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- Human Resources for Rural Health
- Developing Healthcare Technologies for Emerging Markets – Improving Quality, Access and Cost

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Carl Gustav Carus (1798-1869) was a physician, painter and philosopher of nature. Carus, a friend of Johann Wolfgang von Goethe and Caspar David Friedrich, was the first teacher of comparative anatomy in Germany. He is also considered to have laid the philosophical foundations of depth psychology. The University hospital of Dresden is named after him.

"View on Dresden from Augustus bridge" was painted by Carus around 1830. Dresden, his place of living and working, was the scene of the 113th German Medical Assembly 2010.

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Editorial

The economic crisis has criss-crossed the globe. Just as it appears to be under control in one place, it flares up in another. Emissaries of the World Bank and International Monetary Fund travel from country to country with billions in credit and strict controls designed to stabilize the economy. The international assistance is not always met with open arms, such as in Greece, where public demonstrations have protested against the reforms.

Medicine reflects the economy. Almost every economic downturn is followed by a reduction in health care expenditure, one more severe than the other. Politicians are much more likely to cut health care costs than reduce the salaries of civil servants.

But is an economic crisis such a damned phenomenon, that it should lead to the collapse of a health care system? Is it possible to change a defect into an effect? What attitude should the World Medical Association adopt in the face of economic downturn?

The first slogan we should adopt is: "Politicians, hands off the health care budget during economic hard times."

Secondly, we should remind our leaders that in sunny times, they were the first to spend resources on technological advancements that offered marginal returns. For example, the latest computerized tomography or magnetic resonance imaging may have cost twice as much as the previous one, but may have improved resolution by only

ten per cent: or, the entry into electronic medical records led to the collection of massive digital files of which perhaps five percent has any value to the physician. The remainder of the data that has been collected rests in digital cemeteries. Technology changes so rapidly that the radiograms that were scanned in the 1990's are no longer recognized by newer hospital computers today. The CD we are now using will someday be as obsolete as are the floppy discs of only a few years ago.

In the midst of a crisis, politicians will perhaps listen to the fact that doctors care for patients, not computer monitors. Can our scarce resources be spent more wisely?

Thirdly, we should take advantage of difficult economic conditions to push for reform. During these times governments are looking earnestly for additional sources of income. Recessions are opportune times to push for tax increases on unhealthy substances, such as tobacco, alcohol and soft drinks. Higher gasoline taxes encourage less automobile driving and more bicycling.

By the way, dear colleagues and medical leaders, how often have you gone to work by bicycle this year?

*Dr. Peteris Apinis,
Editor in Chief, WMJ*

185th WMA Council meeting in Evian, France 20th–22nd May 2010

The 185th meeting of the World Medical Association Council and its committees took place in Evian-les-Bains, France from 20th to 22nd May 2010, under the Chairmanship of Dr. Edward Hill.

Following the adoption of the Minutes of the 184th Council in Delhi, the President Dr. Dana Hanson gave a brief report outlining his extensive travel since Delhi, highlighting in particular, widespread concerns he had encountered concerning professional autonomy and regulation. He referred to WHO's year of Road Safety mentioning in particular the mortality figures in Russia and felt that WMA should reconfirm its work on Road Safety. The São Paulo Conference on the use of placebo in research held in São Paulo, was a great success. He expressed his thanks to those NMA's whom he had had the privilege of visiting and stressed the enormous value of such visits.

Secretary General's Report (see also fuller report WMJ, 56, 87–96)

The Secretary General commenced his report by expressing his thanks to the Brazilian Medical Association for their help with the São Paulo conference and to the Bundesärztekammer, in particular to Dr. Ramin Parsa-Parsi, mentioning also the scientific work done by the WMA Cooperating Centre, Institute of Ethics and History of Medicine at the University of Tübingen. Acknowledging the continuing work of Dr. Coble, he reported that Books of Hope in 2010, supported by the Chinese Centre of Disease Control, the Chinese Medical Association, the Chinese Association on Tobacco Control and the WMA, presented a speaking book on the dangers of smoking. This targeted low literacy communities, where smoking rates have significantly risen over recent decades. The first 500 speaking

books have the potential to impact on 50-100,100 people and will be accompanied by research analysing its impact on health literacy.

The Caring Physicians of the World (CPW) project extension into Leadership Courses organised by INSEAD Business School in Fontainebleau, France, was realised in a second course held in Singapore – 13th February 2010 - with 29 participants, made possible by unrestricted educational grant from Pfizer Inc. The work was supported by the WMA Cooperating Centre at the Centre for Global Health and Medical Diplomacy in the University of North Florida.

Dr. Kloiber spoke of studies carried out on the need for educational support in the field of policy creation by the Centre for Study of International Medical Policies and Practices at George-Mason University (a WMA Cooperating Centre). He also drew attention to the first issue of a new Journal "World Medical and Health Policy Development" in the autumn of 2009. Finally he paid particular tribute to two staff members who had extended the cooperation with institutions in Geneva, notably WHO with whom the work had intensified. A side event at the UN conference on Human Rights had been organised by the Danish Medical Association's initiative on Human Rights, where there was discussion on the role of physicians on combating/reporting torture.

Dr. Kloiber then referred to the revision of the rules of procedure which had been taking place following council's decision that this should be done. All the relevant documents had been considered with a view to reducing the documentation, identifying common elements and conflicts of laws/rules, etc. and coordinating provisions

into two documents. Documents would be circulated to council members for their comments. It identified those areas of duplication/conflicts, etc., with suggestions for consideration and response, prior to a further meeting to produce the final revision.

Nominations

Dr. Torum Janbu was nominated for the Chair of the Medical Ethics Committee and Sir Michael Marmot to serve as a member of that Committee.

Council adjourned for the Standing Committees.

Medical Ethics Committee

The committee met on 20th May 2010 and Dr. Torum Janbu was elected by acclamation.

The Chair welcomed new members of the Committee, Dr. Poul Jaszczak, Sir Michael Marmot and Dr. Ramin Parsa-Parsi, and the **Minutes** of the October 2009 Meeting in New Delhi were **approved**.

Helsinki and Placebo

Dr. Ramin Parsa-Parsi, chair of the Workgroup on Placebo in Medical Research, spoke to the report on the results of the conference in Sao Paulo and the recommendations which, after referring to there being no urgent need for change in the wording, suggested that possible future revision of the Declaration of Helsinki be considered in the light of new findings (methodological issues, informed consent, research ethics committees, etc.), and that a WMA workgroup should be mandated to:

- **develop a strategy in order to continue the discussion;**
- develop new wording for paragraph 32 which should facilitate future revision of the Declaration;
- consider an expert conference in 2011.

The Chair stressed the broadening of the approach and Dr. Collins-Nakai responding, commented that the wording should refer to the linking of the use of placebo to when agreed treatment was being used in the research, i.e. the words “there should be agreement to the use of placebo when agreed treatment was being used”, be included in any wording, which reflected the view that the use of placebo in a trial should depend on the circumstances, informed consent and the agreement of Local Ethical Research Committees (LERCs).

Dr. Kloiber supported the concept of further work and the Committee adopted the Recommendations in bold above, *and Council later approved the Working Group report.*

Principles of Health Care for Sports Medicine

In considering comments on the Declaration on Principles of Health Care for Sports Medicine, the Chair observed that while it was a good text, things have changed since it was adopted and he queried the need for update. Dr. Haikerwal, however, asked whether there was indeed a need for update as the document was out of date. He mentioned such things as “the need for exercise in relation to non-communicable diseases” and “sport”, referring also to “Keeping Healthy” and suggested revision of the statement on Chronic Diseases. Dr. Collins-Nakai, raising the possibilities of injecting genes to enhance performance, recommended updating to take account of genetic modification. Ms Wapner indicated that the Israel MA would be willing to do this updating, but Dr. Nelson felt that the document was not about exercise for the general population, it was for physicians looking after sportsmen.

The Secretary General reminded the committee that WMA had different policies on sport, e.g. the physician’s role in obesity care is outlined in another document.

While Dr. Nathanson agreed to looking at Obesity and Activity, she would oppose the

CMA viewpoint, and leave the document as generic cover. The statement should be kept as generic as possible. Dr. Collins-Nakai agreeing with Dr. Nathanson felt, however, that the document was not generic enough. After further discussion a motion to reaffirm the document **“Declaration on Principles of Health Care for Sports Medicine” was adopted by the Committee and this recommendation was later adopted by Council.**

Human Rights

Ms Clarisse gave a report on organising the side event at the Human Rights conference on 9th March 2010, chaired by the UN Human Rights Rapporteur. The panel included the Slovenian UN Human Rights representative also the Representative on Human Rights and Torture. She also spoke about the problems raised by anti-abortion legislation which could inhibit action in patients with cervical cancer. She reported that FIGO (Forum of International Gynaecology and Obstetrics) had issued a Press Release concerning Female Genital Mutilation on International Women’s day in February.

Dr. Hill and Dr. Hanson reported on their visit to China where they had discussed organ transplantation with the Chinese Medical Association and the Minister. They were encouraged by the Chinese Association and the Minister having established specific criteria for Transplantation. Three quarters of the hospitals were doing transplants and now were better controlled. Although the topic was on the WMA agenda, for the Chinese this topic was a priority.

Declaration of Tokyo

The committee considered the problems of the implementation of the Declaration of Tokyo and a suggestion that the WMA establish a mechanism to enable cases of torture to be notified directly to WMA, to avoid the problems associated with notifi-

cation in some countries and facilitate the WMA taking action. Dr. Hill also referred to a conference in Sweden on Torture and on the reporting of torture. In this context Dr. Reis (ICRC) commented that it was easy for doctors working in Geneva to report torture, but not so for those working in a country where they were afraid that their house might be destroyed or their wives raped. He suggested that WMA should do something about this.

Sir Michael Marmot spoke of the real limits to what NMA’s can do. They should act and be seen to do what they can. The BMA view is that WMA is doing what it can and the idea of sending this proposal was to give transparency to these actions. The Norwegian MA, appreciating the BMA comments, felt it crucial that we recognise the risks for some physicians in notifying torture, recommending that work continue on mechanisms in which they are not seen to be doing this, but also mechanisms by which information can get to the UN Special Rapporteur. Responding to a question as to whether WMA could organise such a mechanism, Dr. Kloiber commented that WMA had a small office in which everyone had specific tasks. They had neither the means nor resources to do this. What is difficult is that they are besieged by calls from organisations. They could be faced with programmes and campaigns which were not human rights issues.

Dr. Snaedel drew attention to what we in fact have, i.e. the ICRC and WMA working with the Istanbul Protocol with outside support. This showed what can be done with specific activities. Dr. Nathanson felt that we should recommend that the Norwegian Medical Association and Dr. Reis identify simple things which can be done. The Secretary General commented that WMA as an NGO had been successful in getting support from governments and the International Court in the Hague. What would happen if we were known to act as a monitoring body, what would be the re-

action? Currently we are aware of doctors in distress and have taken action. Dr. Reis agreed with Dr. Kloiber and was willing to work on this.

A proposal that the BMA, the Norwegian MA and Dr. Reis continue work on this was recommended and later adopted by Council.

End of Life

A WMA Statement on the End of Life and a background paper on End of Life and Medical Care were considered. It was reported that the Spanish Medical Association had been working on a paper on Euthanasia and had prepared a glossary of terms.

A Statement on terminal illness had also been prepared in the light of the change of attitudes which had taken place. The Spanish Medical Association (SpMA) therefore recommended changes to the Venice Declaration. Reference was made also to issues of Informed Consent, Palliative Care and to many countries still having problems with prescribing opiates where national legislation limits interfered with their adequate prescription – leading to more suffering by patients. It should be made clear that terminal sedation was not Euthanasia, a matter on which the SpMA had issued a Statement. There was a need for team work with doctors and paramedical professionals, also for families to be involved in palliative treatment and for palliative care to be included in medical school curricula. Dr. Snaedel as a geriatrician suggested that the documents be circulated, but Dr. Nathanson observed that the BMA had many problems with the document. There was much good in the paper, but she was concerned about the translation and the BMA had many problems with some of the definitions. She proposed that a working group be formed and address also the problem of continuing unbearable conditions.

After lengthy discussion the Chair thanked the Spanish for the proposal. **A recommendation that a working group be set up was approved and later adopted by Council.**

The committee also received:

- a report from Dr. Blackmer on WMA's work with WHO on Ethics in TB environment (see *Secretary General's report*);
- comment from Sir Michael Marmot on the work of WHO on Social Determinants in the context of Tuberculosis;
- an offer from Dr. Nathanson to distribute through the WMA secretariat an updated UK statement and concept paper on teaching ethical issues, from the Institute of Medical Ethics.

Socio-Medical Committee

The committee was called to order by the chair, Dr. José Luiz Gomes do Amaral.

The committee approved the minutes of its New Delhi meeting last autumn.

Health and Environment

In the context of Health and Environment (see also *Secretary General's report*) the committee considered comments on the statements on **Environmental Degradation and Sound Management of Chemicals** and also a document on **Advocacy Strategy on Climate Change Process**.

Dr. Nakai, chair of the workgroup on Health and Environment, informed the committee that the group planned to submit a draft policy on the "built environment" next spring.

Dr. Dongehun Shin reported on a conference convened by the secretariat of the United Nations Environmental Programme (UNEP) Strategic Approach to Management of Chemicals in Ljubljana in February, on the approach to the involvement of the health sector in chemicals' disposal. Speaking of the need for further

management principles in Chemicals' disposal, he said one of the aims was to reduce health risk in the life cycle of chemicals, i.e. the control of harmful chemicals and the reduction of production. He commented that developing countries have a lack of capacity for sound chemical development.

The committee also received an oral report from Dr. Peter Oris concerning the first negotiating meeting of the UN Environment Programme on legally binding provisions, scheduled for June in Stockholm, at which he would represent WMA. He intended to highlight the Seoul WMA Resolution on Mercury.

Ms Clarisse Delorme speaking to a paper on advocacy strategy prepared by the secretariat for the Health and Environment WMA workgroup, reiterated the Advocacy Committee's discussion on the frustration felt at the failure to include reference to health in the final Copenhagen COP 15 conference agreement and their failure to optimise the increasingly well-evidenced public health benefits of climate change mitigation activities.

Sir Michael Marmot reported that he had personally been lobbied by physicians in the UK about this. In the UK climate is an issue for the people. He therefore supported highlighting this issue with regard to human health.

Dr. Dana Hanson, chair of the Advocacy Advisory Group, supported the proposal by the group to hold a media briefing session on the day before the opening of the UN Climate change Conference to be held in Cancun in December 2010.

The Committee recommended and **Council later accepted that the Statement on Environmental Degradation and Sound Management of Chemicals be sent to the General Assembly with a recommendation that it be adopted.**

Prescribing/Relations between Physicians and Pharmacists in Medical Therapy

There was a long and forceful debate in the committee concerning where ultimate responsibility for prescribing lies. During the debate firm views were expressed by all speakers. Emphasis on the importance of issues of patient safety and access to medicines were stressed as were educational requirements and skills needed to ensure both quality and safety, in the interest of patients. The final decision will be taken at the Vancouver General Assembly in the autumn when the texts of recommendations are submitted to the General Assembly.

Violence against Families, Women and Children

Dr. Nakai introduced the Working Group's revision of the **Proposed Statement on Family Violence revision**, following comments from NMA's. After some discussion amendments were agreed. A recommendation, that the **Proposed Statement on Family Violence be approved and sent to Council later approved by Council**.

Dr. Nakai then indicated the efforts of the group to amend the document **Violence against Women and Girls** to reflect concerns of NMA's. Dr. Nathanson urged that the aim of the document be clear. "Violence is damaging both to the victim and to society". The **recommendation that it be approved as amended and sent to the General Assembly was later accepted by Council**.

Female Genital Mutilation (FGM)

In a discussion on FGM, Dr. Nathanson indicated that although we have a Statement on this issue, governments can still be portrayed as racist in condemning this, since while education was improving, there is still the problem of parents taking children to countries where FGM was accepted. After talking to girls who have such forced FGM

it is clear that they would prefer action to be taken.

Dr. Hill reminded the committee of the WHO/UNICEF/UNFPA Global Strategy to stop healthcare providers from performing FGM. WMA had been involved in the drafting process and it fitted in with WMA policy.

Dr. Kloiber commented that what we wanted was to achieve FGM abolition and to help victims. We will achieve a preventative effect for those emigrating. The Norwegian Medical Association commented that screening has not been shown to prevent FGM and there remained the question "at what age screening should be done?" Also FGM can be difficult to identify. Dr. Nakai said that screening of immigrants can identify risk and referred to a European Parliamentary document on this issue. Dr. Nathanson felt that clearly screening could not be forced, but often at screening this can be used as an opportunity to prevent and educate.

Classification of WMA 2000 Policies

Prisons and Tuberculosis

The committee recommended that the **Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and other Communicable Diseases undergo a major revision** on which the BMA and the ICRC volunteered to work. Council later **approved this recommendation**.

Advocacy

Dr. Hanson, chair of the Advocacy Advisory Group, in his oral report raised Advocacy issues relating to WMA's role in climate change. He mentioned also the increasing role of the World Health Professional Alliance's (WHPA) speaking for more than 26 million health professionals in global health debates. There was increasing concern amongst WHO

member states on Primary Health Care, and he proposed that WMA should organise a Primary Health Care conference in 2011. **Council later agreed to a small working group examining the feasibility and possibility of cooperation with other international PHC bodies of Organising a Primary Healthcare conference in March 2011.**

Dr. Haikerwal, speaking about the work of WMA with WHO, raised the Issue of Social Determinants of Health which should be addressed at such a conference. Sir Michael Marmot had hoped to raise the issue of Ethics in the Committee of the Commission on Social Care. He referred to health inequalities and the interest not only in the causes of health inequalities but also in the causes of causes in health. Where do physicians fit in to this? He listed three points:

- the responsibility to put one's house in order concerning universal access to health promotion;
- the role of physicians as advocates;
- the importance of knowledge of the determinants of health.

Council later agreed that this be pursued (*see resumed council below*).

Medical Care for Refugees

The committee considered a "**Proposed Revision of the WMA Resolution on Medical care for Refugees and Internally Displaced Persons**".

The Swedish Medical Association moved that the revised proposal be approved and also commented that the current legislation in their country was very restricted and the Association had highlighted this. Dr. Nathanson supported this excellent document being sent to NMA's for comments and indicated particular difficulties with medical care of such persons awaiting the approval of permission to stay in the country.

The recommendation that the revised document be referred to NMA's for comments was later approved by Council.

World Economic Forum (WEF)

Dr. Julia Seyer reported a recent meeting in London on a WEF initiative to improve access to health data on the grounds that such data play an important role in Health care and health services. To this end WEF is working with parties with relevant interests such as health professionals, patient groups, private industry and universities, to draft a global charter to strengthen access to health data which can produce more effective management of health providers and of individual health interests. Such a document needs to balance these interests with ensuring the protection of individual's privacy, as well as ensuring the quality and standardisation of data collected and the underlying principle of equity. Dr. Haikerwal observed that probably most countries have this information but governance was needed. Sir Michael Marmot was not clear about whether principles were concerned with privacy and data, or about collecting data. The Secretary General thought it important to be involved in this. WMA was in line with the other health professions on these issues and WEF was providing a platform for discussion.

Medical Aid in Disaster Areas

The Chairman, Dr. Amaral, gave a detailed account of the Brazilian Medical Association's organisation of medical aid "SOS Haiti" following the earthquake in January 2010. Within 21/22 days following a call for volunteers 907 physicians from various specialties had offered to go to Haiti. He made particular reference to the work which was enabled to be carried out in a Canadian Hospital based in Haiti, which made space available to enable these physicians to engage in surgery, notably the orthopaedic surgery required. He referred to the many NMA's who had provided assistance and

the collaborative assistance in neighbouring Dominica.

Concluding his remarks he commented, "A world safety zone does not exist on this planet" – and appealed for WMA to assist in coordinating the spread of the experiences of NMA's in responding to Disasters and the potential for WMA to participate in coordinating NMA's responses to disaster assistance.

A number of NMA's spoke of their experience in responding to Haiti and other disasters over recent years, stressing the importance of disaster preparedness and expressed the feeling that WMA should act as a focal point in coordinating the experiences of NMA's, etc. Reference was also made to a forthcoming WHO report on Disasters.

Counterfeit Drugs

Dr. Seyer then gave an account of the launch of World Health Professions Alliance

(WHPA) campaign on Counterfeit Medical Products, "Be Aware". She stressed the impact of counterfeit drugs, both patent and generic, on patient safety such as the major risk of increasing drug resistance in tuberculosis. This affected also the confidence of the public in available drugs. In parts of Asia and South America 30% of the drugs were counterfeit and the profits from these amounted to between 5 and 10 million dollars. It should be noted that counterfeit was not limited to the developing world. It also is a problem in the developed world via for example on-line purchases of which some 50% were counterfeit. The WHPA had defined principles and had also identified patients as victims of this activity. WHPA had set up a tool-kit on "counterfeit drugs" for both professionals and public. This was accessible on both WMA and WHPA websites. Workshops are being organised at which action points will be emphasised. These will take place in Africa and America, to which government representatives will be

among those invited. She asked WMA and NMA's to distribute the toolkit which was available for downloading from the web. This work was also being coordinated with WHO.

Non-Communicable Disease Management

In updating the committee on UN policy work on Non-Communicable Diseases the AMA reported that together with the American Academy of Family Physicians it organised a group to influence the Statement. WHO has also an agenda on this topic. At the World Health Assembly, member states' representatives had spoken on this issue and the AMA had been in contact with them. It was anticipated that a paper would be produced for the General Assembly in 2011.

Dr. Seyer thanked Dr. Ishii for a draft on Non-Communicable Diseases and indicated that there would be a UN conference on this topic later in the year. There was pressure to add this topic to the MDGs. It was important that the role of health professionals be included in these discussions.

Dr. Ishii also reported that there was a collective voice from Asia appealing to physicians to work with patients on "Patient Safety".

Dr. Nathanson said that Sir Michael had referred to his work on Social Determinants in Health. The BMA was preparing a paper on the role of Physicians, which would be published.

The Chairman, Dr. Gomes do Amaral, gave an extensive report on the medical aid "SOS Haiti" rapidly organised by the Brazilian Medical Association responding to the earthquake disaster in January 2010. In response to an appeal 907 physicians volunteered to go to Haiti. He detailed the tremendous problems encountered and paid tribute in particular to the Canadian help which arrived and provided much

needed Ophthalmic and ENT services, to the supplies sent from Ethiopia, the help in neighbouring Dominica and to NMA's and others who responded to the need for specialist services, notably orthopaedics. He warned that "A safety zone does not exist on this planet" and appealed for volunteers in WMA to spread the experience of NMA's in responding to disasters.

Dr. Ishii in thanking Dr. Amaral said the Japanese Medical Association had sent volunteers and stressed that Japan had substantial experience of earthquakes. Dr. Nathanson said that the BMA had links with the Red Cross, UNICEF, Médecins sans Frontières, etc., and directed people as appropriate. Resources were provided from the NHS as donations from their stockpiles as appropriate, and the government had doubled its aid. The public in responding to an appeal gave 10 times more than this.

The Israel Medical Association, whose vice-president had organised rehabilitation services which were also needed, felt that this type of emergency needs support from the WMA. The AMA had organised an emergency response team with PAHO and the Department of Defence organised a consultation on the management of disasters. An AMA/American College of Surgeons delegation was sent to organise an evaluation of needs. The SpMA has established a register of volunteering specialists – more than 1000 – and expanded the training of volunteers.

The Chair commented that we had needs for disaster assistance in 2005, 2006 and also Haiti. Climate change was also to be expected. He felt that WMA should play a role as a central control for Medical Aid in these circumstances. It would not be easy.

Dr. Haikerwal said they had the same problems with the Tsunami in 2004. The AMA had lots of experience: lots of equipment and manpower arrived but was blocked from being quickly deployed. WMA should

coordinate learning from these experiences. Dr. Nelson commented we don't know when the next disaster will hit us. What was important was disaster preparedness. WMA should be a focal point for this.. She had students from medical school but no means of coordinating their help. Brazil had given an example of how to coordinate assistance.

WHO Global Strategy on the Prevention of Alcohol Abuse

Mr. Dag Rekke, Technical Officer, Management of Substance Abuse Department at WHO, reported that the 63rd meeting of the World Health Assembly had just adopted the **WHO Global Strategy on the Prevention of Alcohol Abuse**.

Addressing the question "Why this Global Strategy" he explained that a collaborative study on disease cause and outcome had identified alcohol as the 3rd leading risk factor for global causes of diseases. It was therefore a global issue. He illustrated the huge problems of morbidity and the huge variation in mortality in sub-groups such as male/female/age and also referred to some protective effects of alcohol. Young people were the most damaged, e.g. 30% in the European region. There were great variations in determinants. Addressing the question of why should this become a global issue now, he outlined the history of research and resolutions starting in the early 80's with French research into the social consequences of alcohol abuse and then further research, expert committees and WHA resolution over the succeeding years. In 2002, "Alcohol" – a WHA report – listed alcohol as the fifth leading factor in disease causation. In the following years things moved towards the concept of a global strategy which was the subject of wide consultation, and a draft mandate for a global strategy began to emerge, culminating in the Global Strategy just adopted. While member states have agreed the Strategy, it is not legally binding, it was meant to complement governments' ac-

tions. The evidence basis for damage from alcohol was good but there were huge differences in member states. This called for a comprehensive approach. There was a need for leadership as reflected in the WMA Santiago approach. National Health Service commitment was essential. While there was little evidence basis for actions, availability and pricing of alcohol were important.

Harm reduction processes should try to reduce the negative consequences of alcohol abuse. Illicit production needed to be addressed. Because of ethanol which is an added risk. Globally WHA has four axes:

- public health advocacy;
- resource mobilisation;
- problems of implementation;
- need for a going concern – swings between no action and aggressive action.

In the Executive Board, Cuba and Sweden were working in cooperation. Referring to the effects in the older generation he spoke of Diabetes and Alzheimer's disease. There was a need to balance between the positive and the negative aspects of alcohol. Further information was accessible on the web at www.who.int/substanceabuse.

Dr. Nathanson was delighted that WHO had acted. In the UK 25% of the population is abusing alcohol and we are seeing cirrhosis in the early 20's. This was a problem throughout the European Region of WHO. Referring to the major problem of how to deal with the Industry, she referred to the problems the UK had experienced with the tobacco industry and said that the UK was now experiencing the same with alcohol. Dr. Snaedel said the industry had its own strategy. It had learnt from the tobacco industry to urge support for programmes to deal with alcoholism but to oppose limits on price levels. Dr. Haikerwal observed that while the WHO Strategy was not legally binding, there was a need to understand what governments were signing up to. He

referred to the problems of binge drinking, Alco-pops, and especially mentioned cheap wine in Australia, which was difficult to deal with.

Dr. Hill emphasised that action such as banning advertising at university sports and local zoning had been successful. There was a need to get primary prevention from childhood to the mid 20's.

Mr. Rekve said that actions have to be local and politically supported and there was a need to monitor effects as to the efficacy of actions. Referring to young people's problems and patterns of drinking; in the north this had been picked up because of violence. For others it was the social consequences and he quoted the French students and binge drinking.

The alcohol industry was difficult. Member States' concerns reflect the fact that the industry is a commercial producer and governments have an interest because of alcohol and tax. Member States agree that distribution should be examined, e.g. Alco pops. The Industry is focused on its strategy and Mr. Rekve called for an NMA strategy. He felt that an index of Member State involvement was the fact that 32 States spoke in the WHA debate.

Mr. Rekve was warmly thanked for his presentation.

Finance and Planning Committee

The meeting was opened by Dr. Haik-erwal, in the Chair, and the minutes of the previous Tel Aviv meeting were **ap- proved**.

Mr. Hallmeyer gave a presentation on the pre-audited financial statement, detailing the various aspects of the report and stating that the finances were in a good position. The audited Financial Statement was recommended for approval by Council which later also **adopted it**.

The Secretary General, speaking to the Report on Financial Dues, thanked NMA's for paying their dues, recognising that in view of the financial problems they had done their best. He commented that dues only reflect part of the contribution of NMA's, which also contributed their work, expertise, and time to WMA, for which he thanked them.

Turning to the changes to the different groups' dues, he said this had had a positive effect attracting a number of countries that would not otherwise have joined. Account had also been taken of countries' with problems due to disasters, etc.

Strategic Plan

The Secretary General referred to the work done during the period of the Strategic Plan suggested in 2004 and which has run from 2006 to 2010. There had been governance changes, a review of dues which will have a final review in 2 years. The result of implementing the Strategic plan could be seen under three heads:

- There is a stronger focus on ethical fora.
- Advocacy had been developed.
- Other services developments.

Speaking of Advocacy and the Business Development Group, these had been successful in policy development and its recognition, especially in Helsinki development and protocol. We have been successful in Alcohol and Tobacco actions and recently we have received an invitation to participate in a World Economic Forum initiative. Our actions should continue to be more proactive.

We had been successful in getting participation with WHO and with others. Our number had increased to 95 members of which 15 were new, and we continue receiving new applications for membership, e.g. Serbia, Mozambique. Turning to the provision of services, many educational materials had been produced and the courses provided on Ethics, Prisons and Tuberculosis and MDRTb

were very successful. We had also worked with other Health Professions, e.g. on the problems of Counterfeit Drugs and on the problems of member states' needs due to lack of resources. We are now at the end of this WMA strategic plan and need to produce a plan for 2011–2015, considering a new focus possibly on humanitarian aid.

Business Development Group

Dr. Nathanson gave this report on behalf of the Chairman of the Group. She spoke of the increasing use of the web portal. Referring to ways of raising money she congratulated the Secretary General on the success of the conferences, e.g. Helsinki, São Paulo. The portal had other uses such a CPME/CPD. Concerning CPME, **the business group had held two meetings and recognised the need to speak to major producers. She had had discussions with the BMA Publishing Group, or producers** of on-line material. She invited other NMA's to discuss this. E-learning is very expensive, £ 20–30 a module. A Round table had been suggested at which WMA would invite a number of different industries to meet together and learn how WMA needs could be met. At its meeting in April the WG had set out the principles for such a meeting to avoid misunderstanding of the purpose of the meeting and avoid industry influencing WMA policy. There are concerns about this and it is hoped that the document of principles would ensure that these concerns be met. The portal could have a subset.

Concerns were expressed by a number of speakers, but Dr. Nakai indicated that she had worked with the AMA and the American College of Cardiology which have such a Round Table and found it to be successful without ethical problems. Dr. Hill considered that the discussion was premature. However, the Secretary General, bearing in mind that comments had already been considered, said the document had been finalised two days previously. It was decided that this document be circulated to constituent members for comment.



WMA Meetings

A working group chaired by Dr. Ramin Parsa-Parsi had met twice and considered whether the time connection for Spring Council meetings with the WHA was necessary. The Business Group considered that a “disconnect” would provide WMA with more flexibility. It could permit a better balance between meetings of Council and the General Assembly.

It was proposed that the Spring council meeting in Australia be held on 7–9th April. This would have the advantage that hotel prices would be lower as the date was remote from Easter. Two other issues were still under discussion.

The Secretary General reminded the committee that a “disconnect” with WHA was a general suggestion and Dr. Haikerwal felt it was time to discuss the pros and cons of the link with WHA. Dr. Bagenholm observed that there were a number of people who were included in national WHA delegations. It was therefore useful to have Council meet before WHA. She posed the question “Do we lose by a disconnect?”.

Dr. Parsa-Parsi commented that only two WHA delegations included NMA individuals. The working group felt that there could be travel economies. The Secretary General felt that there could be advantages if the meeting went elsewhere and that there were advantages in holding meetings in an NMA venue. May in Geneva was not economic. Dr. Nathanson considered that geographical decoupling could be to the advantage of non-European countries. Furthermore the period after May was difficult for the Secretariat. The committee adopted the Recommendations, **all of which were later adopted by Council:**

The annual spring meeting of the WMA council not be linked temporarily to the World Health Assembly meeting and this proposal was later adopted by Council.

That the 188th Council session be held in Sidney on 7–9th April 2011.

That the Report on the Arrangements for future WMA General Assembly and Council meeting be approved.

Dr. Apinis also informed the Committee and later Council that the Latvian Medical Association in cooperation with the World Medical Association is holding a conference on “The Financial Crisis – Implications for Health Care – Lessons for the Future” to take place in Riga, Latvia 10–11th September 2010.

Dr. Nakai spoke about the arrangements for the General Assembly this year in Vancouver mentioning in particular, arrangements for CPME recognition and also the Sponsorship Fund.

United Arab Emirates

Dr. Parsa-Parsi informed the committee that it was felt that United Arab Emirates were underrepresented. The Secretary General, the Danish and Norwegian Medical Associations had discussed this. It was suggested that an expert conference be held to demonstrate to the UAR the type of work the WMA did. The Gulf Region countries have been the most open in the Region. He had spoken to the President of the Emirates Medical Society and he seemed keen. He suggested that an Expert conference be held in Dubai, jointly organised with the UAE. Possibly the Arabic Medical Union could join in the organisation. A topic suggested could be Patient Safety and Medicine. He suggested that this be a Recommendation to Council. D. Nathanson thought the topic “Patient Safety” was very broad, would this be narrowed? What about policy and getting experts together? Dr. Parsa-Parsi said this would have to be discussed with partners. The Secretary General commented on the difficulty of communicating with the UAE. After further

discussion in which a positive mood was expressed, it was agreed to **recommend** that the concept of an expert conference in December 2011 be explored and this **Recommendation was later adopted by Council (see below).**

Uruguay reported that it was thinking of having a meeting of the National Medical Associations of Latin America Forum, to which the President and Secretary General would be invited.

The **Council approved** the following recommendations of the committee:

- **“The annual spring meeting of the council be not linked to the World Health Assembly meeting”.**
- **“The 188th Council session be held in Sydney on 7–9th April 2011”.**
- **“The Future General Assembly and Council session paper be approved: (General Assembly, Vancouver 13–16th October 2010, 188th Council Sydney 28–30th April 2011, General Assembly, Montevideo, Uruguay 12–15th October 2011)**
- **“that holding an expert committee meeting in Dubai at the beginning of 2011 be explored and that the topic be determined in collaboration with the Emirates Medical Society”.**

Membership

The committee recommended and Council approved, forwarding the application for Constituent Membership from the Associação Médica de Moçambique to the General Assembly, recommending it be admitted to membership of the WMA.

Associates

The committee received a report of the WMA Association Membership for 2009 and considered a Revised Proposal from the Workgroup on Reform of the Associate Membership and Comments. **Both documents were later approved by Council.**

Consolidation of WMA Governance Documents

The committee considered documents on the Consolidation of the Association's Governance, By-Laws, etc., together with the explanatory memorandum. The committee thanked those who did this work. It proposed that the document be circulated to constituent members for comments and that the workgroup continue its work on consolidating these four documents into two. *This was later approved by Council*

Outreach

The committee received an oral report from the WMJ Editor in Chief and the paper written Public Relations Report October 2009–April 2010.

Resumed Council meeting

*The Council considered the **Socio-Medical Affairs committee** report, using the process of the consent calendar by which only items in documents before the committee on which members wished discussion would be debated. The other items considered to be approved and are formally adopted in the approval of the committee report. They are shown in **bold** above in the text of the committee discussion reports.*

Strategic Plan

The American Medical Association sought clarification on the process for developing the Strategic 5-year planning, mentioning in particular, input into the process, e.g. on disaster planning. The Secretary General replied, explaining that the present document was a draft and reminded members that last Strategic Plan draft went to the Executive and was referred to Finance and Planning. The question of Humanitarian Aid was not in the draft and would have to be considered this time. It was open to Council members to make suggestions and comments. Dr. Nathanson (BMA) commented that many organisations had a 3 or 5-year plan and also

annual priorities for particular years, e.g. government actions, economic crises, etc. Could WMA have both a 5-year plan and consider short term plans also such as - for the next year - the Economic Crisis? The Secretary General indicated that WMA had had this in 2005 and 2006 largely because WMA was proactive but it faded away in 2007. BMA said that in its annual plan it was proactive – dealing with things one wants to deal with. Rolling plans were somewhat generic. The Secretary General said WMA had done this in the Advocacy Group. Dr. Haikerwal felt we were in a better position in our work as a result of the Secretary General's action. It would be useful to define times for discussion of this in the run up to Vancouver to support the Secretary General. Such support should be available to the Secretary at the right time. Dr. Kloiber responded that the Social Work Group would start on the website in June. The process could be made transparent in this way for committee members to contribute. Dr. Bagenholm agreed that it was important to have a role in contributing to the Strategic Plan. She supported also an annual plan and also felt that there should be input before October. Dr. Nakai agreed that the process should include more than the Executive Committee and supported an extra half day for this in Vancouver. Mr. Wapner said the WMA had moved forward. The Strategy Group had discussed how much this fits in with NMA aims and strategic plans. The Secretary General was open to new ideas. Dr. Kloiber responding to this said it would have to be done with the Executive well before Vancouver. Dr. Haikerwal indicated that the Finance and Planning committee would take this planning on board in relation to the WMJ through the Finance and Planning Committee in Vancouver.

Prescribing/Relations between Physicians and Pharmacists in Medical Therapy

There was a resumption of the lively discussions on Recommendations on the documents on Drug Prescription and that on the Relationship between Physicians and Phar-

macists in Medical Therapy. *The Council, following a reconsideration of the recommendation on Drug Prescription, decided that "The Proposed Revision to the Proposed WMA resolution on Drug Prescription" be circulated to WMA constituent members for their comments.*

Following discussion and a number of divisions on motions to amend the document on Physicians and Pharmacists in Medical Therapy, Council decided that: "The Proposed revision of WMA Statement on the Relationship between Physicians and Pharmacists in Medical Therapy, as amended, be forwarded to the General Assembly with the recommendation that it be adopted".

United Arab Emirates

There was also further discussion on the recommendation concerning the holding of an Expert Conference in the United Arab Emirates (*see above*).

Disasters

Dr. Amaral, referring to the discussion in SMAC on Disasters asked if it was possible to set up a work group to consider the role of WMA in Disasters. The Secretary General responded that before doing this a paper on the topic was needed and asked the Brazilian Medical Association to prepare a preparatory paper.

A motion to approve the rest of the Finance and Planning Committee report was approved.

Medical Ethics Committee Report

Council then turned to report of the Medical Ethics Committee and, following the calendar extraction process (*see above*), there was a short discussion on the proposal for discussions with the Emirates. Concern was expressed about the absence of any reference to possible partners in the suggested expert conference, nor to content, e.g. Qual-



ity or Patient Safety. It was suggested that the conference would be jointly organised and topics would be chosen after joint discussion with EMA. The Chair said that the Executive would make decisions on how this matter be processed.

Following a motion, the report of the Medical Ethics committee was **approved**.

WHO and World Health Assembly

Council heard a report from Ms Julia Seyer on the WHO and the World Health Assembly. She emphasised two issues. Concerning **Counterfeit Medicine** she said the WHA had had some conflict with WHO over this issue. Some emerging countries considered that this was more an issue for The World Trade Organisation rather than WHO as it primarily concerned Intellectual Property. Dr. Margaret Chan, the WHO Director General, said it was about Public Health. There had been an emotional debate and a lot of redrafting was going on but there was no news of the outcome. The sec-

ond issue was **Codes of Practice concerning the migration of Professionals**. After 2 years Member States had tried to get ethics and migration out of the debate and the document had been weakened. The Global Health Force Alliance is to hold the Second Global Forum on Human Resources for Health in Bangkok in January 2011.

Dr. Bagenholm spoke of the importance of getting medical representatives into national WHA delegations as there were very few doctors on the delegations. She had been a delegate for six years. The Chair commented that delegations were very political and largely administrative. Dr. Wilson (USA) commented that the USA usually included a physician in their delegation and added that the removal of links between the date of WMA meetings and WHA would be of assistance.

Other business

Dr. Nathanson reminded council that Sir Michael Marmot had mentioned trying to

ensure that physicians were represented at the **Global Conference on Social Determinants in Health Conference**. The BMA will bring a paper on this topic to the General Assembly in Vancouver. Following a suggestion to have a work group to consider how WMA could be involved in this conference, Dr. Nathanson indicated that she could work with Sir Michael to prepare a paper on our involvement rather than having a work group, a view with which the Chair **agreed**.

Dr. Seyer reported that the WHPA works closely with WHEN, the World Health Editors Network which had published a Health Literacy guide and an Advocacy guide. Both of which were accessible on the WMA website.

The Council meeting was terminated with the extending of thanks to the staff and to the interpreters and to members for their work.

Dr. Alan J. Rowe

World Medical Association Appeals for Release of Sudanese Doctors

28th June 2010

The WMA has appealed to the President of Sudan, Omar Al Bashir, for the release of six Sudanese doctors, arrested and detained without charge for their activities as members of the Doctors' Strike Committee calling for better pay and working conditions for doctors in Sudan.

Dr. Dana Hanson, President of the WMA, has written to the President urging the Sudanese authorities to release the six doctors immediately and unconditionally and to provide them with any medical attention they might require. The six doctors – Dr. Alhadi Bahkit, Dr. Ahmed

Alabwabi, Dr. Ashraf Hammad, Dr. Mahmoud Khairallah, Dr. Abdelaziz Ali Jamee and Dr. Ahmed Abdallah Khalafallah – had, according to reports, been detained without charges and some had been severely beaten.

Dr. Hanson added:

‘The World Medical Association is deeply concerned by the situation of these six doctors who have been denied the fundamental right to a fair trial and are exposed to ill treatments and torture.

We consider them prisoners of conscience, as they appear to have been imprisoned solely in relation to their activities of the committee calling for better working conditions for doctors in Sudan.’

He also called on the President to reform the 2010 National Security Act to remove the excessive powers of the National Intelligence and Security Services (NISS), in particular powers of arrest and detention without judicial oversight for four-and-a-half months. Dr. Hanson has also written to Mohamed Atta Al-Moula Abbas, Director of the NISS, in Khartoum.

A committee of Sudanese doctors has been campaigning since 2003, to improve the working conditions of doctors in Sudan. It has organised several strikes, the latest of which led to their arrests.

Highlights of the Third Geneva Conference on Person-centred Medicine

The Third Geneva Conference on Person-centred Medicine in May 2010 followed the inaugural Geneva Conference of May 2008 [1] and the Second Geneva Conference of May 2009 [2] as landmarks in a process of building an initiative on *Medicine for the Person* through the collaboration of major global medical and health organisations and a growing group of committed international experts [3].

The Conference took place on 3–5 May 2010 at the Marcel Jenny Auditorium of the Geneva University Hospital and the Executive Board Room of the World Health Organisation. It was organised by the International Network for Person-centred Medicine (INPCM), the World Medical Association (WMA), the World Organisation of Family Doctors (Wonca), and the World Health Organisation (WHO), in collaboration with the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses (ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the Council for International Organisations of Medical Sciences (CIOMS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the International Federation of Gynaecology and Obstetrics (FIGO), the World Association for Sexual

Health (WAS), the World Association for Dynamic Psychiatry (WADP), the International Federation of Medical Students' Associations (IFMSA), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the European Association for Communication in Health Care (EAHC), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), Ambrosiana University, Geneva University, and the Paul Tournier Association.

The Third Geneva Conference on Person-centred Medicine, under the overall theme of *Collaboration across Disciplines, Specialties and Programs*, examined through a set of sessions the guiding value of person- and people-centredness, ethical aspirations, basic communication skills, fundamental clinical care activities, the challenge of surgical and intensive care procedures, the vicissitudes of the life cycle, and the implications of cultural diversity.

The Conference Core Organising Committee was composed of J. E. Mezzich (INPCM President and World Psychiatric Association President 2005–2008), J. Snædal (World Medical Association President 2007–2008), C. van Weel (World Organisation of Family Doctors President 2007–

2010), I. Heath (Royal College of General Practitioners President), M. Botbol (WPA French Member Societies Association President), I. Salloum (WPA Classification Section Chair), and W. Van Lerberghe (Director of WHO Department for Health System Governance and Service Delivery). Also collaborating organisationally were O. Kloiber (WMA Secretary General), A. M. Delage (WMA Secretariat), R. Kawar (WHO), and J. Dyrhaug (WHO).

Financial or in-kind support for the Conference was provided by 1) the International Network for Person-centred Medicine (core funding), 2) the World Health Organisation (covering invited participants' travel and accommodation expenses, a conference reception, and some secretarial and logistic services), 3) University of Geneva Medical School (auditorium services and coffee breaks), 4) Paul Tournier Association (a conference reception and the conference dinner for a group of invited participants), 5) The World Medical Association (local secretariat and printing services and support to extend the conference dinner to all participants) and 6) Participants' registration fees.

The Conference was opened by authorities of the University of Geneva Medical School, the Director of the WHO Department for Health System Governance and Service Delivery representing the WHO Assistant Director-General for Health Systems and Services, the President of the World Medical Association (WMA), and the core members of the Organising Committee. The opening address was delivered by the INPCM President, who presented a progress report on the INPCM's first months of existence emerging from the Second Geneva Conference. He touched on the establishment of a governing Board and initial organisational bases, development of an active publications programme including a journal supplement with the edited papers from the First Geneva Conference, a well-visited website, an institutional logo, and the organisation of the Third Geneva Con-



Logos of the institutions collaborating on the organisation of the Third Geneva Conference on Person-centred Medicine



Left to right: I. Salloum, M. Botbol, J. Snaedal, D. Hanson, C. van Weel, I. Heath, G. Gold, and W. van Lerberghe, at the Opening of the Third Geneva Conference while the president of the International Network JE Mezzich speaks from the podium.

ference including presentations from stellar academic leaders and a record number (22) of collaborating organisations, most prominently the World Medical Association and the World Health Organisation.

The first session of the scientific program involved a symposium on person-centred medicine and primary health care organised by WHO. The key speaker was the Director of the WHO Department for Health System Governance and Service Delivery who presented arguments on why measuring person-centred medicine and people-centred care is vital. His presentation was commented by general practitioner, academic and patient representatives. The need to develop procedures for appraising the extent to which person- and people-centred care take place emerged as a clear recommendation.

A symposium on ethics and the person-centred approach constituted the second scientific session. It started with an examination of the problems derived from reifying disease and restrictively considering numerical data which undermine full attention to subjective experience and the suffering person. The second presentation argued that attention to the social determinants of health is crucial for advancing human rights and ethics in health care. The final paper presented an African perspective including references to local concepts (*Ubuntu* and *Batho Pele*) suggesting the value of placing

people first, respect for diversity, and that what is good for the person is more important than what is good for his health.

The third session was a symposium on basic communication skills, a topic of increasing interest for person-centred care. Discussed first was an overview of research on communication behaviours which critically influence health care process and outcome. Such behaviours include providing room for a patient's story, exploring emotional cues, showing empathy, and framing information and advice in a positive way, as well as optimising outcomes through patient enablement, control, reassurance and adherence to jointly decided care plans. The second presentation pointed out that adequate person-centred communication is a cornerstone of good clinical practice and requires dedicated training, and that the content of person-centredness can vary depending on context and culture. It included interactive discussions attending to literature-based guidelines and participants' views. The third presentation on clinical teaching reviewed interviewing educational technologies while consistently focusing upon person-centred principles.

The fourth symposium examined central clinical care activities from a person-centred perspective. The first presentation on personalised diagnosis suggested a paradigmatic shift by focusing on both ill and

positive health and the whole person, and reported on international surveys and focus groups yielding salient recommendations for improving diagnostic systems. The second reviewed treatment plans as the written record of shared decisional and interactive processes between patients and clinicians, aimed at achieving desired life goals beyond the illnesses that threaten hopes and dreams. A third presentation charged that most contemporary medical treatment is focused on relief of acute symptoms of illness rather than the promotion of health and well-being, and that specific procedures are emerging to facilitate the latter. The final presentation commented on current clinical services with constrained incentives based on volume rather than persons' values, and reviewed evolving person-centred *medical home models* that demonstrate the challenges and rewards of transforming practices and are gaining acceptance from health professionals, business leaders and policy makers.

The fifth session involved a panel discussion on special initiatives for person-centred care presented by representatives of international organisations of patients ("focus on the whole person, not just the disease") and medical students ("holistically seeing the person as a whole and not a sum of parts"), Italian ("forming PCM clinical teachers") and British ("need for a medicine of the whole person") universities, the World Federation for Mental Health ("treating the whole person concerning both physical and mental health"), psychodynamic ("self-reflection and self-monitoring of transference and countertransference feelings in daily clinical work") and public health ("global strategy for introduction of the PCM model") programmes, and INPCM projects on person-centred diagnosis ("a new model with related regional and national developments") and informational platforms ("to facilitate INPCM internal and external communication and full range of activities").

The sixth session, a symposium on the team approach in person-centred health care em-

blematic of the Conference's overall theme, was presented by officers from the top global organisations of family doctors, nurses, social workers, and pharmacists. For the Wonca's president, responsiveness to the person's needs and values, continuity of care, and team work based on common values and objectives are at the core of person-centred medicine. The International Council of Nurses representative proposed that health systems be redesigned to optimise nursing contributions to health teams in general and to person-centred care in particular. According to the representative of the International Federation of Social Workers, these professionals bring emphases on contextualisation and patient's empowerment to person-centred team work. Finally, the representative of the International Pharmaceutical Federation highlighted the specific expertise that pharmacists can bring to collaborative practices in a variety of hospital and ambulatory settings and to adherence to care programmes.

Seventh in the core programme was a symposium on person-centred care in the context of surgical and intensive procedures. First discussed was person-centred surgery which reviewed the importance of dialogue under time pressures, the need for understanding the person's condition and avoiding harmful procedures. Next a presentation from the International Federation of Gynaecology and Obstetrics reviewed the enormous development of multiple marker screening in early

pregnancy which has led to more individualised informed consent decision making and counselling as well as to health care system efficiencies. Finally considered were experiences at a Mongolia hospital intensive care unit where simple procedures such as providing a protective gown and conducting auscultation with body positions that afford greater patient privacy seemed to enhance person-centred and more effective care.

Next was a symposium on life cycle and person-centred care. It started with a presentation on person-centred paediatric care, which emphasised the uniqueness of every child, the need to attend to his physical, emotional, social and spiritual needs through primary, secondary and tertiary prevention. Next was a discussion of old-age person-centred care, which pointed out that personal life-style and historical patterns of diseases influence the presentation of symptoms and needs. It also noted that clinical care should pay special attention to abilities and disabilities to decide on a care plan, which should be designed considering the patient's wishes and aspirations. Completing this symposium was an examination of human development as fundamental to defining a person and person-centred care. Such definition lies at cross-roads between changes and continuity, maturation and personal history.

The last symposium of the core conference dealt with cultural and social diversity in

person-centred care. The role of culture in the conceptualisation and experience of illness and positive health, as well as for effective health communication was considered first. A second presentation reviewed the socioeconomic implications of comprehensive diagnosis, treatment and research, particularly in lesser-developed countries. Health policies based on the assessment of positive health- and person-centred care were noted as promising to deal with the less resourced and more vulnerable sectors of the population. The last paper referred to the abundant documentation on gender having a profound impact on clinician-patient interactions across many countries and medical conditions, and in terms of diagnosis, treatment as well as patient adherence and patient satisfaction, and noted that this information seems to have been largely ignored in general health care planning.

After the core conference and as the last session of the whole event, a special meeting was held at the WHO Executive Board Room focused on people-centred care in low and middle income countries. After opening words from the WHO Assistant Director General for Health Systems and Services and the INPCM President, a set presentations highlighted experiences in implementing people-centred services in several low and middle income countries: El Salvador, Malaysia, Rwanda, Thailand, and the United Republic of Tanzania.



Left to right: E. Velasquez, J. Wallcraft, S. Steffen, M. Dayrit, R. Montenegro, W. Van Lerberghe, T. Sensky, C. Etienne, A. Miles, CW. van Staden, JE. Mezzich, I. Salloum, R. Cloninger, J. Trivedi, and S. Rawaf, at the WHO Satellite Meeting on People-centered Care in Low and Middle Income Countries at the WHO Executive Board Meeting Room



The presentation from El Salvador focused on empowering women, men, families, and communities to improve maternal and neonatal health. Communities participated in identifying and implementing new ways of ensuring care around pregnancy and childbirth. Since the initiation of the programme in 2006, maternal deaths have dropped to zero in 90% of the municipalities involved. Furthermore, the process of consensus building has developed community capacity and ownership by its various participants. Intersectoral links and coordination mechanisms also have been strengthened. In Malaysia, the Government has incorporated the principles of people-centred care into numerous national policies and strategies. These “person-centric” policies included a focus on wellness, empowerment of individuals, families and communities, as well as integrated services throughout the life course. Malaysia also introduced several innovations to improve health care quality and people-centredness such as the home-based health cards. The presentation from Rwanda highlighted the integration of mental health services in the national health system and at the community level. Mental disorders are managed with a holistic perspective whereby affected individuals are not only seen in terms of their disorders, but also in terms of their history, community, and current life circumstances. Families are key partners in care and communities are involved in fighting stigma and supporting people with mental disorders to join the health centres and also to reintegrate into society. The presentation from Thailand reviewed the multiple settings engaged in people-centred care, its prime movers and activities aimed at dissemination and transformation into policy, and found people-centred primary care as a key element of universal coverage policies. The person-centred experience reported from Tanzania dealt with efforts to improve care of people receiving antiretroviral therapy through organising focus groups to understand patients’ concerns and barriers to care and addressing them. Since the initiation of the project, one year ago, demand for services has increased three-fold in participating health centres.

After the individual country presentations, the Director of the WHO Department for Health System Governance and Service Delivery formulated comments recognising the importance of the reports for person- and people-centred care and pointing out the need for advances in systematic conceptualisation and measurement. An ensuing roundtable discussion on future avenues for making health care more people-centred across the world was chaired by the Director of the WHO Department for Human Resources for Health, and had as panelists the Secretary General of the World Medical Association, a psychiatry professor from India, a primary care and public health professor from the United Kingdom, and a patient/user consultant. Comments were also offered by a number of conference participants including the President of the World Medical Association. After an agile and interactive general discussion, conclusions by the Assistant Director General for Health Systems and Services highlighted the importance of the event for advancing people-centredness and the recent World Health Assembly resolution on the renewal of primary health care [4].

Preceding the core conference, a work meeting on person-centred medicine was held. It dealt with the ongoing building of the International Network for Person-centred Medicine [5] and its projects on person-centred diagnosis and clinical care guidelines, a South Asian effort, public health guidelines, and collaboration with the World Federation for Mental Health as well as on institutional developments on publications, internet platform, and informational base.

A conference closing session offered summary comments and a consideration of next steps. These included broadening the engagement of health organisations, academic institutions, and experts across the world; further construction of the International Network for Person-centred Medicine, its institutional identity, governance, and operational structure; upgrading of the INPCM Website, informational base and clearinghouse

functions; continuing publications in major journals and development of an international journal of person-centred medicine; research projects on diagnosis, clinical care and public health; increasing collaboration with WHO, based on 2009 World Health Assembly resolutions promoting people-centred care; and planning for a Fourth Geneva Conference on Person-centred Medicine in early May 2011.

Members of the Third Geneva Conference Organising Committee: Juan E. Mezzich (International Network for Person-centred Medicine, President; World Psychiatric Association, President 2005–2008), Jon Snaedal (World Medical Association, President 2007–2008), Chris van Weel (Wonca, President 2007–2010), Iona Heath (Royal College of General Practitioners, President), Michel Botbol (WPA French Member Societies Association, President), Ihsan Salloum (WPA Classification Section, Chair), Wim Van Lerberghe (Director of the WHO Department for Health System Governance and Service Delivery)

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Human Resources for Rural Health



Edward Hill

The year 2009 has now come and gone and clearly we are a very long way to having attained "Health for All."

Despite the differences between developing and developed countries, access is the major health care issue in rural areas around the world. Even in countries where the majority of the population lives in rural areas, the resources are concentrated in the cities.

All countries have difficulty with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas.

The World Health Report 2006 concluded that there is a sharp demand for human resources in health care in many countries of this world. For 57 countries in Latin-America, Africa and Asia, the World Health Or-

ganization classified the shortage of health professionals as "critical."

Looking at the ratio of physicians to population, we find a ratio of 1:500 in the wealthier countries of the world. In some places, such as European countries, that ratio is as low as 1:250, compared to a ratio of 1 physician for every 50,000 people in some parts of the world. This unfair distribution is further aggravated by the fact that the populations with the fewest health professionals carry the highest burden of disease.

But this is not the only mal-distribution we have. We have seen a strong tendency towards urbanization during the last decades. This has been accompanied by a concentration, often an overconcentration, of health professionals in urban areas and a corresponding shortage of physicians in rural areas.

Urban centers, which offer better pay and better opportunities, are especially attractive to highly skilled people like physicians and other health professionals. We as professionals cannot stop this trend; rather, it is up to the politicians to decide whether they wish to mitigate it. Perhaps a paradigm shift will be necessary, as mass urbanization appears to generate more problems than solutions. While politicians, governments and international bodies like the European Union have focused to bring **people to work**, it may be time to do the opposite and to bring **work to people**.

Fortunately, not many governments in the world force their professionals to work at a certain location or another. On the other hand, the freedom to migrate leaves us with the question of how to provide services to rural populations, especially for those in the poorer countries of this world. So what is our role as health professionals?

Let me return to the World Health Report 2006: the report demonstrates why health professionals and especially physicians from Sub-Saharan Africa leave their home countries.

Yes, money is the most important factor, but close behind are other reasons, which taken together may be even more important. These include bad working conditions, a lack of treatment options for patients, missed opportunities for professional development, violence in the workplace, and others.

Living conditions are also important factors: substandard housing, no schools, no infrastructure, a lack of mobility and, again, no chances for development would provide reasons for anyone to move their family to a better place.

So what can be done to alleviate the situation in the most affected areas? The World Health Organization has developed the strategy of **task shifting**. Put simply, this means leaving the work of health professionals to minimally trained lay people. I can only agree with Lincoln Chen, who wrote in the last issue of the WHO Bulletin:

"The recent rush of "crash programmes" to train large numbers of community health workers has rightly attempted to address long-standing deficiencies but these emergency actions cannot be seen as a sustainable solution."

This is a key statement reminding us that a sustainable approach is still missing at the global level.

We have to attract as well as effect a higher retention rate of health professionals in their areas. Fair payment is a good start, but it will not be enough. Better working and living conditions are essential as well; there must be prospects for health professionals' work, their lives, and their families.

Here are a few examples of what can bring about improvement:

- As a part of the World Health Professions Alliance and together with many partners and the support of the Global Health Workforce Alliance, we are driving the Positive Practice Environments Campaign. We are collecting and disseminating knowledge about best practices for improving workplaces in health care. We see this as a major strategy not only to improve retention, but also to make the health care workplace more attractive for young people.
- On the policy level, we have supported the development of strategies by the WHO addressing the high demand for human resources in health care in rural areas.
- The most recent WHO recommendations for education, regulation, financial incentives, and management and social systems support should help to identify and attract more health professionals for rural areas and to encourage them to stay in those environments.
- Dana Hanson, the president of our organization, has just started a program looking into questions such as: what makes physicians resilient? What gives them staying power? What are the success factors that make physicians stay and continue to work in their home places and countries? What is it that causes them to stay when they could find a better income in other places?
- In India, the ministry of health is looking into a new curriculum that reaches out to students, especially from rural areas, who normally would not have the opportunity to enter a medical school. In a stepwise process, these students will be educated to become finally fully qualified physicians, receiv-

ing much of their practical training in rural settings.

- It is hoped that the World Health Assembly will pass a charter on ethical recruiting and encourage wealthy countries to do more to become self-sufficient and avoid contributing to brain-drain from poor countries.
- Finally, there are e-health, telemedicine, and yet-to-be-implemented technological advances to help foster professional development in rural regions.

These examples are not exhaustive. I recommend the last issue of the WHO Bulletin for your attention; it deals specifically with the problems of rural health and gives a good overview of the current problems and potential solutions.

As a family physician myself, I would like to mention the 2008 World Health Report entitled "Primary Health Care – Now more than ever." It provides more than a fresh look on primary health care; it is truly a new and more serious approach towards putting high quality primary care at the center of comprehensive health care systems.

Understanding primary care as the core of the health care system, instead of seeing it as a cheap substitute for comprehensive care, will make a huge difference to the people served. And at the least the relative absence of secondary and tertiary care in many rural areas will underline the necessity of excellent primary care.

In conclusion, we must work on both ends: self sufficiency and ethical recruiting practices on the side of the wealthier nations, and improving working and living conditions in poorer countries for physicians or health professionals in general.

Physicians want to be sure that what they do is meaningful and beneficial to their patients. They want to have at least a fair

chance to help their patients and to serve their communities. The strategies I mentioned should be stepping stones to improve rural health care, including the poorer and under-resourced areas of the world.

What we are calling for is nothing more than a basic human right. Regardless of where one lives – in a rich country or a poor, in a city or in the countryside – everybody should have access to good health care.

We will only see reduced costs and improved quality in health care in the world when every world citizen has access to a well-educated and well-trained primary care team to manage their medical needs and health care.

*Dr. Edward Hill
WMA Chairman of Council*

BMA Presidency Acceptance Speech: Fighting the Alligators of Health Inequalities



Sir Michael Marmot

In his acceptance speech as BMA president, Michael Marmot told the BMA annual representative meeting on Brighton on 29 June 2010 that doctors should be active in tackling health inequalities and social injustice

It is midsummer. It is appropriate to have a midsummer night's dream. In my midsummer night's dream, what visions did appear!

Me thought I was translated: president of the BMA.

To quote Puck: Lord, what fools these mortals be!

President of the BMA? Surely not. Not me.

I confess to a rich fantasy life but, had I but thought about it, presidency of the BMA would have seemed marginally less probable than playing the viola with the English Chamber Orchestra or winning the senior tournament at Wimbledon.

That I should be surprised to be approached to be president of the BMA is not false modesty – remember: don't be modest, you're not that great – no, my surprise was entirely reasonable. My research has been focused on inequalities in health. Latterly the focus has been on what can be done to address the issue. Both in research and policy I have emphasised the circumstances in which people are born, grow, live, work, and age. These all loom larger as causes of health inequalities than defects in our healthcare system. Heart disease is not caused by statin deficiency; stroke is not caused by deficiency of hypotensive agents. I have emphasised not just the causes of health inequalities – behaviours, biological risk factors – but the causes of the causes. The causes of the causes reside in the social and economic arrangements of society: the social determinants of health.

My first reaction, then, was that I was an odd choice for BMA president. My inner monologue quickly changed that to: an imaginative choice. No one is more concerned about health inequalities than the medical profession, whether the causes lie within or without the medical care system. Either way we have to deal with the consequences of inequalities in health. I would argue, and will argue now, that a concern with social injustice as a cause of health inequalities engages the best instincts of the medical profession. For all these reasons, I am really pleased to be taking on the presidency of the BMA.

(Not just pleased, but reassured, when it was explained that the president does not get engaged with the trade union side of the house.)

Agreeing to become president of the BMA presents me with a major challenge: learning to speak without a PowerPoint presen-

tation. I'm an academic. We like our data to support us. The last time I performed in public without slides was in the school play. I played MacDuff in Shakespeare's *Macbeth*. Macbeth was of course brought down by the dread virus of ambition.

Shakespeare had ambivalence about ambition. Julius Caesar was assassinated because Brutus and the rest were worried about his ambition.

I want to say a word about ambition.

When I was a student in the 1960s it was uncool to admit to ambition. That, of course, was ridiculous, as everyone in this room, each with ambition, can testify. But the key question is ambitious for what?

My predecessor, Averil Mansfield, said to me: you may be the first BMA president with an agenda – perhaps a politer word for ambition. I do have an agenda, an ambition, an obsession, even, and that is to contribute to reduction of health inequalities. My year as president will have real meaning if I can help encourage other doctors to be active in the challenge to reduce avoidable inequalities in health, not just here within Britain, but globally between countries.

At such a moment as this, perhaps I may be allowed a personal reflection on the link between research and action. I have spent much of my working life on curiosity driven research. A central hypothesis was that the gateway between society and health was through the mind.

I retain that ambition. But something changed along the way.

If, after publishing a paper, someone asked: so what? the answer was: to publish another paper.

At the end of every paper, there was a distinctive bird call: more research is needed, more research is needed. But I now have a new bird call: more action is

needed, more action is needed. The two calls harmonise well. To caricature only slightly, I went from wanting to work towards good research to wanting to work towards a good society AND have good research done.

I can sum up the change: I was invited by the British government to conduct a review of health inequalities, and what could be done to address them. I published my review in February this year and entitled it: *Fair Society: Healthy Lives*. It was a statement that in my judgment, and that of the people who worked with me on the review, if we took seriously the move to a fairer society, health would improve, and health inequalities would diminish.

So close is the link between social and economic arrangements and health that we can see health as social accountant. Health and the fair distribution of health – health inequalities – tell us how we are doing as a society. The simple answer is: we're doing well but can do better.

Let me illustrate. In my review of health inequalities, *Fair Society Healthy Lives*, we emphasised not just the poor health of the poor, but that health follows a social gradient; for example, the more years of education the longer the life expectancy and the better the health. Those with university education have the best health. We calculated that if everyone over 30 had the mortality rate as low as those with university education we could prevent 202 000 premature deaths, EACH YEAR. Does anyone in this room think other than that should be largely avoidable?

In the US, a similar calculation suggested that if African-Americans had the same mortality rates as whites there would have been 800 000 fewer deaths over a decade. When I spoke of this to the American Public Health Association one commentator asked movingly, how many times do

we need to learn the same lesson? 800 000 times is too many.

Let me go further: life expectancy for women in Zimbabwe is 42, in Afghanistan 44. By contrast, in Japan it is 86. There is no good biological reason why there should be a 44 year difference in life expectancy across the world. This 44 year difference arises because of our social and economic arrangements.

To address these inequalities in health within and between countries, the World Health Organization set up the Commission on Social Determinants of Health. The director-general of WHO, JW Lee, invited me to chair the CSDH.

Our report was published in 2008 as “Closing the gap in a generation.” Closing the gap? Are we bonkers? A 44 year gap in life expectancy between countries, an 18 year gap within countries, and we want to close the gap in a generation?

It was a statement that we have in our heads the knowledge, we have in our hands the means, to close the gap in a generation. The question is: what do we have in our hearts? Do we have the political will?

An illustration: we said in the CSDH report that one billion people live in slums. We estimated that it would cost \$100 billion to upgrade the world's slums. I thought: no one will take us seriously. Who would find \$100 billion for anything?

When I last looked we had found \$9 trillion to bail out the banks. For one ninetieth of the money we found to bail out the banks every urban dweller could have clean running water. Do we have the knowledge? We have the knowledge. Do we have the means? We have the means. Do we have the will?

When I formulated this view, I was not aware that I knew the motto on the BMA crest – with head, and heart, and hand.

Clearly, it was destiny. BMA and I were made for each other.

To come to the heart of the matter. With both the CSDH and the English review of health inequalities, we said that the reason for taking action to reduce social inequalities in health between and within countries was one of social justice. We said that “social injustice was killing on a grand scale”; a toxic combination of poor policies and programmes, unfair economics, and bad politics was responsible for most of the problems of health inequity in the world. The reason for action was an ethical one not an economic one.

In the English review, in my introductory note from the chair, I pointed out that the CSDH report had been criticised as ideology with evidence. The same could be said of the English review. We do have an ideology: health inequalities that are avoidable by reasonable means are quite wrong. Putting them right is a matter of social justice. But the evidence matters.

The evidence suggests that action has to be on the conditions in which people are born, grow, live, work, and age.

Commonly, when we think about action to reduce health inequalities, we debate whether we should focus on smoking, or obesity, or immunisation. Let us remember Halfdan Mahler, the legendary director-general of WHO. In a speech to the World Health Assembly in the mid-1980s Mahler said: “Imagine you are up to your neck in a swamp, fighting alligators; just remember we came to drain the swamp in the first instance.”

Colleagues, if we really want to fight the alligators of health inequalities, we have to drain the swamp. We have to deal with the consequences of an unfair set of economic and social arrangements, and with the causes and the causes of the causes of health inequalities.

We published the commission's report. What happened? I travelled the world, getting jet lag and interference with my gastrointestinal function; did something more happen?

Parenthetically, I have developed a wonderful cure for jet lag. I lie in bed rehearsing one of my speeches and I'm asleep in seconds. I recommend it. Faster than reading Henry James in bed.

On the gastrointestinal front, I did ask at one hotel: Is the water safe to drink? I was told: all the drinking water in this hotel has been passed personally by the manager. I was impressed by the manager's prodigious talents if not greatly reassured.

Since indulging in this work on social justice and health, I have, however, developed three other medical conditions that perhaps, as a medical audience, you can help me with.

First, a state of near continuous excitement. There must be some pills for this condition. We said we wanted to create a social movement. I scarcely understood what that was. But I would say that the signs are promising.

A Peruvian colleague wrote to me with a quote from *Don Quixote*. "Ladran, Sancho, segnal que cabalgamos." The dogs are barking, Sancho, it a sign that we are moving.

Among the signs of movement are:

- A WHO resolution.
- A discussion at ECOSOC, and an endorsement of the CSDH from Ban Ki-Moon
- Spain made social determinants of health a priority for their presidency of the EU.

A number of countries have taken it on: Chile, Brazil, Costa Rica, Sri Lanka, Norway, Denmark. I am excited.

Now we have the UK with my inequalities review. With the help of the BMA and the

royal colleges I want to keep this on the national agenda.

Is this ambitious? Good heavens yes! Ambitious to create a better society, and a better world.

The second condition I have developed is selective hearing loss. It is somewhat related to my state of evidence based optimism. I cannot hear cynicism. With both the CSDH and the English review the process was inclusive. It involved hundreds of people. The English review of health inequalities is being implemented locally and regionally. Thirty local areas and regions are developing plans to implement the Marmot review. As one US colleague put it: when he argued for social determinants of health, his director told him he had become Marmotised.

The third medical condition is that something has happened to my eyes: they water at embarrassing moments.

Pascaol Macoumbi, former PM of Mozambique and a member of the Commission on Social Determinants of Health, said at the end of our meeting in Vancouver: I haven't felt so energised since my country got independence. I had this watery condition of my eyes.

When I saw how the Self Employed Women's Association works to improve life for the poorest most marginal women in India – the right to work, micro-credit schemes, child care, health care, insurance, upgrading slums – again this watery condition of the eyes developed.

In Thailand, they talk of the triangle that moves the mountain: knowledge, politics, and people. That softened me up but I was dry eyed until Thai children sang: "We are all stars of the same sky. We are all waves of the same sea. It is time to learn to live as one." Then, I lost it.

Let me come back to my theme of ambition for what? The dominant view of the last 30 years has been that we are all greedy and motivated by self interest. Further, by pursuing our self interest society benefits. Wow! The intellectual fount for such view is Adam Smith: "It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest." In other words, by pursuing our own self interest society flourishes. That idea seems to have driven out all others.

Adam Smith did say that. That's the part we remember. It is a travesty of Adam Smith to think that is all he said. We've forgotten his important other insights: "No society can surely be flourishing and happy, of which the far greater part of the members are poor and miserable."

"To feel much for others and little for ourselves; to restrain our selfishness and exercise our benevolent affections, constitute the perfection of human nature."

In the name of self interest we have allowed inequality to flourish.

Tony Judt: "Under conditions of endemic inequality, all other desirable goals become hard to achieve.

"Inequality is not just a technical problem. It illustrates and exacerbates the loss of social cohesion and the tendency to confine our advantages to ourselves and our families..."

"If we remain grotesquely unequal, we shall lose all sense of fraternity... The inculcation of a sense of common purpose and mutual dependence has long been regarded as the linchpin of any community."

At the invitation of the French Ministry of Health I went to Paris to do a day on the Commission on Social Determinants of Health and the English review. For that or other reasons, France is taking up the health inequalities agenda. I asked a French

colleague why President Sarkozy, a right of centre president, would embrace this? I was told that all French children grow up with the motto of the French Revolution: Liberté, Egalité, Fraternité. In France they may not do too much about the first and the third, but égalité is central.

In the UK, and the US, the degree of inequality that we have created is harming the next generation. Which among the rich countries has the least social mobility? The US, followed by the UK.

Ambition: If the medical profession were out only for its own interests, we would not have become doctors. Of course, we are

exercised by pay and conditions, but at the core our ambitions are not selfish and we are concerned with social justice.

Let us use those twin concerns – for the wellbeing of others and for social justice – to make a difference to health inequalities.

I referred to Don Quixote a few moments ago. At times Don Quixote seemed an appropriate caricature of what I have been doing: a supposed knight running around trying to be chivalrous and everyone laughing at him. When I said this to the Spanish minister of health he said: “We need the idealism of a Don Quixote, the dreamer, and the pragmatism of a Sancho Panza.”

So, dream with me of a fairer world, but let us take the pragmatic steps necessary to achieve it. In the words of Pablo Neruda, which I used both at the launch of the global commission and the English review: “Rise up with me against the organisation of misery.”

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Recent Progress in Air Pollution and Health Studies



Dong-Chun Shin

“Urbanization and Health” was selected by WHO as the theme for World Health Day 2010 to highlight the serious health impact of urbanization. The theme is most timely and highly relevant because the majority of the world population already lives in urban areas and this proportion is expected to further increase. Accordingly, urban health should be rec-

ognized as the key focus of global public health policy.

Even though each city faces its own unique set of health challenges, a range of common health risks can be associated with today’s typical urban environment. Most of such threats are operated and controlled outside the health sector domain including unsafe drinking-water, sustained solid waste, unhealthy diets, road traffic, and urban air pollution.

Urban air pollution by excessive particulate matter or ozone levels is one of the most widespread and dangerous. According to numerous studies, air pollution reduces life expectancy and aggravates many respiratory and cardiovascular diseases. Premature deaths associated with air pollutants were more likely to be from cardiac causes than respiratory ones¹. Although the general public may not yet fully grasp the severity of air pollution hazards, concern about air pollution and other environmental health im-

pacts has increased significantly in many countries.

Most air pollution and health studies reporting an adverse health effect have focused on physical illness. More recently, researchers have started to study the possibility of brain pollution or air pollution-related mental conditions such as suicide and IQ deficits. In Korea, the association between particulate matter and suicide was identified. A possible association between particulate matter and suicide was observed among individuals with cardiovascular disease². Also, prenatal exposure to air pollutants may adversely affect a child’s intelligence. In New York City, children exposed to high levels of air pollutants (especially, polycyclic aromatic hydrocarbons) in the womb demonstrated lower IQ scores than less exposed children³.

Air pollution has long been a problem in the industrial nations of the West. It has now become an increasing source of environmental degradation in the developing nations of Asia. Air pollution has become part of the daily existence of many people who work, live and use the streets in Asian cities. Each day, millions of city dwellers breathe air polluted with chemicals, smoke

and particles that dramatically exceed World Health Organization guidelines. Deteriorating air quality has resulted in a significant impact on human health and environment in Asia.

While some improvements in air quality have been achieved, levels of PM and ozone continue to exceed WHO air quality guidelines in large Asian cities. Tokyo and Seoul have succeeded in turning around their air quality and establishing management plans including source control, stricter air quality standards and health protection programs. But air quality in New Delhi, Kolkata, Hanoi, Beijing and other developing country cities are still unhealthy. These cities need immediate technical and medical assistance.

National Medical Associations in each country should be prepared to cooperate with the World Health Organization to reduce air pollution and protect public health. Preventive action is critical in good public health management. Governments in each country should set up national level institutional mechanisms for air pollution related medical research and monitoring to support more effective policy-making. Medical associations have to address the health issues related to air pollution and encourage their governments to take corrective action.

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Volcanic Eruptions – Health Implications



Jon Snaedal

Iceland has been the focus of international attention because of catastrophes on two occasions in the last two years. Even though these events have seemingly nothing in common, there are some similarities. The first catastrophe was late in 2008, a man made economic crisis. The second one was a recent natural catastrophe, a volcanic

eruption in a glacier. The similarities are that both were uncontrollable. The difference was however in the preparation for the catastrophes. In the case of the economic crisis there was hardly any preparations and because of that there was a great unrest in the society leading to change in government and a replacement of all individuals responsible for any preparatory measures. In the latter case there was however a feeling by the people of responsible actions by all involved. The scientists had warned of a possible eruption for over a year but in a low profile. All preparatory actions were therefore in place and could be mobilised in a couple of hours, the most dramatic one a total and immediate evacuation of a defined area on two separate occasions. The population has therefore great confidence in the scientists and the civil service responsible for all actions for such an event.

The most grave immediate health implication of a natural catastrophe is the loss of lives. That did fortunately not happen in

this case. Because of the swift actions, no individual was ever in a real danger. The other possible health implications are either physical or psychological. The attention has been on the effects of the ash pouring down on the population. There has been an increasing number of pulmonary cases, rarely serious, and a greater number of cases with irritation in the eyes. Interestingly, this has only been seen in adults, mostly those that needed to work outdoors for attending the animals but the children seem not to have been affected. The reasons for this is that many of them have been sent away and others not allowed to be outdoors while the ash was pouring down. It has to be stressed that the depth of ash has only been up to 5 cm in the most affected areas, most often of some few millimetres but it is made up of very small particles that can easily be inhaled deep into the lungs. There was a fear of toxic effects of the ash as the experience has shown that some volcano's produce ash with high concentration of fluoride. This proved to be toxic to animals and some speculations were on toxic effect on humans (an eruption in 1947 in Hekla) but that was never verified. Measurements during the current eruption showed rather low concentration

of fluoride or in fact other elements that could be toxic to humans.

Other possible health effects of the eruption are psychological. To live nearby an erupting mountain is a stressful situation and many are not able to cope with that. They have to leave their homes and live elsewhere for an uncertain amount of time. Some of them have already decided not to turn back to their homes but as this eruption has not been prolonged, this number will most likely not increase. The long term effect of the displacement is not known in this event but by experience from the displacement of a community of 5000 individuals in 1973

after a volcanic eruption in Heimaey (= The island of our homes) south of Iceland the effects are minimal in most cases providing there is social, psychological and economic help. This experience is helpful now.

To be affected by the effects on air traffic is another issue. This was the greatest disruption of air traffic in the world measured by the number of flights and passengers affected. The most serious effect is on emergency air traffic, which was not allowed either. The patients in these cases had to rely on ground transportation, which resulted in delays in attending a medical facility. It has not been evaluated how many patients were affected

in this way or the consequences of that. Apart from this there is the huge number of passengers worldwide that have been affected by delays of air traffic, which resulted in many kinds of inconveniences, practical, economic and psychological. The full scale of that will hardly ever be known but there are many tales of various difficulties because of this eruption of the volcano with the unpronounceable name, Eyjafjallajökull (= The glacier on the mountains of the islands).

*Dr. Jon Snaedal,
Icelandic Medical Association*

1st International Summit on Tobacco Control in Asia and Oceania Region

**CMAAO's Activities on Tobacco Control in the Region
February 25 to 27, 2010 Sampran, Thailand**



Wonchat Subbachturats

Summary

On February 25-28 2010, the Medical Association of Thailand hosted the first International Summit on Tobacco Control in the Asia and Oceania Region at the Rose Garden Riverside Hotel in Sampran district, Nakhonpathom Province, Thailand. The



Masami Ishii

event was assigned by the Confederation of the Medical Associations in Asia and Oceania (CMAAO) Congress and Assembly in Bali, Indonesia, November 5-7, 2009. A Tobacco Control Programme was decided upon and approved as a flagship programme of the CMAAO starting this year; progress will be reported annually at the Conference

and General Assembly, wherein member countries can share experiences of success and barriers.

The Summit was attended by 12 countries in the region: Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Myanmar, Philippines, Singapore, Taiwan, Vietnam and Thailand. The programme consisted of presentations from experts, evidence-based reports of the current situation in each country on the health hazards from tobacco smoking and the effects of second-hand smoke, group discussion, and the production of a statement and declaration on tobacco control in the Asia and Oceania Region, with recommendations for member countries to practice and collaborate at three levels: medical associations, individual physicians, and the national level. All participating NMAs signed the proclamation, agreeing to unite and work together towards developing a regional network on tobacco control and to make tobacco control one of their highest priorities.

*Dr. Wonchat Subbachturats,
Chair of CMAAO, President-elect of
the Medical Association of Thailand*

The overview of the historical efforts of CMAAO for Tobacco Control

Short history

The Confederation of Medical Associations in Asia and Oceania (CMAAO) has marked more than 50 years of history. I have held the position of CMAAO Secretary General since 2006.

The 44th CMAAO Midterm Council Meeting, held in Manila, Philippines, celebrated the CMAAO's 50th anniversary. This meeting started the discussion of tobacco control as a major agenda item and successfully built momentum toward regional cooperation for tobacco control.

The WMA has several statements on tobacco and smoking, the first of which was adopted in Austria in 1988. The WMA joined the implementation process of the WHO's Framework Convention of Tobacco Control, or FCTC. The WMA's statements include:

- Statement on Health Hazards of Tobacco Products (adopted in Austria, 1988; revised in Germany, 1997 and in Denmark, 2007)
- Statement on Physicians and Public Health (adopted in Indonesia, 1995; amended in South Africa, 2006)
- Statement on Health Promotion (adopted in Indonesia, 1995)
- Statement on Tobacco Manufacture, Import, Export, Sale and Advertising (adopted in the United States, 1990, rescinded in Santiago 2005)

If we look back over the history of the CMAAO, the symposium theme at the CMAAO Midterm Council Meeting held in Taipei 1988 was "Tobacco or Health, for Asia and Oceania." This theme seems to have been selected as a response to the "Tobacco or Health Plan of Action for the period 1988-1995" proposed by the Di-

rector General of the WHO in 1988. The CMAAO Midterm Council in Taipei adopted a Declaration on Health Hazards of Tobacco Products. By citing the WMA's Statement on Health Hazards of Tobacco Products, which was adopted the same year, it strongly urges CMAAO members to pursue the actions in the statement. Stickers to promote Smoke Free Asia and Oceania were also produced. The president of CMAAO at that time was Dr. Songkram of Thailand.

The momentum against tobacco smoking has been sustained in Thailand since that year, and has now emerged again in the CMAAO with greater energy. We are currently involved in the second wave of the CMAAO's efforts to tackle this crucial issue in our region. Tobacco control is a very difficult issue, so we should consider various, up-to-date efforts, and regularly evaluate their performance.

The theme of the 53rd Annual Scientific Meeting of the Medical Association of Thailand, which was held in Krabi, Thailand in October 2009, was "Smoking Cessation Programme in Asia and Oceania." This meeting was very successful due to the efforts of Dr. Somsri and Dr. Wonchat.

The meeting was attended by international representatives from the medical associations of Thailand, Malaysia, Myanmar, Brunei, Japan, and representatives from governments and the WHO. We had very informative lectures on each country and the Asia and Oceania region, followed by active discussions on smoking cessation programmes.

At the CMAAO Bali Congress in November 2009, a proposal to take cross-regional anti-smoking actions was adopted. The expansion of these activities is currently being considered under the leadership of the Medical Association of Thailand.

As a result of the efforts made so far, the first International Summit of the Asia and

Oceania Region on Tobacco Control was held in Thailand, hosted by the CMAAO, the Medical Association of Thailand (MAT), MASEAN and the Thai office of the WHO. It adopted a declaration "The Sampran Declaration of Asia and Oceania Region on Tobacco Control".

The Sampran Declaration on Tobacco Control in the Asia and Oceania Region has been circulated to all member countries in the CMAAO and MASEAN, and the project's progress will be followed up at the CMAAO Conference each year. This will be the first and leading collaboration in controlling tobacco consumption at the regional level.

*Dr. Masami Ishii,
Secretary General of CMAAO,
Council Member of WMA, Executive
Board Member of JMA*

February 2010

The Sampran Declaration on Tobacco Control in Asia and Oceania Region CMAAO, Medical Association of Thailand, MASEAN and WHO Thai Office

Preamble

Tobacco use is the leading cause of preventable death, killing more than 5 million people each year worldwide. Second-hand smoke kills about 600,000 people who were non-smokers each year. Most of these deaths are in low- and middle-income countries including countries in Asia and Oceania. Apart from other well-known health hazards, tobacco use also increases morbidities such as malnutrition and subfertility, hence urgent action is needed.

The WMA, representing the medical associations of the world, issued a statement on

the health hazards of tobacco products in 1988 at the 40th World Medical Assembly. This was amended at the 49th and 59th WMA general assemblies. The CMAAO adopted the WMA statement in 1988. With the entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2005, the global tobacco control community has made considerable progress against the global tobacco epidemic.

According to the WHO Report on the Global Tobacco Epidemic, 2008 and 2009, the majority of the world's smokers are in Asia and Oceania, which makes tobacco control in the region the main challenge. Only a few countries have a national policy on comprehensive tobacco control. Most users are inadequately warned about the extreme addictiveness of tobacco and the full range of health risks. In all CMAAO countries, cessation services are still insufficient to help the 360 million smokers. Although second hand smoke is easily prevented, only few countries have comprehensive smoke-free environment legislation. The health of more than one third of population in the region is at risk from exposure to second-hand tobacco smoke and remains unprotected.

In this regard, government and policy makers must play a pivotal role in ratifying and enforcing the WHO FCTC. The medical profession must recognize its role and social responsibility in tobacco control.

At the individual level, doctors should be agents of change in the battle against tobacco use. The medical profession is deeply committed to tobacco control and a smoke-free society. The CMAAO, together with all other organizations such as the WHO, will partner with the regional and national tobacco control organizations to act decisively against the tobacco epidemic – the leading global cause of preventable death.

The success of this program is going to be wholly dependent on the proactive role of the medical profession in tobacco control

and prevention of its health hazards, the co-operation of the general public through the civil societies who will reinforce the medical profession and the commitment of the national government to enact and enforce laws directed towards tobacco control.

Recommendations

The CMAAO urges the CMAAO members to take the following actions to help reduce the health hazards related to tobacco use, at:

I. National Medical Association Level

1. Adopt a policy position opposing smoking and the use of tobacco products, and publicize the policy so adopted.
2. Prohibit smoking at all business, social, scientific and ceremonial meetings of the National Medical Association.
3. Develop, support, and participate in programs to educate the profession about the health hazards of all forms of tobacco use. Convince and help smokers and smokeless tobacco users to cease the use of tobacco products, and develop cessation programmes for tobacco users and avoidance programmes for non-smokers and non-users of tobacco.
4. Strongly urge individual physicians to be role models (by not using tobacco products), healthcare team leaders and spokespersons to campaign and to educate the public about the deleterious health effects of tobacco use, exposure to second-hand smoke and the benefits of tobacco cessation and making a smoke-free home.
5. Mandate all medical schools, hospitals and other health-care facilities to prohibit smoking on their premises.
6. Introduce or strengthen educational programs for physicians to prepare them to identify and treat tobacco dependence in their patients.
7. Strengthen and cooperate with the regional network to develop an effective regional system on tobacco cessation. Support widespread access to effective

treatment for tobacco dependence - including identification of smokers in the routine services and provision of counseling, necessary pharmacotherapy and other appropriate means.

8. Develop and endorse a clinical practice guideline on the treatment of tobacco use and dependence.
9. Urge the national authorities to add tobacco cessation medications to the List of National Essential Medicines and Health Security System.
10. Mandate medical schools, research institutions, and individual researchers not to accept any funding or any form of support from the tobacco industry.

II. Individual Physician Level

1. Ask every patient for smoking history and provide brief advice to every patient along with referral to specialized cessation treatment.
2. Do not accept any funding or any form of support from the tobacco industry.

III. Government Level:

1. Support MPOWER¹ as the main tobacco control strategy released by WHO.
2. Advocate the enactment and enforcement of laws that:
 - a. provide for comprehensive regulation of the manufacture, sale, distribution and prohibit any form of promotion and advertisement of tobacco products. All forms of promotion of tobacco products including sponsoring sports events and entertainment should be banned.
 - b. require written and pictorial warnings about health hazards to be printed on all packages of tobacco products.
 - c. prohibit smoking in all enclosed public places (including health care

1. (M= Monitor tobacco use and prevention policies, P=Protect people from tobacco smoke, O=Offer help to quit tobacco use, W=Warn about the dangers to tobacco, E=Enforce bans on tobacco advertising and promotion, R=Raise taxes on tobacco products)

- facilities, schools, and education facilities), workplaces (including restaurants, bars and nightclubs) and public transport.
- d. prohibit the sale, distribution, and accessibility of cigarettes and other tobacco products to children and adolescents.
- e. prohibit the sale of tax-free tobacco products.

- f. prohibit all government subsidies for tobacco and tobacco products.
- g. prohibit the promotion, distribution, and sale of any new forms of tobacco products that are not currently available.
- h. increase taxation of tobacco products, using the increased revenues for prevention programs, effective

- cessation programs and services and other health care measures.
- i. curtail or eliminate illegal trade in tobacco products and the sale of smuggled tobacco products.

IFMSA and 1.2 million Worldwide Medical Students Fighting Against the HARMFUL USE OF ALCOHOL



Florian Stigler

IFMSA and its Standing Committee on Public Health

The International Federation of Medical Students' Associations (IFMSA) represents 1.2 million medical students through its 97 national member organisations. Founded in 1951, it was officially recognised by the WHO in 1969. IFMSA works as an independent, non-governmental organisation towards improving global health.

Running one of the biggest student-led exchange programmes worldwide and working

at community levels to tackle health-related problems sum up our main focus. Every year more than 10,000 students go on exchange through the IFMSA and get to appreciate the culture and medical practice, or participate in research in a different country. Our local level activities and projects focus on medical education, human rights, reproductive health and public health. This article will focus on one of our public health-related activities: Our fight against the harmful use of alcohol on a global scale.

But first, an introduction to some of our main public health activities. Medical students from all over the world are part of the IFMSA Standing Committee on Public Health. These students execute projects and activities that aim to promote health in the local communities, by laying emphasis on preventive measures. Students work on topics ranging from child health, tobacco, alcohol abuse, diabetes and obesity, to malaria and TB in high-risk countries. Other initiatives try to advocate for change by approaching key stakeholders and using the media to make our voice heard. Last but not least, we try to focus on ourselves. As public health topics and advocacy are not core topics in most universities worldwide, we try to develop our skills and knowledge and

those of other medical students. We want to become health professionals with a more holistic concept of health and who are able to promote change within our profession.

The harmful use of alcohol – a youth perspective

Alcohol consumption is responsible for 2.5 million unnecessary deaths worldwide [1]. It is also accountable for additional damage towards the immediate environment and the society as a whole. The damage attributable to alcohol consumption is described by the Royal College of Physicians as “catastrophic”. Altogether, “passive drinking” affects more people than “passive smoking” [2].

When we look at the European Union (EU), alcohol is a huge burden. It is the “third most significant risk factor”, being responsible for 6.5% of all deaths and annual cost of €400 billion (social and intangible costs), which equals almost 4% of EU's GDP [3, 4].

What can society do?

Most measures employed to fight the burden of the harmful use of alcohol are measures at a population level. Increasing taxes on alcohol products seems to be the most effective intervention. Although governments are often concerned about losing revenue, the opposite is the case. Revenue increases as the reduction of consumption is smaller than the increase in taxes [5]. Other

common measures are the introduction of a minimum age for drinking or anti-drink-driving measures like the reduction of blood alcohol concentration limits.

What can physicians do?

We as (future) physicians are in regular contact with high-risk individuals. Brief advice in a primary care setting is proven to be effective and cost-effective [4, 6]. A Cochrane Review even showed that the mean consumption was reduced by 12% [7]. We, as the next generation of health professionals, will need more training on approaches to delivering brief advice than we currently receive. Physicians can play a much bigger role against the burden of harmful alcohol consumption than just curing the damage it causes.

As physicians, we are respected members of our societies and our health advice is taken seriously. Still, there is misinformation even within physicians as well as medical students worldwide. "Small amounts of alcohol can have beneficial effects". There is evidence supporting this statement – but is there evidence that this is also a helpful advice...? Every harmful drinker started with small amounts. The following figure

might put the beneficial effects of alcohol consumption into a broader picture. Indeed, there are deaths prevented by low-dose alcohol consumption. But in every age group, there are more deaths caused than prevented by alcohol consumption!

Why are we as a youth organisation concerned?

We are concerned because young people are strongly affected. Of all years lived with disability attributed to alcohol, 34% were experienced by persons aged 15–29 years [9]. We, as representatives of young people, think that we have the right to be protected. We are dissatisfied if manipulative marketing by the alcohol industry is used to influence our decisions and behaviour.

IFMSA, GAPA & the WHO Global Strategy to Reduce the Harmful Use of Alcohol

In May 2010, during the WHO World Health Assembly, all 193 member states adopted the "Global Strategy to Reduce the Harmful Use of Alcohol"⁽¹⁾. This milestone for global public health describes harmful consumption as a major threat for global health and offers solutions which can



Derek Rutherford (GAPA) and Florian Stigler (IFMSA)

and should be implemented by all member states.

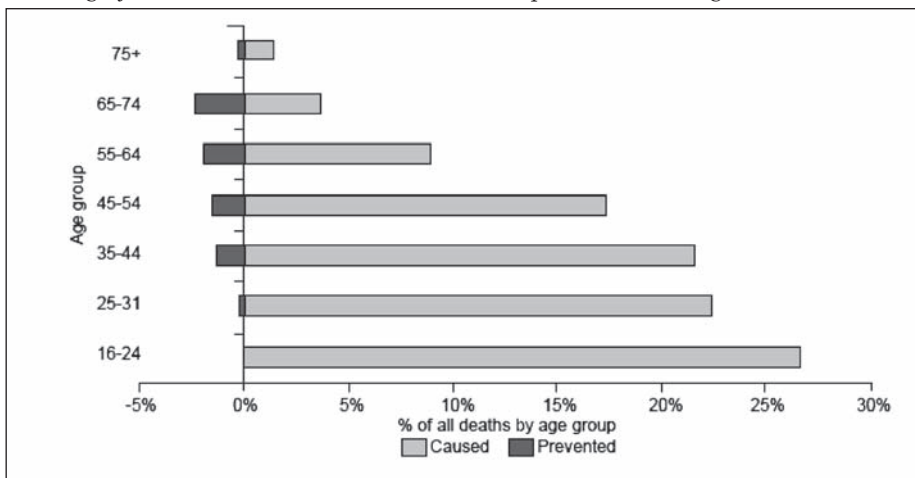
We, as IFMSA, do welcome the adoption of the strategy although we know that it is a long way towards achieving its aims. We, as worldwide medical students, are an affected high-risk group on our own. Therefore we advocated towards the World Health Assemblies in 2008 and 2010 to support a stronger protection of medical students and youth in general.

We are proud of our persistence in our actions and our fight against the harmful use of alcohol.

We are proud of being members of a strong youth movement, the Alcohol Policy Youth Network (APYN), which successfully hosted the European Conference "Alcohol Policy and Young People" in Budapest, Hungary.

We are proud of our great collaboration with the Global Alcohol Policy Alliance (GAPA). Our fruitful partnership was especially highlighted by the attendance of GAPA Chairperson Mr. Derek Rutherford at our last IFMSA General Assembly in Thailand. We have been inspired by his speech towards our 850 participants and it was fantastic to see the enthusiasm of worldwide medical students towards such an important but often neglected topic. We are looking forward towards further collaborations of IFMSA and GAPA.

Percentage of male deaths attributable to alcohol consumption in 2005 (England) [8].



We as IFMSA are proud to represent the voice of 1.2 million medical students and to fight the global burden of the harmful use of alcohol!

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Developing Healthcare Technologies for Emerging Markets – Improving Quality, Access and Cost

Introduction

Healthcare technologies have seldom been under more scrutiny. In mature and developed markets, governments and providers are using methodologies such as comparative effectiveness and health technology assessments to evaluate the benefits of diagnostics and other medical devices. Some observers view this as simply a way to limit ever growing expenditure in healthcare, but most accept that new technology should show that it has clinical utility and be more cost effective than current practice.

Similar logic is being applied to health technologies for emerging markets. Consideration of cost and clinical effectiveness is being conducted in tandem with the additional challenges that these markets pose – such as isolated geographies, shortages of professional medical workers, poor infrastructure, often overwhelming demand and, of course, very limited funding. With such challenging circumstances, emerging nations' needs for better access to appropriate technologies is paramount. It is incumbent upon companies like GE¹ to do all they can to help.

As a global, technology based, diagnostics and healthcare solutions business, GE sees its critical contribution as making cost-effective life-saving technology more accessible in the semi-urban, rural and developing areas which often bear the brunt of the disease burden. This is epitomised by GE's healthymagination programme which aims to deliver technologies and solutions that improve the quality, access and cost of health in all of our markets.

Healthymagination is GE's commitment to work in our businesses and in partnerships to develop the appropriate new technologies and solutions that will help deliver improved access to better quality and cost effective healthcare [1]. That commitment applies to the poorest and richest countries alike: to those places with underserved

Healthymagination

healthcare systems where technology can improve access and patient outcomes; and to places where technology is regarded as a driver of healthcare costs and where, instead, it needs be used to drive efficiencies and improvements in delivery.



Mike Barber

So, how does healthymagination apply to, say, rural India, China or Africa? When healthymagination was launched in May 2009, GE CEO Jeff Immelt highlighted two products that looked to the future. The MAC 400 Electrocardiogram device and the

1 GE is a trademark of General Electric Company



Mike Barber with the Vscan ultrasound scanner at the WMA lunch. The portable MAC ECG device and Venue 40 ultrasound scanner being demonstrated.

Venue² 40 tablet sized portable ultrasound scanner. These devices are battery powered, portable, self contained and simple to use. They are examples of using the consumer electronics boom to miniaturise and adapt technology that was once the sole preserve of the hospital, and take it into clinics and rural locations remote from mainstream medical facilities. Both take healthcare to the patient rather than the patient to the healthcare provider and both were developed and manufactured in the markets for which they are designed.

In an article published in the Harvard Business Review [2] Jeff Immelt, Vijay Govindarajan and Chris Trimble describe how GE has changed its traditional “glocalisation” business model, where products were developed in home markets like the USA and Europe for these markets, then adapted for sale elsewhere – often by reducing specifications and manufacturing locally. This model worked to some extent, but frequently the products were not suitable for local circumstances - too big, too complicated, susceptible to power fluctuations and difficult to use and maintain in physical

² MAC, Venue and VSCAN are trademarks of GE Healthcare companies

environments quite different from those they were originally designed for. And, despite lowering the capital cost of equipment, financial models for its use and upkeep based upon home market experience did not work and were not sustainable. There needed to be a major change in mindset.

The company now increasingly researches, develops and manufactures the right technology for local needs in the country or region of use as part of GE’s “in country for country” approach to

new technology development. This is easier said than done, and the Harvard Business Review paper describes in detail how the management structures and systems of GE had to change to allow local autonomy and responsibility to take decisions, research local needs and critically, in a company renowned for financial rigor, secure and allocate financing for the new products. In short, GE teams with deep local knowledge and unprecedented autonomy in China, India and a dozen other countries now manage the development and production of new products to meet local needs. In an interesting twist, because these new products do not compromise on quality, some are finding a use “back home” in the developed markets. This has become known as “reverse innovation.”

Reverse innovation

Technologies designed to meet the specific medical needs and circumstances of developing nations are proving popular in more developed markets, particularly where there are large rural, underserved populations. The MAC series of electrocardiograms (ECG) is a good example of this. Originally developed in India, their ease of use and portability make them equally attractive for primary care physicians and nurses in clinics and on

home visits in other countries including the USA. These machines are even used by “flying doctors” serving the Inuit populations in Northern Canada and data from examinations can be examined on the spot or transmitted to specialists in urban centres for analysis or second opinion.

In today’s financially restrained times, technology that enables more diagnostic tests to be conducted outside of the hospital environment or at the patient’s bedside, rather than referral and physical transport, are likely to be attractive in helping to improve healthcare system efficiencies. Marketing these technologies in developed as well as emerging markets allows the development costs to be spread wider and hence the price point to the developing market can be set at a level that enables the country to purchase and maintain the technology – meeting GE’s healthymagination commitments relating to quality, access and cost.

New healthcare technologies for global challenges

Innovative medical technology is now being developed for almost all the diseases and conditions found across developing nations. Until relatively recently the predominant focus was on medicines, vaccines and prevention and awareness campaigns. Now there is a welcome shift towards new and better technologies for screening, earlier diagnosis, treatment assessment and monitoring.

The World Health Organisation is a case in point. It recently published the result of its call for innovative devices that address global health concerns [3]. Six out of fifteen applications that it has selected to highlight are in diagnostics and screening. These range from a portable on site cell sorter and counter for HIV and malaria diagnosis, to a transcutaneous bilirubin measurement system to provide an alternative to blood sample analysis for the diagnosis of hyperbilirubinaemia in newborn infants. Other devices selected have applications in mater-

nal and newborn care, such as neonatal suction devices and baby warmers. These reflect the rising global focus on the challenges of Maternal and Newborn Health which are prominent in the United Nations Millennium Development Goals (MDGs).

Maternal and Newborn Health

MDG 5 aims to reduce by two-thirds the mortality rate among children under five – and deliver this by 2015. Of the 139 million babies born worldwide every year, nearly 4 million die in the neonatal period, the main direct causes being preterm birth, severe infections and asphyxia. The real tragedy is that most of these deaths are preventable. With just five years to go, reaching the MDG will require new levels of cooperation amongst everyone concerned, from doctors to midwives, Governments to NGOs and researchers to businesses. It will also require a reappraisal of the ways in which healthcare technologies are developed and deployed, especially in areas where neonatal mortality rates are the highest. GE is playing its part.

As part of GE's global healthymagination commitment, we expect to expand our Maternal-Infant Care portfolio by 35% - offering targeted technologies to over 80 countries in order to increase local access to care. Included already are safety tested, affordable and easy-to-use infant care products that provide warmth for newborns, phototherapy to treat jaundiced infants and incubators for premature babies. Some of these products are designed and manufactured in India and Turkey. GE is now working on developing very simple warmers and phototherapy devices for developing nations at dramatically reduced cost. A novel method for providing oxygen to mothers in childbirth and to newborn babies is also under consideration.

Another new product already available is the Vscan handheld portable ultrasound scanner, developed in emerging markets. Its clinical applications are currently being assessed in both emerging and developed

markets for a wide range of diseases and conditions. Though not yet approved, these include assessing its capabilities and protocols for its use in maternal and neonatal care applications in emerging markets.

Ultimately, our vision is for Vscan to be as ubiquitous as a stethoscope and to achieve that it must have a truly global reach. As in consumer electronics, unit costs will be reduced as more clinical applications are approved, production increased and other design innovations are deployed. The goal is to reach a point where the purchase, training and upkeep costs can be recovered by a sustainable pricing model in even the lowest income countries of the world. This is a goal that was simply unimaginable only a few years ago and now promises to bring to anywhere powerful diagnostic capabilities previously the exclusive domain of the hospital.

Working in partnership

Having designed new technologies the next challenge is to test, refine and deploy them in the field. Lessons have been learned from the GE Foundation's keystone philanthropy programme "Developing Health Globally" [4]. This programme is improving the healthcare capacity in Africa, South East Asia and Latin America by equipping hospitals and clinics with the technology they need and ensuring staff are properly trained in its use. Using volunteers from GE and GE Healthcare the programme has shown that what is actually required on the ground is often not what is perceived from afar and that what works in Geneva, may not in Ghana. In short, the learning is that there is no substitute for having people *in situ* on the ground.

It is here that GE is actively seeking partnership with Governments, professional organisations and increasingly NGOs with a presence in developing markets. While we may have design team and sales and marketing and business expertise in many countries, we sometimes lack the infrastructure on the ground to take the new technologies

out to the patients. Fortunately, there are many global and local NGOs experienced in this type of work and we are keen to join with them to provide the training programmes and capacity building in country for testing new technologies. Through this type of partnership we can better reach the end users to determine if a new technology really will be of use on the ground. If yes, working in a partnership could also allow us to develop clinical protocols and appropriate uses for the technologies, speed up delivery, provide the right training and support needs and minimise costs.

Much remains to be done. GE is not claiming to have all the answers to ensure that all parts of the world have access to innovative technologies that improve health. We do however understand the problems and can see many of the obstacles in the way. Through healthymagination and the development of new technologies 'in country for country' we are committed to working to help overcome the challenges. It will require more collaboration, partnerships, clear thinking and the courage to do things differently. Please join us in our journey.

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Note: This article is based on an address by Mike Barber to the World Medical Association's Annual Lunch at the World Health Assembly, Geneva, 18 May 2010

*Mike Barber, Vice President
healthymagination, General Electric*

News from the CPME: Board meeting in Brussels on 22nd June



Birgit Beger

Introduction

At its Board meeting on 22nd June, chaired by CPME President Dr Konstanty Radziwill, the CPME said good-bye to Lisette Tiddens-Engwirda, who left the CPME upon her retirement after 8.5 years as secretary general. The board welcomed Birgit Beger, the new secretary general as of 1st July 2010.

Content discussions were in-depth and the agenda full, since the meeting in April had fallen victim to the travel restriction based on the Icelandic volcano. From the many subjects dealt with in June, there are a number of significant items of interest to the medical profession.

e-Health

In the world of electronic communication there are no national borders, and e-health presents a rapidly changing healthcare policy area. The CPME has made involvement in this policy area a focus for years, with the aim of ensuring that technology is used to support the cornerstones of the

patient/doctor relationship with a view to better and easier access to healthcare. With this engagement we try to counterbalance tendencies of focussing e-health on economical and technology developments, circumventing the importance of departing from patients' needs.

Health care for the ageing population and chronic disease management indeed find a backup in e-health tools, as does cross-border prescription in Europe where citizens are more and more mobile. E-health is high on the agenda of EU governments and the European Commission. In the last years we have seen projects like eSOS (transfer of electronic patient summaries, e-prescribing) and CALLIOPE (interoperability project), CALLeSO (combination of both projects), as well as the 2009 Council conclusions on e-health which present a political mandate for a more consolidated approach to co-operation on e-Health in the EU. The CPME is involved in these concrete projects as well as in the e-Health users' stakeholder group which is chaired by the previous president of the CPME, Dr Michael Wilks.

At the CPME it was agreed that the issue of data protection and patients' consent should be further strengthened in the debate, since this is a particular area in which the interest of the patient is under potential risk. The focus for this topic will be brought into the user group and a thematic network on limits and barriers of e-health.

Pharmaceuticals – CPME response to European Medicines Agency consultation¹

¹ The European Medicines Agency Road Map to 2015: The Agency's contribution to Science, Medicines, Health is available here: <http://www.ema.europa.eu/htms/general/direct/roadmap/roadmapintro.htm>

The European Medicines Agency launched a consultation on its Road Map to 2015 which presents the EMA's new strategic vision and sets out the Agency's priorities for the next five years.

In its response to the consultation, the CPME in general agreed with the roadmap proposed, but underlined the importance of engaging the medical profession in order to properly address public health needs. Moreover, the CPME stressed the global nature of medicine development and research in support of the Helsinki Declaration². This is one of the most important documents and guideline for doctors when it comes to research on human beings and it deals with the ethical issues implied. Furthermore, as regards clinical trials, the CPME stressed that it is of great importance that all clinical trials are registered in a publicly accessible global database to avoid redundant clinical studies which is another important topic covered by the Helsinki Declaration.

Organ donation

The CPME rapporteur on organ donation, Dr Frank Ulrich Montgomery, reported that the CPME's amendments to the draft proposal for a "Directive of the European Parliament and of the Council of 8th December 2008 on standards of quality and safety of human organs intended for transplantation [COM (2008) 818]"³ were accepted by the rapporteur MEP Miroslav Mikoláik (SK, PES), so that the final version of the document now includes all key demands of the CPME and safeguards the interests of doctors and patients. The CPME's advocacy work was very successful in this initiative.

² WORLD MEDICAL ASSOCIATION DECLARATION OF HELSINKI, Ethical Principles for Medical Research Involving Human Subjects, adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964, please see: <http://www.wma.net/en/30publications/10policies/b3/17c.pdf>
³ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0818:FIN:EN:PDF>

The draft directive now aims to integrate harmonised regulations for the fields of “blood, blood products, cells, tissue and organs of human origin”. The CPME amendments sought to avoid loopholes in the draft directive as regards parts of organs if it is their function to be used for the same purpose as the entire organ in the human body, and for so-called “complex tissue”. Furthermore, the amendments aim to diminish bureaucratic hurdles and try to ensure the good practices of the tissue directive 2004/23/EC and its implementing directives. In light of the communalism of transplantation medicine successfully established over many years in some EU member states, the CPME amendments are of crucial significance; retaining the previous formulations of the draft directive would, in some countries, have unnecessarily resulted in abandoning the proven and tested organisational structures. In countries where there are high standards these standards will, thus, be maintained. The Council approved the directive on 29th June 2010 and it awaits its publication in the Official Journal.

European Working Time Directive

On 24th March 2010, the Commission published a communication (COM 2010(106) final)⁴ on reviewing the Working Time Directive 2003/88/EC.⁵ In the years 2004–2009 the Commission’s proposal to amend the Directive could not reach agreement with the Council and the Parliament despite intensive discussions and a conciliation process.

The CPME believes that it is vital in the interest of the healthcare work force and their patients to maintain high standards of protection from long working hours and depraving working conditions as well as guaranteeing safety for the patients. The

⁴ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0106:FIN:EN:PDF>

⁵ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:299:0009:0019:EN:PDF>

current Working Time Directive provides sound definitions for “working time” and “rest period” which have proven successful in bringing down overall working times and in reconciling private-life and work-life. Also, the European Court of Justice in the cases SIMAP, Jaeger and Dellas, ruled that the “on-call time periods” must be counted hour-for-hour as working time which is strongly supported by the CPME. Since the Working Time Directive is a valuable tool – provided Member States have implemented it – the CPME is rather hesitant towards a review. In particular, if one of the motives for the revision is to create competitive cost advantages for businesses by making production times more flexible. For example, individual opt-outs from the 48-hour limit to average weekly working time are considered as a very critical element in the current Working Time Directive and any review should not allow further derogations from the full protective scope of the directive. The overall scope of the European Working Time Directive should not turn from a protective to an economic one.

The CPME will closely monitor further developments in the review process and will take an active stand for the interests of the healthcare workforce and their patients.

Health inequalities

The well-being of and care for their patients is the prime concern and responsibility of physicians. Physicians apply their expertise to the best of their knowledge for the benefit of the sick and for the prevention of ill health. Research for new approaches and technologies to improve health, and contribution to policy making in clinical and public health are also important obligations for the medical profession.

At the board meeting, the CPME adopted a position paper on health inequalities, please see: http://cpme.dyndns.org:591/adopted/2010/CPME_AD_Brd_220610_014_final_EN.pdf

[org:591/adopted/2010/CPME_AD_Brd_220610_014_final_EN.pdf](http://cpme.dyndns.org:591/adopted/2010/CPME_AD_Brd_220610_014_final_EN.pdf)

In the position paper reference is made to a CPME response to a Consultation on European Commission Communication “Solidarity in Health” of 2009, (please see: http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/cons_paper_en.pdf), where the CPME suggested several measures to reduce inequalities in health. Some of these are not directly healthcare-related as for example education, social cohesion, fiscal and taxation policy, etc. While the CPME supports action in these areas to reduce health inequalities, as an organisation for medical doctors, CPME concentrates its lobby activities on health issues and give priority to these measures:

- *Improving the data and knowledge base and mechanism for measuring, monitoring, evaluation and reporting.*
- *Improvement in infrastructure, especially water and housing.*
- *Secure the right to health for disadvantaged people including illegal entrants and asylum seekers.*

The current position paper addresses also the decisive national level (National Medical Organisations) as regards ways of improvement of health inequalities, like for example:

- *Drawing the attention of governments to international conventions or charters that secure the right to health.*
- *Lobbying national health authorities for better health care particularly for disadvantaged groups.*

Ethical trade in medical goods

The CPME has started work on a network which brings together national reports on ethical trade in medical supplies. In the UK and Sweden good practices already exist which aim to tackle the ethical implication of producing medical goods in low cost countries, for example

child labour, health and safety, and workers' rights.

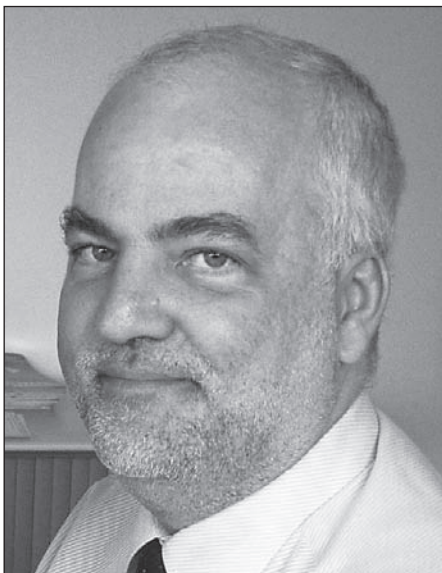
In 2009, the CPME already undertook first steps to raise awareness among the European medical associations and EU decision makers.

The aim of the current work is to assess whether European standards on ethical trade will be helpful to safeguard rights. Furthermore, the CPME is aware that the European Commission is developing social standards for ethical procurement to which the CPME could contribute from the European doctors' point of view.

The next CPME board meeting and general assembly will take place in Brussels on 27th November 2010. For further information, please contact Birgit Beger at birgit.beger@cpme.eu

Birgit Beger, Secretary General, CPME

The Training, Qualification and Continuous Professional Development of the Medical Specialist in the Future, a Challenge for the UEMS



Bernard Maillet

Introduction

A hybrid yet comprehensive structure – specialist, political and scientific

The European Union of Medical Specialists (UEMS) was established in 1958, one year after the signing of the Rome Treaty, and is the representative organisation of the National Associations of Medical Specialists in the European Union, its associated and observer countries and beyond. With

a current membership of 35 countries, the UEMS represents an estimated 1.5 million specialist doctors, notably through its 38 Specialist Sections and Boards and 8 Multidisciplinary Joint Committees (MJC's). It has strong links and relations with the European Institutions (Commission and Parliament), the other independent European Medical Organisations (e.g. PWG, UEMO, CPME) and the European Medical / Scientific Societies.

Its structure consists of a Council responsible for and working through its Specialist Sections and MJC's, each with its own European Board, addressing training in the Specialty and incorporating representatives from academia (Scientific Societies, Colleges and Universities). An Executive, made up the President, the Secretary-General, the Liaison Officer, and the Treasurer, is responsible for the daily functioning of the organisation.

By its agreed documents, the UEMS sets standards for high quality healthcare practice for the benefit of patients and the harmonisation of high level training across Europe that are transmitted to the Authorities and Institutions of the EU and the National Medical Associations (and through them the National Health Authorities) stimulating and encouraging them to implement its recommendations.

In 2000, the UEMS established the extremely important European Accreditation Council for Continuing Medical Education (EACCME®), which facilitates the exchange of CME credits obtained by attending international medical congresses. This recognition is achieved by virtue of common memoranda of agreement on mutual recognition reached between UEMS, the National Accreditation Authorities and the American Medical Association.

A further step forward was realised in 2010 at the Istanbul Council of the UEMS where the European Accreditation Council for Medical Specialist Qualification was officially created. It was agreed to start with a pilot project for a period of two years for three Specialties and have a harmonisation of the Assessment of the Training.

The oldest of the European medical organisations

On 20th July 1958, delegates from the professional organisations representing medical specialists of the six founding countries of the new European Economic Community convened in Brussels and set up the UEMS. Thanks to the leadership and perspicacity of its founding members, the UEMS soon established contacts with the newly created European Institutions to define the basic principles in the field of training for European medical specialists. During its 50 years of existence, the UEMS continued to deliver a considerable amount of work with the constant aim to promote the quality of care across Europe.

When addressing the issue of quality, the UEMS obtained from the European Commission and the Member States that the highest levels of training for the future medical specialists of the Six Common Market countries would be guaranteed by European legislation. This vision of the future resulted in the elaboration of common general criteria, applicable to all specialists wishing to move from one member country to another.

To realise this ambitious objective, the UEMS created in 1962 Specialist Sections for each of the main disciplines then practiced in the Member States. These groups of experts, made up of representatives of the national associations of the specialty concerned, carried out a considerable workload with the idea of coordinating and harmonising specialist training and criteria for the recognition of medical specialists. Today the UEMS has 38 Specialist Sections and Boards as well as 8 Multidisciplinary Joint Committees (MJC's) all together having about 2000 specialists working on those important issues.

This active collaboration with the European Institutions and Member States led to the adoption in 1975 of the first Directives providing for the free movement of doctors across Europe by ensuring the recognition of their qualifications.

The UEMS naturally contributed to further improvements and updates to the Doctors' Directives following to the successive enlargements of the European Community. These also led to important changes in the bodies and composition of UEMS. Progressively, the number of UEMS Sections increased and reaches now 38.

In order to support the implementation to these Directives, the European Commission established the Advisory Committee on Medical Training (ACMT) with an aim to engage European professional medical organisations, universities and national governments. The UEMS, through

its Specialist Sections, was naturally deeply involved in the consultations launched by this body. Each Section was asked to report on its understanding and possible proposals regarding the developments occurring in the specialty. Progressively, four reports of the ACMT, conducted by Members of the UEMS Executive, were implemented by the Commission when updating its legislation.

Confronted with the need to a greater involvement of the academic world, the UEMS created in 1990 European Boards as working groups of its Specialist Sections to address issues related to medical training and ultimately guarantee optimal care by raising quality and training standards. Thanks to this closer collaboration, European Charters were elaborated on various issues such as specialist training, quality assurance in specialist medicine or the autonomy of practice for medical specialists.

In 1999, the UEMS set up the European Accreditation Council for Continuing Education (EACCME®) with an aim to harmonise and improve the quality of specialist medical care in Europe through facilitating the mobility of health professionals for learning and training purposes. In the fields of continuing medical education (CME) and continuing professional development (CPD), the EACCME ensures access to recognised high quality CME-CPD activities by securing the exchange and recognition of CME credits for medical specialists in Europe through the European CME Credits (ECMEC's).

In the recent years, the UEMS has shown itself to be very active in major issues dealt with at the EU level. These include among others the consolidation of the Doctors' Directive into the Directive on the recognition of professional qualifications; the organisation of working time; and patient mobility and cross-border care.

The UEMS has celebrated its 50th Anniversary having celebrations held in Brussels from 17th to 19th April 2008.

In 2007 at the initiative of the Section of Pediatric Surgery a meeting was organised in Glasgow where the Sections met that were organising European Board Examinations with the aim to harmonise those. At that time 11 UEMS Sections were represented and the so-called Glasgow Declaration was issued at the end of the meeting.

The main points on the Glasgow declaration are: the European Board Examinations have no Legal Value and they can be seen as complimentary to National Examinations. We have to promote the European Examinations, as they can be considered as a Label of Excellence. Important is to set a clear Curriculum and to have a Reference Book. There should be clear Eligibility criteria and we have to harmonise the certificates for successful application.

In the meanwhile, the Council for European Specialty Medical Assessment (UEMS-CESMA) has been more formally installed and working very well. Today 28 UEMS Sections are participating in the activities of this group and have support of the UEMS Council and Executive, the UEMS President as well as the UEMS Secretary-General being ex-officio members of UEMS-CESMA.

UEMS-CESMA together with the Working Group of the UEMS Council on Post Graduate Training will be part of the ECAMSQ together with the National Licensing Authorities in the European Union as well as the UEMS Executive.

The introduction of e-learning material in the EACCME® (European Accreditation Council for Continuous Medical Education) « package » from 9th April 2009 onwards

Since 2000 the UEMS is working on the harmonisation of the Continuous Medical Education and Continuous Professional Education in the European area, by creating the European Accreditation

Council for Continuous Medical Education (EACCME®). From 2004 on the EACCME® has signed an agreement with the American Medical Association for the mutual recognition of international events happening on both sides of the Atlantic Ocean.

First the EACCME® took into consideration for the accreditation only live events but obviously e-learning is becoming an important tool for physicians to improve their knowledge, skills and attitudes so it was decided by the UEMS Council to also consider e-learning material for accreditation and this started on 6th April 2009.

The introduction of long distance learning was also an opportunity for the UEMS to improve the quality criteria for the evaluation of the e-learning activities and those criteria, being very strict and of high standards, will in the future be retrofitted to live events.

The document UEMS 2008.20 (Revised) presents the criteria that have to be fulfilled for e-learning material before being approved and granted for credits by the UEMS-EACCME®.

Another important improvement in the UEMS-EACCME® process was the change in provider who is taking care of the web-based application form. In January 2008 the UEMS decided to introduce a web-based application form as the numbers of events applying for UEMS-EACCME® accreditation were increasing and the manual processing became too demanding for the UEMS Brussels Office Staff.

From the start the intention was to have a fully efficient system including the evaluation by the experts of both UEMS Sections as the National Accreditation Authorities and also to increase and improve the communication between the different partners in the process, the applicant, the experts and the UEMS-EACCME®.

As with all new systems that are introduced, we experienced some problems at the start but unfortunately, it seemed that they were not appropriately solved and many complaints remained so that we had to change the webmaster and since January 2010 the system works extremely well and there are nearly no complaints any more concerning the processing of the applications.

The actual webmaster is providing an excellent service to UEMS-EACCME® and things are going softly and efficiently now.

This can be measured as since the introduction of the new webmaster, the number of applications is increasing quite strongly but globally, the quality of the events remains outstanding in a large proportion.

Also the number of agreements between the UEMS Sections and Boards and the MJC's as well as the National Accreditation Authorities is increasing steadily and moreover, contacts have been undertaken with other areas of the world such as Canada, Australia and the Middle East to reinforce the position of EACCME® and the accreditation issue all over the world.

The agreement between the UEMS-EACCME® and the American Medical Association on the mutual recognition of credits was first issued in 2002 as a pilot and since 2006 it was a real agreement.

Now in July 2010, the agreement has been renewed as both parties reviewed the process and decided to include also e-learning material being an important tool nowadays.

We do not have to forget that especially with the introduction of the e-learning material, borders are vanishing and the whole issue of CME-CPD is getting more and more global and worldwide.

The launch of a new structure: the European Accreditation Council for Medical Specialist Qualification (EACMSQ)

Both the "Charter on Specialist Training" and the "Charter on Quality Assurance of Specialist Practice in the EU" stresses the importance of assessing the training at one level or another. Obviously, the Policy Statement on Assessments during Postgraduate Medical Training crystallises the thinking of the UEMS Council in this respect. Everything starts with the definition of clear and harmonised training programmes and curricula so that candidates have a strong base to build their education upon.

This work has been done by our different UEMS Sections and Boards as well as the MJC's and is continuously updated. Many Sections are also participating in the UEMS Council for European Specialist Medical Assessment (CESMA) project. CESMA started in February 2007 at a meeting organised by the Section of Paediatric Surgery in Glasgow and has gained momentum steadily since with more Sections and Boards becoming involved.

In 2009, at the April Council meeting, a first presentation of the ECAMSQ was given by the UEMS President, and this can be seen as the first step in the starting up of this very important initiative. The aim is to combine the UEMS-CESMA project and the Working Group for Post Graduate Training of the UEMS Council and create a structure, similar to EACCME® for CME-CPD involving all the important stakeholders in the field of PGT in Europe.

Similarly to the EACCME®, the partners involved here are the UEMS Sections and Boards and the MJC's as well as the National Licencing Authorities.

The Council decided in its meeting of Istanbul in October 2009 to establish the ECAMSQ, with the ECAMSQ becoming

operational in 2010 (starting with a pilot project lasting for two years and involving three specialties, Anaesthesiology, Cardiology as well as Radiology).

Orzone and UEMS share the vision of improving healthcare quality through the harmonisation of training and education in Europe. For this purpose a collaboration has been established for developing a comprehensive electronic platform to support medical training, assessment and continuous professional development. The strategic direction for the establishment and the primary focus of this initiative is to extensively improve the education and training of European medical doctors, improving medical outcome and patient safety.

As an organisation, the UEMS promotes the best possible standards of harmonised specialist training, continuing medical education (CME) and professional development (CPD), as well as quality assurance of specialist medical practice.

By doing so, the UEMS is committed and serves to encourage decision-makers as well as healthcare professionals to ensure appropriate mechanisms for safe specialist medical care across Europe and this for each European citizen.

As this topic clearly involves Trainees in the different specialties, the Permanent Working Group for Trainees (PWG) will have a delegate in the ECAMSQ. It is obvious, that in order to have free movement of Specialists in the European Union and the Specialties to be recognized throughout the Member States, the training curriculum and content should be very similar everywhere in Europe and an Assessment would confirm the ability of a Specialist to work in similar conditions within the European region.

ECAMSQ will be a structure that will help in this harmonisation process easing access to all EU specialists to all kinds of equiva-

lent positions all over Europe. Obviously, as in EACCME® it is fundamental to involve strongly the National Training & Licensing Authorities of the different Member States in the process in order to guarantee the value of the end product.

It is clear that the ECAMSQ has to receive its mandate from the national licencing authorities.

Thoughts on the revision of the Directive on the Recognition of Qualifications (Dir 2005/36 EC and 2006/100 EC)

The Directive on the Recognition of Qualifications was updated in 2006 with the admission of Bulgaria and Romania as Member States of the European Union but there were no major amendments introduced at that time.

As the Directive will be revised in 2012, we have to think on issues that are important and that could be introduced or modified. First of all, the denomination of the Specialties have to be looked at and for instance the name of one Specialty, "Physical and Rehabilitation Medicine" has to be corrected as it is now cited as "Physiotherapy". Secondly, the minimal length of training of the different specialties has to be updated as for instance for Anaesthesiology, the Directive only considers a minimal Training Time of 3 years although the profession globally advocates a training of at least 5 years. In this respect it should be also good to consider including not only length of training but also the required competences as identified by the Core Curriculum as proposed by the different UEMS Sections and Boards as well as the MJC's (the so-called Chapter 6 of the UEMS Charter on Post Graduate Training).

A crucial concept that could be introduced and would help a lot in the recognition of special fields of activities in medicine is the

concept of so-called "Particular Qualification".

Nowadays, the actual Directive only recognises Basic Specialties but activities such as Intensive Care Medicine and Oncology are left aside and ignored.

It will be a major task of the UEMS to convince the European Parliament, the European Commission and the National Authorities of the different EU Member States, that the introduction of these Particular Qualifications are an important issue to help many of our Colleagues active in some fields of Medicine to be recognised all over Europe and by having this, help to enhance the healthcare of the European Citizen.

Likewise the actual version of the Directive, there will be a list in the Addendum listing the different Particular Competences that would be recognized also presenting the countries where they are already existing.

Conclusion

As reflected in this article, the UEMS is very active in many different fields concerning Specialised Medicine and there are still a lot of important challenges that remain to be realised. One of those being the whole issue of e-Health that will increasingly influence our practice through telemedicine, e-prescription or electronic patient record for instance.

The mobilisation of all the actively involved members of the UEMS in the different bodies, the delegates from the National Medical Associations, the delegates of the UEMS Sections and Boards as well as the MJC's as well as the participants in both the EACCME® and the ECAMSQ will be needed to achieve those important goals that have been set up in the Strategy Document of the UEMS that lies at the basis of all those initiatives.

*Dr. Bernard Maillet,
Secretary General UEMS*

The Hong Kong Medical Association



TSE Hung Hing

Our Purpose

Founded in 1920, the Hong Kong Medical Association brings together all medical practitioners practising in, and serving the people of, Hong Kong. Its objective is to promote the welfare of the medical profession and the health of the public. With the current membership of over 8000 from all sectors of medical practice, it speaks collectively for its members and aims to keep its members abreast of medical ethics and issues around the world.

Our Role

The Association is the official representative body of the local medical profession. It represents the medical profession in local governmental and professional bodies, as well as regional and international medical organisations. Post-1997, the relationship between the Association and its counterparts in Mainland China has become closer. Into the new Millennium, its representative role has been further enhanced with the staunch support of its membership and strong affiliation to organisations with laudable missions and objectives.

Our Structure

The Association is now directed by a Council of 25 members elected from the membership at the Annual General Meeting. The Council is advised and assisted by a number of standing and ad hoc committees in its deliberation and formulation of policies. As a non-governmental and non-profit organisation, the Hong Kong Medical Association runs numerous programs, professional or community alike, with volunteers and resources mainly from its own membership.

Our Home

The Association's headquarter is in Wanchai since 1975. In view of increasing membership and activities, the Association established an education centre in the city centre in 2002.

Our Programmes

Consensus Building

The Association holds discussion forums on public health policies, on health care funding policies, on professional code and conduct, on all issues concerning public health and safety as well as the professional practice. Discussion forums facilitate person-to-person exchange of views. Such discussions are also held on the Internet, via the HKMA News and direct communication with council members and representatives in various government and non-governmental boards and councils. The collective views are reflected to the authorities via the Association.

Continuous Medical Education

The Association runs regular CME activities in form of lectures, seminars, sympo-

sia, workshops, discussion group, clinical attachments in hospital, etc. to provide opportunities for continuous medical education. The Association also set up a structured and systematic programme for the recording and accreditation of members' efforts in CME.

Since 2002, an online CME program has been set up on www.hkmacme.org and members can login to do CME online.

Membership Development

The Duty Council Member Scheme helps solve problems encountered by members in their daily practice. The Young Doctors Programme serves the new graduates by holding career talks, tracking the career paths, monitoring the employment opportunities in the public sector and facilitating placements in the private sector. The District Organisation links and brings closer doctors practicing in outlying districts. We have now developed 8 community networks, which are vested with the role of developing district programmes of continuing medical education, private-public cooperation and public medical education.

Special Interests Groups

Members with similar interests are grouped together to promote a good cause while sharing their common interests. The HKMA Choir and the HKMA Orchestra present concerts to raise funds for charity. The Hikers challenge the MacLehose Trail of 100 km within 48 hours to raise funds for Oxfam. The Sportsmen compete at various sports tournaments organised by the Association to promote sportsmanship and fraternity. The Dragon Boat Teams culture team spirit while testing their physique and mind to the extreme at the races.

Social Functions

The Association organises regular hiking, outings, visits and annual dinner to foster



The HKMA Council 2009–2010

friendly relationship amongst members and their families and friends.

Community Projects

For the past fifteen years, the Association maintains the only territory-wide Organ Donation Register, which not only records the wishes of willing donors but also serves as an indicator of the awareness and acceptance of organ donation after death. Awareness promotion programmes are conducted from time to time in conjunction with the Department of Health, the Hospital Authority. In December 2008, with our cooperation, the HKSAR Government set up a Centralised Organ Donation Register. Data stored in the HKMA Organ Donation Register migrated gradually to the centralised system.

In conjunction with various government and non-governmental health-conscious organisations, the Association is also promoting healthy life styles such as quit smoking, healthy eating and “Say No to Drugs” to the younger generation via the one-school one-doctor scheme.

The Association is working in collaboration with public-spirited organisations in

promoting the use of serving chopsticks & spoons, and regular daily physical activities such as walking 8000 steps a day to the general public.

Hotlines & Directory

Sponsored by Pacific Century CyberWorks Ltd., the Association runs the MediLink Hotline 90000-222-322 for the public to search for medical clinics, which are open during long holidays. A directory of doctors is put on the Internet for public information at www.hkdoctors.org to facilitate referral of patients between the public and private sectors. A hotline for report of illegal sales of drugs is run at Tel No. 2528 6644.

The HKMA Charitable Foundation

Since 1990, the Association has been raising funds for various charitable organisations through public performance of its Orchestra and Choir. The unreserved support of its membership and friends of the medical profession has endeavored to alleviate the sufferings of the sick, the poor and the underprivileged. For the Association to work more closely with its supporters in community and charity projects, the Hong Kong Medical Association

Charitable Foundation was formed in 2006 to consolidate and manage all efforts with a view to better recognition of the contribution of the supporters. Public-spirited individuals and corporations are welcome to join the Foundation. Together we make the world, in particular the Hong Kong Special Administrative Region, a healthier and happier place to live.

Our Pledge

The patient’s well-being is in the heart of our members whose welfare is in the heart of the Hong Kong Medical Association. We pledge to serve both the community and the doctors. Together, we speak with one heart and in one voice to safeguard the health of the people of Hong Kong.

*Dr. TSE Hung Hing, Immediate
Past President of the Hong
Kong Medical Association*

Helping to Meet the Challenges of the Future

113th German Medical Assembly in Dresden



Domen Podnar

“The health policy framework must be designed to ensure that each patient receives quality care. It must be about the individual and not about power. Likewise, it must be about the patient and not about politics,” said Professor Dr. Jörg-Dietrich Hoppe, President of the German Medical Association at the opening of the German Medical Assembly.

A total of 250 delegates from the 17 German State Chambers of Physicians met to discuss health, social and medical professional policy issues at the 113th German Medical Assembly in Dresden on 11th to 14th May, 2010.

The German Medical Assembly is the “Parliament of the Medical Profession” in Germany. This annual general assembly of the German Medical Association (*Bundesärztekammer*) is held at different venues each year. The location is selected from proposals by the individual state chambers of physicians. Each state chamber of physicians (SCP) receives two seats as their Basic Representation at the assembly. The remaining 216 seats are distributed among the individual state medical associa-

tions in proportion to the number of members in the SCP according to the d'Hondt system. The German Medical Assembly, initially founded as the Annual Meeting of the *Deutscher Ärztevereinsbund*, has been held annually since 1873 except in years when it was forced to break during World Wars I and II and the Nazi regime. It convened for the 113th time in the historic city of Dresden. Prof. Dr. Jörg-Dietrich Hoppe, President of the German Medical Association (GMA), has served as President and Chairman of the German Medical Assembly since 1999.

“The future challenges are enormous, and the physicians want to help tackle them,” said Hoppe in his opening address. That is why the German Medical Assembly focuses on different core themes each year. This year's core themes were

- Health Care Provision Research,
- Regulation on Post-graduate Medical Education and
- Rights of Patients – Duties of the State and Society.

Health care provision research is a top priority of the German Medical Association (GMA). Therefore, the GMA launched a funding initiative to promote research into routine health care provision to individual patients and the patient populations in hospitals, medical practices and other health care facilities in 2005. The goal of the initiative is to develop concepts for better patient care, to produce reliable statistics on the shortage of physicians, and to provide information on the work situation of physicians, among other things. The GMA has provided a total of €750,000 in funding for various projects relating to health care supply research each year since 2005. The funding initiative covers a period of six years. The delegates voted to extend support for the

German Medical Association's initiative. A conceptual draft of the follow-up initiative is to be elaborated by the next German Medical Assembly meeting.

The new (Model) Regulation on Post-graduate Medical Education was also on the agenda. In Germany, post-graduate medical education falls under the jurisdiction of the 17 state chambers of physicians (SCP). The Model Regulation on Post-graduate Medical Education is a proposal submitted to the state chambers of physicians to ensure a certain degree of harmonisation, and the SCPs are not bound to accept it. The state chambers of physicians and professional groups were involved in the drafting of the proposed Regulation on Post-graduate Medical Education to ensure that it was up-to-date. Evaluation of post-graduate medical education was another topic of discussion in Dresden. Post-graduate education teachers and students were asked about their experiences in a survey conducted according to a Swiss model. The German Medical Association hopes that these efforts will help to achieve higher quality continuing medical education.

“Health care provision structures should focus primarily on the medical needs of the patient. They should not be dominated by cost reduction targets,” demanded Dr. Frank-Ulrich Montgomery, Vice-President of the German Medical Association in his speech on the core theme “Patient Rights”. The German Medical Assembly is in favor of codifying the rights of patients in Germany, but does not consider a new law to be necessary. Standards on patient rights in Germany have already been developed in a number of laws, professional codes for physicians, and many years of case law. Furthermore, the German Medical Assembly ascertained that a growing “Europeanisation” of patient's rights issues was unmistakable. The proposed new regulations on patients' rights in cross-border health care provision, patient information in the pharmaceutical sector, and organ transplantation are a case in point.

In further resolutions, the German Medical Assembly called for the government to introduce anonymous health insurance for foreigners without residence permit status and to systematically implement the UN Convention on the Rights of Persons with Disabilities, among other things.

The German Medical Assembly engaged in an intensive discussion of the challenges that doctors face in their professional lives due to politics.

The 250 delegates as well as 80 international guests from 27 countries followed the discussions. In addition to the World Medical Association leadership, the presidents or representatives of many national medical associations were present in Dresden.

Several resolutions were adopted to guide the direction of policy-making in the next years, particularly that of the German Medical Association.

The Board of the GMA will take this mandate and will present the results at the 114th German Medical Assembly in the north German city of Kiel. The next president and the two vice-presidents of the GMA will be elected for a period of four years at that time.

Domen Podnar, German Medical Association, International Department

Lessons Learned from the Estonian Electronic Prescription System



Vallo Volke

The Estonians are really keen on new technologies. In Estonia it is a common practice to cast your vote in parliament elections via the internet, make your tax declaration in the internet or park your car by using a mobile phone. Thus, it is not surprising that many e-health projects have also been established in Estonia. Small population (1.34 million) makes the country a perfect place to test new innovative ideas.

However, not all of the projects have been that successful. At the beginning of 2010 a universal

electronic prescription system was launched. The goal was to collect all prescriptions in a central database, so that to make all currently or previously active prescriptions of the patient easily accessible to doctors and pharmacists. Despite the fact that the new system has suffered from frequent technical problems and has not yet gained the planned dominance, it is time to share the experience of doctors after using the system for half a year.

Strong points of the new system

The central database gives a clear and quick overview of the drugs used by the patient. Thus, unnecessary or potentially dangerous drugs or drug combinations can be easily identified and stopped. As currently only about 50% of prescriptions are made electronically, the full advantage for the patients is yet to be seen.

The majority of drugs are used chronically by patients. The electronic system makes the renewal of the prescription a one click procedure for the doctor.

Occasionally, it may be very useful to have a possibility to make prescription while the patient is not present in your office. However,

er, there is also a risk that some doctors may abuse the possibility and prescribe without seeing the patient.

Problems and limitations

When relying on a universal electronic system, the technical functioning of the system must be guaranteed. Unfortunately, the Estonian system has had major blackouts during the so-called rush-hours;

From the patient point of view, not having a paper prescription makes it harder to recall when the renewal of prescription is needed;

Protecting patient confidentiality is always an issue with electronic systems;

With older patients it is common that someone else buys the drugs prescribed. In such a situation the traditional prescription is actually more reliable. To make a purchase for someone else by using electronic prescription in Estonia you have to present your ID card and you need to know the social security code of the patient. I am not completely convinced that it is a safe and reliable practice.

What went wrong with the project?

The electronic prescription system project was led by the Estonian Health Insurance Fund and it is part of a bigger e-health initiative in the Estonian healthcare. The vast

majority of the problems seem to derive from inadequate involvement of key partners, namely doctors and pharmacists. The importance of the involvement of doctors in every step of the project development could not be overestimated.

All in all -- how satisfied are Estonian doctors with the electronic prescription system?

Well, the current 50% prescription rate via e-system is pretty much the answer. Hopefully, the technical problems will be solved

and the full potential of the system will be seen soon.

Useful links: Estonian Health Insurance Fund (www.haigekassa.ee)

Vallo Volke, MD, PhD, Estonian Medical Association

Bringing eye care information to those who need it most

In most low- and middle-income countries, there is a critical shortage of skilled eye care personnel - including ophthalmologists, optometrists, ophthalmic nurses and others - and a desperate need to build human resource capacity. The Community Eye Health Journal is a free publication which helps to address this need by providing up-to-date and practical eye care information to eye care personnel underserved cities, towns, villages and rural areas across the developing world and have little or no access to refresher training, libraries or the internet.

The journal is published by the International Centre for Eye Health, London School of Hygiene and Tropical Medicine, UK, and paper copies are sent free to readers in low- and middle-income countries; it is also available on CD-Rom and online at www.cehjournal.org. As of June 2010, each issue contains a continued professional development (CPD component), consisting of multiple-choice questions readers can use to test their understanding of the articles. These questions are written for us by the International Council of Ophthalmology in the style of their Advanced Examination and are relevant to the widest possible range of readers.

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How you can help: We know that many eye care workers do not yet know about this free resource. If you have ideas on how to reach them, would like to subscribe, or even wish to donate to support the journal, please visit www.cehjournal.org or write to Anita Shah, admin@cehjournal.org, International Centre for Eye Health, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, United Kingdom.

We are on Facebook (search for 'Community Eye Health Journal') and on Twitter (www.twitter.com/cehjournal) and welcome your input and feedback.

113th German Medical Assembly in Dresden



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