. The event is supported by the Global Health Workforce Alliance (GHWA), WHO, International Labour Organisation (ILO), the International Council of Nurses (ICN), Public Services International (PSI) and other relevant health organizations. We are still in the very early preparation stage of this event. The WMA Secretariat intends to take an active role and to involve constituent members as appropriate.

WHO is developing “**Guidelines on retention strategies for health professionals in rural areas**”, which should be adopted at the World Health Assembly 2010. The aim is to ensure access to health care for people living in rural areas and thus improve the health outcomes, including the Millennium Development Goals (MDGs). The guidelines will be based on three pillars: educational and regulatory incentives, monetary incentives and management, environment and social support. Decision makers on the national and local level and health facilities should receive evidence on the impact and effectiveness of various retention strategies that have been tried and tested. WMA, as the secretariat of the World Health Professions Alliance, is member of the core expert group developing the guidelines. Two meetings in Geneva have already taken place and the next one will be in June 2009.

WMA staff member Dr. Julia Seyer, as secretariat of the WHPA has been invited to join an independent merit review panel organized by the **Global Health Research Initiative**. The panel will review research proposals submitted in response to a competition launch in January 2009 by the “**Africa Health Systems Initiative Support to African Research Partnerships**” programme (AHSI-RES). AHSI-RES is a 5-year research programme (2008-2013) that forms one component of the Africa Health System Initiative (AHSI) supported by the Canadian International Development Agency (CIDA). AHSI is a 10-year initiative focused on strengthening national-level health strategies and architecture, ensuring appropriate human resources for health, strengthening front-line service delivery and building stronger health information systems, all with special attention to equity considerations. The first AHSI-RES round of the review process will be in June 2009.

WMA participates as a member of the steering group in the **Mobility of Health Professionals research project**. The general objective of the research project is to assess the current trends of mobility of health professionals to, from and within the European Union and their reasons for moving. Research will also be conducted in non-European sending and receiving countries, but the focus lies on the EU. This research project is a medium-scale collaborative project, with the goal of facilitating informed policy decisions on health systems by developing a scientific evidence base related to the impact of mobility of health professionals. The first meeting with all partners was held in November 2008 in Brussels.

Counterfeit Medical Products

Counterfeit medicines are drugs manufactured below established standards of safety, quality and efficacy and therefore risk causing ill health and killing thousands of people every year. Experts estimate that 10 per cent of medicines around the world could be counterfeit. The phenomenon has grown in

recent years due to increasing sophistication of counterfeiting methods and the increasing amount of merchandise crossing borders.

At the last **Executive Board Meeting of the WHO in January 2009**, a report and draft resolution on counterfeit medical products were discussed and all member states stressed the importance of protecting public health against risks caused by counterfeit medications. However an intense debate began on the definition of counterfeits versus substandard medicines. So far WHO has focused on counterfeits while largely ignoring the broader (and more politically sensitive) category of substandard drugs. WHO's recommendations are subject to the whims of member states. They find it easier to tackle counterfeits rather than substandard drugs because the latter are often manufactured by taxpaying firms within their borders.

WMA, together with the members of the WHPA, organised a very well attended **Mission and NGO briefing** on this important topic in April 2009 just prior to the WHA. The objective was to raise awareness of this public health threat and communicate the opinion of the health professions.

Primary health Care

The **World Health Report of 2008, 'Primary Health Care – Now More Than Ever'**, critically assesses the way that health care is organized, financed, and delivered in rich and poor countries around the world. The WHO report documents the failures and shortcomings over the last decades that have left the health status of different populations, both within and amongst countries, dangerously out of balance. The report urges the importance of a holistic health care approach where primary health care plays an important role as a facilitator between prevention, secondary and tertiary care. The report focuses health care systems on 4 pillars: universal coverage, people-centred health care, leadership reform to make health authorities more accountable and to promote

and protect public health in general. With the World Health Report 2008, and the report on Social Determinants of Health, WHO placed inequity in health care and social disparities at their centre of activities.

The **Executive Board of the WHO** in January 2009 discussed a **draft resolution on primary health care, including health care system strengthening**. On behalf of the World Health Professions Alliance, the WMA made a public statement during the Executive Board session. Further debate will take place during the World Health Assembly in May 2009.

WHO invited WMA to take part in a global consultation on the **contribution of health professions to primary health care** and the global health agenda in June 2009.

Alcohol

In May 2008, the World Health Assembly adopted a resolution requiring WHO to intensify its work to curb harmful use of alcohol. Members States call upon WHO to develop a global strategy for this purpose. The resolution also requests the WHO Director-General to consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators regarding ways in which they can contribute to reducing the harmful use of alcohol. In line with the WMA Statement on Reducing the impact of alcohol on health and society (WMA General Assembly, Santiago 2005), the WMA secretariat monitors the drafting process of the WHO strategy and has developed contacts with relevant WHO officials and civil society organisations to collaborate in the process.

On the 23 October 2008, the WMA Advocacy Advisor, Ms. Clarisse Delorme, moderated an **NGO briefing on reducing the global alcohol harm**, organised by GAPA (Global Alcohol Policy Alliance). The objectives of the briefing were to understand the WHO process related to the strategy, to begin discussions on substantive and po-

litical proposals to promote an effective, evidence-based global strategy, and, finally, to develop further working relations between civil society actors involved in this area.

On the 24 November 2008, Dr. Otmar Kloiber, and Ms. Clarisse Delorme, participated in the **WHO roundtable meeting with representatives of NGOs and health professionals on ways they could contribute to reducing harmful use of alcohol**. This was an opportunity to raise, amongst others issues, WMA's concerns that medical associations and individual physicians be fully involved in WHO strategy on alcohol.

As a follow-up to this, Ms. Clarisse Delorme, together with George Hacker from GAPA, met with several Permanent Representatives (Denmark, Sweden, Norway, Chile, South Africa, US, New Zealand) in Geneva to discuss countries' positions and involvement within the WHO regional consultative process on the draft strategy.

Obesity and Diabetes

The World Medical Association has developed, together with the Geneva Social Observatory, a **Workplace Strategy on Diabetes and Wellness**. The Workplace Strategy on Diabetes and Wellbeing is a guideline for employers and employees to educate and raise awareness about diabetes, and provide examples of healthier lifestyles during work. The aim is to mitigate the ill effects of diabetes on personal health, workplace productive and health care costs. In a research study, examples of activities to improve the well-being of employees are collected and offered as a menu of choices for companies. Depending on their capacity and needs, companies can implement all or only individual parts of the menu. The guideline are now finalised and the implementation phase will begin soon.

Health and the environment

WMA Workgroup on Health and the Environment, chaired by the Canadian

Medical Association, was established in the summer of 2008. For 2009, the workgroup agreed to focus its attention on health and climate change, in view of the global United Nations conference on this topic in Copenhagen in December 2009. In 2010, the workgroup will focus on environmental degradation and the built environment.

In January 2009, the workgroup produced a set of recommendations, which it circulated to WMA constituent members for input prior to presentation of a resolution at the 182nd Council Session in May 2009. A **WMA conference on health and climate change will take place on 1 September, 2009 in Copenhagen**, with a view to “testing” and developing further WMA recommendations. Following further revision after this conference, the WMA resolution will be considered again by the Council at its pre-Assembly meeting. If approved, it will be submitted to the 2009 General Assembly for adoption. If adopted, the WMA will be in a position to advocate strongly for input and changes at the UN Conference in Copenhagen in December 2009.

Following the adoption by the 2008 General Assembly of the WMA **Statement on Reducing the Global Burden of Mercury**, WMA joined the **UNEP Global Mercury Partnership** in December 2008 in order to contribute to the partnership goal to protect human health and the global environment from the release of mercury and its compounds (<http://www.chem.unep.ch/MERCURY/Sector-Specific-Information/Mercury-in-products.htm>)

Human Rights

During the reporting period, the WMA secretariat launched several lobbying actions, based on information from Amnesty international, to support **physicians in distress** worldwide:

2 Egyptian doctors Raouf Amin al-Arabi and Shawqi Abd Rabbuh sentenced to 15

and 20 years of prison and 1500 and 1700 lashes respectively in Saudi Arabia for having facilitated the addiction of a patient to morphine after prescribing the medicine for her pain relief following an accident - December 2008

Dr. Arash Alaei and Kamiar Alaei (Republic of Iran) sentenced to 6 and 3 years of imprisonment respectively for ‘cooperating with an enemy government’, specifically with US institutions in the field of HIV & AIDS prevention and treatment - January 2009;

The WMA also intervened on behalf of Majid Movahedi who was sentenced last March in Iran to be blinded in both eyes with acid – a process that would involve medical professionals. Recalling its firm opposition to punishments that constitute cruel, inhuman and degrading treatment amounting to torture, WMA emphasizes in the letters to Iran authorities that, according to international medical standards, it is unacceptable to involve physicians in this inhuman and degrading treatment

WMA is actively involved in developing the **“Right to Health as a Bridge to Peace in the Middle East” joint seminar**, which will take place 27-30 October 2009 in Turkey. The seminar is being organised by the International Federation of Health and Human Rights Organisations (IFHHRO), the Norwegian Medical Association (NMA), the Human Rights Foundation of Turkey (HRFT), the Turkish Medical Association (TMA) and the WMA. The objectives of the meeting are to discuss what role the medical profession can play in securing equal access to health care for the population and to facilitate the communication among health professionals in the participating nations.

WMA maintained regular contact with Anand Grover, the **UN Special Rapporteur on Health** in order to increase the role of health professionals in the promotion of the human right to the highest attainable standard of health.

Social determinants of health

In August 2008, the Commission on Social Determinants of Health published its final report **“Closing the Gap in a Generation – Health Equity through Action on the Social Determinants of Health”**. In this 200-page report, the Commission addresses global health through social determinants, i.e., the structural determinants and conditions of daily life responsible for a major part of health inequities among and within countries, and proposes a new global agenda for health equity.

WMA – on behalf of the World Health Professions Alliance (WHPA) – presented a statement on this report, with a focus on the health workforce. In this statement, the WHPA welcomed the recommendation directed at national governments and donors to “increase investment in medical and health personnel”, but regretted that the report in general does not give more attention to health professionals as key players in addressing the social determinants of health and the inequalities health professionals face in their daily work.

Ethics

Clinical research involving human subjects has proliferated in developing countries in the recent past, increasing concerns about ethical and legal implications of misconduct and violations of subjects’ human rights and welfare because scientific and ethical review of protocols are inadequate or as a result of poor or absent drug regulatory systems. WMA was invited to the international Round Table - **Biomedical Research in Developing Countries: the Promotion of Ethics, Human Rights and Justice** - to compare and exchange expertise and experiences between national and international institutions, on the issue of protection of human participants in biomedical research. Participants stressed the importance of building capacity in biomedical ethics review in developing coun-

tries by supporting education and training curricula of health professionals and community health workers, in order to facilitate the creation of institutional Research Ethics Committees.

Speaking book

WMA launched the **Speaking book on Clinical Trials** on the occasion of its General Assembly in Seoul 2008. This project was done together with the South African Medical Association, the SADAG (South African Depression & Anxiety Group) and the Steve Biko Centre for Bioethics in Johannesburg. The purpose of the project is to provide proper information on clinical research to illiterate populations so that they can make informed decisions about participation. The project was made possible by an unrestricted educational grant provided by Pfizer, Inc.

Caring Physicians of the World (CPW) Initiative "Leadership Course"

The CPW Project began with the *Caring Physicians of the World* book, published in October 2005 in English and then published in Spanish in March 2007. Regional conferences were held in Latin America, Asia-Pacific and Africa regions. The CPW Project was extended to include a leadership course organized by the INSEAD Business School in Fontainebleau, France, in December 2007, in which thirty-two medical leaders from a wide range of countries participated and the second Leadership Course was held at the same place in December 2008 for one-week with thirty participants and it turned out with successful results and feedbacks. Planning has begun for the third Leadership Course at the INSEAD Business School in Singapore in February 2010. The curriculum includes training in decision-making, policy work, negotiating and coalition building, intercultural relations and media relations. The courses were made possible by an unrestricted educational grant provided by Pfizer, Inc.

2. External Relations

World Health Professions Alliance

The WPHA is now a decade old. The context within which it is working has changed, and so have the organisations which make up the alliance. Three of the four organisations have taken on new leadership since the alliance was created. As a result, the CEO's feel that it is time to refresh its strategy, and identify how it can best use the resources available to achieve its objectives. This will be done in a two-day strategy seminar in June 2009.

World Federation for Medical Education

The WFME brings together medical faculties and the profession. During recent years it has focused on describing global standards for basic and post-graduate education of physicians as well as for the Continuing Professional Development. The WMA General Assembly endorsed these standards.

Currently, the WFME works on encouraging and supporting countries and medical schools to engage in, or to improve, their accreditation. Although not itself an accrediting body, the WFME - together with WHO - strongly support the use of accreditation as a method of documenting and improving the quality of education and achieving comparability in the international arena.

Based on a mutual agreement with the WHO, the WFME together with the University of Copenhagen (which hosts the WFME office) has taken over from WHO Headquarter the register of institutions for higher education in health care. The WFME now develops this register in an online database called **Avicenna Directories**, which will not only list the institutions as named by their governments, but also provide information about their accreditation status and the accrediting body.

Administration

After renegotiating the contract with the company DGN-Service, the WMA has

finally signed a contract with DGN to develop and install a new web portal for the WMA. The new web portal will provide the platform for cooperation with the members of WMA, allow online payments for meetings, books and associate membership dues, and, most of all, it will facilitate more timely presentation of content on the public website. Work on the new design and information structure, as well as for the payment system, is underway.

The Secretariat wishes to record its appreciation to member associations and international organizations for their interest in, and cooperation with, the World Medical Association and its Council during the past year. It thanks all those who have represented the WMA at various meetings and gratefully acknowledges the collaboration and guidance received from the officers, as well as the Association's editors, its legal, public relations and financial advisors, and its officials."

Council then received the Reports of Standing Committees, noting the appointment of **Dr. Jen Winther Jensen as Chair of Ethics Committee, of Dr. Haikerwal as Chair of Finance and Planning and of Dr. J.C.Gomez Amiral as Chair of Medical Social Affairs Committee.**

Ethics Committee Report

In the course of consideration of the report of the Ethics Committee, Council **approved** the following new or revised statements for referral to the General Assembly and **recommended** their adoption:

- Declaration of Madrid on Professionally led Regulation (revised May 2009);
- Statement on Conflict of Interest
- Revision of WMA Declaration of Ottawa on Child Health (Section 1)
- Revision of Statement of Medical Process Patents
- WMA (revised) Statement on Genetics and Medicine.

Council also **approved** section 2 of this revision to be used as a guideline for Advocacy.. Council also **approved** the Third section of the revision of the Declaration of Ottawa (revised) for publication on the WMA website, on the understanding that it was not WMA policy. Council **approved** the appointment of Ms Delorme as the WMA's nominated representative to the International Rehabilitation Council on Torture Victims, replacing Professor Nathansen whose six year term had expired.

Medico-Social Affairs Committee.

Council **approved** the following new or revised Statements and Resolutions to be forwarded with a Recommendation for **approval** by the General Assembly:

- Declaration with Guidelines for Continuous Quality Improvement in Health Care
- Revised WMA Resolution on the Medical Workforce (as amended)
- Revised Resolution on Improved Investment in Health *now entitled*
- "Improved Investing in Public Health"
- Proposed Statement on Health and Climate Change"

Finance and Planning Committee

Council noted that the Committee had received reports on Dues, the Interim unaudited Financial Statement, and an oral report on the Strategic Plan. It was also informed that the arrangements for the General Assembly in New Delhi in October 2009 and

in Vancouver 2010 had been approved and that in connection with Future Meeting Planning, invitations for the 188th General Assembly had been received from the Czech and Australian Medical Associations. It was also reported that the WMA website was being redeveloped and it was hoped that this would be launched at the meeting in New Delhi later this year..

Council also **approved** a proposal "Cooperative Relations with Academic Centres and Institutes".

World Health Assembly(WHA)

Council received a report on the agenda for the World Health Assembly of WHO and the Advocacy Advisor spoke on the logistics and the WMA activities during the WHA. the following week,

Other business

Council Resolution on Medical Neutrality

The Israel Medical Association introduced a new proposed resolution (Council 182/Resolution Medical Neutrality/May2009) reaffirming existing WMA policy. The Council made one amendment to the document and **approved** the revised resolution. (Council 182/Resolution Medical Neutrality/May2009)..

Nuclear Weapons

A report that the Japanese Medical Association (JMA) had adopted a Resolution

on the Abolition of Nuclear Weapons was supported by Council **reaffirming** WMA existing policy on Nuclear Weapons (.) The JMA also reported that it was trying to involve physicians in environmental issues

Prohibition of Physician Participation in Torture

Council also **amended and adopted** a Resolution from the Norwegian Medical Association(NMA) **revising** the WMA resolution on Prohibition of Physician Participation in Torture. (Council 182?Resolution Non-participation on Torture/May2009/Rev))

The American Medical Association(AMA) requested that copies of a letter to President Obama from the AMA be circulated to Council. This expressed its grave concern about the allegations of involvement of health personnel in torture of detainees and offered the President its assistance in ensuring that all physicians were aware of their ethical obligations and that such actions never occur under US jurisdiction.

Violence against Physicians

The Spanish Medical Association (EsMA) reported that violence against health professionals was now a major problem in Spain.

*Dr. Alan J. Rowe, Co-Editor of
the World Medical Journal*

Task Shifting On-Line Moderated Discussion

Summary of the discussion, held in May 2009

The Global Health Workforce Alliance (GHWA) is organising regularly online discussions on topics dealing with health workforce issues. The first one was on Task-Shifting in May 2009. Over a duration of nine days round about 250 experts, health

professionals and politicians from 56 countries highlighted different important themes of Task Shifting.

The discussion started with an acknowledgement of a global shortage of health

workforce, which results in unmet health care needs in many areas of the world.

However the problem lies not only in the quantity of delivered health care, it's also very important to deliver high quality of care worldwide, even in areas with a high burden of health care workers shortage. One way to achieve the high quality of care is to shift from an public health care approach only toward a patient focussed care within a

public health care system approach as well. Emphasis lies also on preventive care, health promotion and “health literacy” (which is to teaching individuals how to better take care of themselves).

Furthermore it is important to focus on capacity building and training to attract, retain and educate health professionals. The regional imbalance of capacity building leads to migration of health professionals and a lack of health professionals and specialists for certain diseases.

While implementing task shifting in the health care system much resistance is encountered. The fear in general is that task shifting leads to a downgrading of quality care and ends in two class health care. Therefore it's important to understand which type of care could be shifted?, are the health workers or new cadres qualified for this?, who is taking the responsibility and is there supervision?. Sometimes governments use task shifting and the implementation of these new cadres as short-term solutions to address the human resources in health crises in countries.

Key Summary Recommendations

1. Given the fact that task shifting could be considered when looking at solutions to human resources in health shortages, broad recommendations flowed from the discussion:
2. Planning - task shifting must be considered as only one aspect of the national health workforce and health care plan.
3. Involvement of the local level - a bottom-up approach in local level planning to ensure what is demanded is necessary and will be supported by the community.
4. Adaptability - there is no one size fits all for task shifting thus the implementation of task shifting must be determined in context - situation, resources and types of tasks to be shifted.
5. Education & Training - a minimum level of education and well-structured training programmes are necessary for a successful implementation of tasks.

6. Quality Control - standards of professionalism must be created, monitored and maintained.
7. Systems Development - task shifting should take place within a proper functioning system to ensure smooth functionality.
8. Regulations - to ensure that equity, respect, and uniformity of personhood is brought to the persons who are part of the new cadres of workers. Legal frameworks that would support task shifting must be put into place. Task shifting should not be considered cheap labour.
9. Retention - solutions must be found that will ensure that individuals remain i) not only within the health care system, but ii) within their own countries'

health care system and in iii) the areas (regional and district) where demand for services is greatest. Thus career paths must be set, incentives created and acknowledgements introduced.

More information about this topic and the report of the discussions can be found under the link <http://www.who.int/workforcealliance/en/>

Each WMA member is welcomed to participate in future GHWA online discussions. In order to get registered at the GHWA online platform please contact either Julia Seyer julia.seyer@wma.net or directly to Yann Siegenthaler at GHWA siegenthalery@who.int.

Julia Seyer, WMA Medical Advisor

Shaping the Future of Health Professionals' Regulation

2nd World Health Professions Conference on Regulation

The regulation of health professionals is emerging as one of the most topical issues among health care disciplines in the 21st century. Next February 18th, 19th 2010, the 2nd World Health Professions Conference on Regulation WHPCR 2010 will be held in Geneva, hosted by the World Health Professions Alliance and World Council of Physio Therapy.

Professions, governments and policy makers alike are devoting time, money and energy into investigating how regulation can improve comprehensive patient care and outcomes, and decrease the costs of healthcare. That is why the World Health Professions Alliance, with World Council of Physio Therapy, has taken up the task of bringing together experts in all fields of healthcare and regulatory policy at the World Health Professions Conference on Regulation WHPCR 2010.

This will be the second such conference – the first was held in May 2008 and was met with an overwhelmingly positive attend-

ance and response. Over 500 participants, representing a diverse selection of health practitioners and policy makers, were engaged in the theme “The role and future of health professions regulation”.

This time the theme will be “Shaping the future of health professionals' regulation”. It will be an opportunity for learning, knowledge exchange and multidisciplinary professional growth on an international platform, and is aimed at professional organisations, representatives of regulatory bodies, governments, along with leaders in healthcare, academia and patient groups. All conference delegates will be invited to participate in the first ever global survey designed to capture information about the regulation of health professionals. Data obtained from this survey will be presented early in the conference and be available for discussion during the professional group sessions.

Regulation is a consequence of the social contract established between professions and society representatives (i.e. govern-

ment). While the scope and practice of many healthcare professions change and will change throughout the world, so is and will be the regulation model. Regulation encompasses many aspects of the healthcare professionals' life, from their education to their activities and their entry in the profession. Each of the chosen themes will explore these aspects of regulation and how each profession may best contribute to the

constructive evolution of health professions regulation worldwide.

The objectives for the themes of WHPCR 2010 are to:

- Debate the future control and direction of health professional regulation within the context of changing scopes of practice;
- Examine the regulatory and professional issues related to the international migration of health professionals;

- Critically evaluate the relationship between health professional education, regulation and standards of practice.

The 2nd World Health Professions Conference on Regulation (WHPCR 2010) 18-19 February, 2010 Geneva. For more information on the programme and how to register, please visit www.whpa.org/whpcr2010

Julia Seyer, WMA Medical Advisor

Accessing Health Care for Undocumented Migrants - European observations

An integrated and efficient health system that provides primary, secondary and tertiary care is an essential element of a healthy and equitable society. In many parts of the world, where access to health care is limited to certain groups of the population, there is a persistence of profound inequalities in health status.

Undocumented migrants are among the most vulnerable groups in society and they occupy a position from which accessing health care is very difficult. While health care provisions are often in place for refugees and asylum seekers, undocumented migrants are repeatedly excluded from social protection plans.

Definition

Undocumented migrants are people without **any** residence permit authorising them to stay in their desired country of residence. They may have been unsuccessful in the asylum procedure, entered irregularly by evading boarder control, entered using false documentation, or overstayed their visa. In referring to this group we do not include those who have been granted refugee status nor asylum seekers who have applied for refugee status and whose requests are being processed. Asylum seekers whose application for refugee status has been denied and

whose residency is not officially tolerated are considered undocumented migrants. Irregular residency status, ineligibility to work legally, insufficient and ambiguous health care entitlements, all in combination with the constant fear of being denounced, prevent undocumented migrants from seeking health care along normal paths.

In referring to this group, the term "undocumented migrant" as opposed to "illegal migrant" or "illegal alien" is preferred. In employing this alternative terminology we avoid the negative and discriminatory stigma of "criminal" that is implied by "illegal migrant".

Pregnant women, child birth and children are particularly sensitive areas within the larger discussion of health care for undocumented migrants. While this article does not provide specific details of these issues, it recognizes that they may deserve the particular attention of the WMA and national medical associations.

Lack of Data

There is little quantitative data about this population's general health status and access to health care. There is a need for publication of data where it exists and further research where it does not. Even the number of un-

documented migrants in Europe remains at best a rough estimate. Increased publication of data, and research would prevent instances in which legislation is developed based on qualitative or anecdotal evidence.

The 2007 the Hamburg Institute of Economics was involved in a study funded by the European Commission, DG Research, under the Sixth Framework Programme, called "Clandestino: Counting the Uncountable". This project estimates that in 2005, 2.8 - 6 million undocumented immigrants resided in Europe. This number includes foreign nationals without any valid residence permit and working tourists, but excludes asylum seekers and officially tolerated persons [1].

A report by Médecins du Monde in 2007 published the findings of a survey given to 835 undocumented migrants from seven countries within Europe (Belgium, Spain, France, Greece, Italy, Portugal, and the United Kingdom). Among other findings, the most common reported health concerns were digestive, musculoskeletal, physiological and, for women, gynaecological [2]. This survey, similar to others like it, is not representative of the health status of the entire population of undocumented migrants, as participants had already made contact with a treatment center when they completed the survey.

Barriers to accessing health care for undocumented migrants vary significantly among migrant-receiving countries, as national legislation varies. Though not providing

specific details into each of these situations, this article should serve as a general introduction to the issue.

There are a number of factors that prevent undocumented migrants from seeking health care along normal paths.

Insufficient Entitlement

In the majority of migrant-receiving countries, health care entitlements for undocumented migrants are insufficient; entitlements are limited to “emergency”, “urgent”, or “immediately necessary” care [3, 4]. These concepts are poorly defined and, as a result, the provision or withholding of health care is often at the discretion of health care staff. In some instances these definitions are largely meaningless. In the case of chronically ill patients, long-term regular treatment, which might not be considered emergency care, is nonetheless vital to the patient’s health. In many instances, national law does not reflect international obligations to recognize access to health care as a basic human right.

Article 25 of the 1947 United Nations Universal Declaration of Human Rights states “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

Similarly, article 12 of the International Covenant on Economic, Social and Cultural Rights, which entered into force 1976 and which 160 parties have ratified to date, states that member states are obligated to recognize the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

According to the WHO fact sheet No.31 titled The Right to Health, “the right to health is a fundamental part of our human rights and of our understanding of a life in dignity.”

The WHO understands the Right to Health to include the following entitlements: **The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health, the right to prevention, treatment and control of diseases, access to essential medicines, maternal, child and reproductive health, equal and timely access to basic health services, the provision of health-related education and information, participation of the population in health-related decision making at the national and community levels.**

Furthermore, the WHO maintains that “**Non-discrimination** is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health” [5].

The International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, which entered into force in 2003, seeks to outline the rights of migrant workers, including those residing irregularly whose irregular status renders them natural targets of exploitation. Articles 25 and 28 speak directly to the right of health care of migrants residing irregularly. Unfortunately, while several countries of origin of migrants have ratified the convention, critical western migrant-receiving states have not. (neither the United States, Canada nor any nation of the European Union has ratified the Convention).

Sweden has been long hailed as a leader in human rights and social welfare programs. Health care access of vulnerable groups in Sweden was examined by Paul Hunt, former UN Special Rapporteur on Health, in his 2007 report “Mission to Sweden”. This report reveals some significant gaps in the Swedish health care system. In it he communicates clearly the right to health as a fundamental human right. He makes an interesting point by distinguishing human rights from citizen rights. In section 72 of his report he writes “The Special Rapporteur notes that under

international human rights law, some rights, notably the right to participate in elections, to vote and to stand for election, may be confined to citizens. However, human rights are, in principle, to be enjoyed by all persons” [6]. Health care, as it follows, is not a citizen’s right but a human right. In many countries the right to health is not enjoyed universally as it is linked to citizenship.

Often national law does not fully integrate the right to health into domestic policy. Exclusionary legislation and in other cases lack of legal entitlements limit access to secondary care for undocumented migrants.

In the UK, subsidized care to undocumented migrants is limited to emergency care. Here, when undocumented migrants are unsuccessful in registering with a GP to acquire coverage under the National Health System, they are liable for all charges for care beyond that deemed “urgent” and “immediately necessary”. In the UK a pregnant undocumented woman with HIV is not entitled to subsidized medication to reduce the risks of HIV transmission to her baby [3]. In the UK all undocumented migrants are liable for the full charge of ARV treatment. Undocumented migrants, as a population, when left unable to access subsidized health care, pose a risk to public health.

Lack of Health Literacy

There is significant lack of awareness and understanding of health care entitlements of undocumented migrants on the part of both health care professionals and undocumented migrants themselves. This concept can be referred to as Health Literacy. Even in situations where legal entitlements to subsidized care do exist, a lack of awareness and understanding of entitlements and other administrative barriers inhibit the realization of those entitlements.

In France undocumented migrants are theoretically entitled to State Medical Assistance (Aide Médicale de l’Etat – AME) which entitles them to all kinds of free

health care. However, according to a report released by Médecins du Monde in 2005, this right is rarely realized [7]. Undocumented migrants often do not know they have the right to health care and when they do, sometimes have difficulty meeting administrative requirements. Among other documents, applicants for AME coverage are required to provide a valid identity card (passport, birth certificate, national ID card) and proof of residency in France (even if irregular) for more than three months. Both requirements can prevent undocumented migrants from accessing healthcare.

In Germany providing assistance to undocumented migrants for financial gain can be criminalised under the “penalization of assistance” regulation and some public institutions have the “duty to denounce” when they interact with undocumented migrants. While medical professionals are exempt from both these regulations, a report by NGO PICUM suggests that the mere existence of these laws creates an atmosphere of distrust that further discourages undocumented migrants from seeking out the healthcare they may be entitled to [3].

Ethical perspective versus political perspective?

The WMA Declaration of Geneva - International Code of Medical Ethics, adopted in 1949 by the World Medical Association during its 3rd General Assembly, outlines a physician's ethical obligation to the patient. The Lisbon Declaration, adopted by the 34th World Medical Assembly in 1981, outlines the rights of the patient. Within the Lisbon Declaration, Principle 1 - Right to Medical Care of Good Quality specifies that “every person is entitled without discrimination to appropriate medical care.” The Lisbon Declaration further specifies that “whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.”

From some perspectives this clause could be applied to the professional ethical dilemma physicians face as they treat undocumented migrants. National regulations may indicate that as a result of his or her status a patient is not entitled to a particular form of care. Physicians, however, have the responsibility to provide unbiased evaluation of patient health and treatment. Once a patient's status becomes known, physicians may have to interpret ambiguous health policy to determine whether care will be covered. In cases where patients are liable for all charges, physicians may need to decide whether he or she will give care to someone who may be not legally entitled to it. In situations where undocumented migrants have no entitlements to healthcare beyond that which is “emergency” in nature, physicians who agree to give care to undocumented migrants may receive no remuneration. Such regulations attempt to force physicians to compromise their ethical obligation to give treatment on a non discriminatory basis.

The protection of the physician, therefore, deserves the particular attention of the WMA. Individual physicians and hospitals who treat undocumented migrants should not be perceived as taking a political stance, nor seen as acting in discordance with national regulations as they carry out their ethical obligations to provide care.

In many countries access to state subsidized health care is linked to legal residency status. In some nations there is a trend to strengthen this link as a method of immigration control. Denying undocumented migrants access to health care becomes a punitive measure; a method of deterring future irregular immigration and encouraging those who are residing irregularly to leave. There is debate surrounding not only the ethics of this trend, but also the notion of health care as a “pull factor”. What role does access to healthcare have in the decision-making process of migrants? There is fear that equal access to health care for undocumented migrants would trigger a wave of irregular

immigration that would overwhelm western health care systems. Non governmental organization PICUM argues that the belief in health care as a “pull factor” is poorly substantiated [8, 9].

It is the opinion of some that immigration policy should be kept entirely separate from health care. According to Dr. Henry Ascher of the Nordic School of Public Health based in Sweden, it is inappropriate for doctors to function as part of the immigration control system. He illustrated his point with the example of a physician working in an emergency ward giving treatment to a group of young people who have been injured following a street gang fight. It is not the physician's role to make judgments in regard to which of his or her patients acted as aggressors and which were victims in the fight, and then proceed to give care based on these judgements. These judgments are the responsibility of the justice system. The physician should proceed by administering treatment based on severity of the condition. Similarly, requiring physicians to consider the residency status of patients forces physicians to assume a role that is not theirs and asks them to compromise their ethical obligations to the patient.

Dr. Ascher stresses the importance of preserving public trust in health care providers. Just as the public should have trust in the justice system to defend the right to representation and a fair trial, patients should have security in knowing that doctors will evaluate their condition and administer appropriate treatment based on no consideration beyond that of their health status.

A role for the WMA

The World Medical Association could play a key role in identifying the role of national medical associations in addressing access to health care of undocumented migrants. The WMA could encourage medical associations to support physicians as they honour their ethical obligations to patients. In conformity with WMA policy, this would

demonstrate WMA's dedication to reduce health inequality through the development of integrated and non-exclusionary health care systems around the world.

WMA survey

The WMA recently created and sent a survey to member medical associations that looked into undocumented migrant access to health care. Among the 18 participating medical associations, 12 are within the European Union. 70% reported they were aware that undocumented migrants were experiencing difficulty in accessing health-care and 50% reported that they had taken some form of action to address the issue. These initiatives vary in nature and scale. 82% reported that they considered insufficient entitlements and lack of health liter-

acy as barriers that prevent undocumented migrants from accessing care.

References

1. Hamburg Institute of International Economics, Database on Irregular Migration, <http://irregular-migration.hwwi.net/Europe.5248.0.html>
2. Médecins du Monde European Observatory on Access to Health Care, European survey on undocumented migrants access to health care, 2007, available at <http://www.mdm-international.org/IMG/pdf/rapportobservatoireenglish.pdf>
3. PICUM (Platform for International Cooperation for Undocumented Migrants), Access to Health Care for Undocumented Migrants in Europe, 2007, available at <http://www.picum.org/data/Undocumented%20Children%20in%20Europe%20EN.pdf>
4. Averroes Project, Health for Undocumented Migrants and Asylum Seekers Network, <http://www.huma-network.org>
5. UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31, The Right to Health*,

June 2008, No. 31, available at: <http://www.unhcr.org/refworld/docid/48625a742.html>

6. Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health "Mission to Sweden", 2008, available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/sweden.pdf

7. Médecins du Monde, Rapport 2005 de l'observatoire de l'Accès aux Soins de la Mission France de Médecins du Monde, 2005, available at http://www.medecinsdumonde.org/thematiques/l_observatoire_de_l_acces_aux_soins

8. Robinson. V and Segrott.J, Understanding the decision making of asylum seekers, Home office Research Study, Home office Research, Development, and Statistics Directorate, 2002, available at <http://www.homeoffice.gov.uk/rds/pdfs2/r172.pdf>

9. Albrecht, H.J Fortress Europe? Controlling illegal immigration, European Journal of Crime, Criminal Law and Criminal Justice, Volume 10, Number 1, 2002, pp. 1-22(22); 2002.

Lauren Storwick, WMA Secretariat

Bringing Fair Trade to Health Systems: What You Can Do



Olivia Roberts

Most people would not knowingly buy goods produced by children in dangerous conditions, earning less than US \$2 a day. Yet unfair and unethical working conditions are behind the supply of some medical products and services to health systems throughout the world.

An article in the British Medical Journal in August 2006 reported concerns in the manufacture and supply of surgical instruments from Sialkot, northern Pakistan, to



Mahmood Bhutta

healthcare markets in the developed world. The 50,000 skilled manual labourers who manufacture instruments in Sialkot typically earn less than US \$2 per day, have no secure income, and are exposed to a wide variety of occupational hazards. Furthermore, there are an estimated 5,800 children employed in the industry, mostly working full-time, and some as young as seven years old. Research by Swedish NGO, Swedwatch, confirmed these problems in supply chains to health systems in Europe and the United States.



Eva Nilsson Bågenholm

Surgical instrument manufacture is not the only industry where labour abuses are a concern. Research has also identified problems in the production of textiles for healthcare from India and Pakistan. A risk assessment by the Ethical Trading Initiative suggests that a significant number of goods and services for healthcare are at risk of abuse of labour standards, and one report identified a number of medical products manufactured in South and South-East Asia that may be subject to unethical trade practices.

Talking to suppliers to the UK and Sweden, we know that their products end up in hospitals and clinics around the world. As these are global supply chains, with manufacturers supplying multiple markets, it is reasonable to assume that the same products supply markets in the rest of Europe, the United States, Canada, Australasia and other regions and countries.

So what does this mean for medical associations? The British Medical Association (BMA) has been working closely with partners to investigate and address these issues. The BMA formed the Medical Fair and

Ethical Trade Group (MFETG), which is an independent group with membership from fair trade groups, industry associations and government bodies. The MFET Group is coordinated by the BMA International Department and the promotion of fair trade in healthcare goods is a key objective for the BMA's work on improving global health.

The Group aims to promote fair and ethical trade in the manufacture and supply of medical commodities. Recent successes include a code of conduct for all major suppliers of healthcare goods to the UK, and the development of guidance by the NHS Purchasing and Supply Agency - the group responsible for national purchasing decisions. These tools enable the UK health system to question suppliers about whether they have adhered to basic labour rights in the production and supply of their goods. The British Medical Association will be engaging with its members and other health professionals to help them learn to ask the right questions and bring change to these industries. Another exciting effort is supporting the development of product lines that may represent especially good practice in fair and ethical trade, including fair trade and environmentally friendly rubber for surgical gloves, and fair trade cotton for healthcare textiles.

In Sweden, the three largest authorities for health care have jointly produced a Code of Conduct for fundamental social responsibility in procurement contracts with suppliers, and there are plans to make the Code apply nationally in the near future. Recently signed contracts will be monitored annually, and suppliers asked how they comply with the contract. If problems are discovered, further steps include requesting the supplier to contact the producing factory or to undertake independent audits to assess labour conditions.

Both the guidance in England and the Swedish Code of Conduct contain the following points as key principles of developing fair and ethical trade:

- Suppliers shall respect principles of fundamental social responsibility in business deals.
- All products shall be produced according to ILO and UN fundamental labour conventions and shall be related to health and safety legislation in the manufacturing country.
- Discrimination, forced labour or child labour must not occur.
- Wages shall be paid as agreed directly to workers.
- Remuneration must not be below national statutory minimum wage.
- Weekly working hours must not exceed legal limit and overtime is to be paid for.
- Working environment shall correspond to international guidelines.

When combined, the policies in the UK and Sweden have the potential to affect billions of dollars of health service contracts per year. However, this is still only a small percentage of healthcare expenditure: the UK and Sweden together account for only 7% of hundreds of billions of dollars global purchasing of medical devices. If guidance and policies were developed in other countries throughout the world, the impact could be much more significant. But this will only happen if key partners work together, and with suppliers, to identify problems and fix them.

We are now working with other medical associations in Europe and recommend the following actions for all medical associations:

- Contact the British Medical Association for advice (email fairtrade@bma.org.uk).
- Contact your members about this issue to get their support.
- Contact your national health service purchasing agency or regional body to ask them to engage on this issue.
- Contact your local industry association and ask them about their supply chains.

We need you to join us to mobilise health professionals throughout the world to insist

that their health system treats the world fairly.

References

1. British Medical Association [homepage on the Internet] [cited 2009 September 11]. Available from: www.bma.org.uk/fairtrade
2. Bhutta MF. Fair trade for surgical instruments. British Medical Journal [serial on the Internet] [cited 2009 September 11]. Available from: http://www.bmj.com/cgi/pdf_extract/333/7562/297?rss=
3. Impactt - supply chain strategy organisation [homepage on the Internet] [cited 2009 September 11]. Available from: <http://www.impacttlimited.com/2008/12/09/nhs-pasa-publish-%E2%80%98ethical-procurement-for-health%E2%80%99-to-develop-ethical-trade-for-health-supplies/>
4. Ethical procurement for health guidance. NHS [homepage on the Internet] [cited 2009 September 11]. Available from: <http://www.pasa.nhs.uk/PASAWeb/NHSprocurement/Sustainabledevelopment/Ethicalprocurement/>
5. Purchasing and Supply Agency Sustainability reports. NHS [homepage on the Internet] [cited 2009 September 11]. Available from: <http://www.pasa.nhs.uk/PASAWeb/NHSprocurement/Sustainabledevelopment/>
6. Bjurling K. The dark side of healthcare. 2007. Swedwatch [homepage on the Internet] [cited 2009 September 11]. Available from: http://www.swedwatch.org/swedwatch/in_english/reports
7. The Stockholm County Council, Västra Götaland Region and Region Skåne. Sustainable procurement [homepage on the Internet] [cited 2009 September 11]. Available from: http://www.skane.se/upload/Webbplatser/MASkane/Dokument/Socialt_ansvar_Hallbar_upph_en.pdf
8. Department of Health. K Global Health Strategy 2008-13 [homepage on the Internet] [cited 2009 September 11]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702

*Olivia Roberts,
British Medical Association
Dr. Mahmood Bhutta,
Medical Fair and Ethical Trade Group
Dr. Eva Nilsson Bågenholm,
Swedish Medical Association*

The Second Geneva Conference on Person-centred Medicine

The 2nd Geneva Conference on Person-centred Medicine in May 2009 followed the inaugural Geneva Conference of May 2008, both as landmarks in a process of building an initiative on medicine for the person through collaboration of major global medical and health organizations and a growing group of committed individuals.

The Conference took place on 28 and 29 May 2009 under the auspices of the University of Geneva Medical School and the University Hospitals of Geneva organized by the World Medical Association (WMA), the World Organization of Family Doctors (Wonca), and the International Network for Person-centred Medicine, in collaboration with the Council for International Organizations of Medical Sciences (CIOMS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the World Association for Sexual Health (WAS), the International Association of Medical Colleges (IAOMC), the World Federation for Medical Education (WFME), the International Federation of Social Workers (IFSW), the International Council of Nurses (ICN), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the International Alliance of Patients' Organizations (IAPO), and the Paul Tournier Association. The editor-in-chief of the World Medical

Journal was in attendance and invited the preparation of this report.

The Conference had as its aims: to examine and discuss key concepts of person-centred medicine and practical approaches for its implementation, to elicit useful initiatives on person-centred medicine, and to engage international medical and health organizations on the Conference's theme.

The Conference Core Organizing Committee was composed of J.E. Mezzich (World Psychiatric Association President 2005-2008), J. Snaedal (World Medical Association President 2007-2008), C. Van Weel (World Organization of Family Doctors President 2007-2010), and I. Heath (World Organization of Family Doctors Executive Committee Member at Large). The Conference Secretariat was based at the International Centre for Mental Health, Mount Sinai School of Medicine, Fifth Ave & 100th Street, Box 1093, New York, New York 10029-6574, USA.

Financial or in-kind support for the Conference was provided by the University of Geneva, the Paul Tournier Association of Geneva, Person-centred Medicine & Psychiatry Programs, Conference registration fees, and the International Network for Person-centred Medicine.

The Conference was opened by the Rector of the University of Geneva and the Vice-Dean of its Medical School, as well as by the members of the Conference Core Organizing Committee. All remarked on the tradition that was emerging engaging Geneva as encounter point for the development of person-centred medicine.

The 1st scientific session involved presentations of leaders and representatives of the International Alliance of Patients' Organizations, the International Network for Person-centred Medicine, the World Health Organization, the World Medical Association, the World Organization of Family Doctors, the Council of International Organizations of Medical Sciences, and the International Council of Nurses. The presentation of policy statements and relevant institutional programs reflected the value ascribed by these organizations to person-centred medicine. Details on the presentations made in this session and the following sessions can be found in the abstracts presented at the SGCPM Report at www.personcenteredmedicine.org.

Eight special initiatives relevant to person-centred care were presented in the 2nd session. The presentations were made by representatives of several major organizations collaborating in the Second Geneva Conference and other prominent work groups. The diverse experiences presented from a range of fields revealed a number of substantive achievements and promising opportunities for a medicine of the person.

Concepts and meanings of person-centred medicine were the subject of the 3rd session. They focused on the role and worth of the person in medicine, the cruciality of a sense of identity, empathy and engagement for optimal clinical care, and the value and impact of life experiences for the development in each individual of personalized medicine and health.

The 4th session presented and discussed procedures for person-centred diagnosis.



Particularly covered were the significance of multilevel explanations and diagnosis in medicine, the key features of a person-centred integrative diagnosis addressed to appraise whole health using standardized and narrative descriptions reflecting interactions among clinicians, patient and family, as well as the prospects for person-centred diagnosis in general medicine.

A panel on programmatic contributions for person-centred medicine in a 5th session offered an opportunity for the presentation of brief statements by representatives of the twelve collaborating organizations and groups from across the world. They attested to the relevance of person-centred approaches to medicine for an ample range of medical, health and social institutions.

The 6th session, at the beginning of the second day of the Conference, discussed procedures for person-centred treatment and health promotion. These included general features of person-centred integrative care, the prospects for a person-centred *medical home* in the United States, and WHO perspectives on person-centred healthiness, social determinants, and health promotion.

Person-centred medicine for children and older people was discussed in the 7th session of the Conference. Such vulnerable populations represent particular challenges and opportunities from scientific and ethical viewpoints. The uniqueness and developmental sensitivity of the child were highlighted. Also pointed out were the complexity of health conditions in older people and the imperative need to attend to their values and perspectives.

Training and research on person-centred medicine was the subject of the 8th session. Specific topics included the development of pertinent guidelines and curricula for person-centred clinical care, the assessment of an epistemologically based person-centred medicine at Ambrosiana University in Milan, training and research on commu-

nication for person-centred outcomes, and broad programmatic features and objectives of research on person-centred clinical care.

The 9th session of the Conference reviewed person-centred health systems and policies. WHO's new focus on persons for the development of more promising global health policies and systems, as affirmed by the latest World Health Assembly, was given pointed attention. Also discussed was the role of health informatics for the construction of personalized medicine and complex health care systems. Last but not least was a review of the role and documented value of the person for the conduction of health care, training and research

The final 10th session presented a conference summary and outlined next steps. Among the general conclusions were:

- a commitment to the importance of person-centred medicine for the health of people, noting the participation of a vast array of important medical and health organizations, a wish to share and collaborate, and an understanding of the importance of grasping opportunities;
- the growing availability of resources, including general concepts and procedures as well as teaching materials and research tools;
- the importance of fitting the above resources into health care systems and into particular health care encounters, with particular attention to person-centredness as an intrinsic quality rather than as an additional commodity, and the value of comprehensiveness, continuity, and attention to context as crucial features of good clinical care.

Proposals for future conferences included the need to build bridges to the various specialties in medicine, the participation of different patient groups, and the inclusion of representatives of additional health disciplines. Emphasis was made on consolidating the ideas from the first two conferences, and to use that for further work to enhance person-centred medicine.

Anticipated next steps include the following:

- Completion of a joint editorial to be published in a wide circulation international journal.
- Preparation of a 2nd Geneva Conference Summary Report.
- Publication of a monograph containing the papers presented at the 2nd Geneva Conference.
- Collaboration with WHO on Person-centred Medicine topics related to the 2009 World Health Assembly Resolutions.
- Organization of scientific events relevant to person-centred medicine, such as a prospective New York Conference on Well-Being and Person in Medicine and Health.
- Organization of a 3rd Geneva Conference on Person Centred-Medicine in early May 2010, prospectively focused on a team approach across specialties and disciplines.
- Establishment of a clearinghouse of Person-centred Medicine documents.
- Upgrading an internet platform to support our archival, informational, communicational, and programmatic needs.
- Development of an International Network for Person-centred Medicine to stimulate the above activities and to organize initiatives on conceptual and ethical bases, diagnosis, clinical care, training, research, health systems, and public policies.

The 2nd Geneva Conference was distinctly perceived by its participants as a stimulating success in terms of food for thought and shared commitment to build a paradigmatic shift in medicine and health care. A 3rd Geneva Conference is widely anticipated as the next landmark in this unfolding process with the emerging International Network for Person-centred Medicine as the collaborative and flexible structure to co-ordinate and move forward our vision and programmatic efforts.

Juan E. Mezzich
WPA President 2005-2008

Person Centred Pediatric Care



James Appleyard

Each child is a unique individual. Each child is conceived within and delivered from their mother. Each child is influenced uniquely by their father, the wider family, the culture of the local community and the nation state. The infant grows and develops through childhood and adolescence into an adult within five areas - mentally, physically, intellectually emotionally and spiritually. In those children nurtured in an environment of love, joy and peace, their spiritual dimension will widen. They are more likely to survive the journey to adulthood and the significantly different physiological, psychological and pathogenic features which occur at the different ages.

The paper looks at how this person centred paradigm effects the individual child and the community in which he or she lives and the harmful consequences of "depersonalization". At first thought such a paradigm seems vague and without much scientific credibility.

But in a comparative study by Cigdem Kagitcibasi and colleagues, the motivations for child rearing by 20,000 parents from 9 countries were assessed as "valuable" in three domains - economic, social and psychological [1]:

- the "**economic**" reason which involved the material benefits that children may bring both when they are children and when they grow up, to be a security in old age;
- the "**Social**" reasons which are related to the general social acceptance that normal adults are given when they have children, and the desire for continuation of the family;
- the "**Psychological**" intention for the fulfilment of children - with love, joy, pride and companionship.

In those countries whose mothers viewed their children to fulfil their own individual potential with love, joy pride and companionship had the best child survival rates

Poverty breeds disease and disease causes poverty. Disease in just one family member may have disastrous effects on the children through loss of care and reduced family in-

come, causing older children to leave school to support the family. The tragedy of the AIDS orphans is all too apparent in Africa.

Poor families compensate for children's deaths by having a large number of children, with the expectation that sufficient will survive to care for the parents in their old age. Large families simply cannot afford education and health care for each child. Conversely reduction in mortality can be a spur to reducing fertility rates. The evidence linking fertility levels to infants under the age of 1 yr and child mortality under 5 is powerful. Countries who have infant mortality rates of less than 20 have an average total fertility rate of 1.7 children. In countries which have infant mortality rates of over 100 have an average total fertility rate of 6.2. children. When children are valued in their own right rather than for utilitarian purposes, family size is smaller. This demonstrates the importance given to each individual child on the survival of the community

The mother's education is clearly another important factor but one which is also associated with the family's increased earning capacity. The clear message is that looking after children means less and not more mouths to feed, better education, healthier adults and improved economic progress

Yet UNICEF's statistics reveal that some 10 million children worldwide are not adequately cared for [2]. They die under the age of 5 years, mainly unnecessarily, from treatable illnesses and from lack of local, national and international will to recognise the importance of each child as an individual person

At international level the overwhelming majority of countries have signed up to Article 24 of the 1989 United Nations Convention on the Rights of the Child. This recognises the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, and states that



nations shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Health care systems tend to respond by identifying and measuring some measurable constituent parts of a child's problem at the expense of the child as a whole person whose complex needs interact – the whole child being more than the sum of the individual components. What counts for each child may not be counted and what is counted may not count.

This reductionist approach has fostered the move towards greater specialisation and the relative deskilling in primary care at which level it is practical to look at a child in the family and community setting.

A target culture has grown up in the understandably cost conscious management environment of most health care providers, where individual episodes of care are measured in isolation of a child's overall needs. The overall costs to the child, the family and the local community are not measured. What appears to be a "saving" may shift the cost to another sector and create an even greater burden for the family

This culture of isolated short episodes of care has had an effect, that of the physicians working "shifts" within the health provider system. The concept of any continuing duty of care by the physicians towards their child patient is vanishing.

At individual level such professional care for a child is crucial – the child must be treated as a person. This is only possible when the attending physician is an independent professional and inspires trust.

A profession is defined as "a vocation in which knowledge of some department of science or learning", or "the practice of an art founded upon it is used in the service of others" [3].

A profession is characterized as having a code of ethics reflecting the integrity and morality of its members, a complex body of knowledge which should be used altruistically in the service of others as an autonomous professional person yet accountable to a professional association and through the code of ethics to society in general.

The code of ethics from the time of Hippocrates that should govern the behaviour of members of the medical profession is based, in my opinion [4], on seven principles:

1. The prime importance of the person seeking help from a physician – patients and their individual autonomy;
2. Beneficence – to do good and act in their best interests;
3. Non maleficence – to limit any harm;
4. Fidelity – the duty of care;
5. Truthfulness – the need for transparency;
6. Confidentiality – it is essential to keep the patients "secrets";
7. Justice – to be fair to all.

These principles need to be inscribed into the conscience of the physician as part of the medical ethical culture [5]. They provide the ethical "compass" to navigate through the complex issues that confront physicians throughout their professional lives.

A physician's personal ethics and his integrity – his conscience – form the most important and safest resource in medical practice worldwide. It is the basis of the trust between the physician and his or her patient.

That is what makes the art of medicine so challenging and at the same time rewarding. There is no one right answer. Just the right answer, based on the best judgment for the individual.

Within the medical care of children, it is the child who is the person central to the physician's attention.

The World Medical Association's current Declaration of Ottawa (1998) provides an important ethical framework [6].

It states:

"The health care of a child, whether at home or in hospital, includes medical, emotional, social and financial aspects which interact in the healing process and which require special attention to the rights of the child as a patient".

"The wishes of each child need be taken into account in any clinical decision. These wishes should be given increasing weight dependant on her/his capacity of understanding. The mature child, in the judgment of the physician, is entitled to make her/his own decisions about health care."

From this person centred paradigm, as Stafford Beer's work in the field of cybernetics has illustrated, a viable system model can be constructed so that knowledge sharing and decision making can evolve without hierarchical control [7] to further the best interests of each child in every community.

References

1. Kagitcibasi C. The value of children: a key to gender issues. *Int Child Health*. 1998; 9: 15-24.
2. The United Nations Children's Fund. The state of the world's children 2007. UNICEF, 2006.
3. The shorter Oxford English dictionary. 3rd ed. Oxford: Oxford University Press, 1944.
4. Appleyard WJ. 'Professionalism' Icelandic Medical Association. Laeknaping, 2004.
5. Vikstrom J. 'Service of humanity' Pro humanitate. Finnish Medical Association, 2000.
6. World Medical Association Declaration of Ottawa on the rights of the child to health care. Ottawa, 1998.
7. Kawalek P. Athenaeum Forum Exchange, 2009.

*James Appleyard MD FRCP FRCPCH
Children's Physician
Past President, WMA.*

The International Network for Person-centred Medicine:

Background and First Steps



Juan Mezzich



Jon Snaedal



Chris van Weel



Iona Heath

The earliest roots of person-centred medicine can be found in ancient civilizations, both Eastern (such as Chinese and Ayurvedic) and Western (particularly ancient Greek), which tended to conceptualize health broadly and holistically. This notion is reflected in the encompassing definition of health inscribed in the constitution of the World Health Organization (WHO, 1946). Also noticeable in medical traditions from those early civilizations is a personalized approach to health care.

The modern development of medicine has, however, neglected the above considerations and privileged conceptual reductionism, paid absorbed attention to disease, super specialization and fragmentation of services as well as commoditization and commercialism in the field. This has interfered with attentiveness to the whole person and his/her ill- and positive-health as the natural focus of medical science and practice and to the ethical imperatives connected to promoting the autonomy, responsibility, and dignity of every person involved.

Endeavors to refocus medicine on the person of the patient, the clinician and the members of the community at large have

been distinctly noted in the past century. Illustratively, Paul Tournier, a Swiss general practitioner discovered the transformational value of critical interpersonal experiences and of attending to the whole person and the biological, psychological, social and spiritual aspects of health. He presented his vision on *Medicine de la Personne* (Tournier, 1940) and 19 other books translated to over 20 languages. Around the same time, American psychologist Carl Rogers demonstrated the significance of open communication and of empowering for individuals to achieve their full potential (Rogers, 1961) and proceeded to develop a *person-centred approach* to therapy, counseling and education.

During the second half of the 20th Century, Frans Huygen in the Netherlands, Ian McWhinney in the UK and Canada, and Jack Medalie in the United States and Israel struggled with the ongoing limitations of modern medicine noted above and committed themselves to promote a broad and contextualized understanding of health with high concern for their patients' well-being. They went on to develop a generalist medical specialty under the terms of general practice and family medicine (Huygens, 1978; McWhinney, 1989), which has char-

acteristically focused on *patient-centred care*. Sustained efforts to establish a person-centred medicine program on epistemological grounds and to build a corresponding medical school and clinical teaching method have been undertaken by Giuseppe Brera (1992), rector of Ambrosiana University in Milan.

Another inspirational medical figure has been Finn psychiatrist Yrjö Alanen, who engaged patients by paying careful attention to the meaning of their experiences and the nature and significance of their needs, and artfully combined pharmacological and psychosocial therapeutic techniques. His *need-adaptive assessment and treatment* approach (Alanen, 1997) has impressed not only professional colleagues but even critical patient groups.

Noteworthy too are the emerging responses from a number of global medical and health organizations. The World Health Organization, which incorporated in its constitution the above mentioned comprehensive definition of health, has recently introduced the term *dynamic, meaning interactive*, to characterize the relationship among dimensions of well-being and has started discussions on the possibility of adding a spirituality dimension. Furthermore, for the first time WHO is placing people/person at the center of healthcare and public health, as reflected on the resolutions of the World Health Organization's 2009 World Health Assembly.

Linked to person-centred care perspectives is an ethical frame of reference that

seeks to assure equal opportunities for all, particularly in terms of access to care, with an emphasis on the rights of individuals in need of health care (www.wma.net/policy). The triad of caring, ethics, and science are reaffirmed as the enduring traditions of the medical profession (Coble, 2005). The physicians' obligation to respect human life rather than to extend it blindly has been cogently argued (Snaedal, 2007). This has been incorporated by the World Medical Association (WMA) into the Declaration of Helsinki for Medical Research and the International Code of Medical Ethics (www.wma.net/press_releases).

The renaissance of family medicine after the Second World War was informed by holistic perspectives which grounded the role of the general practitioner/family physician in an integrated approach to the care of patients and their families in the context of a specific local community (McWhinney, 1989). The World Organization of Family Doctors (Wonca) has recorded its commitment to persons and community in its basic concepts and values – continuity of care, care for all health problems in all patients within a societal context (www.woncaeurope.org).

The tension between the disease and the person experiencing the disease is particularly tangible in mental health care. In fact, as documented by Garrabe (2008), the beginnings of the World Psychiatric Association (WPA) in 1950 already revealed interest on the concept of the person as central to the field. That interest evolved to the point that in 2005 the WPA General Assembly established an Institutional Program on Psychiatry for the Person. This program sought to articulate science and humanism to promote a psychiatry of the person, *for* the person, *by* the person, and *with* the person (Mezzich, 2007). Among its signal conferences were those organized in London (October 2007) in collaboration with the UK Department of Health and in Paris (February, 2008) in cooperation with the WPA French Member Societies. In addition to a number of

journal papers, monographs have been prepared on the Conceptual Bases of Psychiatry for the Person (Mezzich, Christodoulou & Fulford, in press) and on Psychiatric Diagnosis: Challenges and Prospects (Salloum & Mezzich, 2009).

Geneva Conferences on Person-centred Medicine

The Geneva Conferences on Person-centred Medicine took place at the Geneva University Hospitals on May 29–30, 2008 and May 28–29, 2009 as landmarks in a process of building an initiative on medicine for the person through the collaboration of major global medical and health organizations and a growing group of committed individuals. The institutions formally involved in either or both Conferences included the World Medical Association (WMA), the World Organization of Family Doctors (Wonca), the WPA Institutional Program on Psychiatry for the Person (IPPP), the International Network for Person-centred Medicine, the Council for International Organizations of Medical Sciences (CIOMS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the World Association for Sexual Health (WAS), the International Association of Medical Colleges (IAOMC), the World Federation for Medical Education (WFME), the International Federation of Social Workers (IFSW), the International Council of Nurses (ICN), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the International Alliance of Patients' Organizations (IAPO), the University of Geneva School of Medicine, and the Paul Tournier Association.

The 1st Geneva Conference on Person-centred Medicine was aimed at presenting and discussing the experience on person-centred principles and procedures gained through a Person-centred Psychiatry Program, exploring the conceptual bases of person-centred medicine, and engaging interactively major

international medical and health organizations. It included sessions on international organization perspectives on person-centred medicine, related special initiatives, conceptual bases of person-centred medicine, personal identity, experience and meaning in health, a review of Paul Tournier's vision and contributions, person-centred health domains, clinical care organization, person-centred care in critical areas, and person-centred public health. The upgraded papers presented at the Conference are being published as a supplement of the International Journal of Integrated Care (Mezzich, Snaedal, van Weel & Heath, in press)

The 2nd Geneva Conference was aimed at probing further key concepts of person-centred medicine and reviewing a number of practical approaches for the implementation of this approach through a collaborative effort with an enlarged number of international health organizations. Through nine sessions, it covered institutional perspectives and activities on person-centred medicine, other relevant initiatives, concepts and meanings of person-centred medicine, procedures for diagnosis, treatment and health promotion in medicine for the person, person-centred medicine for children and older people, as well as training, research, health systems and policies on person-centred medicine. Among the conference conclusions were a wide commitment to the importance of person-centred medicine for the health of persons and populations, clarification of the availability of conceptual, educational and research tools, and the need to fit these into health encounters and systems, affirming person-centredness as an intrinsic quality rather than an additional commodity. There was consensus on organizing a 3rd Geneva Conference where emphasis would be placed on building further bridges to the specialized sphere of medicine, other health professions, and various patient groups. Among additional next steps are the organization of relevant scientific events such as a New York Conference on Well-Being and the Person, publication of a joint edito-

rial in an international journal, preparing a monograph with the papers presented at the Second Geneva Conference, responding positively to requests from WHO for collaboration on people-centred care strategies adopted by the 2009 World Health Assembly, and further development of the International Network for Person-centred Medicine to help move forward collaboratively an optimized vision for health care.

Constructing the International Network for Person-centred Medicine

The International Network for Person-centred Medicine (INPCM) is a non-for-profit educational, research, and advocacy organization emerging from the above outlined Geneva Conferences process and aimed at developing opportunities for a fundamental re-examination of medicine and health care to refocus the field on genuinely person-centred care.

Person-centred medicine is dedicated to the promotion of health as a state of physical, mental, social and spiritual wellbeing as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person. To this effect, the INPCM seeks to articulate science and humanism in a balanced manner, engaging them at the service of the person. The purposes of the INPCM may be further summarized as promoting a medicine *of* the person (of the totality of the person's health, including its ill and positive aspects), *for* the person (promoting the fulfillment of the person's life project), *by* the person (with clinicians extending themselves as full human beings with high ethical aspirations), and *with* the person (working respectfully, in collaboration, and in an empowering manner).

The expected INPCM activities include the following:

- Organization of conferences and other scientific meetings promoting person-centred care in medicine at large and in

its various specialties and related health fields;

- Preparation of person-centred clinical practice guidelines relevant to diagnosis, treatment, prevention, rehabilitation and health promotion;
- Preparation of educational programs, including curricula, aimed at the training of health professionals on person-centred care;
- Conduction of studies and research projects to explore and validate person-centred care concepts and procedures;
- Preparation of publications to disseminate and advance the principles and practice of person-centred medicine;
- Development of advocacy forums and activities to extend and strengthen person-centred medicine with the participation of clinicians, patients and families, as well as members of the community at large;
- Establishment of an internet platform to support archival, informational, communicational, and programmatic efforts on person-centred medicine.

All organizations and individuals who have participated actively in relevant programmatic activities, such as the Geneva Conferences, will be invited to participate in the INPCM. It will be organizationally developed and guided initially by a board of five to eight persons with a clear track record of work on person-centred medicine and who are committed to the promotion of the fundamental purposes of the organization. Additional structures to be considered are an advisory council (composed of eminent experts and representatives of major collaborating organizations) and an operational council (composed of leaders of emerging INPCM Programs, i.e., conceptual and ethical bases, diagnosis, clinical care, training, research, health systems, and public policies).

Support for the INPCM and its activities is expected to come, as it has been for its initial steps, from academic institutions, professional societies, governmental organiza-

tions, foundations, person-centred medicine and psychiatry non-profit program funds, and conference registration fees. Any support from industry sources will be accepted provided it is transparent and unrestricted.

Further information on the INPCM can be obtained at www.personcenteredmedicine.org.

Colophon

Early scientific and ethical efforts coalesced through the First and Second Geneva Conferences, and are finding fruition in the International Network for Person-centred Medicine. Encouragement is afforded by the wide array of collaborating organizations, the scholarly dedication of committed individuals, and the conviction that the greatest asset of any community is its capacity to organize itself.

References

1. Alanan YO. Schizophrenia: its origins and need-adaptive treatment. London: Karnak, 1997.
2. Brera GR. Epistemological aspects of medical science. *Medicine and mind*, 7: 5-12, 1992.
3. Coble Y, ed. *Caring Physicians of the world*. World Medical Association, Ferney-Voltaire, France, 2005.
4. Garrabe J. Historical views on psychiatry for the person. Paris Conference on Person-centered psychiatry; World Psychiatric Association, French Member Societies Association, 2008 Feb. 6-8.
5. Huygen FJA. *Family medicine, the medical life history of families*. New York: Brunner Mazel, 1982.
6. McWhinney IR. *A textbook of family medicine*. Oxford: Oxford University Press, 1989.
7. Mezzich JE. Psychiatry for the person: articulating medicine's science and humanism. *World Psychiatry*. 2007; 6: 1-3.
8. Mezzich JE, Christodoulou G, Fulford KWM, editors. *Conceptual bases of psychiatry for the person*. Psychopathology. In press.

9. Mezzich JE, Snaedal J, van Weel C, Heath I, editors. Conceptual explorations on person-centered medicine. International Journal of Integrated Care. In press.
10. Rogers CR. On becoming a person: a therapist's view of psychotherapy. Boston: Houghton Mifflin, 1961.
11. Salloum IM, Mezzich JE, editors. Psychiatric diagnosis: challenges and prospects. Chichester, UK: Wiley-Blackwell, 2009.
12. Snaedal J. Presidential Address. World Medical Journal, 2007; 53: 101-2.
13. Tournier P. *Medicine de la personne*. Neuchâtel: Delachaux et Niestle, 1940.
14. World Health Organization. WHO Constitution. Geneva: WHO, 1946.

Juan Mezzich,
WPA President 2005-2008.
Jon Snaedal,
WMA President 2007-2008.
Chris van Weel,
Wonca President 2007-2010.
Iona Heath,
Wonca Executive Committee.

Ethical , Moral, and Legal Responsibilities of Physicians: an Islamic Perspective



Nariman Safarli

Azerbaijan as Muslim country. Azerbaijan, an oil-rich republic of 8.1 million on the shores of the Caspian Sea, has seen a revival of Muslim faith since it became independent with the collapse of the Soviet Union in 1991. Approximately 93.4 to 96 percent of the population of Azerbaijan is nominally Muslim. Azerbaijan at the same time is a secular country, Article 48 of its Constitution ensures the liberty of worship to everyone. According to paragraphs 1-3 of Article 18 of the Constitution religion acts separately from the government, each religion is equal before the law and the propaganda of religions, abating human personality and contradicting the principles of humanism is prohibited. At the same time

the state system of education is also secular. The law of the Republic of Azerbaijan (1992) "On freedom of faith" ensures the right of any human being to determine and express his or her view on religion and to execute this right.

As a Muslim physician. In my paper I add information about the responsibilities and duties, basic norms and values, which a Muslim doctor in particular and any doctor in general must adhere to while delivering his or her services in the society.

I know that the most important thing for a Muslim doctor is to be interested in the basic values and principles of Islam. This interest will be in the foreground of his or her duties and responsibilities which will bestow loyalty and wisdom upon his or her profession, as well as cast his or her perceptions upon a strong foundation of our religion so that he or she may perform his or her duties as a real faithful believer.

Most of this information was extracted from the Islamic Code of Medical Ethics Kuwait Document published by the International Organization of Islamic Medicine in 1981 and from FIMA Year Books which are published regularly by the Federation of Islamic Medical Association. Some of these recommendations were taken from the paper – "The Medical Ethics - An Islamic

Perspective" written by Dr. Mohammad Iqbal Khan and from the paper – "Medical Ethics from Islamic Law" written by the Prof. Omar Hassan Kasule, and some of this information I collected during my participation at various professional workshops and seminars held in Malaysia, Jordan, and the USA.

Ethics, morality and law are vitally important in our world. Ethical, moral, and legal responsibilities are at the heart of a physician's competent professional behaviour and scientific undertakings.

Islamic and Secularized Ethics. The main task of Islamic ethics is to understand and expound the ethos of Islam as conceived in the Qur'an and elaborated in the Sunnah of the Prophet.

In Muslim countries, in any discussion of ethics, there is a tendency to look towards religion. Islam is believed to be able to fully restore the harmony between religion and science. Ethics in Muslim countries is inseparable from religious jurisprudence. New regulations and guidelines on ethics were compiled and put into practice using the Islamic point of view as the basis.

Islamic bioethics is intimately linked to the broad ethical teachings of the Qur'an and the tradition of the Prophet Muhammad (s.a.w.), and thus to the interpretation of Islamic law. Bioethical deliberation is inseparable from the religion itself, which emphasizes continuities between body and mind, the material and spiritual realms

and between ethics and jurisprudence. The Qur'an and the traditions of the Prophet have laid down detailed and specific ethical guidelines regarding various medical issues.

The Qur'an itself has a surprising amount of accurate detail regarding human embryological development, which informs discourse on the ethical and legal status of the embryo and foetus before birth.

The main principles of "western" bioethics (autonomy, beneficence, non-maleficence and justice) are acceptable according to Islam, but interpretation of them can differ. For example, there is a limit on autonomy; sometimes the interests of the society is preferred to individual rights. Also the main principles of the Hippocratic oath are acknowledged in Islamic bioethics, although the invocation of multiple gods in the original version, and the exclusion of any god in later versions, have led Muslims to adopt the Oath of the Muslim Doctor, which invokes the name of Allah. It appears in the 1981 Islamic Code of Medical Ethics, which deals with many modern biomedical issues such as organ transplantation and assisted reproduction.

Some physicians in Westernized Muslim countries say that to strictly apply Islamic medical ethics to modern medicine is tantamount to a reactionary movement of a return to subduing science under the hegemony of religion. They say that modern medicine is embarking on new unprecedented frontiers of cloning, genetic engineering and human spare parts generated by stem cells. It should be given full freedom to develop and experiment without any religious restrictions or hindering rigid ethical codes. These physicians believe that the 'non-religious' rational 'versatility' of medical ethics is a more suitable moral guide to modern medicine. Such physicians share with their western colleagues a negative approach towards the role that religion can play in moulding medical ethics and practice. In effect they are opposed to the whole field of the Islam-

ization of western sciences, often discussing this subject with mockery and ridicule.

To the average Muslim doctor and to those who show respect to their religion, such statements can only come from a person who is ignorant about Islam as a religion and world view and one who lacks depth of knowledge about the religious aspects of medical ethics. One does need neither to defend Islam as a way of life nor the flexibility of its *usul al fiqh* in creating a spiritually guided modern medical ethics. It encourages every new development, discovery or innovation in the field of science and medicine, but within the framework of the spiritual honour Bestowed on man by his Great Creator. The impressive literature published by the Federation of Islamic Medical Association (FIMA) and other Islamic medical organizations and universities is quite convincing to any unbiased scientist.

Islamic Ethics are derived from religious convictions and traditions and are therefore constant and will remain so for all time. On the other hand, secular ethics are framed by a society which is fickle, inconsistently ruled by a majority vote and devoid of religious restrictions. For example, one has seen the change from a total prohibition of abortion to the current "abortion on demand" by the patient accepted by society.

Similarly, Euthanasia (Mercy Killing), which was illegal and still is in most countries in the west is "quietly" acceptable to societies where elderly people, with children not prepared to look after them, opt for ending their lives with the cooperation of their doctors while the Governments look the other way!

In much the same way, at first artificial insemination involved egg and sperm fertilization of legally wedded couples, then sperm "banks" resulted in children with unknown fathers and now with surrogate motherhood the children may not know either their real father or mother! These are the result of sci-

entific advancement; and what cloning may produce will be an ethical nightmare. The conceptual and moral problems of secularized medicine has some paradigms that we do not accept as Muslims. Death is rejected as a natural phenomenon and resources are wasted in terminal illnesses. Aging is also not accepted as a normal process. There is no consideration of balance and equilibrium in selecting treatment modalities with the result that an unacceptably high number of patients are being treated for side effects of modern therapeutic agents. Too much narrow specialization leads to lack of a holistic approach to the patient. The physician behaves as a technician and turns a blind eye to the moral and social issue of the day that affect the health of his or her patients and claims that his or her responsibility is medical care only. Secularized medicine has no consistent set of ethics regarding malpractice, fraud, and bias in research. Accepting only empirical knowledge and negating other sources of knowledge had also created new problems. By denying a religious and moral dimension, secularized medicine operates in a presumed moral vacuum. It is a gross mistake to attempt to solve social and medical problems of a moral or spiritual nature by use of technology. At the time when the first discussions among Islamic scholars were held about organ transplants, attitudes were more divided than they are today. There have always been those against and those for transplantation. A belief from earlier times has been passed on, i.e., that it is permitted to transfer not only tissues, but also a bone from an animal whose meat is edible. By analogy, the possibility of transplanting an organ from a non-Muslim to a Muslim and vice versa is pointed out. A Muslim physician is obliged to give the same aid, or medical care, both to a non-Muslim, as well as to a Muslim.

But when the patient deteriorates and realizes that he or she is being terminal, it is the Islamic responsibility of the Muslim doctor to council the patient and to convince him or her that all his or her agony will wash

away his or her sins, and his or her patience will surely secure for him or her the pleasure of Allah. But if the patient is actually dying, then spiritual words of optimism about the forgiveness of our Merciful Lord and happiness in life after death can have unequalled positive effects on the patient and much reward to the doctor. Repeating the creed to those whose soul has already reached their throat is again an act of great Islamic importance particularly for those poor Muslims who die alone in a hospital bed. For the Muslim doctor to ask the nurse about a dying person, give a quick glance at his or her medical reports and just go away without contemplation or *du'a'* or feelings about the angels around the death bed or the unseen pleasures and punishments round the corner, is the action of a secularized physician.

Islamic Law (Shariat) is comprehensive and encompasses moral principles directly applicable to medicine. It is noteworthy that there is a wide overlap between Islamic ethics, the Islamic rulings and law, so that some religious principles such as eternity of life or seeking perfection could be very important in ethical decision-making in an Islamic setting.

Secularized Law denied moral considerations associated with "religion" and therefore failed to solve issues in modern medicine requiring moral considerations. The medical profession and society at large were not ready to face the new challenges. The existing positive secular laws are lacking in moral spine. It becomes necessary to develop secular ethics as a new discipline to deal with the challenges.

Moral responsibilities of Muslim doctors. A Muslim doctor is a Muslim even before he or she becomes a doctor, but after becoming a doctor his or her responsibilities increase manifold. During his or her professional duties, he or she comes into contact with a large number of people. To them all, his or her character is like a model. He or she,

therefore, should exhibit good character and Islamic way of life, keeping his or her life in accordance with the teachings of Islam. There should be no controversy in the practical life of a Muslim physician and he or she must be a living example of the Islamic way of life and should never exhibit any action contrary to his or her beliefs. Only then physicians can be sources of inspiration for others and only then they can link their patients with The Lord.

But what is it that makes a Muslim doctor different from other non-Muslim doctors? From the technological and scientific points of view, all doctors fall in one category. However, when it comes to practice, the Muslim doctor finds him or herself bound by particular professional ethics plus his or her Islamic directives issuing from his or her belief. In fact, the Muslim doctor—i.e., a doctor who tries to live his or her Islam by following its teachings all through—is expected to behave differently in some occasions and to meet greater responsibilities than other non-Muslim doctors.

A Muslim physician should be a good role model. He or she must present him or herself as a person of high moral character. He or she must be polite, humble, dutiful, honest, truthful and trustworthy. He or she should be performing his or her duties with excellence as the rewards of excellence are excellence "Could the reward for excellence be anything but excellence" (Qur'an- 55:60). One can only provide the excellent service if he or she excels in professional knowledge, expertise and strength of personal character. Prophet Mohammad PBUH said, "I was sent down by Almighty Allah for the perfection and excellence in morality" (Hadith Ibne Majah).

A Muslim doctor has a two-fold of motivation to remain ethical and maintain good moral characters i.e. he or she is answerable to the society, profession and has to abide the law of the land, but a Muslim doctor has the added motivation to remain ethi-

cally correct due to his or her beliefs, his or her piety and his or her Islamic obligations. This second motivation which might or might not be observed by others is the most powerful tool to keep a Muslim doctor ethical and God fearing.

An important demand of academic honesty is that a doctor should continue throughout his or her life to develop his or her scientific knowledge and keep him or herself updated about new researches. Allah Almighty taught this prayer to the Prophet: O My Lord! Advance me in knowledge (Qur'an-20:114).

A field of knowledge that deals with human life warrants even more careful attention and continued expansion. Regular weekly or monthly meetings of doctors at the local level for discussion on difficult and interesting cases may also be an effective means for increasing one's knowledge. Meeting other doctors from time to time or to seek their advice about patients is another means of adding to one's knowledge. Allah has said in the Qur'an: If you do not know, ask those who are knowledgeable (Qur'an-16:43).

Before commencing medical practice, it is obligatory for a Muslim physician to obtain the required knowledge and skill, and to remain at the cutting edge in his or her field of interest in medicine. It is further stressed in another Hadith "That a Muslim performs his duties with excellence". One cannot achieve excellence in his or her professional skills without constant effort and desire to excel in his or her profession.

The Muslim doctor is obliged to acquire the best possible knowledge and expertise and has to deliver his or her services to ailing humanity without any discrimination and without any worldly gain. If a patient can pay for the consultation, it is fair enough to take the fee. But if he or she is unable to pay, the physician cannot refuse his or her services. If a physician refuses to give his or her services because he or she is not being

paid, he or she is committing sin. One of the several rights which a Muslim has on another Muslim is, "Whenever he falls ill he is being visited by other Muslim; whenever he is consulted for some matter he must impart his consultation with the best of knowledge and *taqwa*". A medical professional is directly responsible to his or her fellow human beings.

Muslim physician strongly believes that he or she is not only accountable for all his or her deeds, but he or she is quite hopeful that while he or she is abiding by the divine guidelines he or she shall never go astray. "Surely it is for us to give guidance" (Qur'an 92-12).

However, honesty includes academic honesty, but it is being mentioned separately because of its importance. It is a must for a doctor to acquire adequate knowledge about the profession he or she has studied and adopted as a career. The Holy Prophet has said, "The one, who treats patients without enough knowledge, will be answerable before Allah for the harm he might cause" (Hadith: Abu Dawud).

Apart from many other rights of a Muslim on another Muslim, two important aspects of this act of *ibada* are directly related to medical profession. A doctor has to provide medical consultation to his or her patient whether paid or unpaid. If a person is unable to pay the consultation fee of a doctor, a Muslim doctor has to provide consultation free of cost according to the best of his or her knowledge and expertise. Though charging consultation fee is permissible within limits.

When Muslim doctor deals with a patient, he or she seeks Allah's pleasure through it. Immediate and material gains are not his or her objective, though Allah accepts his or her efforts and gives health to his or her patients. Benefits, material gains, name and fame are all a reward, but these are of only

secondary importance to a Muslim doctor who seeks Allah's pleasure.

A Muslim physician must be honest in all of his or her dealings, especially when providing necessary care and advice to his or her patients and their concerned relatives. He or she must honestly evaluate his or her capabilities and practice those sections of medicine over which he or she has gained mastery. He or she should not hesitate to consult a specialist in a particular field for the best handling and management of his or her patients. According to the Qur'anic injunctions and the Sunnah "one must not indulge himself in matters about which he does not have knowledge and expertise". You shall not follow any one blindly in those matters of which you have no knowledge, surely, the use of your ears and the eyes and interpretation – all of these, shall be questioned on the day of Judgment (Qur'an- 17:36).

Prophet P.U.H said "Those who practice medicine without having its proper knowledge and expertise will be responsible for their acts" (Nisai; Ibne Majah). Those who will cause damage to the body or soul of their fellow human beings, due to lack of knowledge or expertise, will fall in this category of ignorance and negligence. One must also not discriminate between the patients irrespective of their social status or economic backgrounds. "No white has any superiority over a black or a black over a white except on the basis of *Taqwa* (God consciousness). A doctor is supposed to deliver his or her services and expertise by the best possible means and ways irrespective of what is he or she going to get out of it in terms of money. One should not discriminate between his or her private and official practice. A person who is unable to pay does not deserve an inferior quality or obsolete treatment options.

The deeper a doctor feels for humanity and considers him or herself a healer appointed by the Creator, the greater he or she would strive for removing sorrow. The Holy

Prophet has said that Allah loves a person who performs whatever he does in the best manner (Hadith: Abu Dawud).

The Holy Prophet has told us: He who gives wrong advice to his brother commits dishonesty (Hadith: Mishkat). If there are more than one way for treating a patient, then benefits and harms of every treatment should be explained to the patient besides giving the honest opinion as to which treatment is best for him or her. The decision, then, should be left to the patient and see what he or she opts for. If another doctor has a better treatment, you should refer the patient to him or her without hesitation. It would be dishonest to keep the patient as a source of income.

The Physician is truthful whenever he or she speaks, writes or gives testimony. He or she should be invincible to the dictates of greed, friendship or authority that might pressurize him or her to make a statement or testimony that he or she knows is false. Testimony is a grave responsibility in Islam.

Legal responsibility of Muslim physicians.

More than any other professional, the Muslim medical doctor is confronted more frequently with questions regarding the Islamic legitimacy of his or her activities. There are almost daily controversial problematic issues on which he or she is supposed to decide: e.g. birth control, abortions, opposite sex hormonal injections, trans-sexual operations, brain operations affecting human personality, plastic surgery, extra-uterine conception, and so forth. The Muslim doctor should not be guided in such issues merely by the law of the country in which he or she is residing (which may be non-Muslim). He or she must also find the Islamic answer and rather adopt it as much as he or she can. To find the answer is not an easy matter, especially if the doctor him or herself has no reasonably solid background in the field of Islamic teachings. Yet, to gain such knowledge is very simple and would not consume as much time as generally

presumed. In general, every Muslim must have a preliminary knowledge of what is reprehensible and what is prohibited. One has to admit that our early education as individuals is very deficient in this regard. But this does not justify our ignorance of the essentials of our religion and our indifference towards its injunctions. There is no difficulty nowadays to obtain a few reference books about our Shari'ah and to find out the answers to most, if not all, our medical queries. The importance of Islamic knowledge becomes conspicuous when the subject of the issue is purely technical and thus lies beyond the reach of the normal religious scholar. Besides, there are many secondary questions that arise in the course of dealing with patients where the personal judgment of the doctor is the only arbiter. There, as always, the doctor needs a criterion on which he or she can build his or her code of behaviour and the ethics of his or her medical procedure. The Practice of Medicine is lawful only to persons suitably educated, trained and qualified, fulfilling the criteria spelt out in the Law. A clear guidance is the Prophet's tradition: "Who-so-ever treats people without knowledge of medicine, becomes liable".

After medical graduation, though a doctor has legal right to treat all patients, but it is neither practically possible nor morally permissible for every doctor to start treatment for every ailment or try to do that. This is why a doctor has to limit the area of his practice. In this limited area, it is his or her duty to acquire comprehensive knowledge about the ailments, and keep updated. It is also because the knowledge about ailments and their treatment has grown so vast that it is almost impossible for one person to have a grasp over the entire field of knowledge. This is how, long ago, the idea of specialization in different areas of medical sciences started. Now, specialization is required almost in every field.

Morality, ethics and law are not the same. Morality refers to standards of behaviours

by which people are judged and ethics encompasses the system(s) of beliefs that support a particular view of morality. Ethical concepts and principles are used to criticize, evaluate, propose, or interpret laws. Societies use laws to enforce widely accepted moral standards. Societies use laws to regulate conflicts over ethical issues in order to guarantee social stability and democratic order. Legal systems often illustrate national morality. Ethical systems are enforced and codified for the "public good." Laws are based on the ethical system of a society. Because laws change slowly, the morality of a society can and often does conflict with the codified ethics of the society. Moral systems begin with the individual, based on a sense of "good" and "evil" in some cases. Religious morality often conflicts with social ethics, especially when a religion's morality conflicts with existing laws and greater social ethics.

Achieving the holistic balance is only possible where action in medical practice has its moral, ethical and legal basis.

To clearly understand what is the relationship and interrelatedness between ethics, morality and the law in an Islamic setting I would like to illustrate ethics, morality and law as a basis of medical practice from viewpoint of Muslim doctors with very simply three overlapping circles in iconic model – a simple Venn Diagram as below. Any action in medical practice must be ethical, moral and legal (ethical, moral and legal spheres overlap each other equally and completely).

We suggest that ethical, moral and legal concepts as a basis of medical practice must be present in every medical curriculum, if we want that medicine may play in the future its decisive role in shaping a civilized world concerned for the respect of the human person. Increasing interrelation of medicine, religion, ethics and law requires greater understanding and analysis of medical ethics issues and the provision of culturally-adapted solutions.

To conclude, the role of the Muslim doctor is briefly to put his or her profession in service of the pure religion Al-Islam. To this end, he or she must know both: medicine and Islam.

References

1. Mohammad Iqbal Khan. Medical Ethics - An Islamic Perspective, FIMA Year Book 2004
2. Kasule, Sr., Omar Hasan. Medical ethics from Maqasid al Shariat : Presented at the International Scientific Convention jointly organized by the Jordan Society for Islamic Medical Studies, JMA and the Federation of Islamic Medical Associations at Amman, Jordan 15-17 July .
3. The Islamic code of medical ethics. World Med J 1982;29(5):78-80
4. Athar,S., Fadel,H.E.,Ahmad,W.D. et al. Islamic Medical Ethics: The IMANA Perspective. J Islam Med Assn 2005;37:33-42
5. Abdallah S. Daar and A. Khitamy "Bioethics for clinicians: 21. Islamic bioethics CMAJ - January 9, 2001; 164 (1).
6. Islamic Code of Medical Ethics – Kuwait Document – published by International Organization of Islamic Medicine -1981, revised 2004.
7. International Ethical Guidelines for Biomedical Research involving Human Subjects (An Islamic Perspective)- prepared by Islamic organization for Medical Sciences-2004

Nariman Safarli MD, President of the Azerbaijan Medical Association, Chairman of Forum for Medical Ethics in Azerbaijan (FMEA), Fellow of Fogarty International Centre and NIH on Research Ethics

International collaborative initiative surgical Manpower development: a plea to do more in low –income-countries

Collaborative Surgical Manpower Development



Titus S Ibekwe



Bolutife A Olusanya



Paul A Onakoya



Adeyinka O Ashaye



Onyekwere GB Nwaorgu



Odunayo M Oluwatoshin

Introduction

Global burden of diseases especially in the developing parts of the world is a threat to human existence. Low income, poor infrastructures, inadequate skilled manpower to contain the controllable diseases in Africa and other developing nations make the situation pitiable[1, 2].

The millennium development goals (MDG) of the United Nations (UN) [3] and World health Organization Programs had identified these problems; however, a lot still needs to be done in the areas of supportive initiatives to assist the developing nations achieve these goals. The collaborative ef-

forts of international organizations, donor agencies, are very much needed to help develop adequate work force and infrastructural know how to tackle this challenge.

The benefit from such efforts on our health institutes on short and long term basis could be unimaginable as will be illustrated in this presentation. Yet there are so many unexplored areas of human health development. To this end, we focus on illustrating the positive multiplier effects on manpower and community development a well organized and coordinated collaborative effort in highly skilled surgical specialties (Ophthalmology, Plastic Surgery and Otorhinolaryngology) and the need to expand to

other areas like Pediatric Otolaryngology where hearing loss is a common problem as observed in the UCH.

Speech, a social attribute unique to man is invariably a product of good hearing. Therefore early evaluation and subsequent hearing conservation and rehabilitation are necessary. Unfortunately, the cost of achieving this is prohibitive making international Collaboration indispensable especially in the developing nations of the world.

It is on this concept we highlight the importance of international collaboration.

Reviewed records on collaborative activities

Other major collaborative institutes in Nigeria include:

- Ebonyi State University Teaching Hospital Abakiliki
- Military Hospital Ikoyi Lagos
- Jos University Teaching Hospital Jos
- University of Nigeria Teaching Hospital Enugu
- Federal Medical Centre Owerri
- Lagos State university Teaching Hospital Lagos
- Murtala Muhammad Specialist Hospital Kano
- Specialist Hospital Bauchi

Furthermore, applications from many more medical centers in Nigeria were being considered by the smile train.

The burden of Cataract and blindness

The most recent global data on the prevalence of blindness estimates that about 37 million people are blind while another 124 million are visually impaired [4, 5]. The WHO estimates that about 75% of global blindness is avoidable and over 90% of blind people live in developing countries [6]. Cataract is responsible for about 48% of global blindness [4] and 33-70% of blindness in Nigeria [7-13]. Majority of those

affected have little or no access (geographic and financial) to health services [14, 15]. As a result the quality of lives of these patients deteriorates and fewer patients present to the hospitals. The low volume of patients undergoing cataract surgery had a negative impact on the training capacities of the eye care training centers available in Nigeria.

Collaborative remedial efforts and outcome

International Council of Ophthalmology (ICO) conducted site visits to a number of eye care facilities in Nigeria in April 2004. Training and infrastructural deficiencies in

the delivery of eye care services in Nigeria were found and this resulted in the initiative to establish a model regional ophthalmic training center in West Africa. The Ophthalmology Department of the University College Hospital Ibadan, Nigeria was chosen for this purpose. The initiative was co-sponsored by the International Agency for Prevention of Blindness (IAPB) and Carl Zeiss Company. The main aim was to improve ophthalmic training through implementing initiatives to increase patients' volume, focus on subspecialty training, provision of infrastructure and strengthening of management / operational systems.

An initial take-off boost was given by Dr. El-Margaby, the then president of Middle East African Council (MEACO)], who donated consumables for 500 cataract surgeries. The surgical programme started in September 2006. The patient load for cataract surgeries increased by 247.9% within the year (*table 1*). A positive impact was also felt on the residency training as regards the increased number of cataract surgeries (211.1%) performed by the senior resident Doctors as primary operators.

Despite the increase in the volume of surgical turnover, the quality of surgeries were not compromised rather the frequent exposure and hands-on experience of the resident doctors made room for good quality assurance in the patients management. This was demonstrated by a significant increase in the proportion of patients with good visual outcome defined at Visual Acuity (VA) 6/18 or better after cataract surgery. An increment from 68.4% to 85.5% was recorded. This is close to the WHO standard of about 90% record of VA 6/18 or more. Again, the insertion of intraocular lens after the cataract extraction has been perfected by the trainees and is now the standard practice in the hospital. The impact of the initiative on the social lives of the patients is currently being evaluated, however, the goal of VISION 2020: the right to sight is being achieved in no small way.

Table 1.

Cataract surgeries and ICO initiatives

Parameters	Pre ICO Initiative (2006)	Post ICO Initiative (2007)	Percentage (%)Increase	Z-test @ 95% confidence Interval (Z-values)
Average Cataract surgery load per Annum	282	699	247.9	12.03
Average cataract extractions per senior Resident Dr.	45	95	211.1	3.85

Table 2.

Established centers for the smile train cleft repair initiatives in Nigeria and activities in 2008/2009

Institutes	Proposed no of free repairs /year	Achieved no of free repairs / year
Lagos University Teaching Hospital	100	90
National orthopaedic Hospital Enugu	100	75
University College Hospital Ibadan	60	20
Univ. of Maiduguri Teach. Hospital	50	61
Obafemi Awolowo Teach. Hosp. Ile Ife	50	50
Fed Med Center Gombe	50	48
National hospital Abuja	40	25
Ladoke Akintola Univ. Teach Hosp. Osogbo	40	23
Ahmadu Bello University Teaching Hospital Zaria	40	47
Usman Danfodio UTH Sokoto	33	13
Aminu kano Univ. Teach. Hospital kano	25	40
Univ. of Ilorin Teach. Hospital	20	15

Cleft lips and palate disorders and collaborative remedies

Cleft lip and /or palate are major problems of the developing nations where millions of children carry their clefts un-repaired due to economic and infrastructural impoverishment [16, 17]. Apart from the distorted cosmesis, feeding and speech are usually impaired and is often associated with social stigmatization [18, 20]. As a result, integration in schools, work places and social gatherings are seriously hampered. The surgical time for the repairs of cleft could be as short as 45 minutes and the cost as

low as \$250.00 [21, 22]. However, bearing in mind that most developing countries of the world, including Nigeria, live below the poverty line (per capita income less than USD\$ 826) [17] it stands to reason why this is not readily affordable. Since March 2000, a non-governmental organization called "Smile Train" has offered free cleft surgeries for 280,738 children worldwide. The mission was to focus on cleft lip and palate repairs, empower local doctors in developing countries with the skills and resources through collaborative training to achieve best safety/quality rewards among cleft charities at lowest possible costs [21].

The University College Hospital (UCH) Ibadan Nigeria is one of the centres in Nigeria where the Smile Train services are offered. This is mainly a plastic and reconstruction teams' work, however, a multidisciplinary management of the patient is necessary. The ENT surgeons, speech therapists/pathologists, maxillofacial surgeons are members of the team in the UCH, Ibadan.

As shown on *table 2* above, UCH center has one of the highest renewable quotas of 60 cleft repairs. The contract was signed in December 2006 and first installment of payment for sponsorship of the repairs made in January 2007. Within the first quarter of the year, 33.0% of the target per year has been achieved with good outcome (devoid of significant anesthetic or surgical complications). Apart from the social benefits to the patients and the relations, it is also an avenue for exposure and training of the resident doctors in this field of endeavor.

Benefits and other area of need

Like the ICO surgical initiative, the program helps to pool the cases of cleft to the designated centers. This enhances skill and exposure of the trainee surgeons and as noted by the co-coordinator of the program in UCH Ibadan, the exposure to the trainee doctors has been worthwhile. A similar observation was also made by the trainees.

Regional workshops and trainings are also held regularly on the cleft repairs. A bi-monthly and quarterly academic conference by the members of the multidisciplinary team is being integrated into the program in UCH Ibadan. This will ensure proper evaluation, auditing and a high standard of practice.

A close evaluation of the above two projects resulting from international surgical initiatives and collaborations had revealed a tremendous improvement on the training of resident doctors in skill acquisition and manpower development. It has also improved the health and social lives of the populace especially the less privileged in the developing countries who cannot afford the surgical fees. It is in this light we identified SNHL among children (excluding acute or chronic otitis media) as an important area that has constituted a burden to the Otorhinolaryngologists in a developing country like Nigeria.

Sensorineural hearing loss in children

The disease burden posed by this ailment in our environment deserves an urgent attention including assistance from donor agencies just like the ICO/IAPB 'Cataract' and the 'Smile train cleft repair' initiatives. In 1995, the WHO indices showed that about 12 million people world wide had disabling hearing loss (>40dB) and that warranted a declaration by the World Health Council that all member countries should prepare action plan for early detection of hearing loss through screening tests for newborn, toddlers and infants [24]. Ten years later (2005), statistics showed that this "hidden handicap" had affected about 250 million people, out of which about 75% live in the developing countries and 25% were of early childhood onset [25].

From the above review, Sensorineural hearing loss among children constituted about 14.6% of all pediatric cases seen in ORL Department out of which about 72.0% fall

within the under 5 age group. Regrettably, the actual onset and possible etiologies in most of these cases are not known. This is in consonance with the findings in earlier studies in Nigeria, Ghana, Sierra Leone and the Gambia which revealed that 21-36.5% of cases of Sensorineural hearing losses were either of unknown cause or suspected congenital causes [26-30]. In fact, presentations are mostly dependent on when the parents feel that there is undue prolonged poor cognitive response. Most times these patients are presented to the hospital beyond the critical period of the acquisition of speech, language and cognitive functions (within the 1st year of life) [31,32].

In the past these late presentations were attributed to socio-cultural and superstitious beliefs of the parents [27, 33]. However, emerging facts have shown that this trend is changing and most parents are becoming aware but the impending limitation is in the affordability of the medical bills [26, 34]. Again, most of the medical facilities in Nigeria and indeed most developing countries lack the needed infrastructures and manpower to tackle the challenges. The intense investigative (genetic, audiological and imaging) and rehabilitative tools required for the effective management of these patients are lacking.

Genetic/familial factors are recognized world wide as strong links to immediate or late manifestations of Sensorineural hearing loss [35]. Syndromic and non-Syndromic forms have equally been identified. Sickle cell anemia, predominant in black race, has been identified by several authors as a predisposition to Sensorineural hearing loss probably through the vaso-occlusive effect on the microvasculature of the cochlea of the young infants [36-38]. Apart from Sickle cell anemia and probably Connexin 26 (detected in Ghana through collaborative efforts by Brobby et al) [39, 40], other hereditary causes are poorly studied and hardly detected early in our sub region. Necessary manpower for hearing genetic

studies in Africa is needed in designated centers to fill in this gap.

Obstacles to remedy

The basic universal hearing screening for the newborn, infants and pre-school aged, which is the expected standard worldwide [41 – 43], has a great set back in Nigeria. The tools needed for this purpose like Otoacoustic emission (OAE), Automated Brain Response (ABR), Screening and diagnostic Audiometers and Tympanometers are lacking. These are not readily available in specialists' centres not to talk of the other health facilities where birth deliveries are taken. OAE and ABR, which are automated machines designed for the purpose of hearing screening in children costs about USD\$3,000.00 and \$8,000.00 respectively. At least two each are needed in designated screening centres to enhance maintenance and sustainability of this program. As correctly observed by Olusanya et al, government contributions to health in developing countries (as low as 24%) are far cries compared to developed countries (as high as 81%) and this translates to nearly 90% out of pocket expenses for the populace in the developing countries within their limited income. This means that at best the government role in these countries could only be facilitatory –i.e. sensitization and creation of awareness among the populace on the existing programme. Therefore, sponsorship of such programs in developing nations like Nigeria will largely depend on International collaborations with professional organizations, donor agencies through private public partnerships [44].

Rehabilitative technologies through hearing aids and cochlear implants are either too expensive or non-existent in Nigeria. Most families cannot afford hearing aids. Up to date, only two cases of cochlear implantation carried out in Jos, Nigeria, in 2005 at ECWA missionary hospital in collaboration with House Institute USA has been

recorded. Temporal bone surgeries and Otolaryngology training in Nigeria needs urgent attention from international surgical and Otorhinolaryngological initiatives. Basic and functional temporal bone laboratories are few amongst our ORL training centers in Nigeria.

Conclusion and way forward

As observed on the impact in these specialties, efforts need to be improved, sustained and expanded to other fields to avoid a skewed effect where other areas are neglected with the anticipated consequences as exemplified in the Pediatric Otolaryngology specialty.

References

1. Fosu AK. Poverty and development. *Bull World Health Org.* 2007;85:734.
2. The 2002 report on the joint action of EU and UN Commission to tackle health threats in developing countries. Brussels: European commission printing office; 2002. http://www.euro-pa-eu-un.org/articles/en/article_1444_en.htm. Accessed 04/22/08.
3. The 2007 report of the Millennium Development Goals Africa Steering Group. New York: UN publication. 2007. http://www.mdgafrica.org/steering_group.html. Accessed 03/29/08.
4. Resnikoff S, Pascolini D, Etya'ale D, et al. Global data on visual impairment in the year 2002. *Bull World Health Org.* 2004;82:844-851.
5. Magnitude and causes of visual impairment. *Bull World Health Org.* 2004; fact sheet no 282.
6. Global initiative for elimination of avoidable blindness, 1997. *WHO/PBL* 97.61
7. Olurin O. Causes of blindness in Nigeria, a study of 1,000 hospital patients *West Afr Med J Niger Med Dent Pract.* 1973;22:97-107.
8. Osuntokun O, Olurin O. Cataract and cataract extraction in Nigeria. *BJO* 1973; 57:27-33.
9. Ayarun JO. Blindness in mid-western state of Nigeria. *Trop. Geo. Med.* 1974:325-335.
10. Nwosu SNN. Blindness and visual impairment in Anambra state (Nigeria). *Trop. Geog. Med.* 1994:346-349.
11. Adeoti CO. Prevalence and causes of blindness in a tropical African population. *West Afr J Med.* 2004; 23:249-252.
12. Adeoye A. Survey of blindness in rural communities of South Western Nigeria. *Trop Med Int Health.* 1996;1:672-676.
13. Oluleye TS. Cataract blindness and barrier to cataract surgical intervention in three rural communities of Oyo State, Nigeria. *Niger J Med.* 2004;13:156-160.
14. Rabiun MM. Cataract blindness and barriers to uptake of cataract surgery in a rural community of Northern Nigeria. *Br. J ophthalmol.* 2001;85:776-780.
15. Mpyet C, Dineen BP, Solomon AW. Cataract surgical coverage and barriers to uptake to cataract surgery in the leprosy village of the North eastern Nigeria. *Br.J. ophthalmol.* 2005; 89: 936-938.
16. Onah II, Opara KO, Olaitan PB, et al. Cleft lip and palate repair: the experience from two West African sub-regional centres. *J Plas Reconstr Aesthet Surg.* 2007; 61: 879-882.
17. Obuekwe O, Akpata O. Pattern of cleft lip and palate in Benin City, Nigeria. *Cent Afr J Med.* 2004; 50:65-69.
18. Orkar KS, Ugwu BT, Momoh JT. Cleft lip and palate: the Jos experience. *East Afr Med J.* 2002; 79:510-513.
19. Olosoji HO, Ukiri OE, Yahaya A. Incidence and etiology of oral clefts: a review. *AFRJ. Med Med Sci.* 2005;34:1-7.
20. Osuji OO, Ogar DI, Akande OO. Cleft lip and palate as seen in the University College Hospital, Ibadan. *West Afr J Med.* 1994; 13:242-244.
21. Levitt SD. Smile train. *Freakonomics.* Newyork Times Bull 2006/11/08 (WWW.freakonomics.blogs.nytimes.com/2006/11/08/smile-train). Accessed 03/07/08.
22. Midler B. Smile train Mission. *WWW.smiletrain.org/2008/1/13.* Accessed 03/07/2008.
23. Gottret P, Schieber G. Health Financing Revisited: A Practitioner's Guide. The World Bank, Washington DC; 2006.
24. The 1995 Reports on Resolution of the 48th World Assembly on Prevention of hearing impairment (WHA 48.9.) Geneva; 1995. World Health Organization <http://www.google.co.ke/search?hl=en&q=48th+World+Assembly+on+Prevention+of+hearing+impairment+&btnG=Google+Search> Accessed 03/04/08.
25. World Health Organization: Preventing chronic diseases – a vital investment. Geneva 2005.
26. Dumade AD, Segun-Busari S, Olajide TG, et al. Profound Bilateral Sensorineural hearing loss in Nigerian Children: Any hearing Shift in Etiology? *The Journal of Deaf Studies and deaf Education* 2007;12:112-118.
27. Ijaduola GTA. The problems of profoundly deaf Nigerian child. *Post graduate Doctor-Africa* 1982;4:180-184.
28. Wright ADO. The Etiology of childhood deafness in Sierra Leone. *The Sierra Leone Medical and Dental Association Journal* 1991;14:205-209.

29. Brobby GW. Causes of congenital and acquired total Sensorineural hearing loss in Ghanaian children. *Trop. Doc.* 1998;18:30-32.
30. Holborow C, Martinson FD, Anger N. Study of Deafness in West Africa. *Int J Pediatr otolaryngol.* 1982;4:107-132.
31. Kennedy CR, McCann DC, Campbell MJ, et al: Language ability after early detection of permanent childhood hearing impairment New Eng J Med. 2006;354:2131-2141.
32. Prpić I, Mahulja-Stamenković V, Bilić I, et al. Hearing loss assessed by universal newborn hearing screening--the new approach. *Int J Pediatr Otorhinolaryngol.* 2007;71:1757-1761.
33. Lasisi AO, Ajuwon AJ. Beliefs and perception of Ear, nose & Throat related conditions among residents of a traditional community in Ibadan, Nigeria. *AFR J. Med Meds Sci.* 2002;31:45-48.
34. Cooper RS, Osotimehin B, Kaufman JS, et al. Disease burden in sub-Saharan Africa: what should we conclude in the absence of data? *Lancet* 1998;351:208-210.
35. Han B, Dai P, Qi QW, et al. Prenatal diagnosis for hereditary deaf families assisted by genetic testing. *Zhonghua Er Bi Yan Hou Tou Jing Wai Ke Za Zhi.* 2007;42:660-3.
36. Mgbor N, Emodi I. Sensorineural hearing loss in Nigerian children with sickle cell anemia. *Int J Pediatr Otorhinolaryngol.* 2004; 68:1413-1416.
37. Odetoyinbo O, Adekile A. Sensorineural hearing loss in children with sickle cell anemia. *Ann Otol Rhinol Laryngol.* 1987;96:258-260.
38. Onakoya PA, Nwaorgu OGB, Shokunbi WA. Sensorineural hearing loss in adults with sickle cell anemia. *Afr J Med Med Sci.* 2002;31:21-24.
39. Brobby GW, Muller-myhsok B, Horstmann RD. Connexin 26R143W mutation associated with recessive non-syndromic Sensorineural deafness in Africa. *N England J Med.* 1998; 338:548-550.
40. Hamelmann C, Amedofu GK, Albrecht K, et al. Pattern of connexin 26(GJB2) mutations causing Sensorineural hearing impairment in Ghana. *Human Mutat.* 2001;18:84-85.
41. Grill E, Hessel F, Siebert U, et al. Comparing the clinical effectiveness of the different newborn hearing screening strategies. A decision analysis. *BMC Public Health.* 2005;5:12.
42. Ptok M. Early Diagnosis of hearing impairment in children. *Z Arztl fortbild Qualitatssich.* 2004;98:265-270.
43. Universal newborn hearing screening fine-tuning the process. *Curr opin Otorhinolaryngol Head and neck surg.* 2003;11:424-427.
44. Olusanya BO, Swanepoel DW, Chapchap MJ, et al. Progress towards early detection services for infants with hearing loss in developing countries. *BMC Health Serv Res.* 2007;7:14.

Dr. Titus S Ibekwe, MBBS (Nig),
FWACS, FMCORL, ENT Division,
Department of Surgery, College of Health
Sciences, University of Abuja Nigeria.
Dr. Bolutife A Olusanya, MBBS (Ib),
FWACS, Department of Ophthalmology
University College hospital Ibadan.
Dr. Paul A Onakoya MBBS (Ib), FWACS,
FMCORL Department of ORL University
College Hospital Ibadan Nigeria.
Dr. Adeyinka O Ashaye MBBS, FMCOPh,
FWACS, Department of Ophthalmology
University College hospital Ibadan.
Dr. Onyekwere GB Nwaorgu, MBBS (Ib),
FWACS, FMCORL, Department of ORL
University College Hospital Ibadan Nigeria.
Prof. Odunayo M Oluwatosin MBBS
(Ib), FMCS, FWACS, Division of Plastic
Surgery, Department of Surgery University
College Hospital Ibadan Nigeria.

Re-thinking Means and Ends: Economic Crises, Health and Access to Health Services in Europe

About a year ago, a crisis related to developed countries' housing markets contributed to a global financial collapse and led to the worst world economic crisis since 1929. Years of equity wealth in world market capitalization have been destroyed and millions have lost their jobs. An additional twelve million people more than expected before the crisis will fall below the \$2-a-day poverty line this year and seven million more than expected will experience "absolute poverty" (\$1.25 a day). The pandemic H1N1 threatens to make things even worse while major lingering contributing crises to health problems (demographics, environment, energy) have not been resolved. Billions have been invested in rescuing banks and funding recovery programs, the revenue base of social protection is shattered and debt may jeopardize the economic prospects of coming generations.

ardize the economic prospects of coming generations.

The World Health Organization is coordinating the health response. A high-level consultation on "Financial Crisis and Global Health" was held in Geneva in January 2009. The April 2009 meeting on "Health in Times of Global Economic Crisis" in Oslo and the 62nd World Health Assembly in May were also crucial. The 59th European Regional Committee in September will hold further discussions.

What are the likely implications for health in Europe? No "scientific" predictions can be made. I will briefly review what is known about the determinants of health (including available evidence from previous economic



Nata Menabde

crises) and issues related to regional health services access.

There is consensus about the causes for the improvement in world health in recent dec-

ades. In 2008 both the report of the Commission on Social Determinants of Health and the European Ministerial Conference on Health Systems, Health and Wealth confirmed that in a context of declining fertility, improvements were due to combined interventions at social level (nutrition, housing, education, etc) and at the health system level (population and personal services, such as care of the newborn, vaccines, treatment of injuries, etc.).

However severe equity gaps persist. Worldwide, 42 countries account for 90% of total child deaths. In the European Region there is a difference of 35–40 years in average life expectancy between rich people in Luxembourg and poor people in Tajikistan; a child born in the Commonwealth of Independent States is three times as likely to die before the age of five as a child born in the European Union (EU); maternal mortality in Central Asian Republics double the regional average. Problem exists even within the EU: men in Latvia and Lithuania live 14 years less than in Sweden and Ireland (65 versus 79 years); in Slovakia, infant mortality from respiratory diseases in 2001 was 8.34 per 1000 live births, while the median in the European Region was 1.6.

Do previous recessions offer clues about the likely evolution of health in Europe in the future?

Different negative health impacts were reported: low income countries experienced increases in infant and child mortality and micronutrient deficiency, plus anemia in women; in higher income countries, problems included mental health problems and suicides, with occasional crisis duration-related increases in adult male mortality. Spain in the 1980s and Finland in the 1990s showed no noticeable negative impact; although perhaps the adverse consequences of recession took longer to manifest, or only appeared within marginalised subgroups. State welfare institutions, including health systems, seem crucial, i.e., whether or not

government spending fell and rapid action was taken even if revenues decreased. If so, capital expenditure –infrastructure, equipment– was usually delayed. Imported medicines and technologies became more expensive if the local currency was devalued.

Whenever household incomes fell, domestic health spending (especially private) also fell. Utilisation of health facilities that charged for services always declined, with people switching to government and subsidised (e.g. NGO) facilities.

This leads to the issue of comparative health service utilization in Europe. Clearly, universal access to health services is an *effective and efficient way to reduce poverty and social inequalities* by ensuring the positive effects of preventive, therapeutic and care related action and preventing the catastrophic expenses attached to health services utilization.

Beyond that broad objective, squaring health service accessibility in Europe raises enormous challenges. First, access indicators have little comparability; if outpatient contacts per person were used as standard, for example, the baseline in the WHO European Region would rank from more than 15 (Czech Republic) to 1.5 (Albania). If hospital admissions as a percent of the population were used instead, the range would go from 26% (Austria) and 23% (Russia) to 5% (Azerbaijan) or 8% (Netherlands).

Second, such “contacts” reveal little in terms of services to the population because of the different input combinations each country uses in producing them. For example, health professionals’ density is three times higher in Germany (46.5/1,000 inhabitants) than in Portugal (13.5/1,000 inhabitants) and indeed those numbers are split differently among professional categories (doctors, nurses, etc); Ireland for example has 15.5 nurses/1,000 inhabitants, which is five times more than Turkey’s 3.1/1,000 inhabitants.

Third, there are huge differences in ways that resources are spent, ranging (at **purchasing power parity (PPP)**) from US\$ 5,686 per person per year in Luxembourg to US\$ 93 in Tajikistan. The fractions spent by the public versus the private sectors, collected as pre-paid insurance versus as direct out-of-pocket payments, etc., are enormously varied as well.

Fourth and most importantly, comparing quality (“fitness for use”) would require a deeper understanding of health needs (burden of disease and equity), context (values, expectations, socioeconomic situation, technological development, political climate) and health systems (“the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health within the political and institutional framework of each country: it encompasses personal and population services as well as activities to influence policies and actions of other sectors addressing the social, environmental and economic determinants of health”). *Health intelligence for policy making* and better assessing health system performance is mostly “work in progress” at the moment and needs to be further developed.

In summary, overcoming this economic crisis requires well targeted, timely investments in health systems as part of economic stimulus packages *because it is good for health, social stability and the economy*. Improved access is a particularly critical objective. The crisis however calls for doing things differently, avoiding duplication, fostering partnership, strengthening health governance and improving performance assessment, as stated in the “Tallinn Charter” from the European Ministerial Conference on Health Systems, Health and Wealth in June 2008.

Dr. Nata Menabde
Deputy Regional Director,
World Health Organization
Regional Office for Europe

Climate Changes and Health – There is Some Good News...



Jens Winther Jensen

The WMA has entered into the debate on climate and health. Recently, the WMA and the Danish Medical Association held a seminar in Copenhagen to discuss the WMA draft Statement on Health and Climate Change and the state of the climate in the world today. Immediately after the seminar the WMA issued a statement declaring that health should be given a much greater priority at the UN Global Climate Change Conference in Copenhagen in December 2009. You can access this statement on the Danish Medical Association website www.laeger.dk.

The purpose of the WMA-DMA sponsored Copenhagen, seminar which took place 1 September 2009, was to gather the knowledge on the present global situation and provide input to the WMA Statement on Health and Climate Change. The statement will inspire National Medical Associations to take action to prevent health related consequences of climate change. The Statement is being edited and will be presented for adoption at the upcoming WMA General Assembly in New Delhi in October. Thereafter, the statement will be

directed at the United Nations Conferences of the Parties – COP15 in December 2009 also to be held in Copenhagen.

However, the initiative to get health on the global agenda must begin now.

At the seminar we learned that global warming will have very serious consequences on health. Everybody will feel the consequences in their daily lives and the consequences are irreversible.

All signals of melt-down – waters rising, droughts, heat waves, fires, desert spreading – are well described and were explained again at the seminar by presenters from Asia, Africa, Australia, Europe and North America.

Not so widely understood are the consequences for the respective physicians and the health care systems all over the world. How will climate changes affect health professionals and the ability to provide health care? Do we need to adjust health infrastructures now – and if so, how?

The presenter from the WHO expressed bewilderment that we have been discussing climate change for so long, but only within the last couple of years have we begun to talk about the health aspects and consequences on health of the global change in climate. Are we reacting too late? Time will tell.

There are many regional differences in the effects of climate change and the reaction of authorities. France is the first western country to give the health aspect top priority when discussing climate change. Maybe this is related to the fact that France has experienced heat waves that have cost lives, mainly of elderly people. Besides this fact, former French colonies in Africa will

probably experience some of the worst consequences of global warming.

There are also huge differences in the fa-



cilities that greatly impact how the country deals with dramatic changes in the climate. These facilities relate to infrastructure.

In South Africa 40 percent of all hospitals are without clean water and water shortages are critical. It will be the responsibility of governments to ensure that strategies on infrastructure are implemented to avoid the most severe consequences of climate change and do not increase inequality in the access to health care.

The climate changes will further accentuate inequalities in health if we do not react in time.

The good news is that there is strong correlation between what is good for our health and what will benefit the climate. Get out of the cars and hop on a bike! This will lower the CO2 emission. The consumption of salads and vegetables instead of beef will also benefit the climate, since a lot of CO2 is used in the production of meat. In these and many other ways, the preventive measures of ill health and climate change coincide. One of the positive outcomes of the Copenhagen seminar was the statement: "What is good for the climate is good for health." Now, we all must begin working to change habits and influence our governments.

Dr. Jens Winther Jensen

Climate Change and Health Care – a Summary of the Sessions at the WMA Seminar held in Copenhagen on September 1st, 2009

Ongoing global warming is caused by humans' increasing emission of greenhouse gases, this warming is causing global climate changes, and these changes have local, regional and global health implications. The seminar in Copenhagen was an opportunity to review the state of the art concerning health implications of climate change, and to comment on the proposed WMA position statement.

The health consequences of climate change could, according to *Colin D. Butler (The Australian National University)*, be understood using a classic health model: primary, secondary and tertiary health impacts. The primary health impacts include heat waves, injuries after floods or fires, infrastructure collapse; secondary consequences are vector-borne diseases, food and water-borne infections, and allergies; and the tertiary consequences would be famine, local and regional conflicts, displacement, refugees, and developmental failure. Dr. Butler stressed that tertiary consequences would cause the greatest health impacts in this century.

Education is crucial, though not sufficient to solve these problems. Dr. Butler emphasized the need for changes in university and professional education. In particular, education at the undergraduate and postgraduate levels needs to focus on sustainability and limits to growth.

Ms. Francesca Racioppi Acting Head of Rome Office, (WHO) noted that when we think about the trends created by the financial crisis, we can quickly understand that a crisis caused by climate change would similarly weaken our capacity to respond. We need to

think in the medium and long term and not just about the next election.

Dr. Mike Gill (Professor Public Health, University of Surrey, UK) proposed that health professionals became more aware of certain and immediate health benefits of climate change mitigation. Life style changes, such as active transportation will mitigate climate change and will have a positive influence on obesity, heart diseases, diabetes, cancer, respiratory diseases, road traffic injuries, and osteoporosis. As those in wealthier countries change their lifestyles, they will also bring about equity.

The WHO estimates that the prevalence of preventable disease in high income and low-income countries due to environmental degradation is, respectively, 17% vs. 25%. Understanding and surveying for the socio-economic determinants of health are essential to developing effective public policy. *Dr. Maura N. Ricketts (Director, Office for Public Health, Canadian Medical Association)* concluded that an understanding is not achieved without an emphasis on research.

Ms. Susan Wilbum (Dep. of Public Health and Environment, WHO) urged physicians, medical associations and countries to work collaboratively to develop systems for event alerts to ensure that health care systems and physicians become aware of high risk climate events as they unfold, and receive timely accurate information regarding the management of emerging health events.

In Asia, the most populous continent, the marine and coastal ecosystems are likely to be affected by sea-level rise and temperature

increase, as is agriculture. The risk of hunger and water resource scarcity is growing, reported *Professor Dongchun Shin*. The Himalayas provide water to a billion people. South Asian countries must prepare for the impacts of global warming, melting glaciers and subsequent loss of potable water.

Even without climate change Africa is already suffering severely from public health problems that are exacerbating morbidity and mortality more than in other continents, *Drs. Sandrine Segovia-Kueny and Louis-Jean Calloc'h* summarized. WHO estimates that climate change is already claiming 150,000 human lives annually and most of this happens in Africa. Climate change (and global warming) is creating climatic instability, which interferes with the rainfall patterns and affects domestic agricultural production. *Minister for Development Corporation, Mrs. Ulla Toernaes* in her closing remarks reminded us that the poorest countries are the most vulnerable to the negative impacts of climate change and thus that those who have contributed least to the problem are facing the most severe consequences. *WMA General Secretary, Dr. Otmar Kloiber* further contributed to this perspective by his closing remark that "we owe our possibilities (to act, mitigate and adapt) to those who don't have them".

Øjvind Lidgaard, Professor, Rigshospitalet, Dept. of Obstetrics & Gynaecology, University of Copenhagen, Denmark
Maura N. Ricketts, Director, Office for Public Health, Canadian Medical Association, Canada

Is Climate Change the Fifth Horseman?



Mike Gill

"I believe that climate change will ride across this landscape as the fifth horseman. It will increase the power of the four horsemen that rule over war, famine, pestilence, and death – those ancient adversaries that have affected health and human progress since the beginning of recorded history" (Dr. Margaret Chan, Director General World Health Organisation, The 2007 David E. Barmes Global Health Lecture)

The welter of arguments to justify immediate action to mitigate climate change is now well known. Increasingly the arguments linking climate change to global health are being loudly articulated. Indeed, Dr. Margaret Chan, Director-General of the World Health Organisation, two years ago described climate change as the defining issue for public health during this century. „With impoverished populations in the developing world the first and hardest hit, climate change is very likely to increase the number of preventable deaths. The gaps in health outcomes we are trying so hard to address right now may grow even greater." (David E. Barmes Global Health Lecture 2007) .

Since then two major publications have set out the detail of the impact of climate change on humans and on human health [1,

2] (see Figure 1). There is no getting away from the facts that climate change is now having huge impacts on human health, that these will become greater if no action is taken, and that the most vulnerable are the world's poorest, already most vulnerable to poor health and premature death, and least responsible for greenhouse gas emissions.

This growing threat has to be added to the other major threats to the health of poor people across the world. Chronic diseases, for example, now impose their heaviest burden in low- and middle-income countries. They place enormous strains on health systems. In many parts of the world the additional burden of climate change will break them. Some of its effect will be direct – for example through increased insect-borne disease, food poisoning, and injury and infectious disease from flooding. Much larger though will be its indirect effects. Crop failures will cause famine, water shortages will cause conflict, as will mass migration and economic collapse. All will cause death.

These are perhaps the most obvious reasons why health professionals should be clamouring for firm global action to control greenhouse gas emissions to mitigate climate change, and to provide sufficient resources for middle and low-income countries to increase their adaptive capacity, in other words to become more resilient

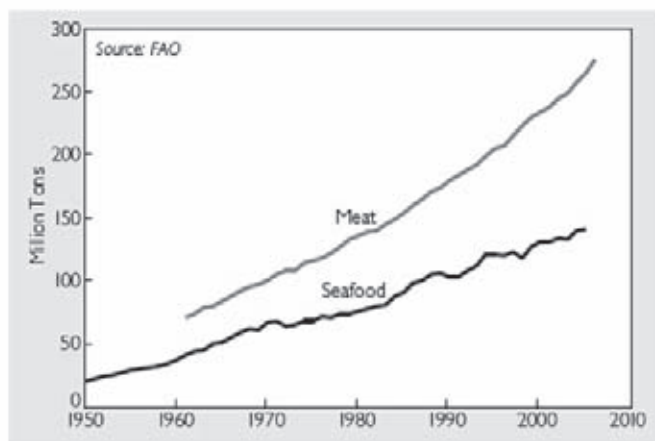
to the threats to which they are already exposed or which are now unavoidable.

There is also a very different set of arguments which health professionals in general, and doctors in particular, need to state, and which politicians and negotiators from the rich countries may find easier to hear and act on. These arguments are based on the size of the benefits to population and individual health which arise from mitigation actions. Actions in the energy sector, for example how we choose to generate electricity, in the transport sector, for example through the promotion of active transport, in the built environment, for example how energy-efficient buildings are, and in the food sector, for example through adjustments in our meat and dairy product consumption, all

Figure 1



Figure 2
World meat production (1950–2006)



these may have a profound effect on health in both rich and poor countries.

Mitigation actions will halt the spread of many of those chronic diseases borne of urbanisation – increasingly unhealthy diets, sedentary lifestyles, and obesity. These are already putting health and health systems under intolerable strain, often in the poorest countries. In Cambodia for example one in ten adults has diabetes and one in four hypertension. Cardiovascular disease accounts for 27% of deaths in low-income countries (often at a younger age than in higher-income countries). The combined deaths from malaria, tuberculosis and HIV/AIDS account for only 11% [3, 4].

So on top of the arguments rooted in social justice – that we should end poverty and reduce global inequalities in health – it is clear that health is no longer a mere consumer of resources. It is also a producer of economic gains, as a result of those very actions being considered to avoid runaway climate change. One of the most important of these is in the realm of transport, a major and increasing source of greenhouse gas emissions. As well as the important effects on road-traffic injuries, urban air pollution, energy-related conflict, and environmental degradation,

there are significant health gains associated with replacing fossil-fuel based transportation with walking and cycling. For example the economic cost of obesity to the UK by 2050 has recently been projected to reach £50 billion at today's prices, in addition to the £10 billion direct cost to the NHS [5]. On the other hand Woodcock and colleagues have modelled the potential

health gains for an average car-driving woman, age 35–44 years, changing to riding a bicycle in London, where almost three quarters of car trips are less than eight kilometres. They conclude she would lose 15g fat tissue per day, the equivalent of 5.6kg fat tissue per year. She would rapidly reduce her risk of premature mortality by 20–40%, breast cancer risk by 25%, all cancer risk by more than 20%, and risk of developing diabetes mellitus by more than 30% [6].

Interventions to curb the current global increase in meat consumption, which is five times what it was fifty years ago (see Figure 2), are similarly likely both to reduce greenhouse gas emissions (agriculture is responsible for 22% of total global emissions, more even than transport) and to benefit health, especially in high-income countries mainly through reducing the risk of ischaemic heart disease (especially related to saturated fat in domesticated animal products), obesity, colorectal cancer, and, perhaps, some other cancers [7].

Currently 2.4 billion people depend on traditional biomass for cooking. This has major health effects: about 1.6 million people die every year from the effects of exposure to high levels of indoor air pollution, largely in low-

Figure 3

The Times
May 25, 2009

Climate change is the cholera of our era

The medical profession needs to wake up: we should be in the vanguard of the green revolution

Muir Gray

income countries [8]. It also generates large quantities of black carbon, now known to be the second strongest contribution to global warming after carbon dioxide emissions [9]. A mitigation action essential to controlling climate change – addressing the lack of access to clean energy for such large numbers of people in low-income countries – will thus also confer huge health benefits.

Realizing these potential health benefits requires public and political support for the mitigation actions that will induce them. To achieve this, health professionals must make both politicians and the public aware of the scale of those benefits. In this task so far we have not done well. A recent article by a doctor in the Times newspaper in the UK likened climate change to cholera in the nineteenth century. Just as fear of cholera outbreaks that killed rich and poor in Victorian times led to vast sums being spent on sewers and ensuring clean water supplies, the physician asserted, so „the medical profession should be in the vanguard of this new revolution in public health” [10] (see Figure 3). The responses to this call to action were revealing: as well as bringing out the frank „climate change deniers’ in force, there was a strong theme of „doctors should stick to their own area of expertise”. While those who respond to newspaper articles are not a scientifically random sample, this response nonetheless supports the impression that there is much work to be done before the public in the UK understands the dual

benefits of low carbon living. With this understanding comes a critical reduction of the political risk associated with promoting and supporting an equitable global agreement to control greenhouse gas emissions. The health benefits of low carbon economies and low carbon lifestyles provide powerful impetus to politicians in terms of being able to carry their electorates with them along what is an irreducibly radical path if the global agreement is to achieve its objectives.

The stakes are high and so the level of our efforts must be commensurate with what we have to gain by achieving our goals. We must leverage the public's trust of the medical profession, which endures despite global health crises and occasional bad publicity [11,12]. We need to do a better job of illustrating the clear links between environmental strategies and improved health, clearly articulating the major benefits of appropriate action. Where possible we should lead personal life styles which are climate-friendly, and encourage our patients to do the same. And we should hone our advocacy, ensuring that politicians, as well as the public, get the message.

At a time when health systems across the world face significant financial constraints, this message is one of the few „good news” stories around. Health systems based on strategies that facilitate low carbon living and deliver health care using low-carbon approaches and technologies, will indeed deliver better health outcomes, save money and protect our planet.

Until now the voice of the health professions has been virtually silent in the UN negotiations and conferences on the environment. This is in contrast to the business sector, which in 2007 produced, for example, the Bali communiqué [13]. The Climate and Health Council is working to rectify this. This Council is an organization led by doctors with the aim of mobilising health professionals across the world to tackle climate change. They have mounted an ambitious

global campaign, designed to ensure that the voice of the health profession is heard before and during the forthcoming international Climate Conference in Copenhagen in December 2009. By the commencement of the conference, the objective is to have gathered hundreds of thousands of health professional signatories from across the world to apply pressure on governments to sign a meaningful agreement in Copenhagen. For the Council, „meaningful” means that the deal should be based on the following three principles.

- a) A scientifically-assessed and globally binding commitment to cap and reduce carbon emissions to avoid atmospheric concentrations greater than 450ppm, recognising that this target may be subject to revision in light of further scientific information.
- b) A mechanism for ensuring that resources are transferred to those countries where both living standards and fossil fuel use have been low. These resources include those needed to enable population stabilisation.
- c) An approach to development which, by giving people the capability of making low carbon choices, minimises green house gas emissions.

For more information, please visit the Climate and Health Council website at (www.climateandhealth.org). All health professionals are encouraged to sign the pledge, which can be found at (www.climateandhealth.org/pledge).

References

1. The anatomy of a silent crisis: the human impact report. Global humanitarian forum. Geneva, 2009 [homepage on the Internet] [cited 2009 September 11]. Available from: : <http://www.ghf-geneva.org/OurWork/RaisingAwareness/HumanImpactReport/tabid/180/Default.aspx>
2. Costello A, Abbas M, Allen B, Ball S, Bell S, Bellamy R, [et al.]. Managing the Health effects of climate change. Lancet and University College London Institute for global health Commission. Lancet 2009; 373: 1693-733.
3. Anderson GF, Chu E. Expanding priorities—confronting chronic disease in countries with low income. N Engl J Med. 2007; 356: 209–11.
4. Neglected global epidemics: three growing threats: chapter 6. In: World health report 2003: shaping the future. Geneva: World Health Organization, 2003
5. Foresight - tackling obesities: future choices. Foresight [homepage on the Internet] [cited 2009 September 11]. Available from: <http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp>
6. Woodcock J, Barister D, Edwards P, Prentice AM, Roberts J. Energy and transport: series on energy and health. Lancet. 2007; 370: 1078-88.
7. McMichael AJ, Powles J, Butler C, Uauy R. Food, livestock production, energy, climate change, and health. Lancet 2007; 370: 1253-63.
8. Haines A, Smith KR, Anderson D, Epstein PR, McMichael AJ, [et al.]. Policies for accelerating access to clean energy, improving health, advancing development, and mitigating climate change. Lancet 2007; 370: 1264-81.
9. Ramanathan V, Carmichael G. Global and regional climate changes due to black carbon. Nature Geoscience. 2008; 1: 221-27.
10. Muir Gray J. Climate change is the cholera of our era. The Times [serial on the Internet]. 2009 May 25 [cited 2009 September 11]. Available from: http://www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article6355257.ece
11. Ipsos Mori. Trust in Professions [homepage on the Internet] [cited 2009 September 11]. Available from: <http://www.ipsos-mori.com/researchpublications/researcharchive/poll.aspx?oItemId=15&view=wide>
12. American Medical Association. Which professionals does the public trust the most, and the least? American Medical News [serial on the Internet]. 2005 Jan. 3-10 [cited 2009 September 11]. Available from: www.ama-assn.org/amednews/2005/01/03/prca0103.htm
13. Bali communiqué [homepage on the Internet] [cited 2009 September 11]. Available from: http://www.cpsl.cam.ac.uk/our_work/climate_leaders_groups/clgcc/international_work/the_bali_communique%C3%A9.aspx

Prof. Mike Gill, The Climate and Health Council Board member, University of Surrey, UK

In memoriam: Angel Orozco

In 1955, at the age of 25, Angel Orozco followed his father from his then poor home country, Chile, to New York City. With the ambition of finding a job in America and making a living for himself, he left Chile by boat and landed in Norfolk, Virginia. In Norfolk, he bought a bus ticket northbound to New York. Oblivious to the laws of segregation in the American south, he was confused by the stares of the other passengers as he made his way to the back of the bus and sat down among a group of black women. His neighbours welcomed the friendly, buoyant young man and Angel had found a group of friends with whom he remained in contact for the rest of his life.

At that time, the World Medical Association was located at New York's Columbus Circle. There Angel found his first and last employer in the beginning of 1956. Though he probably did not know it at the time, this job would take him across the globe and back many times. He began his WMA career as a helping hand and finished it as the organization's Executive Director – a position he occupied for more than two decades. It was he and fellow staff-member, Thomas Kennedy, who took responsibility in 1975 for moving the WMA from New York to the Geneva area to be closer to the WHO and the heart of the international community. He and Tom (who later moved to Denmark and joined the staff of the Danish Medical Association) settled the office just outside of Geneva in Ferney-Voltaire, a tiny French village with only 6,000 inhabitants. There were not even proper office buildings in Ferney to house the WMA at that time, so the WMA purchased a villa in a residential area and this became home for the WMA and its staff for the next 25 years. During his many years in France, Angel remained a legal resident of New York state and a US citizen, an identity he cherished along with his Chilean citizenship.

During most of Angel's tenure as Executive Director, the WMA did not have a full-time Secretary General present in the office, but a series of volunteer Secretaries General who remained in their own countries and served primarily as spokesmen for the organization. The

running of the office, the management of the staff, and the work of the WMA was Angel's responsibility – and one he took very seriously. He rarely left the office until 7 or 8pm and often stayed late into the night. He helped lead the WMA through, and beyond, its first half-century, a successful era marked by progress as well as controversy. Through all of that, Angel was wholly committed to serving the WMA members and officers, no matter what level of effort was required. He was universally loved by his staff – an extreme rarity for the boss of any organization. In a nutshell, working with Angel was fun. He demanded a lot, but his informal style, fierce loyalty and protective nature made him more than a boss to most who worked for him. He was also a friend, a confidant and even a father figure to some of his younger staff.

Angel's work with the WMA was full of adventure – and the occasional misadventure! He was arrested twice in relation to WMA business: once due to false allegations and once for transporting the registration fees from the General Assembly in Venice with him on his attempted return to France. Carrying that amount cash over the Italian border was illegal at the time. It never occurred to Angel that a person could be prohibited from carrying his own money with him – a law of which he became aware only after being arrested on the train on the border Italian-Swiss border and taken in custody. In both cases, Secretary General Dr. André Wynen, bailed Angel out of jail and brought him home.

Officially, Angel retired from the WMA in 1994 at the age of 65. He returned to his home country, Chile, re-established himself with his family in Viña del Mar, and bought a small farm in the hills between the coast and Santiago. Despite his official retirement, he remained a consultant and a friend to the WMA until last year, helping with annual meetings and providing invaluable institutional memory in every area, from process, to policy, to politics. His final meeting with WMA was in Divonne in 2008. Although most of us probably did not realize it beforehand, Angel had been battling cancer for many years already when he



Angel Orozco

Born 4 September 1929 in Iquique, Chile

Died 21 April 2009 in Viña del Mar, Chile

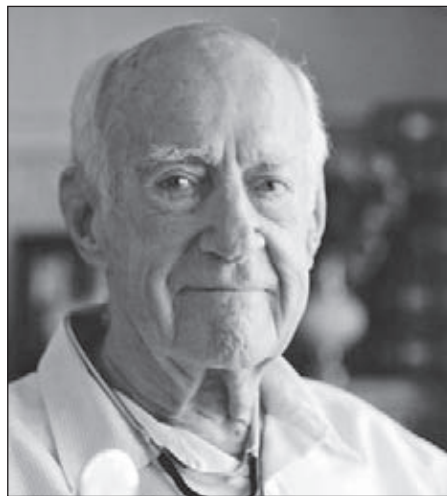
finally he felt too tired to make the trip to the 2008 General Assembly in Korea.

For 54 years, Angel Orozco was a fixture in the World Medical Association. He was affectionately considered by many to be the "godfather" of the WMA. He was honoured by numerous member associations for his service to organized medicine, including the German Medical Association's Medal of Honour. However, those who knew Angel know that he would count as far more significant than his professional accomplishments, the deep and lasting friendships he developed and maintained until the very end of his days. Those who treated Angel with respect were rewarded with a life-long friend, full of energy, entertainment and humour. From the women on the bus in Norfolk to new WMA members who may only have met him last year, Angel was quick to offer his friendship and steadfast in sustaining it.

Although we learned of the severity of his illness nearly a year before his death on April 20, 2009, the news of Angel's passing came as a terrible shock to all of his friends and colleagues. The WMA will not be the same without him. It was an immense pleasure to work with him and a wonderful and enriching experience to know him. Angel may be gone, but his ideas and spirit will forever remain part of our organization and our lives. He is deeply missed.

Otmar Kloiber with Joelle Balfé

In memoriam Edward R. Annis



EDWARD R. Annis, M.D., died September 14, 2009 at his home in Miami with several of his children and loved ones at his bedside. He was predeceased by his wife, Betty McCue Starck, to whom he was married for 64 years. They raised 8 children.

In 2005 Dr. Annis was honored to be included in the book *Caring Physicians of the World*, which profiled 65 “caring physicians” from 58 countries around the world, exemplifying the universal and enduring medical traditions of caring, ethics and science. “The term “Caring Physicians” immediately conjures up images of those who spend their lives serving patients in poor and disease-stricken environments. There are however other types of caring physicians, with roles equally important. These are the physicians whose caring is manifest by working in the public arena to influence public policy to meet the healthcare needs of patients and the physicians who serve them.”

Dr. Annis excelled at caring for patients as a practicing physician for many years. He began his medical career in Tallahassee, Florida, before moving to Miami, Florida, where he became Chief of Surgery at Mercy Hospital. Dr. Annis was passionate about healthcare access for all patients, and used his medical and social

leadership skills to advocate for patients and the medical profession throughout the world. He served as President of the American Medical Association from 1963 -1964, and in the same year as President of the World Medical Association.

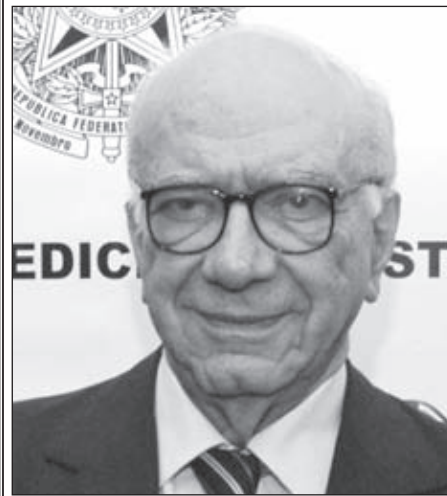
Dr. Annis was a gifted orator with an exceptional understanding of the advocacy process for developing health policy. Despite the emotion created by the complex issues, Dr. Annis was always clear, constructive and statesman like. He honed his oratory skills in high school, at the University of Detroit and Marquette Medical School in Milwaukee, Wisconsin where he received his medical degree in 1938. In his role as advocate for physicians and patients, he made many appearances on national television and radio, and spoke with politicians and presidents including John F. Kennedy and Senators Humphrey, McNamara, Proxmire, Javits and Gore.

Dr. Annis was a strong critic of inefficiencies and unnecessary bureaucracy in healthcare. In 1962 he gave a famous speech in Madison Square Garden, to a television audience of 30 million people, presenting the physicians’ response to government dominated medicine. Recently, this famous televised speech was entered into the United States Congressional Record. His book, *Code Blue: Health Care in Crisis*, was published in 1993.

Regarded as one of the giants of American medicine, Dr. Annis mentored and inspired many and achieved much, receiving many honors and filling many important leadership positions over his lifetime. When asked what had been his greatest achievement in life, his answer speaks volumes for this caring physician: “My family”. When asked to explain his passionate service to patients and medicine, he responded, “My whole approach is that no person in the nation should be denied medical care if they need it, whether they can pay for it or not.”

Dr. Yank D. Coble

In memoriam Pedro Salomão Kassab



Pedro Salomão José Kassab, a Brazilian physician, grandson of Lebanese immigrants, graduated in medicine at University of São Paulo (USP) in 1953 and specialized in dermatology. He had highlighted activity on medical associative affairs. He served as general secretary of the Brazilian Medical Association (AMB) from 1963 to 1968 and between 1968-1981, he became president of this association. In 1976 he was elected president of the World Medical Association. He was the second Brazilian doctor to hold this position.

Dr. Kassab was also a member of the consulting council at the University of São Paulo, School of Medicine. Beyond medicine, education was another passion for him. In 1957 he became director of one of the most important and traditional schools of São Paulo, The Liceu Pasteur. He was president of the Education State Council in 2006-07 and he also directed The Superior Education Chamber of this organ.

Pedro Kassab passed away on 15th September 2009. He had seven sons and ten grandsons. One of his son’s is the current mayor of São Paulo.

The Brazilian Medical Association

Under the Influence - the Damaging Effect of Alcohol Marketing on Young People

The British Medical Association (BMA) has issued a report focusing on the damaging effects of alcohol marketing on young people. The Association's Science and Education department and its Board of Science has published the report "Under the influence", which is authored by Professor Gerard Hastings and Kathryn Angus.

The report points out that alcohol consumption in the UK has increased rapidly in recent years, not just among young people, but across society. The population is drinking in increasingly harmful ways and the result is a range of avoidable medical, psychological and social harm, damaged lives and early deaths. Alcohol marketing communications

have a powerful effect on young people and come in many forms. These include traditional advertisements on television through ubiquitous ambient advertising to new media such as social network sites and viral campaigns. The cumulative effect of this promotion is to reinforce and exaggerate strong pro-alcohol social norms.

The report also points out that stakeholder marketing by the alcohol industry, including partnership working and industry funded health education, has served the needs of the alcohol industry, not public health.

In its conclusions, BMA reports that "The reality is that young people are drink-

ing more because the whole population is drinking more and our society is awash with pro-alcohol messaging, marketing and behaviour."

The measures recommended by the BMA include a comprehensive ban on all alcohol marketing communications; minimum price levels; increase the level of excise duty; and several other measures.

Although the report is based on the British alcohol scene, it would be interesting reading around the world.

The alcohol industry has protested against the recommendations of the report.

The report may be downloaded from the BMA web site: http://www.bma.org.uk/health_promotion_ethics/alcohol/undertheinfluence.jsp?page=1

Contents

Editorial	85	International collaborative initiative surgical Manpower development: a plea to do more in low -income-countries	112
The 182 nd WMA Council Meeting	85	Re-thinking Means and Ends: Economic Crises, Health and Access to Health Services in Europe	116
Items from the 182 nd WMA Council meeting in Tel Aviv, May 2009	86	Climate Changes and Health – There is Some Good News... ..	118
Task Shifting On-Line Moderated Discussion	93	Climate Change and Health Care – a Summary of the Sessions at the WMA Seminar held in Copenhagen on September 1 st , 2009	119
Shaping the Future of Health Professionals' Regulation	94	Is Climate Change the Fifth Horseman?	120
Accessing Health Care for Undocumented Migrants - European observations	95	In memoriam Angel Orozco	123
Bringing Fair Trade to Health Systems: What You Can Do	98	In memoriam: Edward R. Annis, MD President, World Medical Association, 1963-64	124
The Second Geneva Conference on Person-centred Medicine ...	100	In memoriam: Pedro Salomão Kassab	124
Person Centred Pediatric Care	102	Under the Influence - the Damaging Effect of Alcohol Marketing on Young People	125
The International Network for Person-centred Medicine:	104		
Ethical , Moral, and Legal Responsibilities of Physicians: an Islamic Perspective	107		

WMA Conference on Climate Change, Copenhagen, 1st of September



Belgrade, 17th to 19th of September, ZEVA Meeting

