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- Medicine and politics – CPME 50 years
- Multi-Drug Resistant TB in prisons
- Cognitive neuroscience

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Cover painting:

This oil painting, entitled "Rocky Mountains 1936", hangs at the offices of the Canadian Medical Association (CMA) in Ottawa. It was painted by Sir Frederick Banting, who, along with Dr. Charles Best, discovered insulin in 1921. Banting, born in Canada in 1891, was an accomplished artist and may have had a successful career as a painter were it not for his work in medicine. He was killed in February 1941 while serving his country in the Second World War. The painting was donated to the CMA by his widow, Lady Henrietta Banting.

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No time for depression – a busy year ahead for WMA

Editorial

Signs are good that the economic downturn is behind us, and the challenges before us will not allow us to continue lamenting about it. However, it will be interesting to see whether there are real lessons-learned from this crisis or whether we all fall back to business as usual, unable to process those lessons, unable to implement change.

During the UN Climate Change Conference in Copenhagen, in September of last year, politicians achieved results which, in scientific terms, would be considered as “suboptimal”. Yet their delay will give us more opportunities to emphasize the health effects of climate change. To mitigate those effects will be crucial, but our ability to respond to climate change also must be examined. Regardless whether we will have to react to the spread of diseases around the world, the drastic changes to the human habitat in many regions, or to natural disasters - Haiti has shown that we still can improve. – This is a little weird. How does Haiti show us anything about the spread of disease or changes in the human habitat? Also, are you saying that our response to Haiti shows that we *have* improved, or that there are still improvements we need to make? I can't quite figure out what you're saying here. I'm also not sure how it all fits in with climate change, which is the topic of the paragraph. If you can clarify your thinking on this, I'll smooth it out as soon as I receive it. (Or, as soon as I wake up. Just wrapped another 16 hour work day here and there's another one coming tomorrow!)

The resources that have been leveraged and delivered to help Haiti are a good sign for global solidarity and we applaud those who have engaged personally to do relief work in the country. But Haiti also reminds us how unequally resources, including medical resources, are distributed in the world and that our efforts to expand the qualified, adequately equipped health work force still have far to go. Numerous countries are in a perpetual state of emergency, without having experienced an earthquake or other calamity, and they deserve our attention and help as well. People are suffering and dying across the globe. And when some say they never have seen a catastrophe equal to the one Haiti, maybe it is because we are constantly turning our eyes away from places like Darfur and certain areas of Sub-Saharan Africa.

For the last few years we have been examining the question “Why do physicians go away?” The answers have been plenty, but they all boil down to the same basic premise: because of poor working and living conditions and insufficient pay. Still, we see that many of our colleagues continue to fight the uphill battle every day and remain on their job, often under staggering conditions. The question we would like to ask them is “What makes you continue?” Physician resilience will be one of the interesting topics WMA President. Dr. Dana Hanson, will help us address this year.

Another under-appreciated problem before us is the growing influence governments exert on health care, especially with respect to our professional independence. Diminishing the professional status of self-governing bodies by taking away sovereign functions and putting them under government direction, or abolishing obligatory membership in order to weaken them are just a couple of examples of what we currently observe. If physicians wish to remain a respected profession with a protected relationship between ourselves and our patients, then we must act now and with authority. Governments around must not succeed in reducing physicians to “service providers” or simple technicians who are subject to the orders handed down by “payers” – whether they are governments themselves or private insurance companies.

The WMA is committed to continuing our educational work on Multidrug-Resistant Tuberculosis, which we combine with efforts to improve infection control, and we will step up together with our partners in the World Health Professions Alliance against counterfeit and substandard medicines that threaten the health and safety of our patients.

It is difficult to predict all that 2010 has in store for us, but it will not be boring. We have had a few highlights already and there are more to come, including:

- On the occasion of the 126th World Health Organization Executive Committee Session from 18-27 January, WMA, together with our partners in the World Health Professions Alliance, urged that the draft “Global Code of Practice on International

Recruitment of Health Personnel” be discussed at the next World Health Assembly.

- In Sao Paulo from 1-3 February, assisted by our member organization from Brazil, we brought together the most high-profile international experts to discuss some of the most difficult ethical issues associated with placebo use in clinical trials.
- WMA convened the third Caring Physicians Leadership Course with INSEAD – this time at the INSEAD Campus in Singapore (February 8-13).
- The World Health Professions Alliance will discuss regulation of the health profession during the second World Health Professions Conference on Regulation (Geneva February 18-18) and
- From 3-4 May, the third Conference on Person Centred Medicine will gather in Geneva.

- The leaders of the nursing, dentistry, pharmacy and medical professions will meet in Geneva the day before the World Health Assembly to evaluate and celebrate the first 10 Years of our alliance (May 16).
- WMA Council will convene in Evian, France from 20-22 May.
- In September (tentative 10-11), in Riga, Latvia, we will examine the effects of the global economic crisis on the world’s health care systems and what we can learn from our experiences.
- October 13-16 will bring together the members of the World Medical Association for our WMA General Assembly in Vancouver, Canada.

Dr. Otmar Kloiber, WMA Secretary General

WMA Conference in Riga

In order to discuss the implications of the financial crisis for health, the World Medical Association in cooperation with the Latvian Medical Association will organise the two days conference on *“The Financial Crisis – Implications for Health Care. Lessons for the future”*. Conference will take place in Riga, Latvia on 10th and 11th September, 2010.

The financial crisis has affected the economies of nearly all countries around the world. While some countries experienced “only” a recession, some countries are still in deep recession leading some countries to factual insolvency. However, now after the billions invested in rescue packages for financial institutions and a first wave of economic recovery programmes the situation is showing some signals of stabilisation. One of the sectors of economy, which is also suffering is health care. Health care systems in many countries seem to be rather stable and only moderately affected while others experience significant budget cuts, which leads to terminating essential health care services in some areas. In the process of economical recovery it is important to invest also in health care to keep people healthier so they can work more productively, which leads to faster economical recovery. Since the begin-

ning of the crises, analyses of its impact on the health sector have been undertaken in many countries and a range of recommendations and strategies has been suggested to the governments. Clearly, the responses will vary from country to country. Nevertheless, strategies will need to combine measures to protect the health budget and to prioritize sectors and groups and to preserve and even strengthen the quality and efficiency of the health sector performance.

The conference is expected to gather between 300 and 400 professionals from Europe, Asia and America. Based on evidence drawn from international experience and research, the Conference, with the participation of health experts and health professionals, will provide an overview of the major threats and challenges to the health systems caused by the economic crisis. Participants will identify current key problems and challenges faced by the health systems in Europe and globally. Speakers at the conference will outline responses that countries so far have developed in addressing these problems and challenges and look into some priority areas to assess the effect of the economic recession and to explore effective policies in resolving the main problems created. The

value of this conference will be experience gained and finding the best possible solutions for leading health care systems out of the crisis for faster improvement of health and recovery of economy.

More information about the conference is available at www.riga-wma.lv.

*Rinalds Muciņš,
Latvian former Minister of Health*



Doctors for the environment

On November 28th, the Brazilian Medical Association in partnership with the University of São Paulo Medical School and the Institute Health and Sustainability, organized a conference on climate change called “Doctors for the Environment”.

Dr. Dana Hanson, president of World Medical Association (WMA), was invited to open the conference. He spoke about the need to examine climate change from the perspective of patient health. “We’re not here to find out who is guilty or to judge anybody. We put individuals at the center of discussions. Why the health of the population is not the focus of Cop 15?”. During the presentation, Dr. Hanson highlighted points of the Declaration of Delhi, which was translated into Portuguese and released during the event by the Brazilian Medical Association. Finally, he called on Brazilian doctors to engage with this issue.

The second block of the event began with a talk by Dr. Paulo Saldiva, head professor of pathology at the University of São Paulo.

“Although Brazil has advanced legislation of the environmental point of view, man was not included”. To Saldiva, there is not an engagement with human health and this is largely to blame on doctors. “Few managers understand health. In Brazil, we are better prepared to deal with hepatitis B or with H1N1 than, understand the effects of climate change on health”. The pollution, according to data presented by Dr. Saldiva, caused the death of 4 million people last year in São Paulo, far more people than the H1N1 outbreak. “Physicians should use the credibility and their work to do something, as they may be guilty of the sin of omission in a near future”.

After an analysis from the perspective of health, Carlos Nobre, a chief researcher at the National Institute for Space Research (INPE), presented an overview of climate change in terms of the environment. For him, the changes in climate are the biggest challenge that humanity has ever faced. “The Earth’s natural capital is being squandered”. In a comparison with the economic crisis,

the researcher said that the planet is being mortgaged to subprime loans. “The amount of money needed to mitigate some effects of climate change is less than required to help the banks.” For him, the planet passed many points of no return and if the developing countries cross the line of sustainability the situation will get even worse. “We need to invent a new model of development”.

Eduardo Jorge, São Paulo’s Secretary of the Environment, followed the discussion by saying that the responsibility is no longer only on the hands of the more developed countries. “In all areas we can do something to reduce the damage”. He presented some environmental projects that the city of São Paulo is working on: Construction of energy plants at landfills to convert methane into energy, a city’s initiative to reduce the emission of pollutants through the vehicle inspection, protection of water sources and increasing the number of parks.

*Helena Fernandes,
Communication Department,
Brazilian Medical Association*

“Physicians suffering from silent desperation”, says WMA leader

The medical profession and governments have been urged to pay more attention to the issue of stress and burn out among physicians, according to the President of the World Medical Association.

Dr. Dana Hanson, a Canadian dermatologist, said that the medical profession must strive to remove the stigma surrounding burn out, while governments must address the problem, since healthy resilient physicians equalled longer professional lives and, more importantly, more accessible care for patients.

Dr. Hanson, addressing The Global Forum of Health Leaders conference in Taipei, Taiwan, said that according to surveys in Canada and elsewhere some 45 per cent of physicians were in an advanced state of burn out, with an even higher figure in developing countries.

But why did one physician thrive in his or her career while another experience stress? The answer lay in part in being able to manage and recover from adversity. Resilience meant rising to challenges, responding creatively, learning and growing.

Physicians, he said, should not have to choose between saving themselves and serving their patients. Many physicians who were outwardly patient and enthusiastic were inwardly burning and finding their work less rewarding. The global shortage of physicians was leading to chronic overwork and stress.

Dr. Hanson said that healthy physicians meant healthier patients, greater satisfaction, safer care and a sustainable workforce.

Physicians were generally healthy when it came to tobacco use, and contrary to popular belief, drug and alcohol use was no greater in the medical profession than it was in other occupations.

Yet more demands on physicians and their increasing lack of control were leading to a silent desperation among physicians. Women in the profession in particular appeared to be at greater risk of suicide, and a significant proportion of all physicians had symptoms of depression and anxiety, according to surveys.

Dr. Hanson said that the image and professionalism of physicians, the threat to their self regulation, patient safety and accountability without authority all contributed to mental stress.

He said it was time the profession's leaders and governments recognised these facts and

took action to support physicians, through national leadership, raising awareness of the problems and reducing the stigma of burn out and education.

Nigel Duncan, WMA Public Relations Consultant

Task-shifting or task-sharing? – Reflections from within the European Union (EU)



Michael Wilks

From a European perspective, the debate on what is commonly (and often mistakenly) called task-shifting has crystallised around the European Commission's recent "Green Paper" on the European Workforce. The main drivers for this are seen as the demographic changes in the population, the increasing use of information technology in healthcare, and the changing expectations of patients. The amount of time a doctor is available to patients is also affected by the impact of the European Working Time Directive, an increasing proportion of women doctors, and a change in attitude on the "work-life" balance that doctors, like other members of society, should enjoy.

Demographic changes affect both doctors and patients. Both groups are ageing to-

gether, with a consequent increase in chronic diseases and a reduction in the number of physicians available to treat them.

One key issue in any debate about how a workforce should be reconfigured is, essentially – who does what? What tends to get in the way of such a debate is an impression that doctors are resistant to change, and hold on to old patterns of working in order to retain power. This perception is often difficult to shift, but a more useful and responsible way of approaching the "who does what?" question is to start with two principles that are unarguable. The first is that shifting tasks from one group to another has to be conditional on also shifting the training. The second is that task-shifting should never be done for purely financial reasons, as to do so will undermine care through the delivery of sub-optimal services.

Another major but variable demographic factor is migration. Movement of doctors from Eastern to Western Europe has been predominantly driven by economic factors. The EU's long-term goal must be to convert that into a two-way migration based on a desire for professional self-improvement.

The predicted increase in the number of patients with long-term chronic illness is a direct result of increased longevity and progress in treating or containing acute illness. The influences of obesity, smoking, alcohol excess and income inequalities will long be

with us. Better screening will identify more treatable disease, and much of this disease load will be added to the burden faced by healthcare systems, whose budgets will be stretched. The depressing evidence from the work done to date on health inequalities is that much of this healthcare spending will have a marginal impact on the overall health of many groups of EU citizens.

Our patients will expect more information, more involvement in their care, and greater freedom to be treated in a place – or even a country – of their choice. The central importance of the doctor/patient relationship will not change, but improved interoperability between IT systems, greater access to information and more freedom of choice will dramatically alter the way this is conducted.

How should the EU and its doctors approach the way these influences will affect us? From the European Commission's point of view, a large stumbling block will be the familiar tension between Member State autonomy and what is often seen as EU interference. All the countries in the EU jealously guard their right to run their healthcare systems; the EU has a role in "adding value" where it can do things that member states cannot do alone. Public health issues such as global warming, and communicable disease monitoring are examples of this. The Green Paper's approach to a "European" workforce is limited by this concept of subsidiarity, leaving the Commission some room for influence in areas such as professional mobility and cross-border healthcare. But with increasing mobility of

patients *and* doctors, the influence of economic migration, and an opening up of the market for health, can the EU allow itself to continue to think in terms of twenty-seven workforces instead of one?

The terms “skill-mix”, “task-shifting” and “task-sharing” are often deployed without adequate definition or context. In CPME’s (Standing Committee of European Doctors) view, tasks can never be “shifted” from one healthcare professional group to another for purely economic reasons, tempting though this is for governments squeezed between the twin pressures of financial crisis and increased demand for care. CPME and its fellow European Medical Organisations have always emphasised that the right training for the task is essential, and that when it comes to transferring responsibility for any aspect of care to another professional, there are two “non-negotiables” to protect patient safety. The first, as mentioned, is training, but equally important is that any sharing or shifting of tasks takes place within the context of a team, in which skills are defined, and lines of accountability exist.

Here it is important to stress a fundamental difference between doctors and all other healthcare professionals, based on the concept of the acceptance of risk. Doctors are trained to accept risk; perhaps the best practical example of this is the uncertainty inherent in a list of differential diagnoses a doctor works through, eliminating one in favour of another on the basis of experience, training and investigation. Uncertainty is a feature of all healthcare provision, but the risk associated with this is mitigated in the way much of other health professionals’ work involves the use of protocols. Protocols will define or limit practice and also risk, but their existence also demands that when the limits or boundaries of what a protocol allows are reached, then the risk has to be handed on. In most practical scenarios this will involve a doctor, so while doctors *can* work in isolation (although they rarely do), most other healthcare professionals have to

be based within a team hierarchy. Another important factor is that doctors and other health professions whose tasks are shifted will also need to be confident that other members of the team to whom they are shifted do possess the necessary skills.

Apart from creating differences in professional behaviour, this fact also adds a new element to the workforce dilemma. High standards of care, especially in highly specialised centres, are not usually produced by individuals but by teams. The levels of care achieved will be built up over time as teamwork, experience and training evolve. There is therefore a need for the preservation of teams and not just their individual elements. This provides an opportunity, through the support that can be given to professional development, and through professional migration, for a new approach. What needs to be developed, rather than the somewhat woolly concept of an ethical recruitment policy, is a real and sustainable transfer of skills, knowledge and experience between specialist centres.

Information technology (referred to as “E-Health” in Europe) is transforming healthcare delivery, although we are still in the foothills of a transforming journey. There are three main challenges that this revolution is delivering to patient care. The first is the quantity (but not necessarily the quality) of data. The second is how IT systems communicate, within and across organisational and national borders. Thirdly, this information needs to be contextualised so that it is useable in, for instance, providing relevant information to patients and assisting them to be better involved in their care. Developing the last of these offers part of a solution to the workforce dilemma.

The European Commission’s Green Paper extended the definition of the workforce to include carers. One could ask: “why stop there; why not include patients?” If we are serious about more patient involvement and self-management – and we should be – on

principle alone – then information is key. The electronic patient record will provide a powerful tool, not just for improving patient safety by sharing information across the healthcare team, but in also providing a route for better monitoring through telemedicine, targeted information flows to assist self-management, and (with appropriate consent) the use of data for healthcare service planning and for research.

We can see these types of developments in many countries. In Europe their particular focus is to support cross-border healthcare. Although the right of free movement is a fundamental EU principle, creating the opportunity for patients to obtain care across Member States’ borders has been limited by the organisational and financial problems it poses. However, as patients move around more, relevant information to support their care must also be transferable. Large-scale pilots are being developed in up to twelve EU member states to test the technical, legal and ethical aspects of sharing electronic summaries and “e-prescribing”.

There are enormous advantages (and risks) in these developments. The greatest advantage is in safer patient care, supported by improved information-sharing. Using the electronic patient record as a vehicle for enhancing information flow to doctors and to their patients is a clear benefit, but the challenge will be to “translate” that information in a way that is useful and relevant.

The obvious risk is that breaches of patient confidentiality will destroy confidence in the system, leading to withholding of information. At present, doctors are more sceptical of the risk of data leakage than patients. Patients see the benefit of not having to repeat their history to a variety of different healthcare professionals, while doctors are suspicious of unauthorised access for purposes other than patient care.

In relation to the role of the doctor, the information revolution opens up access to

medical records by a wider number of professionals with involvement in the immediate care of patients. With widening access will come the desire to take on new roles, so the central question – “What is a doctor?” – is not just a theoretical one. In the EU we will soon be looking at the review of the Di-

rective on the Recognition of Professional Qualifications (Directive 2005/36). Up to now, the ability of doctors to move around the EU has been conditional on possessing relevant qualifications. As the demand increases for doctors to demonstrate *current* competence, appraisal, revalidation and

licensing are going to appear on the EU's agenda. This will sharpen the focus on what constitutes the core work of a doctor.

Dr. Michael Wilks,
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Multi-Drug Resistant TB in prisons

In the past ten years, resistant forms of Tuberculosis, and particularly Multi-Drug resistant Tuberculosis* (MDR-TB), have become a health menace of epidemiological proportions, recognized as such by all international medical organisations such as WHO, CDC, IUATLD, WMA, MSF**, and many more. The World Medical Association, at its Annual Assembly in New Delhi in October 2009, underlined the importance of this issue by putting it on the agenda of its Scientific Session***.

TB specialists around the world have been and are still debating how best to tackle MDR-TB and its even more serious derivative, Extensive Drug Resistance (XDR). Diagnostic procedures, classification of different categories of resistance patterns, and actual management and treatment of the disease are among the many priority issues undergoing constant review.

In prison settings, all the major issues that constitute “pitfalls” to good TB management are enhanced when dealing with MDR forms of TB [1,2]. A few additional considerations need to be addressed, taking

into account the communications received at the WMA 2009 Scientific Session, in the light of the specific constraints encountered in prisons and other custodial settings.

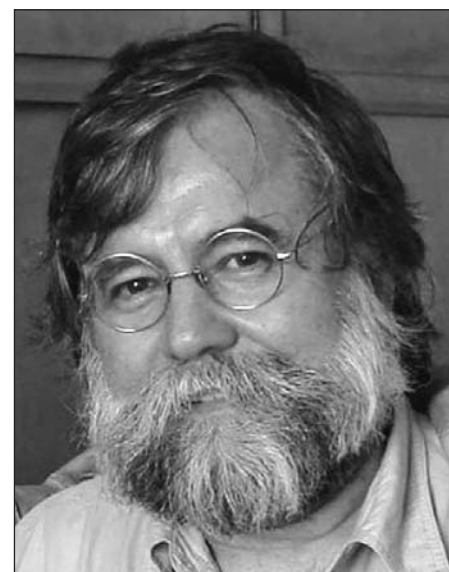
Three separate (but, of course, linked) issues are here considered:

- diagnosis of TB and its resistant forms, and particularly the use of Drug Susceptibility Testing (DST)
- individual treatment vs. standardized treatment regimens
- additional issues specific to custodial settings

Diagnosis and selection of anti-TB drugs according to DST

The greatest risk for TB transmission is posed by patients with undiagnosed or unrecognized infectious TB [3], hence the importance of diagnosis of the disease, and selection of the correct anti-TB drugs to use for treatment. Both should always be based on two complementary criteria: first, the **history** of previous anti-TB therapy, and second, *reliable DST*, meaning testing that has been subject to quality control according to internationally approved standards [4].

The taking of the patient history of previous therapy, is often problematic, and difficult – if not outright inadequate or even sometimes totally absent in prison settings. The reasons for this are more complex than mere negligence, and are sometimes difficult to grasp in developed, high-resource coun-



Hernán Reyes

tries, without the many problems described further on.

As is well-known, the definition of a “new patient”, as someone who has *never* taken any anti-TB drugs, or taken them for **less than 30 days** time, is an essential component in the diagnostic procedure of “normal”, i.e. drug-susceptible TB. This is all the more important for drug-resistant forms of the disease.

As has been amply described elsewhere [5], before the passage of at least 30 days, there is simply not enough time for a sufficient number of spontaneous mutations to constitute a sufficient population of resistant forms of *Mycobacterium Tuberculosis*. It is therefore essential to have this situation

* Defined as being resistant to at least Isoniazid (H) and Rifampicin (R).

** World Health Organization; Center for Disease Control and Prevention; International Union against Tuberculosis and Lung Disease; World Medical Association; Médecins Sans Frontières (Doctors w/o Borders).

*** See the WMA website for additional information on the Scientific Session: www.wma.net

clearly defined at the start. In the best of scenarios, a health professional, physician or nurse, may inform the prisoner/patient about TB disease, and why it is crucial to have the exact information, and (hopefully) why any deviant responses may be detrimental not only to the patient but also to fellow inmates and to any visiting family members.

“Initiation of drug therapy in patients with proven MDR-TB requires assessment of the history of treatment as well as meticulous laboratory studies to characterize the susceptibility of the specific strain.”

Iseman MD. Treatment of Multidrug-Resistant Tuberculosis. N Eng J Med 1993; 329: 784-91

In prison settings, inmates may or may not tell the truth about their history and many other issues, for different reasons. While logical reasoning may seem straightforward enough to health workers unfamiliar with prisons, custodial settings differ greatly from the “outside world”. There is a broad range of factors influencing the way a prisoner answers the questions posed to them.

The first obstacles to obtaining quality patient history relate to the actual health professional asking the questions. Prisons in low-resource countries – most often the very countries with a high prevalence of TB and also of MDR TB – are often notoriously understaffed, particularly regarding health staff. Experience has shown that poorly paid, insufficiently trained, and, hence, poorly motivated health staff are not well equipped for dealing with complex health issues such as TB – *a fortiori* resistant forms of TB. Poor history-taking is a major shortcoming in many prison health services. It is also still the sad reality in many prison systems worldwide, that National TB Control Programs (NTPs) do not visit the prisons in their country, or, if they do, they most often do not have a clear picture of the realities therein. NTPs are sometimes not allowed to

enter prisons, for administrative or security reasons. Quite often, NTPs have a passive attitude towards prisons, and tend to ignore them. Therefore, medical staff working in the prisons often lack training on “normal” TB – let alone its resistant forms. Such medical staff, even prison doctors, often fail to diagnose tuberculosis because they lack the proper training and supervision that would put TB in the forefront of differential diagnosis of respiratory diseases.

Even those prison systems that have qualified, motivated staff (i.e., that provide adequate salaries and on-going training), are often, nonetheless, under-staffed. In these situations, overworked health personnel simply do not have the time to take an adequate case history for TB cases. Ideally, in contexts where resistant TB is a reality in the outside world (and consequently would need to be actively looked for in prisons), previous treatment history should be taken by a highly trained physician. To take an adequate *history of treatment*, this person should know about first and second line TB drugs; their availability and use in the country and their adverse effects (so as to recognize them as required). There should be sufficient time per patient, even up to possibly an hour or so, to ensure all aspects are duly addressed. It has been often suggested that there be at hand a display of the different pills available in the country (and their boxes!), so that the physician can present the patient with a choice of visual possibilities and increase the likelihood they will recognize drugs they have taken previously.

As anyone who has worked in most prisons in developing countries will know, the ideal situation described above is, unfortunately, merely wishful thinking, and is not about to become a reality in most prisons of developing countries any time soon.

An additional issue that may negatively affect treatment decisions is one that can arise in both low and high-income countries. Prisoners are not the most cooperative of pa-

tients. For a whole panoply of reasons, from wanting to obtain perceived “privileges”; to desiring transferral to hospital; to other considerations of a totally non-health related nature; prisoners may knowingly provide false information to health staff. Experience from ICRC TB programmes in different countries have shown that prisoners can and do give the answers to the questions that they believe will lead to the “geographical”^{****} or categorical classification that the prisoner has decided he or she wants – and not according to medical criteria, which should be the determining factor.

The need for Drug Susceptibility Testing hardly requires any justification in the management of Tuberculosis and its resistant forms, even though many factors still limit its widespread use in developing countries [4; 5]. The difficulties inherent to the delay in obtaining results, the possible mishaps in the technical performances necessary, and the real problems inherent to the adequate interpretation of results have all been described. The additional complications of differentiating DST *in vitro* results from *in vivo* treatment realities are yet another element the argumentation.^{*****}

In prisons, the first snag regarding DST is twofold: first the *cost*; second the *training of lab staff*. Monetary considerations should theoretically no longer be an obstacle, now that TB and MDR TB have been recognized by the WHO and practically all countries

****“Geographically” meaning “being sent to a specific prison, which the prisoner wants to be sent to, regardless of any health consideration...”

***** 10 years ago, both WMA in its “Declaration of Edinburgh on Prison conditions and the spread of Tuberculosis and other communicable diseases” (Oct 2000), and EFMA/WHO in its “Warsaw Statement on Tuberculosis and Prisons” (March 2000) called on national medical associations to urge governments to take urgent action on these issues.

While there has been some progress in influencing improvement in healthcare and disease control in hospitals as Dr. Reyes warns the difficulties in achieving change persist and the need for NMAs to act remains. ED.

as real health emergencies, and given the availability of financial resources from such entities as the “Global Fund” (GFATM). In reality, however, prisons are often *last* on the priority list for funding of any kind*.

DST, even for First Line Drugs (FLD), needs some form of laboratory setup, and lab staff. Even Sputum Smear Microscopy (SSM), the basic of basics in TB diagnosis, requires a lab technician trained to correctly do a Ziehl-Neelsen stain – and other staff trained and qualified to read the slides. DST of course is more complex of course than SSM, and involves a more significant investment in both money and training. While nobody argues that such investments are not necessary; the point is that prisons are way behind in developing the adequate infrastructures, in recruiting and training adequate staff, and retaining them by paying them correctly so they do not leave to go into the private sector. Most important: prisons need to create and develop a working relationship with, and receive support and supervision from, their respective NTPs. DST for Second Line Drugs (SLD) is problematic, difficult, costly and sometimes unreliable in the best of settings – and would be even more so in prisons. This is all the more regrettable, as prisons are assuredly a high-risk environment for development of resistant forms of tuberculosis.

Based on ICRC experience working in prisons in different countries, even adequate laboratories and trained staff need constant supervision. In many cases, visibility into the prison system from outside, and strong accountability, will also be necessary. There are many forms of “corruption” that can occur within the laboratory component,

* Global Fund to Fight AIDS, Tuberculosis and Malaria

** With the exception of high-security prisons, perhaps, in those countries concerned by the so-called “war on terrorism”...

It has not yet been considered nor documented whether TB is a significant worry among such “special” inmates...

which have been described elsewhere [2]. However, if the “rigging” of lab results was considered as a major shortcoming for “normal TB”, the issue becomes of overriding importance when the much more deadly forms of TB, MDR or XDR, are the issue. The old DOTS acronym, no longer in use, could be perhaps used to remind local staff of the need to supervise the obtaining of sputum:

Directly Observed Taking of Sputum...

To have true and interpretable results for all patients in MDR-TB cohorts, it is thus essential that there be no “cheating” of any kind. Sputum exchanges between prisoners have now been documented in many countries and measures to prevent any such deception. Less straightforward is the thwarting of “fake” results, obtained by threats or “arm-twisting” of lab staff or even medical personnel. This phenomenon has been observed in ICRC field work, but is for obvious reasons very difficult to document, let alone publish. It is essential however to keep such possibilities in mind, and for those responsible for TB programmes (above all the NTP) to do everything possible to avoid them.

Individual treatment vs. standardized treatment regimens

The issue of individual vs. standardized treatment is an on-going controversy across the TB realm that also has implications for the prison setting. For some of the obvious reasons already outlined above, it will be much easier to implement a standardized regimen in a custodial setting. Medical and health staff, particularly if under-staffed, will better be able to handle a standardized regimen. With the advance of MDR and even XDR TB, there will be understandable arguments for Individual Treatment Regimens (ITRs) for specific patients. It will thus be necessary to provide the staff and

training – as well as all the safeguards necessary – for adequate management of these more complex cases in prisons.

It is in this context that the matter of adequate and direct supervision can be mentioned. Directly Observed Treatment (DOT) is a *must* in a prison setting. Prisoners may decide, for reasons of their own, either *not* to take their full prescribed treatment, or to take, “on the sly”, a different treatment, smuggled in from outside, by often well-meaning family members. Standardized treatments often rely on “blister packs” for observance of adequate posology. While the system has obvious advantages for the patient outside prison, the inverse argument cannot be made for prisoners. Health staff cannot simply rely on the absence of the pill in the blister pack to “confirm” adherence to treatment. *All* tablet swallowing needs to be controlled, individually, and with the “nurse insistence” tailored to each individual patient. This applies not only to the initial phase of treatment, but also to the continuation phase.

The old acronym can also be used as a reminder to Health Staff supervising treatment:

Directly Observed Tablet Swallowing...

The “spine-numbing” scene of a tin vat, placed in the middle of a collective cell for some twenty inmates, in a prison in Central Asia, half filled with a collection of different pills and blisters of all sorts of medicines, dumped there literally by the inmates who had received them in their continuation phase of TB treatment, and “sorted out” and taken (or not) as desired, without any control whatsoever, is hopefully a vision from the past***. However, inadequate supervision of treatment, fostered by negligence, igno-

***The “tin vat” incident is no “metaphor”: it describes an actual situation seen by the author in 2000.

rance, or fear of violence from some patients^{****} still does occur, and needs to be addressed by providing more, better trained, and better supervised staff for TB programmes^{****} in prisons.

Additional issues specific to custodial settings

Many additional issues have already been stated and detailed in previous publications. Their relevance for the management of “normal TB” treatment is even more significant for all resistant forms of TB, including MDR TB & XDR.

Management of adverse effects of treatment

Correct management of adverse effects of treatment, and, in fact, their identification in the first place, has significant importance in the prison setting. FLDs are known to have effects that lead to self-interruption of treatment by prisoners, if these patients are not properly coached, counselled and assisted by the medical and nursing staff. In the case of MDR TB, as is well known, SLDs have even greater adverse effects. Furthermore, because the duration of treatment is 24 months or more, such adverse effects can and will become even more annoying to patients, increasing the importance of ensuring sufficient support and expertise in their management.

Erratic treatments are one of the main causes of the selection of resistant strains of

^{****} In some countries, prisoner “bosses” or “bullies” will steal drugs given to patients, either forcefully, if they have not yet been swallowed and are being taken back to the cells, or by threatening patients to conceal them from health staff, and deliver them up...

^{*****} Two nurses in different contexts told the author (only last year, 2009!) of how they had been threatened by inmates, who did *not* want to take their Rifampicin, so as to sell it or trade it off somewhere... Again, for obvious reasons, these menaces were impossible to “document” fully. Supervision was of course tightened.

TB bacilli. It is therefore vital that health staff working with TB patients in prisons be sufficiently trained in all aspects of adverse effect management, and be suitably firm in their dealing with often difficult patients who “want to have it their way”.

Contact management and identification

A final issue arising in prisons, particularly in overcrowded ones, is that of difficulties in contact finding. Indeed, even where staff and resources are sufficient, it can be an overwhelming task to identify contacts when a prisoner identified as having contagious pulmonary TB has been living in an impossibly overcrowded cell, and mingling with dozens or even hundreds of other inmates. When staff and resources are limited, this effort is even more difficult.

Apart from the simple fact that there may not be enough personnel to determine which prisoners are at the highest risk for contagion, there will again be additional complications of the motives of the subjects, similar to those factors that complicate an initial diagnosis for TB. As soon as inmates realize that there is an effort underway to identify contacts of a diagnosed peer, they may decide that there is something to be gained from being identified as one (such as a free trip to the hospital for investigations; better food in a health setting; being excused from work; fewer security measures; etc.). Thus prisoners may present themselves and (falsely) declare themselves to be “contacts”, when, in fact, they are not. These complications may be very difficult to overcome, but health staff should at least be aware of the different possibilities and NTPs need to determine how factor them into their overall evaluation of the TB situation in the prison.

All factors that have been mentioned here need to be addressed by the relevant authorities. Administrative and structural considerations, such as overcrowding, are a threat



to prison health and hence to public health. The recruiting, training, supervision, and adequate salaries of prison health staff need to be addressed as well, and the resources necessary to ensure them must be obtained. There is no place for complacency in the management of tuberculosis – all the more so now that the much more deadly forms of resistant TB are a growing menace to the prison population, and community at large!

In Conclusion

Prisons have recently, that is in the past ten years or so, finally been recognized as focal points in the fight against Tuberculosis. Many (one would like to say “most”, but such is not yet the case) major International fora on Tuberculosis now have at least one afternoon, or even a full day, on specific prison issues regarding TB, MDR TB and TB-HIV Co-infection.

It has been the objective in these few modest pages, to underline once again the many issues – some already well-understood and others arising from the difficulties inherent to the evolving disease itself – that need to be known regarding prisoners and prisons in the fight against TB and its dangerous, continuous evolution to increasingly resistant strains. Knowledge of the problems is half the battle. Dr José Caminero stated at the 2009 WMA Assembly Scientific Session on MDR TB:

“If this is already true in the “outside world”, it is even more so in the prison world, and in

custodial settings in general. It is hoped that pondering the few comments made here will be useful to all dedicated medical staff working in these difficult situations."

Finally, as a final impetus for government health and political authorities to dedicate sufficient attention to the issues mentioned here, it must be reiterated that tuberculosis is not an isolated issue that concerns only second-class outcasts (*sic*) who are locked up behind walls, bars and fences. Epidemics in prisons, including TB and the continuing emergence of drug-resistant forms of the disease, can and will spread to the outside community. In addition, control of the TB

pandemic has been further complicated by the co-existing HIV pandemic.

All stakeholders must remember that:

Good Prison Health is Good Public Health!

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Neuroimaging and the birth of cognitive neuroscience



Elkhonon Goldberg

We are all familiar with the terms neurology, psychiatry, neuroradiology, psychology, etc., however a few decades ago a new term appeared - "neuroscience." Neuroscience is an eclectic interdisciplinary field devoted to the studies of the brain. Sometime more recently, perhaps two decades ago or so, yet another term was born - "cognitive neuroscience." Cognitive neuroscience is

devoted to the study of the brain mechanisms of higher-order mental functions: language, attention, memory, and even decision-making. Even relatively recently, these complex functions of the brain were regarded as too intricate to allow rigorous scientific investigation. They were the purview of classic psychology whose adherents not only did not know anything about the brain but took pride in not wanting to know. It was assumed that cognition could be studied as a Platonic object without bothering to relate it to the biological machinery that makes it run.

To a large extent it was a "sour grapes" situation, since even if they desired the information, there was not much in the scientific research arsenal that would enable one to study the brain mechanisms of the mind with any degree of precision and rigor. To the extent that this was possible at all, our understanding of the relationship between the brain and cognition was inferred from the observations of the effects of various forms of brain damage on behaviour.

All this began to change with the advent of powerful neuroimaging tools. It has been said that the advent of these methodologies were to neuroscience what the invention of telescope had been to astronomy, or the invention of the microscope to biology. Neuroimaging completely revolutionized the ways the brain mechanisms of higher-order cognition are studied.

We distinguish between two broad classes of technologies: structural neuroimaging and functional neuroimaging. Structural neuroimaging includes Computerized Axial Tomography of the brain (CT) and, particularly, Magnetic Resonance Imaging (MRI) of the brain. Whereas in clinical practice a neuroradiologist usually "eye-balls" the images generated by these technologies, in research, CT and MRI data are subject to precise quantitative measurements, called quantitative morphometry, which make much more precise characterization of various features of normal and abnormal brain possible. More recently, various methods, Diffusion Tensor Imaging (DTI) among them, have been developed to examine pathway architecture in the brain. Owing to these various neuroimaging methods, we now know that gender differences exist in normal brains. The two hemispheres are more symmetric in fe-

males than in the females; certain aspects of the corpus callosum are thicker in females and certain long intrahemispheric pathways are thicker in males. We know that the hippocampi may exhibit size reduction in people likely to develop Alzheimer's disease long before any clinical symptoms emerge. We know that the brains of people who eventually develop schizophrenia exhibit abnormal neurodevelopmental course years before the first clinical symptoms emerge. We know that chronic anxiety is associated with hippocampal atrophy and Post-Traumatic Stress Disorder (PTSD) is often linked to a reduction in size of the ventromedial prefrontal cortex. We know that the effects of experience-driven neuroplasticity may result in an actual size increase of the brain regions involved in particularly vigorous cognitive activities. These are but a few examples of the findings obtained with the methods of quantitative morphometry and tractometry.

Functional neuroimaging includes Positron Emission Tomography (PET), Single Photon Emission Computerized Tomography (SPECT), Near-Infrared Optical Imaging, and, particularly, functional Magnetic Resonance Imaging (fMRI). These technologies are based on different underlying physical principles and their discussion is outside the scope of this review, but they all permit direct examination of activity patterns in a living brain. While characterizing regional patterns of neural activity is the ultimate goal pursued by functional neuroimaging, this is accomplished, as a rule, through various "proxy measures" presumed to be highly correlated with neural activity levels. Blood oxygen levels in fMRI or glucose metabolism levels in PET are examples of such proxy measures. In principle, functional neuroimaging can be used both in a resting state and during various mental activities.

As mentioned earlier, functional neuroimaging has revolutionized both cogni-

tive and clinical neuroscience. In clinical neuroscience functional neuroimaging was particularly instrumental in helping characterize disorders devoid of clear-cut macroscopic focal brain lesions, e.g. various neuropsychiatric and neurodevelopmental disorders. Studies using PET and SPECT helped clarify the mechanisms of various such disorders. Aberrant activity in the striatum (putamen and caudate nuclei) in Obsessive-Compulsive Disorder (OCD) and Tourette's syndrome; "hypofrontality" in schizophrenia and certain affective disorders; and exceptional frontal-lobe vulnerability in closed Traumatic Brain Injury (TBI) are but a few examples of such findings.

For a variety of technical and conceptual reasons, cognitive neuroscience has focused predominantly on activation paradigms using fMRI, where brain scanning takes place while the subject is engaged in various cognitive tasks. An elaborate research methodology has developed to support such studies, sometimes referred to as "subtraction methodology." The specific findings acquired with this methodology are too numerous to list here. These findings have permitted direct test and validation of many of the assumptions about functional organization of the brain inferred in the decades past from the lesion studies, and have served to infuse our understanding of the brain mechanisms of complex cognition with an unprecedented degree of neuroanatomical precision.

For the first time in the history of brain research, it became possible to directly examine the temporal dynamics of complex mental processes as they unfold in time in the course of learning. It became possible to examine how particular brain regions work in concert as interactive neural networks underlying complex cognition and how these network interactions may become aberrant in various disorders. Furthermore, it became possible to study various higher-order func-

tions often referred to as "metacognitive," such as complex decision making, social cognition, and the mechanisms of insight into other people's minds ("mentalizing"), both in normal individuals and in various poorly understood disorders such as autism.

This, in turn, expanded the frontiers of cognitive neuroscience into the areas of interface with other disciplines, such as economics, politics, social interactions, and ethics. As a result, entirely new areas of inquiry have coalesced on these boundaries between traditional disciplines, and we hear about "neuroeconomics", "neuromarketing", "neurolaw" and other "neuro's" unimaginable even a few decades ago, which are concerned with the brain mechanisms underlying cognition and behaviour in these diverse arenas of human endeavour.

Different eras are characterized by different directions of thrust of scientific inquiry. Just as the first half of the twentieth century was the era of physics and the second half of the twentieth century was the era of biology, the foreseeable beginning of the twenty-first century is shaping up as the era of neuroscience in all its multiple and constantly expanding applications. If, as it has been said, the brain is science's "last frontier", then we are finally on the verge of piercing and eventually conquering this frontier.

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Action alert

Country-level support needed now for the global strategy to reduce the harmful use of alcohol

The draft of the WHO Global Strategy to Reduce Harmful Use of Alcohol (GAPA) is now available at the WHO website (document EB126/13 in English, Spanish, French, Arabic, Russian & Chinese): www.who.int/substance_abuse/activities/global-strategy/en/index.html, and here: apps.who.int/gb/e/e_eb126.html

The document consists of three parts: The report by the secretariat, including a draft resolution for consideration by the WHO Executive Board, the Draft Strategy itself, and a two page summary of the evidence for the effectiveness and cost-effectiveness of the proposed interventions. In addition, the document contains a bibliography on evidence on harmful use of alcohol, published separately on the WHO Substance Abuse website.

Although some of the sections of the draft strategy should be improved and strengthened, we believe that the Strategy effectively addresses issues that will be critical in public health efforts to reduce the toll of alcohol throughout the world. The attached GAPA response provides general and specific comments regarding both the strengths and weaknesses of the existing draft.

The draft Strategy will be submitted to WHO Executive Board January session for discussion and approval. The international drinks industries and their social aspect organisations have launched several initiatives to influence the Strategy process. Those initiatives include industry front-group International Center for Alcohol Policy (ICAP)'s recent publication of "Working Together to Reduce Harmful Drinking", an attempt to strengthen industry's role in

the development and implementation of a Global Strategy.

GAPA expects that some Member States might attempt to weaken the scope and content of the Strategy, and may even block its adoption. The Executive Board meeting begins on January 18 in Geneva and NOW is the time for concerned GAPA partners and other nongovernmental organisations to act at country-level in support of the adoption of the Strategy. May we also suggest that you spread this action alert to others in your network.

ACT NOW

We strongly urge you to contact your Health Minister (or health ministry) now in support of the Global Strategy. Please ask for a meeting with the Minister, or members of the delegation that will attend the WHO Executive Board meeting. We encourage you to raise the following points in your contacts with your Minister and/or EB delegation, depending on the situation in your country:

1. Express your support for the Draft Global Strategy as a key starting point in addressing the global threat to health represented by the harmful use of alcohol;
2. Make your strong recommendation that the Strategy should be adopted in its current version at the minimum, and possibly with amendments strengthening it in the way outlined in the attached GAPA response document;
3. Assert that the harmful use of alcohol on the global level is a long-overdue responsibility of Member States and the WHO;

4. Emphasize that the involvement of non-governmental organisations is essential in policy development and implementation and that NGOs are willing to collaborate fully with WHO and Member States in this process;
5. Address the need to limit economic operators' involvement in the Strategy and to insure that policies and programs at all levels are developed by public health interests independent of commercial conflicts;
6. Recognize that additional resources will be required at all levels to implement effective national, regional, and global strategies to reduce the harmful use of alcohol, and countries in the developed world should make the necessary funds available to WHO;
7. Convey the information that representatives of the Global Alcohol Policy Alliance (GAPA) will be attending the Executive Board meeting and look forward to conferring with country delegations at that time. Please encourage your Health Minister and delegates to get a global NGO perspective during the EB session.

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Response of the Global Alcohol Policy Alliance to WHO's

Draft Global Strategy to the Reduce the Harmful Use of Alcohol December 2009

In January 2010, the Executive Board of the World Health Organization will consider a Draft Global Strategy to Reduce the Harmful Use of Alcohol. This proposal comes none too soon, considering the enormous impact that alcohol has on global public health. The excessive use of alcohol is the third-leading risk factor for premature deaths and disabilities in the world, accounting for some 2.5 million deaths in 2004. That equates to 3.8% of all deaths and 4.5% of the global burden of disease as measured in disability-adjusted life years lost.

The Global Alcohol Policy Alliance (GAPA)* strongly supports the December 3, 2009 Draft Global Strategy and recommends it to the Executive Board and Member States for approval. Although some of its sections should be improved and strengthened (as indicated below), we believe that the Strategy effectively addresses issues that will be critical in public health efforts to reduce the toll of alcohol throughout the world. In particular, we note the following essential component strengths of the Strategy:

- Its foundation rests on strong, evidence-based policies that can provide guidance for Member States;
- It recommends, in accordance with the evidence base, essential policy interventions regarding price, availability, drink-driving countermeasures and marketing;
- It addresses the need for resource development and issue prioritization in implementing alcohol prevention strategies at the global and national levels;

* The Global Alcohol Policy Alliance (GAPA) is a worldwide coalition of NGOs, medical professionals, and researchers who work to prevent alcohol problems and reduce their toll on society. GAPA, which includes representation from all inhabited continents, was formed in 2003 and is headquartered in London, England.

- It recognizes that the involvement of civil society is essential in creating the political will to address alcohol issues and implement national and global prevention strategies;
- It acknowledges the responsibility for health-sector leadership within multisectoral collaboration on efforts to combat alcohol problems at all levels;
- It suggests a special focus on protecting the young, non-drinkers, and populations at risk from harmful use of alcohol, such as women, indigenous peoples and other low-income or minority groups;
- It anticipates the involvement of all parties, including "economic operators", in implementing strategies at all levels, while pointing to reasonable distinctions in their roles, depending on commercial interests involved.

GAPA believes that the Strategy's Aims and Objectives, Guiding Principles, and Policy Options and Interventions are clear, balanced, and comprehensive. They express a vision that can begin to address global harm from alcohol.

GAPA Concerns

Alcohol Marketing Issues

GAPA is disappointed by the weakness of the policy discussion concerning the marketing of alcoholic beverages. In particular, we note that the suggested policy interventions include co-regulation and industry self-regulation as "appropriate" parts of the strategy. Neither of these has an evidence base of effectiveness – in fact, several studies of self-regulation have found it ineffective. Voluntary codes of good marketing practice are routinely violated, nearly impossible to enforce in a timely manner, and condone

much of the advertising and promotion, such as sports sponsorship and trans-national marketing messages, about which Member States have expressed concern.

GAPA believes that self-regulation and/or co-regulation are hopelessly inadequate substitutes for strong governmental regulation of alcohol marketing, and that the Strategy should reflect that reality. The strategy also weakens the specific recommendations in this section by removing the word "ban" and leaving "restrict" as the only option. The evidence base is strongest in support of bans on marketing, and various forms of marketing are already banned in numerous Member States. Therefore, bans should be explicitly on the table as options for Member States.

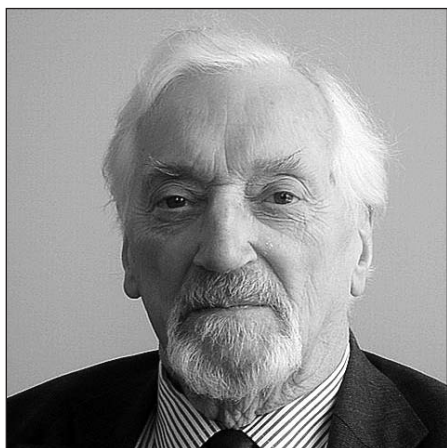
Appropriate Roles for Different Parties

The document contains several references to the need for "partnerships" and GAPA welcomes the call for various governmental and non-governmental entities to partner with WHO to address these problems. The document also addresses the appropriate roles of different parties concerned about alcohol policies. GAPA believes that the Draft Global Strategy should be improved by explicitly addressing the "appropriate" role of "economic operators" in the process of developing and implementing evidence-based, prevention-oriented policies to reduce the harmful use of alcohol.

To avoid conflicts of interest, the strategy should clearly state that policies and programmes to reduce alcohol-related harm need to be developed independent of commercial interests. Economic operators should avail themselves of opportunities to be in dialogue with WHO and other governmental bodies regarding their contributions, in their roles as alcohol producers, distributors, sellers, promoters to the reduction of alcohol problems. Such contributions to the implementation of alcohol strategies at all levels should be consistent with a duty to avoid interfering with public health objectives and public health policy.

Reflections on the Standing Committee of European Doctors' (CPME)

Fiftieth Anniversary 1959-2009



Alan Rowe

When the Monet/Schumann inspired initiatives extended the early post-second World War agreements in some States (such as the Coal and Steel Treaty, Paris 1951) to build structures which would militate against any further European conflicts culminated in the Treaty of Rome (1957) and the establishment of the European Economic Community (EEC), the medical profession reacted by forming a "Comité Permanente des Médecins de la CEE" (CPME or CP). This year CPME celebrates its 50th anniversary.

The various Treaties signed by Member States had created a political economic community with legislative powers on defined topics (which have increased as the Community has expanded and subsequent Treaties and changed new or amended legislation have been adopted). This article provides some information on the background to the CPME's foundation, its work and some of the problems it faced in the following years.

The following short glossary of terms used in this article will assist those not familiar with the EEC and associated institutions.

European Economic Community (EEC) later known as the **European Union (EU)**

The Council of Ministers (The Council) consists of Ministers from Member States who adopt legislation, Regulations, Directives and Decisions etc.

Regulation: European Legislation which has to be directly incorporated into national law.

Directive: European legislation, the effect of which has to be incorporated in national law.

Decision: Specific measures which are binding on those to whom they are addressed.

European Commission is effectively the Executive of the EU, comprising representatives of the Member States appointed as Commissioners with specific responsibilities for differing sectors (Directorates General (DG's) within the European Commission. It is responsible for proposing legislation and guarding the implementation of the provisions of the Treaties.

After 50 years of impressive activity the CPME (referred to in its early years as the "CP", an acronym used in the early part of this article), has good reason to look back and reflect on the wisdom and work of those who, in the light of the Treaty of Rome (Tof R) 1957, recognised the need were responsible for its foundation, and to those individuals who over the years have made huge contributions to the work of the CP. The tasks which CP has undertaken on behalf of the medical profession (and the citizens) of the European Union have contributed enormously to the realisation of the principles and evolving ambitions of the European Community which, amongst its many other objectives, were to meet the social, healthcare and safety needs of its citizens and the facilitation of free movement

of workers, including the medical, paramedical and pharmaceutical professions.

Foundation

The "Comité Permanent des Médecins de la C.E.E." (Standing Committee of Doctors of the EEC, ultimately changed to *Standing Committee of European Doctors*), was founded in Amsterdam in 1959 by the original Six National Medical Associations (NMAs) of the Member States of the European Economic Community, Belgium, France, Germany, Netherlands, Italy and Luxembourg; all of them members of the World Medical Association (WMA).

The founding NMAs' activities were essentially **to defend the principles on which medical practice should be based**, both in the interests of healthcare of all the citizens of Six member states of the European Community which also meant engagement as "the patient's advocate" (a role often referred to in CP debates), in addition to **safeguarding the standards of the medical profession in sustaining its role and functions in the European Community.**

The CP Statutes (1960) initially provided for each NMA to undertake the Presidency and Secretariat in rotation annually. This was soon changed to 2 then to 3 years, and is currently two years (2010).

From the earliest meetings of the CP, in addition to the formal members, a representative of the Austrian Medical Association and a representative of the World Medical Association were present as Observers. They were joined as observers by the British Medical Association in 1961 and soon after by the NMAs of those countries with applications to join the EEC including Denmark, Ireland and Norway. Norway withdrew its application when the referendum rejected membership at the first community enlargement when Denmark, Ireland and the UK joined the EEC (1972). Thereafter observer status was offered to those NMAs

whose countries were seeking membership of the EC.

The structure, organisation and activities of the CP over the years has naturally been influenced not only by major events and EEC legislation in the evolving European Community and its society, but also increasingly by global events and developments, including advances in scientific and technical knowledge, political, social and demographic change, the communication revolution, natural disasters and new challenges in disease control.

Language and Interpretation

The CP, comprising representatives from various member states speaking different languages, had a particular need for clear understanding of the draft legislation they were dealing with. From the beginning a team of interpreters were necessary. Both simultaneous translation and on occasions consecutive translation were used, although the latter was abandoned as it was so time consuming. The expertise of the interpretation team with their particular knowledge both of medical technical language and that associated with legal and community affairs (many also worked in the European institutions) made a huge contribution to the work of the committee. Now the CPME works mainly in English.

CP - The early period

In one sense, the first period of CP activity was largely focused on problems associated with Freedom of Movement, Professional Recognition and Practice in the European Economic Community (EEC). Essentially this period began in 1959 (The EEC officials responsible for the drafting of legal Directives providing for the freedom of movement of professionals referred to in article 57 (also 48.4 and 60) of the 1957 Treaty of Rome had begun their enquiries in 1958).

The full implications at this time of the most important article 57 (see *box*) and

the problems with which the CP were faced need to be put into context.

Article 57 (Treaty of Rome)

1. In order to facilitate access to and engagement in non-wage-earning activities, the Council shall issue directives for the mutual recognition of diplomas, certificates and other evidence of qualifications. The Council shall so act, on a proposal of the Commission and after the Assembly has been consulted, during the first stage unanimously and subsequently by qualified majority vote.
2. With the same object, the Council, on a proposal of the Commission and after consulting the Assembly, shall before the transitional period ends issue directives for the co-ordination of the legislation, regulations and administrative rules of Member States as regards persons taking up non-wage-earning activities. **Voting must be unanimous on the following matters:** i.e. those which are the subject of legislation in at least one Member State; those concerned with the protection of savings, in particular the granting of credit and the carrying on of the banking profession; **and the conditions governing the carrying on of the medical, para-medical and pharmaceutical professions in the various Member States.** In all other cases, the Council shall act unanimously during the first stage and subsequently by qualified majority vote.
3. **In the case of the medical, para-medical and pharmaceutical professions, the progressive removal of restrictions shall be dependent upon the conditions for exercising them being co-ordinated in the various Member States**

In the late 1950's there were a few limited bilateral agreements between individual countries for mutual recognition of medical degrees and qualifications (somewhat later, the Nordic Agreement on Cultural Co-operation (1971) laid the grounds for mutual recognition in the Scandinavian countries, fulfilled in 1975. The decision in article 57 of the Treaty of Rome therefore raised considerable problems. Hence, in part, the special provisions for mutual recognition of qualifications and coordinating provisions for health professionals' activities set out in article 57. These required unanimous decision by the Council of Ministers initially in adopting proposed legislation and decisions

thereafter by qualified majority; also that progressive abolition of restrictions for the medical, paramedical and pharmaceutical professions be dependant upon coordination by Member States.

Clearly the Commission needed some form of Medical Advisory Body providing the voice of the medical profession and other health professions in the process of producing draft proposals for Directives. (In fact it did not officially establish one until the 1975 Doctors Directives were finally adopted, when a Council Decision set up an Advisory Committee on Medical Training (ACMT) in the Commission).

The NMAs, however, foresaw the need for the profession's views to be coordinated and promoted to the EEC authorities and thus the CPME was founded in 1959. The Commission accepted discussions/communications with the CP, recognising the value of information and opinions from such a body and its importance in representing the physicians in Member States. *(In this connection it is of interest to note that in the original Statutes, article 1 referring to the national delegations from each country determined representation of member associations as "6 delegates and 6 alternates are to be nominated by the NMA or national professional organisation in such a manner that the delegation is representative of the medical body of its country").*

Other European bodies representing specific areas of medical practice, AEMH (hospital doctors), FEMS (Salaried doctors), UEMO (general practitioners) PWG (Junior doctors) became CP observers and appointed liaison officers to the CP.

By 1972/3 the relevant time the EEC Commissioner, Professor Ralf Dahrendorf (later Lord Dahrendorf), recognised that more rapid progress needed to be made and that there were still basic problems to be solved. He therefore convened the famous "**Dahrendorf Hearing**" (October 1973) in which parties from the Old Six and the three new acceding countries were included. Other

interested parties included the Universities, the practicing Medical Profession, other health professions, the EEC institutions, Consumer organisations, National governments and other bodies. From this Hearing emerged the concept of an Advisory Committee on Medical Training (ACMT). Thereafter, progress was more rapid.

However, only in **1975 (after 16 years of discussion of drafts and redraft of proposals from the Commission!)** was there sufficient agreement amongst Member States for Directives to be adopted by the Council of Ministers as the basis for mutual recognition of both basic and specialist medical degrees and diplomas, as well as coordinating provisions for those wishing to migrate within the European Community.

These directives (75/363/EC & 75/364/EC) covered mutual recognition of basic medical qualifications and a number of specified specialties, as well as the necessary coordinating provisions.

Although there had been CP representations concerning specific training for General Practice in the early 60's, it was not until 1986, after nearly 20 years of continual consideration, discussion and representations, that an initial Directive (86/457/EEC) was adopted. Even so recognition for the purposes of practice as a general practitioner in a national social security system was only to be complied with by 1995. The directive also provided for a report by the Commission on developments and experience in the intervening years on which the Council should act to extend the training to all general practitioners.

Some of the proposals made by the CP and other bodies on the various draft proposals were not included in the final texts adopted by the Council in 1975. Notably, the idea of an obligatory "period of adaptation" in the host country before a migrating physician would be free to practice independently in medical practice. Such a "period of adaptation" was strongly sup-

ported by the CP, a view also supported by both the European Parliament and the Economic and Social Committee. (This view has been subsequently raised again in various EEC institutions from time to time) It would be many years before the Commission incorporated such an idea in the General Service Directive covering those professions for whom no specific Directive had been adopted.

Directives for Nurses, Midwives, Pharmacists and Veterinary Surgeons were soon adopted in the years following 1975. All of these were subject to coordinating directives for these health professionals on more than one occasion. At all stages of the processes leading to the adoption of these directives, their amendments and co-ordination, the CP's work included scrupulous monitoring of the texts and their implications and discussions with the European Commission.

The "doctors' directives" can be regarded as the foundation Directives for freedom of movement of health professionals in the European Union. They continue to be discussed and revised, dealing with changes in the specialties, clarification and expansion of issues in the '75 Directives (such as occasional non-established provision of services, cross boarder medical practice, recognition of certain specialties) and incorporated in coordinating directives. They will no doubt continue to develop from time to time, reflecting other major changes and developments.

In this connection it is significant to note that in 1976, the concerns of the legal profession (who had no directives at that time) were discussed at a conference celebrating the 10th anniversary of the "Cahiers de Droit Européene" entitled "The free movement of lawyers and doctors in the European Economic Community", The conference considered the lawyers concerns about possible directives for their own profession) in the light of the approach adopted in the doctors' directives. At this conference many of the

problems of the 1975 doctors' directives were reflected in the concerns of the lawyers. ("Cahiers de Droit Européen" 1976, Supplément)

CP and Other European Directives

While questions arising from the 1975 doctors directives added considerably to the work of the Standing Committee, it must be recognised that in addition to the work associated with the medical directives (especially the role of **Occupational Health** which professionally had already been involved in the context of the **1951 Coal and Steel** and later in the **1957 Euratom Treaties**), and work on Social Security, the CP increasingly had to monitor and act on many non-medical directives adopted by the EEC but having implications for medical practice both in healthcare and other fields than medicine, Examples include the Directive on "Liability for Defective Products", a draft Directive on "Liability for Defective Services" which – eventually abandoned – re-emerged again some years later, and the so called "Advertising Directive" on pharmaceutical products, notably article 3.

CPME The Middle period – Maastricht, Amsterdam

The second period of the CPME's activity, starting in the early 80's, was influenced by a number of factors. In one sense, the most important event relating to health in the EU in this period was the formal reference to Public Health in Title X, article 185 of the Treaty of Maastricht (1993) (the first time that actions in the health field had been mentioned in the European Treaties!) – and the inclusion of an article in Title XI on Consumer Protection. The political changes in Europe in the early 90's and the rather later enlargements of the membership of the European Community were also to impact on the CP, its organisation and membership. In this period the CP had continued to enlarge its membership, first from 9 to 12 and then 15, plus many observers, most of whom later became members.

Although already dealing with an enlarged agenda in the early 80's and 90's subsequent events, notably the establishment of DG SANCO (General Directorate, Health and Consumer Affairs) in the late 90's, increased the workload on the CP in responding to EU policies and activities even more. In addition by the late 1970's and early 80's the CP had already extended its activities to include issues arising from organisations outside the EU, including the Council of Europe, WHO, the GATT negotiations etc. In a globalising world, towards the end of the 20th century and beyond, the incidence of diseases such as AIDS in the 80's, SARS in 2003 and MRSA, as well as rapidly increasing scientific developments such as those arising from genetic research and the genome project, have raised more clinical and ethical problems. All of this has been in addition to the expanding work of the EU in the field of Information Technology and more recently on E-health, which requires considerable CPME engagement.

A Brussels Office

For over 30 years the CP from time to time had heated debates about establishing an office in Brussels or Strassburg. The increased workload eventually led to work being started to review and consolidate the CPME's position in 1992. It developed by way of establishing a Brussels office and staff, a Board and an Executive Committee and ultimately an employed Secretary General.

These major decisions approved in 2002, reflected the increasing achievement of the CPME over the preceding decades of its aim to respond to and influence developments in the European Community.

Committees

In order to carry out its work the CP had, from its earliest days established committees or working groups. In the first four decades of its existence these reflected the fundamental planks of medical practice, its engagement with society, as well as various

more specialised areas. For many years the list was extensive comprising the following:

Professional Training	Occupational Health
Hospital Doctors	Paramedical Professions*
Social Security	Doctors the Pharmaceutical Industry
Salaried Doctors	Juristes**
Medical Ethics	General Practice

While the functions of most of these committees are clear, and can be related to the structures mentioned later which have replaced them, the following notes indicate the functions and value of two committees which have disappeared.

* The Paramedical Committee (also no longer existing) reflected the provisions of Article 57 of the Treaty of Rome referring to the medical, paramedical and pharmaceutical professions". The CP by the late 60's had established a committee on the Paramedical Professions, in whose role and education the medical profession had considerable interest. At a very early stage in the late 70's however, one incident is worth recording as it reflect a widely held attitude at that time – an attitude which has radically changed since then. It should be noted that for at least two thirds of the last century amongst the old Six and a number of other countries of continental Europe, doctors played a major role in controlling the schools of nursing. The emphasis was on nurses and others as "paramedicals", who were to assist and be responsible to doctors. On one occasion, when the committee was discussing the paramedical professions, it was pointed out that "just as the organisation and functions of the medical profession were evolving, so also were the roles of the paramedical professionals and this was naturally to be expected. It was further pointed out that the first two Chairs of Nursing had just been established in European Universities and that no doubt this trend would ex-

tend and also be reflected in other paramedical fields. Despite support from one of the lawyers this produced an explosion from the Chairman who castigated both speakers and commented: "No-one will interfere with the acts reserved as fields of activity for specialists." How things have changed!

** The Juristes Committee (legal assistance is now sought when it is specifically required) was of particular importance, especially in the consideration of the many initial drafts of the Doctors Directives in the late 60's, the 70's and early 80's. At the time of the CP's foundation, all delegations in the CP were accompanied by their lawyers. This was largely a consequence of the Treaty of Rome, the consequential legislation and its implications for National Law in Member States and for medicine. It's work expanded with the development of legislation from other sectors of the Commission which had implications for medicine and as advances in technology (such as data storage), medical research, healthcare services – their provision and safety, took place. This committee's advice on the Doctors' Directives was invaluable, both in the drafting period and also with the problems continually arising once they had been adopted, or as various proposed amending directives appeared. This also applied to their assistance on wide ranging directives with implications for medicine and healthcare. Unsurprisingly, the Juristes also greatly assisted in the formulation of Charters and Declarations relating to the work of the committees and, of course, the drafting of the CP Statutes and their various revisions.

Today, following the review referred to above, a smaller number of committees, reflecting the broad areas of engagement, are currently as follows:

- Medical Training, continuing professional development and quality improvement
- Ethics and professional codes
- Organisation of health care, social security and health economics
- Public health, prevention and environment

2000 and beyond*

In a European Union now enlarged to 27 Member States, the CPME today has a Brussels office, is registered as an International Association under Belgian Law and has a membership of 27 National Medical Associations, 2 Associated Members, 2 Observers and 9 Associated bodies. One look at its website today (www.cpme.eu) shows its continuing engagement with other European Medical bodies, its policies^{**}, statements and decisions; its engagement with and representations to the major Institutions of the European Union; participation with European non-EU bodies both medical and non-medical, and its inclusion in the European Commission's consultations. All of this recognises the importance attached to its opinions by the relevant EU institutions, demonstrates the significance of the CPME's work, its growth in stature and its influence over the past fifty years.

Over the past 50 years there were occasions when there were substantial differences of opinion both between national delegations and even within delegations, and there were frank and often forceful expression of views in the early and middle phases of CP's exis-

tence. However, there were few occasions on which unanimous or substantial consensus in the debates were not eventually reached. Differing legal systems and social security provisions (both affecting medical practice) contributed substantially to the problems of ensuring that adequate discussion recognised the difficulties and the problems they might pose in particular member states. Healthcare provision in certain individual member states had not, for financial, political, administrative or other reasons, developed to the general standards of the majority of member states. Cultural, linguistic, national and even philosophical factors all played a part in achieving agreed positions. To achieve this called for understanding by all parties of the real problems of certain NMAs. These were sometimes medico-political, sometimes cultural, which led to some delegations' difficulties in understanding the difference between influencing proposed supranational legislation, as opposed to national legislation or regulation relating to healthcare and professional practice.

National Delegations sometimes approach discussions with a strictly national position based on their own experience. This has called for considerable diplomacy in explaining overall trends within the European Community. For some countries this was more difficult than for others. Nevertheless eventually decisions had to be taken,

sometimes involving compromise - a process which could take a considerable time in order to achieve a form of words acceptable to the majority. On occasions this might require agreement that representation be made by the CP directly to appropriate institutions on specific problems which some aspects of draft proposals for Community legislation would pose for national authorities and NMAs in certain member states.

As the Community has substantially enlarged in the last two phases of its development and bearing in mind the increasingly globalising world, **the need for diplomacy, readiness to appreciate and understand the contributions, the manner and background against which such expressions of opinion are made from other EU countries**, has become even more important. Unfortunately there is currently evidence of a failure by some NMAs to recognise the importance of full participation by all the EU national medical associations (**including respect for these qualities**) by the representative NMAs in influencing proposed EU legislation and other actions affecting the medical profession through the open dialogue and professional positions reached by the CPME. Such attitudes disregard some of the fundamental aims and objectives of the EU set out in its Treaties.

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* A More detailed account will appear in a history of the CPME in preparation.

** The Policies of the CPME can be found at www.cpme.eu/policy.php

The European Patients' Forum (EPF)

EPF was founded in 2003 and has become the 'umbrella' of patient organisations in Europe. Our foremost aim is to be a united and influential patients' voice in Europe and to promote the patients' perspective in EU healthcare debates. We try to reflect the patients', their carers' and families' unique and direct experience and expertise in healthcare through member organisations' links with representative national, regional and local patient organisations in all 27 EU Member States. Currently we represent 39 patient

organisations, which are chronic disease-specific patient organisations working at EU level and national platforms of patient organisations.

The European Patients' Forum focuses on genuine patient involvement in EU health policy and projects, as well as exchange of good practice and peer support among and within patient organisations at European level. We try to promote a holistic, patient-centred, non-discriminatory interpretation



Nicola Bedlington

of healthcare, to include prevention and the social, economic, environmental, cultural and psychological aspects of health.

Our vision is high quality, patient-centred, equitable healthcare for all patients across the European Union. Our activities and actions are driven by five fundamental goals:

- Equal access for all patients to best quality information and healthcare;
- Patient involvement in health-related policymaking and assessments, programs and projects;
- Patients' perspective to be included in decisions on health economics and health efficacy;
- Sustainable and inclusive patient organisations to effectively represent patients and their interests;
- Patient unity as part of a patient movement at European level.

In the light of these goals, the European Patient Forum produces targeted communication tools, engages in evidence-based surveys linked to patient-centred healthcare, develops qualitative and credible evidence on patients' experience, participates constructively in major external health events and works in cooperation with appropriate research networks and other NGOs in the health care sector to enhance grass-roots evidence based argumentation for campaign and policy work.

We organise annual regional advocacy seminars in different parts of Europe. Our next one will take place in Sofia, Bulgaria and will involve 50 patient leaders from that region. We also hold an annual conference to help to profile our core policy priorities. In 2007, the EPF Conference focused on "Empowerment, Information, Sustainability", and in 2008 on "Health Literacy".

We respond on a regular basis to consultations by the European Commission on legislative proposals such as the Pharmaceutical package on information to patients, fake medicines and pharmacovigilance.

We work closely with the European Parliament, the European Council, the Member States and the European Commission to anchor a patient-centred health care policy in a long-term European strategy. In this context, we do not limit our campaign work to EU institutions, but also try to build relationships with other important institutions such as the World Health Organization – Europe Region, Council of Europe and the OECD.

In 2008, we launched "The Patients' Manifesto – 150 million reasons to act" that calls for vital new measures in three fundamental areas to improve the quality of health care delivered across the European Union:

- Equal and timely access to safe, effective diagnosis, treatments and support;
- Better information and resources allowing patients to be partners in determining their care;
- Provision for a patient's voice to be heard in Brussels and throughout the European Union.

The Manifesto is linked to the European Commission's "Europe for Patients" campaign. It has been widely distributed among EPF Member organisations, the European institutions, and other relevant stakeholders at both national and European level, and has succeeded in raising significant interest at national level. For example, in co-operation with national parliaments, Poland, Lithuania and Romania have hosted activities in support of this initiative. EPF has also received enquiries from patient organisations in Serbia and Turkey who wish to use the Manifesto as a basis for their own advocacy work at a national level.

EPF has actively participated in the Pharmaceutical Forum, a three year process involving the European Commission, the Member States and representatives from other stakeholders to explore the future of pharmaceuticals and public health in terms of information to patients, pricing and reimbursement and relative effectiveness. The conclusions and recommendations of the Pharmaceuti-

cal Forum received political endorsement during a high level ministerial meeting in October 2008; and EPF co-organised with the European Commission a Conference in March 2009 on using the outcomes of the Pharmaceutical Forum effectively.

Regarding the directive on cross-border healthcare that passed its first reading in the European Parliament on 23 April 2009, EPF worked with MEPs, Ministers of Health from all EU countries, health attachés and permanent representatives, and supported a series of amendments of interest to patients, including the need for stronger co-operation between Member States on cross-border healthcare and exchange of information and good practices, the legal anchoring of principles of quality and safety of health care, the introduction of a European Patients' Ombudsman, the active involvement of patient organisations, patient involvement in health technology assessment etc. to ensure that the directive becomes as inclusive and equitable as possible.

Currently, EPF is implementing the project VALUE+ on the meaningful involvement of patients in EU health projects, that is funded under the Public Health Programme, as well as the project RESPECT, that tries to identify the needs of children and their families in clinical trials and to elaborate methods by which these needs can be translated into empowering and motivating participants in future clinical trial research.

EPF is growing as a pan-European patient body that defends the patients' interests and needs in the European health debates. We will enlarge our advocacy work and active involvement in relevant health projects and fight for patient-centred, equitable health care throughout the European Union.

For more information on the European Patients Forum please consult: www.eu-patient.eu

EPF value+ conference confirms the importance of patient involvement in EU health-related policies and programmes

EPF's Value+ conference on meaningful patient involvement on December 9–10, 2009 in Gothenburg reported on the outcomes of the two-year Value+ project, co-funded by the European Commission. The Value+ project showed the need for enhanced political commitment to patient involvement in EU health-related policies and projects at all levels from local to EU level. Meaningful patient involvement means putting the patient at the centre of healthcare projects. This results in positive project outcomes which in turn contributes to patient-centred equitable healthcare policy-making throughout the EU.

Perhaps more than any other policy area, health policymaking has a huge impact on the lives of individual citizens and patients. Patients and patient organisations should have a role in those decisions that will affect their own lives and the community as a whole. Patients' knowledge and personal experience bring clarity and a unique insight to policy discussions.

Political representatives from the Swedish Presidency and Poland, and officials from the Member States, EU institutions, patient leaders and other stakeholders came together at the conference for the unveiling of three project deliverables which include the Value+ Toolkit to support patient and patient organisations in getting involved in health related projects and policy, the Value+ Handbook aimed at project coordinators and leaders to show them how to involve patient organisations and work effectively with them. And thirdly, the Policy Recommendations which are the result of the findings in relation to the assessment of patient involvement in health projects supported by the European Commission.

Patient organisations support the policy recommendations aimed at the European Commission, European Parliament, European Council and Member States. Through the recommendations, EPF is calling for action to ensure patient involvement is integrated in the health policy-making process and programmes.

- A new EU level policy instrument should include a code of best practice and guidelines to guarantee patient involvement at all levels.
- EPF believes that financial assistance should be required from the EU budget to support patient groups in their participation in the political process.
- The EU should create a European Centre on Patient Involvement to facilitate the transfer of best practice to provide information and capacity building.

Speaking at the conference, Göran Hägglund, Swedish Minister of Health and Social Affairs reflected on patient centred equitable healthcare in Sweden and noted some important measures taking place that reflect increasing patient empowerment and patient involvement. He highlighted shortening waiting times for access to different treatments, increasing in the number of healthcare providers, patient safety, and the importance of reaching an agreement regarding patient rights on the cross border healthcare directive as key priorities.

The European Commission has recognised the need for patient involvement in health-related policymaking in its White Paper 'Together for Health: A Strategic Approach for the EU 2008-2013' which claims that healthcare is becoming increasingly patient-centred. Community health policy needs to begin with patients' rights, which include participation and influence on decision-making. Although there is a growing trend within the European Commission towards patient involvement, more needs to be done not only within the Institutions. Support from other stakeholders and patient groups



Göran Hägglund, Swedish Minister of Health and Social Affairs and EPF President Anders Olauson

in understanding the role of patients is also needed.

EPF President Anders Olauson stated that "during recent years, the patients' voice and views have been recognised increasingly as not just important, but a core requirement in health policy development. There is however a gap between the recognition that the patients' experience and expertise are a crucial part of the quality/sustainability equation, and how to do this effectively and transparently in policy and in practical terms".

The conference may have marked the end of EPF's 2-year EU-funded project on patient involvement, but in many ways it marked the beginning of new networks, new partnerships and a new way of thinking on patient involvement.

For further information and updates of the project deliverables, visit the European Patients' Forum (EPF) website at www.eu-patient.eu. EPF is a not-for profit, independent organisation and an umbrella representative body for patients' organisations throughout Europe. Representing the EU patient community we advocate for patient-centred equitable healthcare and the accessibility and quality of that healthcare in Europe.

Nicola Bedlington, EPF's Executive Director

UEMO – A common European voice for General Practitioners/Family Physicians



Isabel Caixeiro

The European Union of General Practitioners/Family Physicians (UEMO) represents the European General Practitioners and Specialists in Family Medicine in Europe.

Created in 1967, our members are the independent and most representative national organizations representing General Practitioners/Family Physicians in the European countries. At present, the following countries are represented at the UEMO:

Austria	Iceland	Slovakia
Belgium	Ireland	Slovenia
Bulgaria	Italy	Spain
Croatia	Lithuania	Sweden
Czech Republic	Luxembourg	Switzerland
Denmark	Malta	Turkey
Finland	The Netherlands	United Kingdom
Germany	Norway	
Hungary	Portugal	

The UEMO's core mission is to study and promote the highest standards of training, practice and patient care within the field

of general practice/family medicine and to defend the role of general practitioners/family physicians in the healthcare systems. UEMO advocates for the ethical, scientific, professional, social and economic interests of European GP/FPs and protects their freedom of practice, all in the interest of their patients.

UEMO stands for the united views of its members and represents them through the appropriate channels before the relevant European authorities and international organisations. In this context, UEMO seeks to work closely with other European medical organizations (CPME, UEMS, FEMS, PWG) and WHO-Europe.

In the period 2007–2010, Portugal is responsible for the presidency of UEMO, with the involvement of the UEMO steering team: Isabel Caixeiro (President), Luís Filipe Gomes (Secretary General) and Manuela Santos (Treasurer). The Board is also composed of Vice-Presidents Henry Finnegan (Ireland), Eirik Bø Larsen (Norway), Ferenc Hajnal (Hungary) and Francisco Toquero (Spain).

The current presidency has set ambitious goals for this four-year mandate. Hence,



*The Presidency team of the UEMO:
At the centre, Dr. Isabel Caixeiro, President.
To her right side, Dr. Luis Filipe Gomes, Secretary-General and to her right Dr. Manuela Santos, Treasurer.*

definition of priorities, strategies and main actions are being actively defined and pursued with the involvement of all UEMO members.

The Portuguese Presidency highlighted as priorities for UEMO:

- Recognition of the General Practice/Family Medicine as a specialty with the development of specialist postgraduate training curriculum in all European Union countries, and update of Directive 2005/36/EC, of 7 September 2005 on professional qualifications;
- Full development and implementation – in accurate technical terms (job/tasks description) – of the core content for the European General Practitioner/Family Physician and its implications at ethical, organisational, training, quality assurance and appropriate technology levels;
- Development of the status of General Practice in Europe, at all levels;
- Promotion of General Practice/Family Medicine in the undergraduate medical curriculum;
- International co-operation within General Practice/Family Medicine organisations and with other medical organisations in Europe

UEMO's activities and main areas of intervention are:

The value of highly qualified General Practitioners/Family Physicians

There are many opportunities for General Practitioners/Family opportunities to develop their professional role and ensure that their full potential is realized. They are increasingly involved in promoting the best use of health systems resources and continuity of care for the benefit of patients. Ideally, everyone should have the possibility to choose a personal Family Physician and to maintain a solid relationship with that practitioner for as long as they wish. The Family Physician is the critical first contact for most health problems as well as for continuing care.

At the same time, there are many compelling reasons to promote wide dialogue between General Practitioners/Family Physicians and other specialists, fostering the performance of complementary roles, which is essential for the interests of patients.

Because General Practitioners/Family Physicians cover a wide range of tasks within the framework of healthcare systems, concerns may arise related to how to address the quality and status of general practice in the different countries.

A glance to the recent history of General Practice/Family Medicine clearly demonstrates that this activity is gradually becoming one of the more complex areas in the medical practice. The risk of falling into lower practice standards must be mitigated. General Practitioners/Family Physicians must deal effectively with undifferentiated problems, co-morbidity, polipharmacy, sophisticated biomedical and psycho-social phenomena, and psychosomatic problems. They must also be attentive to opportunities for preventive interventions, health promotion and health education.

This broad professional role requires high-level training programmes, continuing education and quality assurance activities, similar to those associated with other medical speciality training – an issue that is crucial for health systems' response and sustainability across Europe.

In some European countries, the recognition of General Practice/Family Medicine as a medical speciality remains an ongoing debate, involving medical organisations, governments and academic bodies. Nevertheless, there is a consistent movement towards the specialization of General Practitioners/Family Physicians, which is a new landmark in health systems' organization and will contribute new approaches to primary care settings. A recent survey carried out of UEMO members reports as follows:

Country	National recognition of GP/FM as speciality
Austria	NO
Belgium	NO
Bulgaria	NO
Croatia	YES
Czech Republic	YES
France	YES
Denmark	YES
Finland	YES
Germany	YES
Hungary	YES
Iceland	YES
Ireland	YES
Italy	NO
Luxembourg	NO
Malta	YES
The Netherlands	YES
Norway	YES
Poland	YES
Portugal	YES
Slovakia	YES
Slovenia	YES
Spain	YES
Sweden	YES
Switzerland	YES
Turkey	YES
United Kingdom	YES

UEMO has actively promoted a number of activities aiming to encourage the GP/FM specialty to be acknowledged as a peer of the other medical specialties at EU level, namely in common provisions of the Directive 2005/36/EC, dated as of September 7, 2005 on the recognition of professional qualifications. UEMO also supports national efforts in those countries seeking to develop GM/FM specialty.

Mobility of health care professionals and patients

The European health systems face a set of new challenges resulting from the abolition

of borders across the European territory, globalisation, and migration of populations looking to raise their socio-economical status. Well-prepared General Practitioners/Family Physicians have a major role to perform in this new era, in which primary care must be the anchor of affordable and sustainable health care systems.

Free movement of doctors and of other health care professionals due to mutual recognition of diplomas, in particular within the EU, still raises some questions associated with quality, professional liability, and transparency of qualifications. Regardless of the significant moves forward, countries and authorities have yet to effectively reinforce mutual cooperation in a way that best safeguards the public interest, establishes efficient and suitably dimensioned health care services, and ensures patient safety. The global shortage of health professionals cannot be solved by encouraging mobility, which will only lead to brain drain in the less developed countries though massive migration of their much needed medical workforce.

At the Primary Care level, health systems still need to work on their mutual cooperation to promote a comprehensive and rational approach on mobility. As mentioned above, the recognition of the specialty of General Practice/Family Medicine by the European legal framework is fundamental to promote actual mobility of General Practitioners/Family Physicians. Without that provision, GP/FPs' mobility will be reduced and based on lower qualification requirements.

Patients' interests must also be assured by means of clear and accountable measures that on one hand allow patient mobility across borders as an option for the patient, but which on the other hand do not force him to seek health care in another country. There may be good and various reasons to seek health care in another country, but patients should be able to find continuity of care in or close to his or her community.

Empowerment and autonomy of citizens concerning personal and collective health matters

Promotion of patients' rights in Europe is a strong social and political issue. Patients are also being asked to take more responsibility for their own health. This requires more education and information, and efforts to protect patients from an uncontrolled self-medication market and the risk of polypharmacy. The empowerment of patients can only be effective if it is grounded in a solid doctor-patient relationship in a system capable of providing personalised, affordable and qualified health care.

These are clearly subjects already approached by the UEMO and that require continuous attention in the near future. As a partner of European Institutions in health fields, UEMO will monitor and advise on all issues related to primary care impacts and enhanced health care provided by General Practitioners/Family Physicians, in the interest of patients and for the purpose of health interventions towards health gains.

Increasing demand for cost-effectiveness and quality, grounded in universal access to health care

There is currently some tension around the "gate-keeper" concept that exists in some European countries, as a result of very different medical cultures that vary from country to country. Because the tradition of free access to any specialised care has been a reality for many years, concern has been expressed that General Practitioners/Family Physicians could be advocating misuse and promoting limited access to other medical specialised care merely for cost-containment reasons. However, the increasing labyrinth of medical technology available to the population and its significant impact at social and economical levels demand that General Practitioners/Family Physicians support and guide patients through a range of complex options. The success of health systems in these topics should be promoted through informa-

tion and education, rather than by coercion or prohibition. Facilitator mechanisms can be more helpful to meet the demand of universal access to quality and cost-effective care than administrative restrictions.

Funding models and specific interests of the various health care players have established distinct organisational lay-outs in which competition inhibits cooperation. Never-ending debates will continue around major themes like sustainability, funding, quality, and health provision. However an effort should be made to find innovative solutions emphasising co-operation over competition. Considering this scenario, General Practitioners/Family Physicians are clearly indispensable to achieving cost-effectiveness in health care and to co-operating and coordinating efforts in the best interest of patients.

Information & communication technologies in healthcare

The widespread integration of information technologies into daily health care environment raises a broad range of expectations, nevertheless one should be aware that, while they may solve some health problems, they may magnify others, and that they may cause added strain to health systems, professionals and patients. Recently implemented features such as electronic health records, telemedicine and remote medicine, expert systems, smart cards and data protection are undoubtedly influencing and shaping the future of General Practice/Family Medicine. European countries have been trying to deal with this unceasing influx of technologies by developing a number of national projects along with global European projects. UEMO has a clear vision of this emerging field and considers the appropriate use of technology as an improvement. It is clearly a valuable tool in facilitating primary care investigation faster when needed and improving communication between primary and secondary care levels, though major aspects such as data protection and confidentiality of health records must be carefully considered.

The future role & strategy of the UEMO

As the main representative of General Practitioners/Family Physicians in Europe, UEMO continues to establish itself as a critical link to the EU health institutions, the European Parliament and the European Commission. UEMO is already fully incorporated as a non-profit organisation under the Belgian law, which will significantly reinforce the voice of General Practitioners/Family Physicians at the EU level.

The UEMO seeks to represent all European General Practitioners/Family Physicians and is therefore actively looking for new members coming from as yet unrepresented countries. Wider representation allows the organisation to circulate its input more actively from the practice level in GP/FM to the policy and steering level. UEMO also understands that closer cooperation with other European Health Organisations as well as with global health entities such as the World Medical Association and the World Health Organisation is fundamental to the common development of a clear primary care agenda at EU level.

That is the reason why the UEMO has been seeking to improve coordination with WONCA and EURACT – as a first step, working together with these entities will influence positively the qualification of current and future General Practitioners/Family Physicians, in the area of more appropriate and evidence-based interventions in health care and patient interest.

UEMO is also involved in fostering recruiting strategies and policies for new GP/FPs and has therefore engaged in strengthening bonds with the *Vasco da Gama Movement* that emerged from coordinated efforts of WONCA-Europe and EURACT to disseminate, promote, and develop the GP/FM speciality in Europe.

As a representative medical organisation, UEMO maintains and promotes united



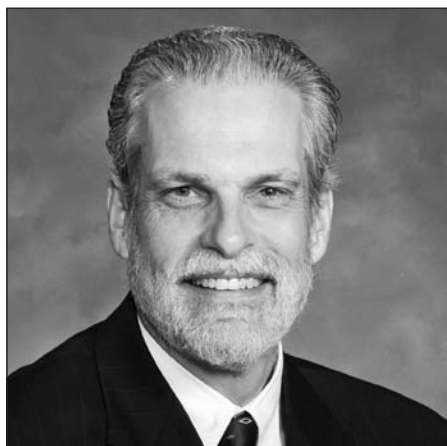
views amongst medical organizations and regularly meets and debates common positions with CPME, UEMS, FEMS, EANA, CEOM, AEMH and PWG. A strong, coherent and active position of all doctors is a paramount to reinforcing trust of the European health systems and the provided health care services among patients and other health stakeholders.

After 40 years of continued activity promoting primary care and General Practitioners/Family Physicians medical practice, UEMO's Portuguese Presidency is currently engaged in further developing this mission. Each and every one of the UEMO activities is a solid contribution to the overall goal of "serving the interests of patients", which is not only the mandatory requirement for all medical interventions, but should also be the

driving force behind the policy and political activities of the medical profession. General Practitioners/Family Physicians, like Primary Care itself, are committed to ensuring that health care activities are driven by the needs of citizens and further the objectives of disease prevention and health promotion. We work today to prepare the future.

Dr. Isabel Caixeiro, President

Gearing up for emergencies – a vital component to our nation's health



J. James Rohack

From the influenza pandemic and Fort Hood shootings to the unforgettable tragedies of Sept. 11 and Hurricane Katrina, our country has endured a number of catastrophic events and public health emergencies in recent years. The good news is that as these events continue to surface, physicians and communities nationwide have continued their preparation for effective response.

In conjunction with the Health and Human Services Public Health Emergency Medical Countermeasures Enterprise Stakeholders Workshop, the AMA recently hosted the Third National Congress on Health System Readiness. Physicians and other stakeholders in medicine, as well as government

and community leaders, joined the nation's leading public health preparedness experts in Washington, D.C., to review current research and science related to recent disasters and public health emergencies worldwide, and to establish a framework for response. And they discussed how to manage and respond to a real, yet unpredictable crisis we now face – the 2009 H1N1 influenza pandemic.

The pandemic has received global attention ever since the virus emerged in April 2009. The AMA's *Disaster Medicine and Public Health Preparedness* journal just published a special issue about the pandemic, including articles on point-of-care testing and biothreats, pediatric considerations in extending and rationing care in public health emergencies, and operational considerations in mass prophylaxis work force planning. And the AMA's *Pandemic Influenza: A primer and resource guide for physicians and other health professionals* provides insightful recommendations on preparedness and response to an influenza pandemic.

In light of recent events, a group of physicians agreed during the AMA's disaster medicine caucus at the Interim Meeting of the AMA House of Delegates in Houston that all health professionals and local communities need the proper training and resources to know what to do in these situ-

ations. Fortunately, the right tools and education are already under way.

The AMA, in cooperation with four major medical centers, established the National Disaster Life Support™ (NDLS™) Program in 2003 to standardize emergency response training and strengthen our nation's public health system. Summoning more than 75,000 participants, the program has 70 training centers throughout the United States that offer the NDLS™ Program courses.

One component of this program, the Advanced Disaster Life Support™ (ADLS®) Course, has been revised to include training in mass triage, hospital response and planning, surge capacity, and skills stations and clinical scenarios, and is expected to be available to the public in June.

For individual citizens, the CitizenReady™ program, developed collaboratively by the AMA, the Federal Emergency Management Agency and the National Disaster Life Support Foundation, Inc., is being piloted in cities and towns across the country via an initial program that focuses on the influenza pandemic.

As we've seen from experience, disaster can strike at any time – and without notice. The best way to ensure that our patients, homes and communities are safer is preparation. Have a plan. Practice it. And be ready.

J. James Rohack, MD, President of the AMA
This column originally appeared in the Dec. 4 edition of AMA eVoice.

Report of the 26th CMAAO Bali Congress

Note by the Secretary General

The 26th Confederation of Medical Associations in Asia and Oceania (CMAAO) Congress and 45th Council Meeting was held in Bali, Indonesia, from November 5th to 7th, 2009. The Congress was attended by 50 representatives from 12 NMAs (Japan, Hong Kong, India, Indonesia, Republic of Korea, Malaysia, Myanmar, New Zealand, Philippines, Singapore, Taiwan, and Thailand). The Council Meeting took place on the 5th and the Congress Grand Opening Ceremony and Assembly Meeting were held on the 6th, with the meeting continuing on the 7th, followed by the symposium.

One of the main events of the Congress was the passing of the Presidential Medal from Immediate Past-President Dr. Somsri Pausawasdi of the Medical Association of Thailand to the President-Elect, Dr. Fachmi Irish of the Indonesian Medical Association, during the Grand Opening Ceremony on the 6th. Following that, the 9th Taro Takemi Memorial Oration was presented. This is an oration event commemorating Dr. Taro Takemi, a Japanese doctor who served as president of JMA for 25 years and contributed to the establishment of CMAAO. Dr. Azrul Azwar, Professor at University of Indonesia, CMAAO Past-President, and WMA Past-President spoke on "The Role of Primary Physician in Achieving the Millennium Development Goals (MDGs)".

At the Council Meeting, I presented a report, as Secretary General, of the main CMAAO activities for the past years. In the report I spoke about the discussion focused on the topic of the economic crisis and healthcare, which was the theme of the symposium during the Congress. I also touched upon the topics of task-shifting and prescription rights, which are also becoming issues for the WMA, and the anti-smoking issue, which is an issue common to

all countries. Representatives of the NMAs also delivered a Country Report of their NMAs activities for the past year.

The application of the Myanmar Medical Association for CMAAO membership was approved, bringing CMAAO membership to 18 NMAs.

The main agenda for the Congress also included some organizational issues, such as consideration of how and when future Congresses and Mid-term Council meetings should be held and how executive board members should be selected with a view to strengthening CMAAO's organizational structure. Since these reforms involve matters requiring broad changes to the CMAAO Constitution & By-laws for operation, it was decided that the Constitution & By-laws Committee would take the central role in preparing a draft proposal, and that revision would be carried out at future CMAAO meetings.

With regard to the main items currently being considered by CMAAO, it was decided to divide the responsibility of pre-

paring proposed statements on important topics among NMAs. In particular, it was agreed to make the anti-smoking problem, which is common to all member NMAs, a permanent theme and continue discussions at future meetings. Moreover, to facilitate more efficient utilization of the CMAAO website, a decision was made that all member NMAs should prepare reports of their activities and proactively send them to the Secretariat at the Japan Medical Association.

With respect to future meetings, the 46th CMAAO Mid-term Council Meeting will be held Kuala Lumpur, Malaysia, in 2010 and the 27th CMAAO Congress will be held in Taipei (Taiwan) in 2011.

A symposium entitled "Impact of the Financial Crisis on the Health System" was also held, with presentations by representatives of nine NMAs.

In addition, elections were held for Office Bearers for 2009-2011, the results of which are shown below.

Masami Ishii, MD
Secretary General of CMAAO
Vice-chair of WMA

CMAAO Office Bearers for 2009-2011

President	Fachmi Idris	Indonesia
President-Elect	Ming-Been Lee	Taiwan
Immediate Past-President	Somsri Pausawasdi	Thailand
1st Vice President	David Kwang-Leng Quek	Malaysia
2nd Vice President	Dong Chun Shin	Korea
Chairman	Wonchat Subhachaturas	Thailand
Vice-Chairman	Peter Foley	New Zealand
Treasurer	Yee Shing Chan	Hong Kong
Secretary General	Masami Ishii	Japan
Assistant Secretary General	Hisashi Tsuruoka	Japan
Adviser	Tai Joon Moon	Korea
	Yung Tung Wu	Taiwan

What can medical journals do for global health?

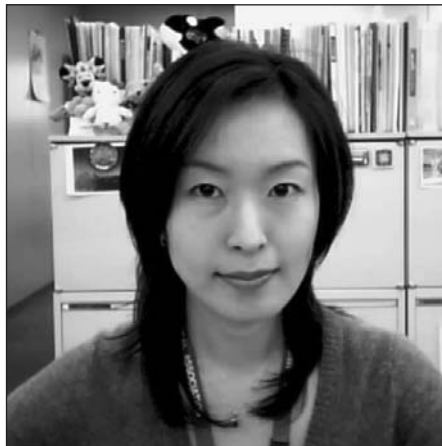


Masami Ishii

Introduction

The official English-language Journal of the Japan Medical Association, *JMAJ* was first published in 1958 as *Asian Medical Journal (AMJ)* to advance medical science and healthcare in Asia and to strengthen the influence from abroad on Japan's health policies by introducing JMA's policies. At that time, JMA had a strong leader, Dr. Taro Takemi, who served as the JMA president for an exceptionally long period of 25 years (1957-1982). He was actively engaged in international affairs, held the WMA General Assembly Tokyo in 1975 and became the 29th WMA president. Under his leadership, the foundation of international activities of the JMA was built including participation in the World Medical Association (WMA, 1951), creation of Confederation of Medical Associations of Asia and Oceania (CMAAO, 1956), and the establishment of Takemi International Health Program in Harvard School of Public Health (HSPH, 1983) [1].

The JMA publishes another journal in Japanese, *the Journal of the JMA*. The Japanese journal has a peer review system for original



Mieko Hamamoto

contributions while *JMAJ* currently does not. Both journals mainly publish invited review articles, but the readership of the Japanese journal is mainly JMA members while *JMAJ* is published for global readers, mostly outside of Japan.

Scientific journals on general medicine published in Japan are not so highly evaluated internationally. Some people argue that the JMA should publish a medical journal that would be internationally recognized. Therefore, we decided to conduct a survey questionnaire on periodicals published by National Medical Associations, in collaboration with the Takemi Program in HSPH, to clarify what periodicals NMA's publish, with a focus on exploring unique approaches and effective ways to transmit useful health information to global readers.

Summary of the Survey on NMA Journals

This section presents some results related to the NMA characteristics and their journals on general medicine. The full report is available in the *JMAJ 2009;52(4)* [2].

In October 2008 we emailed a questionnaire to all 92 NMAs in the WMA and CMAAO, and received responses from 31 (34%).

Table 1 provides the numbers of NMA members and staff. Membership ranged from the smallest, Luxembourg (1,150) to the largest, Germany (395,000). Of the 29 NMAs that reported their type of membership, 86% (25) responded that it was voluntary. The US had the largest staff (1,000), far more than that of the runner-up, the UK (450) and other NMAs. Staff density is the number of staff per thousand physician members.

Approximately 71% of the journals (20/28) had five staff members or fewer. The journals with the largest staffs were *JAMA* (100, US), *BMJ* (40, UK) and *CMAJ* (32, Canada) [2], followed by India and Norway (20) and the Netherlands (15).

Sources of published articles in NMA journals are shown in **Table 2**. Overall, the majority of published articles were contributed by "outside authors" or general manuscript submissions from authors who did not work for the journal. Among the 29 journals that reported the peer review percentage, 66% (19) peer reviewed more than 90% of their articles [2].

The official languages of the WMA are English, Spanish and French (the official language of the CMAAO is English). In all, 69 NMAs (75%) used English as their official language, followed by Spanish (16/92, 17%) and French (7/92, 8%). Approximately 71% (22/31) of journals were published either partly or fully in English [2].

Among the 26 journals that reported online availability, full text was available for free in 73% (19) (**Figure 1**). In the case of *JMA*, the English journal is freely available, but the Japanese journal is open to its members only.

Thus, we have found that the numbers of people and participation rates of NMAs varied widely, but approximately 70% of the NMA journals had five or fewer staff personnel, used English at least partly, and were freely available online. According to the self-reported classification, 16 journals were defined as journals published mainly for domestic readers and 15 journals were for global readers [2]. Of the 26 NMAs, only 4 NMAs, including Japan, published two or more general medical journals both in their native language and English [2].

The survey did not capture the complete global picture on NMAs and their periodicals, with only 2 responses out of 16 NMAs in Latin America, none from Africa (12), and missing data on each question. Nevertheless, it has strength as the first interna-

tional comparative survey of this sort, which collected a wide range of data, with friendly cooperation of WMA and CMAAO – the two international organizations representing physicians.

Factors for Success

What is success for journals published by medical associations, and how do we measure it? As Sir William Osler once said, “the practice of medicine is an art, based on science”[3]. Here we review two journals from the concepts, science and art.

New England Journal of Medicine

The *NEJM* is one of the most successful scientific journals on general medicine, with the oldest history since 1812 and the high-

est impact factor (52.589 in 2007) [4]. The publisher, the Massachusetts Medical Society, has 21,291 members as of 2008 and over 400 staff members [5], with high staff density of 18.79.

The secret of the journal's success is accidental – Mr. Stephen Morrissey, Managing Editor of the *NEJM* responded, after a little pause, in the interview conducted by Hamamoto in May 2009. He also characterized the journal by its operation with almost all sections in-house except printing, and especially emphasized the graphic section producing superb illustrations. Unlike typical commercial publishers, they are basically citable for free, creating a virtuous circle where citations breed citations.

Table 1. Numbers of NMA Members and Staff

	No. of Members	Participation Rate (%)	No. of Staff	Staff Density
Australia	26,000	(50)	42	1.62
Azerbaijan	1,480	(5)	8	5.41
Bangladesh	35,000	(80)	120	3.43
Belgium	-	(25)	10	-
Brazil	120,000	(36)	45	0.38
Canada	69,000	(70)	170	2.46
Czech Republic	-	-	23	-
Germany	395,200	(100)	100	0.25
Hong Kong	7,557	(70)	25	3.31
Hungary	30,000	(95)	11	0.37
Iceland	1,254	(99)	5	3.99
India	175,000	(27)	85	0.49
Israel	18,000	(94)	70	3.89
Japan	165,086	(60)	189	1.14
Korea	75,476	(80)	137	1.82
Luxembourg	1,150	(73)	3	2.61
Macedonia	4,500	(75)	3	0.67
Malaysia	7,897	(36)	22	2.79
Netherlands	38,906	(58)	137	3.52
New Zealand	4,000	(40)	10	2.50
Norway	22,055	(97)	120	5.44
Philippines	28,000	(50)	22	0.79
Spain	206,000	(96)	25	0.12
Sri Lanka*	3,000	(20)	10	3.33
Switzerland	33,655	(98)	71	2.11
Taiwan	37,518	(100)	32	0.85
United Kingdom	138,000	(64)	450	3.26
United States	231,000	(33)	1,000	4.33
Uruguay	8,500	(60)	26	3.06
No. of responses	n=27	n=28	n=29	n=27
Mean	69,749	(64)	102	2.37
Median	30,000	(67)	32	2.5

* Sri Lanka is a member of CMAAO only.

Table 2. Sources of Published Articles (n=29)

Area*	Journal**	Outside Authors	Editors	Invited Articles
Pacific	G	98%	0%	2%
Pacific	G	90%	5%	5%
Pacific	G	90%	2%	8%
Asia	G	90%	0%	10%
Euro	D	90%	5%	20%
Asia	G	90%	5%	5%
Asia	G	90%	5%	5%
Latin Am	D	85%	10%	5%
Euro	D	80%	20%	0%
Euro	G	70%	15%	15%
Euro	D	70%	20%	5%
Euro	D	70%	15%	15%
Euro	D	68%	0%	6%
Asia	G	65%	0%	35%
Asia	D	50%	40%	10%
North Am	G	33%	33%	33%
Euro	D	30%	20%	40%
Pacific	D	30%	50%	20%
Euro	G	5%	90%	0%
Pacific	D	5%	0%	95%
Pacific (J of the JMA)	D	3%	0%	97%
Pacific	D	0%	50%	50%
Pacific (JMAJ)	G	0%	0%	100%
Euro	G	yes	yes	yes
Asia	G	yes	yes	yes
Euro	G	yes	yes	yes
North Am	G	yes	yes	no
Asia	D	yes	yes	yes
Euro	D	yes	yes	yes
Mean		57%	17%	25%
Median		70%	5%	10%

* Journal names have been kept anonymous except Japan.

** G stands for global journal and D for domestic journal, based on the NMAs definition.

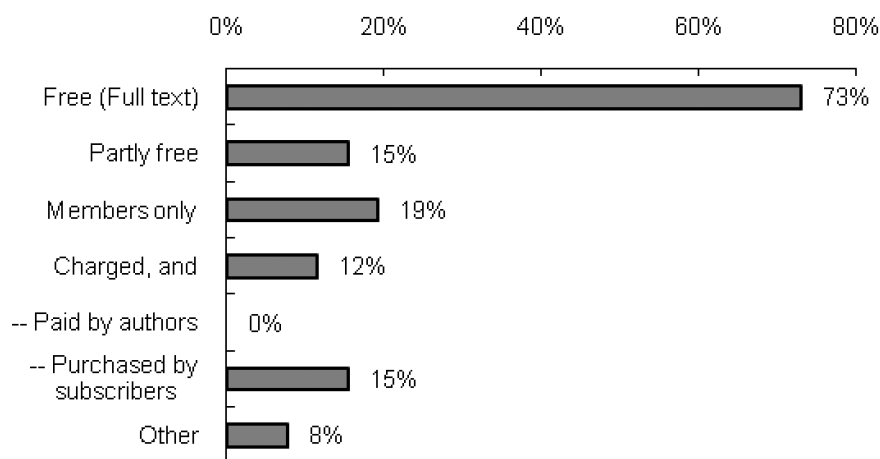


Figure 1. Online Availability of NMA Journals (n=26)

But the journal obviously has a geographical advantage; in addition to an editorial board consisting of international members, it has editors, most of whom are practicing in hospitals in the Boston area or teaching in Harvard and other schools. They attend the editorial meeting every Thursday afternoon. However common online communications have become, it is a great advantage to have editors and staff within a short distance that enables them to meet face to face easily. Its longstanding success must be an accident caused by that certain environment in Boston, USA.

World Medical Journal

The *WMJ* must have gone through various transitions since the first publication in 1949 [6]; a discussion as to the title of WMA's official publication [7] and a proposal to transform the *WMJ* into an international peer-reviewed journal [8] in 2006 are still fresh in our minds.

Dr. Pēteris Apinis, the new Editor-in-Chief since 2008, President of the Latvian Physicians Association and the former Health Minister of Latvia, reported that the *WMJ* aims to become a powerful information spreader of world medicine, with three keywords: informative, interdisciplinary and

actual [9]. He actively asks colleagues for contribution of manuscripts, and was witnessed walking around the rooms with a camera in his hands to patiently excavate the faces of participants and information from all parts of the world in the WMA meetings.

The WMA General Assembly New Delhi 2009 adopted WMA Declaration of Delhi on Health and Climate Change, and elected Dr. Ketan Desai from India as President of the WMA for 2010-11. Many participants must have felt a growing interest in social medical issues, and the power of India, a rising nation with more than one billion people.

For the *WMJ* to achieve its goal, scientific evaluation is hard to make, and whether the title should be journal or bulletin is not important. It will have a significance and originality in the art of medicine including human nature, by covering WMA's reality and voices of physicians across the globe.

Concluding remarks

Medical journals have various directions to head, and we often know little about what is necessary to go in that direction. It is not easy to make the journal sustainable and of

the highest quality because our resources are limited. *NEJM* represents an ideal form of scientific journals, and *WMJ* has strength in human network spreading around the globe. *JMAJ* will maintain the current policy, closely associated with *WMJ*. We believe that NMAs can turn information accumulated in each country into a shared asset of the world through more vocal, online and off-line communication.

Acknowledgments

We would like to express our sincere appreciation to all the NMAs, Otmar Kloiber and Sunny Park for their cooperation to the survey. We would also like to thank Michael R. Reich and Hisashi Tsuruoka for their valuable comments.

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The right to health as a bridge to peace in the Middle East

In recent years many have asserted that the right to health is a critical element of peaceful societies and that health professionals have a role to play in peace processes. In 1998 the 51st World Health Assembly formally accepted *Health as a Bridge for Peace* as a feature of the “Health for All in the 21st Century” strategy. According to the World Health Organization “health can be a neutral meeting point to bring conflicting parties to discuss mutually beneficial interventions”.

Efforts to engage the medical profession across geographic and political boundaries have been underway for several years. The Norwegian Medical Association organized, under the auspices of the World Health Organization, five meetings from 1993 to 1997 among the medical associations from the new republics in former Yugoslavia. The underlying theory for these meetings was that physicians have ethical standards in common that go beyond ethnic and national interests.

In 2007 Brazil, France, Indonesia, Senegal, South Africa, Thailand and Norway formed an alliance to put health on the global foreign policy agenda. They stated that “The world is facing many common problems related to health, and therefore foreign policy must be more health sensitive.” This group identified a number of elements that deserve greater attention:

- development and use of health indicators to better assess peace and reconstruction processes;
- roadmaps for health recovery as a peace-making tool;
- more empirical knowledge of the effect of health intervention at different stages in conflicts.

Most recently, from 27-30 October 2009, the World Medical Association and medical associations and health and human rights organizations from Egypt, Iraq, Israel, Netherlands, Norway, Palestine and Turkey met in Kuşadaşı in Turkey to discuss health as a bridge to peace in the region. The purpose was to stimulate and improve communication among health professionals in the region, as a first step in a process we hope will establish collaboration structures among medical associations in Middle East.

Before the conference in Turkey, all participating organizations completed a questionnaire on the right to health in their country. The meeting began with a presentation of the survey results. Each organization highlighted two or three items related to health and human rights, which then formed the basis for the discussion agenda.

The conference provided a forum for valuable dialogue and exchange of information and experiences in the area of the right to health. Different countries face different challenges and during the discussions the political realities, particularly in Israel and Palestine, often surfaced. One of the main objectives of the meeting was to establish a common project on which the participants could collaborate. Various suggestions for future projects were discussed:

- training physicians on ethics and human rights;
- initiating activities to increase the professional capacities of physicians who play an important role in the prevention of torture;
- monitoring the implementation of two recent WHO resolutions – the first on the revitalization of primary health care

as the key element of comprehensive health care systems and the second on the social determinants of health;

- addressing the negative impact of war, conflict and violence on the health of the population;
- analysing health disparities in different countries of the Middle East;
- holding governments accountable for realizing the right to health.

Toward the end of the conference it became clear that it was difficult to find one project all could agree on. The participating organisations found the meeting valuable, but would need more time for building trust and getting to know each other better. However, the participants agreed to continue to meet, and realised the necessity of dialogue in order to establish sustainable collaboration structures on the issue of right to health.

It was decided that the topic for the next meeting should be: The role of health personnel in health and human rights.

The meeting was co-organized by five organizations: two National Medical Associations (the Norwegian Medical Association and the Turkish Medical Association), one national human rights organization (the Human Rights Foundation of Turkey) and two international networks: the International Federation of Health and Human Rights Organizations and the World Medical Association.

*Bjorn Oscar Hofrvædt,
Metin Bakkalci,
Otmir Kloiber,
Eline Thorleifsson,
Adrian van Ees*

Organization of the Professional Self-Government of Physicians and Dentists in Poland

The Polish (Supreme) Chamber of Physicians and Dentists (Naczelna Izba Lekarska) and the regional chambers of physicians and dentists (okręgowe izby lekarskie) are the organizational bodies of the professional self-government of physicians and dental practitioners who are associated in the chambers with equal status.

The professional self-government of physicians and dental practitioners in Poland was founded in 1922, dissolved in 1952 and reestablished in 1989. There are currently 23 regional chambers and a separate chamber of military physicians and dentists that has the legal status of a regional chamber, though its members span the entire country. Chambers of physicians and dentists address a range of matters concerning the practice of medicine and dentistry in Poland.

The highest authority of the Polish Chamber of Physicians and Dentists is the General Medical Assembly, and the regional medical assemblies are the highest authorities of the regional chambers. In the period between assemblies, the Supreme Medical Council and regional medical councils are the decision-making bodies at the state and regional levels, respectively. Every physician and every dental practitioner who holds the right to practice the profession in Poland is a member of one of the regional chambers by virtue of the law.

Number of members of the chambers in 2009:

Physicians – 132 694;

Dental practitioners – 36 633;

Persons with both professional titles – 594.

The tasks of the self-government of physicians and dentists include:

- supervising the proper and conscientious exercise of the medical professions;
- determining the principles of professional ethics and deontology binding all physicians and dentists and overseeing compliance;
- representing and protecting the medical professions;
- integrating the medical circles;
- delivering opinions on matters concerning public health, state health policy and organization of healthcare;
- co-operating with scientific associations, universities and research institutions in Poland and abroad;
- offering mutual aid and other forms of financial assistance to physicians and dentists and their families;
- administering the estate and managing the business activities of the chambers of physicians and dentists.

The Chambers:

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

The organs and members of the Supreme Chamber (term of office: 2006 - 2010)

Supreme Medical Council

Consists of 75 members – representatives of Polish physicians and dental practitioners elected at the General Assembly.

President **Dr. Konstanty Radziwill**

Secretary **Dr. Mariusz Janikowski**

Vice-Presidents: **Dr. Ryszard Golański,**
Dr. Anna Lella,
Dr. Andrzej Włodarczyk

Deputy Secretary **Prof. Jerzy Kruszewski**

Treasurer **Dr. Andrzej Sawoni**

Members of the Presidium: **Dr. Zdzisław Annusewicz, Dr. Romuald Krajewski,**
Dr. Wojciech Marquardt,
Dr. Andrzej Matyja

Supreme Screener for Professional Liability **Dr. Jolanta Orłowska-Heitzman**

Chairperson of the Supreme Medical Court **Dr. Jerzy Nosarzewski**

Chairperson of the Supreme Audit Committee **Dr. Jarosław Zawiliński**

International policy of the Polish Chamber of Physicians and Dentists

One of the important areas of activities of the Polish Chamber of Physicians and Dentists is participating actively in international organizations of physicians and dentists and collaborating with medical and dental organizations and chambers abroad.

The Chamber is active in the following international organizations of doctors and dental practitioners:

- Standing Committee of European Doctors (CPME);
- European Union of Medical Specialists (UEMS);
- European Forum of Medical Associations and the World Health Organization (EFMA/WHO);

- Symposium of Medical Chambers of Central and Eastern Europe;
- World Medical Association (WMA);
- Council of European Dentists (CED);
- World Dental Federation (FDI);
- European Regional Organization of the World Dental Federation (ERO/FDI).

In 2008 the Chamber applied for constituent membership in the World Medical Association. The application was approved at the General Assembly in Seoul in October 2008 and the Chamber became an active WMA member again on January 1, 2009. The Polish Chamber of Physicians and Dentists was one of the founding WMA member associations, though its membership ceased when the Chamber was dissolved in 1952.

Dr. Konstanty Radziwill, President of the Polish Chamber of Physicians and Dentists, is a Vice-president of the Standing Committee of European Doctors (CPME) and was elected to the position of the CPME President for the years 2010 – 2011.

Since October 2008 Dr. Romuald Krajewski, Member of the Presidium of the Supreme Medical Council, is currently serving as Vice-President of the UEMS.

The Polish Chamber of Physicians and Dentists also co-operates on regular basis with national medical chambers and medical organizations from many other countries.

Provided by the Polish Chamber of Physicians and Dentists

Messages from Taiwan Medical Association



Ming-Been Lee

The celebrations of Doctors' Day in November 2009 marked the year end for the Taiwan Medical Association. However, the commitment to end people's suffering with improved quality care is our never-ending mission, particularly during and after a disaster. In this article we review three major events that demonstrate TMA's interaction with the international community, the public and our local peers.

Taiwan Medical Association Celebrated Doctors' Day

The TMA celebrated 2009 Doctors' Day on 12 November in the presence of Dr. Dana W. Hanson, President of the World Medical Association, Dr. Masami Ishii, Vice-Chairman of the WMA, Dr. Cecil B. Wilson, President-Elect of the American Medical Association, Prof. Vivienne Nathanson, Director of Professional Activities, British Medical Association, and Dr. Dongchun Shin, Chair, Executive Committee of International Relations, Korean Medical Association. Nearly 500 senior doctors were openly acknowledged for their four to six decades-long contributions. The ceremony highlighted ten outstanding physicians receiving the TMA Role Model Award and compliments from distinguished foreign guests.

Before the award giving ceremony was the International Seminar on Health for All: Problems and Solutions, chaired by TMA President Dr. Ming-Been Lee. Focusing on

health insurance and the physician-patient relationship, the seminar invited abovementioned international speakers and welcomed broad participation from all over the country, including TMA's boards of directors and supervisors, international affairs committee, heads of regional branches and professional medical societies to share and exchange views. Dr. Hanson, Dr. Ishii and Dr. Shin provided overviews of the healthcare systems in Canada, Japan and South Korea, respectively. Dr. Wilson, drawing on the experience of AMA, provided in-depth analysis on health policy making in the United States, while Prof. Nathanson elaborated on the experience of the doctor-patient relationship in the United Kingdom. The celebrations were honored by President Ma Ying-jeou's attendance in the afternoon.

Post-conference programmes for our guests began with the Bureau of National Health Insurance in Taipei, where the General Manager Shou-Hsia Cheng received the visitors with his vivid illustration on the operation of NHI in Taiwan. The group also visited the Buddhist Tzu Chi Hospital in Hualien on the east coast and learned about their worldwide humanitarian work. The tour ex-



tended to the south, cordially accompanied by TMA's member organizations Tainan and Kaohsiung Medical Associations.

It is worth noting that prior to the Doctors' Day programs, the TMA had arranged for our guests to deliver speeches to the participants of the 5th Global Forum for Health Leaders during 9th and 10th November. The Forum was organized by Taiwan Joint Commission on Hospital Accreditation and sponsored by the Department of Health.

Five honorable speakers from overseas expressed their compliments at Doctor's Day Celebrations.

Disaster Management

On 8th August this year, southern Taiwan was devastated by super-typhoon Morakot. Large-scale mudflows and landslides brought the death toll to 634. The TMA took immediate action by setting up a disaster relief working group to support the government's disaster management efforts. All physicians were summoned to cooperate with local health authorities and provide medical services. Members of TMA were highly appreciated for their voluntary services, donations and sponsorship of affected areas.

During post disaster reconstruction and rehabilitation, the TMA places priority on consolidating resources and providing specialty care, adequate health information and education, as well as financial, pharmaceutical and psychological support. To this end, the TMA appealed to professional associations of physicians, lawyers, accountants and

architects to participate in helping alleviate victims' trauma. In the meantime, heartfelt condolences from national medical associations in other countries were received with gratitude.

Although almost 100 hospitals and clinics in the typhoon-hit areas suffered from various degrees of damages, they resumed services without delay to ensure proper care for people in need. TMA President Dr. Ming-Been Lee, deeply concerned about local TMA members as well as the victims, traveled to the sites in November and December to console victims while urging the medical community to continue services and focus on rehabilitation.

The TMA delegation, led by President Dr. Ming-Been Lee, visited indigenous people in Taitung, an area hit severely by Typhoon Morakot and short of medical resources.

Major Projects Granted From Department of Health

Professional Autonomy

For two consecutive years the TMA received the Bureau of National Health Insurance delegation programme of Professional Autonomy Affairs under the Primary Care Global Budget System. Professional autonomy and point-value management in the primary care community have resulted in a better healthcare environment. Achievements of the programme include: 1) enhanced quality of care; 2) health facilities at the primary level received counseling; 3) response to complaints from patients;

4) participation in the planning of primary care global budget payment system; 5) planning of and capacity building for personnel in the review panel; and 6) improved medical service review practice.

Continuing Medical Education Accreditation

The TMA also participated in the 2008 Department of Health (DOH) Accreditation Programme of Continuing Medical Education (CME) in Medical Ethics, Medical Regulation and Medical Quality. By the end of 2008, we received 2,330 cases and our high quality accreditation plans were satisfactory to the DOH, course organizers and physicians. We helped physicians obtain necessary points to renew their licenses. An accredited administrative platform was established to analyze and review all CME courses, and organize academic conferences with partner institutions to improve both teaching and learning.

In addition, we continued to act as the agency to accredit CME courses. We completed accreditation of CME courses, academic meetings and international symposium organized by medical schools, associations, societies, teaching hospitals and other agencies. Individual physicians' application for CME points were processed and accepted. A special team was assigned as a liaison to assist CME course providers and physicians on the recipient side.

*Ming-Been Lee, MD,
President of the Taiwan Medical Association*

The Israeli Medical Association

The Israeli Medical Association (IMA) is an independent professional organization representing Israeli physicians. The IMA was established in 1912, and includes among its members over 90% of the medi-

cal personnel working in Israel's health funds, hospitals, state institutions and private clinics. The IMA is responsible for establishing professional norms and ensuring high standards of medicine in Israel

and is involved in shaping national health policy, influencing the legislative process and presenting the achievements of Israeli medicine to the global healthcare community. The IMA is similarly responsible for overseeing physicians' working conditions and for formulating and clarifying rules of medical ethics.



Leonid Eidelman

One of the major activities undertaken by the IMA in recent years was a lengthy arbitration process designed to raise physicians' salaries and implement reforms to their working conditions. In recognition of the serious legal, ethical and financial costs of striking, the IMA agreed in July 2000, on behalf of all publicly employed physicians, to give up the right to strike for ten years in exchange for this mandatory arbitration. The arbitration process only began in 2005, and in 2008 it was decided that doctors would receive a salary increase of approximately 23.5%; however, no real reforms on issues such as manpower and continuing medical education were realized.

Another recent and ongoing project initiated by the IMA relates to the increasingly troublesome phenomenon of violence against physicians. The IMA approached this problem on several fronts. For instance, the IMA has proposed several bills in Parliament to prevent violence against medical personnel, such as one bill intensifying the punishment for those who attack medical personnel and another allowing doctors to refuse to treat previously violent patients, except in emergency situations.

The IMA also appealed to the Supreme Court to obligate the Ministry of Health to

implement an emergency plan as well as to implement the permanent directives from a report previously issued by the Director General. The Supreme Court criticized the Ministry of Health for not implementing its own plan. Immediately following this criticism, the Ministry of Health budgeted 2 million NIS to reduce violence against physicians and *Clalit* Health fund, the largest Health fund in Israel, budgeted 2.5 million NIS for the same purpose.

In addition to the legal measures implemented, the IMA manages an emergency hotline for doctors who have been victims of violence, providing immediate advice and referrals. The IMA also contracts with a professional security company that accompanies doctors who have been attacked and appear to be in danger, and provides professional advice. In conjunction with a professional media company, the IMA produced a video clip on the topic of violence against physicians that was broadcast on Israeli cable television.

Finally, the IMA partnered the pilot project, "Hospitals without Violence" at Wolfson Hospital and advanced a pilot of mobile emergency buttons in the operating room of Sheba Medical Center. The IMA also initiated a forum of all the bodies representing workers in the health sector to contend together and to pressure decision makers to deal with the problem of violence.

Another topic which the IMA chose to address this year is that of physicians' health. Viewing the health of physicians as a prerequisite to the proper care of patients, the IMA set up a hotline that provides confidential referrals to doctors seeking medical help in various fields. The IMA is also preparing information booklets for employers and physicians discussing issues related to physician health and raising practical suggestions such as: healthy food and exercise, immunizations and periodic checkups, naps during rotations, and making the workplace "breastfeeding friendly".

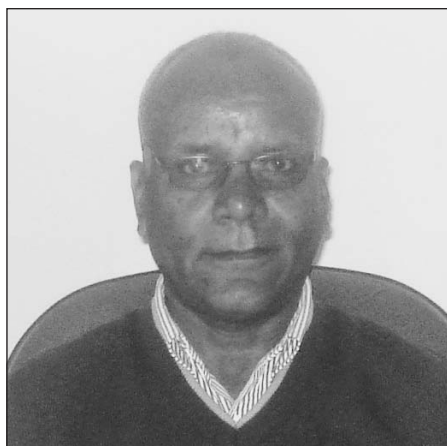
The IMA also developed several workshops for coping strategies and burnout prevention. A pilot workshop was held for residents at Soroka Hospital in Beersheva and considered very successful.

The IMA has also been working on the key issue of Inequalities in Health. In Israel, as in many countries around the world, health services are available and accessed differently across geographic, economic and socio-demographic lines, resulting in health disparities. In order to combat this increasing problem, the IMA convened a committee which discussed the problem in depth and produced a report on health inequalities in Israel. Following this, several actions were taken by the IMA including developing a training programme to teach physicians how to treat patients who are different from themselves, a telephone survey to assess the impact of health inequalities in Israel, and meetings with government officials took place.

This desire to improve the health of less fortunate populations is always at the forefront of the IMA's agenda. Another example can be found in the clinic the IMA, along with the Ministry of Health, established in November 2008 at the Tel Aviv central bus station. The purpose of the clinic is to provide for people who do not yet have legal status and are therefore not receiving treatment at regular health institutions; this includes both refugees and those work immigrants who do not have legal status or any sort of health insurance. The IMA and the Ministry of Health opened the clinic, which functions by way of donations and volunteer doctors and is intended to provide primary health care to the refugees. The clinic was established as a temporary measure until there is proper legislation regarding health coverage for these populations.

*Prof. Leonid Eidelman
President of Israeli Medical Association*

The Ethiopian Medical Association



Mahdi Bekri

The Ethiopian Medical Association was founded on July 20th 1961, when His Imperial Majesty Haile Selassie I graciously granted a Royal charter to the Association and consented to be Patron of the Association. Its first constitution was promulgated in the same year. Expatriate doctors played a prominent role in the early history and accounted for the majority of its membership.

Dr. F. Hylander, Swedish nationality, was the first president of EMA and Dr. Yohannes Kibreth, Ethiopian, was elected as the 2nd president of EMA in 1962. The organization became a member of the WMA in 1963 and is also founding member of the Confederation of African Medical Associations & Societies (CAMAS).



EMA Executive Committee with Minister of Federal Ministry of Health

Vision:

A healthy and prosperous Ethiopian community with access to quality health services provided by physicians who have the opportunity to continuously enhance their professional capacity, exercise their rights and enjoy the benefits of their profession, and practice freely in an environment that respects medical ethics.

Mission:

To ensure the rights and benefits of physicians through lobbying and advocacy, to enhance their professional abilities through continuous development of their medical knowledge in service to their patients, and to work with the government and other partners for the improvement of quality health services to the Ethiopian community.

Objectives:

1. To promote the professional excellence of members in preventive and curative medicine and medical research
2. To promote the science and art of medicine and improve public health
3. To promote and maintain intellectual and professional freedom
4. To provide professional and technical advice to the Ministry of Health and other concerned organizations
5. To publish the Ethiopian Medical Journal and other professional journals as the need arises
6. To provide a forum for the exchange of professional ideas, knowledge and experience among the members of EMA
7. To provide Continuing Medical Education for all doctors practicing in Ethiopia

In pursuit of the above objectives, the EMA holds annual medical conferences where members exchange ideas, knowledge and experience; publishes Ethiopian Medical Journal quarterly; and provides continuing



EMA 44th Annual Conference at United Nation Conference center - Addis Ababa, 2008

medical education to update the knowledge of its members.

During the last three years, the EMA has reorganized the Secretariat, increased its capacity and worked closely with the Federal Ministry of Health and International Organizations. Other accomplishments include:

- In-house capacity building
- Development of a five-year Strategic Plan
- Establishment of four branch offices
- Development and implementation of projects
- Revision of the Constitution of EMA
- Collaborative activities with different stakeholders
- Essential steps towards the realization of EMA's future house

The projects EMA is implementing are:

- Research-based incentive for physicians working in remote hospitals
- Human resource capacity building to accelerate ART uptake in Ethiopia
- Support of routine immunization services
- Infection prevention

EMA is pleased to partner with WMA, other sister associations and organizations in implementing projects of mutual interest.

Please visit our website: www.emaethiopia.org

Dr. Mahdi Bekri, Executive Director of Ethiopian Medical Association

The Organización Médica Colegial De España



Jose Ramon Huerta Blanco

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

The OMC activities are focused on very diverse areas, always related to the medical profession. Besides the habitual activities of record and professional control as well as qualifications, the OMC promotes continuous medical training activities for which it has a specific Foundation. It also has a Central Medical Ethics Commission which not only studies the cases that it receives from the Medical Colleges, but also carries out studies and documents about the position of the medical profession in fun-

damental ethical questions that concern it. Thus in the last months, it has updated its positions on medical care at the end of life and on the regulation of a conscience clause for health care professionals who don't want to perform abortions.

The OMC has a digital journal "Doctors and Patients" which maintains updated information about questions of medical health care and social interest, but also of information and interest for patients. Also the OMC has approved the creation of a Social Council to foster and to promote meetings and collaboration with patients who are the *raison d'être* of medicine.

In the last year the OMC has tightened its bonds of collaboration and action with the most representative medical entities of Spain: the medical trade unions, the Conference of Deans of Medical Universities, the State Council of Medical Students, the Federation of Spanish Medical Scientific Associations and the National Commission of Specialities in Health Sciences, integrating with them all what is known as the Forum of the Medical Profession.

In addition, the OMC is developing a wide activity in defence of the medical association and contributing its point of view to the legal regulations. Our association understands that the association formula is the one that best guarantees the social protection of patient's interests, the fulfilment of Ethics, the control and regulation of the profession, which has been commended the protection of an important asset: health. The OMC is developing efforts and taking measures to assure the conscience clause for health care professionals when faced with the modification of the Law on Abortion. Also it undertakes intense actions to assure that the authority to prescribe drugs is re-

served to health care professionals because the competence to prescribe is inseparably linked with the diagnosis for reasons of efficiency, quality and safety in health care.

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

Recertification of the competences of health care professionals and reassociation depending on the fulfilment of professional, psychophysical criteria and of accredited updating of professional competence is another of the challenges that the Spanish medical organisation has to face after 2010, reinforcing the corporate commitment with the patient and society and transparency towards health care professionals and society.

The Spanish medical organisation has a very extensive international collaboration. It plays an active role in the World Medical Association, European medical organisations like the CEOM (European Council of Medical Orders) and organisations of medical specialists (UEMS), general practitioners (UEMO), hospital health care professionals (AEHM), doctors in training (PWG). The cooperation with the countries of Latin America organised through the FIEM (Latin-American Forum of Medical Entities) is of special interest, without forgetting the social and solidarity action for which the OMC has formed a Solidarity Foundation with the purpose of promoting and channelling help and cooperation for medical – health care in countries with precarious health care and vulnerable and needy populations.

*Dr. Jose Ramon Huerta Blanco,
International Relations Coordinator*

Medical Confederation of the Argentine Republic



Jorge Carlos Jañez

As a consequence of the neoliberal policies implemented, repetitive budget cuts have damaged the social, political and institutional situation not only in our country, but in the entire Region.

Health services have been deteriorating gradually, the public healthcare spending is decreasing in terms of the income per capita ratio, and the scarce resources had to be adapted by giving importance to treatment over prevention. At the same time, new changes have been introduced in the financial aspect, there is a rising tendency to privatisation and the operating expenditure belongs to the user now.

Within the framework of these neoliberal policies, several reasons were stated which privilege the following: expenditure is now afforded by the users of the system, private resources are excessively used and the public services administration is decentralised.

In addition to the aforementioned, the sector shows an extreme sanitary anarchy, a lack of coordination between the public and the private sector, which results in the dou-

bling and superposition of services and the low use of resources.

Social Security defnancing is a consequence of the unreleased unemployment rate. The unemployed population lost their health insurance coverage which led to the overload of Public Hospitals as well as a fall in the private sector provision of services. As a result, doctors who perform in this subsector have been directly affected.

Given that the infrastructure and the public sector supplies are in bad condition, doctors lack all kind of support before patients. The latter not only demand a medical assistance that doctors cannot provide on their own, but also take legal action against them more frequently. Thus, a patient's right before an undesired treatment result was turned into the so-called "medical malpractice insurance industry".

It is even worse when faced by unrestrained relatives or the same patient, since they are becoming more and more aggressive, and may end up assaulting physically. Apart from these unfortunate situations, the doctor's proletarianisation must also be mentioned. It is caused by several factors:

- Professional Plethora which shows a doctor to patient ratio of approximately 360. In some large places, big urban centres, the ratio is 120 inhabitants per doctor.
- Increase of professional medical licenses up to 5 times faster than the population.
- No planning of geographical distribution.
- High percentage of specialists (80%, 70% out of this 80% are in the big urban centres).

After the proposal of the National Integrated Health System in 1973, which was abolished, and laws 23660/61 of the Nation-

al Health Insurance (last essays on national policies), there was a crisis in the service provider which still continues, and signs indicate that it will get worse.

This deep crisis demands a health system reform in accordance with a STATE POLICY under consensus of all participants, basing the system programme on the following proposal:

- Give priority to Primary Attention (Mother & Child Programmes, Special Plans for the needed, etc.) as a response to the emergency.
- Complement all subsectors in order to shift the fragmenting system by using the idle installed capacity.
- Coverage based on an Obligatory Medical Insurance.
- State administration and regulation which comprises:
 - High Complexity
 - High Medical Technology
 - Medicine
- Regulation of the professional practice which comprises:
 - Adaptation of programmes of study in the Medical Schools
 - Planning the number of students who enter Schools according to the System needs
 - Planning access to the work source
 - Programming the geographical distribution
 - Professional certification and recertification
 - Professional Career
 - Regulation of specialisations

*Dr. Jorge Carlos Jañez,
President of Medical Confederation
of the Argentine Republic*

COP 15 – success or failure?

The COP15 – Conference of the Parties – has been the talk of Copenhagen and the rest of the World, since December last year when the city was transformed into a giant hotel with a display of leaders from all over the world. Copenhagen was meant to be the place where an agreement of tremendous importance to our planet should be realized.

The World Medical Association worked hard to gain access to the COP 15 NGO conference by applying for observer status to the UNFCCC. In the end, access was not granted and WMA had to pursue other means of participating in the negotiations. Fortunately HEAL – the Health and Environment Alliance – offered to include Dr. Jens Winther Jensen and CEO Bente Hyl-dahl Fogh from the Danish Medical Association in its delegation, to represent the WMA.

The Health and Environment Alliance is a European umbrella organisation, based in Brussels, working for health and the environment. At the COP15, HEAL had invited a number of NGOs to join in their efforts to place health on the agenda at the NGO conference of the COP15.

The HEAL delegation included: the Standing Committee for European Doctors (CPME), International Federation for Medical Student's Associations (IMFSA), European Public Health Alliance, Climate and Health Council, Health Care Without Harm, Harvard Medical School, Medsin-UK and others.

HEAL succeeded in public promotion of its agenda during the COP15. An article was published in the NGO Newsletter on climate negotiations "ECO". The delegation also posted information on the "Pre-scription for a Healthy Planet" website,

where health professionals are encouraged to sign up at: www.climateandhealthcare.org. Furthermore, WHO delegates attended one of the HEAL side events. It was an opportunity for HEAL to present the views of the medical community on the importance of health impacts on climate change.

The HEAL delegation, as well as other delegates to the NGO conference, had massive problems actually gaining access to the conference venue, including standing in line outside for about six hours in the winter cold, as the number of accredited delegates to the UNFCCC far outweighed its capacity. In the end, the WMA delegates did not gain access to the Center, but invited the HEAL delegation for a debriefing at the Danish Medical Association building on the last day of the official NGO conference, the 17th of December 2009.

At the debriefing, participants agreed that the conference was not a success, given the fact that no goal for reduction of CO₂ emissions was reached, but valuable lessons had been learned. The International Medical Students' Association had formed strong relations with the WHO and the importance of building strong alliances before arriving at the COP was stressed many times during the meeting. The need to be very accurate about the cost and means of turning proposals and ideas into working initiatives was also underlined. This applies to policy as well. For example, when WMA recommends in a policy declaration that the public health systems should be strengthened, the recommendation must be accompanied by concrete, detailed initiatives if the message is to be received and understood by decision makers.

The recommendation from the HEAL delegation in view of the next COP16 in Mexico was therefore to:

"Build relations with key decision makers well in advance of the event, build strong alliances with other health professionals such as nurses, midwives, medical students as well as journalists before the next COP to ensure that the message we wish to convey is heard, but, perhaps most importantly: be very specific about the goals we wish to achieve and the cost implications."

Success or failure? The delegation was hopeful that the next COP will be more effective given that valuable work has been done to form a base to take decisions and lessons have been learned by the world leaders.

The challenges are still in front of us. The positive relationship between reducing green house gasses and obtaining better health must be pursued by world leaders and by doctors.

*Bente Hyl-dahl Fogh, Chief executive officer,
Danish Medical Association,
Christina Lumby Rasmussen,
Danish Medical Association*

“Climate change is the greatest global health threat of the 21st century”

When the four of us arrived in Copenhagen last Saturday, mid-way through negotiations, we were shocked to see that concepts of Global Health equity were absent from the UNFCCC’s text. In 1992, with the creation of the UNFCCC, human health was described as one of guiding principles of the framework. Nineteen years on, at the 15th Conference of the Parties, we see no such mention of health.

As medical and global health students, and members of the International Federation of Medical Students’ Associations (IFMSA), this fact was of great concern to us. We are convinced that health should be placed at the centre of negotiations, providing an effective framework for a successful global deal. Our views were supported by three other delegations (the Health & Environment Alliance, Health Care Without Harm, and the World Health Organisation), with which we formed an unofficial coalition.

The Bella centre (the chosen venue for the ‘historic’ conference) was enormous, and full of negotiating teams, members of civil society, security and UN staff, all busy trying to culminate the last year of work into what could hopefully be a successful round of negotiations. If we were to be effective, we had to be organised, and smart with the few precious days we had in Copenhagen.

We set out to promote the concept of health within the UNFCCC negotiations, and build lasting relationships and our own capacity for coming COPs. We did just that.

We wrote letters to, and met with country delegations who were either most affected by climate change, had brought their health ministers to the negotiations, or had already included ‘health’ as a central theme in their national statement. We encouraged them to

speak out in plenary, attend our side-events and actions, and plan to put them in contact with medical students and clinicians from their country interested in climate change. This was highly successful, and we received interviews and statements from many countries around the world (including the UK, France, Ghana, Burkina Faso, Indonesia, the Maldives, and the Netherlands, among others). All the while we were feeding information to our fellow students in the IFMSA through blogs, videos, interviews and daily summaries.

On Wednesday the 16th, we staged a UN approved ‘Action’ with the Health Environment Alliance and Health Care Without Harm. This involved a visit from a ‘surprise’ doctor, vocally teaching a ward round of medical students about the correlations between climate change and health. Not only has climate change been revealed to be “The greatest global health threat of the 21st century” (The Lancet Series), but recent studies have shown that there are co-benefits for health associated with the mitigation of climate change. The doctor presented the conference with our “Prescription for a Healthy Planet”, imploring the health sector to participate in the debate. The event was held within the Bella centre, received significant media coverage from national and international sources, and was well attended by various health delegations, including the WHO.

With the conclusion of the conference, we sat down and asked ourselves, “What next?” Negotiations were unsuccessful, more work was needed, but we were not disheartened – we were left wanting more.

We had covered significant ground, established links with like-minded organisations, and people were starting to mention human

health when they spoke of climate change. But if we are ever to be successful, we need the international health community to actively engage in discussion.

We require further research and data highlighting the economic benefits of health and climate change mitigation. We plan to connect students with the health and environment ministers we met, as well as with healthcare professionals currently active in this field. Most importantly though, we will learn from this experience, further educate ourselves, and build capacity for COP16 in Mexico.

One thing is certain, we will be back.

IFMSA Delegation to the UNFCCC COP15, Copenhagen – Nick Watts (Australia), Jonny Currie (UK), Guppi Bola (UK), Mori Mansouri (UK), Yorgos Polychronidis (Greece)

Written by Nick Watts

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