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# World Medical Journal



Official Journal of the World Medical Association, Inc

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- Annual General Assembly
- Climate Change: Governments Need to Hear from Medical Professionals
- Sustainable Health Financing

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Volodymyr Sydoruk "The doctor came", 1970's,  
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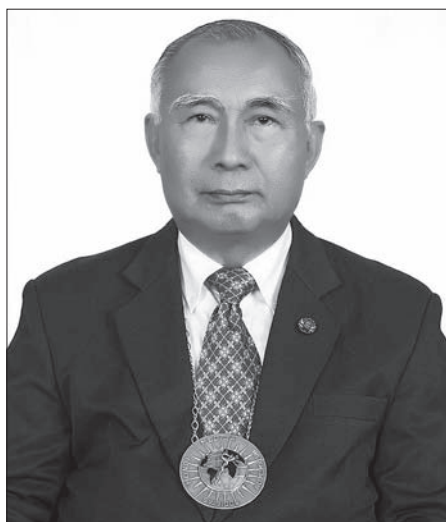
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## Message from the President of the World Medical Association

**Dr. Wonchat Subhachaturas**



*Dr. Wonchat Subhachaturas*

Dear Presidents and Ex. Com. of the NMAs., Doctors, Colleagues and friends,

It has been a great honour given to me to work for the WMA as President for the year 2010-2011 at the WMA General Assembly in Vancouver, Canada, on 15<sup>th</sup>. October 2010. It has been, as well, a great honour to the Medical Association of Thailand which occupies only 1 vote at the meeting to receive a majority one single ballot. This meant a lot to Thailand and Thai people.

Therefore, it is absolutely my responsibility, as a doctor from a small country, in Asia, to spend my all ability to shoulder this big job at the global level. I do promise that I will do my best to achieve the objectives and goal of the WMA as stated. However, this could not be a reality without good cooperation and collaboration from all of you who will carry on the most parts of our professional responsibility to make the people at every corners of this world healthy at the National level.

To achieve that goal, I propose that every NMAs should break the barrier and frontier between us. There must be no boundary in Medicine. Every NMAs should be responsible for sharing health data, health problems and bring them to the meeting and congress for discussion and find out the best suitable solution. The solution that we are making out of experience sharing may not be an absolute one for everywhere but at least it may be a principle standard or guidelines for our practices to fit the variable situation and environment in each country.

Health Information must be circulated to all NMAs by means of various communications in order that we, at every part of the world, can be aware and able to prevent the

spreading of the communicable diseases as well as to learn from each other the best way to prevent and cure the non communicable.

Case referring and sharing of the investigations using high cost technology and equipments can be done through our NMAs with the WMA Secretariat Office as a Centre of communication and resource data bank.

It is always true that doctor's rights and responsibility come together and leads to good relationship amongst the doctors and patients. Medical Ethics is the most important and standard of practices in Medical Profession which will bring in the trustfulness to all of us.

One year of Presidency is not at all long, so I invite and welcome all of your suggestions and comments to improve and benefit our WMA future development.

Thanks and looking forwards to our close relationship.

*Kind regards,  
Wonchat Subhachaturas  
MD, FRCS, FICS,  
Thailand  
President of the World Medical  
Association 2010-2011*



## The World Medical Association General Assembly

*Vancouver, British Columbia*

*October 13-16, 2010*

### Reflections by Secretary General, Canadian Medical Association



*Paul-Émile Cloutier*

The Canadian Medical Association (CMA) is very proud to have been host for the recently completed World Medical Association (WMA) General Assembly meeting. Although the meeting lasted only four days, CMA staff had been busy planning and preparing for it since 2006. Vancouver was chosen as the host city, and I think most will agree that this was a superb choice.

Staff from the CMA joined the WMA secretariat in Vancouver a week before the meetings began, and they were then joined by delegates from 50 countries. Working groups met Oct. 12, with the General Assembly itself beginning Oct. 13.

Over four days, delegates discussed and debated important and topical issues of concern to the physicians of the world, including health and the environment, the debate for which was led by Canada, violence against women and children, and the relationship between physicians and

pharmacists. Several new policies were adopted, and are outlined elsewhere in this issue of the *World Medical Journal*.

I think it is safe to say that a true feeling of camaraderie and consensus-building emerged during this meeting, particularly with respect to the issue of prescribing rights. It was very gratifying for me, as CEO of the host national medical association, to witness this very effective collaboration involving physicians from all parts of the world.

The camaraderie was also obvious at the numerous social events held during the meetings, from the opening reception at the Pan Pacific hotel to the trip across the Capilano suspension bridge and the dinner atop Grouse Mountain.

I would be remiss if I did not express the pride felt by the CMA as one of our own, Dr. Dana Hanson, gave his valedictory address at the end of his very successful year as WMA president. I would also like to thank the CMA's outgoing WMA Council representative, Dr. Ruth Collins-Nakai, for all of her hard work, and welcome our new council member, Dr. Robert Ouellet.

I would also like to give special thanks to the people I

have the pleasure of working with every day at CMA headquarters. Over the past few years they have worked tirelessly to ensure that this meeting would be successful, and I am sure you will agree that it was. In particular, I would like to thank our executive director of international affairs, Dr. Jeff Blackmer, and his team Karen Clark, Jackie Chapman-Davis, Jay Remillard, Lucie Boileau, Eve Elman, Dr. Maura Ricketts, Jill Skinner and Pat Rich.

Finally, I would like to thank you, the delegates from national medical associations around the world, for your attendance at the meeting in Vancouver. Because of your preparation, participation and friendship, this was a General Assembly to be remembered.

*Paul-Émile Cloutier,  
Secretary General and Chief Executive Officer  
Canadian Medical Association*



## The World Medical Association General Assembly

Vancouver, British Columbia October 13-16, 2010

### General Report

The 61<sup>st</sup> annual General Assembly held at The Fairmont Hotel in Vancouver, Canada, from October 13<sup>th</sup> to 16<sup>th</sup> was attended by representatives from almost 50 national medical associations.

Speaking at the opening of the ceremonial session on Friday October 15<sup>th</sup>, *His Honour the Honourable Steven Point*, Lieutenant Governor of British Columbia, said that the WMA had a global vision. He welcomed the recent movement of looking back at indigenous medical knowledge and expressed his opinion that it was absolutely crucial to try to broaden our horizons and understanding. The work of coming together was the question of our time and we had to believe that we could make a difference by doing so.

Following the Honourable Steven Point, *Dr. Jeff Turnbull*, President of the Canadian Medical Association, welcomed the WMA. He said that since the WMA was founded, the world had become not only a smaller place but, unfortunately, a more fragile one as well. He spoke about the remarkable changes in health care and revealed that the health status of Canada's poor was comparable to that of countries with a fraction of its gross domestic product. The social determinants of health still led to massive unacceptable health inequities worldwide. He remarked that these were challenges the WMA had and must continue to address.

He spoke about the myriad challenges Canada's physicians faced and said that, "We strive to provide the best care for our patients. But we face the same issues as medical professionals in other countries stress, burnout and fatigue to name a few." He noted that the medical profession in

Canada was aging, with the average age of the Canadian physician being older than the average Canadian citizen. He concluded by saying "We face having fewer physicians to meet a growing need. I believe the WMA must continue to speak out for the welfare of its members as they continue to serve their patients."

*Dr. Dana Hanson*, the 60<sup>th</sup> President of the WMA, followed and in his valedictory address, spoke about the three E's Energize, Engage, Educate. Energize the profession. Engage the public and Educate governments. "In my travels, I clearly see physicians who entered our profession for many varied reasons but all of them, all of us, have at least one common reason the vision to reach out and help those around them. In medical school we were bright, young and altruistic. But what we often see today are physicians who have stepped out of medical school into a world financial crisis, severe physician shortages, often a demanding, critical public, the loss of the golden age of antibiotics, and the erosion of self regulation to name just a few problems. Physicians are often tired and disillusioned."

He said an area of personal interest to him had been the resilient physician what could be learned from those who continued to function in situations where others could not and, from that learning, help all of them continue to serve. This is what he called energizing the profession.

*Dr. Hanson* called on physicians to engage the public in the battle to improve health. He said that financial crises often resulted in slashed health budgets and he followed with the question "But why is there no







outry by the public that the disease burden remains the same or greater?" He said that during his year as President, the WMA had highlighted health and the environment "something which, regardless of causes, will touch untold millions of people in a very real and concrete way when it comes to their health." But he asked why patients were so surprised when physicians pointed this out to them in clinics and hospitals.

These were just two examples of where the WMA had a role, in partnership with national medical associations, in engaging the public to realise that in order to address their individual concerns they must be partners with the medical profession and other healthcare professionals. He said that governments across the world had not been educated by the right people when it came to health issues. He asked why the climate change conference in Copenhagen last year had no reference to health in its final draft? Why were 80 percent of the observers 'industry' based while only a handful of healthcare representatives and environmentalists were present?

He continued by asking why governments always listen to the World Bank and the International Monetary Fund about our economic health, often to the detriment of public and individual health? Why were health systems seen as a cost centre when they had been proven to be a positive economic investment? And why, with a resurgence of infectious diseases and drug resistance, were there common drug shortages and a paucity of new drug innovation?

"Part of the answer to these vital questions is that we, along with the public, have not educated governments and industry. They have only heard part of the story. Yet the public and the medical profession together represent a powerful force that no government could oppose. The World Medical Association and national medical associations have a vital role in society not just at the bedside but indeed well beyond."

*Dr. Edward Hill*, Chair of Council, then brought to the Assembly a recommendation from the Council that President-Elect, *Dr. Ketan Desai*, who was not able to be present in Vancouver to be installed as President, be considered "disabled" and unable to carry out his duties. He proposed that *Dr. Desai's* inauguration be suspended indefinitely. This would then require an extraordinary election to elect a President for 2010/11. The recommendation was approved. In the election that followed, three candidates were nominated *Dr. Eva Bågenholm* from Sweden, *Dr. Mikhail Perelman* from Russia and *Dr. Wonchat Subhachaturas* from Thailand. All three candidates addressed the Assembly and in the voting that followed, *Dr. Subhachaturas* was elected on the first ballot.

*Dr. Subhachaturas*, President-Elect of the Medical Association of Thailand, became the first doctor from Thailand to hold the post of WMA President. He is a neurosurgeon who did his medical training in Bangkok and worked for many years at the city's Central Hospital before moving to Charoenkrung Hospital where he became Director. He was Deputy Secretary of the Bangkok Metropolitan Administration and currently works at the Thai Health Professional Alliance Against Tobacco.

Following his installation, *Dr. Subhachaturas* spoke to the Assembly about how the medical profession needs to be united. He said that even though physicians spoke different languages they were all in the same boat and rowing the same direction. With good will, they could connect with one another, with the health of the people of the world as their target goal.

At the plenary session of the Assembly the following day, *Dr. José Gomes do Amaral*, President of the Brazilian Medical Association, was elected unopposed as WMA President-Elect. He will become the third Brazilian to become President when he takes up the post at the Association's annual Assembly in Montevideo, Uruguay next year.

*Dr. Gomes do Amaral* is an anesthesiologist and specialist in critical care in São Paulo, where he works at Santa Helena Hospital. He is also Chairman of Anesthesiology and Critical Care Discipline at the Surgery Department, at Sao Paulo Federal University.

The Assembly adopted the following policy documents from the Socio-Medical Affairs Committee:

## Violence against Women and Girls

The Resolution on Violence against Women and Girls warned that this issue had become a worldwide institutionalised phenomenon and a major public health crisis. In its first policy Declaration on the issue, the WMA urged physicians and their national medical associations to pay far greater attention to the issues of female feticide, female genital mutilation, forced marriages and honour killings and to condemn gang rape as a weapon of war and a crime against humanity.

*Dr. Ruth Collins-Nakai*, Canadian Medical Association, who headed the WMA's workgroup on the issue, said: "These forms of violence reflect the persistence of gender inequalities worldwide. Physicians can be the agents of change and promote a shift of mentality for the achievement of women's human rights, their dignity and integrity." (see full text p. 224)

## Environmental Degradation

The Statement on Environmental Degradation and Sound Management of Chemicals warns that chemical contamination of the environment continues to exert harmful effects on global public health. *Dr. Hill* said "As we have seen from recent environmental disasters, the public continues to be at great risk from chemical contamination. Governments have the primary responsibility to protect the public's health from these hazards and our job as the World Medical Association, on behalf of the world's

physicians, is to highlight the human health risks and to recommend action." (see full text p. 220)

## Family Violence

The Statement on Family Violence, which revises previous WMA policy, offers proposals for increasing awareness and involvement among physicians, including the need to oppose violent practices such as dowry killings, honour killings and the practice of child marriage

(see full text p. 222)

## Medical Refugees

The Statement on Medical Care for Refugees, including Asylum Seekers, Refused Asylum Seekers and Undocumented Migrants, and Internally Displaced Persons was adopted.

(see full text p. 226)

## Physicians and Pharmacists

A revised Statement on the Relationship between Physicians and Pharmacists in Medical Therapy was adopted after a lengthy debate. At issue was a sentence in the original document that "The right to prescribe medicine should be solely the responsibility of the physician".

*Dr. Jon Snaedal*, from the Iceland Medical Association, proposed an amendment to delete those words, arguing that it ran counter to the collaboration the WMA engaged in with other health professionals who, in many countries, also had a right to prescribe under certain circumstances.

But *Dr. Frank Montgomery* from Germany supported the original wording which he said was the essence of the document. "We as physicians want for ourselves the right and the responsibility to prescribe", he said.

*Dr. Kgose Letlape* from South Africa said that if this wording was supported, in South







ARGENTINA



CHINA



AUSTRIA



HAITI



CAPE VERDE



AZERBAIJAN



BAHAMAS



CÔTE D'IVOIRE



MOZAMBIQUE



GHANA



ICELAND



SOUTH AFRICA



UKRAINE



FINLAND



ANGOLA

Africa it would condemn more than four hundred thousand people a year to HIV related deaths. South Africa had more than two million people who could not access doctors and who were dying unnecessarily from HIV and they were being treated by prescribing nurses and other health professionals.

*Dr. Ruth Collins-Nakai* from Canada said the ability to prescribe should be a competency-based decision, not an autonomy based decision. If people had the appropriate training then they had the responsibility and the obligation to prescribe. However *Dr. Pedro Nunes* from Portugal said that prescribing was the responsibility of the doctor. It would be very strange if a medical association would give up what physicians had achieved so far.

*Dr. Arie Kruseman* from the Royal Dutch Medical Association, supporting the deletion of the sentence, said there was ample evidence that specialist nurses, if properly trained, performed equally, and in some situations, even better than doctors in their treatment of certain chronic diseases. *Dr. Peter Foley* from New Zealand said the WMA must not be seen to be just protecting the physicians. They were here for their patients and healthcare was a team delivery. *Dr. Vivienne Nathanson* from the British Medical Association said that to deny access to healthcare to many people in many countries was so retrogressive that the WMA would look back in the future with great shame. The best qualified person available should be able to prescribe to people in dire need of treatment.

The Assembly eventually agreed to substitute the sentence "The right to prescribe medicine should be solely the responsibility of the physician" with "The right to prescribe medicine should be competency based and ideally the responsibility of the physician".

The revised Statement was adopted. (*see full text p. 227*)

## Drug Prescription

A Resolution on Drug Prescription was then adopted setting out principles on prescribing. (*see full text p. 228*)

## Finance and Planning

The Assembly received an oral report from the Treasurer *Prof. Jörg-Dietrich Hoppe*. It approved the Audited Financial Statement for 2009 and adopted the Budget for 2011.

## New Members

Applications for membership from the Mozambique Medical Association and the Serbian Medical Chamber were approved.



## Bylaws

The Assembly approved and adopted a consolidation and revision of the WMA Bylaws, marking the end of a year-long task related to updating and amending outdated and repetitive documents.

## Students

It was agreed that junior doctors and medical students should have their membership fees for WMA Associate Membership waived for the first five years after graduation instead of the present three years. *Dr. Hanson*, who was instrumental in encouraging this change, said this would give junior doctors an important platform within the WMA.

## Associate Members Meeting Report

It was agreed that three documents – Professional and Ethical Use of Social Media, Ethical Principles for Medical Research on Child Subjects and Physicians' Ethical Responsibilities regarding Bio Banks – be referred to Council for discussion.

## Ethical Organ Procurement

It was reported that a working group would be set up to examine organ procurement, including the issues of transplantation from executed prisoners, the commercialisation of organ transplants, presumed and other systems of consent and related issues.

## Council Report

The Council's detailed report to the Assembly about significant developments during the year referred to the WMA's involvement in the WHO global action plan on noncommunicable diseases and activities to progress the WHO Framework Convention on Tobacco Control. The Association had also been involved in the global strategy to reduce the harmful use of alcohol.

On the multi drug resistant tuberculosis project, as part of the Lilly MDR-TB partnership, the TB refresher course for physicians had been launched during the General Assembly in 2009 in Delhi. The purpose of the course was to set the baseline for basic knowledge on the subject, with the existing Multi-Drug Resistant TB course providing more advanced knowledge. The TB refresher course had been nominated by the United States Center of Disease Control as an educational highlight and had received an award. Over time, both courses would be translated into different languages. The Georgian Medical Association had offered to translate the TB refresher course for free.

To increase the outreach of its TB and MDR TB educational activities, the WMA had held a train-the-trainer course in TB and MDR-TB





in China, based on the existing training materials from the courses held in South Africa and India. In April 2010, the WMA and the Chinese Medical Association organised a third workshop in Hangshuang with the help of the Chinese Thoracic Society. Thirty leaders of TB hospitals from all over China took part in the training. The government and the provincial health department honoured the activities of the WMA and the Chinese Medical Association.

The WHO had developed a policy on ethics in the TB Setting, and launched the policy during a conference and workshop in Athens in May this year. The WMA was invited to address the issues related to health professionals in the policy and *Dr. Jeff Blackmer* from the Canadian Medical Association offered to draft this part of the policy, which addressed the duty to treat and the risks and obligations to patients. The WMA, together with the International Council of Nurses, International Hospital Federation and International Committee of the Red Cross, and in close cooperation with the WHO, organised an inter-professional workshop on Health Care Worker Safety and Infection Control in the Context of Drug Resistant TB in Benin in September. Forty-eight physicians, nurses, managers and laboratory technicians from Benin, Burkina Faso, Mali, Ivory Coast, Guinea and Senegal discussed the infection control measures in their hospitals and the challenges to improve the situation and developed ten recommendations for their TB hospitals.

On counterfeit medical products, the WMA and the members of the World Health Professions Alliance had developed the "Be Aware" toolkit for health professionals and patients to increase awareness of this topic and provide practical advice for actions to take in case of a suspected counterfeit medical products. Workshops were being organized.

A WMA workgroup on health and the environment, established in 2008, had been

involved in the global United Nations Framework Convention on Climate Change and the Association had been involved in action to reduce the global burden of mercury and the management of chemicals.

The WMA had continued its close involvement in the Positive Practice Environment Campaign, a global five-year campaign spearheaded by the World Health Professions Alliance that aimed to ensure high-quality health workplaces for quality care. The first activities on a country level started in Uganda, Morocco and Zambia. National researchers conducted studies about the working conditions of health professionals in these countries and during two-day workshops, national and local health professionals, governments and researchers developed an action plan to improve the working conditions of health professionals.

The Association had also been involved with the UN Millennium Development Goals, in workplace violence in the health sector, patient safety and with the International Rehabilitation Council for Torture Victims. It had also participated as a member of steering groups in two projects commissioned by the European Union on the mobility and migration of health professionals.

The Caring Physicians of the World project had continued with further leadership courses organised by the INSEAD Business School. The courses had been made possible by an unrestricted educational grant provided by Pfizer, Inc. During the year, Books of Hope, with the support of Pfizer, the Chinese Center of Disease Control, the Chinese Medical Doctors Association, the Chinese Association on Tobacco Control and the WMA presented a speaking book on the dangers of smoking. It targeted a low literacy community that had experienced significant increases in smoking rates over the last decades, yet could not benefit from much of the written informational products on tobacco cessation and the dangers of smoking.



The WMA had campaigned on behalf of physicians in distress worldwide.

It had sent an appeal to the President of Sudan 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. WMA members were invited to act in support of these doctors, for their immediate release and the assurance that they were not being tortured. The six doctors were subsequently released.

The WMA also wrote to the Iranian authorities concerning the cases of Dr. Arash Alaei and Dr. Kamiar Alaei who were sentenced to six and three years' imprisonment respectively, for 'cooperating with an enemy government'. But despite strong calls from the international medical and scientific community, the brothers remained in jail, more than two years after their arrest. The WMA considers them prisoners of conscience, as they appear to have been imprisoned solely in relation to their work with international and specifically US institutions in the field of HIV and AIDS prevention and treatment.

The WPHA had celebrated its 10th anniversary during the year and the four main health professions—physicians, nurses, pharmacists and dentists—had now been joined by the World Confederation for Physical Therapy. Together they had shown that working in collaboration instead of along parallel tracks, benefited both patients and health care systems. The WHPA amplified the policy and advocacy messages of member organisations and facilitated coherence and synergy among the messages of national member organisations.

The WHPA had established an expert working group on collaborative practice to search for best practice models of collaborative practice in different health care settings and different regions, to advocate for these

examples among WHPA members, and to encourage national or regional organizations to replicate these models.

## Open Session

In the session set aside for representatives to report on any issue of interest to the Assembly, *Dr. Cecil Wilson*, President of the American Medical Association, spoke about health care reform in the US. He said that not since the creation of Medicare providing insurance for senior citizens in 1965 had America witnessed such sweeping legislation. The Affordable Care Act set out to boldly reform the American healthcare system to increase access for millions, reform insurance industry practices and place new emphasis on quality and prevention, all while reducing cost. It remained to be seen whether all the items could be achieved. But it was already clear that the right goals were in place and over the coming months and years the AMA would remain involved every step of the way. They would push to correct those items the law got wrong, improve those it got right and tackle those it failed to address.

*Dr. Rudolf Henke*, a member of the Medical Council in Germany, talked about physicians' employment contracts in Germany and serious concerns relating to interference in physicians' union representation.

*Dr. Douglas Leon Natera* from the Venezuela reported on the freezing of doctors' contracts in his country. This had led to 45 per cent of doctors leaving their hospitals, 25 percent going into private practice and 15

percent to other health care professions. Now thousands of new "community doctors" were being educated with lower standards, which would create huge problems not only for the profession but for patients.

## Scientific Session

Earlier in the week the scientific session was held on the theme of "Health and the





Environment” and the keynote speaker was *Professor Sir Michael Marmot*, professor of Epidemiology and Public Health at University College, London. He spoke about the 40 year difference in life expectancy between different countries and between different regions in the same country. Environment was one reason, but social and economic factors were another. He compared the 28 year difference in the life expectancy for men living in Glasgow, Scotland with the life expectancy of men in India which is eight years longer than the life expectancy of men in the poorest parts of Glasgow.

Explaining why he was an evidence based optimist about the future, he said that being rich was not a necessity for a country to improve life expectancy. Costa Rica had a relatively low income but remarkably good health. It had abolished its military in 1948 and put the money into education, social protection, clean water and health care. Now life expectancy there was the same as in the United Kingdom, yet their gross national income was one third of that in the UK.

His conclusion was: “If we put fairness at the heart of all decision-making, health would improve and health inequities would diminish”.

*Dr. Diego Bassani*, an epidemiologist from the University of Toronto, spoke about the huge problem of indoor air quality in developing countries. He presented data on the effect of using solid fuels inside houses and said people did not realise how low the quality of air was inside the homes of most people in the world.

*Dr. Dongchun Shin*, chair of the Department of Preventive Medicine at Yonsei University College of Medicine in Seoul, Korea, spoke about the strategic approach to international chemical management and said that environmental toxic chemical exposure was now ubiquitous in our everyday life. He warned that the world was facing a big

environmental disaster which he referred to as chemical warfare. *Dr. Peter Orris*, Chief of the Occupational and Environmental Medicine Clinical Service at the University of Illinois at Chicago Medical Center, spoke about the current status of knowledge on mercury toxicity and its phasing out in health care.

*Dr. Alan Abelsohn*, a family physician in Toronto, addressed the meeting about the health impact of climate change. He talked about the science of climate change, and the direct health effects from extreme weather events which would become more evident. The indirect effects would include more air pollution, air allergens and an increase in vector borne diseases. He said that rather than bringing new diseases, climate change would change the distribution of diseases.

*Dr. Lawrence Frank*, Bombardier Chairholder in Sustainable Transportation at the University of British Columbia, spoke about the health impact of community design, focused around travel patterns. *Dr. Ray Copes*, Director of Environmental and Occupational Health at the Ontario Agency for Health Protection and Promotion in Toronto, spoke about adaptive measures at local and regional levels to mitigate the health impact of climate change.

The last two speakers were *Dr. Kue Young*, Professor and TransCanada Pipelines Chair in the Dalla Lana School of Public Health at the University of Toronto, who spoke about Health and Environment in Circumpolar Indigenous Peoples, and *Dr. Robin Walker*, Vice-President, Medicine at the IWK Health Centre in Halifax, Nova Scotia and a Professor of Paediatrics at Dalhousie University, who spoke about Child health and the environment.

## 2011 Annual General Assembly

The 2011 WMA General Assembly will be held in Montevideo, Uruguay from October 12 to 15.



## Policy Matters

Earlier in the week, a number of issues were raised during the committee meetings, which included:

### Medical Ethics Committee

#### End of Life Care

*Dr. Torunn Janbu*, Chair of the Medical Ethics Committee, reported that a document on end-of-life palliative care was being prepared by a working group for consideration at the next meeting in Sydney, Australia.

#### Use of Placebo in Medical Research

*Dr. Ramin Parsa-Parsi*, from Germany, reported on the workgroup's progress on developing a proposal for revising paragraph 32 of the Declaration of Helsinki. At the expert conference in Sao Paulo earlier in the year, the question arose regarding placebo research use in resource poor settings. *Dr. Parsa-Parsi* said another international expert conference led by the WMA would be required to resolve this and to develop a proposal for a new wording of paragraph 32. He recommended holding a conference in the summer of 2011, which Council later approved.

#### Declaration of Tokyo

An oral report was received from the workgroup considering guidance to national medical associations on how best to use the Declaration of Tokyo, which addresses physician participation in torture. *Dr. Vivienne Nathanson* from the British Medical Association said this was one of the WMA's Declarations that was cited internationally and it was important for national medical associations to have guidance on how to respond to allegations of violations of patients' health rights and physicians' professional ethics in custodial settings. A draft document would be

circulated to NMAs for consideration at the next meeting.

### Socio-Medical Affairs Committee

#### Declaration of Edinburgh

It was agreed to circulate for comment revisions to the WMA Declaration on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases.

#### Statement on Chronic Disease

It was agreed to circulate for comment a statement on the Global Burden of Chronic Disease for consideration at the next meeting.

#### Violence in the Health Sector

The Israel Medical Association presented a draft statement on Violence in the Health Workplace, arguing that it was a big problem in many countries and yet the WMA had no policy on the subject. It was agreed to circulate the document to NMAs for comment and consideration at the next meeting.

#### Social Determinants of Health

The committee recommended that a workgroup be set up to consider the social determinants of health. *Sir Michael Marmot*, President of the British Medical Association, presented a draft paper arguing that the inequalities of the health of the public should be a core concern of the medical profession and of the WMA. The recommendation was approved by the Council.

*Mr. Nigel Duncan,*  
Public Relations  
Consultant, WMA



## Statement on Environmental Degradation and Sound Management of Chemicals

### PREAMBLE

This Statement focuses on one important aspect of environmental degradation, which is environmental contamination by harmful domestic and industrial substances. It emphasizes the harmful chemical contribution to environmental degradation and physicians' role in promoting sound management of chemicals as part of sustainable development, especially in the healthcare environment.

Most chemicals to which humans are exposed come from industrial sources and include, food additives, household consumer and cosmetic products, agrochemicals, and other substances (drugs; dietary supplements) used for therapeutic purposes. Recently, attention has been concentrated on the effects of human engineered (or synthetic) chemicals on the environment, including specific industrial or agrochemicals and on new patterns of distribution of natural substances due to human activity. As the number of such compounds has multiplied, governments and international organizations have begun to develop a more comprehensive approach to their safe regulation.

While governments have the primary responsibility for establishing a framework to protect the public's health from chemical hazards, the World Medical Association, on behalf of its members, emphasizes the need to highlight the human health risks and make recommendations for further action.

### BACKGROUND

#### Chemicals of Concern

During the last half-century, the use of chemical pesticides and fertilizers dominated agricultural practice and manufacturing industries rapidly expanded their use of synthetic chemicals in the production of consumer and industrial goods.<sup>1</sup> The greatest concern relates to chemicals, which persist in the environment, have low rates of degradation, bio-accumulate in human and animal tissue (concentrating as they move up the food chain), and which have significant harmful impacts on human health and the environment (particularly at low concentrations).<sup>2</sup> Some naturally occurring metals including lead, mercury, and cadmium have industrial sources and are also of concern. Advances in environmental health research including environmental and human sampling and measuring

techniques, and better information about the potential of low dose human health effects have helped to underscore emerging concerns.

Health effects from chemical emissions can be direct (occurring as an immediate effect of the emission) or indirect. Indirect health effects are caused by the emissions' effects on water, air and food quality as well as the alterations in regional and global systems, such as red tide in many oceans, and the ozone layer and the climate, to which the emissions may contribute.

### National and International Actions

The model of regulation of chemicals varies widely both within and between countries, from voluntary controls to statutory legislation. It is important that all countries move to a coherent, standardized national legislated approach to regulatory control. Furthermore, international regulations must be coherent such that developing countries will not be forced by economic circumstances to circumvent potentially weak national regulations. An example of a legislative framework can be found at <http://ec.europa.eu/environment/chemicals/index.htm>.

Synthetic chemicals include all substances that are produced by, or result from, human activities including industrial and household chemicals, fertilizers, pesticides, chemicals contained in products and in wastes, prescription and over-the-counter drug products and dietary supplements, and unintentionally produced byproducts of industrial processes or incineration, like dioxins. Furthermore, nanomaterials, in some circumstances, can be regulated by synthetic chemicals regulations but in other cases, may need explicit regulation.

### Notable International Agreements on Chemicals

Several notable agreements on chemicals exist. These were prompted by the first United Nations Conference on the Human Environment declaration in 1972 (Stockholm) on the discharge of toxic substances into the environment.<sup>3</sup> These agreements include the 1989 Basel Convention to control/prevent trans-boundary movements of hazardous wastes, the 1992 Rio Declaration on Environment and Development, the 1998 Rotterdam Convention on informed consent and shipment of hazardous substances, and the 2001 Stockholm Convention on Persistent Organic Pollutants.<sup>4,5,6</sup> It should be noted that little information is available on the efficacy of the controls.

### Strategic Approach to International Chemicals Management

Worldwide hazardous environmental contamination persists despite these agreements, making a more comprehensive approach



to chemicals essential. Reasons for ongoing contamination include persistence of companies, absolute lack of controls in some countries, lack of awareness of the potential hazards, inability to apply the precautionary principle, non-adherence to the various conventions and treaties and lack of political will. The Strategic Approach to International Chemicals Management (SAICM) was adopted in Dubai, on February 6, 2006 by delegates from over 100 governments and representatives of civil society. This is a voluntary global plan of action designed to assure the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that minimize significant adverse effects on human health and the environment. The SAICM addresses both agricultural and industrial chemicals, covers all stages of the chemical life cycle of manufacture, use and disposal, and includes chemicals in products and in wastes.<sup>7</sup>

## WORLD MEDICAL ASSOCIATION (WMA) RECOMMENDATIONS

Despite these national and international initiatives, chemical contamination of the environment due to inadequately controlled chemical production and usage continues to exert harmful effects on global public health. Evidence linking some chemicals to some health issues is strong, but there is not evidence for all chemicals, especially newer or nano materials, particularly at low doses over long periods of time. Physicians and the healthcare sector are frequently required to make decisions concerning individual patient and the public as a whole based on existing data. Physicians therefore caution that they, too, have a significant role to play in closing the gap between policy formation and chemicals management and in reducing risks to human health.

### The World Medical Association recommends that:

#### ADVOCACY

- National Medical Associations (NMAs) advocate for legislation that reduces chemical pollution, reduces human exposure to chemicals, detects and monitors harmful chemicals in both humans and the environment, and mitigates the health effects of toxic exposures with special attention to vulnerability during pregnancy and early childhood.
- NMAs urge their governments to support international efforts to restrict chemical pollution through safe management, or phase out and safer substitution when unmanageable (e.g. asbestos), with particular attention to developed countries aiding developing countries to achieve a safe environment and good health for all.
- NMAs facilitate better communication between government ministries/departments responsible for the environment and public health.

- Physicians and their medical associations advocate for environmental protection, disclosure of product constituents, sustainable development, and green chemistry within their communities, countries and regions.
- Physicians and their medical associations should support the phase out of mercury and persistent bioaccumulative and toxic chemicals in health care devices and products.
- Physicians and their medical associations should support legislation to require an environmental and health impact assessment prior to the introduction of a new chemical or a new industrial facility.
- Physicians should encourage the publication of evidence of the effects of different chemicals and dosages on human health and the environment. These publications should be accessible internationally and readily available to media, non-governmental organizations (NGOs) and concerned citizens locally.
- Physicians and their medical associations advocate for the development of effective and safe systems to collect and dispose of pharmaceuticals that are not consumed.
- Physicians and their medical associations should support efforts to rehabilitate or clean areas of environmental degradation based on a "polluter pays" and precautionary principles and ensure that moving forward, such principles are built into legislation.
- The WMA, NMAs and physicians should urge governments to collaborate within and between departments to ensure coherent regulations are developed.

## LEADERSHIP

### The WMA:

- Supports the goals of the Strategic Approach to International Chemicals Management (SAICM), which promotes best practices in the handling of chemicals by utilizing safer substitution, waste reduction, sustainable non-toxic building, recycling, as well as safe and sustainable waste handling in the health care sector.
- Cautions that these chemical practices must be coordinated with efforts to reduce green house gas emissions from health care to mitigate its contribution to global warming.
- Urges physicians, medical associations and countries to work collaboratively to develop systems for event alerts to ensure that health care systems and physicians are aware of high-risk industrial accidents as they occur, and receive timely accurate information regarding the management of these emergencies.
- Urges local, national and international organizations to focus on sustainable production, safer substitution, green safe jobs, and consultation with the health care community to ensure that damaging health impacts of development are anticipated and minimized.
- Emphasizes the importance of the safe disposal of pharmaceuticals as one aspect of health care's responsibility and the need for

collaborative work in developing best practice models to reduce this part of the chemical waste problem.

- Encourages environmental classification of pharmaceuticals in order to stimulate prescription of environmentally less harmful pharmaceuticals.
- Encourages ongoing outcomes research on the impact of regulations and monitoring of chemicals on human health and the environment.

### The WMA recommends that Physicians;

- Work to reduce toxic medical waste and exposures within their professional settings as part of the World Health Professional Alliance's campaign for Positive Practice Environments.
- Work to provide information on the health impacts associated with exposure to toxic chemicals, how to reduce patient exposure to specific agents and encourage behaviours that improve overall health.
- Inform patients about the importance of safe disposal of pharmaceuticals that are not consumed.
- Work with others to help address the gaps in research regarding the environment and health (i.e., patterns and burden of disease attributed to environmental degradation; community and household impacts of industrial chemicals; the most vulnerable populations and protections for such populations).

## PROFESSIONAL EDUCATION & CAPACITY BUILDING

### The WMA recommends that:

- Physicians and their professional associations assist in building professional and public awareness of the importance of the environment and global chemical pollutants on personal health.
- National Medical Associations (NMAs) and physician professional associations develop tools for physicians to help assess their patients' risk from chemical exposures.
- Physicians and their professional associations develop locally appropriate continuing medical education on the clinical signs, diagnosis and treatment of diseases that are introduced into communities as a result of chemical pollution and exacerbated by climate change.
- Environmental health and occupational medicine should become a core theme in medical education. Medical schools should encourage in the training of sufficient specialists in environmental health and occupational medicine.

### References

1. Wiser G, Center for International Environmental Law, UNEP Forum, Sept. 2005
2. <http://www.unep.org/hazardoussubstances/Introduction/tabid/258/language/en-US/Default.aspx>

3. <http://www.unep.org/Documents.Multilingual/Default.asp?DocumentID=97&ArticleID=1503&cl=en>
4. <http://www.unep.org/Documents.Multilingual/Default.asp?DocumentID=78&ArticleID=1163>
5. Wiser G, Center for International Environmental Law, UNEP Forum, Sept. 2005
6. <http://chm.pops.int/Convention/tabid/54/language/en-US/Default.aspx>
7. <http://www.chem.unep.ch/saicm/SAICM%20texts/SAICM%20documents.htm>

## Statement on Family Violence

Adopted by the 48<sup>th</sup> General Assembly Somerset West, Republic of South Africa, October 1996, editorially revised at the 174<sup>th</sup> Council Session, Pilanesberg, South Africa, October 2006 and amended by the WMA General Assembly, Vancouver, Canada, October 2010

### Preamble

Recalling the World Medical Association Declaration of Hong Kong on the Abuse of the Elderly and the World Medical Association Statement on Child Abuse and Neglect, and profoundly concerned with violence as a public health issue, the World Medical Association calls upon National Medical Associations to intensify and broaden their efforts to address the universal problem of family violence.

Family violence is a term applied to physical and/or emotional mistreatment of a person by someone in an intimate relationship with the victim. The term includes domestic violence (sometimes referred to as partner, spouse, or wife battering), child physical abuse and neglect, child sexual abuse, maltreatment of older people, and many cases of sexual assault. Family violence can be found in every country in the world, cutting across gender and all racial, ethnic, religious and socio-economic lines. Although case definitions vary from culture to culture, family violence represents a major public health problem by virtue of the many deaths, injuries, and adverse psychological consequences that it causes. The physical and emotional harm may represent chronic or even lifetime disabilities for many victims. Family violence is associated with increased risk of depression, anxiety, substance abuse, and self-injurious behaviour, including suicide. Victims often become perpetrators or become involved in violent relationships later on. Although the focus of this document is the welfare of the victim, the needs of the perpetrator should not be overlooked.

Although the causes of family violence are complex, a number of contributing factors are known. These include poverty, unemployment, other exogenous stresses, attitudes of acceptance of violence for dispute resolution, substance abuse (particularly alcohol), rigid gender roles, poor parenting skills, ambiguous family roles,

unrealistic expectations of other family members, interpersonal conflicts within the family, actual or perceived physical or psychological vulnerability of victims by perpetrators, perpetrator pre-occupation with power and control, and familial social isolation, among others.

## Position

There is a growing awareness of the need to think about and take action against family violence in a unified way, rather than focusing on the particular type of victim or community affected. In many families where partner battering occurs, for example, there may be abuse of children and/or of older people as well, often carried out by a single perpetrator. In addition, there is substantial evidence that children who are victimized or who witness violence against others in the family are later at increased risk as adolescents or adults of being re-victimized and/or becoming perpetrators of violence themselves. Finally, more recent data suggest that victims of family violence are more likely to become perpetrators of violence against non-intimates as well. All of this suggests that each instance of family violence may have implications not only for further family violence, but also for the broader spread of violence throughout a society.

Physicians and NMAs should oppose violent practices such as dowry killings and honour killings.

Physicians and NMAs should oppose the practice of child marriage.

Physicians have important roles to play in the prevention and treatment of family violence. Of course they will manage injuries, illnesses, and psychiatric problems deriving from the abuse. The therapeutic relationships physicians have with patients may allow victims to confide in them about current or past victimization. Physicians should inquire about violence routinely, as well as when they see particular clinical presentations that may be associated with abuse. They can help patients to find methods of achieving safety and access to community resources that will allow protection and/or intervention in the abusive relationship. They can educate patients about the progression and adverse consequences of family violence, stress management and availability of relevant mental health treatment, and parenting skills as ways of preventing the violence before it occurs. Finally, physicians as citizens and as community leaders and medical experts can become involved in local and national activities designed to decrease family violence.

Physicians recognise that victims of violence may find it difficult to trust their physician at first. Physicians must be prepared to develop a trusting relationship with their patient over time until s/he is ready to accept advice, help and intervention.

## Recommendations

The World Medical Association recommends that National Medical Associations adopt the following guidelines for physicians:

- All physicians should receive adequate training in the medical, sociological, psychological and preventive aspects of all types of family violence. This would include medical school training in the general principles, specialty-specific information during post-graduate training, and continuing medical education about family violence. Trainees must receive adequate instruction in the role of gender, power and other issues of family dynamics in contributing to family violence. The training should also include adequate collecting of evidence, documentation and reporting in cases of abuse.
- Physicians should know how to take an appropriate and culturally sensitive history of current and past victimization.
- Physicians should routinely consider and be sensitive to signs indicating the need for further evaluations about current or past victimization as part of their general health screen or in response to suggestive clinical findings.
- Physicians should be encouraged to provide pocket cards, booklets, videotapes, and/or other educational materials in reception rooms and emergency departments to offer patients general information about family violence as well as to inform them about local help and services.
- Physicians should be aware of social, community and other services of use to victims of violence, and refer to and use these routinely.
- Physicians have the obligation to consider reporting to appropriate protection services suspected violence against children and other family members without legal capacity.
- Physicians should be acutely aware of the need for maintaining confidentiality in cases of family violence.
- Physicians should be encouraged to participate in coordinated community activities that seek to reduce the amount and impact of family violence.
- Physicians should be encouraged to develop non-judgemental attitudes toward those involved in family violence so their ability to influence victims, survivors and perpetrators is enhanced. For example, the behaviour should be judged but not the person.
- National Medical Associations should encourage and facilitate coordination of action against family violence between and among components of the health care system, criminal justice systems, law enforcement authorities, family and juvenile courts, and victims' services organizations. They should also support public awareness and community education.
- National Medical Associations should encourage and facilitate research to understand the prevalence, risk factors, outcomes and optimal care for victims of family violence.



## Resolution on Violence against Women and Girls

Violence is a worldwide, institutionalised phenomenon, and a complex issue, which includes many manifestations. The nature of the violence experienced by victims is at least partly dependent upon the social, cultural, political and economic contexts within which the victims and their abusers live. Some violence is deliberate, systematic and widespread while others will experience it in covert circumstances; this is especially true of domestic violence in settings where women enjoy legislated equal and protected rights to those of men but culturally still have an increased likelihood of experiencing life-threatening domestic violence.

There is clear evidence in most countries that men can be and are often the victims of violence, including intimate partner violence. They are also statistically far more likely to be the victims of random violence on the streets. Research shows that while men frequently experience such events, they are not associated with systemic abuse in terms of denial of rights, which makes the experience of women so much worse in many cultures. Nothing in this paper suggests that violence against men including boys should be condoned. Actions to protect women and girls are likely to reduce everyone's experience of violence.

### Defining violence

Definitions of violence vary (see footnote), but it is essential that the various forms violence may take are recognised by policy makers. Violence against women and girls includes violence within the family, within the community and violence perpetrated by (or condoned by) the state. Many excuses are given for violence generally and specifically; in cultural and societal terms these include tradition, beliefs, customs, values and religion. Although rarely cited the traditional power differential between men and women is also a major cause.

Within the family and domestic settings violence includes the denial of rights and freedoms enjoyed by boys and men. This includes female feticide and infanticide, systematic and deliberate neglect of girls, including poor nutrition and denial of educational opportunities<sup>1</sup> as well as direct physical, psychological and sexual violence. Specific cultural practices that harm women, including female genital mutilation, forced marriages, dowry attacks and so-called "honour" killings are all practices that may occur within the family setting.

Within society, attitudes towards rape, sexual abuse and harassment, intimidation at work or in education, modern slavery, trafficking and forced prostitution, are all forms of violence condoned by

some societies. One extreme form of such violence is sexual violence used as a weapon of war. In several recent conflicts (e.g. the Balkans, Rwanda) rape was both associated with ethnic cleansing and specifically, in some cases, used to introduce widespread AIDS into a community. The ICRC has examined this issue, and recognises that sexual violence of this sort may be commonly perpetrated against women and girls.<sup>2</sup>

Sexual violence or the threat of it can also be used against men, but culturally, women are more vulnerable and more likely to be targeted. Current conflicts are not based upon battles fought in far away places, but are increasingly concentrated around dense centres of population increasing the exposure of women to soldiers and armed groups. In war and in immediate post-conflict situations, societal fabric can collapse, making women increasingly vulnerable to group attacks.

Lack of economic independence, and of basic education, also mean that women who survive abuse are more likely to be or to become more dependent upon the state or society and less able to support themselves and contribute to that society. Biologically and behaviourally, women are likely to outlive men; denial of the opportunity to be economically independent leaves society with a cohort of older, economically dependent women.

All these forms of violence may be condoned by the state, or it may remain silent on them, refusing to condemn or act against them. In some cases the state may legislate to allow violent practices (for example rape within marriage) and itself become a perpetrator.

All human beings enjoy certain fundamental human rights; the examples listed above of violence against women and girls involve denial of many of those rights, and each abuse can be examined against the UN convention on human rights (and for children the Convention on the Rights of the Child).<sup>3</sup>

In health terms, the denial of rights and the violence itself have health consequences to the girls and women and to the society of which they are a part. In addition to the specific and direct physical and health consequences, the general way in which girls and women are treated can lead to an excess of mental health problems; suicide is the second leading cause of premature death in women.

### Consequences of Violence

The direct health consequence of the violence depends upon the nature of the act. Female genital mutilation for example may kill the woman at the time of infliction, may lead to difficulty in voiding the body of waste products including those of menses, and will give rise to difficulties in childbearing. It also reinforces the ideological concept of women as the possessions of men (on its own, a form of abuse) who

control their sexuality. Gang rape or other forms of sexual violence may result in long-term gynaecological, urological and intestinal difficulties including the development of fistulae and incontinence, which further diminishes societal support for the abused female.

The short and long term mental health consequences of violence may severely influence later wellbeing, enjoyment of life, function in society and the ability to provide appropriate care for dependants.

Gathering evidence is an important role for doctors. Currently many countries do not have mandatory registration of all births, making evidence about infanticide or the effects of neglect difficult to document. Equally, some countries allow marriage at any age, exposing girls to the high risks associated with childbearing before their own bodies are fully mature, let alone the mental health risks involved. The health consequences of such policies and their relationship to other health costs must be better documented.

Denial of good nutritional opportunities leads to generations of women with poorer health, poorer growth and development leading to women who are less fit to survive pregnancy and childbirth or to rear their families. Denial of educational opportunities leads to poorer health for all the family members; good education is a major factor in the mother providing optimal care for all her family. In addition to being wrong in and of itself, violence against women is also socially and economically damaging to the family and to society. There are direct and indirect economic consequences to violence against women that are far greater than the direct health sector costs.

The costs and consequences of violence, including neglect, against women have been reported in many fora including by WHO<sup>4</sup>. The health consequences to the women, their children and thus to society are clear and need to be made explicit to policy makers.

## WHAT CAN THE WMA DO?

The WMA has a number of policies on violence including the WMA Statement on Violence and Health and the WMA Statement on Family Violence. This current (Statement/resolution/ declaration) brings some of these policies together with a coordinated set of action points for the WMA, NMAs and individual physicians.

As most human beings look first for the advantages to themselves, their families and their societies in enabling change, making the benefits of change obvious from the beginning creates a “win:win” solution. Concentrating first on the health aspects, for women, their children, and the broad family is therefore a useful way to enter the debate.

Doctors have a unique insight into the combined effects upon wellbeing of social, cultural, economic and political environments. If all

persons are to achieve health and wellbeing, all these factors need to operate positively. The holistic view from doctors can be used to influence society and politicians. Gaining societal support for improving the rights, freedom and status of women is essential.

## ACTIONS

### The WMA:

- Asserts that violence is not only about physical, psychological and sexual violence but includes abuses such as harmful cultural and traditional practices, and actions such as complicity in trafficking of women, and is a major public health crisis.
- Recognizes the linkage between better education and other rights for women with family and societal health and wellbeing and emphasizes that equality in civil liberties and human rights is a health issue.
- Will prepare briefing and advocacy materials for NMAs to use with national governments and intergovernmental groups addressing the health and wellbeing implications of discrimination against women and girls, including adolescents. This material will include relevant references about the impact of violence on family wellbeing and on societal financial sustainability
- Will work with others to prepare and distribute to physicians and other health workers briefing and advocacy materials dealing with harmful traditional and cultural practices, including female genital mutilation, dowry, and honour killings, and emphasizing the health impact as well as the violations of human rights.
- Prepare practical examples of the impact of violence and strategies for reducing it, such as consensus guidelines that are based upon the best available evidence.
- Will advocate at WHO, other UN agencies and elsewhere for ending discrimination and violence against women.
- Will work with others to prepare templates of educational materials for use by individual practitioners for documenting and reporting individual cases of abuse.
- Encourages others to develop free educational materials online to provide guidance to front line health care workers on abuse and its effects, and on prevention strategies.
- Encourage legislation that classifies gang rape used as a weapon of war as a crime against humanity that is eligible for litigation through the jurisdiction of the International Criminal Court system.

### NMAs should:

- Use and promote the available materials on preventing and treating the consequences of violence against women and girls and act as advocates within their own country.
- Seek to ensure that those devising and delivering education to doctors and other health care workers are aware of the likelihood of exposure to violence, its consequences, and the evidence on

preventative strategies that work, and place appropriate emphasis on this in undergraduate, graduate and continuing education of health care workers.

- Recognise the importance of more complete reporting of the sequelae of violence and encourage the development of training that emphasises violence awareness and prevention, in addition to using better reporting and research into incidence, prevalence and health impact of all forms of violence.
- Encourage medical journals to publish more of the research on the complex interactions in this area, thus keeping it in the professions' awareness and contributing to the development of a solid research base and ongoing documentation of types and incidence of violence.
- Encourage medical journals to consider publishing theme issues on violence including neglect of women and girls.
- Advocate for universal registration of births, and a higher age limit for marriage.
- Advocate for effective implementation of universal human rights.
- Advocate for parental education and support on the care, nurturing, development, education and protection of children, especially girls.
- Advocate for the monitoring of statistics on children, including both positive and negative indicators of health and well-being, and social determinants of health.
- Advocate for legislation against specific harmful practices including female feticide, female genital mutilation, forced marriage, and corporal punishment.
- Advocate for the criminalisation of rape in all circumstances including within marriage.
- Condemn the use of gang rape as a weapon of war and work with others to document and report it.
- Advocate for the development of research data on the impact of violence and neglect upon primary and secondary victims and upon society, and for increased funding for such research.
- Advocate for the protection of those who speak out against abuse, including physicians and other health workers.

## Physicians should:

- Use the material developed for their education to better inform themselves about the effects of abuse and the successful strategies for prevention.
- Provide health care and protection to children, (especially in times of crisis) and document and report all cases of violence against children, taking care to safeguard the patient's privacy as much as possible.
- Treat and reverse, where possible, the complications and adverse effects of female genital mutilation and refer the patient for social support services.
- Oppose the publication or broadcast of victims' names, addresses or likenesses without the explicit permission of the victim.

- Assess for risk of family violence in the context of taking a routine social history.
- Be alert to the association between current alcohol or drug dependence among women and a history of abuse.
- Support colleagues who become personally involved in work to end abuse.
- Work to establish the necessary relationship of trust with abused women and children including respect for confidentiality.

Support global and local action to better understand the health consequences both of abuse and of the denial of rights, and advocate for increased services for victims.

## References

1. At first glance neglect does not seem to equate with violence. But the acceptance of neglect and the lesser rights given to women and girls are major factors in reinforcing an acceptance of causal and systematic violence. In that it denies basic rights, many would classify neglect as a form of violence in and of itself.
2. Rape is considered to be a method of warfare when armed forces or groups use it to torture, injure, extract information, degrade, displace, intimidate, punish or simply to destroy the fabric of the community, The mere threat of sexual violence can cause entire communities to flee their homes. from Women and War, ICRC 2008
3. Women's Health and Human Rights: the Promotion and Protection of Women's Health through International Human Rights Law. Rebecca Cook. Presented at the 1999 Adapting to Change Core Course
4. Women and Health: Today's Evidence, Tomorrow's Agenda. WHO November 2009. ISBN 978 92 4 156385 7

## Statement on Medical Care for Refugees, including Asylum Seekers, Refused Asylum Seekers and Undocumented Migrants, and Internally Displaced Persons

Adopted by the 50<sup>th</sup> World Medical Assembly Ottawa, Canada, October 1998, reaffirmed by the WMA General Assembly, Seoul, Korea, October 2008 and amended by the WMA General Assembly, Vancouver, Canada, October 2010

## PREAMBLE

International and civil conflicts as well as poverty and hunger result in large numbers of refugees, including asylum seekers, refused asylum seekers and undocumented migrants, as well as internally displaced persons (IDPs) in all regions. These persons are among the most vulnerable in society.

International codes of human rights and medical ethics, including the WMA Declaration of Lisbon on the Rights of the Patient,



declare that all people are entitled without discrimination to appropriate medical care. However, national legislation varies and is often not in accordance with this important principle.

## STATEMENT

Physicians have a duty to provide appropriate medical care regardless of the civil or political status of the patient, and governments should not deny patients the right to receive such care, nor should they interfere with physicians' obligation to administer treatment on the basis of clinical need alone.

Physicians cannot be compelled to participate in any punitive or judicial action involving refugees, including asylum seekers, refused asylum seekers and undocumented migrants, or IDPs or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation.

Physicians must be allowed adequate time and sufficient resources to assess the physical and psychological condition of refugees who are seeking asylum.

National Medical Associations and physicians should actively support and promote the right of all people to receive medical care on the basis of clinical need alone and speak out against legislation and practices that are in opposition to this fundamental right.

## Statement on the Relationship between Physicians and Pharmacists in Medicinal Therapy

Adopted by the 51<sup>st</sup> World Medical Assembly Tel Aviv, Israel, October 1999 and amended by the WMA General Assembly, Vancouver, Canada, October 2010

### INTRODUCTION

The goal of pharmacological treatment is to improve patients' health and quality of life. Optimal pharmacological treatment should be safe, effective and efficient. There should be equity of access to this kind of treatment and an accurate and up-to-date information base that meets the needs of patients and practitioners.

Pharmacological treatment has become increasingly complex, often requiring the input of a multi-disciplinary team to administer and monitor the chosen therapy. In the hospital setting the inclusion of

a clinical pharmacist in such a team is increasingly common and helpful. The right to prescribe medicine should be competency based and ideally the responsibility of the physician.

Physicians and pharmacists have complementary and supportive responsibilities in achieving the goal of providing optimal pharmacological treatment. This requires communication, respect, trust and mutual recognition of each other's professional competence. Access by both physicians and pharmacists to the same accurate and up-to-date information base is important to avoid providing patients with conflicting information.

Physicians and pharmacists must provide quality service to their patients and ensure safe use of drugs. Therefore collaboration between these professions is imperative, including with respect to the development of training and in terms of information sharing with one another and with patients. It is necessary to keep an open and continued dialogue between physicians' and pharmacists' representative organizations in order to define each profession's respective functions and promote the optimal use of drugs within a framework of transparency and cooperation, all in the best interests of patients.

### THE PHYSICIAN'S RESPONSIBILITIES

Diagnosing diseases on the basis of the physician's education and specialized skills and competence.

Assessing the need for pharmacological treatment and prescribing the corresponding medicines in consultation with patients, pharmacists and other health care professionals, when appropriate.

Providing information to patients about diagnosis, indications and treatment goals, as well as action, benefits, risks and potential side effects of pharmacological treatment. In the case of off-label prescriptions the patient must be informed about the character of the prescription.

Monitoring and assessing response to pharmacological treatment, progress toward therapeutic goals, and, as necessary, revising the therapeutic plan in collaboration with pharmacists, other health professionals and, when appropriate, caregivers.

Providing and sharing information in relation to pharmacological treatment with other health care practitioners.

Leading the multi-disciplinary team of health professionals responsible for managing complex pharmacological treatment.

Maintaining adequate records for each patient, according to the need for therapy and in compliance with legislation respecting confidentiality and protecting the patient's data.

Where practically possible, actively participating in establishing electronic drug delivery systems within their workplace and supporting those systems with their professional knowledge.

Maintaining a high level of knowledge of pharmacological treatment through continuing professional development.

Ensuring safe procurement and storage of medicines that the physician is required to supply or permitted to dispense.

Reviewing prescription orders to identify interactions, allergic reactions, contra-indications and therapeutic duplications.

Reporting adverse reactions to medicines to health authorities, in accordance with national legislation.

Monitoring and limiting, where appropriate, prescriptions of medications that may have addictive properties.

Documenting adverse reactions to medicines in the patient's medical record.

## THE PHARMACIST'S RESPONSIBILITIES

Ensuring safe procurement, adequate storage and dispensing of medicines in compliance with the relevant regulations.

Providing information to patients, which may include the information leaflet, name of the medicine, its purpose, potential interactions and side effects, as well as correct usage and storage.

Reviewing prescription orders to identify interactions, allergic reactions, contra-indications and therapeutic duplications. Concerns should be discussed with the prescribing physician but the pharmacist should not change the prescription without consulting the prescriber.

Discussing medicine-related problems or concerns with regard to the prescribed medicines when appropriate and when requested by the patient.

Advising patients, when appropriate, on the selection and the use of non-prescription medicines and the patient's management of minor symptoms or ailments. Where self-medication is not appropriate, advising patients to consult their physician for diagnosis and treatment.

Participating in multi-disciplinary teams concerning complex pharmacological treatment in collaboration with physicians and other health care providers, typically in a hospital setting.

Reporting adverse reactions to medicines to the prescribing physician and to health authorities in accordance with national legislation.

Providing and sharing general as well as specific medicine-related information and advice with the public and health care practitioners.

Maintaining a high level of knowledge of pharmacological treatment through continuing professional development.

## CONCLUSION

The patient will best be served when pharmacists and physicians collaborate, recognizing and respecting each other's roles, to ensure that medicines are used safely and appropriately to achieve the best outcome for the patient's health.

## Resolution on Drug Prescription

Adopted by the WMA General Assembly, Vancouver, Canada, October 2010

### PREAMBLE

From the beginning of their studies and throughout their professional careers, doctors acquire the knowledge, training and competence required to treat their patients with the utmost skill and care.

Physicians determine the most accurate diagnosis and the most effective treatment to cure illness, or alleviate its effects, taking into consideration the overall condition of the patient.

Pharmaceutical products are often an essential part of the treatment approach. In order to make the right decisions in accordance with the ethical and professional principles of medical practice, the doctor must have a thorough knowledge and understanding of the principles of pharmacology and possible interactions among different drugs and their effects on the health of the patient.

The prescribing of medication is a significant clinical intervention, which should be preceded by multiple, integrated processes to assess the patient and determine the correct clinical diagnosis. These processes include:

- Taking a history of the current condition and past medical history;
- The ability to make differential diagnosis;
- Understanding any multiple chronic and complex illnesses involved;



- Taking a history of the medications currently being administered successfully or previously withdrawn and also being aware of possible interactions.

Inappropriate drug prescription without proper knowledge and accurate diagnosis may cause serious adverse effects on the patient's health. In view of the possible serious consequences that may result from an inappropriate therapeutic decision, the WMA affirms the following principles on high quality treatment and ensuring patient safety:

## PRINCIPLES

Prescription of drugs should be based on a correct diagnosis of the patient's condition and should be performed by those who have successfully completed a curriculum on disease mechanisms, diagnostic methods and medical treatment of the condition in question.

Prescriptions issued by physicians are vital for ensuring patient safety, which in turn is critical for maintaining the relationship of trust between patients and their physicians.

Although nurses and other healthcare workers cooperate in the overall treatment of patients, the physician is the best qualified individuals to prescribe independently. In some countries, laws may allow for other professionals to prescribe drugs under specific circumstances, generally with extra training and education and most often under medical supervision. In all cases, the responsibility for the patient's treatment must remain with the physician. Each country's medical system should ensure the protection of public interest and safety in the diagnosis and treatment of patients. If a system fails to comply with this basic framework due to social, economical or other compelling reasons, it should make every effort to improve the situation and to protect the safety of the patients.

## World Physicians Call for Inquiry into Congo Rapes

The World Medical Association added its support to worldwide calls for an immediate inquiry into allegations that more than 700 women, men and children were raped when Angola recently expelled thousands of people back to the Democratic Republic of Congo. These atrocities add to the widespread and systematic nature of rape and other human rights violations in the Congo by rebels. More than 8,000 women were raped during fighting in 2009, the UN says.

In a statement to mark the international day for the elimination of violence against women (<http://ndcommunications.hosted.phplist.com/lists/lt.php?id=NORSBk8BBkgMU1Q%3D>), the WMA's chair Dr. Edward Hill said: „The appalling allegations of rape in the Congo are a grim reminder that violence against women has become a systematic weapon of war. This is only the latest in a catalogue of similar atrocities in various parts of the world. As the WMA declared in its Statement last month this is a major public health issue and one on which physicians are calling for absolute zero tolerance.

„Today we are calling in the strongest possible terms for the perpetrators of these rapes to be prosecuted for their crimes. We urge all national medical associations to remind their members to pay far greater attention to these unacceptable violations of the most basic women's human rights.

„Physicians are in a position to document and report all cases of violence against women that come to their attention and I would urge them to do so. We must also seek to protect those who speak out against abuse, including physicians and other health professionals.”

Dr. Nkelani Matondo Norine, from the Order of Physicians of the Democratic Republic of Congo, said that the situation of abused women in the Congo was critical and required urgent attention from the international community and all organizations working for peace and human rights. Mass rape had become a weapon of destruction, much used by the enemy and many physicians were now working for women

victims in the area, including Dr. Denis Mukwege of the Panzi Hospital in Bukavu/South Kivu, specializing in the reconstitution of vaginas, which has already operated on more than mutilated 20,000 women.

She added: „In my political struggle against violence towards women, I always explain the disastrous consequences of sexual assault. It can cause lesions that can have grave consequences in the long run, such as frigidity and sterility. Sexually transmissible diseases, such as HIV, and unwanted pregnancies are other common consequences.

„Psychologically, women feel diminished and humiliated and without proper support from a psychology specialist, they fall into a deep depression. Socially, many women are abandoned by their husbands because of rape. Towards their children, they feel humiliated, in particular those violated in the presence of her children”.

Dr. Nkelani said: “the WMA and its members should put pressure on the UN to take appropriate action towards the Congolese authorities.”

## Health Day at COP16 - Doctors Say: Don't Forget the Health Dividend

Source: [http://www.noharm.org/global/news\\_hcwh/2010/dec/hcwh2010-12-06a.php](http://www.noharm.org/global/news_hcwh/2010/dec/hcwh2010-12-06a.php)

Cancun The "Cancun Climate and Health Statement" launched 6<sup>th</sup> December, 2010, Health Day at COP 16 [1], calls on negotiators to consider the "real costs" of climate change and the benefits of strong action by taking the human health dimension into account.

Endorsed by the World Medical Association [2], the International Council of Nurses and other global health organizations representing millions of health professionals worldwide [3], the Cancun Climate and Health Statement calls on the negotiators to "take into account the significant human health dimensions of the climate crisis along with the health benefits of climate change mitigation and adaptation policies."

Dr. Michael Wilks from the Standing Committee of European Doctors (CPME) [4] in announcing the Statement during a meeting of the World Health Organization [5] says: "Overwhelming evidence exists that reducing greenhouse gases benefits not just health but countries' economies. These "co-benefits" provide all those attending Cancun with a powerful and unifying new narrative - reducing greenhouse gases is good for your health, and for your budget."

One regional example of these co-benefits is recent research published by the Health and Environment Alliance and Health Care Without Harm Europe. It shows that up to an additional 30.5 billion Euros of public health benefits could be achieved each year by 2020 if the European Union adopted a policy of 30% domestic cuts in greenhouse gas emissions (instead of the current 20% target) [6].

But negotiators in Cancun are barely mentioning this health dividend to the climate

talks. "Negotiations seem focused on financial rather than human costs of climate change," says Professor Hugh Montgomery, University College London. "We want them to take into account the fact that, quite aside from any benefits from averting climate change, strong data show that low-carbon living brings with it enormous benefits to health (less cancer, heart and respiratory disease, dementia, diabetes, depressive illness) and with that comes huge savings in healthcare costs. These health gains could substantially offset the costs of mitigation and urgently need to be factored in" [7].

"Monetary estimates of public health savings do not just apply to Europe: a recent independent scientific report shows that such health and financial gains apply worldwide, and especially to countries such as India and China" [8]. "We want the even greater benefits for health in countries and regions other than Europe to be taken into account by governments and acted upon. It is high time for governments to realize that reducing greenhouse gas emissions will improve human health and save them money. Today - Health Day at COP 16 - we plan to take this message to delegates," says Pendo Maro, Senior Climate Change and Energy Policy Advisor, Health Care Without Harm Europe (HCWH Europe) and Health and Environment Alliance (HEAL).

### Contacts

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### Notes

1. Health Day at COP 16 has been organized to bring the health community together to highlight the benefits for public health of strong climate change to delegates. Doctors and health experts believe that this is a crucial argument for why we need to work towards a global agreement.
2. The World Medical Association is a credited observer at the UNFCCC talks. The December issue of its Journal will feature climate change. See WMA website.
3. The Cancun Climate and Health Statement is signed by ten organizations: Climate and Health Council, International Federation of Medical Students' Associations, Health and Environment Alliance, Health Care Without Harm, International Council of Nurses, International Society of Doctors for the Environment, Physicians for Social Responsibility, Standing Committee of European Doctors, World Federation of Public Health Associations, and World Medical Association. It has also been endorsed by Richard Horton, Editor, The Lancet, and Fiona Godlee, Editor, British Medical Journal. It is available in English, French and Spanish.
4. Dr. Michael Wilks, Climate Advisor and Immediate Past President of the Standing Committee of European Doctors (CPME) is part of the Health and Environment Alliance/Health Care Without Harm Europe delegation in Cancun. CPME represents 27 medical associations with approximately 1.5 million members in Europe. Other members are Pendo Maro (see above), Prof Hugh Montgomery, University College London, UK and Walter Vernon (HCWH US Board), San Francisco, USA. More about them at HEAL website and at HCWH website. The delegation is working closely with other groups in Cancun including International Federation of Medical Students' Associations (IFMSA) and Nurses Across the Borders (Nigeria).
5. The Cancun Climate and Health Statement will be announced by Dr Wilks at a World Health Organization and World Food Programme "side event" called "Improving resilience to protect human health and welfare from the adverse affects of climate



change" to be held on Monday, 6 December from 13.20 to 14.40 (Mexico time, minus 6 GMT).

6. "Acting Now for better health, A 30% reduction target for EU climate policy", HEAL and HCWH Europe, Brussels, September 2010.
7. Prof. Montgomery was one of the lead authors involved in The Lancet Series, Health and Climate Change, November 2009. One study

showed that lower carbon policies in London and New Delhi associated more "active transport" (walking and cycling), more public transport and reduced use of private cars could produce measurable benefits for heart disease, cerebro-vascular disease, dementia, breast cancer, lung cancer, colon cancer, diabetes, and depression. It was called "Public health benefits

of strategies to reduce greenhouse gas emissions: urban land transport."

8. Inter Academy Medical Panel, 2010, Statement on the health co-benefits of policies to tackle Climate Change (from Haines A, et al. (2009). Public health benefits of strategies to reduce greenhouse-gas emissions: overview and implications for policy makers. The Lancet. doi:10.1016/S0140-6736(09)61759-1.)

## Time is of the Essence to Achieve a Solution on Patients' Rights

**Commissioner Dalli addressed the High-Level Roundtable on "The Draft Directive on Patients' Rights in Cross-Border Healthcare: Moving Forward on Health Inequalities, Patients Rights, Quality, and Safety", held on 1 December 2010 at the Solvay Library, Brussels.**

Achieving final agreement on the draft Directive on Patients' Rights in Cross-Border Healthcare in the next few months will be an important step forward in codifying patients' rights in European law. While the draft Directive as it stands today is not perfect with some remaining gaps and details that need to be worked out in its key aspects the recommendation of the European Parliament has the broad support of patients and the health community.

This was the strong message from stakeholders the High-Level Roundtable organised by the European Patients' Forum under the patronage of the Belgian EU Presidency, ahead of the Council's debate on the draft Directive on 6 December 2010, and in anticipation of the draft Directive's Second Reading in the European Parliament in mid-January 2011. Indeed, some of the participants were involved in the trialogue meeting that was to take place on the evening of 1 December.

In the words of **Mr John Dalli**, Commissioner for Health and Consumers, the momentum achieved so far in the negotiations

means that "time is of the essence", and flexibility is needed to reach agreement. However, Mr Dalli reiterated that his guiding principle is "patients first", so while the Belgian Presidency and the EP can count on the European Commission's support in finding acceptable compromise solutions, "we should not lose sight of the proposed Directive's original purpose: to clarify patients' rights to access safe and good quality treatment across borders, and be reimbursed for it."

In the course of the day, most of the high-level participants at the Roundtable contributed their views as stakeholders. In addition to the Health Commissioner, they included members of the European Parliament, Commission officials, representatives of the Belgian Presidency and the Permanent Representations of Sweden, Denmark, Romania plus the Swiss negotiating team, as well as leaders of stakeholder organisations (nurses, doctors, community pharmacists, hospital, health managers, medical specialists, the pharmaceutical industry and medical devices industry).

**Mr Jo De Cock**, Head of the Belgian National Institute Health & Disability Insurance (NIHDI) stressed that the Belgian Presidency's approach to the Directive was not a simple application of the EU's internal market rules, but a sector-specific approach on the basis of high quality, equity and universality in healthcare. "The Directive

will create a momentum beneficial to all patients, not just the one or two percent of patients that would need to travel abroad", he said. He also emphasised that the debate is not just about general principles, but about practical issues that affect patients' lives and which therefore require solutions to be found.

**Mrs Françoise Grossetête, MEP**, the Rapporteur on the draft Directive, said that MEPs want to reassure the Council that the purpose of the Directive is not to promote health tourism or facilitate cross-border activity by healthcare providers what is vitally important is that it offers patients the opportunity to access healthcare that is not available to them in their own countries. In this context, she regretted the "lack of ambition" shown by some Member States, which seem willing to accept a continuation of the current system of patients seeking recourse to the courts in defence of their rights.

**Mrs Antonia Parvanova, MEP** addressed the wider topic of health inequalities. She stressed the importance of addressing the existing health inequalities across the European Union, and linked the Directive to the ongoing work by the Commission and the Parliament, including the health inequalities report now being discussed within the ENVI Committee. It is crucial to uphold the right of all patients to access good quality healthcare in their own countries, particularly in the context of the current economic climate. She finally highlighted that the Directive should be seen as a first step, which should later serve to promote a wider approach of public health initiatives at EU level.

Other key issues identified by various contributors included the following:

- The importance of *safety and quality of healthcare* is recognised by all. There appears to be agreement in principle on Member State cooperation in this area, although there is disagreement about the exact mechanisms to ensure safety and improve quality. Mr Dalli said: "I am confident that once adopted, this Directive will pave the way towards a convergence of standards in this area."
- From the patients' perspective, *upfront payment, reimbursement and prior authorisation* remain crucial. In order to ensure equity, and to prevent new inequalities emerging, a workable system must be found to avoid individual patients having to shoulder the financial burden of cross-border healthcare. Mrs Grossetête emphasised that "money must not be a form of discrimination". There is strong support from patients' organisations echoed among MEPs for developing a system to handle cross-border payments directly. Establishing national channels for accessible, clear and reliable information for patients is a crucial component of the process.
- From the perspective of *patients with rare diseases*, obtaining an accurate, timely diagnosis is pivotal point in the delivery of care. A compromise that enables cross-border solutions for rare diseases patients to access

to diagnosis in the first instance, will be an acceptable starting point. It is also crucial that prior authorization be given by specialist physicians familiar with rare diseases and their complexities. A clear procedure should be established for such cases.

- *The importance of eHealth* to patient safety and continuity of care, and its role in the future sustainability of health systems was mentioned by several contributors, while the challenges of achieving interoperability and working cross-border prescriptions were also acknowledged. Speakers felt that those Member States with the most advanced systems should promote the sharing of information and best practices. However, as the area is still controversial, any eventual compromise is likely to be a partial solution, on which further cooperation may be built in future.
- The role of *health professionals*, and the sharing of practitioner information across Member States to improve patient safety were touched upon, as were the practical implications of cross-border healthcare for other actors, such as health managers and administrators.
- Once the Directive comes into force, there will be much work involved in its implementation and its eventual review. The real-life impact of the Directive on patients and all the other parties will only become clear as it is implemented across the EU.

The *involvement of all relevant stakeholders*, including patients' organisations, in this process will be key to its success.

In his summing up at the end of the day, **Mr Anders Olauson**, EPF President stressed the importance of keeping the principles of equity and solidarity at the centre of the draft Directive: "At heart, the Directive is, after all, about people – the patients, who need equitable access to good quality healthcare. We as EPF, and through our member organisations and allies all over Europe, are committed to playing the part of a proactive and constructive partner in this ongoing process, and we look forward to working together with the Institutions, and with all stakeholders to make the Directive the best it can be."

A full report of the High-Level Roundtable will be prepared and disseminated to all participants and stakeholders in the next days.

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Nicola Bedlington, Director

## Stephen Holman awarded Bioanalysis: Young Investigator 2010

Manchester, UK - Bioanalysis announced that Stephen Holman (Michael Barber Centre for Mass Spectrometry Manchester Interdisciplinary Biocentre (MIB), The University of Manchester) has been awarded the Young Investigator of the Year title by the international editorial board of the monthly journal Bioanalysis.

Over the course of 2009/2010, the profiles of 8 international bioanalysts were featured

in the journal, nominated by their supervisors. Each Young Investigator was given the opportunity to highlight their bioanalytical work to date, discuss their future career aspirations and give their thoughts on the future revolution of the field of bioanalysis.

The Young Investigator of the Year award has been awarded by the international editorial advisory board of Bioanalysis in recognition of the achievements of a young

bioanalysts at an early stage of their career. At the end of the year, votes were cast by the international editorial advisory panel to select the winner.

Brian Booth, US FDA, Senior Editor said: "When we launched Bioanalysis, we thought of beginning a regular Young Investigator segment to highlight the development and talents of the youngest generation in this field. They represent the future of this science, and there are very few venues to demonstrate their skills and potential. The purpose of this award is to stimulate these young people and provide some small

reward for their efforts. Stephen Holman was selected this year (among some very stiff competition) because of his involvement in some innovative research, and we anticipate much more from him in the future. Congratulations Stephen!"\*

Stephen Holman commented; "I was very surprised, but also very honoured and humbled, to be bestowed the award of Young Investigator of the Year 2010." He went on to say, "The award will provide a significant boost to my CV given that it is a truly international prize; the list of nominees spanned several continents, as did the selection committee who decided upon the eventual awardee. The journal is quickly becoming established in the field of Bioanalysis, and to be associated with it as the first recipient of the Young Investigator award is a great privilege."

In addition, Stephen's original profile/nomination can be found here: <http://www.future-science.com/doi/abs/10.4155/bio.09.45>

\*The views expressed are those of the author and do not reflect official policy of the FDA. No official endorsement by the FDA is intended or should be inferred.

[www.future-science.com/doi/abs/10.4155/bio.09.45](http://www.future-science.com/doi/abs/10.4155/bio.09.45)

Stephen was nominated for the award by Dr Pat Wright (Pfizer UK) whilst studying for his PhD at the University of Southampton. Pat said: "Stephen has shown himself to be an exceptional advocate for bioanalysis and an outstanding researcher. He quickly adapted his skills to the requirements of his PhD project, acquiring an understanding of mass spectrometry to which even more experienced practitioners would aspire. Within 18 months, he published his first paper, with a second being recently accepted for publication, and he has presented his work at a number of meetings. In September 2008, he received the Michael Barber award for the best student oral presentation at the British Mass Spectrometry Society conference in York, which attests to his enthusiastic delivery as well as the high standard of his science. His outstanding work and position in his peer group was further recognized when he won the poster prize competition, held at the end of the second year

of PhD study at the School of Chemistry, University of Southampton. Stephen has expanded his project to a self-initiated and exciting area that is not only of extreme relevance to metabolite identification, but also increases fundamental knowledge of gas-phase ion chemistry within the collision cell of a mass spectrometer."

Stephen receives a complementary 1-year print and online subscription to Bioanalysis and the next paper he submits to Bioanalysis will be highlighted as "Young Investigator of the Year 2010" and made free-to-view permanently, which we hope will further boost his research career.

Bioanalysis is now accepting nominations for Young Investigator 2011. They should be under the age of 30, including Masters and Doctorate students, Post doctorate researchers and those working in industry. If you wish to nominate a Young Investigator, please contact the Commissioning Editor at: [r.devooght-johnson@future-science.com](mailto:r.devooght-johnson@future-science.com).

## Patient Safety and Quality in Medicine – Permanent Obligation

**A report from XVII ZEVA meeting in Skopje, Macedonia**



*Marija Vavlukis*

From September 30<sup>th</sup> through October 2<sup>nd</sup>, the Macedonian Medical Chamber hosted the 17<sup>th</sup> Symposium of Medical Chambers of the Central and Eastern European Countries - ZEVA.

The central theme of the meeting was "patient safety and quality in medicine". Issues concerning self-governance and self-regulation in medicine were also main topics. The Symposium was attended by 39 participants from delegations of 17 European countries. Members of the Assembly, the Executive Board and members of bodies of the Medical Chamber of Macedonia, as well as representatives of the Macedonian Medical

Association, the Ministry of Health and various NGOs were in attendance.

The meeting began on September 30<sup>th</sup> with a reception organized by the Medical Chamber. Opening ceremonies were properly commenced with opening remarks by the President of the Macedonian Medical Chamber - Vladimir Borozanov. He wished a warm welcome to all guests and participants. Welcome and wishes for successful work on behalf of The Ministry of Health were delivered by Deputy Minister, Vladimir Popovski.

The meeting was enriched by lectures and discussions, especially on topics discussed by Dr. Dana Hanson, President of the World Medical Association, Dr. Otmar Kloiber, Secretary General of the World Medical Association, and Dr. Konstanty Radzivil President of the Standing Committee of



European Doctors. Rich and interesting debate sparked wide interest among the participants, who stressed that the meeting in Skopje opened new horizons in the operation of medical associations.

**Dr. Otmar Kloiber - Secretary General of the World Medical Association**, gave his speech about medical regulation and self-government. At the beginning of his speech he spoke about self-regulation and self-governance in professional organizations and associations. He remarked that self-regulation in an association is a balance between professional and public functions. If the activities of the association are dominated by public offices, membership in such associations is compulsory, but if dominated by professional functions, membership is optional. He pointed out that, in democratic societies, self-regulation means a healthy distribution of power, protecting the freedom of vulnerable groups and those who serve them. It was noted that the challenges of these organizations are:

- Competence,
- Quality,
- Behavior (without the involvement of criminal activities), and
- Providing high quality health care for all.

In regard to patients and patient relationships, it is important to remember that patients are not customers or consumers and healthcare professionals are not only providers of healthcare services. Self-management in healthcare is much more than self-regulation; it involves a contract with society, and often represents more effort than a privilege. Self-regulation is a factor that provides quality care for all.

**Dr. Cornelia Goesmann - Vice-President of German Medical Association** spoke about the system to ensure patient safety from the German perspective. Elaborating on the German experience, she concluded that patient safety must be an integral part of all institutions involved in healthcare, through good communication and cooperation, measures that to some degree have been implemented in daily routine practice. These measures should, in the future, be available to every healthcare professional and be emphasized as the role of experts and boards of arbitration in terms of prevention of adverse incidents and promotion of increased professionalism. Identification and implementation of quality indicators to ensure the safety of procedures and patient safety must be based on scientific research,

by which an authoritarian system will be replaced by a system of learning from errors.

**Dr. Reiner Brettenthaler - from Austrian Medical Association**, shared Austrian experiences on the measures and activities undertaken by Austrian institutional systems to improve patient safety. The focus was on the experiences of utilizing an electronic database for patients, particularly in relation to the prescribing of drugs by doctors and pharmacists, and the possibility of interactions especially in select patient subgroups, such as the elderly and patients with multiple diseases. He underlined that improving care for patients must be accompanied by appropriate legislation. Dr. Brettenthaler also explained the Medical CIRS project for anonymous reporting of critical incidents, and the learning system based on this by health professionals with the support of health authorities.

**Prof. Borozanov- President of Macedonian Medical Chamber** and host of the meeting, gave his introductory lecture about actual situations in the area of patient safety and quality in healthcare in Macedonia. At the beginning he stressed the necessity of consistent terminology in the area of medical



error. It was reemphasized that despite well-documented cases of unsafe care in developed countries, we are lacking the load-bearing unsafe medical care in countries in transition and developing countries, where limited resources, technology and infrastructure contribute to increase this burden. In our field, we need considerable political will and cooperation from all stakeholders in the to improve the education of health professionals in the field of patient safety, and to stimulate research projects in this area, which ultimately will result in improved quality of treatment. Required related systems for documenting and disseminating at the national level will result in linking the institutions of the system horizontally and vertically, including the private and public sectors, based on the principle of fairness and impartiality. What is now a reality in our country is that we have established evidence-based standards in patients' medical treatment beginning in 2006, but we lack feedback on their implementation. A particularly prominent project is the introduction of the electronic medical card, however, we cannot yet speak on the effectiveness of an integrated medical information system.

Patient safety depends on many elements. Doctor-patient confrontations are absolutely an undesirable situation. The improvement of the working environment of medical professionals is critical to providing a healthy work environment. That way we will minimize the role of the human factor as a cause of medical errors. In order to improve patient safety by 2008, a law was introduced to protect patients rights and manuals distributed to facilitate its implementation. Despite numerous systems for reporting cases of unsafe treatment, available data is insufficient. There were less than 100 reported cases in the last eighteen months to state authorities, primarily to the Institute of Public Health and state inspection. This practice shows that patients, or their families, often complain or report cases of unsafe care, not in the system, but at less

appropriate places (in the electronic media, to the Minister of Health in person, to the directors of health facilities, and rarely in the Medical Chamber). Work is needed in this area to ensure one comprehensive system for reporting medical errors.

During the meeting, representatives of medical associations presented their experiences in their work and the problems they face in realizing the goals and tasks through their national reports. Six national reports were presented from five countries from the region (Serbia, Slovakia, Croatia, Romania and Canton Sarajevo - Bosnia and Herzegovina).

## NATIONAL REPORTS

### Serbian Medical Chamber

Speaking on the experiences of the Serbian Chamber, the President of the Medical Association of Serbia presented the legislation on which it operates, including some of their problems. Prominence in the report was given to the policy for prescription drugs. It was emphasized that it prescribing is restricted only to general practitioners, and specialists can only prescribe drugs in rare, specific cases. However, despite this absurd situation Serbian doctors do not forget their ethical principles. In the second part of the report, the president addressed the status of medical professionals. It was noted that only 37.6% of physicians are satisfied with the availability and equipment at work, only 19.2% are satisfied with their earnings, and over 60% are satisfied with the choice of profession.

### Slovakian Medical Chamber

The report from the Medical Association in Slovakia largely concerned the identification of general common interests in relation to:

- Improvement of medical care;
- Increased patient safety;
- Greater satisfaction of all stakeholders in the system.

Measures that can achieve these objectives are: improving the relationship in the relational triangle of doctors-patients-health institutions, improving relations with health insurance funds, the quality of medical care and ways of payment for medical care provided, and the intellectual efforts and opportunities for the public.

### Romanian Medical Chamber

The Romanian delegation presented two national reports. In the first report, attention was given to the relationship between the historical evolution and current situation in order to present the situation in their country and organization, as well as difficulties in the initiation and continuation of reforms. Significant observations in the report were:

- The medical profession in Romania is not treated as a craft but as a liberal profession;
- The healthcare system focuses on each patient individually;
- Restrictions on the role of the legislator in establishing general conditions in healthcare policies is recommended, as well as limiting the misuse of the medical profession. It was pointed out that security and protection of the patient as an individual is not only the responsibility of health authorities.

**The second report** identified two central guidelines aimed toward the Chamber:

- The Chamber represents a guarantee for high standard of medical profession and ethics.
- For physicians, the Chamber is an institution through which they are represented in society, administration and politics.

The Chamber has a legal background and a multitude of functions including: the development of professional ethics and supervision of the profession, the supervision of postgraduate education, continuing medical education, licenses and registration, arbitration, and quality assurance of healthcare

services. The Chamber defends the economic interests of doctors at all levels, including working conditions, represents medical professionals to the media and political entities, and, although often in limited capacity, can participate if called upon in legal projects and other regulatory matters, providing its expert opinion if asked in court or parliamentary bodies.

There are other, social functions of the Chamber as well, for example, an initiative for additional pension insurance intended solely for the medical profession so that they can provide welfare to members in need.

## Medical Chamber of Sarajevo Canton

Dr. Kulenovic gave a comprehensive description of the Medical Chamber of Bosnia and Herzegovina, and the problems faced by the chambers within the country. The assertion of his speech was that the quality of medical care also depends on the condition of medical professionals.

The conclusion was that efforts should be directed towards activities to improve the material and financial wellbeing of medical professionals. To achieve these goals, chambers have to act together with the unions in a measure of solidarity when approaching government institutions. Government institutions should bear in mind that the best way to express respect for the medical profession is through material rewards and a more dignified presentation of the medical profession in society.

## Croatian Medical Chamber

The title of the report of the Croatian Medical Chamber was "between doctors and objective needs and real opportunities as a result of organizational, legal and technological resources". The first part of the report was the presentation of the historical development of the Chamber's organization in Croatia from 1913 until today. The report followed with

the presentation of current activities, such as preparing and maintaining the Register of doctors, the process of licensing, supervision and oversight of the work of doctors, the determination of basic working conditions and prices of services of private doctors. Among other things discussed was the prominent cooperation with educational institutions in the country and the supervision and evaluation of continuing professional training of doctors in Croatia. The Croatian Chamber has the prominent role in cooperation with the Croatian Health Insurance Institute in proposing the basics of the health network as well as suggestions, opinions and expert opinions in this area. The President of the Chamber is a member of the Croatian parliamentary Committee on Health and the Board of Directors of the Agency for quality and accreditation. Regarding patients' rights, this body unconditionally supports their needs, guaranteeing quality and accessibility to healthcare institutions, protecting their rights before the decisions of healthcare administrations, and sanctioning doctors.

## The Second working day was used to address issues of continuing professional development. The introductory speech was given by Dr. Konstanty Radziwill, President of CPME.

Dr. Radziwill spoke about current EU policies and activities of this the CPME. This is an organization of 27 European countries and other specialized European medical associations. The purpose of this organization is to promote high standards in medical practice for all residents of Europe. He stressed the need for further development of electronic databases in healthcare systems and for their availability and a standardization of communication. In terms of patient safety, he noted that the CPME contributes actively in order to complete the project EUNetPaS, especially in the field of education, training and manuals. He also cited other problems in healthcare policy related to the field of patient safety.

## Evaluation of specialist training (Postgraduate Medical Education) in Germany was analyzed and presented to the auditorium by Dr. Klaus – Dieter Wurche, Board member of the German Medical Association.

Dr. Wurche shared the German experience on the evaluation of postgraduate education of residents. Analysis of evaluation that specializing doctors made about the quality of their education is the basis for recommendations provided by the German Association, and refers to postgraduate education. Namely, it is recommended that reports of any specialist training center be analyzed by specialists and residents together. Individual results should be published if necessary, and positive and negative impacts on specialist training should be clearly stated. Emphasis on the importance of clear feedback should be made which would motivate participants to be involved in projects of this kind in future. According to the findings that Dr. Wurche presented for this project, it is evident that residents exhibit little interest in participating in the evaluation of educators and training programs in such a manner (electronic). Those who expressed interest in participating in the project have expressed their dissatisfaction with the workload involved in their practice, bureaucratic procedures, and time pressure and overtime work. Precisely because of these considerations, a clear need for open discussion about these problems was expressed, in order to improve operational models.

## CME in Macedonia - moving towards CPD: is it possible? , was the theme of speech of Dr. Ljubica Georgievska-Ismail, President of the commission for professional medical questions - Macedonian Medical Chamber

Dr. Georgievska-Ismail addressed the process of continuing medical education organized within the activities of the Macedonian Medical Chamber. CME is a tool that covers the gap between current and



optimal medical care. She stays current with healthcare law according to which doctors are bound by CME. Successfully performed, CME is the basis for renewal of medical licenses, an activity that has been legitimately transferred to the Medical Chamber. The current organization of CME is based on global principles for its performance, but the observations are that its impact on professional practice is moderate. This is important because of the introduction of the process of moving from CME to CPD. Continuous professional development is a range of educational activities through which healthcare professionals maintain and develop their capacity to practice safely, effectively and legally within their practice. In her speech, Dr. Georgievska-Ismail stressed the differences between CME and CPD, and

suggested ways to implement CPD. Her main suggestion: There should be a process of learning based on practical work (practice), which can be implemented through four major levels of CPD: identifying areas of improvement, engaged learning, applying new knowledge and skills in practice and control of improvement. She then she addressed the major obstacles in the implementation of CPD: lack of knowledge about the usefulness of education, lack of time, resources and opportunities, the wrong timing and type of educational activities, lack of wider choice of learning and professional conservatism. What is expected as a benefit of regular CPD is well-designed educational activities, physician satisfaction, change in knowledge and behavior and improved medical care to patients.

The main conclusions and recommendations from this ZEVA meeting will be merged into one declaration mainly designed for countries and governments from the ZEVA region. The main idea: it is necessary to change the widely accepted perception of unsafe medical care as a doctor's (medical personnel) error. It is of essential importance to identify patient safety incidents as a result of a system-wide error. The declaration will soon be distributed to all professional associations of the member states of the ZEVA region. The host of the next - XVIII ZEVA Symposium in September next year will be the Polish Chamber of Physicians and Dentists.

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## Climate Change: Governments Need to Hear from Medical Professionals

It is high time for doctors everywhere to stand up and be counted on the impact of climate change on health.

The phenomenon of human-induced global climate change can no longer be refuted [1]. Without any doubt, climate change will hit public health and health services very hard.



*Michael Wilks*

Last year, the world's foremost medical journal, the Lancet described climate change as the greatest potential threat to public health in the 21<sup>st</sup> century. It said that climate change will have devastating effects on human health as a result of changing patterns of disease, heat waves, reduced water and food security, and because extreme



*Genon Jensen*

weather events, such as hurricanes, cyclones and storm surges, will result in flooding and direct injury [2].

With catastrophes like Haiti or Pakistan in the news, no-one finds it difficult to imagine the pressure on medical staff from extreme weather, especially in an era of ever tightening health budgets.

The Standing Committee of European Doctors, Health and Environment Alliance



*Anja Leetz*

(HEAL) and Health Care Without Harm (HCWH) are currently in Cancun, Mexico where the latest round of climate change negotiations is taking place. We are convinced that the leadership of health professionals - with its high moral standing - is vital to persuade governments about the urgency of strong climate change policy. Acting now will save lives and reduce health care and other costs for governments.

## The good news

Fortunately, we have a positive message to help us convince governments in Cancun. Research shows that stronger climate change policy would bring almost immediate public health benefits. This is because some policies aimed at mitigating climate change have the effect of reducing air pollution and therefore improving health.

The so-called "co-benefits" of climate change are entirely separate from the potential health benefits associated with combating global warming. The co-benefits, or side effects of climate change policy, take place because as falls in greenhouse gases occur so do air pollutants such as fine particles, nitrogen oxides and sulphur dioxide. Since exposure to air pollutants is associated with many deaths and substantial morbidity, reducing greenhouse gases as part of climate change policy has the effect of improving public health.

A recent report published by the Health and Environment Alliance and Health Care



*Floods in Venice*

Without Harm Europe quantifies these benefits for countries of the European Union. It estimates that up to 30.5 billion Euros of public health benefits could be achieved within the EU per year by 2020 if the European Union adopted a policy of 30% cuts in greenhouse gas emissions[3].

The health benefits associated with stronger climate change policy in EU countries are mainly due to a reduction in the number of anticipated respiratory and cardiac cases associated with exposure to air pollution. These benefits begin almost immediately the policies are introduced. By 2020 for a 30% domestic cut in greenhouse gas emissions, 140,385 fewer years of life would be lost and 13 million fewer days of restricted activity could be avoided for those with respiratory problems. In addition, there would be 1.2 million fewer days when people would need to use respiratory medication and 142,000 fewer consultations for upper respiratory problems and asthma during the year 2020 [3].

In countries with severely polluted major cities, the benefits for health are likely to even greater. For example, a study in air-polluted Mexico City shows that reducing both ozone and PM10 (a type of Particulate Matter that contributes to air pollution) by just 10% would result in 33,287 fewer emergency room visits in 2010, 4,188 fewer hospital admissions for respiratory distress and 266 fewer infant deaths a year due to cleaner air. This is estimated to result in potential savings of US \$760 million a year [4].

Similar health co-benefits from climate change policy occur when carbon



*Copenhagen, December 2009*

emissions from private vehicles are the target. Studies from New Delhi and London published in the Lancet medical journal have shown how lower carbon policies associated with more public transport, less use of private cars and more "active transport" (walking and cycling) would benefit health. Measurable benefits were recorded for ischaemic heart disease, cerebro-vascular disease, dementia, breast cancer, lung cancer, colon cancer, diabetes, and depression [5].

## Create a force

The World Medical Association has already urged doctors to help steer political thinking on climate change. In his valedictory speech as President at the WMA's annual assembly in Vancouver in October, Dr Dana Hanson voiced his conviction that the World Medical Association, national medical associations and the public should begin educating governments and industry on the vital issue of health and climate change [6].

Both WMA and the Standing Committee of European Doctors have position statements for members to use in writing and speaking to politicians and policy makers [7], and WMA has recently sent a letter to all members urging them to write to their environment ministers.

National medical association around the world should join these efforts if the worst perils of climate change are to be avoided. When doctors speak up publicly, governments listen. The moral standing of doctors within society creates a powerful force. We urge you to turn your attention to treating our ailing planet earth.

For more information - and to let us know about your efforts - please contact Dr Pendo Maro, Health Care Without Harm Europe (HCWH Europe) and Health and Environment Alliance (HEAL) at [pendo@env-health.org](mailto:pendo@env-health.org) or [pendo.maro@hcwh.org](mailto:pendo.maro@hcwh.org)

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## Sustainable Health Financing

Presentation given at the WMA conference of "Financial crisis and its implications for health care", Riga, September, 10-11<sup>th</sup> 2010



Markus Schneider

### Sustainability as a buzzword

Several countries have made serious cuts in public health expenditures during the current period and expect more in the near future to cope with budget deficits and increased public debts caused by the current world financial crises. Sustainability serves in this context as a general principle to guide fiscal policy, however "sustainability" is a buzzword defined

differently around the world and, perhaps, has been universally accepted and used simply because it seems to be immediately understandable. Subsequent to the Brundtland Report (1987) at least the following definition is generally agreed: *Sustainable development* meets the needs of the present without compromising the ability of future generations to meet their own needs[1]. A sustainable health system is one in which the scale and the structure of the state's activities are such that the health needs of the current generation for high quality effective health services may be met without compromising the ability of future generations to meet their needs. No wonder that sustainability compilation is the domain of generational accounts, focusing on fiscal gaps in the long-run [2]. But the long-term view is not suited to deal with the tremendous fiscal imbalances in the short-term and will not provide the appropriate remedy for healthcare system development in the short-term.

Short-term and long-term fiscal gaps of the general government have to be distinguished from the financial sustainability of the healthcare system as part of the

economy. Fiscal stability in the short-term relates to the need for public revenue and public expenditure on healthcare to be in equilibrium within an economic cycle (say five years). Financial sustainability is a broader concept embracing the idea that total (public and private) income and expenditure on the healthcare system should be in equilibrium in the mid-term (say twenty years). Several instruments have been developed to deal with the long-term stability of social and private insurance programs these instruments are not appropriate to manage the immediate burden of fiscal shocks that can overwhelm the financial capacity of a country, (e.g. in the cases of Greece and Latvia).

### Sustainability indicators

Obviously, concepts and measurements are critical to sustainability. Sustainability represents a process rather than a static quality. Indicators of sustainability must therefore capture this movement over time, or capacity for continuity. But how do we measure sustainability? By definition a fiscal imbalance exists if government expenditures exceed tax revenues in a particular period. This fiscal imbalance of a particular period is called the budget deficit. Since the budget deficit adds to the national debt, the budget deficit represents the increase in the



public debt from one year to the next. In the same way the deficit of health insurance adds to health insurance debts.

What is the problem with deficits? It is the related interest payment. The increased debt raises the government's interest spending and decreases the government's ability to spend the revenues for other purposes. For example, suppose the total public deficit was 100% of the GDP, with an interest rate of 5%. If the government's ratio of the GDP was 30%, then the government would have to spend one sixth of its budget on interest payments alone. That is above the financial capabilities of the public health expenditures for Latvia and several other countries. Any increase in public debt would further raise interest payments, thereby reducing the government's available funds for healthcare, education, security, and other purposes. Obviously, such a policy is not sustainable in the long-run. So, the question remains, what to do in the short-run?

The assessment of both short-term and long-term sustainability of public finances is a multifaceted issue and there is not a unique indicator that provides a clear response to what extent a country's public finances are sustainable in the long-term. Hence, the European Commission and the Council assess long-term sustainability of public finances by using both quantitative indicators and qualitative information so that the determinants affecting the long-run state of public finances in the Member States are reflected [3].

Focusing on the inter-temporal balance of the public budget, the S1 indicator shows the durable adjustment required to reach a target debt below 60% of GDP in 2060, as defined in the European Stability and Growth Pact for EU public finance. The S2 indicator shows the durable adjustment required to fulfil the infinite horizon inter-temporal budget constraints, which states that the present value of government purchases and net debts cannot be larger than

the present net value of government revenues. In the EU as a whole and in the Euro area, the sustainability gap is estimated about 2% of GDP according to the S1 indicator and about 3% of GDP according to the S2 indicator [4]. Unsurprisingly, there are large variations by countries, strongly depending on the current debt position. The contribution of health and long-term care to this stability gap is roughly the same as the additional liabilities of the pension systems [5].

While constraints and indexation rules for public pension systems policies are implemented in many countries, the rules for healthcare are rather opaque. As a result, governments can more easily cut healthcare expenditures than public pensions if revenues are falling. Following the experience of the Great Depression, governments should counter-balance sudden drops in private demand. In fact, pro-cyclical cuts of public expenditure, especially health care, have a tendency to aggravate the economic crisis instead of alleviate it [6].

Counter-cyclical fiscal policy should be a short-term economic policy. A short-term indicator of financial need of the health sector is Medicare's sustainable growth rate mechanism, which limits payments for physicians' services. Cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrolment, and real GDP per person. That system is currently projected to reduce the growth of payments to physicians. However, growth rates of public health care will be positive and not negative, as discussed in Latvia and other Central and Eastern European countries. Even in the long-run, in the United States, the Congressional Budget Office (CBO) has anticipated in its last projection that, despite financial crises, spending for Medicare will expand faster than the economy. As a result, by the end of the decade, outlays for Medicare are projected to total \$929 billion

(4.0 percent of GDP), compared with \$519 billion (3.5 percent of GDP) this year [7].

The conclusion is that there are similarities, but also different views on the concept of sustainability and its measurement. While demographic impacts are generally considered rather low, institutional structures and deficit spending are assessed differently by countries, experts, and politicians. Under the perspective of public finance, many politicians see health care rather as a cost factor than as an investment in human capital and consequently a factor of economic growth.

## Drivers of fiscal stability of health care

It is worth the effort to analyse the argument for budget cuts in healthcare in greater detail, as the projections neither consider developments in the past nor health reforms in the future. Clearly, the pressure on healthcare expenditure will be reduced by the compression of morbidity and decreasing prevalence in rates of acute and chronic diseases (decline in chronic diseases) [8]. On the other hand, the pressure on healthcare expenditure will be increased by relatively higher labour intensity and lower productivity growth in the service economy, which leads to relative health care prices above GDP prices or the so-called "Baumol's cost disease" [9]. Further pressure comes from the medical-technical development and consumer behaviour. But, the expenditure side is only one component of the government's accounts. What happens on the revenue side? The prerequisite of a healthy labour workforce is a healthy population which is therefore crucial to sustainable revenue development. Independence of healthcare financing from the general budget and willingness to pay are other factors of sustainable revenue development. Institutional factors that affect financial stability of health financing are the mode of revenue collection income-independent premiums, income related contributions, and taxes, the allocation of risks to public and private schemes, the organisation of purchasing of

providers (single versus multi-pipes), and the contracting and payment of provider (framework versus selective contracts, capitation versus fee-for-service) [10]. Premiums for health insurance have an advantage because they are not directly related to fluctuation, but they do need to be counterbalanced by equity measures. The need to balance increasing needs for healthcare and scarce public resources is present among economic and healthcare policy makers in all countries. Many instruments have been developed to assess the benefits and costs of medical technologies at the micro-level, however, at the macro-level comprehensible models to guide policy for the governance of the health care budget do not exist.

## Health Economy in the driver seat

In many countries the healthcare economy is the largest industry. There is a paradigm shift from healthcare as cost factor toward health as growth factor. The impact of the health economy on the general economy and public finance system can be simulated by healthcare satellite accounts integrated into the national accounts. A satellite account captures all of the economic activities of the health economy. A study of Germany's health economy has shown a considerable export surplus, a large share of the overall economy's total workforce, a marked predominance of service industry, a high share of value added, and significant spillover effects into other industries. The Health-Input-Output-Table makes it possible to exhibit the supply for health commodities in consistent differentiation from the supply of the overall economy. The above mentioned study for the German Ministry of Economics and Technology confirms the strong link between the health economy and overall economy [11].

One particular question of cost containment measures is the impact on final demand in healthcare and the economy as a whole. How do cuts of public healthcare expenditures affect economic growth. The

compilation of production multipliers by the so-called "Leontief Inverse" shows variations of these multipliers for different branches of the health economy between 1.47 and 2.38. On average, a reduction of public health expenditures by 1% will lead to further indirect and induced reductions of the output by in total 1.8%. As a result negative consequence can be expected from cuts of public health expenditures, not only for patients and health professionals, but also for the economy as a whole.

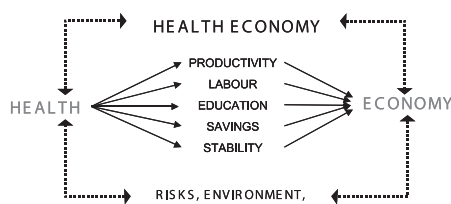
## Health as economic growth factor

Health expenditures contribute in manifold ways to economic development. Health impacts of economic growth take place over several channels [12]:

- The labour force becomes more productive and can generate higher income thanks to improved health;
- Improved health gives people a longer working life – an imperative in our aging and childless society;
- Fewer days are lost to ill health/disability and early retirement;
- Improved health and a longer working life increase the return on investing more in education and helps raise productivity;
- Improved health extends people's healthy-life expectancy. This fuels a higher savings rate and thus creates funds for further investment.

Finally, a stable health sector contributes to the stabilization of the whole business cycle and contributes to the functioning of the labour markets.

**Figure 1: Health impacts**



Source: BASYS, adapted from WHO 2008. [13]

Many studies have confirmed the positive correlation between health and growth. *Subrke et al.* 2005 examined 65 studies about the connection of health in the most diverse developments and their economic effects. The review confirmed that the health of the population is a crucial factor for personal income and the economic growth. In economic growth models, economic growth rises with the productivity of both health generation and the human capital accumulation process. Furthermore, improvements in health raise longevity, which will increase savings (for retirement) and hence facilitate investment, and the occurrence of a demographic dividend that creates an increase in the population of working age [14]. There is also an indirect link, similar to the impact of education, on economic growth. Investments in health, together with investments in education, determine the number of effective labour-services relative to the physical units of labour available that represent potential labour services.

Certainly, there are limits of the contribution of the subsidised health economy to economic growth and productivity across the whole economy [15]. Oversupply and over-medicalisation may harm both economic growth and the health of the population. Taking into consideration the overall development of the health economy and its impact on society, reliable indicators about the performance of health economy are crucial for both healthcare and economic policy. The contribution of the health economy to gross value added, employment, and economic growth can be verified in the framework of health satellite accounts. Additionally, both the contribution to growth and the labour force in the health economy can be compared to other branches of the overall economy. Moreover, the limits of the national accounts regarding the welfare of the nation (beyond GDP) are taken into account.

## Possible roadmaps

The direction of sustainable development is based on the sector view, viewed across

sectors, and fiscal feedback. From the sector perspective, the increase of efficiency within the healthcare system, fiscal discipline, and revenue raising (e.g. via complementary insurance) contribute to sustainable development. Across sectors, economies of scope by a holistic approach can contribute to sustainable development. Links between medical care and the extended health sector (e.g. health tourism, sport, and wellness) and reduction of risk factors have to be considered in the assessment of the health economy. Health risks can be reduced by primary prevention and human capital as growth factors can be strengthened by health education. The inclusion of coverage for the whole population and equity issues are essential in considering such a broad perspective.

From the view point of fiscal stability, the fiscal feed back of cuts or expansions of healthcare expenditures are of particular interest. In most countries healthcare is heavily subsidised. Therefore, the indirect and induced effects on the overall economy and public finance and the feedback have to be compiled to make a proper assessment of healthcare expenditure cuts. Moreover, self-financing of the health economy and independence from the public budget should be checked by both social and private health insurance systems and private financing mechanisms while at the same time balancing access to care.

Securing the safety net of the healthcare system is an imperative in the short-run. It takes generations to develop a healthcare system, train and educate health professionals and implement governance and contract structures. Therefore, avoid pro-cyclical cuts of public health system expenditures because of large impacts on employment and value added; governments should sustain healthcare expenditures despite financial crisis; Avoid healthcare bubbles - prices of health insurance policies or health infrastructure investments rising to a level that appears to be unsustainable and well above

the assets' value as determined by economic fundamentals.

Reforms of the healthcare system within a country are always embedded in a specific institutional environment and value system which has been developed over several generations. Although constraints differ by countries' productivity, development is a must for healthcare, independent of the system, and a prerequisite for sustainable financing. Strategies for productivity development might build on the experience of the industrial side of the health economy and on the results of healthcare system comparisons. If the crises of public finance continue, further measures should be taken under consideration of the impact on the supply side and health of the population. Independently, tradeoffs between different types of investments in human capital have to be considered:

The well-being of future generations will depend not only upon how much stock of exhaustible resources we leave to them but also how much we devote to the constitution of human capital, essentially through expenditure on education, research, and health.

All industrial countries invest a substantial proportion of national income in human capital development. Taking into account both public and private sources of funds, OECD countries had spent 16.8% of their Gross Domestic Product, on average in 2006, on human capital. In many Central and eastern European Countries, as well as in less advanced countries, the investment in human capital is far below this level.

## Conclusions

The following conclusions of sustainable health financing have been drawn:

In the short-term, governments should sustain healthcare expenditures despite financial crises (public deficit financing) because of the strong economic impact of the health

economy on the whole economy and employment;

Cutting resources of healthcare systems is not a likely solution for financial sustainability, rather the focus should be on efficiency and equity;

Understand healthcare as an investment in human capital: long-term fiscal policies have to optimize both health and human capital development (education, R&D, and health expenditures);

Develop international consensus about relevant indicators of financial sustainability of public healthcare expenditures and policies; install an international learning process about best practises in economic and financial crisis.

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## A Prescription for America's Health Care System

### Inaugural Address

AMA Annual Meeting, Chicago, Illinois, Hyatt Regency

June 15, 2010

American Medical Association



*Cecil B. Wilson*

My thanks to the House of Delegates, my colleagues, my friends, and my family for what is truly the greatest honor of my life in medicine.

Some of you know my story of growing up in South Georgia, the son of a Methodist minister. And in the tradition of the

itinerant ministry, moving every few years from town to town and church to church throughout the state. And I recall how, when my brothers and I would head out the door to go to school, our father the Rev. Dr. Wilson would admonish us: "Remember, you represent the whole family. Act accordingly." That simple statement of purpose has guided me through college, medical school, my service in the U.S. Navy as a flight surgeon, and my professional career and personal life in Florida.

It guides me today, and it will continue to guide me tomorrow, when I head out the door to tour this country on behalf of the American Medical Association.

My commitment to you is that now as in the past I will remember that I represent the whole family of medicine. And I will act accordingly.

Life is about opportunities and responsibilities. And nowhere are these found in greater

measure than in the calling we have chosen the profession of medicine. As physicians we have the opportunity to heal, and the responsibility to do no harm. We have the opportunity to care for those who are ill, and the responsibility to deliver the best care possible. And at this historic time, we have the opportunity to assure that our country's healthcare system bears the imprimatur of physicians, and we have the responsibility to bring to that task a voice that is clear, firm and constructive.

In thinking about what I was going to say this evening, I turned to my love of sailing an attraction to the sea and ships sealed during my service in the Navy.

Among the joys of living in Florida are the proximity to the ocean and access to sailboats preferably, someone else's. I've learned that off the coast, the waters are sometimes shallow and the winds variable. Running aground, being whipped by gales, or becoming becalmed are all part of the experience. I recall one sailing trip from St. Petersburg across Florida Bay toward Key West. In early evening, we strayed from the channel and ran aground in the middle of the bay an 850-square mile body of water. To get off the reef, we tried hoisting our sails and lowering them; we cranked the auxiliary engine; we put out an anchor and tried to winch ourselves off. Nothing worked. We

even tried to rock the boat off the entire crew running from one side to the other from port to starboard and back, and from bow to stern and back. By the way, did I say the crew was all doctors? Fortunately, this was in the days before *You Tube* or else we may have gone “viral.”

During this exercise in futility we dislodged the dingy, which then drifted away. One of the crew dove in, swam to it, and climbed in only to discover there were no oars. The dingy, with him in it, was being blown out to sea. Another member of the crew dove in carrying oars and swam to the drifting dingy. Two hours later, two very exhausted sailors came back. Six hours later a rising tide helped free us from the reef, and we could continue our trip.

This reminds me a bit of our journey toward health system reform. Embarked upon with a plan of action, at times diverted off course, at times becalmed but ultimately the country reached its destination. In talking with AMA members around the country, I found most physicians did not dispute the core principles of health system reform.

Rather, physicians disagreed on the interpretation of those principles and the strategy and tactics used to advance reform. Some did not like how we plotted our course, unfurled our sails and set our speed. Others sought a different destination. All were sincere in their views.

To me, these reforms are a long overdue first step a first step toward a better health care system in this country. This legislation is not perfect, but it makes medical care more accessible and coverage more reliable for millions. It makes insurance companies more accountable. It strengthens wellness and prevention. These are no small things. But it's easy to lose sight of what's good amid the finger-pointing, partisanship and just plain anger that marked this debate. It's been said that: “Honest criticism is hard to take especially when it comes from a

relative, a friend, a colleague, an acquaintance or a stranger. Did I leave anyone out?”

I know too well that there are fences to mend, assurances to make, and wounds to heal. I am also well aware that if we dwell on the past, we risk running aground.

Our energies are better spent making health system reform the best it can be for physicians and patients. Now more than ever we need to focus on what's best for our profession and act accordingly. Of course that's easier said than done. This is a complicated system, with many stakeholders involved. And it's also complex work that we do every day. Sometimes we forget that.

Think about it:

Physicians must choose from among more than 60,000 diagnoses; 11,000 surgical procedures; and at least 4,000 different drugs. The pressures on physicians are intense. And we welcome that responsibility. But we also have to recognize that we can do even better. All of us can do better from government officials, to insurers to patients. Well tonight, the doctor is in. That's me. And I would like to offer some prescriptions for our ailing health care system.

Let me start with four of the biggest challenges we face to make health system reform a success:

- medical liability,
- skyrocketing costs,
- inefficiencies in health care delivery, and
- Medicare underpayment.

First, medical liability.

Studies tell us that today 75 per cent of American physicians are forced to practice defensive medicine to order tests or procedures more out of a need to protect against possible litigation, than to improve patient care. This drains as much as 126 billion dollars out of the health care system annually. The health system reform legislation

acknowledges this problem but it does not go far enough to solve it. Ultimately, caps on non-economic damages are the gold standard for successful medical liability reform. They've worked for more than a generation in California, and they are also working today in Texas, Louisiana and other states.

My prescription: Caps. Caps are AMA policy. Caps are the only prescription proven to work.

In addition, we need to explore alternative reforms, such as health courts, administrative compensation systems, early offer models and “safe harbors” for physicians who follow best practices.

Next, cost.

If nothing changes, by 2020 America will spend 4.4 trillion dollars a year on health care. Let me put this in perspective. That means a family of four that makes 80 thousand a year would spend a fourth of their income on health care. That's not sustainable.

My prescription:

We need a comprehensive plan for containing costs and getting the most out of our health care dollars. If we don't, reform will fail.

The AMA has identified four broad strategies to contain costs:

- reduce the burden of preventable disease;
- make the delivery of care more efficient;
- reduce nonclinical costs that don't contribute to patient care; and
- promote value-based decision-making at all levels.

Let me next focus for a moment on one of the accomplices of soaring costs inefficient delivery of care.

From fragmentation of care to a lack of available comparative effective research

data, the current system is plagued by inefficiencies. Some services are over-utilized, others are under-utilized.

My prescription: Focus on making sure patients get the right care at the right time, at the right place.

This means:

- improving coordination of care;
- using more services that address cost and prevention; and
- making available more research to help physicians make the best decisions possible.

Another challenge is all too familiar the Medicare reimbursement crisis. Because of the senseless payment formula, the SGR, physicians are threatened with cuts. Year after year. And year after year, the costs of providing care and running an office continue to rise. The disparity between actual expenses and what Medicare pays are, to use an expression familiar in Florida, like the open jaws of an alligator. And they're ready to snap shut on access for our seniors.

My prescription: Scrap the SGR. Toss it overboard. Feed it to that gator, instead. Replace it with a payment structure that reflects the true costs of providing care in the 21<sup>st</sup> century. We also need new approaches to physician payment that are rooted in the reality of how medical care is provided. For example, Medicare should encourage better disease management, which is especially important for seniors in need of chronic care.

Now, improving our system is not just about tackling the important issues. It's also about fulfilling our responsibilities as stakeholders.

It's been said that Socrates was a teacher who went around giving everyone advice so they poisoned him.

So despite this great personal risk, and well aware of the aphorism that "fools rush in

where angels fear to tread" I would now like to offer some prescriptions to each of the major stakeholders in our health care system.

Starting with the private sector.

To America's health plans, insurance companies, pharmaceuticals and device manufacturers:

You have a special responsibility to the health care system. Your products and services, like ours, directly affect patients' lives and health. This isn't as simple as offering a choice of toothpaste or cell phone.

My prescription: Always remember you are more than just businesses. Keep your business practices transparent and keep the needs of your customers our patients foremost when you develop products and policy. To our leaders in government, especially those in elected offices such as Congress.

We are ill-served by partisan bickering amid a toxic atmosphere that poisons efforts to work together. Turning every policy decision even suggestion into a 30-second attack ad damages our democracy.

The prescription: Develop legislation that serves us well. Move beyond the partisan fight. Seek accommodation or at least understanding across political divides. Tolerate differences of opinion. Do the job for which you were elected!

Above all remember that you represent the interests of the nation. Act accordingly.

To my fellow physicians: This has been a challenging year, and on an issue as complex as health system reform it is inevitable that differences of opinion will arise. Remember, the common ground we share is vast what divides us is not.

Thomas Jefferson once said: "Not every difference of opinion is a difference of principle."

My prescription:

Support the AMA, support all your medical associations they are the only way to focus light on the goals of our profession, the challenges we face, and our efforts to better serve our patients. Do not let others divide us.

Get involved. Make a difference.

To our medical students and residents those who are now learning what this calling entails You are embarking on your careers at an historic time.

Remember: the issues we face are not just challenges they also are opportunities.

Remember too that the system itself may need fixing, the tradition of excellence in this country is as strong as ever. American physicians are world leaders in medical knowledge, technical skills and cutting-edge care. And most important, remember that the profession you have chosen is incredibly rewarding. To heal, to comfort, to relieve pain to be trusted with this most sensitive part of your patients' lives is a great privilege. And after more than 30 years of practice, I can honestly say that the sense of gratification I get from helping patients now is just as strong as it was when I first started out some years ago.

My prescription for you:

Listen to your patients; they will tell you their problems. And sometimes their diagnoses as well. And join the AMA. Join organized medicine. Influence the policies that affect your education and how to pay for it. Influence the policies that affect your future profession. Add your voice.

To businesses remember that investing in the health of your employees today, can lead to significant savings in the long run. And it's not just a matter of offering insurance. It's also a matter of fostering healthier lifestyles.



# World Medical Journal



My prescription: Take an interest in the health of your employees. If they smoke, help them quit. Provide a gym membership or better yet, a gym. Replace some of the candy bars and snacks in the vending machine with healthier options.

The rewards aren't just physical. They're also financial. Healthier employees mean less incidence of obesity, diabetes, cancer, and the costly chronic care that goes with it.

And this brings me to patients. To them to you:

My prescription: Take responsibility for the kind of care you receive. Empower and educate yourself as a patient.

Make important health decisions now such as insuring your family, choosing a personal physician, and documenting your wishes about end-of-life care.

Most common diseases are preventable. Challenge yourself to adopt healthier behaviors. Your well-being is your biggest asset. Don't waste it. Your loved ones will thank you.

Now I'm going to break a cardinal rule of medicine and issue one final prescription for myself.

As president of the American Medical Association, I promise to do what I can to mend the divisions within our ranks. Isaac Newton observed: "We build too many walls and not enough bridges." I plan to heed those words and act accordingly.

One way I plan to do this is through regular conference calls or other means to speak with AMA members. The goal will be in part to update you on the latest developments, but primarily, to hear from you your thoughts, suggestions, questions and concerns.

This will be interactive. A two-way conversation to openly and honestly communicate with each other.

I'm not just going to talk - I'm going to listen.

We will let you know the details soon.

These communications will be a way to address the here and now.

Ultimately, history will judge whether the decisions made during this historic and turbulent time were the right ones.

But I can assure you that these decisions were rooted in principle, not expedience. For a better health care system not a broken status quo. In the interests of our patients not just ourselves.

We did not control events. But neither did events control us. We plotted a course, unfurled our sails, and journeyed on, tempest tossed but hands on the wheel. We helped determine our own fate. The alternative was to have it determined for us.

Earlier, I spoke of a lesson learned on the sea and from it. Let me offer a second, about a race from Daytona Beach to Bermuda. The third day out featured sunny, cloudless skies, moderate temperature, a strong breeze blue water sailing at its best. We were making 16 knots on a downwind tack with all sails flying. Cresting large waves, then plowing into troughs as water broke across the bow. Even as we reveled in perfect conditions, the captain noted that the breeze had picked up and that we should take in some of the sails. But among the crew, there was much second-guessing. We were, after all, "experienced" sailors. We'd taken the Coast Guard courses. We'd learned celestial navigation. We'd sailed around Florida on a serious recreational basis. We knew better. By the way did I say the crew was all doctors?

This "discussion" was interrupted by a loud pow!! blasting from the bow. We looked up to find that a sail had blown out, shredded by the strong winds.

Lessons learned.

A cruise to Bermuda that reminds us that even when the sailing is smooth and the sun is shining, prudence dictates we check the wind, check the sea, check our sails, expect changes and prepare for them. And maybe maybe it tells us that no single one of us has all the answers. If we fail to plan if we let outside forces plot our course and set our speed, we will ultimately drift, powerless without direction or purpose.

That is why the AMA kept our hand on the wheel during the storms of the reform debate. Now, we face a defining moment for organized medicine and the AMA. This is not just a challenge, but a tremendous opportunity. Let's work together to bridge the legitimate differences that exist between us. And let's keep in mind that we're in this boat together.

The poet Ella Wilcox wrote:

One ship sails East,  
And another West,  
By the self-same winds that blow,  
Tis the set of the sails  
And not the gales,  
That tell the way we go.

Like the winds of the sea  
Are the waves of time,  
As we journey along through life,  
Tis the set of the soul,  
That determines the goal,  
And not the calm or the strife.

Tis the set of the soul. We are the family of medicine. We represent our patients. We must set our souls and the course together. Because together we are stronger. Thank you.

*Cecil B. Wilson, MD, American Medical Association, President*

## Freedom of Association



Armin Ehl

Currently the employed doctors in Germany and their trade union, the Marburger Bund, face a very serious problem. The Marburger Bund is the association of the employed doctors in Germany and their trade union as well. It was founded in 1947 and organizes 108,000 doctors. In 2006 the first collective agreements especially for doctors

were signed after a strike period of 14 weeks at the university hospitals and another 7 weeks at the communal hospitals.

In July 2010 the Federal Labour Court ruled that the working conditions in one enterprise can be defined by multiple collective agreements covering different groups of workers (nurses, auxiliary staff, doctors). With this judgement the Federal Labour Court changed its previous interpretation and confirmed the lawfulness of general practice in Germany.

Soon afterwards the German Federation of Employer Associations (BDA) together with the Confederation of German Trade Unions (DGB) started to lobby the German Government in order to change the existing law. In their opinion the collective agreement of the trade union with most members in the enterprise should have precedence over all other collective agreements. They argue that otherwise the enterprises would face too many strikes (they talk about

“Englische Verhältnisse”) and as a result the economy in general would suffer. The losers would be the employees which decided to organise their interests in specialist trade unions (doctors, pilots, train drivers, air-traffic controllers). Among other things specialist trade unions would be at risk to forfeit their right to strike.

The Marburger Bund points out that an alteration of the labour law as pursued by the BDA and the DGB will not only be undemocratic but also violates the Basic (Constitutional) Law of the Federal Republic of Germany (Article 9 (3): Freedom of Association). We do everything we can to convince the government to respect the latest judgement of the Federal Labour Court and leave the law unchanged. Together with other specialist trade unions the Marburger Bund started the campaign “Save the Freedom of Association” ([www.rettet-die-kollektionsfreiheit.de](http://www.rettet-die-kollektionsfreiheit.de)). With this campaign we want to make the general public aware of the problem. We also asked our members to write to the members of the Parliament and let them know their opinion.

Armin Ehl,  
Marburger Bund Bundesverband

## Students Striving to Improve Medical Education – Experiences from International Perspective

### Introduction

The International Federation of Medical Students' Associations (IFMSA), one of the largest international student organizations in the global medical community, aims to serve medical students all over the world. Currently, the IFMSA represents 1.2 million medical students through its 102 national member organizations.

The IFMSA is an independent, non-political organization, founded in 1951, and is

officially recognized as a Non Governmental Organization (NGO) within the United Nations' and recognized by the World Health Organization as the International Forum for medical students. The IFMSA aims to offer medical students a comprehensive introduction to global health issues. This is done by our exchanges with more than 11.000 exchanges taking place per year. It is the largest student-run exchange program in the world, and operates through our work in the fields of medical education, reproductive health, human rights and public health.

### IFMSA and Medical Education

The IFMSA's Standing Committee on Medical Education strives to improve medical education worldwide. In order to achieve this goal, members from all national organizations share their experiences and train each other, organize projects and advocate for the improvement of their curricula.

### Training and sharing experiences

Twice a year, 800 IFMSA members come together to educate one another on issues regarding global health. During these meetings, specific sessions focusing on medical education are organized for members of the Standing Committee on Medical Education. Also, workshops called the Medical



Margot Weggemans

Education Development International Kit Training (MEDIK-T) are organized to give students the necessary knowledge and skills to work with their faculties to re-structure and improve their own education. These peer-to-peer trainings utilize various teaching methods on a wide range of topics (e.g. adult learning theory and curriculum development), with additional support from expert teachers.

In between meetings, students make use of a Wiki-based online platform<sup>[1]</sup> and mailing lists to stay in touch, follow-up on work done during meetings and share ideas for further improvement and new projects.

## Projects

The IFMSA organizes projects on local, national and international levels. The aim of the projects of our Standing Committee are to provide medical students with additional information concerning global health and to make them aware of the role they can play in their own education. Examples include elective courses on tropical medicine and international health<sup>[2]</sup> and online databases where information about curricula and residency systems of many countries can be found<sup>[3]</sup>.



Robbert Duivivier

## Advocacy

Another important aspect of our work is advocacy. The IFMSA aims to empower medical students and improve participation in their medical education either as student-teachers or student-representatives. With our work we emphasize the important role medical students play in the improvement of their education.

In 2004, medical students were the first stakeholders to issue a statement on The Bologna Process; the effort to harmonize European higher education. This statement<sup>[4]</sup> was the result of a series of meetings organized by medical student representatives. Over the years that followed, we have evaluated the implementation of The Bologna Process in Medicine and considered constructive approaches to European policy. In our work, we emphasized the student's role and responsibility as an important stakeholder of The Bologna Process in Medicine<sup>[5,6]</sup>.

We have written an outcome-based core curriculum identifying nine domains with 76 learning outcomes for graduates of European medical schools. The "European

Core Curriculum *the Students' Perspective*" expresses the medical students' opinion on which abilities, knowledge and attitudes students of medical schools in Europe should have gained upon graduation. This core curriculum has served as a framework in numerous countries, and can be adjusted for specific national and local needs<sup>[6]</sup>.

Our statements are used for lobbying university leadership, national professional bodies or governments and relevant international organizations. Representatives of IFMSA are members of the executive board of the World Federation for Medical Education (WFME) and AMEE. They present outcomes of our work during executive meetings and raise awareness of the student point of view. In addition, our members aim to present our views at scientific conferences and in peer-reviewed journals<sup>[7,8]</sup>.

## Conclusion

The work of the Standing Committee on Medical Education of IFMSA aims to improve medical education worldwide. We enable students to share their experiences and empower them to train each other. We organize projects in 102 countries worldwide and advocate for the improvement of medical education through our network of students. The outcomes of our work are disseminated through our professional partner organizations, and by presenting at conferences and meetings. We also intend to publish our work in journals, such as the World Medical Journal, to broaden our sphere of influence.

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## Health Professionals' Mobility – Presentation of a Research Project

The mobility of health professionals is of crucial importance from the point of view of the sustainability of health care systems in member states of the EU. One of the recommendations of the Green Paper on the migration of the health workforce is to establish an EU-wide data collection system to monitor flow of health workers. Monitoring and analysis of the changes and trends can only be based on valid, reliable and comparable data. One of the objectives of the Prometheus project (Health Professionals' Mobility in the EU Study) was to collect valid and reliable data on health professionals' migration particularly of European countries, but also of countries outside Europe. International data collection has never been done before. Comparative analysis was carried out using a set of standardized health workforce indicators.

The main aim of the Health Prometheus Project was to prepare the establishment of an EU-wide health professionals' migration monitoring system (observatory) to support both EU and national decision-making in this area. The project aimed to obtain an overview about the current situation and the changes, which took place in the last decade, in Europe. Moreover, it was based on the available routine data, various reports and grey literature from a network of participating countries and provides an initial mapping of the scale and nature of mobility for all EU countries by different professional cadres. The Prometheus Project

also included and differentiated mobility of health professionals from 3<sup>rd</sup> (i.e. non EU) countries. The findings and experiences regarding the sources, the quality and the comparability of the available data, gathered together in the frame of this project is used to assess the feasibility of a sustainable data collection system on the migration of health professionals, as the future target.

The Health Prometheus Project is an FP7 supported research project (the research leading to these results has received funding from the European Community's Seventh Framework Programme ([FP7/2007-2013] [FP7/2007-2011]) under grant agreement n° [223383]) led by the European Health Management Association and the WHO European Observatory on Health Systems and Policies. There were eleven partner institutions from eight countries. Semmelweis University, Health Services Management Training Centre, Hungary was responsible for data collection and analyses.

The next figure shows the participating countries in the Prometheus Project. There

were project partners (conceptual contribution, data collection and case study), country correspondents (data collection and case study) and country informants (only data collection). Regarding Australia, Canada, New Zealand, Norway and the USA we have collected the data from country experts or online-access websites.

Covered countries by the project		
Project partners	Country correspondents	Country informants
Finland Germany Hungary Lithuania Spain United Kingdom Italy Slovenia	Austria Belgium Estonia Romania Slovakia Turkey Serbia	Bulgaria Cyprus Czech Republic Denmark France Greece Latvia Luxembourg Malta Poland Portugal Republic of Ireland Sweden The Netherlands Ukraine

Other: Australia, Canada, New Zealand, Norway, USA

*Members of Semmelweis Team: Miklós Szócska MD, Péter Gaál MD, Edmond Girasek, Eszter Kovács, Edit Eke MD*



# 100 Years Celebration of the Ukrainian Medical Association



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