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- WMA Presidential Report, 2010–2011
- On the Epistemological Nature of Clinical Ethics

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Window of Hope

This editorial is being written just days before the UN summit on Non-Communicable Diseases (NCDs), which marks only the second time in history that the UN General Assembly has set aside significant time to discuss a health issue. Preparations have been underway for more than a year and the expectations are high.

Non-Communicable diseases now represent the greatest proportion of the global burden of disease. The World Health Organisation, in its approach to NCDs, has focused its attention on four disease groups: heart disease, lung disease, cancer and diabetes. Without doubt, these are crucial problems worldwide, but there is much more to it. Mental health, muscular-skeletal diseases, accident and trauma are just a few examples of non-communicable diseases that are tremendously important but do not enjoy the same level of visibility within the WHO – including in its planning for the NCD summit. Some, such as mental health, have been pushed into the Summit agenda by governments, while others are largely being ignored. This piece-meal approach to NCDs resurrects critical concerns about a flawed approach to global health that we believed we had begun to move past.

In the post-Alma Ata period, the work of international organisations, including WHO, was marked by donor-driven vertical programs tackling specific diseases like HIV/AIDS, tuberculosis, river blindness and malaria. These programs were all well-meaning humanitarian efforts, driven by immediate, visible needs that health funders and the public found very compelling. Yet, as physicians concerned for the full health of our patients, we criticized the imbalanced prioritization of these discrete programs over other programs that would address the overall health needs in the affected regions and contribute to the build-up of comprehensive health care systems.

We were encouraged by a sobering series of analyses and reports – most importantly, the World Health Reports on Human Resources for Health in 2006 and on Primary Care 2008, and a brilliant analysis on the Social Determinants of Health in 2009 – in which the



Otmar Kloiber

WHO recognised the failures inherent in the silo-based paradigm and recommended an epochal shift to a more systematic, primary care-based approach to health. This new paradigm would focus on person-centred care and people-centred health, building and strengthening health systems around a solid core of primary care.

The WMA welcomed and supported this new approach. Thus, we are concerned and disappointed by the current NCD strategy, which appears to be taking us back down the road of vertical programs and away from the holistic approach to human health that we believed that WHO was committed to pursuing. Certainly, a strong focus on heart disease, lung disease, cancer and diabetes is warranted. These are massive health prob-

lems that affect large populations and consume enormous amounts of health resources. And many of their causes are preventable through lifestyle changes, such as smoking cessation, reduction of alcohol consumption, increased physical activity, and better nutrition. However, preventive care can and should be addressed in the context of quality health systems, alongside the full complement of primary, secondary, and tertiary care. Building such comprehensive systems will simply not be achievable if funding is disproportionately funnelled into disease-specific programs. We have learned this lesson once already.

During the upcoming Summit, the national leaders in New York have a chance to turn the focus back toward improved investment in health and in health care across the board – not only where there are donor-driven programs, but at the national level in each country. They can choose to apply the available resources toward the goal of building real health systems that take in account the social determinants of health and provide effective, accessible, quality health care for all persons. It is our sincere hope that they will recognize and seize the opportunity to do exactly that.

*Dr. Otmar Kloiber,
Secretary General WMA*

WMA Presidential Report, 2010–2011



Wonchat Subbachturats

On 11 October 2010, I took off from Bangkok with my colleagues, Prof. Dr. Somsri Pausawasdi, CEO and Past President of the Medical Association of Thailand, Assoc. Prof. Pasert Sarnvivad, Secretary General of the MAT, and Dr. Urchart Kanjanapitak, Past President of the MAT, heading for Vancouver, Canada, to attend the 2010 General Assembly of the World Medical Association, held on 13–16 October, as a delegation team from the MAT, Thailand. The WMA General Assembly of 2010 was not an ordinary and usual one because the President Elect, Dr. Ketan Desai, from the Indian Medical Association, who had been elected President Elect of the WMA in New Delhi in 2009, could not attend the Assembly, which resulted in failure of the installation of the President of the WMA for the year 2010–2011 at the Assembly. The WMA Council, therefore, decided to have the immediate president election, which had happened a few times in the history of the WMA.

On 15 October 2010, the applications for the office of the Immediate President of the World Medical Association for 2010–2011 were announced by the Secretary General, Dr. Otmar Kloiber, at the WMA General

Assembly. There were three applicants on that day.

The ballot was made according to the regulation of the WMA. I was announced to be the winner. At that very moment, my life changed, with the trust and honour that the members of the WMA Assembly had given to me, it was a great pressure (and pleasure at the same time) for me to be not just a member of the Organization, but I needed to carry out heavy tasks and bear responsibility for the Organization and all members of the WMA. As I came from a small country with only one vote, it was a great honour for me, for the Medical Association of Thailand and for the people of the Kingdom of Thailand. I could feel the presidential chain and medal being put around my neck by Dr. Edward Hill, Chair of the Council, at the installation. I realized then that my duty to connect all the medical professions around the world had begun. The problem was how to bring the 97 state and country members and at least 9 million physicians on 6 continents together. It would be impossible to get acquainted with all the member countries in one year. I, then, came up with the decision that if I could get acquainted with them all, I would do my best to see the most as the time and opportunity allowed. I would do my best to encourage them that they are not working alone, but the WMA can be the centre of communication. The Secretary General's office in Voltaire would be the centre for information and collaboration they could utilize for communication among members and collaborative partners. The three main stems of the WMA, the President, the Chair of the Council, and the Secretary General, must be closely working to connect and serve the member countries and all physicians. **The problems of the physicians are ours.** The linkage between the President, the Chair and the Secretary General must be open at all times through e-mailings and monthly Executive Committee calls.

During one year of presidency, a lot of events have taken place on this planet. Natural disasters have hit a number of places in the world, from Chile, Christchurch, and Yunnan to, worst of all, the city of Sendai in Japan, killing thousands of people and inflicting a great devastating loss to the city with a subsequent radiation leak from the power plant. They are not just the natural disasters, but also the man-made disasters that have superimposed and worsened the situation. The political conflicts around the Mediterranean have created and aggravated instability in the medical profession and healthcare. Many of the health personnel have been unethically and unjustly accused. Many of them have been injured, tortured, punished, and jailed.

During my past 11 months (while I am writing this report), I have had the honour of being invited to visit and deliver speeches in many places of many countries on special occasions, such as the annual meetings of Medical Associations and Medical Forums on five continents, the only continent that I have not had the opportunity to visit being Africa.

The list of my presidential visits:

- Jiangyin, China, 26–27 November 2010: International Biomedicine and Technology & Health Care Summit;
- Taipei, Taiwan, 11–14 November 2010: Annual General Assembly of the TMA and Doctor's Day;
- Hong Kong, 29 December 2010–2 January 2011: Annual General Assembly of the HKMA and the New Year Celebration;
- Bangkok, Thailand, 25–29 January 2011: Global Health Workforce Alliance;
- New Delhi, India, 14–17 February 2011: SEARO Expert Consultation on Doctor-Patient Relationship;
- Tokyo, Japan, 2–4 March 2011: Task Shifting;
- New Delhi, India, 16–18 March 2011: Partners for Health in Southeast Asia;
- Sydney, Australia, 3–10 April 2011: 188th WMA Council Meeting;

- Geneva, Switzerland, 13–18 May 2011: WHPA Assembly;
- Oslo, Norway, 24–27 May 2011: Annual General Assembly of the NMA;
- Kiel, Germany, 29 May–3 June 2011: Annual General Assembly of the GMA;
- Chicago, USA, 16–21 June 2011: Annual General Assembly of the AMA;
- Brussels, Belgium, 22–25 June 2011: EFMA Congress;
- Cardiff, UK, 26–29 June 2011: Annual General Assembly of the BMA;
- Taipei, Taiwan, 30 June–2 July 2011: Seminar on Counterfeit Medicines;
- São Paulo, Brazil, 11–16 July 2011: Placibo Meeting;
- Beijing, China, 7–8 August 2011: Organ Transplant;
- Nesebar, Bulgaria, 5–12 September 2011: 2nd SEEMF Congress;
- New York, USA, 17–22 September 2011: General Assembly High-level Meeting on NCDs.
- And the last trip for my presidency would be that to the WMA General Assembly in Montevideo, Uruguay, on 9–16 October 2011.
- Then, as the Immediate Past President, I planned to attend as a representative of the WMA the Social Health Determinants Meeting in Rio de Janeiro, Brazil, on 19–21 October 2011.
- And also, as a representative of the WMA, I planned to attend the Global Alcohol Policy Conference in Bangkok, Thailand, on 28–30 November 2011.
- I do apologize to those NMAs and Organizations that sent me invitations which I failed to use due to time overlap.

Achievement

First and most important: I had partly fulfilled my wish and policy in connecting people and meeting our members as the time allowed. I encouraged them about medical ethics, professional collaboration and empowered them to work heart and soul for the community of Medical Profession as representatives of

the World Medical Association. During my visits, I also had an opportunity to learn a lot from their views and policies of which some were similar and some were different depending on the cultural and economic context, but they could be bonded together.

Secondly: On many occasions, the WMA, either on its own or jointly with the partners, alliances in protecting Health Professions including the Medical Profession, had produced statements against unacceptable, illegal treatment and unethical or unfair justice, such as in Iran, Bahrain, etc.

Thirdly: I had the opportunity to encourage our member states and countries for the unity of our profession, which, I think, is the most important and essential thing in establishing close relationships and ties for the international collaboration and sharing of the Medical and Health information. This will give us a stronger voice in the global community.

Challenges

1. There are still barriers and political conflicts among states and countries and, on many occasions, health provision has been interfered with and Medical and Health Professions have been affected.
2. The Economic Crisis that has continued for the period of my term has been a great barrier to the development of medical care in many countries.
3. Apart from the natural disasters that have happened around the world, killing thousands of people and inflicting a devastating loss to the economy, there have also been several man-made disasters, especially around the Mediterranean, that have also taken away a lot of lives.

What is my concern?

Provision of health care is the ultimate goal of all health and medical personnel, but it cannot be achieved if we don't have:

1. Professional unity;
2. Ethical practice;
3. Equitable provision of health care;
4. Global collaboration within our profession and with other health alliances without discrimination by race, nationality, colours, beliefs, religion, gender;
5. Care for our young generation;
6. Independence from politics;
7. Professional and social responsibility.

I must say that all Medical Associations and organizers of Forums in the cities and countries I visited encouraged me and gave me the opportunity to do what I had said I would do when I was sworn in, i.e. to connect people for the unity of the WMA. I feel grateful for that. Furthermore, they showed great hospitality and generosity to me while I was staying with them. The people who have been working behind the scenes and made my travels possible and comfortable are our Secretary General, Dr. Otmar Kloiber, who has always been my adviser and consultant, and the people at the Secretariat Office in Voltaire, who have done all the jobs for my communication and travels: Sunny, Clarisse, Anna, Julia, Lamine, Nigel and many else. They deserve to have my sincere thanks.

I would like to cordially thank my colleagues at the Medical Association of Thailand, the President, Police Lt. Gen. Dr. Jongjate Aojnepong, the CEO and Past President of the MAT, Prof. Dr. Somsri Pausawasdi, the Secretary General of the MAT, Assoc. Prof. Dr. Prasert Sarnvivad, and the MAT Executive Committee Members.

Most of all, I greatly thank my wife, Professor Dr. Prapaipan Subhachaturas, Deputy Dean of the Faculty of Medicine, Rangsit University, Thailand, and my family, who have always encouraged me to do the job and have taken on domestic cares while I am away, which is almost for one half of the year now.

Wonchat Subhachaturas M.D.
President, WMA

Access to Public Health Facilities: Taking Stock of South Africa's Rural Eastern Cape Province



Michael Mncedisi Willie

Nearly two thirds of the South African population is affected by poor public health conditions. Hardly hit are the poor, in particular rural based communities. Due to infrastructure, underdeveloped roads in rural areas it is not easy to get to a health facility. These communities often have fewer workforce including doctors, dentists and certain specialists and in some instances primary health care services might not even be available. The objective of this article was review government health expenditure, health insurance coverage and distribution of health facilities and how these impact on the Eastern Cape rural communities. We focused on the Eastern Cape Province because the private health coverage is minimal and provision of primary health care services often fails to reach the targeted population. We then recommended interventions that could be employed to overcome some of the barriers to care.

Introduction

Concentration of health facilities in urban areas especially those providing sophisticat-

ed care results in higher opportunity costs of accessing services [11; 18]. Hardly hit by these high costs are mostly the poverty struck rural based communities [14]. The rural areas are often inaccessible due to the poor condition of the roads and accessibility to health facilities influence people's ability to seek health care [2;22].

Ensor and Cooper [11] illustrated that household use of services tends to decline with distance. Ensor and Cooper further reported that the main reason urban citizens, use services more than their rural counterparts largely because such services are accessible and are within reach. Literature shows that poverty, combined with poor public health conditions overcrowded housing, lack of accessible drinking water and sanitation make Africans most vulnerable to ill health [28; 29; 34].

High poverty levels in impecunious communities are as a result high unemployment rates and there are often limited resources in such communities [23]. Resource allocations and health care delivery in South Africa varies from province to province were fewer resources for poor people, in particular rural based provinces like the Eastern Cape which face bigger health challenges than more prosperous provinces like Gauteng and the Western Cape.

The Eastern Cape Province has the highest poverty levels in South Africa. The high incidence of poverty in the province may be linked to the economic neglect of the former homelands Transkei and Ciskei [19]. The province's health services have deteriorated over the past decade of democracy with patients flocking to neighbouring provinces in the hope of receiving better treatment [23]. The objective of this article was review government health expenditure, health in-

urance coverage and distribution of health facilities and how these impact on the Eastern Cape rural communities. We made some recommendations that could be employed to accommodate the under resourced and poverty walloped rural areas in South Africa.

Financing healthcare in South Africa

South Africa's health system consists of a large public sector and a smaller private sector [8]. There are characteristics differences in terms of resources between the two sectors. The public sector is under-resourced, over-used and in most instances the quality of service delivery offered is shoddier compared to private health care facilities; most well equipped resources are concentrated in the private health sector.

Figure 1 illustrates that total health funding exceeded R200 billion to approximately 250 billion in 2009, this represents an increase of 12% between 2005 and 2009 from R4005.4 per capita in 2005 to R4476.0 per capita in 2009, these figures were adjusted for inflation on 2009 constant prices [21]. Out-of pocket payments have roughly remained below 20% of total health care spending over the period 2005–2011.

The data presented showed that in 2008/09 provincial health expenditure exceeded medical schemes for the first time in a decade. However the private health sector financing continues to exceed public health funding levels,. Comparison figures were 34% public health and 57% in 2005 compared figures for 2009. Public and private health expenditure in 2009 was 39% and 54%, respectively. Both the medical aid expenditure and the out-of- pocket reduced slightly for the 2005 and 2009 comparative years [21].

Medical schemes expenditure per capita reduced slightly when adjusting for inflation on 2009 constant prices, the decline

was 6% reducing to R9916.00 in 2009 from R10500.58 in 2005. Provincial health sector expenditure increased by 22% to R1667.2 in 2009 from R1368.92 in 2005, and these were also adjusted for inflation on 2009 prices [21]. The Eastern Cape Province had the highest poverty levels in South Africa, 48% compared with SA average of 33%. Public health spending in the Eastern Cape was under R1 500 per person per year [10]. This was the lowest healthcare spending compared to other provinces. Thus, despite an increase of government spending at provincial level on health, poor households in the province have not shared in the benefits government.

Healthcare spending in South Africa was relatively low to International comparative data on to similar middle income countries (see Figure 2 below) and is slightly lower than the global health care expenditure per capita which is was estimated at R5782.10 using 2007 estimates.

Medical scheme coverage by province

Medical schemes are insurance institutions that cover medical expenses in South Africa. These institutions reimburse their members for actual expenditure on health. People belonging to medical schemes are able to use private sector services. The services in the private sector accessed by close to 16% of the population that is covered by medical schemes as reported in 2009, the proportion of the population that benefits from rich resources offered in the private sector in 2009 was not significantly different to the 15% cover in 2000. This means that a decade later there has not been a significant growth in coverage by medical schemes and yet the private sector takes up the bigger chunk of health care expenditure [13]. Figure 3 depicts the trend of medical schemes coverage.

Figure 3 further depicts the 8.1 lives covered by medical schemes stratified by prov-

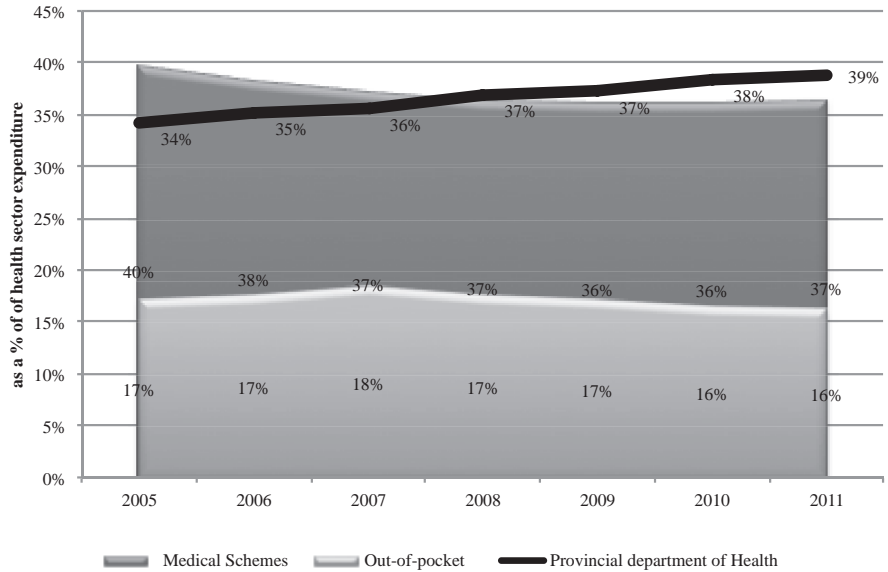


Figure 1. The Sector health financing (2005–2011).

Source: Figures and the graph were estimated by the author from the National Treasury provincial report and local government database and Estimates of National Expenditure, Council for Medical Schemes, Road Accident Fund and South African Reserve Bank.

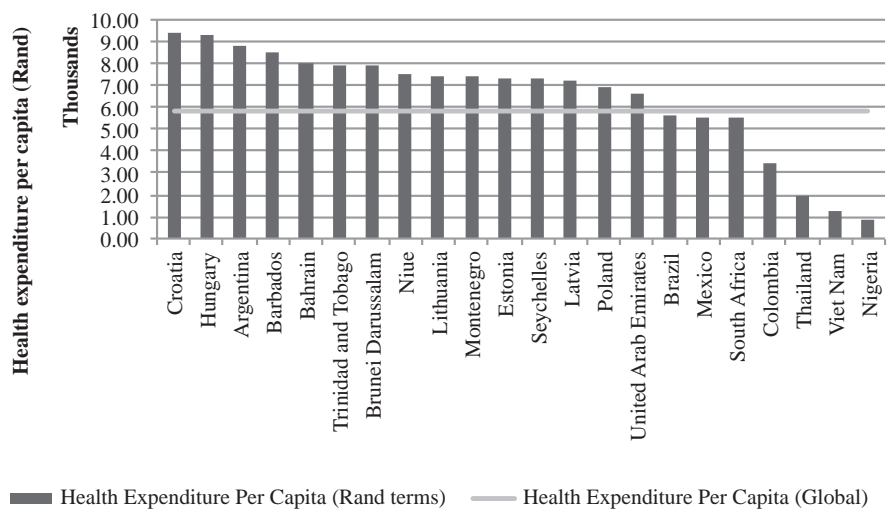


Figure 2. Country comparison of health care spending per capita (2007 figures).

Source: Graph populated generated by the author from WHO reports

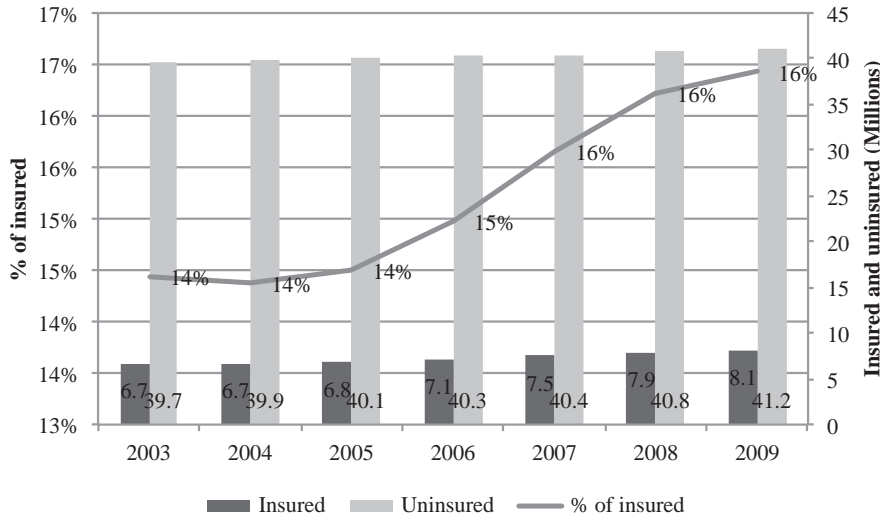


Figure 3. *The Medical scheme coverage.*
 Source: Graph generated by the author and background data sourced from Statistics South Africa and CMS report, 2010

ince. The Gauteng province took up 37% of 8.1 million covered lives, followed by the Western Cape Province and third was the Kwa-Zulu Natal which takes up 15%, only 9% of 8.1 covered lives were from the Eastern Cape. Similarly to the 2% of the 8.1 million lives who were residents in the Northern Cape [6].

Within province analysis revealed that 29% of the population that reside in Gauteng has private health insurance, only 26% of the population that reside in Western Cape province had medical cover, it is of interest to note that within province like Northern Cape 16% of the population has medical cover, this relatively higher than the Kwa-Zulu Natal where only 12% of the population had private medical cover, similarly to the Mpumalanga province 15% of the population in the province belonged to a medical scheme.

The characteristics presented in this section highlighted unequal socio-economic conditions at provincial levels, in particular the Eastern Cape and the Limpopo province where more than nearly 90% of the residents in those provinces did not have medical cover [6]. The GHS by Statistics South Africa in 2009, respondents were asked to respond to a question as to why they do not belong to a medical scheme [32]. The survey reported that 90.0% of households that do not belong to a medical aid scheme say that they do not have money to pay for it. Indeed affordability is a leading indicator to joining a scheme. The proportion of the population in particular, poverty struck provinces residents do not benefits from rich resources offered in the private sector as they don't belong to medical schemes.

Poverty lines in the Eastern Cape

Challenges faced by poverty struck residents in the Eastern Cape, particularly accessing

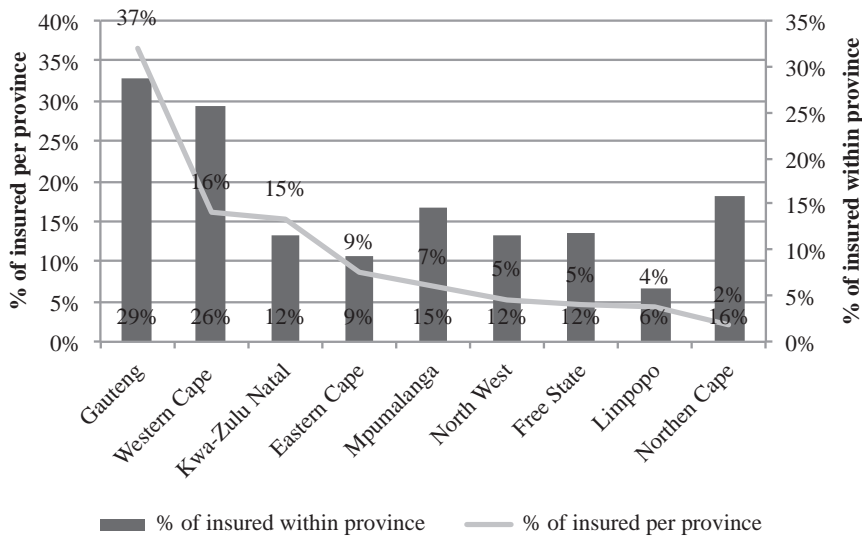


Figure 4. *Distribution covered¹ lives by province.*
 Source: (CMS, 2009; Statistics South Africa, 2009)

¹ Covered refers to people belonging to medical scheme

poorly resourced public health care facilities are alarming and there are many contributing factors attributed to these. Poverty lines in the Eastern Cape vary greatly between ethnic groups, mostly prevalent in African and Coloured communities. Almost two thirds of the population (70%) live in rural areas, this translate to 30% of the population that reside in urban areas [23]. This is a complete reverse to the national comparison (37% rural and 63% urban).

More than two thirds of all Africans in the province live in rural areas which in most are under-resourced, under- developed and do not have adequate health care facilities. Furthermore, poverty rates in the province vary greatly between population groups (73.8% of the Africans are poor compared to the 48.7% of the Coloureds who are also poor). The poverty rate in the province is estimated at 68.4%, clearly poverty is a rural phenomenon in the province and most of the rural based residents are unemployed and do not have descent income [23].

Health facilities in the Eastern Cape Province

The 2008 data presented by Medpages (see Figure 5) estimates 11% of residents in the Eastern Cape belonging to medical schemes; this was comparable to the proportion of private hospitals in the province. Nearly 90% of the population depends on provincial or public hospitals. Two of the biggest public hospitals in the province feature in the top five worst hospitals in the Country, namely the Cecilia Makhiwane and the Umtata General Hospitals [7]. The status due of the two public hospitals further impacts negatively of the public seeking health care. Notwithstanding the feature in the top five worst hospitals in the country, these two hospital's have a responsibility of providing sustainable health service to the people of the Eastern Cape, in particular those who reside in rural areas.

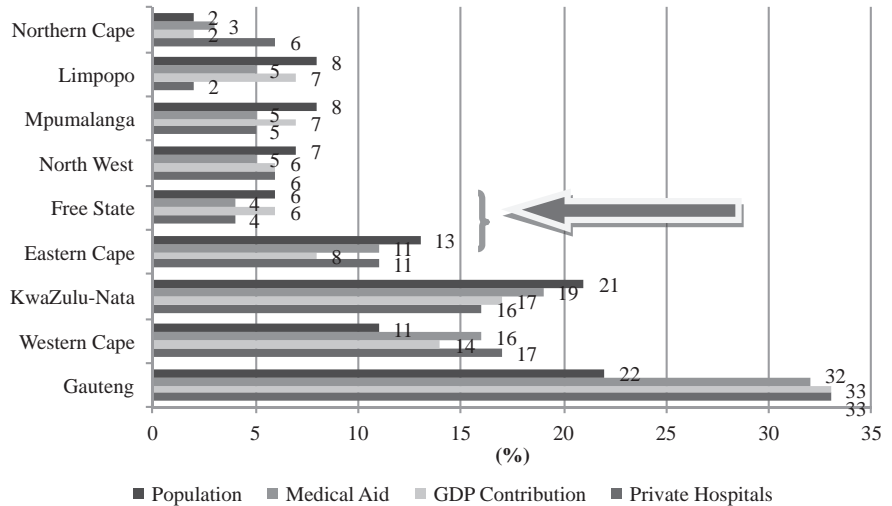


Figure 5. Private Hospitals by province.

Source: Medpages, 2010

Table 1. Number of public health facilities in the Eastern Cape province (2007)

	Cacadu	Amathole	Chris Hani	Ukhahlamba	O.R Tambo	Alfred Nzo	Nelson Mandela	Total
Clinic	58	213	136	44	143	46	43	683
Community Health centre	2	7	3	1	10	2	7	32
Mobile Service	27	42	29	14	13	6	9	140
Satellite Clinic	2	2	2	1			1	8
District Hospital	10	14	14	8	10	4	1	61
Regional Hospital		2	1		3		3	9
Specialised Hospital	5	5	1	2	1	1	4	19
Public sector beds	1164	4243	1438	575	3280	629	2092	13421

Source: The District Health Barometer Year 2006/2007

Various underlying factors results to the health care crisis in the Eastern Cape public health sector and these include amongst others dysfunctional management of the

health care facilities. In some areas clinics are small and unable to service the nearby communities. Table 1 presents the number of public sector health facilities by districts

in the Eastern Cape Province. These are not population based in the province as some of these facilities are not accessible to many, especially in rural district Alfred Nzo, and Ukhahlamba and Cacadu [23].

The Rapid Assessment of Service Delivery and Socio-economic survey in the Eastern Cape revealed that 45.4% of the households in the province had access to hospitals. The highest accessibility to hospitals was the Nelson Mandela Metro (79.5%). Nelson Mandela Metro is more urban compared to the more rural Alfred Nzo (20.8%) and Cacadu District municipality (6.4%). Cacadu District municipality had the lowest response rate to accessing hospitals. Similar patterns were noted with regards to accessing clinics, the lowest level of access to clinics was Alfred Nzo where only 35.3% of households had access to clinics, which implied nearly 65% of the population respondents did not have access to primary health care facilities.

Furthermore, the study reported disparities in terms of provisions of family planning services; only 43% of the households in the province had access to such services, mostly prevalent in urban areas as opposed to rural, Nelson Mandela Metro (76.4%) compared to Alfred Nzo (19%). These data further presented disparities of health care provision within the province; there were great characteristics differences between the urbanised settings and rural based areas within the province. Most residents in rural and poverty struck areas still did not have access to good quality care and even at primary level [1]. There survey revealed correlation between urban setting and rural setting, poverty and provision of health care services.

Primary care level is the first level of contact of individuals, the family and community with the national system where primary or essential health care is provided. Most of the health problems can be dealt with and

resolved at this level [5]. The hierarchy levels of the health care sector in the Eastern Cape Province as well as at national level are disintegrated as a result the PHC system in failing [17]. Shortage of trained staff in PHC is indeed a regularly cited concern of the Eastern Cape NDoH itself, particularly in the rural areas of the Province SHISER and DRA, 2008. Poor and uncoordinated referral system between primary, secondary and tertiary level of care often result in work-overload for health care professionals at secondary level of care institutions [10].

Cullinan [7] further reported that regional hospitals in the province are often the most overburdened of all levels of hospitals, bearing the brunt of the many inadequacies in the district hospitals. A number of district hospitals in the Eastern Cape are unable to perform basic operations such as Caesarean sections because of staff shortages. These get referred to regional hospitals, which are only supposed to deal with more complicated health problems. The Eastern Cape currently does not have any level III hospitals and has a population more than 6 million people [7]. A Level III trauma centre does not have the full availability of specialists, but does have resources for emergency resuscitation, surgery, and intensive care of most trauma patients; this means that there are no specialised services in the province. So as a result people needs to travel; to neighbouring provinces for such services. This again pointed out to unavailability of advances health facilities in the province.

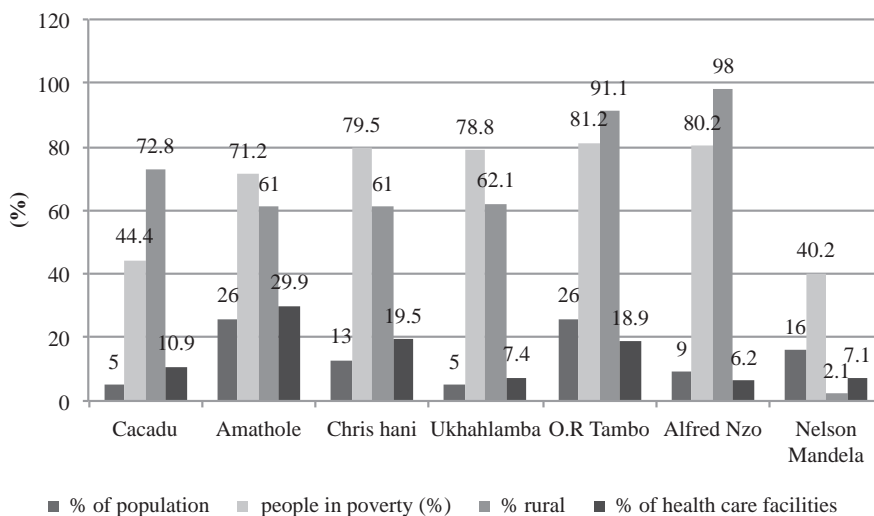


Figure 6. Poverty rates, health care facilities, and population rates per district¹
 Source: generated by the author from different sources: (RASDSSEC, 2008; ECDoH annual reports; [3])

¹ The graph should be interpreted with caution as the data was extracted from different sources and is also evaluated at different time points

Shortage of ambulance services and distance as a barrier to access health care

The rural areas are often inaccessible due to the poor condition of the roads and this influences people's ability to seek health care, the transport of patients to referral points as well as the distribution of drugs and other materials [11]. The Eastern Cape Health

Conference cited drug shortages, long queues, and lack of accountability, a broken referral system, poor treatment of patients by health workers, a weak primary health care system and the long distances patients have to travel as the major problems in the province. Participants said the lack of ambulances, for patient transport and trauma incidents was a major concern. It was also noted that access for emergency deliveries is clearly hampered by long distances.

Poku-Boansi [25] in their paper established that poor state of transport infrastructure and service adversely affected the ability of pregnant women to seek healthcare in the recognised health institutions as a result they rely on traditional birth attendants who lack the necessary skills and equipments to deal with complicated cases.

Fawcus et al. [12] found that up to 50% of maternal deaths from hemorrhage were attributed to the absence of emergency transport. Distance was cited as reason women choose to deliver at home rather than at a health facility (see for Philippines [31] Uganda [17] and Thailand [27]). In other words, women living farther away are less likely to choose a health facility for delivery, although their inferior access makes them the most vulnerable group in case of an emergency.

Many studies reveal the unsurprising fact that household use of services tends to decline with distance, a study conducted by Tanser, Gijssbertsen, and Herbst showed that people in rural homesteads travel four times longer to access care than do their affluent urban counterparts, see table 1 below: Furthermore Literature showed that 70% of the poor in Ghana cited distance from a health care facility as a major obstacle [15]. This is a key reason urban citizen, who is often also wealthier, use services more than their rural counterparts. Lower rural access, reported in many studies, may well be the impact of an interaction between longer distances and less knowledge of treatment [11].

Table 2. *Travel time to clinics and adjusted odds ratio of clinic usage*

Setting	Travel time (minutes)		Adjusted odds ratio	
	Avg	Std. dev	OR	95% CI
Urban	20	9.7	1 ¹	
Peri-urban	55.7	31.8	28.2	19.2–41.3
Rural	83.9	29.3	18	12.5–26.0

Source: [33].

The data reviewed in this section revealed key obstacles that are barrier to accessing care which includes health care charges, **long distances** to facilities, inadequate and unaffordable transport systems, poor quality of care especially in public sector facilities. The following section proposes initiatives that could be explored to reduce or eliminate access barriers to health care in particular the remote areas.

Discussion

Access barriers faced by many South Africans in particular those residing in rural areas require governments, policy makers and health care providers need to better enforce existing policies and regulations. There is a need to engage local government and communities in particular with regard to service delivery and ensuring that infrastructure is place [9]. It should also go beyond to just ensuring that the infrastructure is there, but the maintenance thereof and both the local government and the communities need to play a critical role in this regard.

In addressing access to care, it is important for governments must avail transportation options in all communities regardless of location or population size, this includes making sure that ambulance services are accessible. This is critical to the implementation of the National Health Insurance in South Africa.

There is a number of initiatives that could potentially be explored in dealing with

distance and transportation as a barrier to access health facilities. These include providing subsidies, ferry discounts or travel vouchers for patients that have to travel for medical care these includes transportation vouchers [4].

The expansion of access to high quality primary care will make an enormous difference in health care outcomes in the so called under resourced areas. It is known that providing more resources to attract and retain health care professionals to rural areas is essential to improving access to health care in rural areas. It is imperative to deal with challenges facing residents in rural areas that compromise accessing public health services, in particular those that are heavily struck by poverty. It is pivotal that government agencies like, Department of Health, Social development, and the department of Public works are integrated to work together in improving service delivery.

Conclusions

Poor South Africans do not benefit public health spending by the government and those in poverty are often marginalised. In many instances due to bad communications between government departments. Other contributors include maladministration of public funds which undermine service delivery and result in deteriorating public health care facilities. Indeed unemployment and poverty lines are the highest in the Eastern Cape compared to any other province in South Africa. As a result most



of the citizens cannot afford basic health-care facilities. Also the province like the Eastern Cape has a higher concentration of residents who live in remote or rural areas.

Residents who live in rural areas at times travel greater distances to access different points of the health care delivery system. In most instances health care facilities in these areas are limited or there are just not enough healthcare work-forces. The Government should implement a focused programme to improve operational efficiencies including clear devolution of district and hospital authorities, simplification and better use of management information, and better financial and performance accounting. If the provision of health and medical services is isolated and not seen in the context of poverty reduction, then poor will continue to experience problems and the current trends will still be maintained.

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Articulating Person-centered Medicine and People-centered Public Health: A Report from the Fourth Geneva Conference



Standing LtoR: E Ramirez, A Miles, M Dayrit, R Montenegro, C Maguina, S Rawaf, I Salloum, RA Kallivayalil, G Brera, W Van Lerberghe, M Botbol, J Snaedal, T Epperly, J Appleyard, D Matheson, and H Montenegro. Seated LtoR: E Velasquez, C Etienne, R Kaitiritimba, JE Mezzich and A Fort, at the Closing Session of the Fourth Geneva Conference, WHO Executive Board Meeting Room

The Fourth Geneva Conference on Person-centered Medicine was held on April 30-May 4, 2011, the latest in a series of annual Geneva Conferences on this topic since May 2008 [1-3]. It continued building an initiative on *Medicine for the Person* [4] through collaboration with major global medical and health organizations and a growing group of committed international experts all engaged into an International Network for Person-centered Medicine [5].

The conference took place at the Marcel Jenny Auditorium and auxiliary halls of the Geneva University Hospital and at the Executive Board Room of the World Health Organization. It was organized by the International Network for Person-centered Medicine (INPCM), the World Medical Association (WMA), the World Organization of Family Doctors (Wonca) and the World Health Organization (WHO), in collaboration with the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses (ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Sur-

geons (ICS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the World Association for Sexual Health (WAS), the World Association for Dynamic Psychiatry (WADP), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the International Federation of Medical Students' Associations (IFMSA), the International Federation of Ageing (IFA), the European Association for Communication in Health Care (EACH), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), Ambrosiana University, Buckingham University Medical School, and the Paul Tournier Association, and with the auspices of the Geneva University Medical School and Hospitals.

Under the overall theme of *Articulating Person-centered Clinical Medicine and People-centered Public Health*, stimulated by the WHO World Health Assembly Resolution promoting people-centered care [6], the Fourth Geneva Conference on Person-centered Medicine examined through a set of

diverse sessions how the values and clinical care practices of person-centeredness could be organized in diverse settings, from the bed side to the community.

The Conference Core Organizing Committee was composed of J.E. Mezzich (President, International Network for Person-centered Medicine), J. Snaedal (World Medical Association President 2007–2008), C. van Weel (World Organization of Family Doctors President 2007–2010), M. Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section Co-Chair), I. Salloum (World Psychiatric Association Classification Section Chair), and W. Van Lerberghe (WHO Health Systems Governance and Service Delivery Director). Also collaborating organizationally were O. Kloiber (WMA Secretary General), A.M. Delage (WMA Secretariat), M. Dayrit (WHO), R. Kawar (WHO), and J. Dyrhaug (WHO).

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

Pre-conference workmeetings

The first workmeeting on April 30, 2011 focused on three substantive projects related to the informational framework of the INPCM. These included a presentation on the launching of the International Journal

World Medical Journal



of Person Centered Medicine (IJPCM) as a joint venture of the INPCM and the University of Buckingham Press. The first issue of the Journal has already been published and subsequent issues are in preparation with papers submitted from across the world. The second presentation provided an overview on the updated INPCM institutional website and interactions with related ones, while the third presentation offered an overview on the bases for the development of a bibliographical clearing house and institutional databases.

The second workmeeting was dedicated to the development of Person-centered Clinical Care Guidelines. This project was undertaken from a range of perspectives such as pediatrics, family practice, research, programmatic, and patient vantage points. The attendees were engaged in stimulating discussions on the conceptualization and role of guiding principles within the context of person-centered medicine.

The first workmeetings on May 1, 2011 paid detailed attention to the topic of Person-centered Integrative Diagnosis (PID). An overview of the current status of PID development was followed by 11 brief presentations and discussions addressing the major aspects and domains of the PID. These included diagnostic assessment procedures such as utilizing categories, dimensions, and narratives, the evaluators and the assessment process involving interactions among clinicians, patients, and carers. The presentations also reviewed the PID domains: disorders and comorbidity, disabilities and functioning, positive health and well-being, experience of illness and health, contributors to illness and health (etiopathogenic and risk factors as well as strengths and protective factors). This workmeeting concluded with discussions on diagnostic summary, treatment planning, case illustrations, and validation of the PID model and guide.

The second INPCM workmeeting on May 1, 2011 highlighted person-centered special

developments. These included a pediatric diagnostic model, the revision of the Latin-American Guide of Psychiatric Diagnosis, a French diagnostic project, a person-centered partnership project, a South Asian project, a World Federation for Mental Health-INPCM collaborative project, person-centered care for people abusing substances, and a Mexico-INPCM collaborative project on person-centered care on chronic diseases, and a Janus Project for person-centered young health professionals.

Core conference

The Core Conference was opened on May 2 by Prof. Panteleimon Giannakopoulos, Vice-Dean of the Geneva University Medical School and by Dr. Hernan Montenegro on behalf of Dr. Carissa Etienne, WHO Assistant Director General for Health Systems and Services. They were joined in the presidium by the core members of the Organizing Committee.

The opening address was delivered by the INPCM President, who presented a progress report on institutional achievements and horizons. He highlighted the network's growing number of participating international organizations from 10 in our inaugural 2008 Geneva Conference to 27 in our Fourth annual event. He emphasized the presence of the World Medical Association which inspired and supported the INPCM from its inception and the World Health Organization which has agreed since 2010 to co-organize the Geneva Conference given that people-centered care is one of the policy directions for the renewal of primary health care approved by the World Health Assembly in 2009 (WHA62.12) and has commissioned INPCM this year to undertake a study on the systematic conceptualization and measurement of person- and people-centered care. At the same time, the INPCM scholarly community is moving forward with the procedural construction of person-centered medicine as exemplified

by the recent publication of the Person-centered Integrative Diagnosis model in the Canadian Journal of Psychiatry [7]. An institutional landmark has been the launching this May of the International Journal of Person Centered Medicine [8] which shall enhance immensurably the prospects of our initiative on *medicine for the person*.

The first session of the scientific program was a symposium on the Person-centered and Contextualized Study of Disease. The first two speakers reviewed epistemological and conceptual perspectives, prioritizing phenomenological narratives, in order to broaden the theoretical framework beyond reductionistic biological and behavioral approaches. They also examined possibilities to study disease in a robust and rigorous manner that respects the subjectivity, context and uniqueness of the patient's experience. The other two presentations examined dementia and public health and revealed the feasibility and usefulness of multilevel person-centered approaches. Emerging as convergent recommendations were the need to develop single subject studies, integration of quantitative and qualitative findings, and assessment measures informed by comprehensive theories (such as the one used in the Person-centered Integrative Diagnostic model).

The second scientific session addressed the Components of Care in Person-centered Medicine, making clear that in addition to focused illness treatment, good medical care also involves understanding and support, education and counseling, as well as prevention and health promotion.

A considerable body of evidence was summarized indicating that crucial elements of clinician-patient interaction such as empathy, respect, acceptance, non-judgmental attitudes, openness, information-sharing and joint decision-making may lead to greater patient satisfaction, acceptance of treatment, and better health outcomes. Also emphasized was building trust and striving

to attain professional competence, ethics faithfulness, and effective communication and collaboration.

Six parallel sessions followed in the program, involving interactive workshops, brief oral presentations, and INPCM project discussions.

- The interactive workshop on Enhancing Person-centeredness in Diagnosis and Treatment Planning showed how these two crucial aspects of medical practice can become a powerful tool to enhance person centeredness. This is certainly the case of Diagnosis if considered as a process going beyond a mere nosographical effort. The Person-centered Integrative Diagnostic model carries this process out through the articulation of health status, experience of health, and factors contributing to health, the consideration of both positive and ill aspects of health at each level, and adding narratives to categorical and dimensional descriptions. Although sometimes neglected by clinicians as burdensome administrative paperwork, a treatment plan can become a very helpful instrument to bring about person-centered medicine. It is based on a shared understanding of the patient's health goals and the identification of biopsychosocial barriers that may interfere with positive outcomes.
- The interactive workshop on Research on Clinical Communication focused on practical conditions to promote international research on communication. It offered vivid examples on the pros and cons of observational research on clinical consultations, and stimulated participants to consider conducting such projects.
- The interactive workshop on the Person with the Disease at the Center of Teaching presented Western European, Eastern European and North American approaches to introduce person-centeredness in medical education. In addition to interesting particularities in these regional approaches, joint emphasis was made on the need to train students on empathy, subjective observation, com-

munication, and relational skills and the need to achieve them through early and supervised contacts with patients.

- The interactive workshop on Advancing Well Being and Health Promotion reviewed the place and enhancement of positive health in person-centered medicine at individual and public health levels. Work on personality development appeared to be helpful in this regard. Applications to disabled persons and to work in low resource countries were also discussed, highlighting WHO concerns and experience.
- A session presenting brief oral contributions to the Advancement of Person-centered Care was generated by participants at large. The topics discussed included the importance of context and method in person-centered medicine, experiences from Cyprus' medical education, the teaching of person- and family-centered care in a New York pediatrics residency program, a personal account of experienced disability in the UK, combating fragmentation through integration of health services in the Americas, primary care in the East Mediterranean Region, a case study from Bulgaria, fertility care in the Netherlands, person-centered psychiatry in Russia, British perinatal psychiatry, an orthogonal personality assessment procedure from Puerto Rico, and person-centered young health professionals' perspectives.
- A session with complementary INPCM workgroups meetings was also held. It discussed the advancement of Diagnostic Projects, Clinical Care Guidelines, the Partnership Project (linking professionals with users and carers), and collaboration with the World Federation for Mental Health.

The first General Assembly of the International Network of Person-centered Medicine (INPCM) took then place. It was attended by forty-five colleagues among representatives of major international organizations and individual scholars. Brief presentations were made on the Geneva

Conference's process and the emergence and advancement of the INPCM, as well as on the development and launching of the International Journal of Person Centered Medicine. The main agenda item was the presentation and discussion of an Institutional Plan that reviewed the organization's identity, mission, activities, structure, governance and support, established an International College of Person-centered Medicine as institutional successor of the INPCM, and asked the Board to take steps to implement it and report to the 2012 General Assembly. The General Assembly approved this Developmental Plan by acclamation. A Conference Dinner at a typical Geneva restaurant organized by the Paul Tournier Association followed.

The second day of the core conference was held at the WHO Executive Board Room and started with a Session on Making Progress in People-centered Care: Country Experiences with the aim of identifying health system conditions that are conducive to people-centered care. It opened with an address by Dr. Carissa Etienne, WHO Assistant Director General, who insisted on the necessity to link person-centered clinical medicine with people-centered public health and to involve wide professional and patient organizations to implement and promote such perspectives. Relevant experiences from four countries (New Zealand, Spain, Chile, and Uganda) were then presented, followed by an analysis of these cases in terms of aspects of people-centeredness that were addressed and ending with a final synthesis of main lessons learnt.

The aim of the second Session on Systematic Conceptualization and Progress Measurement was to identify and get agreement on metrics for measuring progress towards people-centered care. In the first presentation, INPCM presented the results of a study that was commissioned by WHO. It involved a substantial literature review and the engagement of a broad international array of health professionals and some patient

and family representatives through a Delphi method and other systematic consultational approaches. This yielded a preliminary person-centered care index, which was subjected to initial content validity and applicability evaluations. The second presentation from Australia was on the People-centered Health Care National Indicators Project which is a WHO initiative for the Western Pacific and South-East Asia Regions that resulted in a regional policy framework on people-centered care and is currently developing related monitoring indicators. The final presentation was done by colleagues in Belgium and the Netherlands on operationalizing the concept of people-centered care and this also involved a proposed indicators matrix.

The session on Stakeholders' Roles and Contributions to Advance Person- and People-centered Care revealed specificities on the prospective contributions of major international health institutions (from professionals to patients and carers) as well as converging perspectives among them. The strong interest stimulated in all session participants led to recommendations to have a similar session at the next Geneva Conference during which institutions would try to present formal policy statements on person-centered medicine and perhaps a conference declaration may be possible.

The third and last day of the core conference offered a plenary symposium on Education in Person-centered Medicine. It presented country perspectives from the UK, Italy, Peru, and India. The presentations highlighted the efforts of medical educators to strike a balance between the ever-expanding scientific content of the curriculum with the need to preserve the humanistic, cultural, and spiritual dimensions of education – education ennobled the healer in both mind and heart allowing him/her to be truly person-centered. The presentation of the WHO Initiative to scale up and transform health professional education emphasized the challenges and actions

towards producing health professionals in poor countries where there were shortages of health workers and where graduates emigrated after completing their training. The presentation focused on current efforts to develop evidenced-based recommendations which might guide policymakers and educators in undertaking interventions to address the shortages and imbalances of health professionals in countries in ways which truly addressed the needs of people (people-centered care).

Concluding remarks

The Fourth Geneva Conference was not only a new landmark in the event series initiated in 2008, but it was special in the following regards. It was sponsored by a record number (27) of international health institutions, it included for the first time parallel sessions which expanded the type and number of sessions offered (including for the first time oral presentations directly contributed by general participants), it reported on the INPCM research study commissioned by WHO on addressing systematic conceptualization and measurement of person- and people-centered care, it witnessed the launching of the International Journal of Person Centered Medicine, and it held our first General Assembly which established the International College of Person-centered Medicine as a successor of the International Network. At its Closing Session, Dr. Carissa Etienne, WHO Assistant Director General, invited all participants to come back next year for an even greater 5th Geneva Conference on Person-centered Medicine.

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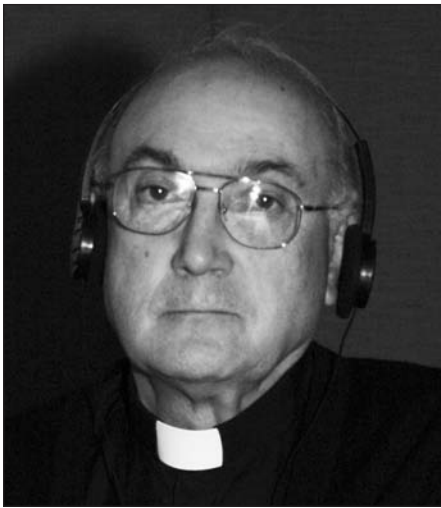
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On the Epistemological Nature of Clinical Ethics: Decision Making or Thinking?



Ignacio Carrasco De Paula

The appearance of contemporary medicine of the new “ethical dilemmas”, created by the increase in technical-scientific possibilities but also from social-economic and cultural evolving, has changed the focus from the formulation of general behavioral norms in medical ethics – as was proper to ethics as it was taught in university classrooms – to problems with the method employed, at the patient’s bedside, to come up with the best clinical decision.

The particular “focus” on the decision in the clinical area has had several positive effects. It has placed emphasis on the need for a rigorous ethical reasoning and, consequently, for the development of tools for ethical analysis supporting the diagnostic and therapeutic choices. Indeed, since clinical ethics began to define itself as an autonomous discipline, between the end of the 1970’s and the beginning of the 1980’s, it has become essentially characterized by the application of an analytical methodology – for a long time Principlism developed by T. L. Beauchamp and J. F. Childress and Neocasistry

by A. Jonsen and M. Siegler – to the deciding process in individual clinical cases.

I consider it undeniable that this practice has produced good results. However, it is also undeniable that, over time, limits have increasingly emerged: the displacement of the “focus” on the procedures tends toward a marginalizing of the ethical judgment. It seems to me that the juridical cases have produced a noticeable influence – often resulting in a failure of the ethical reasoning in clinical practice –, to the point that today it would be possible to outline a kind of history of medical ethics according to certain sentences from judges which caught the attention of public opinion: Quinlan, Cruzan, Schiavo, etc. This has often favored a legalistic interpretation of ethical analysis in medicine, which is continually more preoccupied with observing certain rules, like good clinical practices, respecting privacy, informed consensus, etc. (naturally, all the rules have to be rigorously followed), at the expense of the reflection on what is the just and reasonable interest of the patient.

When the center of the attention is taken up by the decisional process, the ethical analysis can be reduced almost automatically to the evaluation of possible consequences; for example, the choice between surgery or a chemotherapy and/or radiotherapy in the care regarding laryngeal carcinoma will depend exclusively on the percentile of success even though it is well known that, for the patient, the physical image or the ability to speak might weigh more heavily.

Moreover, an informed consent concentrated only on the bare deciding factors which are available in the clinical arena, would render it difficult for the patient to express a true free consent, in that the patient could be compelled to accept something that in

reality they would not want. Consent is not so much about the transition from the decision to its being put into action as it is about the transition from the ethical value to the clinical decision. The doctor should help the patient to consider not only the facts, but most of all the reasons which are at the basis of an eventual decision, otherwise it is easy to subtly fall into the old paternalism which we thought was buried once and for all.

Thirty years after its initial shaping as an autonomous discipline, we can say that the nucleus of clinical ethics still consists in the methodology of analyzing the ethical problems of clinical practice (moreover, well accepted by medical doctors, who really need a mediation between the general moral principle and the individual case) and recourse to ethical consultation (for example, within the ad hoc committee) as expertise in the most complex situations. Nevertheless, it is important to confirm that the efforts to elaborate an ethical approach centered on the person should always remain a priority. It is necessary to think and to apply a clinical ethic which does not lean exclusively on a decisional procedure or on a methodology of analysis of the situation, but which understands the attention to the person – as it regards the patient and as it regards the doctor – in its entirety. What really exists, as a matter of fact, is the person in its individuality and its singularity, while all the rest, including the ethical analysis of the clinical decision, constitutes a descriptive perspective unfortunately partial and sometimes even relative.

The same problematic often in the clinical decision is only one side of a much greater ethical issue, which effects the relationship between the doctor and the patient in its totality and, probably, the very essence of the medical profession. Therefore, today it is becoming increasingly more evident that a clinical ethic which limits itself to offering a solution only in terms of the decisional procedure would not be capable of grasping the complexity of clinical medicine, much less



to give an adequate response to the ethical dilemmas resulting not from an illness but from the very same patient even if often occurring unawares. In any case, we cannot forget that sickness, just as with any coin, has two inseparable faces: the pathology and the way in which the individual patient reacts in a situation of vulnerability, pain and dependence.

Certainly, a methodology of analyzing clinical cases offers the advantage of a greater certainty in the attempt to bring order to the multiplicity of relevant elements within an ethically complex situation and to render objective the assessment of the concrete decision that arises. At any rate, it is good to remember that the “certainty” offered by the methodology of an ethical analysis of the clinical case remains a “morale” certainty, a certainty which provides and takes into consideration the real possibility of making a mistake.

An exclusive trust in methodology causes a rigidity in the subsequent action according to a pre-established pattern which isn't able to take into consideration the total human capacity to act. Reality doesn't always adequate itself to the model, simply because no model elaborated by the human mind can exhaust reality, especially when we base this reality on the human being in all its simplicity and complexity. On the other hand, the same clinical medicine teaches us how the models and the mechanisms learned in the university classrooms rarely

work as a direct rule for the cure of illness in real patients.

One possible solution to the limits of a clinical ethic, intended only as a decisional procedure, is to remember that the “ethical” understanding which the doctor has to acquire in order to arrive at a clinical behavior which is truly virtuous isn't only that offered by the content and the methods of ethical reasoning, but also that which comes from an understanding of the individual patient acquired thanks to clinical experience. The conceptual information which we possess regarding a given pathology and its evolution (medical data, rules and ethical references etc.), as it has been said, constitute a necessary understanding, but this is not sufficient. They are, again, only theoretical ways of understanding which don't yet grasp the variety and dynamic, full of nuances and sometimes unpredictable, of the existential dimension of real life. For a doctor, therefore, knowing the clinical situation necessarily demands an experience involving that individual sick person, so that if a clinical decision is taken, for example, considering only the laboratory parameters, diagnostic reports and ethical advice, without ever “meeting” the patient, in no way could this be called an appropriate ethical behavior.

From this perspective, we know well that, for the doctor, it is important to develop a relationship with the way, perhaps even emotional, in which the patient perceives their condition. The doctor who is moved

by a true interest and by a real compassion as it regards his patient, is able to penetrate his suffering and to recognize the specific traits of the patient's living this illness, to discern the human and existential needs which the patient doesn't always manifest. In the opposite case, if the doctor disregards or ignores the value and the individual dignity of his patient, it will be hard for him to listen (the doctor becomes deaf) and to assume the necessary empathic attitude in order to obtain that kind of understanding. Showing interest and friendship constitute an indispensable attitude in the clinical encounter.

We could conclude, then, affirming that within the clinical ethics of the XXI century, if we avoid confusing model and reality, along with making a decisional procedure absolute, a methodology of ethical analysis in clinical cases could constitute a useful, even though necessary help in the face of more complex clinical cases. Nevertheless, today, non-negligible contributions to clinical ethics come from narrative medicine, from the ethics of healing and, in general, from the ethics of virtue, perspectives which are mostly open to an ethics of relationship and which can effectively integrate the indispensable ethical analysis of the clinical decision.

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Dependency on Sponsorships and Relations to the Pharmaceutical Industry: Experiences from Denmark

For many years, the Danish Medical Association has been preoccupied with the question of creating clear guidelines for

the collaboration between doctors and the pharmaceutical industry. This has been done per agreement with the indus-

try which in turn also profited from a responsible way of conducting business in terms of improving their image. The goal has been to minimise the interdependency between doctors and the pharmaceutical industry.

With regard to the collaboration with pharmaceutical industry there is Danish legislation compelling doctors to inform



Poul Jaszczak

the Danish Medical Board about their involvement be it as a consultant or in the capacity of expert in workshops and educational activities sponsored by the industry or shareholder in a specific Pharmaceutical Company. This practice enables the Danish Medical Board to evaluate the dependency of a physician concerning the relationship with the industry and to review his research findings and actions as a doctor in this light. Shareholders are more likely to view the research findings of a company in a more positive light than independent physicians. The National Board of Health has the authority to limit the right of the physician to prescribe medicine if it fears that the physician is under undue influence of the pharmaceutical industry referring to the prescriptions made by the physician.

In 2006, the Danish Government entered into agreement with other political parties on a plan of action in view of a big increase in the public expenditure on pharmaceuticals. Among the issues for discussion were provisions on the collaboration between health care personnel and the pharmaceutical industry. On the basis of this, the Minister of the Interior and Health passed a set of rules on advertising.

In 2007 the Danish Medical Association made an agreement with the pharmaceutical industry. It was agreed that any initiative or arrangement to which doctors were invited by the pharmaceutical industry – be it post graduate education and courses abroad – should be declared and reviewed by a board. This board was instituted based on an agreement between pharmacists, medical doctors and the pharmaceutical industry.

The board could impose sanctions on both the involved doctors if they did not declare an application to the industry before the board and on the industry if the initiative to invite doctors for postgraduate education was not cleared with the board beforehand. The sanctions were pecuniary and the size of the “fine” was related to the seriousness of the offence.

The pharmaceutical industry in Denmark has now terminated the agreement with the Danish Medical Association and the pharmacists referring to internal rules of the multinational companies. Most pharmaceutical companies are present in many countries and nowhere else in the world have the rules for collaboration with doctors been as strict as in Denmark. The multinational companies have therefore not been able to fit the Danish Model into their yearly reports and since it is very common to do advertising and promotion by presenting gifts to doctors or to organisations, the boards of multinational companies are not willing to abolish this practise which has a positive effect on the prescription of their drugs and the purchases of pharmaceuticals in the hospitals in general.

It is in this light that we have to view the willingness of the industry to sponsor what would appear to be activities irrelevant for their business and with no immediate financial gain. The calculation of these multinational companies is of course that in the long run there is indeed a financial gain and that good relations pay – unfortunately, it

also has an effect on the public expenditure concerning the purchase of pharmaceuticals.

In the future, the regulation of the collaboration between doctors and industry in Denmark will be subject only to Danish national laws since the development that the DMA started has been rolled backwards by the industry itself.

However, the DMA has introduced a set of guidelines to its members stating that the reception of gifts – even pens and notepads – is not appropriate.

The way forward. What should be promoted in order to increase the credibility of doctors and attacking accusations of dependency is securing that there are no ways of influencing one another in terms of conducting business. It should not be possible for the industry to get good will from doctors by sponsoring dinners and courses. It is important to gain the patients’ trust that he or she will receive the best and cheapest medication and for society it is of great importance that doctors are not biased when they prescribe drugs at the expense of society. It will take a lot of dedication to change the ways of the pharmaceutical industry since they conduct business and do it well with the present promotional strategies.

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Physicians and Alternative Methods of Treatment: Do They Go Together?



Gert van Dijk

Introduction: The Silvia Millecam case

In August 2001, Sylvia Millecam died of breast cancer at the age of 45. Millecam was a famous Dutch comedienne and had been voted the most popular woman in the Netherlands many times. Her death came all the more as a shock when it was revealed that her chances of recovery were good in the early stages of her illness. At the start of her illness in 1999, more than 30(!) different physicians – the majority of whom were alternative practitioners – were involved in treating her. Many of the practitioners, including a Dutch faith healer known by her stage name 'Jomanda', repudiated the diagnosis of breast cancer. They referred to a 'bacterial infection', 'fibrositis' or a 'reaction to silicone breast implants'. These 'therapists' then provided her treatments such as salt therapy, electro-acupuncture and magnetic field therapies. These all failed to produce results, resulting in a medical event and death which an oncologist described as 'mediaeval'.

What made the case more complicated was that Millecam rejected conventional treatment comprising surgery and chemotherapy from the start of her illness. She had observed the side effects of chemotherapy among her circle of friends and she herself wanted to avoid this. A second salient detail is that a number of the alternative practitioners were also doctors. Their title of Doctor of Medicine instilled in Millecam trust in the alternative treatment. 'He is a doctor, so it should be fine,' was the way she looked at it.

The Netherlands Healthcare Inspectorate, an organisation associated with the Ministry of Health which supervises the quality of health care, conducted an extensive investigation into the course of events surrounding her treatment and published an exceptionally detailed report (IGZ 2004), which incidentally raises a number of interesting privacy concerns. Three doctors were called to account by the Disciplinary Committee for the Healthcare Sector, which assesses the professional competence of physicians. Following an appeal, two of the physicians permanently lost their title 'Doctor of Medicine'. A third physician was suspended for one year.

Apart from the Disciplinary Committee, the case was also handled by the Public Prosecution Service, which found that criminal errors had also been made as well as medical and professional errors by the practitioners treating Millecam. Following countless legal proceedings, in December 2010 two doctors were sentenced to three and six-week suspended prison sentences. The court found sentencing advisable 'in view of the seriousness of the facts and the consequences thereof, and in view of the importance of marking standards, not only by means of adjudication but also through

punishment'. Faith healer Jomanda, however, was acquitted because the court deemed that it had not been proven that she had dissuaded Millecam from undergoing conventional care, nor had she left Millecam in a helpless state.

Freedom of choice

Sylvia Millecam's tragic death created a great deal of social unrest in the Netherlands and spurred social debate that continues to this day. Her death provoked a turning point in the debate about alternative and conventional medicine. Since that time, it has in fact become clear that the often-heard words 'it doesn't hurt to try' no longer holds true. Alternative methods of treatments can actually inflict harm, simply because of the fact that they may cause patients to miss out on meaningful conventional treatments, or they could delay the start of such treatment. Numerous people have therefore become more critical of alternative practitioners.

Following the disciplinary and criminal court judgements, an important standards and legal framework was developed for the acts of alternative practitioners. Yet these judgements have not curtailed a patient's right of self-determination in choosing his or her own healthcare provider: after all, patients will always retain leeway to approach an alternative practitioner. But the leeway for alternative practitioners, both physicians and non-physicians, has been more clearly defined: they must inform patients correctly about the effectiveness of their treatment and distinguish clearly between conventional and alternative treatments. Practitioners are also not permitted to blindly concur/agree if the patient refuses to face the facts. If the patient clings to an illusion, practitioners must endeavour to refute the illusion and point out to the patient the importance and necessity of undergoing conventional treatment. If need be, the practitioner should sever the treatment relationship. The refusal of patients to undergo



conventional treatment does not grant alternative practitioners a licence to practise. The reason primarily being the vulnerability of patients suffering from a life-threatening disease. The position of such patients makes them grasp at straws all too easily. The court stated in its judgement that 'freedom of choice no longer applies in such a vulnerable situation'.

The Millecam case raises a number of important questions, i.e. how much leeway do physicians still have in diverging from the professional standard, and what should physicians do with patients who reject conventional medicine? Partly prompted by the Millecam case, the Royal Dutch Medical Association published guidelines in 2008 which were preceded by substantial debate in the medical profession.

What are alternative and complementary treatments?

The terms 'alternative treatments' and 'complementary treatments' are catch phrases, covering over three hundred different methods of treatments. A number of these methods of treatment claim to employ a 'holistic concept of mankind', which revolves around the patient as a whole rather than the specific illness. Other methods of treatment, such as chiropraxy, place less emphasis on this aspect. Some forms of treatment, such as bioresonance therapy, acupuncture and homeopathy, conflict with empiricism, the biological principles or the laws of physics. Homeopathy, for instance, assumes that water has a 'memory' which is capable of spurring the body to self-heal. Many alternative treatments are based on various, conflicting effectiveness principles. Homeopathy, for example, assumes extreme dilution, while orthomolecular medicine in fact uses high dosages of vitamins and dietary supplements. Some forms of treatment are harmless from a medical point of view, such as homeopathy, which is chemically identical to the solvent, generally water or alcohol.

Other forms of treatment, such as chelation therapy or herbal therapy, may cause life-threatening complications, or interfere with regular treatments, such as anti-conception or chemotherapy. Many alternative forms of treatment lay claim to an aura of 'naturalness', even though a description of what this means is rarely given. All things considered, alternative or complementary forms of treatment do not have much in common – except that there is no scientific proof of their effectiveness, and for that reason they are not accepted by conventional medicine.

The main difference between conventional and alternative forms of treatment is that conventional medicine seeks to work in line with the requirements of evidence-based medicine (EBM). This implies that physicians are guided by the state of the art in medical science, combined with their clinical expertise, including taking account of the patient's expectations, wishes and experiences. Many alternative practitioners claim that their forms of treatment cannot be scientifically substantiated because they work in accordance with a 'different paradigm' or because each patient is different, and for that reason randomised trials cannot be conducted. In recent years this line of reasoning seems to be waning, and alternative practitioners are similarly claiming to employ evidence-based working methods, and referring to 'evidence-based complementary and alternative medicine' (EBM-CAM). Despite the purported scientific proof thereof, alternative practitioners generally attribute the fact that these forms of treatment do not belong to conventional medicine, to 'conservatism' or 'pharmaceutical industry interests'.

Conventional medicine has always heavily criticised the term 'alternative medicine'. After all, there is no such thing as 'alternative physics' or the 'alternative legal profession'. Who in their right mind would board an aircraft if the pilot were to use alternative methods to steer the aircraft? And, if the non-conventional practitioners were to

actually offer alternatives, why are they not conventional? Moreover, numerous conventional practitioners hold the view that it is dangerous to suggest that alternative forms of treatment exist for serious illnesses. To avert these issues, nowadays alternative practitioners prefer to talk about 'complementary treatments' to suggest that these forms of treatment should be viewed as being *supplementary* to conventional medicine, and not as an *alternative* for the latter.

The term 'complementary' too, however, is subject to criticism. Astrology is also not 'complementary' to astronomy, is it? And, if such medicine can only be complementary, does the term 'medicine' still apply? For that reason the Royal Dutch Medical Association KNMG would prefer to refer to 'non-conventional forms of treatment', versus 'conventional forms of treatment' (KNMG 2008). Since it is uncertain whether these treatments also actually cure an illness, the term 'form of treatment' is more neutral than 'treatment'. According to the definition applied by KNMG, conventional forms of treatment are 'the forms of treatment based on the knowledge, proficiency and experience required for the purpose of obtaining and retaining the title of Doctor of Medicine, which is generally accepted by the medical profession and forms part of the professional standard' (KNMG 2008). In other words: conventional medicine is what physicians who practice conventional medicine do. This also includes experimental forms of treatment, the effectiveness of which still is subject to medical and scientific research, to the extent these have been tested within the statutory assessment framework. 'Non-conventional forms of treatment' are those forms of treatment that fall outside the scope of the above definition. The nature of the definition is purely procedural, and says nothing about any methods or concepts of mankind embraced by the various forms of treatment. The advantage of the above definition is that it is neutral, and does not lay down for once and for all what definition should be ap-



plied to conventional medicine. This leaves open the possibility for incorporating in the professional standard certain treatments, which initially were non-conventional, if it emerges that there is sufficient scientific proof thereof. Another advantage of such a neutral definition, which avoids words such as 'alternative' or 'complementary', is that it does not make a statement on the value or position of alternative forms of treatment.

Legal situation

The Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*, BIG) dating from 1999 regulates the competence of a wide range of healthcare providers in the Netherlands. In addition to safeguarding a patient's freedom of choice, the key objective of the Act is to ensure and monitor the quality of healthcare provision. A third objective is to protect the patient against incompetent and improper conduct by a healthcare provider. According to the BIG Act anyone is allowed to practice medicine. The performance of certain medical acts (such as obstetric and surgical treatments, punctures, injections and anaesthesia) is the preserve of specific professional practitioners. In the Netherlands, making a medical diagnosis is not an act reserved for a specific group of practitioners, and it therefore may be performed by anyone. Because alternative treatments are not the preserve of a specific professional practitioner, alternative treatments may be administered by physicians as well as non-physicians. Medical disciplinary rules only apply to professions protected by the BIG Act, such as doctors and nurses. Alternative practitioners who do not hold a protected title, such as that of a Doctor of Medicine, fall outside the scope of the medical disciplinary rules. They also do not need an official registration. Since the BIG Act is also geared towards the patient's freedom of choice, a situation has arisen in which extremely stringent requirements are imposed on physicians but where non-physicians virtually

have free rein. They also do not carry a title protected by law, and consequently also cannot be discharged from their duties – unlike physicians. The Healthcare Inspectorate does not have any tools for intervening in the practices of alternative practitioners. Consequently, in day-to-day practice it has proven to be extraordinarily difficult to take legal action against alternative practitioners, partly because patients often find it difficult to file a complaint. Moreover, it often is difficult to prove that the treatment has inflicted harm on patients.

The legal situation in which everyone is permitted to practice medicine, barring medical acts reserved for specific practitioners, is not unique to the Netherlands but occurs in other Northern European countries as well. In many Southern European countries, only physicians are permitted to practice medicine.

Seven percent of the Dutch population is estimated to visit a non-conventional practitioner who is not a physician (Statistics Netherlands StatLine database 2007). Countless people do so for 'harmless' ailments, such as the common cold or for chronic complaints, such as rheumatism or arthrosis for instance. For more serious ailments, the conventional physician appears on the scene. There are few people who *solely* undergo alternative treatment. A declining number of Dutch physicians (currently estimated to be less than one thousand) apply non-conventional forms of treatment themselves, usually combined with a conventional practice.

The professional standard

Physicians are required to comply with the 'medical professional standard', which means: 'to act with due care in accordance with the knowledge of medical science and experience as a reasonably competent physician in the same medical category, in the same circumstances with medicines that are

reasonably proportionate to the concrete treatment objective' (Netherlands Health Law Handbook 2000, 41-2, *Handboek gezondheidsrecht*). The definition that applies to the above has become increasingly clear from case law in recent years, as well as how much leeway physicians still have in applying alternative treatments.

The first key requirement imposed on physicians is that each medical treatment should be based on a conventional diagnosis, which must be conducted in the 'proper manner'. Physicians are therefore not permitted to begin a treatment 'out of the blue', nor are they permitted to use non-accepted diagnostic methods. 'Bioresonance tests' or 'vega testing' are therefore off limits for physicians.

Once a conventional diagnosis has been performed, physicians are only permitted to apply treatments for which a medical indication exists. There must also be a concrete treatment objective. For instance, a physician is therefore not permitted to prescribe chemotherapy if there is no indication for doing so, or if this does not, or no longer serves a purpose. The concrete treatment objective may obviously also be palliative care, or removing or relieving the existential pain suffered by the patient.

According to the rules of evidence-based medicine (EBM), the treatment indicated at a certain point in time, is determined by the state of the art in medical science, the clinical experiences of the medical profession and the patient's wishes and expectations. The professional standard may incorporate several treatments for a specific diagnosis. As a rule, the physician will focus on the treatment that will yield the best results, having the least burden on the patient. If a medical indication exists for several treatments, the choice is determined in a meeting between the physician and the patient.

As stated, evidence-based medicine is founded on three underlying pillars: proof,

experience and the wishes and expectations of the patient. The patient's wish can thus never form an adequate reason for administering a treatment. The fact that a patient has asked for a particular treatment or the fact that a patient has consented to a particular treatment, does not discharge the physician from his duty to assess the indication and determine whether a particular treatment would be meaningful from a medical point of view. A physician who is confronted with a patient asking for chemotherapy while there is no medical indication for doing so, or in cases where concrete treatment results cannot be expected based on the state of the art in medical science, is not permitted to comply with the patient's wish. Even if a patient requests a futile medical treatment, such as injecting soda into tumours, the physician is not permitted to comply with the request.

The aspects incorporated in the professional standard at a certain point in time have not been set in stone, and there are always grey areas too where physicians do not agree with the prescribed treatment. The professional standard consequently is not a mandatory rule or 'cookery book medicine'. Each patient is different, and each situation requires another solution. Physicians therefore definitely have the necessary leeway to diverge from the professional standard. If they do so, they must be able to justify to their peers, the patient and society as to why they chose to diverge from the standard. Proper records and informed patient consent are vital in this context.

Physicians and alternative treatments

There are patients like Sylvia Millecam, who reject conventional treatment and wish to undergo alternative treatment – even if they are suffering from a serious disorder. What should physicians do in such cases? Physicians should be the first to earnestly point out the consequences to the patient

if they wish to be treated by an alternative therapist. They are required to continuously highlight the need for conventional treatment. In the Millecam case the alternative healers stated that Millecam herself had refused conventional treatment and they felt that this served as a licence for them to administer their treatments. In the Millecam case, the Disciplinary Committee, however, stated the following in respect of the above: 'A physician can no longer provide a person alternative treatment with impunity if the patient proves to need help which clearly can only be provided in conventional medical circles.' If conventional treatment exists, physicians are not permitted to simply ignore it. And if the patient refuses conventional treatment, this should not serve as a licence permitting physicians to offer all kinds of non-conventional treatments. After all, by doing so they wrongfully raise the patient's hope and expectations. The Amsterdam Court of Justice formulates the above as follows:

"The law gives precedence to the well-informed patient's right of self-determination. This does not mean to say, however, that the physician or the party providing individual healthcare does not carry any further responsibility. If he is asked to provide insight into the motives underlying his choice for applying a certain method of diagnostics or therapy, it will not suffice for the physician or healthcare provider to refer solely to the wish expressed by the patient.'

Another aspect that has emerged from the Millecam case is that patients have faith in the title of Doctor of Medicine. 'He is a doctor, so that should be fine,' Sylvia Millecam's doctors were insufficiently aware of that fact. Physicians must at all times understand that their title of Doctor of Medicine carries a certain authority with it. This imposes heavy demands on what they advise and offer the patient. As the Disciplinary Committee stated in the Millecam case: 'A physician, who also practices in the domain of alternative medicine, is thus not

discharged from acting in the capacity of a physician.' The KNMG formulates this as follows: 'Physicians are constantly aware that the diagnostics, methods of treatments and advice they offer revolve around the authority of the medical doctor/medical specialist education programme and the title of Doctor of Medicine or Medical Specialist.'

Are physicians allowed to offer alternative methods of treatment?

Coming to the key question: are physicians still permitted to apply alternative treatments, such as homeopathy or acupuncture? Clearly, such treatments may only be administered under very strict conditions. Doctors should always first ask themselves whether conventional treatment exists for the relevant diagnosis, and advise the patient thereof. After all, according to the KNMG rules of conduct 'the doctor is not permitted to apply treatments and disregard generally accepted diagnostic and treatment methods in the medical world'. The doctor must provide clear information to patients about the nature of their illness. The doctor must also make clear to the patient what the consequences are of not undergoing conventional treatment. But even if there is no conventional treatment, or this no longer exists, or if the patient rejects such treatment, the doctor cannot simply offer all kinds of treatments, the benefit of which has not been proven. Patients who are dying or whose treatments have finished are still required to be treated in accordance with the professional standard. After all, attention, comfort, pain control and palliative care fall within the scope of conventional medicine.

Furthermore, doctors must at all times avoid inflicting harm on the patient when providing non-conventional treatment. Harm is more than simply immediate

medical damage caused by the treatment itself. When providing conventional treatment, the benefit of the treatment always counters harm. That benefit has not been proven in non-conventional treatments, which makes it more difficult to justify any harmful effects. Harm is also inflicted if the doctor offers false hope of improvement, or recovering from the complaints. And if, as a result of the non-conventional treatment, the patient does not start undergoing a meaningful conventional treatment or does so too late (doctor's delay), this is also viewed as inflicting harm. The doctor is likewise not permitted to provide misleading information about the effectiveness of the non-conventional treatment or substitute a conventional diagnosis for a non-conventional diagnosis. Doctors are also not permitted to attribute a therapeutic effect to a particular treatment if this has not been scientifically proven. The proof must be stronger than the evidence of a certain *method*. Stating that it has been proven that homeopathy works, therefore will not suffice. So, this rules out 'there is scientific evidence that homeopathy works'. A statement of this nature is as meaningless as the statement saying that 'there is scientific evidence that conventional medicine works'. Doctors will have to specify what scientific evidence exists for a *particular* treatment and a *particular* dosage for a *particular* indication.

All in all, the leeway doctors have in applying non-conventional treatments therefore is not that large. And that leeway will probably become even smaller with the continued protocols and professionalisation of the profession of medical doctor, and the continued advancement of EBM. EBM will undoubtedly prove that parts of conventional medicine will likewise not prove to be meaningful, and they will be deleted from the professional standard as a result. That is what progress is all about. The scientific underpinning of other parts of conventional medicine will see further improvement, and that will only serve to enlarge the gap between non-conventional and conventional methods of treatment. Continued scientific research may possibly also show that certain non-conventional treatments are effective, and they will be incorporated in the professional standard as a result. But many non-conventional methods of treatment will end up in the circular files of history – joining the countless others that have been laid to rest here. That too is progress.

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A Mission to Save Public Medicine

After a long and complex struggle, a groundbreaking agreement was reached, one that will greatly benefit public medicine.

Deterioration of the Israeli Health System

In November 2010, the Israeli Medical Association (IMA) officially began negotiations with the Israeli Treasury to discuss

ways to improve the deteriorating health system. The IMA negotiated on behalf of 17,000 doctors employed in public hospitals and clinics. Unfortunately, after months of negotiations, little progress was made.

In early 2011, the Israeli Medical Association (IMA) publically announced the launch of "a mission to save public medicine," demanding additional manpower, more beds in hospitals, an increase



in physician salaries in the periphery and incentive pay for doctors working in specialties suffering from physician shortages.

World Medical Journal



Dr. Leonid Eidelman, IMA President, reported that a doctor's basic gross wage (without overtime and duty work) is only NIS 42 per hour (approx \$12) and should be raised by 50%.

Warning Strike

On the 3rd April, the IMA announced a 2-day warning strike, emphasizing that although we did not want a strike that could harm patients, to remain silent at this time would be akin to abandoning future patients.

Dr. Eidelman stated: *"For the past ten years we have worked with the government agencies to warn them about the biggest problems in public health. For ten years, we spoke with anyone who would listen, but have seen nothing done. Last year, when we realized that the situation was escalating, and soon we will not be able to provide the appropriate treatment for our patients- we decided to act more decisively against the Treasury. After months of negotiations, I regret to say that the Treasury is not interested in improving the health system, whether by adding hospital beds, by adding positions for physicians, or by providing in-depth treatment to existing problems."*

The warning strike operated in all the public health system facilities in the country. Hospitals operated with a skeleton staff, as they do on the Sabbath. Negotiations and sanctions continued throughout the months of March and April, but no agreement was reached.

Physician demonstrations and sanctions

After reaching a stalemate in discussions with the Treasury, on the 27th April physicians staged a large demonstration: approximately 2,500 physicians, medical students and supporters assembled in Jerusalem opposite the Israeli Parliament to protest the

government's failure to effectively address Israel's collapsing public health system.

Medical students from all four medical schools in the country also took on the cause, with around a thousand students transported from their various universities to the capital in order to protest. The students declared a strike and classes were cancelled for the day.

Further protests in support of the physicians struggle were staged during the months of April and May, at the Tel Aviv annual marathon, on Israeli Independence Day and on the Jewish festival Lag B'Omer. This day is typically celebrated by lighting bonfires, and the IMA held a mass rally under the slogan "Doctors are unwilling to continue putting out fires." Approximately 1,500 doctors, interns and medical students attended the rally, threatening to heighten the protest and announcing that on the 1st July they will start to 'work by the book'.

The IMA gave employers and the Treasury 6 weeks' notice, stating that if an agreement were not reached, doctors in the public health care system would start to work in literal agreement with current contracts and collective bargaining agreements, regarding issues such as work hours and on duty shifts. These issues are rarely literally implemented or enforced due to a lack of medical manpower.

Despite an ongoing series of sanctions and protests launched by the Israeli Medical Association, negotiations with the government on public health reform and increased wages for physicians remained unsuccessful. Al-



though inconvenienced, public support for the physicians ran high as people recognized that the system was in vital need of repair.

Other than several days of general strikes, sanctions during this period were interspersed between hospitals and ambulatory clinics, and the North and South of the country, so as not to cause undue hardship to any patient. In addition, throughout the strike, the IMA's "exception committees" worked to ensure that all urgent medical needs were addressed. The committees approved more than half of the requests for treatment presented by patients and their doctors. Physicians continued to treat all patients in life-threatening situations, even on days of full sanctions.

Appeal for Injunction

At the end of May, the Ministries of Health and Finance appealed to the Tel Aviv District Labour Court, requesting that it issue an injunction banning the Israeli Medical Association and doctors working in public hospitals from further work stoppages. On the 2nd June, the court rejected the State's petition. The court accepted a compromise proposed by the IMA, by which the doctors would limit their labor sanctions. The court also ordered the parties to conduct

intensive negotiations for two weeks, after which they would notify the court of their progress. Judge Michael Spitzer told the Ministry of Finance that there was no case for an injunction, since the doctors had not completely shut down the health system, and the strike was considered proportionate.

For three weeks in June the IMA held intensive negotiations with the Treasury under the auspices of the National Labour Court President. At the request of the Court President, the process took place behind closed doors. Partial agreements were reached on several issues; however, there were still major points of contention between the parties.

Work by the Book

On the 1st of July, doctors began to “work by the book”, according to which residents worked only 6 night and weekend shifts per month, instead of the 10-12 which some were working. They worked shorter shifts and left the hospital after completing the handover of their patients. Specialists who were not listed for shift work left the hospitals by 16:00 (except during a medical emergency) and did not take on additional work without remuneration. Out of responsibility to patients the IMA continued to run the exceptions committees to deal with appeals from patients who required urgent care.

Despite the fact that doctors had provided advance warning, the Ministry of Finance and Employers made no effort to prepare in advance or to negotiate matters that would end the crisis. Dr. Eidelman, reported

“We are conducting a fierce struggle to save the public health care system. We were disappointed with the conduct of the Treasury, who refuses to reach an agreement that will bring about health care reform. Now everyone will see the outcome if we work according to contracts and regulations. Unfortunately, if we do not take this step today and show decision makers what

happens when there are not enough doctors and positions for doctors, we will find ourselves in this reality in the future.”

The National Labour Court threatened to issue restraining orders against the physicians, as requested by the state, unless an agreement was reached. On the 24th July, after 15 hours of deliberations, the Labour Court announced that they accepted the position of the IMA, and rejected the employers’ requests for injunctions and the imposition of arbitration on the parties. The court declared that the sanctions which the IMA imposed have been reasonable and proportionate and therefore do not justify an order for an injunction.

The IMA was happy with this decision, which meant we could continue to fight to save the public health system.

Hunger Strike and March to Jerusalem

The following day, on the 25th July, the IMA held a press conference at which Dr. Eidelman called upon the Israeli Prime Minister and Health Minister, Benjamin Netanyahu, to intervene in the dispute. Dr. Eidelman took leave from his hospital and began a hunger strike, which he declared he would not stop until the end of the conflict. He requested that his colleagues not join him in the hunger strike, so that they could continue to responsibly care for their patients.

Concurrently, Dr. Eidelman began a 4-day walk from the IMA offices in Ramat Gan to the Prime Minister’s office in Jerusalem. Following police instructions, he walked with a small group of about 20 doctors each day, so as not to interfere with traffic. Throughout the week, protest marches were held at local hospitals and among community physicians across the country. Dr. Eidelman arrived in Jerusalem on Friday 29th July where he set up a tent outside the Prime Minister’s office.

134 days after the physicians declared a labor dispute and following months of negotiations, there was still no agreement. On the 31st July, Dr. Eidelman met with President Shimon Peres. President Peres promised that he would speak with the political leadership in order to try and reach a solution to the deadlock in negotiations. Dr. Eidelman restated his call for Netanyahu to personally intervene.”

“We were deeply honored to be hosted at the residence of the country’s number one citizen. But it is not honor that we are looking for; we are looking for a solution to the problems plaguing the public health system. We need more doctors to treat our citizens,” Dr. Eidelman stated.

Later that day, approximately 3,000 doctors and residents again protested opposite the Israeli Parliament, demanding a solution to the crisis in the health care system. Despite pleas from government officials and fellow doctors to end his hunger strike, Dr. Eidelman stated that he would continue until an agreement was reached.

Following the demonstration, the protesters marched to the Prime Minister’s residence, where Dr. Eidelman presented a petition with more than 30,000 signatures calling for a solution to save the public health system in Israel.

A most moving display of support afforded Dr. Eidelman by many in the government occurred on the 2nd of August, when he was greeted by a rousing standing ovation at a meeting of the health lobby in the Parliament.

Breakthrough in Negotiations

On the 3rd of August, a breakthrough was achieved in the discussions between the IMA and the Ministry of Finance. The state agreed to add 1,000 staff positions for doctors in hospitals, effective immediately. The 1,000 job slots would be fixed in the

agreement and would be in addition to allocations to expand the number of hospital beds within the next few years. The state also agreed to grants of up to 300,000NIS (approximately \$83,000) for doctors who move to the periphery or transfer to specialties where there is a manpower shortage. In addition, the number of night and weekend shifts of 26 consecutive hours would be reduced to six per month. Following this breakthrough, Dr. Eidelman, ended his hunger strike, which had begun 10 days earlier.

With hope to end the dispute, and following a hearing in the High Court of Justice, the Treasury and the IMA entered into accelerated and intensive negotiations in order to deal with the remaining issues. The IMA also agreed to cancel the work sanctions scheduled for the beginning of the next week. Dr. Eidelman reiterated that the struggle was not over and that many issues still remained on the agenda.

Week-long Mediation

At a High Court hearing on the 15th August, after another week of intensive but ultimately unsuccessful negotiations, the parties agreed to adopt the recommendation of the Court and enter into mediation. The IMA accepted this on the condition that the mediation would be limited to one week only, over the course of which public health care institutions would continue to strike.

The parties agreed that the mediation would include only a few issues, about which an agreement had not yet been reached:

1. Cost of the agreement
2. Distribution of the agreement
3. Duration of the agreement
4. The requirement that doctors clock in and out for shifts.

An Agreement is Reached!

After more than five months of a difficult and complex struggle, marked by intensive negotiations, on Thursday the 25th August 2011 a breakthrough agreement was signed.

The Israeli Medical Association and representatives of the Treasury signed a new collective bargaining agreement, which will change the face of the public health system.

Under the agreement, there will be significant additions to the health care system, including:

- The addition of more than 2.5 billion NIS in funding
- 1000 new doctor positions in public hospitals
- A limit to the number of resident on-call shifts: 6 a month
- Salary increases between 32%–80%
- 49% increase in average hourly wage
- Very significant salary increases for doctors working in the periphery, and a one-time grant of 300,000 NIS for doctors who move to the periphery

- Salary supplements and special grants for doctors who choose to work in specialties with a severe shortage, of up to 300,000 NIS
- 20% of the increases will go into effect immediately, and 70% will be phased in over the next 3 years.

Dr. Leonid Eidelman, President of the IMA stated: *"We set out to bring about change in public medicine in Israel and I'm proud to say that we achieved the goal."*

The road was not easy. But throughout the journey we believed in ourselves and the importance of the goal we set.

In fact, the change we made to the concept, that those who work more will get more, and those who invest more in public medicine will earn significantly more, will assure that the people of Israel will receive a better quality of medicine in a more equal health system.

It is important for me to thank the multitudes of doctors who persevered with the demonstrations and took an active part in the long fight. I also send my thanks and deep appreciation to the Israeli public and patients, who stood behind the doctors and showed us their support and tolerance. You have given us the power to bring about a real change."

*Dr. Leonid Eidelman,
President of the
Israel Medical Association*

European Medical Association

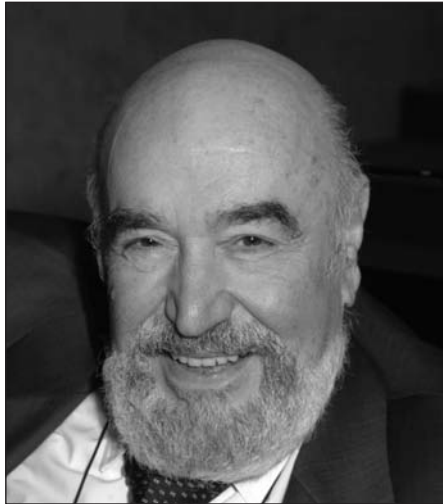
Future Dimensions of Medicine and Wellbeing

There are many definitions and attempts to describe united Europe. No doubt the most important features of this unique consolidation are sense and wisdom. Created in 1990 by doctors from the 12 member states, the

European Medical Association (EMA) was established as an *"international association pursuing a scientific aim"* according to the Belgian law dating 25/10/1919. Now we have members in all European countries

and many doctors from non-European countries are interested in our initiatives.

Twenty years later, the concept of Europe has evolved, and the free movement of people and services is a reality. We have all become more aware of the need for the optimisation of our resources, including in the field of health care.



Vincenzo Costigliola

The role of associations such as EMA, that facilitate the creation of networks and professional collaborations are growing at fast pace.

The European Union, with its 5th, 6th, and 7th Framework Program has given more and more space to research, patient's safety and economic evaluation of healthcare.

Many projects, ranging from undergraduate to postgraduate education, from training of medical translators to paediatricians, from predictive medicine to medicine and meteorology have been carried out and others are still underway. A complete list of projects is available on the EMA website.

EMA is a non-profit association free of any political, linguistic, ethical, philosophical or



Lyubima Despotova-Toleva

financial interests; it is aimed at all doctors in the EU confronted with a new concept of European healthcare and offers the opportunity to be part of a European network of doctors.

EMA's mission is to be a service association; to create an interactive network; to support doctors who decide to practise in another Member State; to encourage and promote European projects; to collect and distribute information on:

- The medical structure of universities, hospitals, etc.
- Doctor's associations
- Specialist medical centres in Europe
- Healthcare legal aspects
- Medical ethics in the Member States
- Therapeutic protocols
- European medical journals
- Training centres in Europe
- Congresses and scientific meetings

Essentially EMA is a forum that brings together colleagues working in the European medical community which aims at im-

proving information, services, transparency and above all, encouraging collaboration and mobility. It's a privileged meeting place between East and West.

The purpose of the European Medical Association is to optimise European scientific and socio-cultural resources.

EMA's main objectives are ambitious but realistic. These are:

1. To boost knowledge and skills to improve medical practice in Europe
2. To influence health policies in line with practising doctor's priorities.

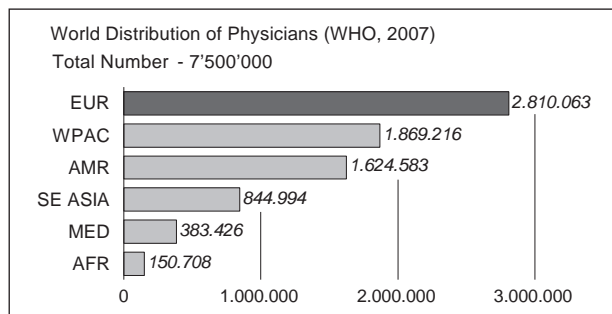
EMA is not a union and does not interfere with actions of existing medical associations or other professional bodies.

Our philosophy is **"Better-informed doctors make better-treated patients"**

EMA's website (<http://www.emanet.org/>) contains information on its activities, history, legal status, mission, main projects and its governing body (i.e.: *EMA Board of Directors and National Representatives*).

EMA is a forum constantly adapting that seeks to interpret and respond to the needs of European doctors and that aims at helping the creation of a European Health Service which is the real challenge for the future.

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European Medical Association on Smoking or Health (EMASH)

What is EMASH?

The European Medical Association on Smoking or Health was founded in 1988 in the premises of the French Medical Association in Paris under the leadership of Prof. Paul Fréour. It is registered at the Prefecture of Gironde, in Bordeaux. It is quoted in the Yearbook of International Organizations 2011 (www.uia.org, item 10009). Cost-free membership is open to physicians, biomedical scientists, pharmacists, nurses and other health professionals mainly from European countries, although health professionals from non-European countries are welcome as associate members. It publishes a quarterly newsletter which is emailed to all its members. The newsletter can also be found in www.hon.ch/emash/.

The aims of EMASH include:

- no-smoking among health professionals;
- no-smoking policies in health associations, hospitals and health centres;
- involvement of health professionals in counselling smokers wishing to quit the addiction;
- pre- and post-graduate education of medical students and physicians in smoking control and cessation.

EMASH and WHO

- As a special chapter of the International Hospital Federation, an NGO in official relations with WHO, EMASH is also in working relations with WHO. It fully supports the WHO Framework Convention on Tobacco Control (FCTC).

International contacts and the EMASH Collaborating Centres

Besides WHO, EMASH maintains contacts with individual experts as well as with international and national health bodies which are active in smoking cessation, prevention and control, including the World Health Organization (WHO), the International Union Against Tuberculosis and Lung Disease (IUATLD), the International Union Against Cancer (UICC), the International Non-governmental Coalition Against Tobacco (INGCAT), the Society for Research on Nicotine and Tobacco (SRNT), the European Network for Smoking Prevention (ENSP), the International Hospital Federation (IHF) and the International Network Towards Smoke-free Hospitals.

Of specific value are the two EMASH Scientific Collaborating Centres: the EMASH/Portugal section at the Medical School, Coimbra, Portugal, and the Institute of Social Medicine, University of Vienna and its subsidiary, the Vienna Nicotine Institute. Besides being present in numerous congresses, EMASH has held so far six international seminars, namely:

1. Health Professionals and Smokers, Royaumont Abbey (Paris), 21-23 November 1990;
2. Smoking and Health, Zandvoort (Amsterdam), 22-24 November 1991;
3. Economic Issues of Smoking and Smoking Cessation, Bari (Italy), 22-24 October 1992;
4. The Role of Health Professional Organisations in Anti-smoking Activities, Sitges (Barcelona), 18-20 November 1993;
5. Guidelines on smoking cessation for general practitioners and other health professionals, Helsingborg (Sweden), 29 Aug.-1 Sept. 1996;

6. Social and economic aspects of reduction of tobacco smoking by use of alternative nicotine delivery system (in collaboration with the UN and the ICAA), United Nations, Geneva, 22-24 September 1997;
7. Consensus seminar on the role of physicians in smoking cessation, risk reduction, and nicotine replacement therapy: the WHY, the WHAT, the HOW. Athens, 5-7 March 1998;
8. Smoking and smoking cessation – IUATLD Congress, Budapest, 12 April 2000.
9. Since 2001, the yearly EMASH/Portugal seminar on Smoking or Health, which is held in October at the medical school in Coimbra, Portugal.

EMASH has also received grants from the EU to carry out international projects: 1) the production of Guidelines on Smoking Cessation for Health Professionals and, 2) Health Professions in Public Education against Smoking.

Need of the future: treatment of tobacco dependence and smoking cessation

WHO's International Classification of Diseases, in its 10th edition, classifies the use of tobacco (F17.2 and 17.3) among the mental and behavioural disorders due to psychoactive substance use (F10-F19) together with alcohol, cocaine, opioids and similar drugs. Although the preventive approaches are essential and must proceed, consideration should be given to medical treatment of smoking which includes therapy and assistance to smokers in giving up the addiction.

EMASH on the WEB

The Health On the Net Foundation, an NGO from the Geneva Cantonal Hospital is hosting the present EMASH website, at: <http://www.hon.ch/emash/>.

Southeast European Medical Forum



Andrey Kehayov

The Southeast European Medical Forum (SEEMF) was founded in 2005 by medical organizations of Albania, Bulgaria, Greece, and Macedonia as a society of organizations of physicians from Southeast European countries – neighboring countries with similar problems. It was later joined by the medical associations of Slovenia, Bosnia and Herzegovina, and Ukraine, and the Serbian Medical Chamber. SEEMF is a legal non-profit entity. It has adopted its Statutes and is registered under Bulgarian legislation. This year, four new applications for membership were received and at a Board Meeting held in September the Forum welcomed its new members: the Georgian Medical Association, the Medical Association of Kazakhstan, the Belarusian Medical Association and the European Medical Students Association.

Its main purpose is to promote the partnership of the medical profession in the SEEMF region, to discuss common problems and to find solutions; to enable exchange of experience, strengthen the relations and elaborate common approaches in all fields of activity of the medical organizations; to develop continuous medical



Jovan Tofoski

education through medical congresses and other forms of mutual activity; to assist its members for improvement of their medical and management-related qualification; to establish contacts and partnership with other international organizations.

The SEEMF has so far held 8 Board meetings and as of 2010 it held the first international Multidisciplinary Medical congress which is intended to provide CME and to update the participants on the latest achievements of the medical science and practice in fields related to high morbidity medical conditions. The first such congress was convened in Bulgaria in September 2010. It focused on different specialized topics as well as on Patient Safety and Health Issues and Health Policies under Conditions of Economic Crisis. The Congress received European accreditation. More than 500 participants from 14 countries attended the event and presentations were made by outstanding physicians from the region, including from Turkey and Germany.

The 2nd International Medical Congress of SEEMF was held in September, 7–11,

2011, Nessebar (Bulgaria) with participation of more than 600 participants from 12 countries and prominent representatives of WMA/WHO.

It was accredited by the European Accreditation Council for Continuing Medical Education (EACCME) and the European Board for Accreditation in Cardiology (EBAC) for 18 hours of External CME credits.

The main Congress topics were four:

- Diabetes and Complications
- Cardiovascular Diseases
- Infectious Diseases
- Oncologic Diseases

The need of such training results from the fact that cardiovascular diseases, diabetes, oncologic diseases, chronic diseases are widespread all over the world and they represent major health issues for the region of Southeast Europe from which region were substantial part of the participants. Cardiovascular diseases cause 2/3 of the overall mortality in the region, another 14% is due to oncologic diseases. About 10% of the population suffers from diabetes and its complications. Another major issue is the treatment of chronic noninfectious diseases which consumes considerable resources. It is necessary that all physicians are aware of the latest concepts of prevention, treatment and early detection methods which could help improve such indicators. The event was intended for a wide range of participants – from general practitioners to senior hospital physicians and managers.

The exceptionally high interest in the Round Table held during the First Congress and the spontaneous vivid discussion it evoked obliged the organizers to allocate some time to similar topics this year as well. The topic of this year's Round Table, namely **Health Reforms and Funding**, opened a broad field for discussion and exchange of experience between the organizations from the region. The list of speakers grew very

long – everybody wanted to share his or her views and/or experience. The participants adopted a declaration which is enclosed.

Two other events that took place during the Congress are worth mentioning. On the last day, before the Round Table discussion a book was presented providing information about all Bulgarian physicians who have dedicated their lives both to the medical profession and to different public functions.

This year SEEMF for the first time awarded eminent physicians. Two persons obtained the award of Outstanding Physician of Southeastern Europe. These were the well-known Bulgarian cardiothoracic surgeon, Prof. Gencho Nachev, and the SEEMF Vice President, Prof. Jovan Tofoski. Dr. Oleg Musii, president of the Ukrainian Medical

Association, was awarded for his contribution in the field of healthcare management and policy, Dr. Stylianos Antypas of the Panhellenic Medical Association received award for his efforts directed to healthcare improvement in Southeastern Europe, Dr. Vladimir Lazarevik received award for his contribution to the development of SEEMF. A special award was presented to the WMA President, Dr. Wonchat Subhachaturas, in recognition of his distinguished contribution to the development of international medical collaboration.

A general conclusion was that the Congress was much more than just professional event, SEEMF became also a cultural phenomenon through which was discovered that we have to take now every advantage to live and communicate in a world without political



boundaries. The SEEMF Board is making all efforts in a spirit of peace, friendship and collaboration continuously to strengthen the Forum and moreover to maintain it as reputable partner to other European and international associations.

*Dr. Andrey Kebayov
Prof. Dr. Jovan Tofoski
E-mail: bulgmed@gmail.com*

Declaration of the Second International Medical Congress of the Southeast European Medical Forum

Nesebar, 7–10 September 2011

We, the participants in the Second International Medical congress of the Southeast European Medical Forum, namely physicians from Albania, Belarus, Bulgaria, Greece, Kazakhstan, Latvia, Macedonia, Romania, Republic of Srpska – Bosnia and Herzegovina, Serbia, Ukraine, in the presence of representatives of the World Health Organization (WHO) and the President of the World Medical Association (WMA), abiding by the basic principles and responsibilities of the WHO and WMA, as well as by the priorities and goals of the unique European Strategy 2020:

1. Shall initiate joint collaboration for promotion of health and welfare of the citizens from the whole region;
2. Shall work for providing conditions for better quality of life and higher life expectancy for the people in the region;
3. Shall work for improvement of the healthcare management by providing expertise, analyses and particular problem solutions with the ambition for real involvement in the health policy of the respective countries;
4. Shall contribute to making health a priority for the whole society, the authorities, non-governmental sector, citizens, private companies, academic community and all other stakeholders.

Governments together with healthcare professionals have to reconsider correlations between economics and healthcare policies.

Medical organizations should safeguard the interests of all physicians, should be self-governing bodies and quality guarantor, and should represent and work for the benefit of the profession.

The issue of healthcare funding in the region is very grave, as was indicated by the participants in the Congress, but each country should try to find solutions according to the specific local situation. What is necessary is adequate and equitably distributed healthcare budget, strong decisions on the reforms to be carried out, prioritising on investments in human capital, improvement of its productivity and better use.

It is high time that the Health Ministries and all other ministries place health issues among the priorities of the politicians and society. A basic principle of a democratic and socially responsible state should be the responsibility for health and the access to healthcare for all citizens, irrespectively of their ability to pay for medical care.

Nesebar, September 2011

HOPE, the European Hospital and Healthcare Federation



Pascal Garel

Life and governance of the Federation

HOPE, the European Hospital and Healthcare Federation, is a European non-profit organisation, created in 1966. HOPE represents national public and private hospital associations and hospital owners, either federations of local and regional authorities or national health services. Today, HOPE is made up of 32 organisations coming from 26 Member States of the European Union (EU), plus Switzerland, covering around 80% of the hospital landscape. HOPE's mission is to promote improvements in the health of citizens throughout Europe, and high standards of hospital care, and to foster efficiency with humanity in the organization and operation of hospital and healthcare services.

HOPE is organised around a Board of Governors, a President's Committee, Liaison Officers, a network of national coordinators of the HOPE exchange programme, and a Central office based in Brussels. The Board of Governors consists of the President and of Governors, one from each EU member

state. It is the forum for all major policy decisions. George Baum, chief executive of the German Hospital Federation was recently elected President, while Sara Pupato, head of the National Inter-regional Agency, was selected Vice President. The President's Committee consists of the President, the Vice-President and three Governors; it oversees implementation and execution of the Board of Governors' decisions, co-ordinates the working parties' work, acts for HOPE, and authorizes legal representation.

Two specific networks are worth mentioning. The network of Liaison Officers was created to improve and professionalize activities. Each Liaison Officer represents his/her organization and is the permanent link between each HOPE member and the central office as well as with other members. Liaison Officers facilitate provide information or facilitate access to information in two main areas: information concerning hospitals and healthcare services in his/her country; and information concerning the position of the represented organization on EU-related issues. This information sharing requires a strong network of contacts and expertise on a wide range of topics.

The network of National coordinators of the HOPE Exchange programme is key to its efficient development. In 1981, pursuant to its objectives, HOPE decided to set up an Exchange Programme for hospital professionals. One of the basic objectives of HOPE is to promote exchange of knowledge and expertise within the European Union and to provide training and experience for hospital and healthcare professionals in this European context. Originally intended for hospital professionals the Exchange Programme is now open to other healthcare professionals and some countries are already hosting partici-

pants in non-hospital healthcare facilities. This Exchange Programme aims to lead to better understanding of the functioning of healthcare and hospital systems within the EU and neighbour countries by facilitating co-operation and exchange of best practices. The HOPE Exchange Programme proposes a 4-week training period intended for managers and other professionals with managerial responsibilities.

Comparative analysis and exchange of best practices

Fostering and facilitating the exchange of information has always been one of the prominent HOPE objectives. In its 45 years of existence, Hope has achieved success in this area in various topics covered through reports, conferences, and seminars. Most recently, HOPE has focused on three main topics: hospital organisation and financing; quality and patient safety; and care in border regions. Members are asked for contributions to activities on some of those issues. For others HOPE joins forces with partners, in particular in consortia of EU financed projects.

On hospital organisation and financing, the most recent element is certainly the growing impact of the financial and economic crisis on healthcare systems in the European Member States. HOPE published a report in April 2011 describing national situations. HOPE also follows several other items. Pharmaceuticals are high on the agenda. In 2009 HOPE joined as a partner the Pharmaceutical Health Information System network. Funded by the European Commission, it aims at increasing knowledge and exchange of information on pharmaceutical policies, in particular on pricing and reimbursement. It puts also a clear focus on the hospital sector, seeking to learn more about pharmaceuticals in hospitals. Another priority topic is personalized medicine and its influence on organization and functioning of hospitals.



HOPE has various activities patient safety. A major development took place in the framework of the EUNetPaS project that concluded in 2010. The main goal of this project, started in 2008 and financed by the European Public Health Programme, was to establish an umbrella network to improve cooperation among Member States in the field of Patient Safety. The results of the project, including the analyses and the recommendations on the implementation of good practices in medication safety, were presented by HOPE during the EUNetPaS final conference in Brussels on 1 July. As a follow up on this, HOPE was invited by the European Commission to take part in a Joint Action on Patient Safety and Quality of Care. On the basis of its the involvement in the MarQuis research project, HOPE started in 2010 its activities on quality strategies with the project consortium DUQuE (Deepening our understanding of quality improvement in Europe), co-funded by the 7th Research Framework Programme.

Care in border regions as well as public health activities are traditional activities in which HOPE devotes time and energy through projects and networks. HOPE is now in the final stage of its EU financed project EUREGIO II, working on cooperation in border regions in the challenging time of the transposition of the Directive on the cross-border care.

Representation and influence

HOPE's representation and advocacy efforts have been of high importance in the recent years in the context of the political changes that occurred at European Union level. The election of a new European Parliament in 2009 and the selection of a new European Commission for President Barroso's second term has indeed had a strong impact on the life of those institutions, in particular within the framework of the 2009 Lisbon treaty. HOPE monitors the European health agenda on a daily basis, building its relationship with institutions and other stakeholders, providing technical advice, and influencing on topics that matter.

There are important developments for healthcare on the European agenda. Several significant decisions have been adopted on cross-border care late payments. HOPE is also involved in other issues such as the Directives of the Pharmaceutical Package and the new initiative "Pilot European Innovation Partnership on Active and Healthy Ageing". HOPE also takes an active part in European debates on patient safety and quality, medical devices, clinical trials, rare diseases, eHealth and healthcare workforce. Those are some of the key issues for which HOPE has had to be vigilant and quick to respond and intervene.

As part of its strategy to increase its visibility, HOPE co-organised and participated in several meetings, seminars and conferences significant at EU level. In line with HOPE activities on patient safety and quality, for example, HOPE participated in the Council of Europe workshop on patient safety organized in Ukraine, going outside of its membership remit. This returned HOPE to the technical assistance realm that was a core of its activities in the 1990s.

Another important HOPE activity is the development of links with the other European associations active in the healthcare field, through exchange of information, joint projects, and joint conferences and seminars. HOPE has regular meetings organized with AIM (payers), AEMH (hospital doctors), BEUC (consumers), CPME (doctors), EFN (nurses), EPF (patients), EUMS (specialist doctors), FEMS (salaried doctors), EAHM (managers), EHMA (managers and academics), EAHP (hospital pharmacists), PGEU (community pharmacists) and UEMO (GPs), as well as with representatives of the industry (EU-COMED, COCIR, CONTINUA). To know more about HOPE: www.hope.be

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Promotion of Public Physicians: a Recent Step Made by the Bangladesh Medical Association (BMA)

In the last few years (before 2009), there were unjustified acts prevailing throughout the country, which stopped routine promotion of public physicians in the respective position. Addressing this issue (including also other ones), the current BMA body received a landslide victory and started to implement their promised acts one by one

and part of this; the current body (led by Prof. Dr. Md. Sharfuddin Ahmed, Secretary General, BMA) initiated a series of communication with different relevant stakeholders including the Government of Bangladesh to reestablish the withheld promotion for all posts in health through the Departmental Promotion Committee (DPC).

The idea was to promote most (around 80%) of professors, associate professors, assistant professors and specialized doctors through a quick inbuilt alternative promotion system, the DPC, and the rest (nearly 20%) through a routine bureaucratic, lengthy process, the Public Service Commission (PSC), which will certainly provide a lot of encouragement to public physicians. This policy was finally approved by the country's powerful inter-ministerial body. The process activities were observed in terms of providing a selection grade and senior scale to track out doctors. Though the process of promotion



Sharfuddin Ahmed

has been started, a few obstacles have been observed like cadre and non-cadre demarcation, very few departmental posts, the country's administrative bureaucracy, etc.

But these have also been resolved through combined effort from the current BMA body discussion along with the respective ministries and professional societies. The highest commitment to activate the physician's quick promotion system came from the country's Honorable Prime Minister Sheikh Hasina with her address to the recent (19th) Bangladesh Medical Conference held in Dhaka, Bangladesh. Her Excellency's commitment also makes the situation easy to achieve other goals, many of which are in the process of completion, like:

1. Quick ad hoc recruitment of 3,551 doctors and arrangement of study leaves for them.
2. Under a special consideration, eight DPCs and the Superior Selection Board (SSB) have been organized, which have promoted and posted one director general of health, five directors, 119 deputy directors, 189 assistant directors/civil surgeons, 100 senior consultants in dif-

ferent disciplines and also awarded a selection grade to 961 doctors.

3. 1,000 assistant professor posts have been created and assignment has also been completed.
4. The Bangladesh Medical and Dental Council Act has been passed by the National Assembly of Bangladesh.
5. Intern doctors' stipend has been increased from 6,500 BDT to 10,000 BDT.

The Bangladesh Medical Association is committed to extend its continuous support to all unfinished or pending decisions about the physician promotion, education and skill development program and to bring the rural and poor population under national health coverage throughout the country.

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Mozambican Medical Association

The Mozambican Medical Association was created on the 28th of March 1992 and has the following objectives:

- Defend the legitimate interests of their associates;
- Defend and promote the health care of the population by having an active position in all aspects that affect or are beyond affecting the health of the population;
- Promote and defend the medical profession concerning the medical education, the working conditions, professional progress, social security and working relationship;
- Promote and defend Professional Ethics and Deontology;
- Promote the continuous medical training to all their members.

The first constituent members were 94 and the actual number is nearly 800 between members and associates. In a country with a population of more or less than 22,416,881 inhabitants (INE, 2010) and covered by

1042 physicians (MISAU; DNPC; DRH-SIP, 2010) between national and expat (specialists that are working in special assignments with the government), it is a defy for the health professionals, especially for the physicians that have a reasoning of 1 doctor per 21,500 inhabitants to assist all the population in this young country (Mozambican independence was gained on the 25th of June 1975).

The age pyramid is one with a large base, with a gross mortality rate of 13.5/1000 (INE, 2007), infant mortality rate of 93.6/1000 (INE, 2007) and life expectancy of 50 years.

The main causes of mortality are still the infectious diseases, such as malaria, diarrhea and pulmonary infections. The HIV/AIDS infection only came to aggravate the described situation and, although it has reduced (it was 16% in adults between 15 and



Rosel Salomão

49 years), it prevails at a rate of 11.5% in adults from 15 to 49 years (INSIDA, 2009). In a brief way, I've tried to present the country's health situation where, in some districts, there is only one physician, usually a general practitioner that has to assist the population 24 hours a day, every week and all year.

World Medical Journal



With this, the AMM is trying to put into practice the continuous medical education in the local working place, allowing the practitioners that are far from the main Health Unit in his/her province but with internet access to review and be aware of the new practices.

As, on the one hand, the Mozambican Medical Association was created to defend the interests of their associates and, on the other hand, is directed at defending the

population's health and care, it chose the theme "Medical Ethics and Deontology" as slogan for the year 2011, to create an open debate where it is expected that the Medical Ethics and Deontology Code approved this year, is known by all physicians and the civil society.

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President,*

Mozambican Medical Association

Icelandic Medical Association



Jonsdottir Birna

The population of Iceland is a little above 300,000 and the total number of physicians is around 1000. The vast majority of them work directly for the national health care system receiving salary by collective bargaining agreement between the Icelandic Medical Association (IcMA) and the Icelandic Ministry of Finance. The global recession hit Iceland very badly in 2008 and the government had to put up a huge amount of money to guarantee personal individual bank credits in the Icelandic bank system that mostly collapsed and would otherwise have gone bankrupt. This has profoundly affected the health care system in Iceland because the government had to borrow the money abroad and

the Icelandic currency krona became worth ½ of its former value. Doctors' salaries have been cut, for very many of them their personal debt, i.e. house mortgage loans, etc., has grossly risen. This situation has led to worse recruitment of young doctors from specialist training that they traditionally do abroad. We used to have 30% of Icelandic doctors working and doing training abroad, but now the percentage has risen to almost 40%. The IcMA has great concerns about this serious situation, and regardless of how we try to wake up the responsible politicians no plans are made and the current round of negotiations is moving very slowly.

The IcMA is both a trade union and a professional society of all doctors in Iceland. We have, as subgroups of different regional societies, different age groups, and especially a very active society of elderly doctors, who regularly meet in our local in Hlidasmari over the winter and organize several travels both in Iceland and overseas every year. Being only a little over 1000, we all more or less know or know of each other.

Iceland has for long been known as the land of ice and fire. Being a not so small volcanic island in the North Atlantic Ocean, it rose to previously unknown infamous fame when the volcano Eyjafjallajökull burst out last year and created an enormous ash cloud that interfered with flight traffic for many weeks in a large

part of Europe. This volcanic outburst has as a spin-off given us more tourists than we have ever had and currently is helping the economy. Economic recovery is the most important factor we have to rely on, or our health care system will be seriously damaged. The IcMA has monitored the medical work force since 2008 and doctors are now almost 15% fewer than were estimated by a long term statistic prognosis worked out in collaboration with our Nordic sister organizations. Icelandic medical doctors have good compliance and most of them who move out of the country get jobs as doctors. Those staying at home load on more work, long hours and postpone retirement. That decision came easily for many since the pension funds greatly suffered in the recession. How this will affect the long term health of Icelanders is yet to be seen – hopefully the recovery will be fast, but the IcMA has taken the standpoint that it is still a wonderful profession we have and one of the major advantages is you can have a choice of many countries to work in when properly trained as a doctor.

The volcano in southern Ilacier sends ash into the air just prior to sunset ON Friday, April 16, 2010. Thick drifts of volcanic ash blanketed parts of rural Iceland on Friday as a vast, invisible plume of grit drifted over Europe, emptying the skies of planes and sending hundreds of thousands in search of hotel rooms, train tickets or rental cars.

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News from the Standing Committee of European Doctors (CPME)

Introduction

At its board meeting in April 2011, the CPME (Standing Committee of European Doctors) adopted a number of policies which demonstrate the variety of health policy of interest to the European Medical Profession.

Furthermore, the current revision of the Professional Qualifications Directive, the Commission's work on a European Professional Card and last but not least, the review of the European Working Time Directive are high on the European doctors' agenda and the CPME is busy consulting its members for the best way forward at European level.

Outcome of the CPME board meeting in April 2011

European Innovation Partnership on Active and Healthy Ageing

At the EU Council meeting on 4 February 2011, Commissioner Máire Geoghegan-Quinn stated:

"I am particularly pleased that EU leaders gave the green light for the launch of the first European Innovation Partnership. This will be on the theme of active and healthy ageing, and will aim to give the average European two more years of good health. As well as having enormous benefits for older people and their families, this would contribute to relieving the strain on public finances".

In a very short time, the European Commission kick-started the European Innovation Partnership on Active and Healthy

Ageing which involves three different Directorates-General: DG Health and Consumer, DG Information Society and DG Research. This multi-disciplinary approach is very much appreciated by the CPME which in the past has stressed the need for a holistic approach to health policies.

The Commission, Member States and a number of selected stakeholders (among which there is the CPME) have formed a Steering Group which sets out the strategy to achieve the overall goal, namely to *give the average European two more years of good health*.

The CPME participates very actively in the work as member of the Steering Group through its president, Dr Konstanty Radziwill, but already at its board meeting the CPME adopted a Statement *CPME 2011/066 FINAL*. In its statement, the CPME defines the main principles to be considered in order to make this partnership successful: while the CPME stresses the important role of eHealth in contributing innovative solutions to long-term chronic care, other more basic issues need to be addressed for the initiative to make a measurable impact. These issues include the changes needed for the healthcare workforce and roles, better integration of social and medical care, improved flows of information across boundaries between primary, secondary and social care, reducing multiple prescribing (polypharmacy) and improving patient involvement through enhanced communication and information, just to mention a few.

The CPME will remain an active partner in this worthy undertaking and looks forward to achieving the goal together with the other stakeholders.

Health inequalities

As mentioned above, the CPME recognises the need for a holistic approach to health policy and its latest policy on health inequalities. *CPME 2011/019 FINAL* analyses three major reasons for caring about health inequalities. The first is that avoidable health inequalities are simply and many would say immorally unfair. The second is that avoidable health inequalities often infringe an internationally acknowledged human right to health. The third is that health inequalities are economically costly – societies with smaller health disparities do better in economic terms than societies with wider health inequalities.

The statement proposes concrete actions which the CPME and its members can undertake to contribute to the fight against health inequalities.

The CPME also referred to the six policy recommendations for reducing health inequalities recently made in Sir Michael Marmot's UK report on health inequalities¹.

These are:

1. *"Give every child the best start in life: increase the proportion of overall expenditure allocated to the early years and ensure it is focused progressively across the [health inequalities] gradient;*
2. *Enable all children, young people, and adults to maximise their capabilities and have control over their lives: reduce the social gradient in skills and qualifications;*
3. *Create fair employment and good work for all: improve quality of jobs across the social gradient;*
4. *Ensure a healthy standard of living for all: reduce the social gradient through progressive taxation and other fiscal policies;*

¹ Marmot M. Strategic review of health inequalities in England post 2010. Marmot review final report. University College London. www.ucl.ac.uk/ghg/marmotreview/Documents

5. *Create and develop healthy and sustainable places and communities;*
6. *Strengthen the role and effect of the prevention of ill health: prioritise investment across government to reduce the social gradient."*

An interesting report on health equalities in the different Member States of the CPME membership will be soon published on the CPME web-site (www.cpme.eu).

Task shifting

In its position paper on task shifting **CPME 2010/128 FINAL**, the CPME makes reference to the WMA resolution of October 2008 and raises its particular concern about the fact that task shifting is often initiated by health authorities, without consulting with physicians and their professional representative associations. The CPME emphasises that patient safety, quality and continuity of care should be the underlying objective of organisation and reforms of healthcare. Therefore, task shifting, if decided by health authorities, should only be through consultation and in accordance with the medical profession and not solely as a cost saving measure.

Revision of the Clinical Trials Directive

The CPME contributed to the Commission's consultation on the revision of the Clinical Trials Directive 2001/20/EC (please see *CPME 2011/037 REV2 FINAL*) and stressed the need to preserve ethical principles in particular with regard to vulnerable persons.

Climate Change

Through its immediate past president, Dr Michael Wilks, the CPME is involved in the United Nations Climate Change

Conference and sought together with the WMA and WHO to make a change at the last conference in Cancun. However, what was almost universally apparent was that little is understood about the beneficial effects on health brought about by greenhouse gas reduction. In addition to the work on the global agenda, the CPME has joined the EU's recently established Green Infrastructure working party. This initiative has been created out of concern for the effect climate change will have on biodiversity. The uncertain effects on infectious disease transmission and prevalence is just one example of a damaging biodiversity impact, but CPME's membership has been additionally welcomed because of its interest in co-benefits, and therefore expertise in emphasising within new Commission work a "health in all" approach to all the EU's climate change work.

For more information on the CPME policy on climate change and environmental health, please see **CPME 2011/059 FINAL**.

Current items high on the political agenda for European Doctors

Currently ongoing work of the CPME very much focuses on two potential revisions of directives of high relevance for the medical profession in Europe: the European Working Time Directive (2003/88/EC) and the Professional Qualifications Directive (2005/36/EC).

The future potential revision of the European Working Time Directive is an issue followed with high interest by the CPME and its members. The CPME together with AEMH, FEMS and EANA responded to 2nd phase social dialogue consultation (*CPME 2011/014 FINAL EMO*). The response recalled the objective of the Working Time Directive which is protecting the

health and safety of workers. If the WTD – as suggested by the Commission – is reviewed solely in the areas of on-call time and compensatory rest, the level of protection (both doctors and their patients) will decrease. Therefore, it is urged that the opt-out clause is to be removed, on-call time is working time as stipulated by the European Court of Justice and compensatory rest has to be granted immediately following longer working periods as also stipulated by the European jurisprudence. The CPME will closely follow the political developments in order to defend the interest of the European medical profession.

The CPME is currently finalising its response to the Green Paper of the European Commission on the revision of the Professional Qualifications Directive. As in its earlier response to the Commission's consultation (<http://cpme.dyndns.org:591/database/2011/cpme.2011-015.CPME.response.PQD.consultation.Final.pdf>), the CPME pointed out that Directive 2005/36/EC has made the migration of physicians in Europe substantially easier. Access to professional employment in other Member States of the European Union has been made considerably simpler by the minimum training requirements set out in Article 24 of the Directive. The medical profession provides a prime example of the advantages of automatic recognition with regard to (specialty) designations and the minimum period of specialty training. This needs to be maintained and enforced provided that specialty designations and the duration, content and quality of specialty training are guaranteed.

In the context of the revision of the Professional Qualifications Directive, the European Commission also develops case studies and pilot projects for the professions under the directive. The CPME is rapporteur in the Commission's steering sub-group for doctors and firmly maintains that any attempts to speed-up and simplify the recognition procedure through a professional card and electronic communication tools

must ensure patient safety and not compromise the existing recognition and registration procedures and the necessary public safeguards.

Giving the high relevance of the Professional Qualifications Directive, the CPME will hold a pre-conference on the subject

in Warsaw ahead of its board meeting and General Assembly on 26 November 2011. The conference will take place on 25 November and will gather the European Medical profession, representatives from the European Commission, the European Parliament and the Polish EU Presidency. More information is to be found on the

CPME web-site: www.cpme.eu; also, please do not hesitate to contact Birgit Beger (birgit.beger@cpme.eu).

*Dr. Konstany Radziwill, CPME President
Birgit Beger, CPME Secretary General*

Social Disparities in Health and the Physician's Role: A Call for Clarifying the Professional Ethical Code



Berit Bringedal

In this article, the authors address the ethics of providing individual healthcare fairly in populations with a social gradient in the distribution of health. They expose a tension within the ethical recommendations of the World Medical Association (WMA): The Physician's Oath in the Declaration of Geneva states that socioeconomic factors should never come between the patient and the physician, while the WMA Statement on Inequality in Health emphasizes that the physician should contribute to a reduction in the unacceptable social inequality in health – an inequality that clearly correlates with social and economic factors. Empirical research indicates that this tension is not of



Kristine Bærøe

theoretical interest only; it may have practical implications as well, in terms of a risk of reproducing and/or enhancing health inequalities in clinical practice. Empirical studies confirm that healthcare to some extent favors the advantaged. This gives no reason to assume the recommendation in the Oath is violated as such. However, the Oath's recommendation of not taking non-medical factors into account can explain an inaccurate understanding and awareness of the fair role of social and cultural factors in patient treatment. By clarifying the positive role of socioeconomic and cultural factors in healthcare and stating this explicitly in physicians' ethical guidelines, these factors may



Eli Feiring

warrant attention both through medical education and in clinical practice. The authors conclude by suggesting a reformulation of the Physician's Oath that may guide more effective and fair care of the disadvantaged and help reduce health inequities produced at the point of care.

Introduction

The World Medical Association (WMA) International Code of Medical Ethics states that "(A) physician shall not allow his/her judgments to be influenced by personal profit or unfair discrimination". At the same

time a social gradient in the distribution of health and disease is well documented; there are dramatic differences in health between the socially advantaged and disadvantaged between and within any country [1]. Should physicians take this fact into account in their clinical practice and act affirmatively to correct socioeconomic biases? Would this be possible whilst preserving the ethos of avoiding unfair discrimination in their professional work?

WMA ethical recommendations: A tension

Avoidance of unfair discrimination is stated in the Physician's Oath in the WMA Declaration of Geneva as: "I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient". Adopted just three months before the UN Declaration of Human Rights, the Oath acknowledges the equal worth of every human being; every individual is morally entitled to equal concern. The Oath does not, however, establish any broader concern for social justice.

At the same time, the WMA recognizes the challenges that social disparities in health poses to the health care system. In 2009, the association adopted a Statement on Inequalities in Health (quoted in Box 1). Although the major causes of health inequalities lie outside health care, the WMA insisted that within the health care system physicians play a major role in health promotion and disease prevention, and states their responsibility "(t)o identify, treat and reduce existing health inequality". The recommended list of physicians' responsibilities includes identification of social and financial factors that impact on inequality, advocating for equal access to health care, and promotion of research and education on social inequality.

The Physician's Oath and the Statement on Inequalities in Health can be seen to pull in

opposite directions. On the one hand, the physician should not let social and economic factors influence clinical judgments. On the other hand, the physician should contribute to a reduction in the unacceptable social inequality in health – an inequality that clearly correlates with social and economic factors.

Empirical support for clarifying the ethical regulation of professional practice

Whether the different regulations are inconsistent depends on their practical interpretations and implications. Some empirical evidence indicates a need for clarification of how 'unfair discrimination' actually should be interpreted in practice. A recent survey of a representative sample of Norwegian physicians found that 55% agreed that physicians *should* contribute to reducing social health inequalities in the population by supplying extra help to patients of low socioeconomic status [2]. On the other hand, most of the responding physicians reported 'never' or 'rarely' to take social factors into account in their clinical practice.

The need for clarification is also supported by other empirical findings. Several studies find that physicians, as everyone else, are subject to unacknowledged influence from social and cultural factors. Such influence can e.g. be observed when physician and patient are similar in socio-cultural aspects, which makes it easier for the physician to judge the patient's situation and needs [3]. Other studies show that patients with higher socioeconomic status have better access to specialized care [4].

To explicitly ignore information about the patient's socioeconomic status in clinical decision making as expressed in the Oath, may lead to an unjustified unawareness of the interplay between socioeconomic factors and access to healthcare. Conse-

quently, physicians may end up enhancing health disparities rather than reducing them because of a lack of attention to the ways socioeconomic factors work in favor of the socioeconomically advantaged on one side and against the disadvantaged on the other.

A reasonable way to take non- medical factors into account

Hence, the open question is how the relevant non-medical factors should be taken into account at the point of individual care. The need to underscore the importance of avoiding irrelevant and/or unfair factors in healthcare decisions is clear. The risk of an unacceptable influence on healthcare decision making from strong economic and/or social interests is always present; as is the risk that prejudice or political belief leads to discrimination – unconsciously or not. Therefore, ordinary medical fairness is commonly interpreted as to allow no other concerns than medical need to influence the decision [5].

That medical need should be the only criterion for priority to care is, however, not as straightforward as it may look at first sight. The reason for this is the close interplay between socioeconomic status and medical need. Any physician will know that patients differ in their ability to utilize the same medical regimen; some patients need more information than others, some need more follow up in order to comply, some need financial support, etc. The differences in ability to benefit from treatment are not only due to medical factors, but are also closely connected to factors in the social and cultural settings of the individual. A reasonable interpretation of what it means to treat patients as moral equals by giving them equal concern is that every patient should have the same opportunity to benefit from treatment. Consequently, a medical need for healthcare must be understood according to the patient's individual biologi-

Inequalities in health: WMA recommendations

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009

The members of the medical profession ... have a major responsibility and call on their national medical associations to:

- Recognize the importance of health inequality and the need to influence national policy and action for its prevention and reduction.
- Identify the social and cultural risk factors to which patients and families are exposed and to plan clinical activities (diagnostic and treatment) to counter their consequences.
- Advocate for the abolishment of financial barriers to obtaining needed medical care.
- Advocate for equal access for all to health care services irrespective of geographic, social, gender, religious, ethnic and economic differences or sexual orientation.
- Require the inclusion of health inequality studies (including the scope, severity, causes, health, economic and social implications) as well as the provision of cultural competence tools, at all levels of academic medical training, including further training for those already in clinical practice.

cal potential *in combination with identification of what it takes to overcome the patient's potential socioeconomic and cultural barriers to benefit.*

Reducing social disparities by fair discrimination

Although it can be argued that factors that influence a patient's ability to benefit from treatment is part of what normally constitutes the concept 'medical need', there is indeed empirically supported reason to be more explicit and clear on this point. Socio-economic and cultural factors are legitimate concerns to consider in individual care in the following sense: When social, cultural, or economic factors are a hindrance to beneficial treatment for the individual, action should be taken to circumvent the obstacles they represent. In this sense, socioeconomic and cultural factors have a role to play in fair discrimination among patients who experience such barriers and those who do not [6].

That the physician should consider socioeconomic and cultural factors as irrelevant

in his/her judgment, or, should not let the judgment be influenced by such factors (as suggested by the Oath), may lead to unjustified ignorance of socioeconomic and cultural factors and increased social disparities in health. Instead, guiding ethical education and physicians' practice by a clarification of how fairness actually may require attention to socioeconomic and cultural factors can help to warrant attention to how socioeconomic factors affect the patient's ability to benefit from treatment. This can, in the next turn, lead to a reduction of unfair disparities.

Conclusion: A call for a reformulation in the Physician's Oath

Based on the reasoning above, we suggest that the Geneva Declaration's negative formulation of the physician's duty to disregard non-medical factors is reformulated to the following positive statement: *All my patients are entitled to equal concern, irrespective of religion, nationality, race, party politics or social standing. I will do my best to*

distribute my time and resources so that my patients have equal opportunities to benefit from treatment despite socioeconomic and cultural barriers. This proposal will dissolve the tension between the recommendations of the Oath and the Statement on Inequalities in Health and, most importantly, it may help to reduce health inequality by improving the effectiveness of healthcare, also for the disadvantaged.

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Patient Non-Adherence and the Patient Rights



Przemyslaw Kardas

Non-adherence – a bird's eye view

Inadequate adherence to medication is a frequent phenomenon in both chronic and acute conditions. Frequently cited WHO report concludes that adherence to long-term therapy for chronic illnesses averages 50% [1]. Indeed, even under conditions of strict healthcare professionals' inspection, which takes place within randomised controlled trials, almost half of the patients who were prescribed an antihypertensive medication have stopped taking the treatment by the end of one year [2]. Surprisingly, the rates of non-adherence with short-term, symptomatic treatments are very similar: when prescribed an antibiotic to cure the infection, up to 40% of patients reveal sub-optimal adherence [3]. Thus, non-adherence to medication seems to be a rule, not the exception.

Medical and economical consequences of non-adherence are profound. Poor execution of medication plan creates a risk to treatment effectiveness. In fact, the poorer the adherence, the poorer the outcome [4]. Thus, poor adherence leads to higher morbidity

and mortality [5]. Considering high rates of non-adherence, this phenomenon stands for one of the major barriers for realising the benefits of evidence-based therapies.

Further consequences of non-adherence include also increased health services utilisation, with hospitalizations at the first place [6]. Finally, this phenomenon is associated with enormous costs. Direct and indirect healthcare costs due to non-adherence were estimated in the USA at the level of \$177 billion in 2000 in total [7].

Recent changes to both economies, and demography brought the problem of poor medication plan execution to the new places in the world. Countries such as China and India struggle now with a tide of chronic conditions, in which effective remedies rely on the daily intake of medication. Solving the problem of poor adherence might be even more urgent need to the healthcare systems of these countries, compared to better prepared, and more wealthy healthcare systems of Western countries.

Concluding this bird's eye view assessment, patient adherence to medication become the global problem of the utmost importance, and the major challenge for the public health.

Patients' right to adhere, or not

No question that the patients are free to choose non-adherence. A portion of this behaviour is unintentional, mostly due to the forgetfulness. However, in the most of cases, non-adherent patients are fully aware of not following the treatment plan. And they have their right to do so.

Changing approach to healthcare professional – patient relationship with regards to adherence is reflected with changing termi-

nology. The term which was predominating scientific publication for approximately four decades was 'compliance'. Unfortunately, over the years it started to evoke negative associations. The concept of 'compliance' was based on one-direction communication, from healthcare professional to patient. In the other words, under this paradigm, patient was only supposed to strictly execute the treatment plan, designed by his or her doctor. There was no place for mutual discussion, and negotiations of the medication scheme. Any deviation from this treatment plan was assumed to be a patient's fault, and was called 'patient non-compliance'.

Over recent years, 'compliance' has been gradually replaced in the medical literature by 'adherence' [8]. This reflects a substantial change from paternalistic perspective of 'compliance' to acceptance of the active role of the patient - in not only the execution, but also a design of medication plan. Just to give a simple example, accepting patient's preferences upfront increases the chances of adherence to the treatment.

Recent findings of the ABC project [9] – European research project developed under 7th Framework Programme - point at even more complex nature of medication-related behaviour. A number of previous studies tried to identify patient profiles associated with either adherence, or non-adherence. Contrary to these attempts, we have found that the same patients might be either adherent, or non-adherent, depending on circumstances. Namely, those strictly following their anti-hypertensive medication are not taking their antibiotics as prescribed in the case of acute infections, and *vice versa* [10]. Therefore, it seems that ALL the patients need some level of support to be adherent, and to obtain the full benefits of prescribed treatments.

This assumption might be perceived as very similar to 'informed choice' concept. Taking right, beneficial decision by the consumer, who is the patient in this case, might only



be expected after providing him or her with well-balanced, objective information, and relevant encouragement. One has to have in mind that nowadays, more and more powerful treatments (eg. anti-cancer, HIV) are being made available in self-administered form. This makes the patients responsible for execution of expensive treatments under ambulatory conditions, without continuous help from healthcare professionals. Not to forget that these treatments are often leading to the adverse effects.

Therefore, it is a need to let all the patients have their right to adhere, as well. However, certain actions are necessary to take to make this happen. Within ABC project, we are aiming to design evidence-based recommendations for European policymakers to increase adherence [8]. We hope that on their grounds, relevant actions would be

taken, to turn the patients' right to adhere into reality.

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One World, one Home, one Heart

The World Heart Federation leads the global fight against heart disease and stroke via a united community of 200 member organizations that brings together the strength of cardiac societies and heart foundations from more than 100 countries. Through our collective efforts, we help people all over the world to lead longer, better, heart-healthy lives.

Every year, 17.1 million lives are claimed by the global burden of cardiovascular disease (CVD), which includes heart disease and stroke, with 82 per cent of deaths occurring in low- and middle-income countries. It is the world's number one killer but a majority of these deaths could be prevented by eating a healthy diet, carrying out regular physical activity and avoiding tobacco.

Global leaders have recognized the urgency to prioritize the prevention and control of CVD with other non-communicable dis-

eases (NCDs), including cancers, chronic respiratory disease and diabetes by holding the first ever United Nations High-Level Summit on NCDs, 10 days before World Heart Day. This year's campaign theme reflects the importance of elevating NCDs up the global health agenda and each individual's responsibility to incorporate heart-healthy behaviours in their home.

With the UN High-Level Meeting on Non-Communicable Diseases (NCDs) taking place in September, World Heart Day presents a great opportunity to communicate messages about the meeting outcomes, and the importance of elevating NCDs up the global health agenda. After two years of focusing on heart health in the workplace, this year we call on individuals to reduce their own and their family's risk of heart disease and stroke. We ask people to take charge of their home's heart health by taking steps such as choosing healthy

food options, increasing physical activity, and saying no to tobacco. As always, our emphasis will be on improving heart health across all nations.

World Heart Day was created by the World Heart Federation in 2000 to inform people around the globe that heart disease and stroke are the world's leading cause of death, claiming 17.1 million lives each year. Together with its members, the World Heart Federation spreads the news that at least 80% of premature deaths from heart disease and stroke could be avoided if the main risk factors, tobacco, unhealthy diet and physical inactivity, are controlled. This year, World Heart Day is taking place on 29 September 2011. National activities organized by members and partners of the World Heart Federation may include public talks and screenings, walks and runs, concerts, sporting events and much more.

*Find out more about the World
Heart Federation
<http://www.worldheart.org/>*

Uruguayan Medical Association (Sindicato Médico del Uruguay)

The Uruguayan Medical Association was founded in 1920. Since its beginnings, the founders decided that the new entity was to be a civil association of free and voluntary entry, a nonprofit organization. Its objectives were the moral and material backup of its members. Improvement of esteem and consideration for the medical profession is also amongst its objectives.

Through the National Medical Conventions, eight of which have been held since 1939, the Uruguayan Medical Association has made important contributions to the continuous study and improvement of health structures in the country. The core of the actual national health system, which the Uruguayan Medical Association supports fiercely, had its origins in the Medical Conventions. The Uruguayan Medical Association not only cares for its members but also is conscious of the role it has within the society and shares with the national health authorities its preoccupation with the health care for all Uruguayan population.

At present, Uruguay has approximately 14,700 active medical doctors. 8,500 of these professionals are members of the Uruguayan Medical Association, and membership is completed with 1,750 medical students, who have representations in all the Association activities.

The organization of the Uruguayan Medical Association is as follows: Assemblies, which convene all members; the Executive Committee formed by 10 members elected by medical doctors and 3 members elected by students; a Referee Council, a Fiscal Committee. There are also 31 advisory committees.

The Uruguayan Medical Association is also member of the CONFEMEL (Medical

Confederation of Latin America and the Caribbean) and also member of the World Medical Association.

Uruguay will host medical doctors from all over the world

The most important meeting of worldwide leading medical doctors will be held at the Radisson Hotel in Montevideo from 12th to 15th October 2011, co-organized by the Uruguayan Medical Association and the World Medical Association.

It is the first time that the Uruguayan Medical Association will host the World Medical Association Assembly, where delegates representing professional organizations from 94 countries will be attending. There have been only two WMA Council meetings (1969 and 1998) held in Uruguay. Only three countries in South America have hosted the WMA Assembly: Brazil, Chile and Venezuela.

The host country

Uruguay (República Oriental del Uruguay as its official name) – is a South American country bordering Brazil in the northeast, Argentina in the west, with coast over the Atlantic Ocean on the southeast and over the River Plate (Rio de la Plata) on the south. With little more than 176,000 sq.kms of land, it has approximately 3,400,000 inhabitants. The capital city, Montevideo, is located in the south of the country, with a natural port on the River Plate, with 1,400,000 inhabitants. Uruguay is member of the United Nations, of the

MERCOSUR (Southern Cone Common Market), the OAS and G77, amongst other international organizations.

Spanish is the native Uruguayan language. This shows the uniform population, its cultural and ethnic profile, characteristics which have helped towards the development of a tolerant and democratic country. More than 95% of the population is literate. The vast majority of young people study a second language, preferably English.

The Uruguayan stability, its profound democratic and cultural tradition, and a high level of safety within its population, makes it a key country in the region.

Traditionally, the Uruguayan economy had depended upon farming produce mostly. At present, the production is being intensified and every day there is an increase in forestry, dairy industry, fishing and agriculture.

Uruguay also plays a fundamental role in the field of services, with great development in the financial and tourism sectors. With outstanding economic indicators for Latin America, the unemployment index is around 5.4%. The national currency is the Uruguayan Peso (\$). Its relation with the US dollar is 20 to a dollar. There is free exchange system in all transactions and financial activities. Buying and selling operations are performed by banks and exchange offices. Many purchases and transactions are also carried out in American Dollars or Euros. The flourishing telecommunications system ensures instant connectivity with anywhere in the world through digital system, internet data transmission and mobile connection systems.

The World Assembly will be held in spring when temperature ranges around 17.5°C.

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“Chips-tax” in Hungary: fiscal measures for public health benefits

The life expectancy at birth in Hungary between 1970 and 2009 has increased from 69,3 years to 74,45 years, the vast majority of which has been achieved in the past 15 years. This seems to be a great success until we compare these figures to the EU-15 (member countries before 2004) which reveals that our lag has increased during this time span from 2,53 years to 6,37 years (WHO HFA database). The main contributors to this are the cardiovascular diseases. In the last decade the underlying lifestyle risk factors were targeted by major, nation-wide public health programs to the tool set of which recently a new element has been added, the so-called “chips-tax”.

The law *No. CIII. of year 2011 on the public health product taxation* entered into force on 1. Sept. 2011. It has three main targets: the sugar, salt and caffeine content with the aim of improving dietary habits and combat obesity. The legislators found important not to burden the disadvantaged groups financially so only convenience foods were included except certain salty spice mixes. Though this is a highly considerable social aspect, on the other hand it might be a weakness of the law: the consumption originated from normal diet itself exceeds the recommended amount of sugar and salt (sodium). It is also controversial that only pre-packaged foods are taxed. The chips-tax skips the problem of energy density or “empty calories” other than refined sugar. Fat content, including the type and special dangers of certain fats (trans fatty acids), though originally was a main element of the law in the planning phase, has been also left out from the scope of this law during its evolution.

The soft drinks are important contributors to the childhood obesity epidemic, so the taxation of the fizzy beverages containing less than 25% fruit and more than 8 grams sugar per decilitre would seem an ideal target; though applying a tax of 5 HUF (1,8 euro cent) per litre the price of which is between 250–400 HUF doesn't seem too strict.

It is questionable whether the temptation and perceived “coolness” of this convenience food group would be stronger or the price sensitivity. In case of energy drinks, the tax is 250 HUF per litre if the caffeine content exceeds 10mg per 100ml.

Sweet snacks are taxed by 100 HUF per kilogram if their sugar content is higher than 25%; in case of chocolates max. 40% of sugar content goes untaxed.

Taxing the savoury snacks is an important addition to the national Stop-salt strategy. The tax on wheat and potato chips and oily seeds will be 200 HUF per kilogram if the salt content is higher than 1%, with the exception of bread and pastry products. The same tax applies to food flavourers if their salt content is higher than 5%.

It is an open question, in lack of available impact surveys, whether the price elevation of savoury snacks would result in a significant decrease in total dietary salt intake resulting a detectable advantage in terms of public health benefits; taking into account that the law doesn't affect the salt intake originated from ordinary, “normal” diet while salt content exceeding the threshold defined by the law occurs in 53, 93 and 97 % of the dairy, processed meat and bakery products according to a recent survey of the National Institute for Food and Nutrition Science. Similarly, a diet survey in Hungarian kindergartens proved a salt intake of 3,5–13,1 grams/day.

Based upon the abovementioned, we regard the „chips-tax” a useful first step but it is important to stress that the end of the road is still far away.

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